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DESCRIBING AN ASSET-BASED INTERVENTION TO EQUIP EDUCATORS WITH HIV&AIDS COPING AND SUPPORT COMPETENCIES

by

VIONA ODENDAAL

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Co-supervisor: Dr. Liesel Ebersöhn

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To my beloved mother

Ma se plek staan verlate en leeg in my hart
ek verlang

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DECLARATION OF AUTHENTICITY

I, Viona Odendaal hereby declare that

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is my own work and that all references appear in the list of references

V Odendaal

Date

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ABSTRACT

DESCRIBING AN ASSET-BASED INTERVENTION TO EQUIP EDUCATORS WITH HIV&AIDS COPING AND SUPPORT COMPETENCIES

by

Viona Odendaal

Supervisor:	Dr. Ronél Ferreira
Co-supervisor:	Dr. Liesel Ebersöhn
Department:	Educational Psychology
Degree:	MEd (Educational Psychology)

The purpose of this study was to explore an asset-based intervention with educators in enhancing their knowledge of HIV&AIDS and their skills in supporting community members in coping with the challenges associated with HIV&AIDS. The goals of the study were firstly to explore and describe the ways in which educators are currently supporting community members infected with and affected by HIV&AIDS (more specifically in terms of coping with the learners in their classrooms and the caregivers or parents of these children). Secondly, the study focused on identifying the areas related to supporting community members in coping with the challenges associated with HIV&AIDS in which the participants (educators) felt that they needed more skills or information. Thirdly, I developed and facilitated an asset-based intervention, in the format of a workshop, with the participants (educators) to address the identified competence limitations. Fourthly, I assessed the outcome of the asset-based intervention in terms of the degree to which it fulfilled the participants' need to be better equipped to support community members infected with and affected by HIV&AIDS.

The primary working assumption with which I approached this study was that educators do possess the necessary competencies to support their communities in coping with the challenges presented by HIV&AIDS. I followed a qualitative research approach and selected a case study research design, applying some participatory action research principles, with the case being an informal settlement community situated in the Eastern Cape. Four participants were selected by means of convenience sampling to participate in face-to-face interviews, upon which four areas of

support in which participants experienced a lack of sufficient competencies could be identified based on analysis. These areas related to **referral of infected individuals**; **coping with infected learners in a classroom** as well as ways in which educators might **support community members on both an emotional and physical level.** These four areas were addressed during an asset-based intervention with ten educators, which I facilitated during a follow-up field visit. During interviews the educators also indicated that they **wanted to support their community (both learners and parents) to cope with the challenges presented by HIV&AIDS** but that **they felt inadequate in supporting the community, despite their efforts.**

After completion of the asset-based intervention, I facilitated a focus group discussion, focusing on whether or not the asset-based intervention had addressed participants' (perceived) lack of competencies in supporting the community to cope within the context of HIV&AIDS. Two sub-themes emerged. Firstly, participating educators reported that they experienced **increased levels of self-confidence in their ability to support** their community in the context of HIV&AIDS, as well as a general feeling of empowerment, as a result of attending the asset-based intervention. The second sub-theme relates to the potential **snowball effect** of the asset-based intervention, whereby participating educators indicated that their role in the community had expanded and that they reportedly could transmit the knowledge obtained during the asset-based intervention sessions to others.

LIST OF KEY WORDS

- Asset-based approach
- Asset-based intervention
- Competencies
- Coping
- Educators
- HIV&AIDS
- Informal settlement communities
- Self-efficacy expectations
- Support

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CHAPTER 1

SETTING THE STAGE

1.1 INTRODUCTION, PURPOSE AND RATIONALE OF THE STUDY

The purpose of this study was to describe an asset-based intervention that was facilitated amongst educators to enhance both their knowledge of HIV&AIDS and their skills in supporting community members to cope with the challenges associated with HIV&AIDS. The goals of the study were firstly to explore and describe the ways in which educators were supporting community members infected with and affected by HIV&AIDS at the onset of my study (more specifically in terms of coping with the learners in their classrooms and the caregivers or parents of these children). Secondly, the study focused on identifying the areas related to supporting community members in coping, in which the participants (educators) felt that they needed more skills or information. Thirdly, I developed and facilitated an asset-based intervention, in the format of a workshop, with the participants (educators) to address the identified competency limitations. Fourthly, I assessed the outcome of the asset-based intervention in terms of the degree to which it fulfilled the participants' need to be better equipped to support community members infected with and affected by HIV&AIDS.

During the initial stages of a study undertaken by Ferreira (2006), it became clear that some educators in the community where she conducted her study did not feel that they possess the necessary skills and knowledge to provide effective support to community members facing the challenges associated with HIV&AIDS (in other words, supporting community members to cope more effectively). This identified need initiated my study. The *Interagency Coalition on AIDS and Development* (ICAD, 2001) advocates that the role of education agencies should change to accommodate HIV&AIDS infected children and that educators ought to become vocal role models to highlight positive lifestyles and open dialogue regarding AIDS in their communities. At the onset of my study, however, it became clear that the educators (participants) did not feel competent regarding the support they provided to community members and children infected with and affected by HIV&AIDS. According to the participants, they required training in this regard.

My interest in undertaking this study stems from conversations with Ferreira and analysis of transcripts made during the initial stages of her study (Ferreira's field work commenced in 2003).

Participants (educators) in her study indicated a distinct need to be informed on basic HIV&AIDS knowledge and competencies, which could enable them to support their community more efficiently. In addition to the potential area of research being voiced by the educators, I became aware of firstly, the vast impact of HIV&AIDS and, secondly, the potential impact that educators might have in supporting their communities in coping with HIV&AIDS, based on literature I came across in this area of interest.

In viewing the vastness of the HIV&AIDS pandemic, I believe that my study could contribute to enhance support structures available to individuals infected with, and affected, by HIV&AIDS. By the end of 2003, the global HIV&AIDS pandemic had caused the death of more than three million people. Of these an estimated 500 000 were children under the age of 15 years. Approximately five million people acquired the HI virus during 2003, of whom 700 000 are reported to be children under the age of 15 years (UNAIDS, 2003). During the same time the estimated number of people living with HIV&AIDS globally was between 34 and 36 million, of whom an estimated 25 to 28.2 million reside in Sub-Saharan Africa (UNAIDS/WHOa, 2004). In South Africa, an estimated five million people were HIV infected by mid 2004, equating to 11% of the population (Statistics South Africa, 2004). UNAIDS statistics reflects a similar picture with an estimated 5.3 million South Africans reportedly living with HIV&AIDS by 2004 (UNAIDS/WHOb, 2004). The number of AIDS related orphans living in South Africa is estimated to be 1.1 million, of whom 250 000 is said to have been newly orphaned during 2004 (Statistics South Africa, 2004; UNAIDS, 2004).

The vast impact of HIV&AIDS requires responses on community level (Gow & Desmond, 2002; Department of Health, 2001). A great need seems to exist to educate community members to create a more positive attitude towards people infected with HIV. This need for change in attitude was also voiced by participants (educators) during the initial phases of the related study by Ferreira (2006) in the community where she (and ultimately I) conducted her (my) study. In this regard educators might be able to model acceptance and support to individuals infected with and affected by HIV&AIDS. Peltzer (2003) elaborates by suggesting that the education of educators regarding the low risk of infection, when they are in casual contact with HIV infected people, might reduce the levels of stigma associated with the HIV&AIDS pandemic, with specific reference to rural communities (Peltzer, 2003).

In reaction to the HIV&AIDS pandemic, the former minister of education, Professor Kader Asmal, issued a National Policy on HIV&AIDS in the National Education Policy Act of 1996, whereby every

school needs to establish a Health Advisory Committee, responsible for the development and implementation of the school's HIV&AIDS plan (Department of Education, 1999). This idea is summarised in the guidelines which accompanied this policy: "*The school has a responsibility to become a centre of information and support on HIV&AIDS in the community it serves"* (Department of Education, 2000:14).

The abovementioned National Policy of 1996 further requires that a continuing HIV&AIDS education programme be implemented in all schools. Such a programme was proposed to be integrated in an age appropriate way, as part of the Life Skills education programme on the various levels (Donald, Lazarus & Lolwana, 2002; Department of Education, 1999). In response, 10 000 educators received training in the Life Skills programme during 1997, aiming to involve two educators in every school in every province. Studies do, however, indicate that educators in some areas (such as rural communities) still only have limited knowledge regarding the HIV&AIDS pandemic, for example, in terms of the transmission thereof (Peltzer, 2003), resulting in the question whether or not the proposed training are indeed reaching all areas and schools in the country. The *Interagency Coalitions on AIDS and Development* (ICAD, 2001) states that HIV&AIDS education efforts have been held back by educators due to their reluctance to deal with sexual issues, cultural resistance and lack of adequate training on HIV&AIDS. A major priority would be to provide better training, information and preparation for educators not only in coping with HIV&AIDS education, but also in coping with the pandemic in their communities on a daily basis.

Apart from supporting communities on a wider scale, educators might fulfil a significant role in supporting children dealing with the trauma of HIV&AIDS. The impact of the pandemic on children is highlighted by statistics, such as the global number of children orphaned by AIDS at the end of 2001, being 14 million (UNAIDS, 2002). Although the estimated number of orphaned children in South Africa varies in the literature, there seems to be consensus that the numbers of AIDS related orphaned children are increasing (Statistics South Africa, 2004; UNAIDS, 2004; Kelly, 2000; Lovelife, 2000). This increase in the number of orphaned children once again emphasises these children's need for care and support.

Apart from other possible sources of support (such as extended family or other community members), educators might be a great source of comfort for children infected with and affected by HIV&AIDS. Extensive literature exists regarding the impact of HIV&AIDS on the quality of education (Kelly, 2000; Lovelife, 2000), educator attitudes and comfort in teaching HIV&AIDS

awareness (Peltzer, 2003; Boscarino & DiClemente, 1996; Burak, 1994), and the need to integrate HIV&AIDS education as part of the curriculum (Bennell, Chilisa, Hyde, Makgothi, Molobe & Mpotokwane, 2001; Kaira, Kohli & Datta, 2000). However, literature regarding potential strategies implemented by educators when faced with children infected with and affected by HIV&AIDS and their parents/caregivers in their schools' communities, is still emerging in nature. In addition, limited literature exists in terms of the training of educators, assisting them not only to cope with their community members' needs but also their own needs, relating to coping and support competencies. As such**, I propose that this study might add to the growing body of knowledge on the role of educators in supporting children and other community members infected with and affected by HIV&AIDS.** Besides the potential theoretical contribution of my study, the study could facilitate action amongst the participants, thereby implying a practical contribution in that they could become role models in supporting the community in coping with the HIV&AIDS pandemic.

Initially my study focused on participants' (educators') competencies, coping and support strategies, the perceptions of their own skills and knowledge in dealing with the challenges associated with HIV&AIDS in their community, and also their expectations in this regard. As part of my study, I then developed and implemented an asset-based intervention with educators to address their perceived lack of skills and knowledge (competencies) to support community members infected with and affected by HIV&AIDS and to cope with learners infected with and affected by HIV&AIDS. The intervention entailed that each participant's (educator's) existing knowledge and skills (competencies) regarding HIV&AIDS related support were identified and mobilised (as they became aware of their competencies) in order to assist them in their support efforts, and in coping with HIV&AIDS in their classrooms and immediate community on a daily basis.

The focus on existing strengths, knowledge and abilities implies an emphasis on the asset-based approach (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996), as the underlying theory of my study. My interest in the asset-based approach stems from my believe that people hold within them (and their environments) the strength and capabilities to solve problem situations. I also believe that the expert who will find the best solution to challenges is the person currently in that problem situation. **As literature on the asset-based approach in terms of HIV&AIDS care and support is still emerging in nature, my study holds the potential value of adding to the existing body of knowledge in this area of research.**

The possible contributions of my study might be useful for:

- educators working in communities infected with and affected by HIV&AIDS;
- parents and caregivers of children infected with and affected by HIV&AIDS;
- community members who are HIV infected; and
- training organisations (such as AIDS training and information centres, tertiary institutions and the Department of Education).

1.2 RESEARCH QUESTIONS

This study was directed by the following primary research question: *How might an asset-based intervention with educators be employed to facilitate feelings of competence with regard to their ability to support community members in coping with HIV&AIDS?*

In order to explore this primary research question the following secondary questions had to be addressed.

- What are participants' (educators') perceptions regarding their existing skills and knowledge (competencies) to support community members in coping with HIV&AIDS?
- How might educators utilise their existing knowledge and skills (competencies) in supporting children infected with and affected by HIV&AIDS, as well as their parents, caregivers or other community members, in dealing with HIV&AIDS related challenges?
- If educators were to take part in an asset-based intervention (workshop) on HIV&AIDS, what kind of information and skill development should to be included?
- To what extent can an asset-based HIV&AIDS intervention with educators meet educators' (participants') expectations with regard to their need to be informed and feel equipped to support others?

1.3 ASSUMPTIONS OF THE STUDY

I approached the study with the following assumptions:

- I believed that role-players, especially educators, possess the skills and strengths to cope with the HIV&AIDS pandemic in the communities where they reside or work.
- I assumed that educators need capacity to cope in the context of HIV&AIDS.

- I assumed that educators are willing and able to identify their own strengths. As such, I assumed that the asset-based approach might be successful to bring about change.
- I assumed that educators are powerful agents who might facilitate change in their communities.
- I assumed that educators would benefit from the facilitation of an asset-based intervention in the form of a workshop, and that the facilitation of awareness amongst educators of their own skills and knowledge (competencies) pertaining to HIV&AIDS, might positively impact on the wider community.
- I assumed that educators would be able to sustain the assets (for example networks and skills) they had mobilised in order to cope with the HIV&AIDS pandemic in their community.

1.4 CLARIFICATION OF KEY CONCEPTS

In order to avoid misconceptions and ensure a clear understanding of the relevant concepts, I now define the key concepts within the context of my study.

1.4.1 Asset-based intervention

The asset-based approach stands in contrast to the needs-based approach. In the needs-based approach, the focus falls on problems, needs, deficiencies and weakness, disregarding the power of individuals and communities, and creating the perception that only external "experts" can solve their problems (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). The asset-based approach, on the other hand, can be regarded as a bottom-up approach, shifting the focus away from a passive waiting for "expert services" and moving towards an enabling perspective. Although every community and individual possesses needs, they also possess abilities and strengths to contribute to their own well-being. However, these contributing aspects need to be mobilised to their full potential in order to empower the individual and community (Ebersöhn & Eloff, 2006).

For the purpose of this study, I planned and facilitated an intervention with ten selected educators (participants). My basic approach was guided by the *asset-based approach,* thereby emphasising participants' existing strengths, skills and knowledge. The assets of the participants, in terms of their current coping skills and knowledge regarding HIV&AIDS were facilitated with the aim of enhancing their sense of competence with regard to supporting their community and learners in

their classrooms, in coping with HIV&AIDS. For the purpose of my study, the intervention I employed took the form of a workshop, as suggested by the HIV&AIDS training manual of the University of Pretoria (Centre for the study of AIDS, 2001). The term workshop describes a process in which people are actively involved in their learning *via* discussions, role play, drawings and planning of action steps. The design of the workshop I selected focused strongly on the expectations of the participants. Due to the format of my intervention, I did not provide *training* in the true sense of the word, although this is the word the educators (participants) used to describe their own perceived need, in order to gain sufficient skills and knowledge (competencies) to support children and community members in coping with the challenges associated with HIV&AIDS.

1.4.2 Equip

The American Heritage Dictionary for the English Language (2000) defines equip as a process whereby one gives someone the skills (and knowledge) they need to perform a particular task. For the purpose of my study, I view the concept equip as the process of enabling participating educators from a Participatory Action Research (PAR) point of view and as raising awareness amongst participants regarding their networks, abilities and recourses to mobilise social action (Ebersöhn & Eloff, 2006; Bhana, 2002). I assume that if the intervention I facilitated with educators was successful, and they experience an elevated sense of being able to support community members, they will in future support community members infected with and affected by HIV&AIDS more effectively, thereby implying social action.

1.4.3 Educators in an informal settlement community

Within the context of this study, educators refer to primary school educators in a selected informal settlement community in the Eastern Cape (Nelson Mandela Metropole). As these educators have since 2003 been involved as participants in a broader ongoing research project (Ferreira, 2006), they continued their involvement by participating in my study.

As Ferreira (2006) states in her study, the term informal settlement communities refers to groups of individuals living in informal settlement areas. Within the South African context, these areas are characterised by limited facilities, for example, running water and electricity, as well as poverty. The specific community selected for the purpose of this study is situated in the Eastern Cape

Province and is characterised by a high incidence of unemployment. Community members residing in this informal settlement areas are also infected with and/or affected by HIV&AIDS. The educators who participated in my study work at a primary school located in this specific informal settlement community.

1.4.4 HIV&AIDS

HIV is the acronym for *Human immuno-deficiency virus*. This virus is spread *via* unprotected sexual intercourse or through direct contact with the blood of a person infected with the HI virus. The HI virus causes AIDS, an acronym for *Acquired immuno-deficiency syndrome*. AIDS is seen as a severe and fatal range of diseases/conditions, such as pneumonia, extrapulmonary tuberculosis and wasting syndrome, where the human body loses its ability to resist infections (Dorrington, Bradshaw, Johnson & Budlender, 2004; Donald *et al*., 2002; Van Dyk, 2001).

For the purpose of this study, *children and parents or caregivers (community members) infected with HIV&AIDS* are regarded as those infected with the Human immuno-deficiency virus (HIV), or who have full-blown Acquired immuno-deficiency syndrome (AIDS). In this study, *children, parents or caregivers affected by HIV&AIDS* are regarded as those individuals indirectly or directly affected by the HIV&AIDS pandemic.

While an increasing number of children are infected with HIV, there are also children affected by the HIV&AIDS pandemic through the loss of educators, caregivers and the health systems in their communities. Although not all AIDS related orphans are infected with the HI virus, they are still affected by it, as the stigma attached to HIV&AIDS may cause extended families (and community members such as neighbours) to be reluctant to accommodate orphans. As a result, such orphans may find themselves not only outside the community, but also outside a family. In this manner both children infected with and affected by HIV&AIDS find themselves in need of care and support due to the nature of the HIV&AIDS pandemic (ICAD, 2001; Loening-Voysey, 2001; Kelly, 2000; Lovelife, 2000; Smart, 2000; UNAIDS, 1999).

1.4.5 Coping with HIV&AIDS

Coping can be described as the process by which an individual attempts to minimise the negative emotional effects which are caused by experiencing adverse events (Lowe & Bennet, 2003).

Keeping a positive affect in the face of adversity is an integral part of the coping process (Egan, 2002). Coping is not a static concept; it is influenced by, and greatly depends on, the individual's social and personal resources as well as the context where the stressor occurs. As individuals experience a variety of stressors in a variety of different situations on a daily basis, coping is continuous and dynamic (Parks in Donnelly, 2002).

Within the context of my study, I adhere to the definition of asset-based coping as formulated by Ferreira (2006). I regard coping as the ability individuals hold to respond to and successfully deal with the challenges they face, by mobilising assets within themselves, other community members and community networks. In this study, the challenges the participants (and community) faced refer to the challenges of coping with HIV&AIDS in the community. Assets that could be mobilised include, for example, skills, knowledge and resources amongst the participants, other community members and the community at large.

Coping from within the framework of my study refers to coping with the challenges associated with support within the context of HIV&AIDS and education. Community members (including learners, caregivers and educators) have to cope with an array of physical, social and psychological challenges, including feelings of uncertainly, shame and guilt. Furthermore, community members have to cope with multiple losses and social stigmatisation (Plattner & Meiring, 2006; A.I.D.S. Training and Information Centre, 2004 [refer to Appendix A]; Save the Children, 2002). Educators do not only need to cope with some of these challenges themselves but are also expected to support their community in coping with the challenges (Marais, 2005; Bennell, 2003; Soul City, 2003; Save the Children, 2002; Department of Education, 2000; Department of Education, 1999).

1.4.6 Support in the context of HIV&AIDS

Support is defined as an act of helping individuals emotionally and/or in a practical way (http://dictionary.cambridge.org). Within the context of informal settlement communities, coping is closely related to accessing social support networks within the community. Therefore, community members infected with and affected by HIV&AIDS rely on social support networks to cope with the challenges associated with HIV&AIDS (Ferreira, 2006; Marais, 2005; Save the Children, 2002; UNAIDS, 2002; UNAIDS, 1999). Consequently, within the framework of my study I view support as social support. Furthermore, I adhere to Thoits' definition of social support in Friedland, Renwick and McColl (1996), , who argues that social support could be reconceptualised as a form of coping

assistance in which significant others are actively participating in individual attempts at stress management.

Within this particular community, support in the context of HIV&AIDS is referred to as displaying acceptance for the person who is infected, providing advice on healthy lifestyles as well as financial assistance and providing food parcels and supplements. Support is also provided by displaying a caring attitude through visiting and counselling community members infected with and affected by HIV&AIDS (Ferreira, 2006).

1.4.7 Competence

Competence is defined as the ability to do something well (The American Heritage Dictionary for the English Language, 2000). For the purpose of my study I view competence as the knowledge and skills which were utilised by participating educators to cope with learners infected with and affected by HIV&AIDS as well as to support community members infected with and affected by HIV&AIDS. Knowledge can be defined as an understanding of or processing information about a subject which has been obtained by experience or study (http://dictionary.cambridge.org), whilst skills can be defined as the ability to perform an activity well, especially since one has practised it (http://dictionary.cambridge.org).

1. 5 PARADIGMATIC PERSPECTIVE

As I aimed to explore and describe educators' feelings, thoughts and ideas, a qualitative approach seemed to be suitable for this study. As a qualitative researcher, I view reality as being socially constructed and emphasise the interactive mode of data collection. I believe that interviews, observations and focus group activities can bring me closer to the perceptions educators hold regarding their ways of coping and perceived lack of sufficient skills and knowledge (competencies), in facing the challenges relating to HIV&AIDS than, for example, questionnaires that are sent *via* post (Mayan, 2001; Denzin & Lincoln, 2000; Berg, 1998).

The epistemological stance of my study is anchored in Interpretivism. I adhere to the belief that the construction of meaning is an interactive phenomenon occurring between people. The fact that Interpretivism highlights the context in which interaction takes place, allowed me the opportunity to interact with participants in their community in an attempt to create shared meaning between

myself and the participants regarding their ability to cope with the challenges of HIV&AIDS (Schwandt, 2002; Denzin & Lincoln, 2000; Mertens, 1998). A more detailed discussion of my selected paradigmatic perspective follows in Chapter 3.

1. 6 RESEARCH METHODOLOGY AND STRATEGIES: A BROAD OVERVIEW

Although my research design and methodology are discussed in detail in Chapter 3, I now briefly outline the methodological choices I made, as this serves as a general introduction to the empirical study I conducted. I selected a case study research design, applying Participatory Action Research principles (Bhana, 2002; McMillan & Schumacher, 2000), with the case being an informal settlement community situated in the Eastern Cape. Both the case and the participants (eight educators at a primary school) were selected by means of *convenience sampling,* as participants were selelcted based on them being easily assessable (Mertens, 1998). The participants (educators) were initially purposefully selected for the broader research study by Ferreira (2006), based on the potential of them possessing rich information, as they encounter community members infected with and affected by HIV&AIDS on a regular basis (Patton, 2002; McMillan & Schumacher, 2000; Merriam, 1998).

As data collection and documentation strategies, I firstly conducted an analysis of transcripts of the related study (Ferreira, 2006), whereby I familiarised myself with the perceived needs of educators with regard to basic HIV&AIDS knowledge and skills (competencies). Analysis of Ferreira's (2006) study also served as rationale for undertaking my study. Secondly, I employed face-to-face interviews (Terre Blanche & Kelly, 2002; Merriam, 1998; Schurink, 1998); an asset-based intervention in the form of a workshop (Ebersöhn & Eloff, 2006; Donald *et al*., 2002; Centre for the Study of AIDS, 2001; Kretzmann & McKnight, 1996); a focus group discussion (McMillan & Schumacher, 2000; Berg, 1998; Schurink, Schurink & Poggenpoel, 1998); and observation-as-context-of-interaction (Mayan, 2001; Angrosino & Mays de Pérez, 2000; Mertens, 1998). I further relied on field notes (Patton, 2002; Terre Blanche & Kelly, 2002; Berg, 1998); visual data (Haper, 2000); and a research journal (Terre Blanche & Kelly, 2002; Poggenpoel, 1998) to document my experiences, observations and reflections.

I thematically analysed and interpreted the raw data, namely the transcripts of the related study (Ferreira, 2006), transcribed face-to-face interviews, the focus group discussion and observations in the form of field notes (Wilkinson, 2004; Terre Blanche & Kelly, 2002; Berg, 1998). My selected

research design and chosen methods enabled me to derive a rich description of the ways in which educators were supporting the community in coping with HIV&AIDS at the onset of my study. I was further able to explore their expectations regarding the facilitation of an HIV&AIDS intervention (workshop) concerning ways of coping with HIV&AIDS related challenges within their classrooms and community, in equipping them with HIV&AIDS coping and support competencies.

1.7 LAYOUT OF THE STUDY

The framework of chapters presented in this dissertation is presented below.

Chapter 1: Setting the stage

In Chapter 1, I presented the introduction and rationale of my study. I stated the purpose of my study, formulated the research questions and set out the assumptions according to which I approached the study. I clarified the key concepts and provided a brief overview of the research design and methodology.

Chapter 2: Literature review

The second chapter focuses on relevant literature with regard to the conceptual framework of my study. Firstly, I discuss the asset-based approach in terms of a theoretical overview, asset-based community development and an asset-based intervention workshop. Secondly, I discuss HIV&AIDS with a focus on the impact and effect of HIV&AIDS on informal settlement communities, education, parents and children. Finally, I provide an overview of coping (with HIV&AIDS) in terms of theoretical aspects of coping, coping within an informal settlement community as well as individual community members' and families' efforts to cope with HIV&AIDS. I conclude the chapter by presenting my conceptual framework.

Chapter 3: Research process

In Chapter 3, I discuss the research process in terms of my selected research design and methodology. My selected methods of data collection, data analysis and interpretation are discussed and justified within the framework of my study. I further explain the manner in which I aimed to enhance the rigour of my study, as well as the ethical principles I adhered to.

Chapter 4: Research results and findings

In Chapter 4 I present and discuss the results of my study. After presenting the results I discuss them against the backdrop of relevant literature, with the aim of identifying correlations and contradictions, thereby presenting my research findings in terms of relevant literature.

Chapter 5: Research overview and conclusions

In this chapter I summarise my main research findings and relate them to the primary and secondary research questions, as formulated in Chapter 1. I make recommendations regarding theory, practice and future research and identify the limitations and potential contribution of my study.

1.8 CONCLUSION

The aim of Chapter 1 was to provide an introductory orientation of the study, as well as a broad view of what is to follow in Chapters 2 to 5. I outlined the purpose of my study, formulated my research questions and stated the assumptions with which I approached the study. I clarified key concepts and briefly introduced my paradigmatic perspective, research methodology and strategies I employed during the study.

Chapter 2 presents a literature review of relevant and contemporary sources. As such, I set out and discuss the underlying theory from which I planned and undertook the empirical part of the study. I conclude the chapter with my conceptual framework.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of the preceding chapter was to provide an introduction to, and the rationale of, my study, creating a basis of orientation for the chapters to follow. I formulated the research questions and presented the assumptions with which I approached this study. Thereafter, I clarified key concepts and presented a brief overview of my selected research design and methodology.

In this chapter I provide a literature review of the asset-based approach, focusing on an overview of the approach, asset-based community development and the asset-based approach as underlying theory of the intervention session, which I facilitated with the selected educators. Thereafter, I discuss the impact of HIV&AIDS on informal settlement communities as well as parents and children, followed by a discussion on the impact of HIV&AIDS on the education sector, with specific reference to the role educators may play in supporting communities coping with HIV&AIDS. Then, I present an overview of coping, followed by literature on coping and support within an informal settlement community, as well as the ways in which families and individual community members currently cope with HIV&AIDS. I conclude the chapter by presenting my conceptual framework.

2.2 THE ASSET-BASED APPROACH

The theoretical framework of my study is the asset-based approach. I selected this approach based on the fact that it accords well with my world view, according to which I regard people as resources and not as problems in need of service (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). The asset-based theory is further closely compatible with the interpretivist paradigm I selected as underlying philosophy. The ontologies of both these approaches reflect multiple realities (Ebersöhn & Eloff, 2006; Mertens, 1998). The asset-based theory further relies on insights from the ecosystemic approach (Ebersöhn & Eloff, 2003). In the following sub-sections I explore the asset-based approach in terms of the underlying ecosystemic theory, the differences between the asset-based approach and the needs-based approach, and finally asset-based community development.

2.2.1 The ecosystemic approach and the asset-based approach

Upon closer examination of the asset-based approach, one might recognise aspects of the ecosystemic theory (Ebersöhn & Eloff, 2003). The ecosystemic perspective is an integration of the systems and ecological theoretical insights whereby a school can be seen as a system with different subsystems, consisting of learners, educators, other staff members and a parent body. The school is located within the system of the local community which is embedded in wider systems such as the provincial government. These systems influence, and are being influenced by, one another (Donald *et al*., 2002). By focusing on the different systems in communities one may be able to identify various assets within each system.

Furthermore, the ecosystemic model investigates the dynamic interactions between the different systems of a unit, in order to understand why things are the way they are at a given time. This view helps to identify how things could change, develop and be healed if necessary (Donald *et al.*, 2002). In viewing a community from this perspective one could bring about community development through intervention in one or more of the different systems. Within the framework of my study I employed asset-based intervention sessions with educators, viewed as one of the subsystems within a wider system.

2.2.2 The asset-based approach in contrast to the needs-based approach

The asset-based approach as theory was initially articulated by Kretzmann and McKnight (1993) in an attempt to counteract the negative effects of the needs-based approach to community development (Mathie & Cunningham, 2003). Within the needs-based approach the image or mental-map one holds regarding poor communities is largely negative, focusing on unemployment, violence, crime, poor health and limited resources. This mental-map of the community might indeed reflect some of the characteristics of what might be found in communities characterised by low socio-economic status, without reflecting the whole truth regarding what one could find (Kretzmann & McKnight, 1996).

Ebersöhn and Eloff (2006) further highlight the fact that the needs-based approach often leads to the labelling of individuals and families. From the needs-based approach professionals attempt to grasp the needs of individuals and families which should be addressed during intervention. The

result could be that individuals and organisations are labelled with words such as '*learning disabled child*' or '*poverty-stricken school*' Ebersöhn and Eloff (2006) regard labelling as reductionistic, as it takes one of the many facets of an individual or organisation and makes that facet the 'whole person', thereby ignoring the many positive facets and capacities of individuals.

One of the most paralysing effects of the needs-based approach is that community members may start to believe that they have special needs, which can only be met by expert professionals outside the community. Community members may become passive consumers and clients awaiting service from outside the community (Kretzmann & McKnight, 1996). The unfortunate truth regarding service provision in South Africa is that it is often limited and, within the context of a pandemic such as HIV&AIDS, delivery of services is limited and far apart (Ebersöhn & Eloff, 2006; Marais, 2005; Department of Health, 2001). Although investigation of the success or failure of current HIV&AIDS models in schools is beyond the scope of my study, it should be noted that, despite government policies and guidelines for school-based HIV&AIDS support (Department of Education, 2000; Department of Education, 1999), a study conducted by Hartell and Maile (2004) found inconsistencies regarding what is happening in schools and government's HIV&AIDS policies and guidelines. Kretzmann and McKnight (1996) emphasise the fact that, historically, community development that is initiated and motivated by forces outside the community is not sustained. Communities must rather be built from within the community, when the local community members commit themselves, their resources and their efforts to enhance and develop the community.

The asset-based approach fosters ownership and community development from within the community. Therefore, the asset-based approach stands in contrast to the needs-based approach by virtue of the fact that it focuses on the capacities and strengths which are present in a community. The asset-based approach does not ignore the fact that communities characterised by poverty experience challenges and difficulties, but focuses on the strengths and resources in the community instead, to address the challenges and difficulties present in communities (Kretzmann, 2002; Kretzmann & McKnight, 1996). As Ebersöhn and Eloff (2006:13) state: '*It is simply a fact that children (and adults) are often faced with enormous challenges, that schools are often under-resourced, and that families and communities do have needs. In spite of this, we have argued that the existence of needs does not necessitate an approach that focuses on needs as the only constructs for planning and developing of interventions'.* Nor does the asset-based approach assume that communities characterised by poverty do not need additional resources from outside

the community. The asset-based approach rather advocates that external resources will be more effectively utilised if the community is fully mobilised and invested in and secondly, if communities can '*define the agendas for which additional resources must be obtained*' (Kretzmann & McKnight, 1996:3).

The asset-based approach was initially articulated within the context of community development. In line with this, the intervention I facilitated amongst educators also focused on identifying and mobilising assets in the sphere of the community (amongst others). Accordingly, I now turn my discussion to asset-based community development.

2.2.3 Asset-based community development

Kretzmann and McKnight (1993) propose three principals that define the asset-based approach as a community development process. Firstly, the process starts with what is present in the community, thus focusing on the assets in communities. These authors provide the following asset-map framework to assist in the identification of assets and resources in the community:

- individual inventory, whereby skills, strengths, talents and previous experiences of individual community members are identified, as well as family and household assets;
- local associations inventory, whereby assets and networks are identified within formal associations such as sport clubs and political associations, as well as informal associations such as book clubs and 'stokvel'[1] gatherings; and
- formal institutional inventory, whereby assets are identified within the local school, non-government organisations, hospitals and social services.

Ebersöhn and Eloff (2006) rely on the ecosystemic approach and elaborate on the abovementioned framework to include:

- a whole social system inventory, whereby assets are identified within the wider social system such as government financial aid for orphans and children in households characterised by poverty, as well as funding available from the national lottery.

Ebersöhn and Eloff (2006) view the creation of an asset map as a process whereby community members become aware of the assets within themselves, their environment and their social networks. By employing an asset-map framework, community members could gain an objective

[1] Stokvel can be described as a type of informal credit-rotating association (Schulze, 1997).

view of their community, leading to the identification of assets, which otherwise might have been overlooked. It is, however, important to keep in mind that assets that are identified should be viewed as assets by the community members themselves (Ferreira & Ebersöhn in Ebersöhn & Eloff, 2006; Mathie & Cunningham, 2003). To illustrate this, a park in the community may be viewed by a visiting community developer as an asset, but the community members might experience it as a challenge if they view it as a breeding ground for criminal activities.

Secondly, asset-based community development is an 'internally focused' process. The focus falls upon agenda building (prioritising) and the problem-solving abilities of community members, community associations and local institutions. In this manner, local definitions, investment, hope, control and creativity within the community are mobilised. This implies that issues to be addressed and the way in which they need to be addressed are in the hands of community members and not in the hands of visiting community developers. Therefore, community members decide which areas of assets should be accessed and mobilised to respond to the challenges within the community. As such, community members organise and drive the community development process themselves (Mathie & Cunningham, 2003; Kretzmann & McKnight,1996).

The fact that asset-based community development focuses on the agenda building and problem-solving capacities and abilities of community members and the assets present in the community, does not constitute a continued positive attitude amongst community members. Ebersöhn and Eloff (2006) refer to a number of limited studies that reveal that the visiting community developer needs to reiterate constantly the focus on the half-full part of the glass, whereby positive psychological aspects such as hope, optimism and faith play a great role in keeping community members motivated.

Finally, the asset-based community development process is a relationship driven process. The focus falls upon the building and re-building of relationships between and amongst individual community members, associations and local institutions. The asset-based approach, therefore, builds social relationships and social capital within the community (Pan, Littlefield, Valladolid, Tapping & West, 2005). Putman (in Emmett, 2000:508) defines social capital as those '*features of social organisations, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated action'*. This can enable communities to attain goals that could not be achieved in isolation.

In informal settlement communities, relationships amongst and between community members and their social networks are regularly well established. Such social networks are viewed as a good source of support (Ferreira, 2006; Marais, 2005; Meintjes, Budlender, Griese & Johnson, 2003; Campbell & Rader, 1997). However, this strong coherence does not constitute or guarantee that community development will necessarily be sustainable. As Dreyer (in Emmett, 2000) points out, social coherence in rural/informal settlement communities is so strong that it could cause a community development project to fail, as members might rather withdraw from the project than face social scrutiny. The fact that asset-based community development focuses on intrinsically generated solutions to intrinsically identified challenges by community members, may enhance the authentic local ownership of community development projects (Ebersöhn & Eloff, 2006).

2.3 THE IMPACT OF HIV&AIDS ON SOCIETY

By December 2003, global deaths related to HIV&AIDS were estimated to be 3 million, of whom 500 000 were children under the age of 15 years. In the same year 5 million people became infected with HIV, and 700 000 of these newly infected were children under 15 years of age, placing the global number of people living with HIV&AIDS at an estimated 35 million (UNAIDS/WHOa, 2004; UNAIDS, 2003). In the South African population 5 million people were infected by mid 2004, which accounts for 11% of the total population (Statistics South Africa, 2004). Statistics presented by UNAIDS reflect a somewhat worse scenario regarding HIV infections in South Africa, placing the estimated number of people living with HIV&AIDS at 5.3 million (UNAIDS/WHOb, 2004). During 2004, 250 000 South African children lost caregivers due to AIDS related deaths, bringing the number of AIDS related orphans in South Africa to 1.1 million (Statistics South Africa, 2004; UNAIDS, 2004).

Marais (2005:45) states that one could make the mistake of looking towards statistics as an indication of the impact that HIV&AIDS has on a society. In this regard he poses the following alternative: '*no matter the statistical abstractions, win or lose, the outcome of societies' encounter with AIDS will be decided by how communities and households are affected and are able to respond'.*

As the community I selected for my study is an informal settlement community, I will now aim to depict the impact of HIV&AIDS on informal settlement communities (which I regard as similar to rural communities in terms of resources, outside service provision, unemployment and poverty). Thereafter, I describe the potential impact of HIV&AIDS on parents, children and lastly on

educators and the education system, in order to highlight the possible roles that educators could fulfil in supporting communities coping with the HIV&AIDS pandemic.

2.3.1 Impact of HIV&AIDS on informal settlement communities

Ferreira (2006) refers to informal settlements as groups of people, unified by shared attitudes, interests, aims and ideas, residing in informal settlement areas characterised by poverty and a lack of facilities such as electricity and running water. The informal settlement community I selected for the purpose of this study is characterised by high levels of unemployment and limited facilities. This community is severely affected by HIV&AIDS, and a care centre in the community is, for example, reported to have provided 17 084 food parcels to families infected with and affected by HIV&AIDS (Information obtained in a pamphlet issued by the care centre, refer to Appendix B in this regard).

The effects of HIV&AIDS on informal settlement communities add to the spiral of poverty and loss of income. Additional care-related expenses, caregivers' diminishing ability to work as the disease takes hold of them, and funeral and medical expenses, contribute collectively to push households already characterised by poverty, deeper into poverty. Family members who would otherwise be able to earn an income often have to spend their time caring for HIV&AIDS infected family members (Marais, 2005; Smart, 2003; UNAIDS, 2002; LoveLife, 2000).

Marais (2005) refers to informal settlement communities and highlights the role of community support as one of the predominant features in a household coping with challenges. Community support may take the form of financial assistance, assisting with labour, providing food or fostering children (Marais, 2005). Meintjes *et al.(*2003) found that most children orphaned due to AIDS in South African informal settlement communities are absorbed by the community in which theses children reside. The study of Ferreira (2006) supports this claim and highlights the fact that most of the care of orphaned children rests on the shoulders of women and the elderly in the community. Marais (2005) agrees and asserts that the role of the elderly in rural/informal settlement communities is becoming more predominant regarding fostering orphaned children. He further states that community support networks such as the extended family or neighbours (mostly women and the elderly) find it exceedingly difficult to cope with the rising number of orphans in their communities.

In an attempt to support community members (caregivers) in coping with orphaned children, the South African government aims to provide social security grants to assist with the financial implications of caring for orphaned children (Meintjes *et al*., 2003). Marais (2005), however, argues that the guardians of these orphans do not only need material support but also counselling, education and social support. In the absence of formal support programmes, guardians may look to educators for guidance and advice, as educators often fulfil a leading role in communities (Department of Education, 2000). Community organisations such as churches, women's organisations and schools often also need assistance in co-ordinating support programmes aimed at caring for orphaned children. As a result, the need remains for systems to be put in place in order to help identify and monitor children and families in need (Meintjes *et al*., 2003; Kelly, 2000; Smart, 2000).

Despite the literature available on community-based support with regard to HIV&AIDS, and the fact that all sectors (including the education sector) need to become involved in community-based support (Marais, 2005; Bennell, 2003; Soul City, 2003; Kmita, Baranska & Neimiec, 2002; Save the Children, 2002; Department of Health, 2001; Department of Education, 2000), little evidence can be found in existing literature regarding practical support for community leaders (such as educators) to support their communities when facing the challenges associated with HIV&AIDS. My study (in collaborating with educators) may contribute in formulating practical guidelines for educators in supporting community members coping with HIV&AIDS. As my study focuses on educators supporting community members infected with and affected by HIV&AIDS, I assume that a substantial proportion of the support educators might provide to community members could be directed at parents. Additionally, in supporting the ecosystemic approach (Donald *et al.*, 2002). I further assume that the impact HIV&AIDS has on parents will inevitably influence children (learners).

2.3.2 The effect of HIV&AIDS on parents

Several challenges are associated with parenting in the context of a family living with HIV&AIDS (Antle, Wells, Goldie, DeMatteo & King, 2001). Parents usually experience continuous feelings of sadness that recur with varying intensity throughout the course of the infection. Parents must also face and adapt to how their own future and those of their children will be different from their hopes and dreams. Lives are shortened and children often have to face the challenges of life without the support of their parents or losing a sibling.

Wiener, Riekert, Theut, Steinberg and Pizzo (in Kmita *et al.,* 2002) indicate that, in the case of a child being HIV infected, parents often experience persistent feelings of depression, anxiety, self-blame and anticipatory grief. These authors indicate that, as HIV&AIDS is ultimately fatal, parents of children infected with HIV experience intense emotional trauma. Their study also reveals that parents regularly feel that they require more information on HIV&AIDS.

In cases where parents are infected with HIV they often have concerns regarding future guardianship and care for their children. Parents regularly engage in 'focused parenting' fuelled by the fact that they have limited time with their children. Parents focus on family values, skills their children might need in the future when they are no longer there and leaving behind a legacy for their children to remember them by (Kmita *et al.*, 2002; Antle *et al.,* 2001).

Disclosure and the stigma attached to HIV&AIDS often represent an added burden on parents or families living with HIV&AIDS. Parents might fear discrimination and rejection, especially when disclosing their status at their children's schools. As social support networks within the community are regarded as a major source of support for parents and children living with HIV&AIDS, non-disclosure creates a barrier to obtaining community support (Kmita *et al.*, 2002; Save the Children, 2002; Wiener *et al*. in Antle *et al.*, 2001).

The psychosocial effect of parenting in a family infected with HIV is profound. As a result, parents need to be encouraged to utilise the support structures they may have access to. Services, including educators and schools, that come into contact with these families (parents) need to educate themselves and convey the fact that they are sensitive to the challenges faced by these families. Such campaigns could include displaying posters and educational material related to HIV&AIDS, hosting workshops on the effect of AIDS on families, and facilitating the family to connect to community-based agencies where they might be able to receive the support and care they require. In doing so, agencies such as schools might be able to create a safe environment for parents to disclose the HIV status of the family, enabling them to gain access to HIV&AIDS related support (Peltzer, 2003; Antle *et al.*, 2001). Kmita *et al*. (2002) state that, when working with families infected with HIV (especially parents), the aim ought to be to empower families and not just to support them by providing care.

2.3.3 The effect of HIV&AIDS on children

Sick children in developing countries are at a greater risk of death than those in developed countries. In Europe, for example, 80% of children infected with HIV survive at least until their third birthday, whilst in Sub-Saharan Africa, 50% of children infected with HIV die by the age of two. The rapid course of AIDS amongst African children might be ascribed to the fact that developing countries generally have less developed health care systems in place and that poor living conditions place these children and other community members at a greater risk of dying. The term poor living conditions refers to, amongst other things, poor nutrition and overcrowded housing, which might increase the likelihood of contracting tuberculosis. Limited access to clean water also renders individuals infected with HIV more vulnerable to waterborne diseases, leading to diarrhoea (UNAIDS, 1999). Smart (2000) states that children with an HIV positive status are more likely to be infected by common pathogens and that these pathogens are more severe and persistent than in HIV negative children.

The stress and trauma that children infected with and affected by HIV&AIDS experience is heart-rending. Caring for a dying parent, or having to find a means of survival for themselves, their siblings and the ill parent, often causes these children to experience increased distress. This parentification process, whereby a child cares for a parent or siblings, is associated with social isolation, thus excluding the child from the traditional community support network. These children are often uncertain regarding the nature of their parents' illness and when AIDS might strike again. Depression, mood swings and feelings of hopelessness often govern the children's daily lives. When they are orphaned, the insecurity associated with an uncertain future may further traumatise the child (Marais, 2005; Loening-Voysey, 2001; Kelly, 2000; LoveLife, 2000; Smart, 2000; UNAIDS, 1999).

Orphaned children are usually placed in government-based orphanages, non-government-based care-houses, taken in by extended families, or may form child-headed households. When children orphaned by AIDS become part of an extended family's household the chances of abuse and neglect increase. Some AIDS related orphans, not infected by HIV, are more likely to die of childhood or common diseases due to the mistaken belief by the extended family that they have become ill because they are HIV infected and that there is no point in seeking medical help (LoveLife, 2000; UNAIDS, 1999). Some problems associated with child-headed households are poverty, lack of supervision and care, school drop-outs, psychological problems and the failure to

thrive (Kelly, 2000; Smart, 2000). Findings in the study undertaken by Ferreira (2006) indicate that orphaned children in the identified community where I conducted this study are often absorbed by extended families. As a result, the participants (educators) in Ferreira's study (2006) indicated that they needed guidance in supporting these families.

2.3.4 HIV&AIDS and the education sector

'Given the seriousness of the AIDS crisis, some commentators believe that schools themselves must be 'transformed' into altogether new types of institutions that can provide comprehensive care and livelihood opportunities for children adversely affected by the epidemic' (Bennell, 2003:10). Although HIV&AIDS affects many sectors in society, such as health care, labour and security, it seems that the educational system is being affected the worst. As a UNICEF publication states: '… *although HIV affects all sectors, its most profound effects are concentrated in the education sector'* (UNICEF, 2000:10). In the following sub-sections, I explore the effect of HIV&AIDS on education, followed by the potential role of schools in supporting communities' coping initiatives with HIV&AIDS.

2.3.4.1 The effects of HIV&AIDS on the education sector

Some authors believe that the vulnerability of the education sector lies in the fact that it is 'person intensive' and involves the reproduction of 'social' and 'human capital' (Marais, 2006; Bennell, 2003). UNAIDS (2006) elaborates on the vulnerability of the education sector and states that the impact of HIV&AIDS on education is reaching critical levels. With specific reference to education in South Africa, it seems that the number of school-aged children has increased, whilst the number of public school educators has decreased. This decrease might in part be ascribed to deaths associated with HIV&AIDS. As an estimated 21% of educators in South Africa are HIV infected it seems that educators are 10% more likely to become infected with HIV than the average population, placing educators and the education sector as a whole in a vulnerable position (Peltzer in UNAIDS, 2006; Statistics South Africa, 2004).

In addition to the vulnerability of educators and the education sector in terms of supply and demand, the quality of education is being challenged by increased absenteeism of educators due to HIV&AIDS related illnesses amongst themselves, and also due to social responsibility associated with HIV&AIDS amongst family members and friends. UNAIDS (2006) states that 60%

of absenteeism amongst educators in Zambia is related to educators having to support friends and/or family members infected with HIV. This publication further argues that educators therefore have less time to engage in lesson preparation, which further impacts on the quality of education. The fact that educators' morale is negatively influenced by the emotional impact of HIV&AIDS might create another barrier to teaching and learning (Coombe, 2000; Education Labour Relations Council, 2005; Das in UNAIDS, 2006).

In response to the vulnerability of the education sector the South African government aims to support educators and schools by creating a policy whereby schools have to establish a Health Advisory Committee, developing guidelines or action steps when HIV&AIDS related challenges arise (Department of Education, 2000; Department of Education, 1999). Many schools have already experienced the impact of HIV&AIDS as colleagues have become ill and died. In addition, learners are often absent as they have to care for ill family members, learners may themselves become ill and die, or learners my lose their parents (caregivers) (Bennell, 2003; Department of Education, 2000). In this regard the Minister of Education in 2000, Prof. Kader Asmal stated:

> *Almost every educator will eventually be teaching some learner who has HIV. In most staff rooms, one or more teachers will be infected. Other school employees will not be exempt. Illness disrupts learning and teaching. Well teachers have to take on an extra load when sick teachers are absent. Learners who are ill fall behind with their studies. When family members get ill or die, teachers and learners carry the burden. When teachers and learners die, schools suffer disruption, loss and sorrow. Many schools will be crippled by the impact of the disease on staff, learners and their families* (Department of Education, 2000:1).

2.3.4.2 The potential role of schools in supporting communities in coping with HIV&AIDS

Educators, who have received formal training, are usually able to grasp information on HIV&AIDS more readily than non-educated community members. Therefore, educators may be able to provide accurate and understandable information on HIV&AIDS to their communities. Educators are regularly regarded as leaders, role models and individuals with great social status within their communities (Department of Education, 2000). Consequently, community members may be more willing to accept information on HIV&AIDS from educators in their local schools. As most households in informal settlement communities have children of school-going age, educators are in a position to 'touch' these households through contact with children, parents and caregivers. The array of support possibilities that educators could provide to informal settlement communities therefore seems wide-reaching (Bennell, 2003; Department of Education, 2000).

Bennell (2003) and Soul City (2003) elaborate on this argument by identifying priority areas and guidelines for educator/school-based support. Firstly, educators and schools might identify, refer and monitor learners infected with and affected by HIV&AIDS. Secondly, educators might collaborate with learners and co-educators on ways to support children and families infected with and affected by HIV&AIDS. Thirdly, educators and schools could involve parents and caregivers in support efforts. Lastly, schools might provide financial assistance, counselling services and feeding programmes to support children and parents infected with and affected by HIV&AIDS. Marais (2005) regards counselling as perhaps the most neglected area in support efforts, but states that schools may be the best starting point for providing psychosocial support to community members (including parents and children) infected with and affected by HIV&AIDS.

Marais' (2005) thoughts are supported by the White Paper(6) (Department of Education, 2001) which indicates that educators are expected to fulfil various roles in their profession and that one of these roles is the pastoral role. The pastoral role of educators requires that educators become focal resources of counselling and that they need to provide learners and parents in distress with guidance and emotional support. However, a document prepared for the Education Labour Relations Council during 2005 states that the pastoral role (counselling role) of educators is enforcing barriers to teaching and learning, as educators do not have sufficient time to engage in both counselling and effective teaching (Education Labour Relations Council, 2005). I believe that statements like these stem from a deficit (or needs-based) model of thinking and that the positive contribution educators might provide to affected and infected learners cannot be minimised in terms of effective time management.

The South African government further aims to support schools and learners infected with and affected by HIV&AIDS by having stipulated a policy, which indicates that schools are requested to establish a Health Advisory Committee (Department of Education, 1999). This committee is responsible for the development of guidelines and action steps to respond to the challenges posed by HIV&AIDS in schools. However, despite the abovementioned guidelines and government policies for educators/school-based support, the support efforts of educators seem to be challenged by two main factors. Firstly, a study conducted by Hartell and Maile (2004) found that discrepancies exist between government's HIV&AIDS policies and guidelines on the one hand, and what is actually happening in schools on the other, as most of these guidelines and policies were not being implemented. These researchers conducted a study amongst four high schools and two

primary schools in Mpumalanga province, finding that the main reasons for failure to implement government HIV&AIDS policies were related to a lack of knowledge on the policies themselves as well as a lack of knowledge regarding the role the school governing body might play in managing HIV&AIDS in public schools. The second factor challenging educators' support efforts lies in the fact that educators seems to perceive themselves as not possessing the necessary skills and knowledge to support community members (including parents and children) infected with and affected by HIV&AIDS (Ferreria, 2006; Peltzer, 2000).

In contrast with findings indicating that educators do not perceive themselves as possessing sufficient knowledge to support community members with the challenges associated with HIV&AIDS, a key assumption in my study was that educators do possess the necessary skills and knowledge (competencies) to support their community in coping with HIV&AIDS. Peltzer (2003) found educators to be well informed regarding issues relating to HIV&AIDS, which supports my assumption that educators are knowledgeable. However, Peltzer (2003) did not relate his findings to how educators might utilise their knowledge of HIV&AIDS in supporting their community.

Yet, the fact that participating educators in my study initially perceived their skills and knowledge of HIV&AIDS as insufficient to effectively support their community members in coping with the challenges associated with HIV&AIDS, brings the concept of self-perception to the fore. Egan (2002) and Enderlin-Lampe (2002) state that self-perception has a great influence on the actual outcome of actions. If educators think that they do not have sufficient knowledge and that they are incompetent to support their communities they will probably not engage in supporting the community or might seize their support efforts based on the belief that they believe they do not possess the necessary skills. Therefore, if one could enhance educators perceptions regarding their skills and knowledge (competencies) in supporting community members one might be able to enhance the support educators provide and potentially could provide to community members.

As one of the advantages of utilising an asset-based intervention is individual capacity building, facilitating asset-based HIV&AIDS intervention with educators might enhance their sense of self-efficacy with regard to their skills and knowledge (competencies) in supporting community members (including parents and children) infected with and affected by HIV&AIDS (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). I now turn my discussion to the support that might be provided, in terms of possible ways of coping with HIV&AIDS.

2.4 SUPPORT AND COPING WITHIN THE CONTEXT OF HIV&AIDS

Coping can be regarded as a process whereby an individual or community attempts to minimise the negative emotional effects of a stressful life event, where such an event is appraised as taxing and in excess of the resources of the person or community (Lowe & Bennet, 2003; Whitty, 2003). Within the framework of my study I adhere to the definition of asset-based coping as defined by Ferreira (2006), where asset-based coping refers to the ability of an individual (or community) to respond to challenges presented by stressful situations (such as the HIV&AIDS pandemic) by identifying and mobilising existing assets within the individual and amongst other community members. The mobilisation of assets further extends to assets available within the community, as well as external resources available outside the community. From this perspective, assets are seen as, amongst other things, skills, knowledge, networks and local resources.

Support is viewed as the act of providing encouragement and help on an emotional and/or practical level to individuals infected with and affected by HIV&AIDS (http://dictionary.cambridge.org). In an attempt to review coping with HIV&AIDS within the context of informal settlement communities I view coping and social support as interlinked, a view which is supported by Ferreira (2006), Marais (2005), Wood, Wolters, Klaas, Perez and Martin (2004) as well as Buchwald (2003). Furthermore, I agree with the argument made by Thoits in Friedland *et al.* (1996) who views social support as a form of coping assistance, where significant others are actively involved in an individual's attempts at stress management. As such, I discuss coping as, amongst other aspects, a means of utilising social support and assets (resources)in section 2.4.3.

In this section of my study, relating coping and support within the context of HIV&AIDS, I firstly highlight some of the theoretical aspects of coping and discuss support within the context of HIV&AIDS. Thereafter, I discuss coping in informal settlement communities as a means of utilising social support networks, after which I provide an overview of the ways in which families and individual community members may cope with HIV&AIDS.

2.4.1 Theoretical aspects of coping

The fact that coping can be viewed as a process whereby individuals or community members aim to reduce stress which could be related to taxing life-events does not imply that I view coping merely as a stress reduction activity. I view the process of coping from a positive dimension, as

coping creates a podium for learning and personal growth (Ferreira, 2006; Fournet, Wilson & Wallander,1998).

Coping has traditionally been viewed as strongly related to personality traits, implying that coping could be relatively fixed over time and across different situations. However, Lazarus and Folkman (in Buchwald, 2003) view coping as a reactional process whereby coping changes in transactions with the situation. I support a view of coping as a dynamic process influenced by various personal (for example, self-efficacy expectations) and situational factors (for example, resources/assets available). Therefore, I view coping as a positive, dynamic life process. Different dimensions and focal aspects become clear in the conceptualisation and understanding of the coping process, as discussed in the following paragraphs.

Hobfoll, as cited by Schwarzer, Starke and Buchwald (2003) developed a multi-axis model with three dimensions in order to understand coping. On the first dimension, coping is seen as either active or passive. Active coping occurs when an individual takes on an active role in dealing with a problem, for example, learning new skills to respond adequately to a stressful life event. On the other hand, passive coping occurs when an individual relinquishes control of the problem to others, for example, when parents place the responsibility and care of an ill child exclusively in the hands of doctors. Secondly, the prosocial and antisocial dimension is considered, whereby individuals either utilise their wider social support network in coping, or prefer to cope in solidarity. The final dimension in Hobfoll's model entails direct or indirect coping, where individuals utilising indirect coping aim to maintain harmony rather than directly aiming at asserting their own needs (Wood *et al.,* 2004; Buchwald, 2003).

The aspects listed below contribute to my conceptualisation of coping:

- *Accountability,* which refers to the perceptions people hold regarding the source of a stressful situation. If individuals believe themselves to be responsible they may react to a stressful situation in self-blame. If the source of the stressful situation is perceived to be the responsibility of others they may react with aggression. Self-accountability is associated with active coping and planning (Lowe & Bennet, 2003).
- *Future expectancy,* which refers to the perception a person holds regarding the outcome of a stressful situation. If a person believes that the outcomes will be positive he/she is likely to respond to the stressful situation more actively and directly (Lowe & Bennet, 2003).

- *Solution-focused potential,* which refers to the solutions or options available to the individual in order to address or resolve the stressful event/situation. Solution-focused potential as initially identified by Lazarus and Folkman, is referred to in the literature (Whitty, 2003; Schwarzer, *et al,* 2003) as problem-focused potential, but in the spirit of the asset-based approach the term solution-focused potential seems better suited. In solution-focused coping the individual believes that a stressful situation is open to change. Individuals are therefore more likely to actively address the challenges presented by an adverse situation (Wood *et al.,* 2004; Schwarzer *et al.,* 2003; Lowe & Bennett, 2003; Egan, 2002; Fournet *et al.,* 1998).
- *Emotion-focused potential,* which refers to the perceptions individuals or communities hold regarding the ability to adapt emotionally to adverse events or situations. If individuals are uncertain about their abilities to adapt to stressful events they may respond with anxiety. Emotion-focused coping usually occurs when an individual perceives that nothing can be done to change the stressful situation actively. Most emotion-focused coping strategies tend to be passive, such as denial or avoidance (Wood *et al*., 2004; Lowe & Bennett, 2003; Schwarzer *et al.,* 2003; Fournet *et al.,* 1998).
- *Keeping a positive affect,* which refers to the ability of individuals to maintain a positive affect in the face of adversity. Keeping a positive affect in coping has been associated with 'broadening' one's thoughts, actions and strategies to cope more effectively with the adverse situation. By reframing adverse situations one may be able to focus on positive outcomes. For example, in the case of coping with the HIV&AIDS pandemic in informal settlement communities, one could encourage community members to focus on success stories such as an orphaned child being enthusiastically absorbed into a neighbour's home (Egan, 2002; Fredrickson & Joiner, 2002).

Coping efforts are influenced by individual characteristics such as self-esteem, optimism and a conviction of self-efficacy (Sumer, Karaci, Berument & Gunes, 2005; Egan, 2002). Bandura, as stated in Egan (2002) views self-efficacy beliefs as one of the most profound aspects that influences emotions, thoughts and motivation. Self-efficacy is seen as a conviction regarding personal abilities to organise and implement a plan of action, in order to manage a forthcoming situation. Self-efficacy plays an important role in the willingness one may have to cope with difficult situations, the amount of effort one might put into attempts to cope and the persistence with which one will continue to face obstacles (Enderlin-Lampe, 2002; Shlomo & Meir, 1995).

Linked to the concept of self-efficacy is personal appraisal and the beliefs individuals hold regarding whether or not they possess the capabilities to rise to the challenge presented by a stressor. Coping is influenced by the balance between the demands of stressful situations/events and the personal resources (including social support) and abilities individuals have at their disposal. If an individual believes that an imbalance is imminent, coping might be negatively influenced (Fournet *et al*., 1998; Cook & Heppner, 1997). I now turn my discussion to support within the context of HIV&AIDS.

2.4.2 Support within the context of HIV&AIDS

Support can be described as an act of helping or providing coping assistance to individuals on a practical or emotional level when stressful life events occur (http://dictionary.cambridge.org; Thoits in Friedland *et al.,* 1996). As mentioned elsewhere, individuals infected with and affected by HIV&AIDS (including parents and children) experience increased amounts of emotional turmoil (Marais, 2005; Kmita *et al*., 2002; Antle *et al.,* 2001; Loening-Voysey, 2001; Kelly, 2000; LoveLife, 2000; Smart, 2000; UNAIDS, 1999). Support provided by significant others or volunteer caregivers (such as educators) may help in creating a therapeutic environment where individuals infected with and affected by HIV&AIDS may be able to share their experiences and emotional hardships (Visser & Moleko, 2001). Care-gives are viewed as '*anyone (professional, lay or family) involved in taking care of the physical, psychological, emotional and or spiritual needs of a person infected or affected by HIV&AIDS*' (Van Dyk, 2001:323).

A study undertaken by Owens (2003) on families as a source of support for individuals living with AIDS defined three categories of support. The first category Owens (2003) describes is emotional support which includes affective support (receiving love, care, empathy and reassurance), family commitment (being included in family activities and outings), and family acceptance (positive feelings of acceptance). The second category of support relates to concrete or tangible support such as housing, assistance with responsibilities and activities and transportation. The third category reflects cognitive or informational support in the form of providing HIV&AIDS information and support in HIV&AIDS advocacy work. Friedland *et al.* (1996) further argue that different combinations of support might be required at varying stages as AIDS progresses. Friedland *et al.* (1996) further state that emotional support is valuable through the course of AIDS, while informational support might be most beneficial during the early stages of the disease, whilst concrete support might be more helpful during the later stages.

As support usually occurs amongst and between people one might argue that support within the context of HIV&AIDS is in truth social support. Social support can be defined as '*the feeling of being cared for and loved, valued and esteemed, and able to count on others should the need arise*' (Friedland *et al.,* 1996). As argued elsewhere, social support and coping can be viewed as intertwined in the process of dealing with the challenges presented by HIV&AIDS within informal settlement communities, which forms the focus of my discussion in the next sub-section.

2.4.3 Coping within an informal settlement community by utilising social support

Due to the high prevalence of unemployment and poverty in informal settlement communities, community members often have limited outside/external resources to cope with adverse events, such as the challenges presented by HIV&AIDS. Community members therefore normally rely on the social support networks within the community and extended family members for support to cope with the challenges associated with HIV&AIDS (Ferreira, 2006; Marais, 2005; Save the Children, 2002; UNAIDS, 2002; UNAIDS 1999). Meintjes *et al*. (2003) as well as Campbell and Rader (1997), describe the boundaries between households in informal settlement communities as flexible and the relationships amongst community members as strong. Consequently, information and responsibilities usually flow spontaneously from the individual to the group. This leads to enhanced opportunities for individual community members to access and utilise the support available in their communities.

Ferreira (2006) found that community members in the community where I conducted my study tend to utilise community-based support structures in order to cope with the challenges associated with HIV&AIDS. She further states that the main resources of community support come from woman and the elderly in the community. Marais (2005) elaborates on the social support networks available in informal settlement communities. He highlights the plight of alternative caregivers, especially elderly caregivers. As grandparents are often the primary caregivers for their orphaned grandchildren they need support to cope with the challenges of raising children orphaned due to AIDS. Most literature concerning children orphaned due to AIDS agrees that caregivers need support and that educators could provide a great deal of support in this regard (Marais, 2005; Bennell, 2003; Soul City, 2003; Save the Children, 2002; Department of Education, 2000). However, little detail is revealed as to how educators should go about implementing such support to the caregivers in a community.

Some authors (Marais, 2005; Smart, 2003) argue that the idea of communities 'coping' with the HIV&AIDS challenges is presumptions, and that the social support networks in communities infected with and affected by HIV&AIDS are '*strained to the breaking point and traditional safety nets unravelling'* (Smart, 2003:4). However, Ferreira (2006) found that the community she selected (and where I conducted my study) is coping with the challenges of HIV&AIDS, by relying on existing assets and local resources. Ferreira (2006) explains the seemingly contradictory findings as being entwined in the different theoretical approaches between these authors and herself. Ferreira (2006) departed from the asset-based approach and focused on the resources, strengths and capacities (assets) within the community, which serve as platforms for support to community members. She states that, by focusing on successful coping within the community, she was not negating the fact that the community is facing great challenges, but by shifting her focus to the assets within the community she was able to facilitate the mobilisation of even more assets (Loots, 2005). I strongly agree with Ferreira (2006), as we share the same underlying theoretical approach, namely the asset-based approach. Additionally, although Marais (2005) and Smart (2003) seem critical of the coping process in communities that are poverty-stricken (such as informal settlement communities), both authors suggest that educators may be able to support communities to cope more effectively with challenges associated with HIV&AIDS. Yet, they provide little guidance on the topic of practical support for educators to cope with the task of assisting and supporting community members infected with and affected by HIV&AIDS. In this manner my study may contribute to the existing body of knowledge in this area of interest.

The South African government has limited government-based resources such as hospital care available, within the context of coping and accommodating the five million people living with HIV&AIDS. The Minister of Health, Dr Manto Tshabalala-Msimang, during 2001, issued national guidelines on home-based and community-based care to support HIV&AIDS infected individuals and their communities. In this document, the minister defines community-based care as '*the care that the consumer can access nearest to home, which encourages participation by people* (in the community)*, responds to the needs of people* (in the community)*, encourages traditional community life and creates responsibilities'* (Department of Health, 2001:1). Dr Tshabalala-Msimang further stated that community-based care can only be successful if all sectors, including the education sector, become actively involved in community-based care efforts. However, she did not indicate *how* the education sector or educators should go about in supporting community-based care.

It seems clear that educators and schools could potentially play an important part in supporting communities in coping with HIV&AIDS (Marais, 2005; Bennell, 2003; Soul City, 2003; Kmita *et al.,* 2002; Save the Children, 2002; Department of Education, 2000). Literature regarding the ways in which educators might support communities to cope with HIV&AIDS and how educators themselves might cope with the HIV&AIDS pandemic in their communities is still emerging. As such, this study could add to the growing body of literature in this area of research.

2.4.4 Community members' coping with HIV&AIDS

The individual community members infected with and affected by HIV&AIDS experience a range of psychological challenges. Some of these challenges include having to cope with multiple losses, feelings of shame, guilt and social stigmatisation (Plattner & Meiring, 2006; A.I.D.S. Training and Information Centre, 2004; Save the Children, 2002).

Plattner and Meiring (2006) refer to Evian, who states that uncertainty seems to be one of the greatest challenges HIV&AIDS infected and affected individuals experience. These feelings of uncertainty centre on how long one will be symptom free, whom to inform about one's HIV positive status, as well as how one became infected and whom one may have infected with the HI virus. The uncertainty of one's own future and the future of the ones that are left behind once individuals succumb to the effects of AIDS lead to feelings of helplessness and depression.

Feelings of uncertainty regarding who to inform about one's HIV positive status often relate to the stigmatisation associated with HIV&AIDS. A stigmatised individual is regarded as a person with a stained identity, which differs greatly from what is socially acceptable. Consequently, stigmatised individuals are actively pushed out of the social group (UNAIDS, 2002). Non-disclosed individuals deny themselves access to informal social support as well as the formal support offered by non-government organisations, health organisations and the government support schemes (Save the Children, 2002; Kmita *et al*., 2002; Wiener *et al*. in Antle *et al.,* 2001). Enhancing a culture of acceptance and support may encourage individuals infected with HIV to disclose their status. In this regard educators could be role models in the community regarding non-discriminating practices (Peltzer, 2003). Educators could also demonstrate that they are sensitive to the challenges HIV infected individuals experience by displaying posters, distributing pamphlets and hosting workshops on the challenges that individuals infected with HIV have to cope with. in this

way educators could provide a safe environment for disclosure, supporting individual community members in coping more effectively with their HIV positive status (Peltzer, 2003; Antle *et al.,* 2001).

Despite having to cope with feelings of uncertainty and fears of discrimination, it seems that individuals infected with HIV cope by finding meaning in the fact that they are infected (Plattner & Meiring 2006; Sikkema, Kalichman, Hoffmann, Koob, Kelly & Heckman, 2000). According to Plattner and Meiring (2006), this means that HIV infected individuals engage in a process of acceptance of their HIV status *via* self-blame and personal deservedness as well as the belief that their HIV infection is a test or punishment from God. They argue that by engaging in these self-diminishing activities the infected individuals gain as well as maintain some sense of control over the cause of their current situation. The aspect of self-accountability comes into play in the abovementioned process (Lowe & Bennet, 2003).

Plattner and Meiring (2006) further state that attributing their HIV infection to God, may make individuals' HIV positive status more meaningful to them. The fact that God or a greater power is responsible for their HIV infection might create a sense of hope, as one participant stated that they '*hope for a good outcome of this event'* (Plattner and Meiring, 2006:244). Ferreira (2006) agrees and indicates that participants in her study coped by maintaining a positive attitude, as well as gaining information on HIV&AIDS related issues, changing their lifestyles and maintaining a healthy diet, amongst other ways.

2.4.5 Coping with HIV&AIDS within the family

UNAIDS (2006) refers to the family structures in sub-Saharan Africa as more resilient than many international scholars had anticipated. This publication refers to '*examples of domestic heroism by AIDS-affected families*' which, despite great challenges, manages to find '*ways to make a living, feed and educated their children and care for the ill*' (UNAIDS, 2006:86). Ferreira's (2006) study supports these sentiments as she found that community members, families and the community as a whole are coping with the challenges associated with HIV&AIDS, within the community where I conducted my study. Although coping within informal settlement communities is strongly linked to social support networks (Ferreira, 2006; Marais, 2005; Save the Children, 2002; UNAIDS, 2002; UNAIDS 1999), families infected with and affected by HIV&AIDS also tend to cope by employing other strategies, which I discuss in the following paragraphs.

A study undertaken by Wood et al. (2004) showed that coping strategies employed by families infected with and affected by HIV&AIDS tend to focus on avoidance of the fact that HIV&AIDS is present in their homes and to relinquish control of the HIV&AIDS challenges to others, for example, medical doctors. Spiritual support and attribution were also found in families trying to cope with HIV&AIDS. Families often reveal an attitude of passive acceptance of the HIV&AIDS status amongst other family members. A study undertaken by Owens (2003) indicates that family commitment and acceptance of HIV&AIDS infections within the family often lead to a greater sense of support and coping within such families.

2.5 CONCEPTUAL FRAMEWORK

Figure 2.1 provides a summary of my conceptual framework for the study.

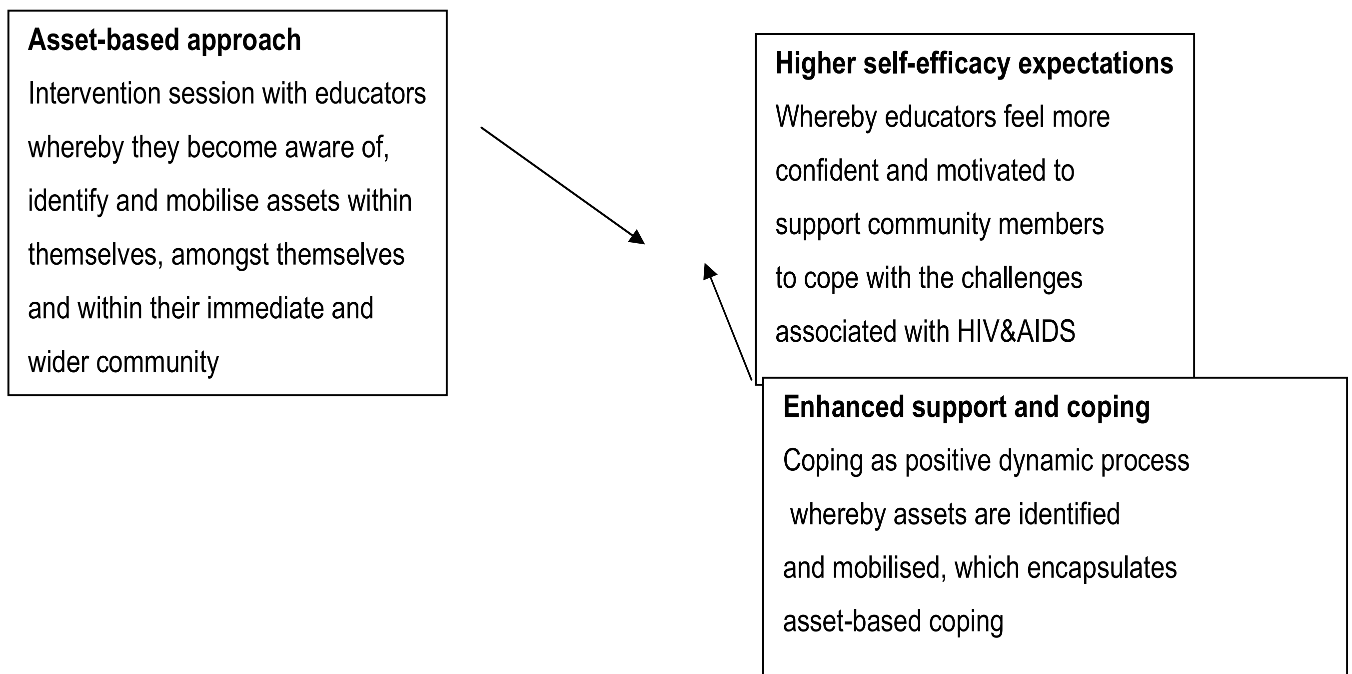

Figure 2.1 : Conceptual framework of this study

I view the concept of coping as a process of growth and learning, whereby individuals gain new insight and skills (Ferreira, 2006; Fournet *et al.,* 1998) I further believe that coping with HIV&AIDS within informal settlement communities could be viewed from the asset-based approach, thereby implying asset-based coping. Ferreira (2006) describes asset-based coping as the ability of individuals to identify and mobilise existing assets within themselves and the community to respond

to the challenges of stressful life events. I view the mobilisation of assets as extending beyond the community and including external resources available outside the community.

For the purpose of this study, I focused on partially preparing educators to support other community members coping with HIV&AIDS. This involved development and facilitation of an intervention (in the format of a workshop) focusing on basic HIV&AIDS information. The HIV&AIDS Training Manual of the University of Pretoria (Centre for the Study of AIDS, 2001) suggests that HIV&AIDS training could take on the format of a workshop. A workshop entails a process whereby participants are actively involved in learning through role play, discussions and the planning and creation of action steps. A key assumption in my study and a fundamental asset-based concept was that educators already possess the necessary knowledge and skills (competencies) to cope with HIV&AIDS. Therefore, educators who participated in the intervention (in the format of a workshop) would not necessarily acquire greater knowledge (learn) about HIV&AIDS, or how to cope with the challenges of HIV&AIDS in their community. They could, however, become more aware of (learn) the fact that they already possessed the necessary knowledge and skills (competencies) to cope effectively with the HIV&AIDS pandemic, before partaking in the asset-based intervention.

The abovementioned discussion also brings the word *training* and my role in the asset-based intervention to the fore. From the analysis of transcripts of the related study (Ferreira, 2006) as well as the face-to-face interviews of my study , educators (participants) used the word *training* in relation to what they perceived they needed to be able to cope more effectively with HIV&AIDS in their community. *Training* in the true sense of the word implies that I am the expert on coping with HIV&AIDS in an informal settlement community and therefore had to provide expert knowledge to educators. Firstly, I believe that such a notion on my part is greatly presumptuous. Secondly, this notion is rooted in the needs-based approach, which stands in sharp contrast to the asset-based approach, whereby the community members are regarded as the experts (Ebersöhn & Eloff, 2006; Kretzmann, 2002; Kretzmann & McKnight, 1996).

In planning and designing the intervention I facilitated, I greatly relied upon the analysis of the related study's transcripts (Ferreira, 2006), as well as the face-to-face interviews I conducted during my first field visit. Therefore, the aspects of coping, which was addressed during the intervention sessions, as well as the selected workshop format, were intrinsically identified by the participants (educators) themselves. Furthermore, by means of facilitation of asset-based

intervention sessions, educators' concerns (and questions) were intrinsically answered by themselves. This aspect relates to the characteristic of the asset-based approach, namely that it is internally focused (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). For the purpose of this study, I therefore assumed that the educators' sense of effective support may be sustained in future.

My role during the asset-based intervention sessions was limited to facilitating a process whereby participants took the lead and took ownership of their communities' coping (Ebersöhn & Eloff, 2006). I did not *help* or *train* the educators, but rather facilitated a process whereby educators became aware of their own skills and knowledge (competencies) regarding *coping with the emotional as well as the physical challenges associated with HIV&AIDS*[2] and in seeking *support for community members (including children) infected with and affected by HIV&AIDS*[3].

As the aim of the asset-based intervention sessions I facilitated was to enhance the educators' perceptions of their existing skills and knowledge of how to support community members in coping with the challenges related to HIV&AIDS, I indirectly aimed at enhancing their self-efficacy expectations. Self-efficacy expectations can be related to enhanced motivation and determination to engage and persist in a course of action (Bandura in Egan, 2002; Enderlin-Lampe, 2002; Shlomo & Meir, 1995). Within the framework of my study *course of action* refers to educators supporting community members in coping with the challenges associated with HIV&AIDS. Therefore, I approached the study with the belief that, by enhancing self-efficacy expectations (related to support effort) amongst educators, one might be able to enhance the support efforts educators engage in to assist and guide community members infected with and affected by HIV&AIDS (Sumer *et al*., 2005; Egan, 2002).

2.6 CONCLUSION

The aim of Chapter 2 was to provide a literature review of the key aspects in my study. I discussed the asset-based approach as the underlying theory of my study, in terms of its basic theory and relation to community development. Thereafter, I explored literature relating to the impact of HIV&AIDS on informal settlement communities, parents and children, as well as on education, aiming to highlight the possible roles educators could play in supporting communities in coping with

[2] Themes addressed during the intervention workshop with educators.

[3] Themes addressed during the intervention workshop with educators.

HIV&AIDS. I then discussed coping, referring to theories and possible aspects that influence coping, after which I discussed coping within informal settlement communities, as well as the way in which individual community members and families generally cope with the challenges associated with HIV&AIDS. I concluded the chapter by presenting my conceptual framework.

In the next chapter, I focus on the research process I employed during my study. Besides discussing the qualitative methodological paradigm I employed, I present the selected interpretivist meta-theoretical paradigm on which I based my study. Thereafter I present the instrumental case-study research design I selected during which I employed participatory action research (PAR) principals. I also discuss my selected data collection and documentation procedures as well as my process of data analysis and interpretation.

CHAPTER 3

RESEARCH PROCESS

3.1 INTRODUCTION

In the preceding chapter I presented and discussed the theoretical framework upon which I relied when undertaking the study. I discussed the asset-based approach in terms of theoretical aspects, community development and an asset-based intervention workshop. Thereafter, I presented a discussion on HIV&AIDS focusing on the impact of the pandemic on informal settlement communities, followed by the effect HIV&AIDS has on education, parents and children. I concluded the chapter with a discussion on coping. Firstly, I presented the theoretical aspects of coping, followed by coping from within an informal settlement community and coping within HIV&AIDS infected families and with individuals infected with and affected by HIV&AIDS.

In this chapter, I describe the design and execution of the empirical study I conducted. I relate my methodological choices to the research questions and purpose of my study. I present a detailed account of the data collection strategies I employed, followed by a discussion on the data analysis and interpretation I completed. Thereafter, I explore my role as researcher, discuss ethical considerations and conclude the chapter with an explanation of the rigour of this study.

3.2 RESEARCH PARADIGMS

I now describe the research paradigms which I employed in my study. Firstly I discuss my methodological paradigm (qualitative research), followed by my meta-theoretical paradigm (Interpretivism).

3.2.1 Methodological paradigm

I undertook in-depth qualitative field research in an informal settlement community in the Eastern Cape (Nelson Mandela Metropole), to explore asset-based intervention with educators as a way of equipping them with HIV&AIDS coping and support competencies. Qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors and descriptions of phenomena (Mayan, 2001; Berg, 1998). I selected a qualitative approach, as qualitative research corresponds

with my belief that reality is socially constructed and that it can only be understood through interaction between the researcher (being me) and the participants (Mertens, 1998). In my study, the feelings, thoughts, insights and behaviour of educators in an informal settlement community formed the focus. The aim of the study was to explore and describe educators' perceptions regarding their skills and knowledge in supporting a community's efforts to cope with HIV&AIDS, as well as how their actions and feelings of competence may impact on their way of supporting the community in coping with HIV&AIDS.

3.2.2 Meta-theoretical paradigm

I followed an interpretivist paradigm, as Interpretivism appeared to be conducive to the aims of my study, which focused on describing and interpreting people's (educators') experiences and feelings, in human terms, and not in terms of quantification and measurement (Terre Blanche & Kelly, 2002). The interpretivist paradigm is also in harmony with my personal view of the 'world', namely that people socially construct meaning *via* their interaction with the world around them. As an interpretivist, I aimed to understand the meaning the participants (educators) give to their world from their points of view, them being the ones who live in that particular world (Mertens, 1998). As such, I emphasised the context in which knowledge is constructed. Schwandt (2000) refers to this process of understanding as empathic identification, where understanding the meaning of human action and interaction requires of the researcher to understand or grasp the subjective intent of the participant. As a researcher following an interpretivist paradigm, I consistantly assumed that people's subjective experiences are real and should be taken seriously (Terre Blanche & Kelly, 2002).

The nature of the knowledge and the relationships between me (as researcher, as well as my co-researchers[4]) and the participants, as well as between the participants themselves, were interactive. Based on the epistemology of my study, I was only able to understand the participants' experiences and feelings through interaction and listening (Terre Blanche & Kelly, 2002; Mertens, 1998). Based on the emphasis that the interpretivist paradigm places on an interactive mode of data collection, I selected interviews, a workshop and a focus group discussion as primary data collection strategies, amongst other techniques. The asset-based approach supports such an interactive stance between the researcher (me) and the participants. Concepts used in the asset-

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[4] As this study formed part of a broader research project, I worked in a research team, with co-researchers R. Ferreira and M. Loots.

based approach, such as *partnership*, *collaborative* and *close proximity,* which are used to describe the relationship between the researcher and participants, illustrate the focus on interaction (Ebersöhn & Eloff, 2003).

3.3 RESEARCH METHODOLOGY AND STRATEGIES

I will now discuss the research process in terms of the instrumental case study research design I employed, as well as the selection of participants and the data collection strategies upon which I relied.

3.3.1 Research design

I selected a *case study* research design for the purpose of this study. A case study research design examines in detail a 'bounded system', employing multiple sources of data found in the setting (McMillan & Schumacher, 2000; Merriam, 1998). This encapsulates the interpretivist paradigm as it focuses on the setting or context, and helps the researcher to interact with the participants, in order to come to a rich understanding of the meanings (realities) they hold. Yen (in Merriam, 1998:27) illustrates the interactive nature of a case study by defining a case study as ' … *an empirical inquiry that investigates a contemporary phenomenon with its real-life contest*,..' The case study I selected can be described as an instrumental case study. I selected the case due to the fact that a particular aspect (educators' perceived lack of sufficient HIV&AIDS related skills and knowledge) could be represented by the case (Stake, 2000; Merriam, 1998).

I decided to employ a case study research design due to its potential of providing detailed descriptions of the educators' coping strategies and the perceptions they held regarding their skills and knowledge on coping with HIV&AIDS in their classrooms and community at the time of my field work. An analysis and interpretation of the themes that arose during initial interviews was incorporated into an asset-based intervention with educators in the form of a workshop. An evaluation of whether or not the intervention altered educators' (participants') perceptions regarding their skills and knowledge (assets) when coping with the challenges associated with HIV&AIDS, or whether or not their perceptions remained the same, can be presented as 'lessons learned' (McMillan & Schumacher, 2000).

The case study research design I chose applied some principles of participatory action research (PAR). Bhana (2002:228) describes the aims of PAR as '*to produce knowledge in an active partnership with those affected by that knowledge, and for the express purpose to improving their social, educational and material conditions*'. Prolonged and sustainable change in problem situations can only occur when there has been a shift in the knowledge-base of those attempting to change. Consequently, the underlying aim of my study was to explore how an asset-based intervention may change (or not) the way educators (participants) think about their own competencies (assets), for example their skills, knowledge and networks in coping with the challenges associated with HIV&AIDS. By facilitating an asset-based intervention, in the form of a workshop with educators, I assumed that the educators (participants) possessed sufficient knowledge and skills. The outcome of a successful PAR research project is a better understanding of the problem situation and raised awareness within the participants with regard to their own networks, abilities and recourses (assets) to mobilise social action (Ebersöhn & Eloff, 2006; Bhana, 2002). In my study I assume that, if my intervention with educators has been successful and educators are experiencing an enhanced sense of being able to support community members infected with and affected by HIV&AIDS, they will support community members more effectively in future, therefore implying social action. The aspect of social action further holds relevance for the rigour of my study in terms of catalytic authenticity (Mertens, 1998). Mertens (1998) adds to the principles of PAR that I applied in my study, by advocating that areas which are addressed during a PAR study ought to be viewed as areas of concern for participants. I adhered to this principle as I addressed a problem situation which was identified by the participants, during the study of Ferreira (2006) and during the face-to-face interviews I conducted.

Based on my decision to employ a case study design, I could rely on certain strengths, as identified by Nisbet and Watt (in Cohen, Manion and Morrison, 2003). In my study, a case study design implies the advantage of immediate intelligibility in so far as the case speaks for itself. By providing a detailed report of my research results in Chapter 4, I aimed to allow readers of this study to experience the research endeavours to such an extent that they might be able to draw their own conclusions. By employing a case study design I might also be able to provide participants with a platform, to express a sliver of their existence when coping with HIV&AIDS, and in doing so, participants might be able to experience their realities as it is constructed by them. As case studies provide the abovementioned platform unique features might be captured that may otherwise be lost in larger scale data. In my study, a case study design might further provide insight into cases which are similar, thus assisting in the interpretation of similar cases, provided that they share close

contextual similarities. In selecting the case (a single bounded system) I was able to rely on the potential advantage that a case being studied in-depth might provide many insights about the topic of research (Patton, 2002; McMillan & Schumacher, 2000).

However, my choice of a case study design also implied certain potential challenges, as identified by Nisbet and Watt (in Cohen *et al*., 2003). Firstly, case studies are not easily open to cross-checking, as they may be selective, biased, subjective and personal. Case studies are prone to the possibility of observer bias, despite attempts to address reflexivity in observation, interpretations and analysis. I attempted to combat these possible challenges of a case study research design by fully embracing the interpretivist paradigm I had selected, according to which the construction of knowledge is seen as interactive and subjective. My study therefore accepts personal involvement in the construction of meaning, in collaboration with the participants and my co-researchers. I assumed throughout my study that, although people's experiences are subjective, these experiences are real and that it should not be taken light-heartedly (Terre Blanche & Kelly, 2002). I therefore respected the indigenous knowledge systems in the community I selected. I further realised that my own indigenous knowledge system influenced the selection, observations, interpretations and analysis of raw data. I attempted rigorous self-scrutiny throughout the entire research process and employed mentor debriefing and critical reflection as strategies (McMillan & Schumacher, 2000). Figure 3.1 represents the research process I employed in my study.

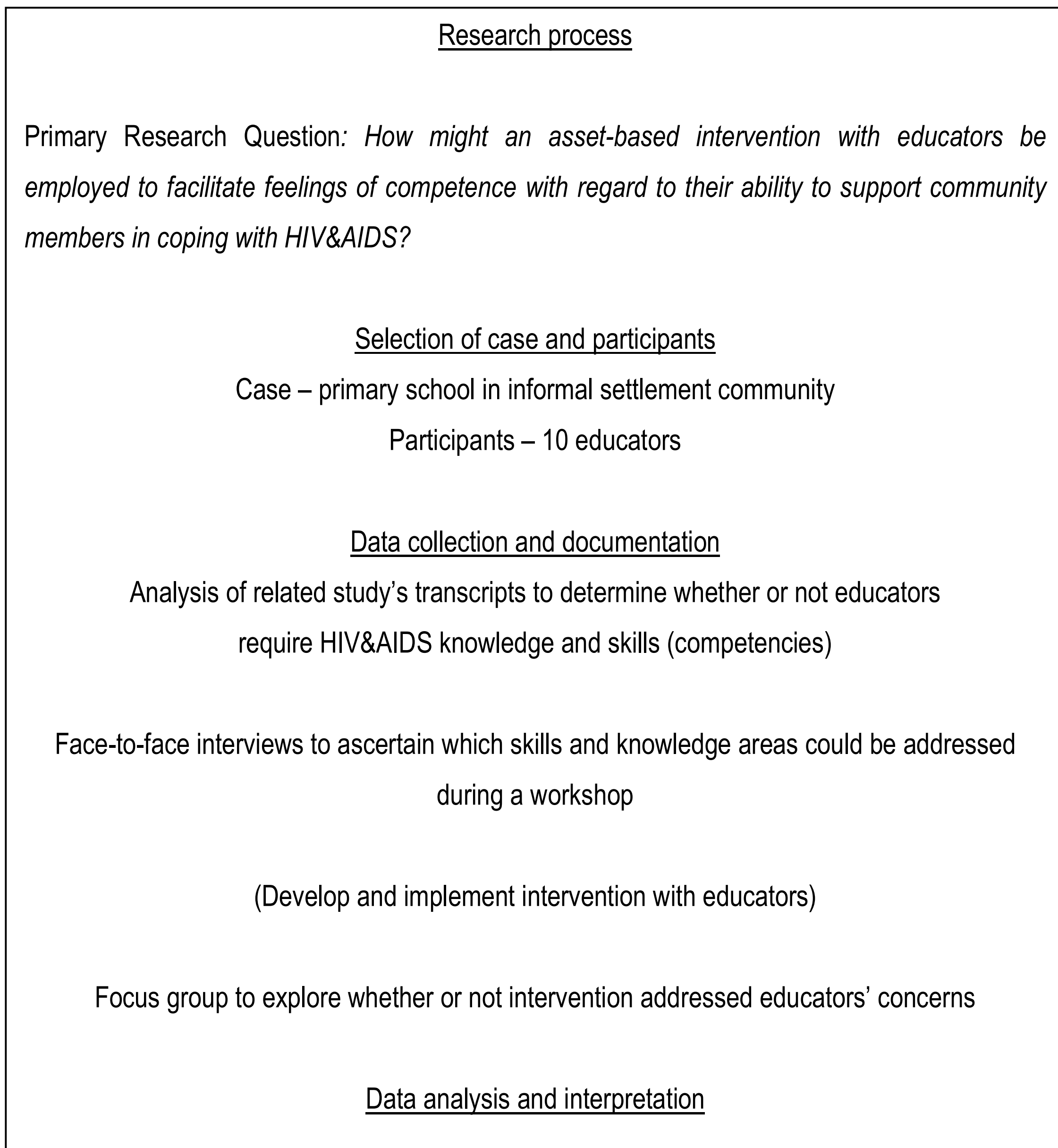


Figure 3.1: Research process

3.3.2 Selection of case and participants

As a case for this study I selected a primary school situated in the Eastern Cape in the Nelson Mandela Metropole. I then selected ten educators from this school as participants. The informal settlement community in which the school is situated is characterised by poverty and a high prevalence of HIV&AIDS. Most learners attending the school live in the surrounding informal settlement community. Figure 3.2 provides a visual image of the informal settlement community where the selected primary school is situated (also refer to Appendix C).

Figure 3.2: Visual presentation of informal settlement community in which selected primary school is situated.

I selected the case based on convenience sampling principles. Convenience sampling '*means that the persons participating in the study were chosen because they were readily available*' (Mertens, 1998:265). The benefit of convenience sampling is therefore that participants are easily accessible. The limitations are, however, that convenience sampling might lead to 'information poor' cases (Merriam, 1998). My convenience sampling is based on Ferreira's (2006) purposeful selection of the case and participants. As such, participants had already been involved in the research project for a period of three months when I entered the research field. The research participants were also familiar with me, as I had acted as field worker in the related study. The fact that Ferreira (2006:106) took great care in purposefully selecting 'an information-rich case' might combat the fact that my study relied on convenience sampling.

I then purposefully selected four educators to participate in the face-to-face interviews I conducted prior to developing and facilitating the intervention. The criteria for selecting these participants were based on the potential knowledge the educators possessed. I selected three educators as they had appeared to be knowledgeable (information-rich) regarding the challenges faced when coping with HIV&AIDS in their community, during the initial stages of field work of the related study by Ferreira (2006). The other educator was selected based on the fact that he had received formal training on basic HIV&AIDS related issues. Accordingly, the possibility existed that this educator could provide

a different point of view on the perceived lack of sufficient skills and knowledge amongst educators in the selected school (Patton, 2002; Merriam, 1998). For the purpose of the intervention (workshop) and focus group discussion, I purposefully selected 10 female educators who had been participating in Ferreira's (2006) study. Table 3.1 provides an overview of the participants in my study.

Research activities involved in	**Number of participants**	**Description of participants**
Face-to-face individual interviews	4 primary school educators	3 female educators who have not received formal HIV&AIDS training and 1 male educator who has received formal HIV&AIDS training
Asset-based intervention	10 primary school educators	10 female educators of whom 3 participated in face-to-face interviews
Focus group discussion	10 primary school educators	The same 10 educators who participated in the asset-based intervention

Table 3.1: Participants in the study

3.3.3 Data collection and documentation

I utilised a variety of data collection procedures, each implying certain strengths and potential challenges. The strengths of one data collecting strategy could therefore compensate for the limitations of another (Berg, 1998). Using a combination of data collection strategies could also increase the rigour of the study, as I was able to gain multiple perspectives from multiple data sources (Terre Blanche & Kelly, 2002; Patton in Merriam, 1998). Gaining many perspectives from multiple data sources is referred to by Janesick (2000) as crystallisation. I now discuss the various data collection and documentation strategies I employed.

3.3.3.1 Analysis of the transcripts of a related study

The first step of my data collection involved an analysis of the transcripts of the related broader study by Ferreira (2006), which commenced in November 2003. Ferreira (2006) explored coping strategies employed by the selected community in response to the challenges related to HIV&AIDS. Another focus of the investigation was the assets within the community, which might be mobilised to assist community members in better coping with HIV&AIDS.

In consultation with Ferreira it became clear that participants indicated a perceived lack of skills and knowledge to support their community in coping with HIV&AIDS. In analysing the transcripts of Ferreira's (2006) data, I followed a deductive approach to content analysis whereby one engages with the data in order to find support for an idea or theme one has in mind (Berg, 1998). Reichertz (in Flick, Von Kardorff & Steinke, 2004:161) argues that although deductions are tautological as they 'tell us nothing new' deduction can be viewed as true-conveying. As such, I approached Ferreira's (2006) transcripts to find support for the idea that educators wanted to obtain basic HIV&AIDS training as well as for educators' perceived lack of knowledge to support their community to cope with the challenges associated with HIV&AIDS. Based on my analysis I identified two main themes. Firstly, educators appeared to hold the perception that they did not posses adequate skills and knowledge (competencies) to support their community in coping with HIV&AIDS related challenges. For example, educators indicated that they wanted to support community members, but felt uncertain of their skills and knowledge as to how to support community members infected with and affected by HIV&AIDS. One educator-participant stated: *we want to support them, but don't know the way to support others*[5] (Ferreira, 2006, Focus group 1, participant 9, p. 2). Secondly, educators were of the opinion that they required training of some sort to be able to support community members (including learners in the classes) infected with and affected by HIV&AIDS, as illustrated by a participating educator: *we want to receive the workshop first, so that we can give them* (Ferreira, 2006, focus group 1, participant 3, p.20). Refer to Appendix D for more examples which support the abovementioned themes derived from transcripts made during Ferreira's (2006) study.

[5] I henceforth use colour to indicate the participants' voices. I rely on different colours to distinguish between the different themes that emerged during data analysis.

3.3.3.2 Face-to-face interviews

Within the context of this study, the purpose of face-to-face interviews was to explore the participants' experiences in the context of coping with HIV&AIDS on a daily basis and their perceived lack of knowledge and skills (competencies), as expressed in their own words. Interviewing can be regarded as a more natural form of interaction with people than questionnaires and, therefore, fits well within the interpretivist paradigm (Terre Blanche & Kelly, 2002). Interviewing involves the extraction and transmission of information. Accurate understanding of the world of the interviewee depends on the interviewer's ability to maximise the flow of relevant, valid and reliable information without distorting the interviewee's values, beliefs, needs and recollection of events. Face-to-face interviewing implies the challenge of creating ways for interviewees to bring the interviewer into their worlds (Merriam, 1998; Holstein & Gubruim in Schurink, 1998).

The essence of a face-to-face interview can therefore be described as the social interaction between the interviewer and interviewee as equal partners, in order for the interviewer to obtain information relevant to the research. This way of social interaction differs from other forms of social interaction, as the interviewer does not try to convey personal feelings, thoughts or beliefs regarding (in this case) HIV&AIDS skills and knowledge for sustainable coping in informal settlement communities (Schurink, 1998).

I used semi-structured interviews and was guided by formulated questions and themes (refer to appendix E). I did not ask the questions in a particular sequence, but rather kept the planned questions and themes in mind throughout the interviews, ensuring that the relevant themes were covered during interviews without jeopardising the natural flow of conversations (Terre Blanche & Kelly, 2002; Merriam, 1998; Schurink, 1998). The interview guide that directed me during the interviews was:

- current copying skills employed by educators (participants) regarding HIV&AIDS challenges;
- sources that the participants utilised to obtain HIV&AIDS related information;
- areas where participants perceived to experience a lack of knowledge or skills with regard to coping with HIV&AIDS in their community; and
- HIV&AIDS training that the participants had received and the manner in which participants were utilising the skills and knowledge received *via* training.

I conducted four individual face-to-face interviews, three of which were with female participants who had not received formal HIV&AIDS training and one with a male participant who had received formal HIV&AIDS training. Each interview continued for approximately 60 minutes. I scheduled interviews *via* telephone contact before entering the research field. I conducted interviews on the school premises after school hours. Each interview involved the selected educator (participant), a co-researcher[6] and myself. I audio-recorded the interviews and transcribed the interviews verbatim (refer to Appendix E in this regard).

The format of interviewing which I selected provided for a systematic collection of data and prevented important information from being overlooked. On the other hand, this type of interview posed the challenge of requiring a trained and proficient interviewer (Patton, 2002; Schurink, 1998). I attempted to address this challenge by constantly bearing in mind that I was not fulfilling the role of a psychologist, (a role that I easily fulfil due to my training as psychologist), sharing empathic highlights and clarifying emotions, experiences and behaviours, but that I was fulfilling the role of researcher, aiming to guide the interviews according to the research agenda (Egan, 2002). I consistently reminded myself of the fact that I was trying to understand reality as it is constructed by the participants. As such, I viewed the interviews I conducted as a manner in which I (in collaboration with the participants and my co-researcher) could socially construct meaning. I was further under constant supervision of my supervisor during the interviews (acting as co-researcher), who provided guidance and feedback when necessary.

3.3.3.3 Focus group discussion

After completion of the intervention, I facilitated a focus group discussion aiming to create an opportunity for participants to reflect on the asset-based intervention I facilitated with them (McMillan & Schumacher, 2000). I aimed to determine whether or not they felt efficiently equipped with skills and knowledge (competencies) to cope with learners infected with and affected by HIV&AIDS and to support community members more effectively. The focus group lasted two hours, was audio-recorded and transcribed (refer to Appendix F in this regard).

A focus group is a purpose driven discussion or conversation of a specific topic which takes place between a group of people with similar backgrounds and interests. Focus groups should be large

[6] Dr. R. Ferreira

enough to provide a diversity of perceptions but small enough for all participants to have an opportunity to share their insights (Wilkinson, 2004; Schurink *et al.,* 1998).

My decision to employ a focus group discussion was based on certain advantages implied by this data collection strategy. Interactions between group members generally stimulate discussions, where one group member reacts to comments made, or questions asked, by another. Participants can thus draw from one another or brainstorm collectively. This allows for a greater number of ideas to be generated through a group discussion than might be obtained through individual interviews (Berg, 1998) Wilkinson (2004) argues that sensitive themes can also be discussed in a focus group setting, as the solidarity amongst group members may contribute to a decrease in discomfort related to disclosure of information on sensitive content. Other advantages that a focus group discussion implied for the study I undertook lies in the fact that it was economical, in the sense that insight of more than one participant could be gathered during a single interview. In addition, the quality of the raw data was enhanced by means of the interaction between the participants, as they corrected and balanced each other's insights, thereby removing false or extreme views from the raw data. Participants further seemed to enjoy the focus group, because of the socialisation involved prior to and during the focus group discussion (Patton, 2002).

The discussion focused on the fulfilment of participants' expectations regarding the enhancement of their skills and knowledge (competencies) in coping with HIV&AIDS, not only in their classrooms but also in support of the wider community. By utilising a focus group discussion as a data collection technique I encapsulated the interpretivist paradigm, as the participants and I were interacting in order to construct meaning. I (in collaboration with my co-researcher) facilitated the focus group discussion directly after concluding the intervention (workshop).

Kelly (2002) views the facilitation of a focus group as a process whereby the facilitator has to maintain a balance between 'focusing in', whereby the discussion is guided by the facilitator towards specific themes, and 'focussing out', where the discussion flows naturally. During the focus group discussion I facilitated, I kept this balance in mind and aimed to steer the discussion towards three main aspects/areas of interest. Firstly, I aimed to investigate whether or not the educators perceived their knowledge and skills (competencies) with regard to HIV&AIDS related issues to have been enhanced by means of the intervention. Secondly, I aimed to steer the discussion towards a dialogue on the confidence level of the educators in supporting community members infected with and affected by HIV&AIDS. Finally, I aimed to establish whether or not the educators

could highlight possible areas where the intervention could improve (for the purpose of potential future intervention workshops with other educators).

During the facilitation of the focus group, I had to address certain challenges. As the response time available to each participant was limited, I had to manage the process, in such a way that no participant felt that she had not been able to get her point of view across. During the focus group, a few participants tended to dominate, not allowing other less verbally inclined participants to contribute spontaneously. I had to actively involve more silent participants, by redirecting questions to them for their views. The possibility further exists that participants with an unpopular view might have contributed less often as they might have feared the negative reactions of other participants. Lastly, I could not ensure confidentiality being kept in the focus group, although I did request participants to keep the content of the discussion confidential (Wilkinson, 2004; Patton, 2002).

I tried to combat the abovementioned challenges of focus group discussions by being aware of the interplay in the group and facilitating the participation of all participants. I aimed to facilitate trust in the group by explaining the importance of confidentiality of what is being said in the group. The participants and I also discussed the issue of negative feedback regarding personal and minority points of view during the orientation phase of the focus group discussion. I managed the more verbally inclined participants by continuously inviting those less verbally inclined to speak freely (Mertens, 1998).

3.3.3.4 Observation-as-context-of-interaction

The qualitative researcher is interested in the observation of people's behaviour in a form that seems to be meaningful for the people involved (Mertens, 1998). I did not employ predetermined categories of measurement or responses during observation, but rather kept my observations broad and descriptive. As Angrosino and Mays de Pérez (2000) rightfully state, observation of human interaction and actions can only be interpreted (made meaningful) within the situational context it occurs in and not by means of predetermined 'codes'. Refer to Appendix G for examples of observations as captured in my field notes as well as Appendices C and H for visual presentations, supporting by observations.

As a qualitative researcher, I was constantly aware of the fact that what I observed might have been influenced by my age, gender and race. I was further aware that another researcher of a

different age, race and gender might have elicited different interactions between the participants, leading to different observations being made. I believe that my behaviour and expectations were dynamic and developing in interaction with the dynamic behaviours and expectations of the participants in my study. I consequently adopted a flexible peripheral-member-researcher role, whereby I observed and interacted to such an extent that an insider perspective was strived to be established (Angrosino & Mays de Pérez, 2000; Mertens, 1998).

This insider perspective is referred to in literature as the emic perspective. By participating, I was able to see what was happening (observing) and also feel what was happening. I was constantly aware of the limitations of my own feelings, and that putting this forward as possible insights into the experiences of the participants may well be presumptuous, as the feelings I experienced while participating in the research field were coloured by my own frame of reference (values, norms, beliefs and previous experience). In accordance with the interpretivist paradigm, I believe that the observations made in this study are interactive, and represent shared meaning making between the participants and myself within the interactive context of the research field (Patton, 2002; Merriam, 1998; Mertens, 1998). On the other hand, the outsider perspective is referred to in the literature as the epic perspective. From this perspective, the researcher is an outsider in the research context, observing interactions and events from afar. In my study such a perspective would not have aligned with the interpretivist paradigm, as Interpretivism emphasises inter-subjective engagement (Bhana, 2002; Patton, 2002; Merriam, 1998).

One of the biggest challenges of observation is to gain enough of an insider perspective (emic) to understand the nature of a group without losing the ability to record and analyse the data in a credible manner, implying an outsider (epic) perspective (Mertens, 1998). In this regard, Terre Blanche and Kelly (2002) explain the seeking of balance between ‘getting to close to participants’ (thereby losing perspective) and ‘staying too distant from participants’ (thereby losing empathy). In my study I aimed to obtain an insider perspective as this perspective reflects the interpretivist paradigm, while still recording and analysing the data in a trustworthy manner, by being aware of my possible bias and recording this in my research book, as well as making reference to it in my research findings. Furthermore, I was aware of the values of both the emic and epic perspectives and reflected on both these perspectives in my findings. However, based on the differences between the backgrounds of the participants and myself, I doubt if I could truly obtain an insider perspective and regard my perspective rather as an attempt to obtain an insider view.

Additional challenges implied by observation as data collection strategy are firstly that observations only focuses on external behaviours, and that the observer can as a result only guess the internal thoughts and feelings of the people being observed. As I utilised interviews in conjunction with observations, I could gain access into the internal worlds of the participants. I also relied upon the observation of non-verbal cues of the participants, such as facial expression, posture and pauses before answering questions. A second potential challenge when using observation is that the researcher may influence the situation being observed, resulting in the data collected in such a situation being unreliable (Patton, 2002; Merriam, 1998). In line with Interpretivism, I continually kept in mind that my presence might have influenced the observations I made.

The strength of observations include the fact that data can be revealed, which might otherwise be disregarded as unavailable. As such, through direct observations I was able to come to a greater understanding of the context in which the participants interact. As such, I am able to provide richer descriptions of the context of my study. By utilising observation I was able to see things that might have routinely escaped the participants in my study as they are immersed in their daily routines and might take these aspects for granted, not being aware of the nuances that a 'fresh pair of eyes' might see (Patton, 2002; Mayan, 2001).

3.3.3.5 Research book: field notes and research journal

Field notes can be described as a constant note keeping process of observations and conversations encountered in the field. The descriptive nature of field notes was important to me in undertaking this study, as it assisted during analysis of the data and might also permit the reader of the study's findings to experience the activities I observed in the field. However, literature warns against descriptions in field notes being coloured by interpretations and not revealing the detail of the situation. For example, words such as *poor*, *anger* and *uneasy* should be elaborated further, in order to avoid unexplained subjective meanings the researcher might convey (Patton, 2002). In this study, I departed from an interpretivist paradigm, implying subjective meaning given to observations by me.

I aimed to write field notes as soon as possible after every encounter in the field. I also recorded notes in private before discussing my experiences with co-researchers, in order to avoid field notes becoming interpretations or views of 'others'. I used pseudonyms in the form of stars (XXX) for

each person and location that became part of my field notes (Terre Blanche & Kelly, 2002; Berg 1998).

Research journals can be described as notes that reflect the researcher's ideas regarding the phenomenon that is being researched, as well as reflections on theoretical, methodological and ethical issues. Research journals may reflect points of uncertainty which may warrant further investigation (Terre Blanche & Kelly, 2002). In my study I combined a research journal into my field notes book, by dividing the page in two, with the one side containing the field note descriptions and the other side analytical comments, which can be regarded as my research journal, thereby creating a research book. Refer to Appendix G for examples of my field notes and research journal in my research book (please note that I provide only one handwritten example of my research book as I typed my field notes and research journal for presentational purposes). In this book,I recorded my personal reactions to what I observed, in an attempt to further my self-awareness and self-knowledge (Patton, 2002; Terre Blanche & Kelly, 2002). As such, my research book contained both descriptive accounts as well as reflective notes on my experiences of fieldwork. This was done in an attempt to contribute to my understanding of what it was like to be in the situation being studied, as well as to the richness of the data collected (Patton, 2002; Poggenpoel, 1998).

3.3.3.6 Visual data

By employing visual data in my study I was able to present images that would have taken many words to convey the information represented in the photograph (Haper, 2000). Bogdan and Biklen (2003) agree and state that photographs might serve as a reminder and allows a person to recapture the detail of the setting. Photographs can also shed light onto the relationships and activities found in the research context (Berg, 1998). In my study, I used photographes to represent both the community and the proceedings of field work I was involved in.

However, Bogdan and Biklen (2003) warn that when employing photographs as data collection strategies and presenting photographs in research findings an ethical issue arises. Informed consent obtained from participants does not automatically include the publication of photographs in which participants are recognisable. In such cases the participants' permission should be obtained. In my study I decided to present photographs as part of my data documentation but I ensured that participants' identities would be kept confidential by making their faces unrecognisable. I also obtained the participants' consent for taking photographs.

3.3.3.7 Intervention with educators

I developed and implemented an HIV&AIDS intervention of limited extent consistent with the asset-based approach. I discuss the process of the intervention I facilitated in more detail in Chapter 4 and include more information in Appendices H, I and J. I relied on my analysis of the related study's transcripts, as well as the face-to-face interviews I conducted, as the framework for structuring the intervention, as well as the information and skills to be addressed during the intervention (workshop).

The intervention took the form of a workshop, during with I (in collaboration with my co-researchers fulfilled the role of facilitator, focusing on the participants' (educators') range of current competencies and coping skills and aligning these, in order to adequately address their perceived shortcomings in dealing with HIV&AIDS in their classrooms, school and the wider community. I assumed that the participants already possessed the necessary skills and knowledge base to support other community members in coping with HIV&AIDS. My role as facilitator was therefore based upon the asset-based approach to intervention, according to which I regarded the participants as the experts with regard to coping with HIV&AIDS in their community (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). I therefore did not depart from the belief that I am the expert providing participants with skills to cope with the HIV&AIDS challenges they face. I moved away from the deficit-model's conceptualision of problem-situations towards an asset-based approach during the development and facilitation of the intervention.

Throughout the intervention (in the format of a workshop), I aimed to facilitate an awareness amongst participants regarding the existing interrelated systems in their community. The focus fell on the fact that the educators (participants) are part of a sub-system within a wider school system, and that the school, in the same manner, forms part of an even wider community and social system. The rationale for the abovementioned was to facilitate awareness amongst participants of available assets amongst themselves, in their school and in the community (Ebersöhn & Eloff, 2006; Donald *et al.,* 2002; Kretzmann & McKnight, 1996).

One potential challenge of an HIV&AIDS intervention in the format of a workshop lies in the possibility of participants feeling uncomfortable when faced with sensitive and emotional issues related to HIV&AIDS (Centre for the Study of AIDS, 2001). However, Wilkinson (2004) argues that

the solidarity found amongst members of a group might decrease the anxiety related to disclosing sensitive information. Whatever the case may be, I tried to create a safe environment during the HIV&AIDS workshop, where sensitive topics such as sexual behaviour and death associated with HIV&AIDS could be discussed. In an attempt to create this safe environment, I opened the discussion by referring to the confidentiality of information shared during the workshop (intervention) as well as the importance of valuing the contributions of each participant, in order to enhance mutual respect amongst participants.

Another potential challenge of group discussions and activities (as in the case of workshops) is that the potential exists that the more dominant participants may overwhelm those less dominant. The active participation of all participants is important (Kelly, 2002). I tried to involve all participants in discussions, by modelling encouragement and respect for everyone's contributions (Centre for the Study of AIDS, 2001). As a result, I faced the potential challenge that a positive feedback circle might develop in which the participants might contribute only because of the positive feedback they received from the group and not in order to add to the understanding being constructed. I was, however, constantly aware of this possibility, in an attempt to address it if it occurred.

I facilitated the workshop two months after the individual face-to-face interviews had been completed. One of the participants assisted me in scheduling the workshop, which took place over two days and altogether lasted four hours. The workshop was facilitated on the school's premises in the staff room.

The workshop commenced with a welcoming session during which the purpose of the intervention was explained, and informed consent was obtained. The orientation stage further focused on providing feedback from the individual face-to-face interviews and introducing the participants to the four areas in which guidance was required, as it emerged from the interviews. The workshop firstly involved small group discussions, during which participants brainstormed about possible resources where HIV infected individuals (parents, children and other community members) might find support, focusing on financial grants, food parcels, medication, social support and services available at the local clinic. After presenting their thoughts to the other participants, participants took part in the creation of presentations concerning possible responses to the needs of a learner infected with and/or affected by HIV&AIDS in their classrooms. Concerns pertaining to physically supporting HIV infected individuals were addressed in the format of a group discussion, after which each participant received an information booklet (refer to Appendix J) which I developed prior to

the intervention and which correlated with the ideas the participants generated. Finally, I encouraged the participants to brainstorm ideas relating to the emotional support one might be able to provide to HIV infected individuals. These ideas where summarised and practised during a role play activity. I concluded the intervention by presenting the synthesised information as generated by the participants on posters and highlighting the main aspects within each of the abovementioned four themes. The workshop was concluded with a presentation of certificates of attendance to the participants (refer to appendix H). A more detailed account of the workshop sessions are included in Chapter 4 and incorporated in the relevant appendices.

3.3.4 Data analysis and interpretation

The aim of data analysis is to transform raw data from transcripts, observation, field notes, a research journal and visual data into a format that may address the primary and secondary research questions (Durrheim, 2002). The data from the transcripts made during the related study (Ferreira, 2006) and the transcribed face-to-face interviews was analysed and then used in the design and facilitation of an asset-based intervention with participants, with the aim of enhancing the support they provided to community members infected with and affected by HIV&AIDS and their coping when faced with HIV&AIDS related challenges in their classroom. The focus group discussion was used as feedback regarding whether or not the asset-based intervention did enhance the participants' perceptions regarding their current skills and knowledge (competencies) in relation to coping with HIV&AIDS, as well as supporting their community to cope with the challenges associated with the pandemic. This discussion was also audio-recorded and transcribed, in order to be analysed and interpreted. Refer to Appendices D, E, F and K for examples of data analysis and interpretations.

In interpretivist research, there is no clear distinction between when data collection stops and data analysis begins. During the data collection phase, the researcher is already developing ideas and theories about the phenomenon being studied. Data analysis is thus an ongoing process and not something that occurs only when data collection has been completed (Terre Blanche & Kelly, 2002; Mertens, 1998). In this study, I relied on my research journal during data collection, in order to reflect on emerging ideas.

I employed content analysis, which can broadly be defined as any systematic and objective technique used for identifying unique, recurring characteristics of messages conveyed in the data

(Wilkinson, 2004; Berg, 1998). Terre Blanche and Kelly (2002), as well as Mertens (1998), provide guidelines for interpretive analysis, which I followed during the data analysis of this study. As a first step I immersed myself into the research material. This includes the verbatim transcripts of the related study, face-to-face interviews, intervention workshop and focus group discussion. In addition, my field notes and research journal also formed part of the raw data. The aim was to familiarise myself with the data by multiple readings of the text. Secondly, I had to deduce themes by inferring general rules or classes from specific instances. The central goal of my interpretation was to discover themes (Kelly, 2002). According to the interpretivist paradigm, this implied a bottom-up approach, analysing the data to find the organising principles that 'naturally' underlie the material. Central to the idea of pattern or theme finding is the notion of repetition, as I could identify themes by virtue of the fact that they re-occurred (Kelly, 2002). Throughout, I aimed to use the language of the participants in labelling the categories or themes: for example, one of the participants referred to their sense of group cohesion as *singing the same song*. (focus group, participant 7, p.4) In organising the data I aimed to move beyond merely summarising the content and tried to identify tensions and contradictions that might increase the range of themes that could be extrapolated from the data.

I conducted coding, as the next step of data analysis and interpretation, although this was interlinked with the process of developing themes. I coded phrases, words, paragraphs or lines that pertained to the theme under consideration. Terre Blanche and Kelly (2002) provide a range of methods by which coding can be conducted, including the use of coloured marker pens, the cut-and-paste function on a word processor, or the use of a software programme. In this study, I considered the use of the cut-and-paste function on a word processor, or the software programme Atlas.Ti. Based on the advantages of these possibilities, as well as my personal preference, I decided to employ the cut-and paste method on a word processor. Next, I employed elaboration, as described by Terre Blanche and Kelly (2002), referring to the process whereby the researcher (in this case me) explored the themes closely to capture the finer nuances which might have been overlooked in the first coding attempt. A cycle of coding, elaborating and recoding was established, until no further significant new insights emerged. The final step in the data analysis of this study entailed interpretation, which includes a written account of the phenomena that I studied, utilising the themes from the analysis as subheadings. Once this was completed I checked my writings for errors. I asked myself questions relating to possible over-interpretation and looked for possible contradictions (Terre Blanche & Kelly, 2002). Gay and Airasian (2003) indicate that it is important

to be explicit regarding the conceptual basis of the themes and what makes one theme different from another.

As a means of enhancing the authenticity of the themes I extrapolated from the data, I employed 'member checking', whereby I verified possible emerging themes with the participants during interviews, as well as during the introduction to the themes in the orientation stage of the focus group discussion, in order to ensure that I understood and presented their perceptions accurately (Schostak, 2002; Merriam, 1998). I also attempted to verify themes which emerged from the data after my second field visit *via* telephonic contact. Although I spoke to two participants and both affirmed the themes as representing their points of view, it seemed that they did not truly understand the purpose of the exercise. Due to the limited facilities at the primary school I was unable to fax or e-mail the emerged themes to the participants to further enhance the credibility by means of member checking.

3.4 MY ROLE AS RESEARCHER

Within this study I found myself in a position where I had to adopt two distinct and sometimes opposing roles, namely the role of researcher and the role of interventionist. I aimed to balance these two roles, by means of critical refection and regular mentor debriefing sessions with my supervisor.

3.4.1 Role as researcher

In qualitative research the researcher can be regarded as the main instrument of data collection. As researcher, I was responsible for selecting the participants (being guided by my supervisor who conducted the related study and knew the participants), observations, finalising an interview schedule and collecting various forms of raw data. I constantly had to pay attention to the values, beliefs and assumptions that I might have imposed on the study, and reflected on these issues in my research journal (Merriam, 1998). Mertens (1998:175) states in this regard:

> *'In general, qualitative research texts recognize the importance of researchers' reflecting on their values, assumptions, beliefs and biases and monitoring those as they progress through the study to determine their impact on the study's data and interpretations'*

During data collection, analysis and interpretation, I viewed reality as socially constructed and acknowledged the fact that multiple constructions of realities exist. Through this lens, I conducted

all interpretations and reflections. As researcher in the interpretivist paradigm, I also focused on the interactive nature of knowledge construction (Kelly, 2002). Therefore, I adopted a flexible peripheral-member-researcher role. As such, I made observations and interacted with the participants with the aim of establishing an insider's perspective, in other words an emic perspective. As my interaction in the field and shared activities with the participants did not immerse me into citizenship within the community, I was able to record data in a credible manner (Mertens, 1998).

3.4.2 Role as interventionist

As I had selected an instrumental case study research design, applying some principals of participating action research (PAR), I assumed the role of change agent, facilitating participants (educators) to generate ideas that might possibly initiate change. In my study, the term change relates to the way educators support community members infected with and affected by HIV&AIDS (Bhana, 2002).

Additional theoretical underpinnings of my study focused on the asset-based approach. From this perspective I also had to assume the role of interventionist. Ebersöhn and Eloff (2006) describe the role of interventionist within the asset-based approach as one of facilitating change. From this perspective I did not engage in activities where I provided participants (educators) with ready-made solutions for the problem situation they were facing with regard to coping with HIV&AIDS related challenges. My role was rather one of creating a platform for interaction (in the form of an intervention/workshop) amongst participants (educators), where they could create their own solutions for the challenges they face in coping with, and supporting community members infected with and affected by HIV&AIDS.

3.5 ETHICAL CONSIDERATIONS

As a qualitative researcher I constantly viewed myself as a guest in the private world of the participants in the study. Throughout this study I aimed to employ good manners and adhere to strict ethics (Stake, 2000). As a masters student in Educational Psychology at the University of Pretoria, I relied upon the Faculty of Education's Research Ethics committee's guidelines. Subsequently I also obtained ethical clearance from this committee prior to my field work (refer to Appendix L in this regard).

In conducting this study I was firstly guided by the principal of *informed consent*, which refers to the right of participants to be informed about the nature and consequences of the research and to *participate voluntarily.* This implies that the participants gave consent, knowing that there were no elements of deceit or manipulation and that they could withdraw from the research at any time (Durrheim & Wassenaar, 2002; Merriam, 1998; Mertens, 1998). Prior to commencing with any data collection activities I obtained informed consent from the Department of Education (as part of the related study), and the principal of the school as well as all participants in the study (McMillan & Schumacher, 2000). Refer to Appendix M in this regard.

Secondly, I adhered to the principal of *confidentiality*, which refers to the active attempts of the researcher to protect participants' identities as well as that of the research location. I did this by systematically changing each participant's name and the names of the location to a pseudonym in the transcripts included in Appendix E and F, as well as in my field notes and research journal (Appendix G) (Christians, 2000; Berg, 1998). Before commencing with data collection, I informed the participants in the study about *confidentiality*, their *right to privacy* and their *freedom to withdraw* from the research at any time. As the face-to-face interviews were conducted individually, *confidentiality* and *anonymity* could be guaranteed. Although this was not the case with the intervention workshop and focus group discussion, *confidentiality* and *anonymity* was discussed and emphasis was placed on the fact that participants had to respect the confidentiality of other group members.

Furthermore I adhered to the principal of the *safety of participants* whereby I did not expose participants to any harm by participating in my study. The principal of *trust* implies that I did not engage in any act of deception in the research process, or in the published outcomes (Faculty of Education, 2006). Guba and Lincoln (in Mertens,1998:42) refer to ethical considerations inherent in case study research, under which the unethical researcher could select data *' that virtually anything he wished could be illustrated*'. As a qualitative researcher employing an instrumental case study research design, guided by participatory action research (PAR) principles, I felt obliged to respond to this statement. The deceitfulness implied in this statement is in sharp contrast with the core of my human existence as I value and respect the integrity, dignity and power others hold (in this scenario my fellow scholars and research participants). I also value honesty and the lessons we learn in life.

3.6 RIGOUR OF THE STUDY

In my study I aimed to adhere to the criteria discussed below, as suggested by Mertens (1998), in order to enhance the quality of my study.

3.6.1 Credibility

In qualitative research, credibility is seen as the parallel of internal validity in quantitative work. Credibility refers to the accuracy with which the researcher was able to portray the way in which participants perceived the social phenomenon under study (Mertens,1998).

I aimed to enhance the credibility of my study by engaging in the research process, as well as the research field, for an extended period of time – until data saturation occurred. As I had acted as field worker in the related study conducted by Ferreira (2006) in the same informal settlement community before I journeyed into the community as a researcher, I was able to engage in numerous observations in an attempt to identify prominent issues, prior to this study (Mertens,1998).

I further relied on peer debriefing with a co-researcher in an attempt to increase the credibility of my study. Debriefing discussions focused on my subjectivity and possible bias (recorded in my research journal) in order to negotiate my subjectivity with my research findings (refer to Appendix G in this regard). Peer debriefing was further employed as discussion platform regarding my research findings, analysis and conclusions (Merriam, 1998; Mertens, 1998).

I employed crystallisation to enhance credibility, whereby I verified the themes under construction in my study from multiple data sources, namely interviews, observations, a focus group discussion on the workshop, field notes, my research journal and visual data (Patton, 2002; Schostak, 2002; Janesick, 2000).

3.6.2 Transferability

Transferability in qualitative research stands parallel to external validity in quantitative research. Transferability refers to the ability of the researcher to provide rich descriptions in order to enable the reader of the research report to determine the degree of similarity between the research

context and other contexts where the findings might fit (McMillan & Schumacher, 2000; Poggenpoel, 1998).

In this study I do claim degree of transferability. I selected a case which represented a specific phenomenon (educators supporting community members in coping with HIV&AIDS) and so I assumed that other cases that represent the same phenomenon (educators supporting community members in coping with HIV&AIDS) might be contextually similar (informal settlement communities), implying the possibility of transferability of findings (Merriam, 1998; Mertens, 1998). However, as I departed from the interpretivist paradigm, I did not assume that the findings of this study could simply be translated to other contexts, as I belief that knowledge creation is an interactive process within a specific context (Terre Blanche & Kelly, 2002; Mertens, 1998).

In this study I aimed to enhance the possibility of transferability by providing rich descriptions of the selected primary school in an informal settlement community in the Eastern Cape, with a focus on the physical setting. I described the context of my study in detail, focusing on educators, learners, parents and other community members infected with and affected by HIV&AIDS.

3.6.3 Dependability

In quantitative research, reliability stands parallel to dependability in qualitative research. Qualitative researchers aim to describe dynamic human interaction, as interaction is interrelated among the members participating in the interaction. It is therefore clear that the research findings in a qualitative inquiry will change over time. I selected a case study research design valuing the uniqueness of the case and what one might learn from this case, rendering a repeat of findings meaningless (Stake, 2000).

Dependability can be viewed as *'whether the results are consistent with the data collected'* and whether or not the findings might be obtained again (Merriam, 1998:206). Dependability therefore reflects the ability of the researcher to track and record the changes in the research process, enabling the possibility of an execution of a dependability audit to evaluate the quality and appropriateness of the research process. In my study, I recorded changes in the focus of my inquiry in my research journal and engaged in peer debriefing regarding the impact of these changes on my study (Merriam 1998; Mertens, 1998).

3.6.4 Confirmability

Confirmability stands parallel to the concept of objectivity in quantitative research and refers to the attempt to minimise the influence of researcher's bias. I aimed to enhance the confirmability of my study by utilising multiple sources of data and multiple data collection strategies. Furthermore, I employed various examples of direct quotations from the participants to support the interpretations I made (Kelly, 2002; Mertens, 1998).

I aimed to provide an account of the participants' interpretations of their own skills and knowledge regarding coping with HIV&AIDS, being mobilised *via* an asset-based intervention. I do not assume that the way in which I interpreted the raw data is the only way the data could have been interpreted. For example, a researcher from the field of educational policies might have interpreted the data in a different way.

3.6.5 Authenticity

Authenticity refers to presenting a balanced view of the perceptions, values, and beliefs of the participants in the study. In this study I present the different points of view of the participants regarding the mobilisation of their HIV&AIDS skills and knowledge (competencies) *via* an asset-based intervention, in order to enhance their coping with regard to learners infected with and affected by HIV&AIDS, as well as supporting community members in coping with HIV&AIDS (Mertens, 1998).

Catalytic authenticity refers to the extent to which the research can enable action, being taken by the participants due to their participation in the study. In this study the word *mobilisation* implies moving into action, thereby indicating catalytic authenticity. However, the question remains to what extent the educators (participants) in this study moved into action. The related study by Ferreira (2006) in the same community indicates that the educators (participants) moved into action to a great extent. It might, however, be fruitful to investigate whether or not the actions taken by the participants are sustainable (Mertens, 1998).

3.7 CONCLUSION

In this chapter I presented and discussed the research process that I employed during the empirical study I conducted. I discussed the interpretivist paradigm from which I approached the study. This was followed by descriptions of the research design (an instrumental case study applying PAR principles), data collection and documentation procedures (an analysis of the transcripts of the related study, face-to-face interviews, intervention/workshop, focus group discussion, observation-as-context-of-interaction, field notes, research journal and visual data), as well as data analysis and interpretation. I then provided the reader with thoughts on my role as researcher and concluded the chapter with discussions on ethical considerations and the rigour of the study.

In the next chapter, I present the research results. I interpret the results in terms of existing literature, thereby formulating and discussing the findings of the study.

CHAPTER 4

RESEARCH RESULTS

4.1 INTRODUCTION

In the previous chapter I provided an overview of the research process that guided this study. I discussed the interpretivist paradigm from which I approached the study and presented the instrumental case study I selected as research design. This was followed by explanations of the data collection and documentation strategies I employed, as well as the manner in which I conducted data analysis and interpretation. I concluded Chapter 3 with discussions on my role as researcher, the ethical considerations I considered and the measures I employed in order to enhance the rigour of this study.

In this chapter I present the research results. I firstly provide an overview of the research as it progressed, as well as my involvement in the research field. I divided the research process in two phases. Phase 1 relates to research activities and results obtained from my first visit to the research field during which I conducted interviews and compiled a research book. Phase 2 relates to research activities and results of my second visit to the research field. During the second phase of my research I facilitated an asset-based intervention as well as a focus group discussion. I present my research results from both phases in terms of the themes and sub-themes that emerged during my analysis and interpretation of the raw data. I provide the reader with colour-coded verbatim quotations of participants to support themes and sub-themes. I conclude the chapter by discussing the findings of this study, linking the results I obtained with existing literature and aiming to highlight similarities and explain contradictions.

4.2 OVERVIEW OF RESEARCH PHASE 1: FIELD WORK, OBSERVATIONS AND INTERVIEWS

Various sources (Patton, 2002; Merriam, 1998; Mertens, 1998) describe the process of entering the research field as a combination of negotiations with gatekeepers in the community, in order to establish trust and rapport. This stage of my research process was a period of personal anxiety, excitement and constant reflection. In the following sections, I reflect on my involvement during the various phases of this study, by referring to the research activities in which I was involved.

4.2.1 Acting as field worker in a related study

By acting as field worker in the related study by Ferreira (2006), I was in the fortunate position to observe and interact within the selected community and research participants before I had to venture into the role of researcher. I now realise that my field work already commenced during those initial stages, when I acted as fieldworker, as I interacted with consciousness (Patton, 2002; Merriam, 1998). It is also during this stage that I commenced with the analysis of the related study's transcripts (Ferreira, 2006).

My co-researcher (supervisor, R. Ferreira) and I visited, interviewed and observed a variety of community members in their homes, as part of the related study. We also visited, observed and conducted interviews with role players at places and organisations, that could be considered to be assets in the community, such as social workers, religious leaders, non-government organisations, clinics and hospitals (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). The purpose of these visits was aimed at data gathering for Ferreira's (2006) study which explored coping strategies employed in response to HIV&AIDS related challenges within the selected community.

4.2.2 Observations: making field notes and compiling a research journal

By employing observation I was able to crystallise emerging findings as observations served to substantiate emerging themes. Furthermore, by utilising observations I was able to gain insight into the context in which interviews took place (Merriam, 1998). I divided the pages of my research book in two, one half containing field notes and the other half entailing my research journal. After each contact session I recorded my observations in the field notes section, allocating pseudonyms to each person and location, which took on the format of stars (XXX). I aimed to document my observations before discussing them with co-researchers and also to keep my descriptions as clear and factual as possible (Patton, 2002; Berg, 1998; Merriam, 1998). For example, instead of writing interpretations: *the participant was emotionally affected by the challenges associated with support in the context of HIV&AIDS*, I would rather describe why I perceived her to be emotionally affected: *She started to rub her hands, wiped sweat of her upper lip while making a fist with one hand....*(field visit 1, 18 February 2004, interview 2, participant 2, p.5.*).* Refer to Appendix G for examples of my field notes.

In the research journal section of my research book, I aimed to record my reflections on the experiences I had in the research field. I reflected on research methodology, for example: *When I looked at her and saw the frustration in her demeanour, I thought to myself: how can I possibly perceive what it is like to stand in her shoes? (emic perspective) I will never come close!!* (field visit 1, 18 February, interview 2, participant 2, p 5) only later to reflect: *I realise now that I share some of her frustration, how can people just lift their shoulders and walk on by when you can help someone in need?* (field visit 1, 19 February, interview 3, participant 3, p. 7) I also reflected on emerging themes, for example: *the greatest asset in this community is the educators' willingness and motivation to support their community. It is something in their character, Ubunto maybe?* (field visit 1, 20 February, interview 4, participant 4, p. 9). As a qualitative researcher my feelings and reactions formed part of the data I obtained, resulting in me reflecting on these personal feelings and reactions (Patton, 2002; Terre Blanche & Kelly, 2002; Merriam, 1998; Poggenpoel, 1998.), for example: *when I heard that the little girl I had met during a previous visit had died, I had to restrain myself from crying* (field visit 2, 3 June 2004, asset-based intervention, p12). Refer to Appendix G for examples of my research journal.

While I was busy analysing the data I had obtained during interviews, I also started analysing observation data. Once I had categorised emerging themes from the data collected during interviews into two main themes I returned to my research book and colour-coded words and phrases which seemed to be relevant to a theme. I followed the same procedure in analysing observations made during the focus group discussion (Wilkinson, 2004; Terre Blanche & Kelly, 2002; Berg, 1998).

4.2.3 Conducting interviews

I conducted four semi-structured, face-to-face interviews with four educators. I had planned these interviews while acting as field worker in the related study, and arranged and finalised the interviews telephonically shortly before returning to the research site, for my first field visit as researcher. The interviews commenced in the Deputy Principal's office and were approximately 60 minutes in duration. I obtained informed consent at the beginning of each interview, as well as permission to audio-record the interviews. The purpose of the interviews was to explore participants' (educators') current modes of support as well as exploring their expectations regarding an HIV&AIDS 'workshop' in order to develop an asset-based intervention with the

educators to address the areas of support and coping in which they felt they needed more competencies (skills and knowledge).

I initially selected five educators to have interviews with, three of whom have not received any formal AIDS training and two (the only two at the school) who had received HIV&AIDS training from the Department of Education. Unfortunately one was ill during my second visit to the research site. As my selected meta-theoretical paradigm was Interpretivism I did not feel comfortable in conducting the interview with the ill educator via e-mail or telephone as I believe that the context in which knowledge is constructed is imperative (Schwandt, 2000). This meant that I conducted only four interviews (refer to Appendix E for transcripts of the interviews).

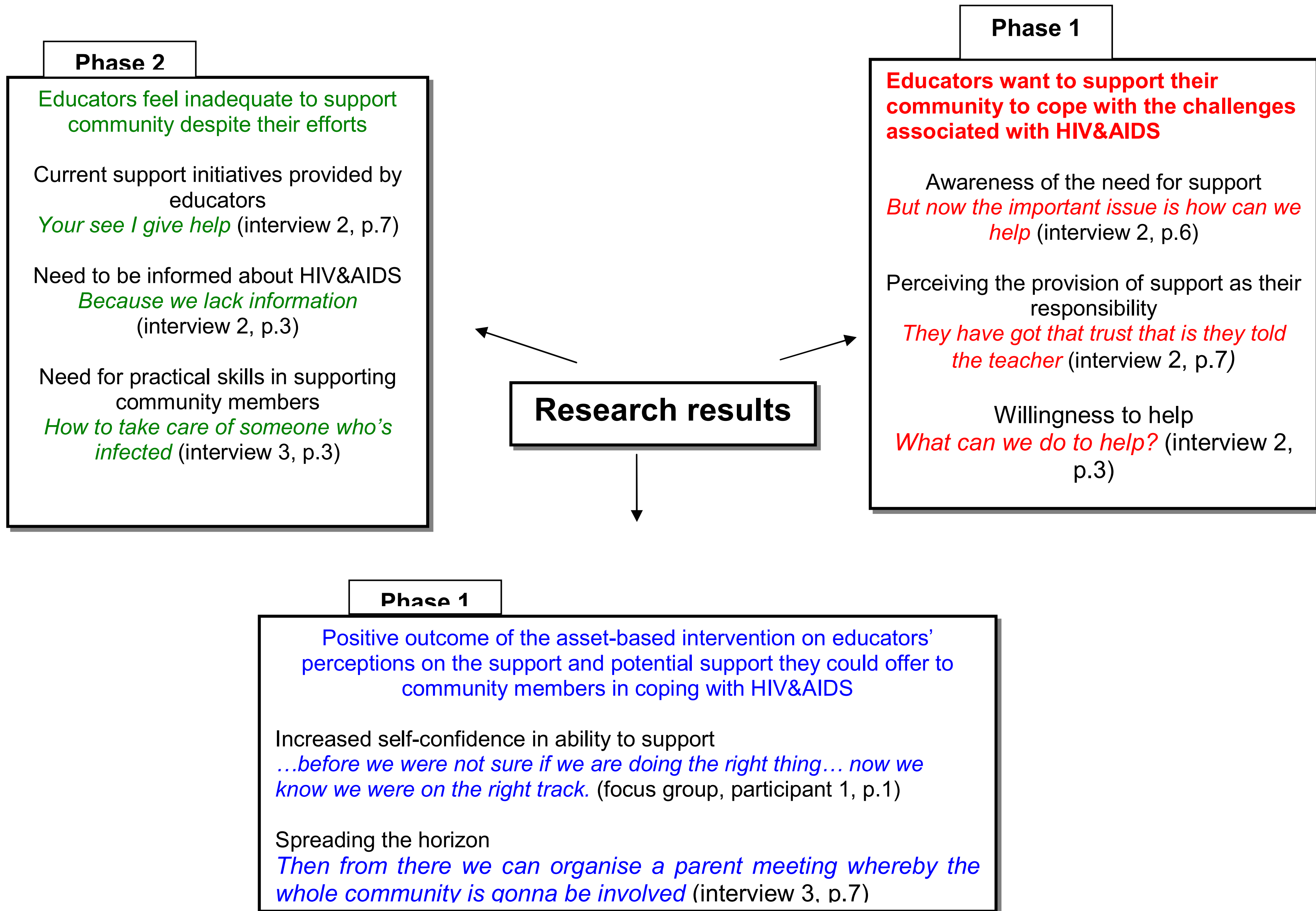
During individual interviews I was guided by the following interview protocol themes, which emerged from my analysis of the transcripts of Ferreira's (2006) initial field work, as well as the theoretical framework of the asset-based approach: the various resources (assets) the educators (participants) utilised to obtain HIV&AIDS related information; the ways in which educators were utilising their HIV&AIDS related knowledge and skills (competencies) to support their community in coping with HIV&AIDS and the associated challenges they face; and the areas in which participants perceived to experience a lack of knowledge or skills (competencies) in this regard. The interview protocol, based on the abovementioned themes (Appendix N) assisted me in obtaining the information I required. The interviews were, however, not conducted in the form of a fixed sequenced question-and-answer-interaction but rather in the form of a conversation between two people, aiming to come to shared meaning regarding educators' support efforts to community members in coping with HIV&AIDS (Terre Blanche & Kelly, 2002; Merriam, 1998; Schurink, 1998).

As stated in Chapter 3, I employed content analysis whereby I searched for recurring themes which emerged from the interviews, by firstly, rereading the transcripts, underlining recurring words and phrases, and making margin notes on emerging themes. I then employed a cut-and-paste method on a word processor to categorise phrases which seemed to reveal the same theme (refer to Appendix K in this regard). The raw product of the cut-and-paste exercise was then synthesised/interpreted (and colour-coded) into two main themes which emerged (Wilkinson, 2004; Terre Blanche & Kelly, 2002; Berg, 1998). Firstly, *educators indicated that they wanted to support their community (both learners and parents) to cope with the challenges presented by HIV&AIDS*, and secondly, *educators indicated that they felt inadequate in supporting the community, despite their efforts*. Each of these two main themes consisted of various sub-themes as discussed in

section 4.3.1 and 4.3.2. Returning to the transcripts of the interviews I colour-coded phrases, which depict the two main themes (Terre Blanche & Kelly, 2002). I am of the opinion that colour-coding themes in the transcript document might increase the ease with which readers can recognise the themes as they emerged during the interviews. Furthermore, it provides the contexts of the conversation, which took place during the interviews (refer to Appendix E).

4.3 RESEARCH RESULTS OF PHASE 1: INTERVIEWS AND OBSERVATIONS

Figure 4.1 provides an overview of my results from both phase 1 and phase 2. I firstly present my research results obtained during the first phase of my research. Based on my data analysis, two main themes emerged from the interviews and my observations. Firstly, educators seemed willing to support their community in coping with HIV&AIDS. Secondly, they already appeared to have been supporting community members despite their perceptions that they were insufficient in their support efforts at the onset of my study. I now discuss these main themes in terms of the relevant sub-themes that emerged. I provide colour-coded verbatim quotations of participants to support the themes and sub-themes.


Phase 2
Educators feel inadequate to support community despite their efforts
Current support initiatives provided by educators
Your see I give help (interview 2, p.7)
Need to be informed about HIV&AIDS
Because we lack information
(interview 2, p.3)
Need for practical skills in supporting community members
How to take care of someone who's infected (interview 3, p.3)
Phase 1
Educators want to support their community to cope with the challenges associated with HIV&AIDS
Awareness of the need for support
But now the important issue is how can we help (interview 2, p.6)
Perceiving the provision of support as their responsibility
They have got that trust that is they told the teacher (interview 2, p.7)
Willingness to help
What can we do to help? (interview 2, p.3)
Research results
Phase 1
Positive outcome of the asset-based intervention on educators' perceptions on the support and potential support they could offer to community members in coping with HIV&AIDS
Increased self-confidence in ability to support
…before we were not sure if we are doing the right thing… now we know we were on the right track. (focus group, participant 1, p.1)
Spreading the horizon
Then from there we can organise a parent meeting whereby the whole community is gonna be involved (interview 3, p.7)

4.3.1 Theme 1: Educators wanted to support their community (both learners and parents) to cope with the challenges presented by HIV&AIDS

In the following sub-sections I report on the results relating to educators' desire to support their community to cope with the challenges associated with HIV&AIDS in terms of three sub-themes which emerged. Firstly, educators seemed aware of the need of the community to be supported; secondly, educators displayed willingness to support their community; and thirdly, educators indicated that they felt that community support is part of their role within the community.

4.3.1.1 Sub theme 1.1: Awareness of the need for support

Educators (participants) in this study indicated a **sense of urgency** with regard to supporting their community. One of the participants summarised this idea as follows: …*the problem is now. What can she use now. What they need now is what is important*,...(interview 2, p.8). Another participant emphasised the urgency by saying: *the thing now, we've got this now……* (interview 3, p.8)[7].

Furthermore, participating educators seemed to be **emotionally affected** by the HIV&AIDS pandemic in their community, as emphasised by the following contribution: *that is why it is a trauma even to us, but we are not going to cry, we must be bold, we must be strong for them, you see* (interview 1, p.8). It further seemed apparent that participating educators were not only emotionally affected by HIV&AIDS in their professional role in the community but also on a personal level. One of the participants stated*: I couldn't take it* (interview 3, p.8) (referring to a friend's disclosure). My observation during this interview supports this statement, indicating possible emotional uncomfort: *he started giggling, bending his head down and shuffled around on the desk he was sitting on* (field visit 1, 19 February 2004, interview 3, p.6).

4.3.1.2 Sub-theme 1.2: Perceiving the provision of support as their responsibility

Participating educators indicated that the **community trusted them** and that they (the educators of the community school) needed to support the community to cope with the challenges associated with HIV&AIDS. One of the participants emphasised this perception:

[7] Iinterview 1 implies participant 1; interview 2 participant 2; interview 3 participant 3 and interview 4 participant 4.

> *because some times they are illiterate, they know nothing, but you know something and when they come to that the teacher knows everything. They've got that trust that if they told the teacher something. But now you feel angry when you cannot help because even now when they come to me, I say I will organise a social worker, well they know that social workers know something about this AIDS, why don't you* (interview 2, p.7).

Participating educators further stated that they felt that **they ought to spread/teach the correct information** on HIV&AIDS to community members. Statements such as the following serve as example: …*you must know what you must say and not to say you see, the way of teaching them* (interview 1, p.5), and:*… you know I want to teach them, maybe the community, the parents about the teaching of the community or of the families. I must know the priority topics, you see, not just to talk, you know, the priority topic* (interview 1, p.8). One participant emphasised that some community members were illiterate, and that educators had the responsibility to continuously inform them about HIV&AIDS related issues:

> *It's worse with these ones, they are not educated, besides the unemployment and poverty but they are not educated. So you speak of HIV and AIDS you have to explain what is it, how one can get it, how it cannot all that stuff but the next day that thing is gone to most of them so you have to speak it again, it mustn't be a once off thing, it must go on, it must continue, ongoing process* (interview 3, p.9).

In addition to providing community members with information, participants indicated that they wanted to provide learners with accurate information regarding HIV&AIDS, in order to prevent learners from becoming infected. This need was summarised by one of the participants in the following words: *to give them education, even though they are going to do it, they must say that I did it knowing very well what the risks are. We cannot run away from the importance of **it*** (referring to educating the young learners) (interview 2, p.6).

4.3.1.3 Sub-theme 1.3: Willingness to help

Participants indicated that they would **like to offer more support** to learners/families infected with and affected by HIV&AIDS than what they were offering at the onset of the study. It seemed as though participating educators were motivated to support their community to cope more effectively within the context of HIV&AIDS. The following contribution serves as an example: *what can we do to help, if there's someone infected, how can that person be helped, at home, at school or at*

work, how can you help that person? (interview 2, p. 3). This willingness of educators to support community members appeared to go beyond practical support and advice. Participants, for example, indicated that they would also want to provide individuals infected with and affected by HIV&AIDS with **emotional and spiritual support,** saying that: *you have to give them emotional support. You can give them spiritual support because when they can help you into the trauma for the family and for themselves* (interview 1, p.1). Another educator indicated her desire to support community members by stating: *we need to treat these learners kindly now – you know, because we used to get parents dying and all these things* (interview 4, p.3).

4.3.2 Theme 2: Educators felt inadequate in supporting the community, despite their efforts

For the purpose of presenting my research results regarding participants' perceived lack of adequate knowledge and skills (competencies) regarding HIV&AIDS, I combined their feelings of inadequacy with the emerged theme of support they were already providing to the community in coping with the challenges associated with HIV&AIDS. This theme further implied the identification and utilisation of assets in the community, as well as the extension of social networks to reach individuals in need.

4.3.2.1 Sub-theme 2.1: Current support initiatives provided by educators

Participants indicated that they were **already supporting community** members in coping with the challenges associated with HIV&AIDS on a **spiritual level,** at the onset of this study. One of the participants summarised this idea by stating: *Because I use to bring her prayers there, three or four woman would go there and pray for her* (interview 2, p.4). Participants further seemed to provide support on a **practical level,** as suggested by the following contribution: *why don't you have a small garden so that you can plant things, that's good advice because you know that she's going to plant vegetables* (interview 2, p.8). Thirdly, participants seemed to support community members by **providing information** on HIV&AIDS, as summarised by one of the participants: *I even gave them, some of them the brochure* (interview 3, p.9). Another participant indicated that, by providing accurate information regarding responsible sexual behaviour, one might be able to protect community members from becoming infected, by saying: *so that's why I want for them to know how can they be infected and how they must take care of themselves* (interview 3, p.10). In addition, participants also seemed to be guiding community members to **access support structures**

(assets) available in the community as illustrated by words such as: *I say I will organise a social worker* (interview 2, p.7).

Furthermore, participants indicated that they were **able to identify and utilise assets** in order to support their community in coping with HIV&AIDS related challenges. Assets were identified by participating educators on a **tangible level** *(You see sometimes it's difficult to go and buy, they can plant veggies in the garden so that they can get a veg to improvise you know* [interview 1, p.6]); within the **media** (*The programmes on TV helped me a lot, the books. There was a book that the department gave us, the department distributed it to all teachers. I used that book. I read it a lot.* [interview 2, p.3]*);* as well as **amongst themselves** (*also at the same time it needs a discussion of that but it's because some teachers have ideas that can help others, you need to talk like this, so to get information even from teachers, teachers know better than I know.* [interview 4, p.4])**.** In addition, participants indicated that they were also utilising their social skills in **building relationships** with parents in order to support families and learners. One of the participating educators described their efforts as follows:

> *for an example, there is this boy, I don't like that child, in fact not that I don't like him, I don't like the way he is and the manner in which he is dirty always, to come to him because even if he wants to go and take a walk and say your son is a nice boy and change the mother's thinking to take better care of him it is then that the mother will start to talk, I think so* (interview 4, p.3).

Other assets that seemed to be identified and utilised by participating educators relate to assets within the **closer community.** One participant said**:** *it's through friends you know, it's through friends when we are discussing the issue of HIV and find out what is it that maybe you can say that has happened to help and you find that people want to help it depends then maybe some are shy* (interview 4, p.1). Other assets that were identified and seemingly utilised in participating educators' efforts to support community members coping with the challenges associated with HIV&AIDS, relate to **citizens' associations.** One participant, for example, referred to the role of churches, stating: *they asked someone to come to our church, a lady who was dealing with these issues,…she can help me too when I'm dealing with these kids and parents* (interview 2, p.10) Participating educators also identified **me as an asset,** as one participant stated: *you as a teacher you must have a role play in counselling you see, because you are here now, you see* (interview 1, p.4).

4.3.2.2 Sub-theme 2. 2: Perceived need to be informed about HIV&AIDS

According to the participants they **did not possess sufficient knowledge** on HIV&AIDS, which made them feel insecure. One participant summarised their feelings: *even us teachers we are not really sure what we know you see. You see sometimes you can feel scared you see* (interview 1, p.4). Participants' perceived lack of knowledge in turn seemed to **hamper the support** they were providing to community members infected with and affected by HIV&AIDS, despite them seemingly providing some kind of support. The following contribution illustrates this idea: *The other one would bring a cheese and bread with cheese, but maybe the cheese is not good for her, but we want to help but we don't know what if it is right or wrong do you understand?* (interview 1, p.7). As a result, during the initial interviews, participants indicated that a **workshop** of some kind could **provide them with the confidence** to elaborate on their support initiatives. The following contributions serve as examples: *Although I heard about them but I need somebody who can give me surety, when we go to a workshop, you know that this thing has helped, now it's going to help* (interview 2, p.8), and: *it's a bit of more weight if someone is saying ' I got this at a teacher workshop'* (interview 3, p.7). Although a perceived lack of knowledge seemed to hamper participating educators' support efforts, the participants did display a willingness **to support** the community. One participant effectively summarised this willingness: *but if I knew more I would have given her more than an advice* (interview 2, p.7).

4.3.2.3 Sub-theme 2.3: Need for practical skills in supporting community members coping with HIV&AIDS

Participating educators indicated that they **did not know how to cope** with an HIV infected **learner in the classroom**. Some participating educators referred to their own insecurities regarding ways of maintaining confidentiality with regard to the HIV positive status of a learner, stating: *we must help all the children but this is confidential a disease like this, but that child is in the classroom, there are a lot of children that is next to her* (interview 1, p.3). Another educator stated: *if she/he has identified that child, take that child with special treatment, now that child also gets embarrassed* (interview 4, p. 4). One of the participants voiced the idea that educators might have to change their classroom practice in order to accommodate an HIV positive learner: *to take the classes equally, irrespective of you know that there's a child who is positive they must then change now to be very kind to that child, because maybe that child will take that, and if you are shouting you will make the child even more sick* (interview 4, p.3).

Furthermore, participating educators indicated that they **required practical guidance** to support community members, saying: *'okay now you've got sores, why don't you wear gloves and put something that will help the sores'. The help, literally help that you can give her, physical things that you can give her, not just talk* (interview 2, p.7). In addition, they seemed to require **guidance on how to refer** community members infected with and affected by HIV&AIDS to relevant support structures, stating: *I want to know about the grant, about the social worker* (interview 1, p. 2).

4.4 OVERVIEW OF RESEARCH PHASE 2: PLANNING AND FACILITATING AN ASSET-BASED INTERVENTION WITH EDUCATORS

The purpose of the asset-based intervention with participating educators was to affirm educators' competencies (skills and knowledge) regarding the support they provide to community members. The asset-based intervention I facilitated with the selected educators commenced two months after I had concluded the face-to-face interviews. Ten educators participated in the intervention, which addressed four themes of approximately 45-60 minutes each. The first three themes were addressed during our first session, while the last theme, certificate ceremony and focus group discussion were completed during the second session.

In the development and planning of the asset-based intervention with educators I relied upon my analysis of the face-to-face interviews with participants regarding their perceived lack of competencies in supporting community members infected with and affected by HIV&AIDS to cope with the associated challenges. Furthermore, I relied upon the theoretical framework of the asset-based approach and the ecosystemic approach, as illustrated in Figure 4.2 (next page).

I aimed at addressing the themes[8] identified by participating educators which they perceived as areas that they needed training on. As such, I adhered to PAR principles as I addressed areas of concern as voiced by the participants. These themes served as focal points of departure in my development of the asset-based intervention

- Where can HIV infected people get help with regard to financial grants, food parcels, medication, social support (contact with social workers) and services provided at a local clinic? *What else we want to know, the resource relief of organisations involved in HIV in PE* (interview 1, p.6);

[8] Please note that I use the vocabulary used by the participants during the individual interviews.

- How can I cope with an HIV infected child in my classroom, for example, how can I, as a teacher, give the child food without other children in the class realising what is going on, or if the child is feeling sick in class, what can I do? *She doesn't feel well, she doesn't want to work, as a teacher what must I do?* (interview 1, p. 2);
- How can teachers physically support HIV infected people in their community? *The help, literally help that you can give her, physical things that you can give her, not just talk* (interview 2, p.7); and

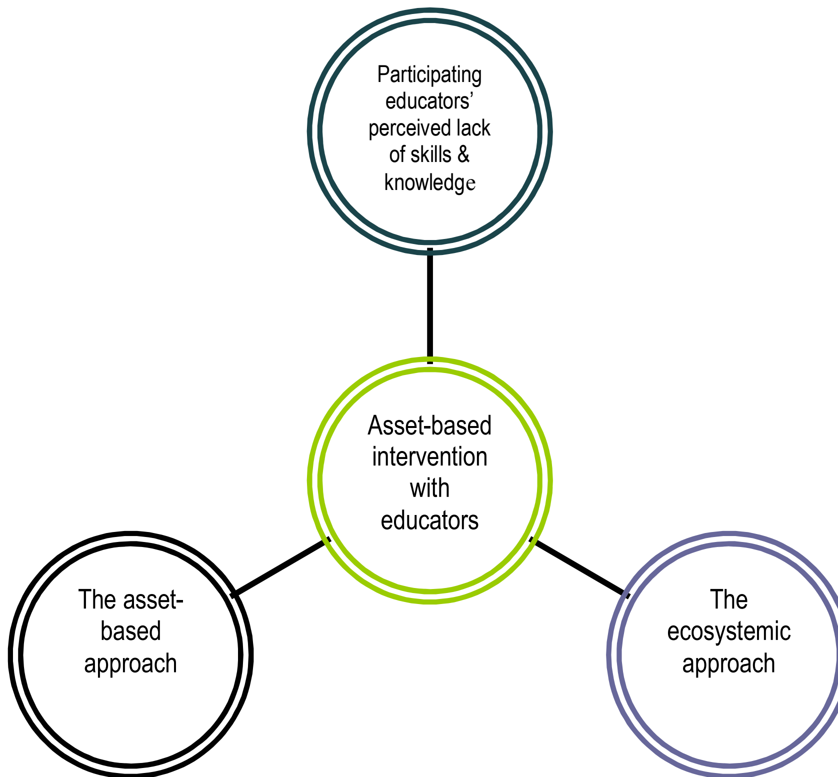


Figure 4.2: Framework for the development of the asset-based intervention

- How can teachers emotionally support HIV infected people in their community? *I want to give her hope, I want to give the support spiritually and emotionally* (interview 1, p.2)

Based upon the fact that participating educators expected a workshop, I decided to address these topics in an interactive format whereby participants would be actively involved through discussions, role play and planning of action steps (Centre for the Study of AIDS, 2001). Furthermore, I decided to address these themes from the perspective of the asset-based approach. Therefore, my role

was that of facilitating the awakening of the knowledge and skill the participating educators already possessed. Facilitation is described by Van Dyk (2001) as assisting individuals to discover what they already know, building upon their experiences and enabling them to explore their own potential. As such I only planned which themes were to be addressed (from the analysis of the face-to-face interviews) and the format in which it should be addressed. The participants determined the content pertaining to each theme (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996). The HIV&AIDS training manual (Centre for the Study of AIDS, 2001) of the University of Pretoria and Van Dyk (2001), suggest that a facilitator requires specific skills which I aimed to employ, such as encouraging participation, keeping the group focused, circulating during small-group activities, guiding towards an objective, listening to participants and probing for more contributions, assisting and clarifying when confusion occurs, affirming and encouraging knowledge and skills which emerge.

I relied heavily on the ecosystemic approach throughout the intervention but especially while addressing the first theme, namely: *Where can HIV infected people get help?* While acting as field worker in the related study (Ferreira, 2006) I became aware of potential assets which community members could access for support in coping with the challenges of HIV&AIDS, for example, the community care centre, the provincial hospital, a Tuberculosis centre, a social worker, non-government organisations (Afrikaans Christian Women's Association) and the AIDS training and information centre (ATICC). Yet, in line with the asset-based approach I was not in the position to provide participants with these potential resources. I rather kept these resource centres in mind to assist with brainstorming activities. Furthermore, I was, and still am, profoundly unfamiliar with the community and the potential resources (assets) available in the community. I aimed to enhance participants' brainstorming by constructing a mental mind-map of the community. This mind-map consisted of the different systems within the community such as individuals, local associations and informal institutions as well as the whole social system (Ebersöhn & Eloff, 2006; Donald *et al.,* 2002; Kretzmann & McKnight, 1996).

I planned to address the second theme, namely: *How can I cope with an HIV infected child in my classroom?* by virtue of the asset-based approach. As I do not view myself as an expert on coping with an HIV infected learner in a classroom, all the content relating to this theme was exclusively generated by the participating educators (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996).

I planned to address the third theme, namely: *How can HIV infected people be physically supported[9] by teachers?* by sourcing knowledge from the participating educators, whereby I adhered to the asset-based approach. However, unlike the other themes where participants and I generated tangible products, this theme was accompanied by an information booklet which I compiled prior to the second field visit (refer to Appendix J). I decided to compile a booklet as this theme touched on a broad range of knowledge and skills, and I did not think that facilitating the creation of such a booklet would be time efficient. I employed two sources to compile the booklet, namely Zimba (2000) and Mkwelo (1997).

I planned to address the final theme, namely: *How can HIV infected people be emotionally supported by teachers?* by employing participants' skills and their ability to show empathy. I utilised the principles presented by Egan (2002) which reflect empathic presence, to form five categories which is related to displaying empathy through non-verbal behaviour, namely face the person, adopt an open posture, lean towards the speaker, maintain culturally sensitive eye contact and remain calm and relaxed. As confidentially is a great concern when interacting with HIV positive individuals I added a sixth category, namely confidentiality. I decided to utilise these categories as 'empathic presence is comforting' (Egan, 2002) and also due to the provision of comprehansive counselling training to participating educators being beyond the scope of the intervention.

I linked the above-mentioned categories to the shape of a hand, with each finger representing a category, encapsulated by a chain around the wrist symbolising confidentially. I decided to employ the shape of a hand to assist participating educators with a quick reference guide on aspects to remember when providing emotional support.

Asset- based intervention: Session 1

Time: *14h00*	***Facilitator:*** *Viona Odendaal*
Venue: *school staffroom*	***Co-researcher:*** *Tilda Loots*
Participants: *10 educators*	***Supervisor:*** *Ronél Ferreira*

The first intervention session commenced with a welcoming section during which informed consent was discussed, followed by each participant signing a consent form (Appendix M). During the

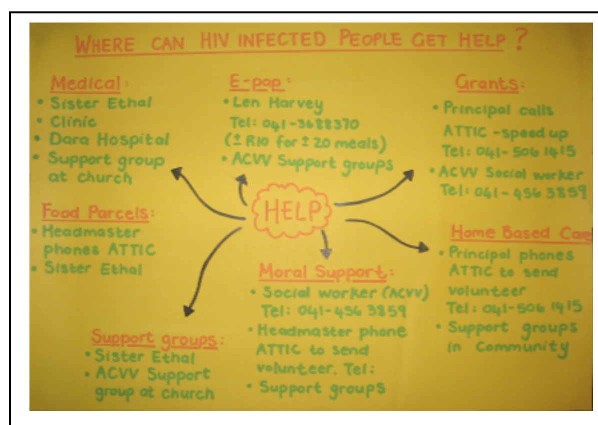
[9] Please note that this theme refers to physical care but in the spirit of Interpretivism I chose to use the words of the participants.

orientation stage, I provided participants with feedback regarding the face-to-face interviews and presented the four main themes that emerged during the interviews. These themes guided the intervention sessions, as described in the following paragraphs.

4.4.1 Topic[10] 1: Where can HIV infected people get help?

Purpose: *Brainstorming possible resources where community members infected with and affected by HIV&AIDS might find support from* ***Goals:*** *Creation of two action maps regarding avenues to investigate for possible support when one suspect a learner is infected with or affected by HIV&AIDS; when a parents is infected with HIV or when both parent and learner are infected with HIV* ***Material required:*** *A4 white paper and pens; 3 A5 poster cardboard; coloured marker pens; telephone directory* ***Time allocation:*** *30 minutes*

I addressed this theme by facilitating a group discussion. Keeping the ecosystemic theory in mind, as a guide to the framework of an asset-map, I encouraged participants to share ideas with one another pertaining to possible sources of help/assistance for community members infected with HIV. The participants creatively generated potential resources in their school, their wider community and within themselves. My co-researchers (supervisor and M. Loots[11]) made notes during the discussion on potential resources, which was summarised in poster format and presented during the concluding session of the workshop. Figure 4.3 is a visual presentation of the summarised poster.



[10] Please note topic refers to the theme that emerged from the data relating to an area to be addressed during the asset-based intervention.
[11] M. Loots conducted a master's study in the same community at the same time, also forming part of Ferreira's broader research project. M Loots focused on facilitating the mobilisation of potential asset that had not been mobilised yet, in order to support coping initiatives in the community.

Figure 4.3: Visual presentation of summarised poster regarding referrals of community members

I then facilitated the formulation of two action plans. These action plans focused on suspected HIV infection of a child; HIV infection of a parent and/or HIV infection of both a parent and a child, emphasising aspects of denial or acceptance, which participants indicated as a focal aspect to consider when one aims to provide support to infected individuals. Figure 4.4 provides a visual representation of the action plan posters participants made. Refer to Appendix H for the additional posters my co-researcher and I made with regard to action plans.

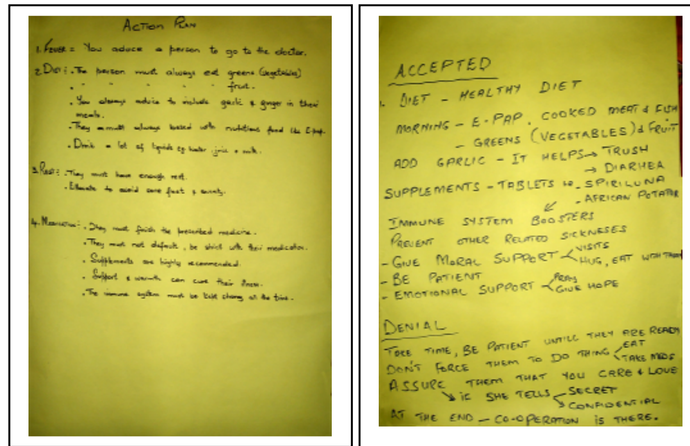


Figure 4.4: Visual representation of the action plans posters made by participants

4.4.2 Topic 2: How can I cope with an HIV infected child in my classroom?

Purpose: *Enhance educators' skills to cope with a learner in the classroom infected with HIV* ***Goals:*** *Creation and presentation of two posters containing ideas as to how to cope with a learner infected with HIV* ***Material required:*** *2 A5 poster cardboard, coloured marker pens* ***Time allocation:*** *45 minutes*

I addressed this theme by facilitating small group discussions and presentations. Participants were divided into two groups of five participants each. I requested each group to create a poster on how to treat an HIV infected child without creating awareness amongst other learners regarding the infected child's HIV status. I gave each group an opportunity to present their poster and ideas to the rest of the participants (refer to Appendix H for notes made by participating educators). Once the presentations had ended I collected the notes in order to integrate them into summarising

posters, which I presented during the concluding session at our following meeting. Figure 4.5 is a visual presentation of the integrated poster.

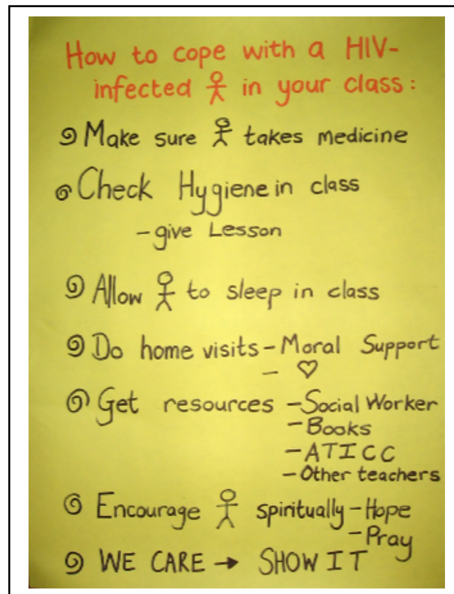


Figure 4.5: Visual presentation of integrated poster on coping with an infected child in a classroom

4.4.3 Topic 3: How can HIV infected people be physically supported[12] by teachers?

Purpose: *Enhance educators' skills and knowledge (competencies) to provide advice to primary caregivers in the context of HIV&AIDS*

Goals: *Brainstorming ideas on physical care in the context of HIV&AIDS*

Material required: *10 Information booklets*

Time allocation: *45 minutes*

I addressed this theme in the form of a group discussion. I requested participating educators to share ideas with one another on what they had done in the past to help HIV infected people in the community, or what they had heard might be done in order to assist others. I firstly asked the participants to elaborate on strategies that might be employed to help someone dealing with fever, diarrhoea, pain, coughing and difficulty in breathing, tuberculosis, skin problems (e.g. rashes, itching or sores), soreness in the mouth and throat causing difficulty in swallowing, tiredness and feeling weak, depression and anaemia/blood deficiency (reduced amount of blood in circulation). I further facilitated a discussion on important guidelines relating to nutrition in caring for an HIV positive person, namely the three types of food (energy giving food, for example rice, sugar, honey,

[12] Please note that this theme refers to physical care, but in the spirit of Interpretivism, I chose to use the words of participants.

bread, pap, cooking oil and sweet potatoes; body building food, for example meat, fish, beans, eggs and chicken; and protective food, for example citrus fruits, mangoes and dark green leave vegetables such as spinach or 'marogo'). Lastly, I facilitated a discussion on the guidelines of eating small amounts of food often, adding sunflower oil to food, drinking a great deal of juices, eating a variety of food and giving soft food if it becomes difficult to chew and swallow.

As this theme involved numerous facts, I distributed information booklets (Appendix J) amongst the participants, which I compiled from Zimba (2000) and Mkwelo (1997) prior to my field visit, to serve as a reference guide as to what had been discussed in terms of coping with the physical challenges of HIV infected community members. I introduced the information booklet as confirmation of the participants' existing knowledge and skills (competencies), after completion of the group discussions. I emphasised the fact that, although the booklet had been created by professionals working with HIV infected individuals, the information correlated with the information provided by the participants, confirming the fact that they already possessed knowledge and skills (competencies) at the time of my field visit.

Asset- based intervention: Session 2

Time: 10h30	**Facilitator:**Viona Odendaal
Venue: school staffroom	**Co-researcher:** Tilda Loots
Participants: 10 educators	**Supervisor:** Ronél Ferreira

4.4.4 Topic 4: How can HIV infected people be emotionally supported by teachers?

Purpose: *Enhance educators' skills and knowledge (competencies) to provide comfort and emotional support to community members in need*

Goals: *Brainstorming ideas on providing emotional support to community members while formulating ideas to form six categories*

Material required: *6 A5 posters, black markers, a poster with a hand-shape with a bracelet drawn on it and 10 certificates of attendance*

Time allocation: *45 minutes*

I also addressed this theme in the form of a group discussion, followed by a role-play activity. Participants were encouraged to brainstorm some of the important aspects to consider when

interacting with people who are experiencing problems, which affect them emotionally (such as feelings of insecurity experienced by HIV infected parents with regard to disclosing their HIV positive status to their children). As the participants generated and voiced ideas I sorted their suggestions into six categories, by writing ideas down on six untitled A5 posters which was placed on the wall behind me. Each poster represented a category relating to emphatic presence, namely trustworthiness and honesty; staying visibly in tune with the person experiencing the problem (for example leaning towards the person); displaying respect and compassion; being patient; and respecting confidentiality (Egan, 2002). I summarised the ideas provided by the participants. Thereafter I introduced them to the abovementioned six categories by, firstly providing titles for each poster and, secondly by displaying a hand shaped poster (refer to Figure 4.6) with a bracelet drawn on the wrist (called the *helping hand)*, as follows (refer to Appendix H in this regard):

Figure 4.6: Visual representation of *helping hand* of emotional support

- **T**humb - symbolising the **t**rustworthiness and honesty facets in counselling;
- **I**ndex finger - symbolising staying **i**n tune to what the person is saying;
- **M**iddle finger - symbolising the **m**essage, with the focus on 'what is the message this person is trying to convey?.' Principals of active listening were briefly highlighted from the ideas the participants generated;
- **R**ing finger - symbolising **r**espect and compassion for the person experiencing the problem;
- **P**inkie finger[13] - symbolising **p**atience; and

[13] This finger is also referred to as a little/small finger, but for the purpose of this exercise I called it a pinkie, as I required a name of a finger that starts with the letter p, in order to link it with the word patience.

- The **c**hain around the wrist (bracelet) - symbolising **c**onfidentiality.

I requested participants to divide themselves into pairs. I provided the opportunity to engage in role-play, in order to practise the *helping hand*. I suggested to the participants that they might start their role-play with a general problematic situation they often face, for example a parent experiencing frustration due to a child not wanting to learn for a test. Once each member of each pair had an opportunity to practise the *helping hand* support, a few volunteers from the group were asked to provide feedback. As facilitator I tried to guide the feedback, focusing on the following questions: *How did it feel? What worked well? What might have been done differently? Could you see the helping hand support in the person listening to your problem?*

I then emphasised that the participants had brainstormed the main ideas and skills that they where practising, and that my role had merely been to synthesise what they had said into six categories, linking these to a 'user-friendly' reminder poster. I further explained to the participants that the skills and ideas they had generated were similar to skills and ideas used by trained counsellors. I also emphasised that they should not regard themselves as qualified counsellors after attending the intervention session. I stressed the fact that they were professional educators who might be able to utilise some of the basic counselling skills to give emotional support to community members experiencing problems (including problem situations related to coping with the challenges of HIV&AIDS).

The asset-based intervention closed with a certificate ceremony where each participant received a certificate, which states that they attended an HIV&AIDS workshop. Refer to Appendix H for a visual presentation of the certificate ceremony as well as an example of the certificates the participants received.

4.5 FACILITATING A FOCUS GROUP DISCUSSION

The purposes of the focus group discussion was to gain insight into the perceptions of the participants in terms of the degree to which their expectations had been met regarding their initial thoughts on '*needing training'* and, secondly, how they had experienced the intervention sessions. McMillan and Schumacher (2000) state that a focus group discussion may be fruitfully utilised to obtain a better understanding of the success of an intervention (or in the authors' words *a training programme*).

The focus group discussion commenced shortly after the second intervention session had been completed. I audio-recorded the focus group discussion and transcribed it verbatim for the purpose of data analysis and interpretation (refer to Appendix F in this regard). As facilitator of the focus group I aimed to enhance the contributions of each participant by managing the more verbally inclined participants and allowing an opportunity to the less verbally inclined participants, in order for them to speak freely (Wilkinson, 2004; Patton, 2002).

I analysed the data obtained from the focus group by means of multiple readings of the transcripts and field notes, underlining words and phrases which seemed to recur. Thereafter, I employed the copy-and-paste function on a word processor, categorising phrases which seemed to represent themes (refer to Appendix K). Once this exercise had been completed I returned to the transcripts' colour-coded phrases which represented the themes (refer to Appendix F) (Wilkinson, 2004; Terre Blanche & Kelly, 2002; Berg, 1998).

4.6 RESEARCH RESULTS OF PHASE 2: FOCUS GROUP DISCUSSION AND OBSERVATIONS

A theme emerged relating to the positive outcome of the asset-based intervention I had facilitated, in terms of educators' sense of the support they were offering their community to cope with HIV&AIDS.

4.6.1 Theme 3: Positive outcome of the asset-based intervention on educators' perceptions of the support and potential support they could offer to community members in coping with HIV&AIDS

Two sub-themes emerged from the data collected after I had facilitated the asset-based intervention. Firstly, participating educators reported that they had gained confidence in their ability to support their community in the context of HIV&AIDS, as well as a general feeling of empowerment as a result of attending the asset-based intervention. The second sub-theme relates to the potential snowball effect of the asset-based intervention. In the following sub- sections, I discuss the manner in which these sub-themes emerged from the raw data I obtained.

4.6.1.1 Sub-theme 3.1: Increased self-confidence in ability to support

Participating educators indicated that they had **gained confidence** in their competencies to support community members in coping with the challenges associated with HIV&AIDS as the field work progressed. They reported enhanced levels of personal skills and knowledge (competencies), stating that: *before we were not sure if we are doing the right thing… now we know we were on the right track* (focus group, participant 1, p.1); *Now I am sure what to say what to ask or what to do when the thing comes* (focus group, participant 4, p.4); *But before you came really we didn't know that we know so much* (focus group, participant 2, p.4) and: *we know a lot, we know a lot. And today we know that we know a lot.* (focus group, participant 5, p.5).

Participating educators reported a heightened sense of self-confidence which in turn seemed to contribute to **decreased levels of the anxiety** they experienced with regard to supporting other community members. One participant summarised their feelings as follows: *now we are not afraid, to assist anyone who come and disclose* (focus group, participant 7, p.2). Another participant added: *there are cases that we will be able to face alone* (focus group, participant 3, p.4). In this manner, participants seemed able to **address their own insecurities** regarding HIV&AIDS based on the asset-based intervention, which one participant stated, saying: *gives us motivation to open even to ourselves of the HIV/AIDS you see* (focus group, participant 2, p.4).

Participants' perceptions and experience that they were **active participants in the asset-based intervention** seemed to contribute to higher levels of self-confidence. One participant stated: *She said that you are going to workshop us. Surely everything should come from you and then we are capacitated. I expected that is what you are here for, but up to now we know a lot and we can do everything possible* (focus group, participant 3, p.4). Active participation in the asset-based intervention sessions further seemed to have motivated educators to **take ownership** and experience **enhanced feelings of empowerment,** as illustrated by the contribution of one participant: *because I was in a mind that you people are going to tell us. But I found it out that we are actively involved. (Uhm..uhm.. agreement in background). It is our thing it is you people together with us* (focus group, participant 8, p.3).

According to the participating educators, their participation in the asset-based intervention further contributed to a **sense of '*singing the same song'*** (focus group, participant 7, p.2.) **(collaboration)** amongst the educators who participated. The following statements serve as examples: *you know that soon we are going to sing the same song* (focus group, participant 7, p. 2.) and: *Because we are 10 we have 2 people that only trained by the department. If we can stand*

there and conduct a workshop. They will be sorry for going there instead of coming here (focus group, participant 8, p.2).

4.6.1.2 Sub-theme 3.2: Spreading the horizon

Participating educators indicated that they experienced their **role in the community as having expanded** after completion of the intervention I facilitated. One participant summarised this view: *What I was thinking was the question of HIV and AIDS that was also for social workers and nurses not for us as teachers, but since you came here you have given us the assurance that we are also social workers and we are also nurses* (focus group, participant 7, p.2). A **snowball effect** seemed imminent as a result of the asset-based intervention, with regard to the systems mentioned below and as illustrated by the included contributions:

- **The wider community:** *As a result by you coming here, I have been involved in many things and I have been exposed to many situations. Some of the situations I was able to help* (focus group, participant 6, p.2); and: *Then from there we can organise a parent meeting whereby the whole community is gonna be involved* (interview 3, p.7).
- **The parents' body of the school:** *I can stand up and say to the parents this is right, this is not right* (focus group, participant 2, p.2).
- **Colleagues:** *You know what we are going to help other teachers* (focus group, participant 5, p.5).

Participating educators further indicated that they could **transmit the knowledge** obtained from the asset-based intervention sessions to others. This was suggested by the following statements: *So you speak of HIV and AIDS you have to explain what is it, how one can get it, how it cannot, all that stuff* (interview 3, p.9); and: *what we want is everybody to expand, they should go and then tell others, not only at the school* (interview 4, p. 5).

Educators also indicated the goal of **community upliftment** as a long-term goal by referring to the current generation of learners becoming adults of the community. One participant summarised this idea by saying: *but if you can teach that earlier because these kids are going to be a community of the area are going to be the future generation of this area, so they will do better than the present generation* (interview 2, p.9).

4.7.1 RESEARCH FINDINGS

I now relate the themes and sub-themes discussed above to existing literature and research, aiming to highlight not only correlations, but also possible contradictions. I present my findings in accordance with the structure of the research results, as presented in section 4.3.

4.7.1 Educators' role in supporting other community members in coping with HIV&AIDS

Participating educators seemed to experience a **sense of urgency** to support their community in coping with the challenges presented by HIV&AIDS. This sense of urgency to support community members in coping with HIV&AIDS related challenges, as found in my study, correlates with many studies advocating the urgency for action to take place in the face of the HIV&AIDS pandemic. Already four years ago the Medical Research Council released a paper entitled *Orphans of the HIV/AIDS epidemic: The time to act is now* (Bradshaw, Johnson, Schneider, Bourne & Dorrington, 2002), propagating for urgent measures to be put into place to respond to the rapidly rising number of HIV&AIDS related orphans. Bradshaw *et al.,* (2002) emphasise that, by providing long-course antiretroviral treatments during pregnancy and opting for caesarean section as a birthing measure, as well as by investing in prevention programmes aiming at changes in sexual behaviour, a decrease in the number of children orphaned due to AIDS might be seen. In addition, UNAIDS (2006:6) states that '*If we do not urgently strengthen the AIDS response, neither the 2010 targets nor the Millennium Development Goal of halting the spread of AIDS and rolling back HIV infections by 2015 will be met*'.

The urgency of educators, who participated in my study, to support their community members in the face of HIV&AIDS could be related to the fact that they appeared to be **emotionally affected** by what they are experiencing with regards to HIV&AIDS. A study undertaken by Hall, Altman, Nkomo, Peltzer and Zuma (2005) focusing on educators' morale, workload and job satisfaction within the context of HIV&AIDS, supports this result of my study, indicating that educators are regularly emotionally affected by HIV&AIDS. Hall and his colleagues found that 6% of all educators were depressed due to colleagues' HIV infection and AIDS related deaths. In addition, 13% of educators were emotionally affected by learners infected with or affected by HIV&AIDS and 11% were depressed and saddened due to the HIV&AIDS infection and the deaths of relatives. It therefore seems clear that educators are emotionally affected by the HIV&AIDS pandemic on a professional as well as a personal level.

Besides experiencing emotional difficulty, the educators in my study revealed that they perceived themselves as **not possessing sufficient knowledge** regarding HIV&AIDS, to support community members effectively in coping with the pandemic. However, a study undertaken by Peltzer (2003), exploring educators' knowledge of HIV&AIDS and their attitudes towards, and control of, HIV&AIDS education, found that South African educators are indeed knowledgeable regarding HIV&AIDS issues. The study was conducted amongst 150 educators, teaching Life Skills in 150 different secondary schools countrywide. A more recent survey undertaken by the Education Labour Relation Council for the Human Sciences Research Council and the Medical Research Council (2004/2005) supports this finding by confirming that South African educators are knowledgeable with reference to HIV&AIDS (Shisana, Peltzer, Zungu-Dirwayi & Louw, 2005). Both these bodies of work support one of the key assumptions on which my study was based, namely that educators do possess sufficient knowledge regarding HIV&AIDS related issues.

However, it seems that, despite findings such as the ones reported on in the previous paragraph, the educators (participants) in my study perceived that they did not possess sufficient knowledge regarding HIV&AIDS, at the onset of my study. Possible reasons for these seemingly contradictory findings and the participants' perceived lack of knowledge might be that they had not yet received formal HIV&AIDS training, as indicated by the majority of participants during data collection activities. It might be concluded that educators who have not received formal training may lack confidence in their own HIV&AIDS knowledge base. This hypothesis was illustrated by one of the participants in my study who had received formal HIV&AIDS training, referring to other educators who had not received training and stating that *they* do not know how to cope with the challenges related to supporting community members in coping with HIV&AIDS. In addition, another educator (participant) indicated that, although she had been exposed to HIV&AIDS related information, she held the opinion that attendance of a workshop would provide her with the confidence to speak with conviction about HIV&AIDS.

Therefore, despite the participants' perceived lack of knowledge, the emotional impact that HIV&AIDS has on them could have contributed to a sense of urgency which impelled educators to take action to support their community's efforts to cope with HIV&AIDS, as they **were already supporting community members** to cope with the challenges associated with HIV&AIDS at the onset of my field work. The fact that participating educators are supporting informal settlement community members is supported by the findings of Ferreira (2006), indicating that educators provide support in various ways, such as co-ordinating the establishment of a vegetable garden

and an HIV&AIDS information and support service centre, which community members infected with and affected by HIV&AIDS might utilise on the school premises. In addition, a vast body of literature (Marais, 2005; Bennell, 2003; Soul City, 2003; Department of Education, 2000) advocates that schools (educators) are important role-players in supporting community members (including learners) infected with and affected by HIV&AIDS, which further supports this finding of my study

The finding that educators who participated in my study appeared to hold the opinion that they did not possess sufficient HIV&AIDS related knowledge and skills (competencies), yet they were supporting community members prior to the asset-based intervention I facilitated, raises the question of self-efficacy expectations in this discussion. Bandura, as stated in Egan (2002), developed a theory of behaviour change known as Self-Efficacy, whereby individuals' perceived ability to perform a specific activity or task influences their motivation and persistence to engage in the activity or task. If individuals perceive that they do not possess the skills and knowledge to engage successfully in an activity, they will be more likely not to attempt the activity, or their initial attempts may not be persistent. This idea is supported by the results in my study, whereby the educators' perceived lack of sufficient knowledge seemed to hinder their support efforts toward individuals infected with and affected by HIV&AIDS. It therefore seems clear that the educators in my study held the opinion that they **required an intervention (training)** to affirm their skills and knowledge (competencies) regarding HIV&AIDS related issues, in order for them to be able to offer better support to other community members in coping with HIV&AIDS.

The call for training of educators to support learners, parents and community members is well documented. Bennell (2003) suggests the training of educators and states that school management might promote a change in attitude to become more proactive in the identification, referral and monitoring of orphaned or vulnerable learners. He further suggests that caregivers need to be involved in the support efforts at schools. A study undertaken by Save the Children (2002) on discrimination and HIV&AIDS also advocates that educators need to educate themselves on the effects of HIV&AIDS and poverty on children, in an attempt to minimise discrimination. The study of Antle *et al.,* (2001) further supports this idea, suggesting that schools and educators (amongst other service providers) ought to be trained regarding the effect of HIV&AIDS on families, and advocating that schools need to be made safe places for community members to disclose their status. In my study, the participants continually emphasised the potential role that educators might play in supporting communities, but also that the necessary training was required for them to fulfil such a role.

4.7.2 Educators' willingness to help community members

During 1999, the minister of Education, Professor Kader Asmal, declared that '*educators can and must help curb the disease and deal with its effects'* (Department of Education, 1999:ii). In this declaration he stated certain guidelines, which were also supported by the participants in my study. Firstly, Professor Asmal asserted that educators need to be role models of responsible behaviour that does not put them at risk of HIV infection. Although my study did not focus on responsible sexual behaviour on the part of educators, the educators (participants) in my study indicated that they were aware of what responsible sexual behaviour entails and that they taught (or had the intention to teach) these principles to learners and community members.

Secondly, Professor Asmal emphasised that South African educators have received formal education and are in a good position to distribute accurate information on HIV&AIDS to the community as well as on coping with the challenges. The participants in my study adhered to this guideline by indicating that some community members are illiterate and that educators found it difficult to convey HIV&AIDS information to them. Participants suggested that the distribution of HIV&AIDS information ought to be a continuous process. Thirdly, educators are regarded as being in the position to reach many children and assist them to protect themselves from becoming infected with HIV. Participants in my study confirmed this statement and this concern, indicating that they were **providing learners with information on HIV&AIDS,** especially in terms of responsible sexual behaviour, in order to protect them from HIV infections (Department of Education, 1999).

Fourthly, Professor Asmal regarded educators as being in frequent contact with parents, and therefore in a position to spread the message about HIV&AIDS deep into communities. Educators (participants) in my study supported this sentiment as they indicated a desire to **broaden their horizon** of teaching HIV&AIDS related issues to include the wider community, and not merely teach within the confines of their school. Fifthly, Professor Asmal stated that educators can create a safe environment (in the workplace) for people (community members and colleagues) to disclose their HIV positive status without fear of discrimination. Applying this guideline to my study reveals that the participating educators thought that, by **building relationships** with community members (parents), one might be able to create such a safe environment for individuals to feel secure enough to disclose their HIV status. Finally, Professor Asmal stated that educators might find

creative ways to support learners and community members with the challenges presented by HIV&AIDS (Department of Education, 1999). In my study this guideline can be related to the ability of participating **educators to identify and utilise assets** amongst themselves, as well as in the community. The utilisation and mobilisation of assets are discussed in detail in the following section.

It therefore seems apparent that educators in my study adhered to the guidelines advocated by Professor Asmal to 'help curb the disease and deal with its effects' (Department of Education, 1999:ii). I found educators' (participants') motivation and determination to offer support to community members to be one of the greatest assets in the selected community. It is most probably through the participating educators' determination and enthusiasm in supporting their community that a great number of community members, including learners and parents of the school, were reportedly supported to cope with the challenges associated with HIV&AIDS.

4.7.3 Educators' ability to identify and utilise assets in support of community members coping with HIV&AIDS

My analysis and interpretation of the data collected during observation and face-to-face interviews prior to the facilitation of the asset-based intervention indicate that participants found creative ways of identifying and mobilising assets within the community. This tendency supports one of the main assumptions of my study, namely that educators are able to identify and mobilise assets, in order to support community members infected with and affected by HIV&AIDS.

During data collection, participating **educators identified themselves as assets** in the community, indicating the possibility that the role of educators in the particular community includes that of counsellor. This is supported by White Paper(6) (Department of Education, 2001) which states that, amongst the nine roles educators are expected to fulfil, the pastoral role is expected through which educators provide emotional support to learners and parents who are facing challenges.

The educators who participated in my study further identified several possible **tangible assets,** such as the establishment of a vegetable garden to enhance nutrition for community members infected by and affected with HIV&AIDS. Marias (2005) and Bennell (2003) support this finding, both advocating that feeding programmes established at schools might provide support to

community members infected with and affected by HIV&AIDS. Although the participants in my study were not involved in a feeding programme at the time I conducted my study, they did mention it as a possible future strategy they were planning to initiate. Participants further indicated that they utilised the **asset of the media** to enhance their knowledge on HIV&AIDS related issues, by referring to television programmes and books distributed by the Department of Education from which educators gathered information relating to HIV&AIDS. This tendency amongst educators who participated in my study can be viewed as a means whereby educators educate themselves regarding HIV&AIDS, related issues which is supported by studies undertaken by Save the Children (2002) and Antle *et al*. (2001). These studies emphasise that educators and other service providers ought to educate themselves on the impact of HIV&AIDS on children and community members in order to create safe environments for individuals to disclose their HIV positive status. The call for training of educators is further supported by Bennell (2003), as stated previously.

In addition, the educators who participated in my study identified and utilised **assets available in the community.** They arranged with social workers to meet community members infected with and affected by HIV&AIDS at the school. In this way, they seemed to aim at assisting community members to gain access to financial assistance available from the South African government. Ebersöhn and Eloff (2006) articulate this area of asset identification and mobilisation by incorporating the ecosystemic approach (Donald *et al.*, 2002). Ebersöhn and Eloff (2006) describe the assets found in this sphere as situated within the wider community.

Furthermore, the educators in my study appeared to utilise **assets found in citizens' associations**, for example speakers at church meetings, as well as assets found in the closer community, such as social meetings of friends. At these social meetings educators would talk about HIV&AIDS and gain information to assist them in supporting community members infected with and affected by HIV&AIDS. Ebersöhn and Eloff (2006) as well as Kretzmann and McKnight (1996), describe this aspect of asset identification and mobilisation as situated in the sphere of local associations, whereby assets and networks are identified within formal and informal associations.

Finally, the participants in my study identified **assets amongst themselves**, such as their ability and skills to establish a vegetable garden at school, which could be turned into a feeding programme in future. Furthermore, participating educators demonstrated their ability to identify assets amongst themselves by viewing fellow educators as sources of ideas concerning how to

support community members infected with and affected by HIV&AIDS and how to cope with HIV infected learners in their classrooms. Kretzmann and McKnight (1996) view this sphere of asset identification as individual inventory, whereby individual strengths, skills, previous experiences and talents of community members are identified.

The results of my study are mirrored in the statement of Kretzmann and McKnight (1996:27) that one should take cognisance of the fact that '*asset-based community-development is intended to affirm, and to build upon the remarkable work already going on in neighbourhoods.'* In addition, Ferreira (2006:274) refers to studies undertaken by Lucas, Foster and Cook which '*emphasise local community members' resourcefulness and innovative ideas of addressing the challenges*', thereby supporting my findings that educators found creative ways to address the challenges associated with HIV&AIDS within the informal settlement community in which I conducted my study.

Ebersöhn and Eloff (2006) use the term '**snowball effect'** in relation to the asset-based approach to intervention. Keeping in mind the interactive nature of the ecosystemic approach (Donald *et al.,* 2002), a movement or change in one subsystem might result in movement and change in other systems. Ebersöhn and Eloff (2006:33) further argue that '*there is also the possibility that one change in an individual can lead to many changes in the whole system because of the interactive relationship between different systems'.*

It would seem that the snowball effect might have been initiated by the asset-based intervention I facilitated during my study, as participants indicated that they were going to co-ordinate with other educators and arrange meetings with parents, aiming to involve the whole community in their future efforts to support community members.

4.7.4 Positive outcome of the asset-based intervention

Ebersöhn and Eloff (2006) identifysome of the advantages of the asset-based approach as participation and collaboration amongst community members, as well as ownership, shared responsibilities, immediacy, providing relevant and practical solutions, flexibility, mutual support and individual capacity building. I will now aim to highlight these advantages as described by Ebersöhn and Eloff (2006) referring to the findings of my study.

- **Active participation and collaboration** was generated by the facilitation of the asset-based intervention with the selected educators. As I viewed the participating educators as the experts in finding solutions to the challenges they face when supporting community members infected with and affected by HIV&AIDS, they were actively involved during the asset-based intervention and ultimately created the content of the intervention. Participants described their active participation and collaboration as a process characterised by the sharing of information. Some of the educators who participated utilised a metaphor to describe their feelings of active participation, by stating that educators are now going to *sing the same song*.
- **Taking ownership and an enhanced sense of empowerment** were generated amongst the participants in my study by means of the asset-based intervention. The educators who participated stated that eventually they believed that the 'workshop' (asset-based intervention) was not truly necessary, as they discovered that they had possessed the information generated through the asset-based intervention. This seems indicative of an awareness raising outcome of the intervention, as baseline data (Ferreira, 2006) indicated that they were unaware of the fact that they possessed the skills and knowledge (competencies) to support their community effectively prior to the intervention.
- **Sharing responsibilities** to support community members infected with and affected by HIV&AIDS was highlighted in my study, as the educators who participated were of the opinion that their role in the community expanded as the study progressed, and included the roles of social workers and nurses. Therefore, it seems apparent that the participating educators shared the responsibility for supporting and caring for community members in partnership with other professionals such as social workers and nurses. In addition, the educators in my study displayed an enhanced sense of collaboration amongst themselves, confirming that educators shared the responsibility for supporting community members. Furthermore, the educators felt that the facilitator and research team shared a common goal with them, namely to support community members in coping with the challenges associated with HIV&AIDS.
- The main concern participating educators centred on was their perceived lack of knowledge and skills (competencies) to support individuals infected with and affected by HIV&AIDS effectively. The asset-based intervention seemed to address this concern instantaneously **(immediacy)** as the educators who participated in my study indicated during the focus group discussion that they then realised that they possessed the necessary knowledge to support their community.
- **Relevant and practical solutions** were generated during the asset-based intervention, as participating educators created posters that served as action maps, practical guides and

solutions to the challenges they faced in supporting other community members. The first asset-action-map focused on the resources available in the community to support HIV infected individuals. The second map focused on possible strategies for coping with an HIV infected learner in the classroom, whilst the third practical solution centred on physical support of an HIV infected individual. Participants' contributions were reflected in the information booklet they received at the end of this section. The discussion further resulted in a summarising poster, focusing on the emotional support educators might provide to individuals coping with HIV&AIDS. From this poster it seems clear that participating educators identified and utilised assets in the community (such as arranging social workers to meet parents at school and arranging for HIV infected learners to be taken to the local clinic), as well as amongst themselves (such as ideas to support HIV infected learners in the classrooms by engaging in classroom practices that promote tolerance) to address the challenges they face in supporting community members coping with HIV&AIDS.

- The principle of **flexibility** is implied as an advantage of the implemented asset-based intervention, as the educators who participated created solutions to the challenges they faced when supporting community members in coping with HIV&AIDS. As a result, they could change their action maps (coping plans) as new challenges arose. Participating educators were informed that they were free to add information to the booklet they had received regarding physical support for HIV infected individuals or change the *Helping Hand of Support Poster,* they had created in order to facilitate emotional support to individuals coping with HIV&AIDS.
- **Mutual support and a caring environment** were enhanced amongst the participants in my study. Kretzmann and McKnight (1996) state that the asset-based approach aims to build on what is already present in the community. In this aspect, the implemented asset-based intervention built on strong foundations of mutual support and caring, as participating educators indicated that they valued the contributions of their colleagues, and that they would prefer to offer more support to community members coping with HIV&AIDS. This implied that participants were building a caring environment in which individuals might feel safe to disclose their HIV status and an environment which is further emphasised by Peltzer (2003), Save the Children (2002) and Antle *et al.* (2001), advocating that schools (amongst other service providers) ought to become safe places for individuals infected with HIV&AIDS to disclose their status.
- **Individual capacity building** appeared to have been generated by the asset-based intervention as the participating educators' knowledge and skills (competencies) to support

community members effectively in coping with HIV&AIDS were affirmed. Participating educators indicated that they were unaware of the fact that they possessed sufficient knowledge and skills (competencies) to support community members at the onset of my study. Furthermore, by affirming their existing knowledge and skills (competencies), the educators who participated appeared to gain confidence in their abilities to support their community in coping with HIV&AIDS. Some of the participating educators stated (towards the end of my study) that they were not afraid to face the challenges associated with a person disclosing an HIV positive status, as they knew what to say and what to do in such a case.

The finding on capacity building further relates to Egan's (2002:302) reference to aspects of individual capacity building, emphasising the concept of Self-Efficacy Beliefs: *'self-efficacy is based on ability and the conviction that their ability can be used to get the task done'.* The fact that participants' knowledge and skills (competencies) regarding aspects of support in the face of HIV&AIDS seemed to have been affirmed during the asset-based intervention might have enhanced their self-efficacy. Egan (2002:302) further states that *'merely acquiring skills does not by itself increase clients' self-efficacy. The way they acquire them must give them a sense of their competence'.* As the asset-based approach attempts to enhance, identify and mobilise individuals' assets (such as skills, knowledge and previous experiences), thereby building upon individuals' capacities (Ebersöhn & Eloff, 2006; Kretzmann & McKnight, 1996), it seems that the way in which educators were made aware of their skills and knowledge during this study might have enhanced their sense of competence.

4.8 CONCLUSION

In this chapter I provided an overview of my involvement in the research field, reflecting on the processes in which I participated. I then presented the research results in terms of the main themes and sub-themes that emerged. Thereafter, I discussed the research results in terms of existing literature and research, aiming to highlight similarities and explain contradictions.

In the next chapter I focus on the conclusions I came to at the end of my study. Thereafter, I reflect on the possible limitations and value of my study. I conclude with recommendations stemming from the study.

CHAPTER 5

RESEARCH OVERVIEW AND CONCLUSIONS

5.1 INTRODUCTION

In Chapter 4 I reported on the results and findings of my study. In relating the results I obtained to existing literature, I aimed to highlight correlations as well as contradictions.

In this chapter I present an overview of the preceding chapters. I come to final conclusions by addressing the research questions, as formulated in Chapter 1. I conclude the chapter by reflecting on the possible limitations and value of my study, and by formulating recommendations arising from my study.

5.2 OVERVIEW OF THE PREVIOUS CHAPTERS

In **Chapter 1**, I stated the introduction and rationale of my study. The aim of Chapter 1 was to provide an orientation for the study. I attempted to justify my selection of the phenomenon I researched.

I presented my research questions and the assumptions with which I approached my study. I defined the key concepts of my study, namely asset-based intervention, educators in an informal settlement community, HIV&AIDS, coping with HIV&AIDS, support in the context of HIV&AIDS as well as brief clarifications of the terms equip and competencies. I presented a brief overview of the paradigmatic perspective I selected, my research methodology and research strategies. I concluded Chapter 1 with an overview of the chapters of this dissertation.

Chapter 2 included a literature review of the underlying theoretical aspects relevant to my study. I aimed to provide the reader with the context from which I planned and undertook the empirical study, and interpreted my results. I discussed the asset-based approach in terms of asset-based theory, with reference to the origin of asset-based theory and the ecosystemic approach, followed by a review of asset-based community development and the asset-based approach, as the underlying theory of the intervention I facilitated with the educators during this study.

Thereafter, I presented an overview of the impact of HIV&AIDS on informal settlement communities, parents, children and the education sector, focussing on the potential roles that educators might fulfil in supporting their communities to cope with HIV&AIDS. Chapter 2 came to a close with a discussion on coping and support within the context of HIV&AIDS. This discussion focused on coping within informal settlement communities by utilising support structures, as well as coping with HIV&AIDS on an individual and family level. I concluded the chapter by presenting my conceptual framework.

In **Chapter 3**, I presented the empirical study which I conducted. I described the research process that I employed in conducting my study. I discussed the interpretivist paradigm as the underlying philosophy of my study and aimed to highlight the link between the asset-based approach, my selected research collection strategies and the paradigmatic perspective of Interpretivism.

I discussed the instrumental case study research design I selected, during which I applied some PAR principles. I presented my selection of ten educators of a primary school, located in an informal settlement community in the Eastern Cape. Thereafter, I provided an overview of the multiple data collection and documentation strategies I employed, namely an analysis of the transcripts of a related study, face-to-face interviews, an asset-based intervention, a focus group discussion, observation-as-context-of-interaction, a research book and visual data. I described the manner in which I conducted data analysis and interpretation and concluded Chapter 3 with a discussion of the roles I fulfilled during my study, namely the dual role of researcher and interventionist.

In **Chapter 4**, I presented my research results. I firstly provided an overview of my activities in the research field. I reflected on my experiences as field worker for the related study (Ferreira, 2006), on observation and the process of keeping a research book, as well as conducting interviews. Thereafter, I presented the two main themes which emerged from the interviews and observations. The first theme related to aspects referring to the participants' desire to support community members in coping with the challenges of HIV&AIDS. The second theme centred on educators' feelings of inadequacy regarding the support they were already providing to community members.

I then turned my discussion to the development and planning of the asset-based intervention with the selected educators, followed by the implementation of the intervention and facilitation of the focus group discussion. Thereafter, I presented my research results which emerged from the focus

group discussion and observations as themes relating to the positive outcome of the asset-based intervention I facilitated, with reference to educators' feelings of competence in their support efforts. I closed Chapter 4 with a discussion of the research results in terms of relevant literature and research, thereby presenting my findings.

5.3 ADDRESSING THE RESEARCH QUESTIONS

The main research question of this study was: ***How might an asset-based intervention with educators be employed to facilitate feelings of competence with regard to their ability to support community members in coping with HIV&AIDS?*** It seems that the way in which educators' feelings of competence were enhanced lies in the developed and implemented asset-based intervention. However, I realise that this is only one of the many ways in which educators' confidence regarding supporting their community might have been enhanced, and that I did not control for outside variables which might have contributed to educators' reported enhanced confidence. Yet, the fact that the participants in my study reportedly gained an enhanced sense of competence is supported by Ebersöhn and Eloff (2006), who highlight the advantages of an asset-based intervention as (amongst others) an enhancement of individual capacity, ownership and collaboration. Participants in my study reportedly **gained confidence**, were able to **address their own insecurities** based on the asset-based intervention, experienced **decreased levels of anxiety** to engage in support efforts and reportedly experienced **enhanced feelings of empowerment.** Participants indicated that they are **singing the same song** as a result of the asset-based intervention which reflect enhanced collaboration amongst participants. In an attempt to elaborate my answer to the main research question, I now address the secondary research questions, as formulated in Chapter 1.

5.3.1 Secondary research question 1: What are participants' (educators') perceptions regarding their existing skills and knowledge (competencies) to support community members in coping with HIV&AIDS?

I found that the participants in my study expressed themselves to be inadequately skilled and lacking accurate knowledge (information) regarding HIV&AIDS. Participants, for example, indicated a lack of competence on how to cope with or support HIV infected learners in their classrooms at the onset of my study. Participants stated that they are insecure regarding accurate HIV&AIDS related information and, although participants displayed a desire/willingness to support community

members (physically, emotionally and spiritually), they were apprehensive regarding the advice, guidance and referral of individuals infected with and affected by HIV&AIDS. Participants further felt that their support efforts were hindered by their (perceived) lack of skills and knowledge (competencies) regarding HIV&AIDS and indicated that a workshop of some sort might eliminate some of the insecurities they were experiencing.

5.3.2 Secondary research question 2: How might educators utilise their existing knowledge and skills (competencies) in supporting children infected with and affected by HIV&AIDS, as well as their parents, caregivers or other community members, in dealing with HIV&AIDS related challenges?

Findings relating to secondary research questions indicate that the participants in my study were emotionally affected by the HIV&AIDS pandemic. The participants indicated that they felt that community members trusted educators (participants) to support and guide them as they faced the challenges associated with HIV&AIDS. This probably resulted in a sense of urgency amongst participants to offer support, despite their perceived lack of skills and adequate knowledge (competence).

As a result, I found that the participants in my study reportedly supported community members to cope with the challenges of HIV&AIDS despite their perceived inability to do so effectively. I found that participants allegedly supported other community members by identifying and mobilising (utilising) assets on a tangible level (for example, providing fruit to learners); within themselves (for example knowledge regarding adequate nutrition and utilising their social skills to build relationships); and amongst themselves (for example sourcing ideas to give effective support to community members infected with and affected by HIV&AIDS from other educators). Participants also reportedly identified and mobilised assets in the local community (for example obtaining HIV&AIDS related information from speakers at the church), as well as within their social networks (for example sourcing ideas and knowledge relating to HIV&AIDS from friends). Identification and mobilisation of assets in the greater community (for example accessing the services of a social worker) and media (for example obtaining information from television programmes) also seemed to have served to assist participants in their support efforts.

Participants in my study appeared to support community members infected with and affected by HIV&AIDS spiritually and emotionally. Participants, for example, visited community members and

prayed for them. Support on a practical level included advising community members to plant vegetables. Participants further reportedly supported community members by providing information and guidance on HIV&AIDS related issues, by distributing pamphlets and meeting community members at school.

5.3.3 Secondary research question 3: If educators were to take part in an asset-based intervention (workshop) on HIV&AIDS, what kind of information and skill development should be included?

Participants indicated that they required guidance to cope with learners infected with and affected by HIV&AIDS. Participants firstly indicated their need for assistance relating to physically assisting learners infected with and affected by HIV&AIDS, for example providing food and allowing learners infected with and affected by HIV&AIDS to rest in the classroom without compromising the confidentiality of their HIV positive status. General classroom practices such as discipline and shouting in the classroom were identified as another area of concern. Participants thirdly indicated the need for assistance in guiding community members in terms of advice regarding illnesses and infections associated with HIV&AIDS. Specific symptoms that the participants often asked about included scores and fewer.

Participants further indicated that they would like to provide emotional support to community members. Emotional support was described by most participants as counselling, as well as the provision of accurate information to community members regarding HIV&AIDS, in an attempt to support them with the physiological and psychological impact of the pandemic. Guiding community members to access resources (assets) available in the community, that offer support to HIV infected individuals (for example aiding community members with procedures to apply for financial assistance from the Department of Social Development), was also identified as an area in which participants perceived themselves as having limited knowledge and skills.

From my perspective I would liked to have had more time to address areas of physical care with the participants, as I fear that the asset-based approach was somewhat compromised during this section of the intervention. Although participants provided information on physical care, I believe that it would have been more fruitful to allow participants to create their own information booklet. However, I feel that the asset-based intervention as a whole was successful, as educators gained confidence in their own capacities to support the community.

5.3.4 Secondary research question 4: To what extent can an asset-based HIV&AIDS intervention with educators meet educators' (participants') expectations with regard to their need to be informed and feel equipped to support others?

The asset-based intervention I facilitated seemed to address the expectations of the participants to be more informed to offer enhanced support to the community. Utilising an asset-based intervention with educators meant that they were actively involved. My findings indicate that active participation in the identification of assets (knowledge, skills, ideas and previous experience) amongst and within themselves, might have impacted positively on participating educators' self-confidence and enhanced motivation to support their community. In turn, active participation in the asset-based intervention provided participants with an opportunity to address their own insecurities regarding HIV&AIDS. The positive outcome of the asset-based intervention is supported by Ebersöhn and Eloff (2006) and is regarded as elevated ownership, collaboration and empowerment, as well as sharing responsibilities (viewing their role in community as expanded), generating flexible, practical and immediate solutions to concerns, generating mutual support and a caring environment, as well as enrichment of individual capacity.

Additionally, findings seem to indicate that the asset-based intervention might have a snowball effect (Ebersöhn & Eloff, 2006) whereby support incentives might spread from one system (school) in the community to other systems (parent body) in future. This is however a mere hypothesis, which requires further investigation. In the same manner, participants also indicated that they would transmit the competencies obtained by participating in the intervention to other educators, as well as beyond the boundaries of the school. Participants identified community upliftment as their long-term goal as they prepare and nurture the adults of the further by educating the young.

5.4 CONCLUSIONS

This study aimed to explore the potential value of an asset-based intervention with educators to enhance educators' competence in supporting their community to cope with HIV&AIDS related challenges. I found that an asset-based intervention potentially enhanced the support structures/assets (namely educators) in an informal settlement community. The asset-based approach implies that a paradigm shift is required of community members (in this case educators) from a needs-based approach an to asset-based approach, when dealing with challenges. The

asset-based approach seemingly reinforces the assets (modes of support) which are present in a community. During the asset-based intervention I facilitated discussions on the following themes (as identified by the participants during initial face-to-face interviews): ways to cope with learners infected with or affected by HIV&AIDS in the classroom; guidelines on referral of community members infected with and affected by HIV&AIDS; as well as ways to support community members infected with and affected by HIV&AIDS on both a physical and an emotional level.

By employing the asset-based approach as underlying theory of the intervention I facilitated with participants (educators), I aimed to facilitate an awareness of the assets the participants possessed within themselves (their skills and knowledge), amongst themselves (brainstorming ideas as a group) and within their local and wider community. Through addressing the abovementioned themes during the asset-based intervention I facilitated, participants (educators) were able to create a plan of action to cope effectively with a learner infected with and affected by HIV&AIDS. They were also able to create a plan of referral where community members infected with and affected by HIV&AIDS could find support and guidance. Finally, participants generated knowledge and skills to support community members presenting with infections and illnesses associated with HIV&AIDS, both physically and emotionally.

As the participants in my study were actively involved in the creation and generation of knowledge and action plans, they apparently gained confidence in their own abilities to offer support to other community members. Confidence is associated with positive self-efficacy expectations, which in turn are associated with motivation and determination in a course of action (in this case supporting community members infected with and affected by HIV&AIDS). I can therefore conclude that the asset-based intervention I facilitated seemingly enhanced educators' feelings of competence in terms of the support they provided to community members infected with and affected by HIV&AIDS. It appears that the participating educators' support efforts were enhanced, in which case community members infected with and affected by HIV&AIDS have access to support in coping with the challenges they face related to HIV&AIDS. Furthermore, by employing an asset-based intervention with educators, I assumed that their enhanced sense of support would motivate them to take ownership of other support efforts in the community. From a community development perspective, ownership is associated with sustainability (Kretzmann & McKnight, 1996). As the educators who participated displayed an enhanced sense of ownership, one might assume that their support initiatives may well be sustainable. However, the fact that this is a mere assumption indicates that further exploration of the sustainability of the educators' support efforts is needed.

5.5 POSSIBLE LIMITATIONS OF THE STUDY

As my study focused on a limited number of participants (educators) in a selected school within one informal settlement community, transferability of the findings cannot be assumed. However, I followed an interpretivist paradigm and therefore did not aim at obtaining generalisable findings, as I believe that knowledge creation is an interactive process occurring within a specific context. Rather, by aiming to obtain transferable findings, I provided rich descriptions of the perceptions of the participants in the selected school.

The difference in culture, experience and language between the participants and myself (and my co-researchers) leads to the possible limitation that the findings of my study may be subjective and coloured by my own indigenous knowledge system. As stated previously, I celebrate and respect the indigenous knowledge systems of all people. I aimed to provide a description of the participants' perceptions of the aspect I explored, by engaging in member-checking (although to a limited extent) to ensure that the emerging themes reflected the sentiments of the participants. I also reflected on my experiences in my research journal to foreground my interpretations during data collection, analysis and interpretations. Furthermore, as my study followed an interpretivist paradigm, I assumed that the creation of shared meaning (knowledge) occurs in an interactive and subjective manner between individuals and therefore embraced my own experiences in this study.

As I am currently in training, to become an educational psychologist, I found myself divided between my role as researcher and my future profession. Although I followed an interpretivist paradigm and value the subjectivity of shared meaning, I had to constantly reflect on the dual role I fulfilled. I had to monitor myself as researcher and refrain from providing therapy when interacting with participants in need of support. By being aware of this aspect, and being under continuous supervision during interactions with participants, I could reflect on these aspects, pondering their possible influence on my research findings. Once the research activities had been concluded I provided the participants in need of support with an opportunity to debrief as I view this as an ethical and moral duty. Perhaps I should have rather referred them for outside counselling, as my chosen strategy compounded my role confusion.

The fact that only female participants participated in the asset-based intervention and subsequent focus group discussion might have coloured the findings of my study. The possibility exists that, as

a result, I presented gender-based perceptions regarding educators' support to community members infected with and affected by HIV&AIDS.

Finally, a potential limitation of my study relates to the fact that the intervention (workshop) I facilitated with educators was not explored as a pilot study. Therefore, I was unable to explore other avenues which might have proved to be more fruitful. As such, the factors influencing my findings might potentially be related to aspects not yet explored. I was also unable to control for outside variables which could have contributed to the reported change in confidence, as reported by the participants.

5.6 POTENIAL VALUE OF THE STUDY

Although my study implies certain limitations, I also believe that a contribution may flow from this study.

5.6.1 Theoretical value

The fact that literature relating to the way in which educators practically support community members infected with and affected by HIV&AIDS is still emerging in nature, indicates the possibility that my study may contribute to existing theory on educators' support of communities infected with and affected by HIV&AIDS. Further contributions of my study on existing theory may include educators' perceptions regarding their skills and knowledge (competencies) of HIV&AIDS related issues, as well as the support they could offer community members, following an asset-based intervention focusing on competence within the field of support for individuals infected with and affected by HIV&AIDS.

As I approached my study form the underlying theory of the asset-based approach, the knowledge generated during my study could further contribute to the growing body of literature on the asset-based approach, specifically in terms of the potential value of applying the basic principles of the asset-based approach during the planning and facilitation of an intervention (programme/'workshop'). Additionally, existing theory on the potential benefits of the asset-based approach might be enhanced, in terms of self-efficacy expectations.

Furthermore, my study could contribute to the development of educational psychology theory by suggesting a means of facilitating and implementing group intervention as a strategy to provide therapeutic services, as well as working within schools situated in communities characterised by poverty and limited external resources.

5.6.2 Methodological value

In addition, I believe that the chosen methodology in my study is valuable in that it allowed the educators (participants) to perceive themselves to be competent to support their community in coping with HIV&AIDS. I believe that the participants' motivation and determination to support their community has increased as a result of their involvement in the data generation activities. In this manner, from a PAR perspective, my study might have indirectly affected community members in the Nelson Mandela Metropole to cope more easily with the challenges they face in terms of the HIV&AIDS pandemic.

5.7 RECOMMENDATIONS

I now make recommendations arising from my study, in terms of recommendations for training, further research and practice.

5.7.1 Training

As the supporting of educators is viewed as part of the professional role of educational psychologists one could look toward expanding the training of educational psychology students to include the facilitation of an asset-based intervention with educators. Practising educational psychologists might also benefit from engaging in asset-based group intervention strategies, whereby therapeutic and support services might reach a wider audience. In addition, the training of educators might be elaborated further in terms of HIV&AIDS competencies, as well as support possibilities to learners and other community members.

5.7.2 Research

The assumption (hypothesis) of this study was that an asset-based intervention with educators might enhance their confidence to provide support to community members infected with and

affected by HIV&AIDS. I found that an asset-based intervention holds the potential to provide participants with more confidence regarding the support they might provide community members in coping with the challenges associated with HIV&AIDS.

This study could be replicated to investigate whether or not the positive outcome of the asset-based intervention I facilitated was unique to the selected case, or whether a similar positive outcome would also be seen in other communities. Similar research projects could further focus on the challenges associated with HIV&AIDS, or even on other challenges communities face, for example crime, exploring to what extent an asset-based intervention might be employed in other contexts. Such research projects could include other community members (outside the education sphere), in order to explore how their feelings of competence might be enhanced in order to cope with the daily challenges they face.

In addition, research projects could be initiated to investigate the sustainability of the support efforts that the participants in my study reportedly provided to community members. One might also explore whether or not the participants did indeed share their knowledge regarding HIV&AIDS related challenges with other educators and community members, as they indicated they would do. Furthermore one might consider exploring the role gender plays in support initiatives. Investigating community members' experiences of the support received from educators might be considered as yet another research area of interest.

Further research projects might focus on investigating outside variables which might also have contributed to the change in confidence, as reported by participants. Additionally, one might launch projects aiming to verify support actions in the community. Finally, engaging in a mixed method study, focusing on pre-testing participants' knowledge, confidence and support actions and post-testing these once an asset-based intervention had been implemented, might be a fruitful area of research.

The following hypotheses emerged which might merit related research in this field:

- Informal settlement community members seem to trust educators to support and guide them with regard to the challenges associated with HIV&AIDS.
- The fact that informal settlement community members trust educators to support them with HIV&AIDS related challenges might render educators to experience a sense of urgency to support community members infected with and affected by HIV&AIDS.

- Educators can mobilise available assets to enhance the support initiatives they (educators) offer community members infected with and affected by HIV&AIDS.
- Educators employed in informal settlement communities can support community members infected with and affected by HIV&AIDS on an emotional, spiritual and physical (practical) level.
- Educators employed in informal settlement communities can support community members infected with and affected by HIV&AIDS, by providing information and guidance on HIV&AIDS related issues.
- Educators might be able to address their own insecurities relating to HIV&AIDS issues by participating in an asset-based HIV&AIDS intervention.
- Educators might experience decreased levels of support related anxiety following participation in an asset-based HIV&AIDS intervention.
- An asset-based intervention with educators employed in an informal settlement community might have a snowball effect on support initiatives in the community.

5.7.3 Practice

Within the framework of community development and the HIV&AIDS pandemic, it might be fruitful to initiate and facilitate projects which utilise a similar asset-based intervention with educators in other schools and communities, in order to enhance educators' sense of competence in supporting the communities in which they serve. Within the sphere of the education sector, it might also be worthwhile to investigate the possibility of educating educators in the field on aspects relating to the asset-based approach, in order to enable educators to launch similar interventions in the schools where they find themselves in. Educator training institutions might therefore focus on educating students about the asset-based approach and providing students with practical sessions in schools, to experience the positive outcome asset-based intervention might have.

5.8 CONCLUDING REMARKS

The main research question of this study was to *investigate an asset-based intervention with educators to facilitate feelings of competence with regard to their ability to support community members infected with and affected by HIV&AIDS.* The aim of the study was therefore to design and facilitate an asset-based intervention amongst educators, in order to explore and describe

whether or not such an intervention would enhance their competence in supporting community members infected with and affected by HIV&AIDS.

In my study I firstly investigated educators' perceptions regarding the support they were offering community members in coping with the challenges associated with HIV&AIDS at the time I commenced with my field work. Thereafter, I planned and facilitated an asset-based intervention, based on educators perceiving their own knowledge and skills as being limited. However, after facilitation of the asset-based intervention, a positive impact on participating educators' perceptions of the support they were offering, and could potentially offer, to community members infected with and affected by HIV&AIDS related challenges, was evident.

As part of the positive impact of my study on educators' sense of efficiency in supporting community members infected with and affected by HIV&AIDS, their motivation and determination to support their community reportedly increased. This research study seems to have affected the degree of support offered by participating educators to community members in coping with HIV&AIDS. The potential value of the asset-based intervention on educators' perception of their skills and knowledge (competencies) in supporting community members in coping with HIV&AIDS was summarised efficiently by a participant during the focus group discussion:

> *we thought that we are going to be passive. But it didn't happen like that… That is what is with us, so you get something from us and that is where you found out that these people know everything... Now that it is over we see that it is 10% from you and 90% from us because we are living in this community and we know everything. We thought that we know nothing. So you take something you see knowing that you've got treasure. But we didn't know that we have treasure* (focus group, participant 6, p.5).

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Appendix A

Pamphlet obtained during field work:

AIDS training & information centre (ATICC)

PORT ELIZABETH MUNICIPALITY
A.I.D.S. TRAINING AND INFORMATION CENTRE

A.I.D.S. TRAINING COURSE

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PORT ELIZABETH MUNICIPALITY A.I.D.S. TRAINING AND INFORMATION CENTRE

A.I.D.S. TRAINING &
INFORMATION CENTRE
P.O. BOX 293
PORT ELIZABETH
TEL.: (041)506-1415

A.I.D.S. TRAINING &
INFORMATION CENTRE
GROUND FLOOR, BRISTER HOUSE
MAIN STREET, PORT ELIZABETH
TEL.:(041)506-1415

A.I.D.S.

Acquired Immune Deficiency Syndrome

HISTORY

In 1981, American doctors found a group of homosexuals who had died of a rare type of pneumonia. Dr. Luc Montagnier of the Pasteur Institute in Paris and Dr. Robert Gallo of the *United States of America both isolated the guilty* **A.I.D.S.** *virus which has since been renamed* the Human Immune Deficiency Virus or H.I.V. virus. **A.I.D.S.** has developed into the deadliest disease of the century — one which, at present, is incurable.

CAUSE

The H.I.V. virus, a so-called Retro virus which lives in and kills cells. When the H.I.V. virus enters the body it attacks and destroys the helper -T cells. These helper -T cells normally defend the body against infections. Once they have been destroyed by the H.I.V. virus the body is rendered helpless to many infections and even cancer.

HOW DO WE GET *A.I.D.S.?*

The virus is spread by infected blood, semen and vaginal fluid.
Because the virus can be present in semen and vaginal fluid, this means, for most people, the only real danger comes through having sexual intercourse with an infected person. This means **ANAL** or **VAGINAL** sex. It could also be that **ORAL** sex can be risky.

So the virus can be passed from man to man, man to woman, and woman to man. For those **DRUG ADDICTS** who inject drugs there is the **ADDED RISK FROM SHARING NEEDLES** with someone who is infected. Finally **BABIES BORN TO MOTHERS WHO ARE INFECTED** have a 50% chance of being born with the virus.

MOST IMPORTANT

HOW CAN YOU AVOID A.I.D.S.?

Most people who have the virus don't even know it. They may look and feel completely well. So you cannot know who is infected and who isn't. To protect yourself follow these guidelines:

The more sexual partners you have, especially male partners, the more chance you have of having sex with someone who is infected. It is **SAFEST TO STICK TO ONE FAITHFUL PARTNER.**

FEWER PARTNERS — LESS RISK

Unless you are sure of your partner, always use a condom (sheath or rubber). This will reduce *the risk of catching the virus. But it is* **NOT 100% SAFE — YOU MUST PLAY SAFE!**

USE CONDOMS FOR SAFER SEX

It is also best to use a water-based lubricating gel with the condom. Ask your chemist for advice.

The contraceptive pill is no protection against **A.I.D.S.**. Anyone who abuses drugs **SHOULD NOT INJECT.** If you do, **NEVER SHARE EQUIPMENT** (needles, syringes, mixing bowls, etc.). You could be injecting the virus straight into your blood stream. It is extremely dangerous.

DON'T INJECT — NEVER SHARE.

OTHER POSSIBLE DANGERS

It is not safe to use equipment for ear-piercing, tattooing or acupuncture, unless you know it is unused or has been sterilised. Nor is it safe to share a toothbrush or a razor with someone who is infected. These things could give you the virus through infected blood.

HOW WE DON'T GET A.I.D.S.

The Government's clear medical advice is that you cannot get the **A.I.D.S.** virus from normal social contact with someone who is infected. You cannot get it by shaking hands. Nor is there any record of anyone becoming infected through normal kissing. There is no danger in sharing crockery or cutlery. Nor can you catch it from public baths or toilets. In hospitals, standard disinfection precautions protect patients, visitors and staff. Giving blood is safe. All the equipment is only used once. And all the blood used in this country for blood transfusions is rigorously checked.

HOW SAFE IS IT ABROAD?

In some countries blood transfusions are not checked for the A.I.D.S. virus. In those places where the virus is widespread, **DO NOT**, if you can possibly avoid it, **HAVE BLOOD FROM A LOCAL DONOR.** Also in certain developing countries, medical equipment may not be properly sterilised. If you can, avoid any treatment involving injections and surgical procedures.

IMPORTANT! Avoid sexual intercourse in such countries especially north of South Africa.

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IF Y… NK YOU ARE … TED

If you think you may be infected go to your family doctor for advice about having a test. Or go direct to a clinic for Sexually Transmitted Diseases for confidential advice and a test if you wish. If you have the virus, they will let you know and give you help and support. You must consent to the test.

DO YOU NEED MORE INFORMA-TION?'

The true picture about A.I.D.S. is that, at the moment, relatively few have the virus in this country. Those most at risk now are:

- Men who have anal sex with other men.
- Drug misusers who share equipment.
- Anyone with many sexual partners, and the sexual partners of any of these people.

But the **VIRUS IS SPREADING.** And as it does, so the **RISK OF HAVING SEX WITH SOMEONE WHO IS INFECTED INCREASES.** Ultimately, **DEFENCE** against the disease **DEPENDS** on all of us **TAKING RESPONSIBILITY** for our own actions.

More detailed information is available from the above address or your local doctor, hospital or health clinic.

EMERGENCY TELEPHONE NUMBER : (041) 506-1415

GLOSSARY — 1

AIDS	Acquired Immune Deficiency Syndrome
AIDS related complex (ARC)	various symptoms which people infected with the AIDS virus may develop including drenching night sweats, unexpected and considerable weight loss and persistent fever
Anal Intercourse	penetration of the anus (rectum) of a man or a woman by a penis
Antibiotic	a substance that attacks bacteria but not viruses
Antibody	protein made by a person's immune defence system in response to a disease. If you have antibodies to the AIDS virus, it means that you have been infected by the virus
Antigen	those parts of a disease-causing organism that cause our bodies to produce antibodies
Antiviral	a substance that prevents or treats an infection caused by a virus
Artificial insemination	the fertilisation of an egg by a sperm without sexual intercourse
AZT	a drug that destroys the AIDS virus and delays the onset of symptoms in people infected with the AIDS virus
Bisexual	a person sexually active with both males and females
Blood donation	giving blood for use in medical emergencies
Blood transfusion	receiving blood after a major accident or during certain operations
Carrier	an AIDS carrier is someone who has become infected with the AIDS virus and may or may not show any symptoms of the infection
Condom	a contraceptive usually made of thin latex rubber and worn on an erect penis. Condoms greatly reduce the chances of both males and females catching sexually transmitted diseases, including AIDS. Also known as French letters, sheaths and "Johnnies"
Counselling	talking through the implications of a course of action with an expert. Anybody taking the AIDS antibody test receives counselling
Factor VIII	a substance in the blood essential for blood-clotting. Haemophiliacs are usually unable to make their own Factor VIII
Foetus	a developing child in the womb
Gay	(male) homosexual
Haemophilia	an inherited disorder of some males in which their blood cannot clot properly. Haemophiliacs can lead relatively normal lives if they receive regular blood products such as Factor VIII from other people
Heterosexual	someone attracted sexually to people of the opposite sex
HIV	Human Immunodeficiency Virus: another name for the AIDS virus

GLOSSARY – 2

Homosexual	someone attracted sexually to people of the same sex.
Immune deficiency	a situation in which the body's defence system against disease doesn't work properly
Immune system	the body's defence mechanism which fights off infections and diseases
Incubation period	the time that passes between a person getting infected by the organism which causes a disease, and first showing signs of the disease
Intravenous	into a vein
Kaposi's sarcoma	a rare type of skin cancer which affects about one in four people with AIDS
Lesbian	female homosexual
Opportunistic infection	diseases which a person gets when his or her immune system is not working well
Or	mouthing of your partner's genitals. It is difficult to be certain but this *probably carries a risk of transmission* of the AIDS virus, especially if a male ejaculates in his partner's mouth
Pn stis carinii	*the organism which causes a rare lung disease found in about a half of all* the people who develop AIDS
Re ercourse	*penetration of the rectum (anus) of a man or a woman by a penis*
Retrovir	the commercial name for a drug (AZT) which delays the onset of symptoms *in people infected with the AIDS virus*
Safer sex	techniques of sexual activity which reduce the chance of catching or *transmitting the AIDS virus and other sexually transmitted disease*
Semen	the fluid that spurts from the penis when a male ejaculates
Seropositive	blood which contains a particular antibody. Someone who is AIDS-positive has antibodies to the AIDS virus in his or her blood. The opposite of *seropositive is seronegative*
STD	Sexually Transmitted Disease. Diseases such as gonorrhoea, thrush and *AIDS which can be passed on during sexual intercourse*
Syndrome	a set of symptoms found together and indicating the presence of a *particular disease*
T-lymphocytes	types of white blood cells produced by the body to fight disease
Virus	a tiny agent or particle which can only reproduce inside a living cell. Many human diseases, such as measles, colds and chickenpox are caused by different *kinds of viruses. Viral diseases cannot be cured by antibiotics*

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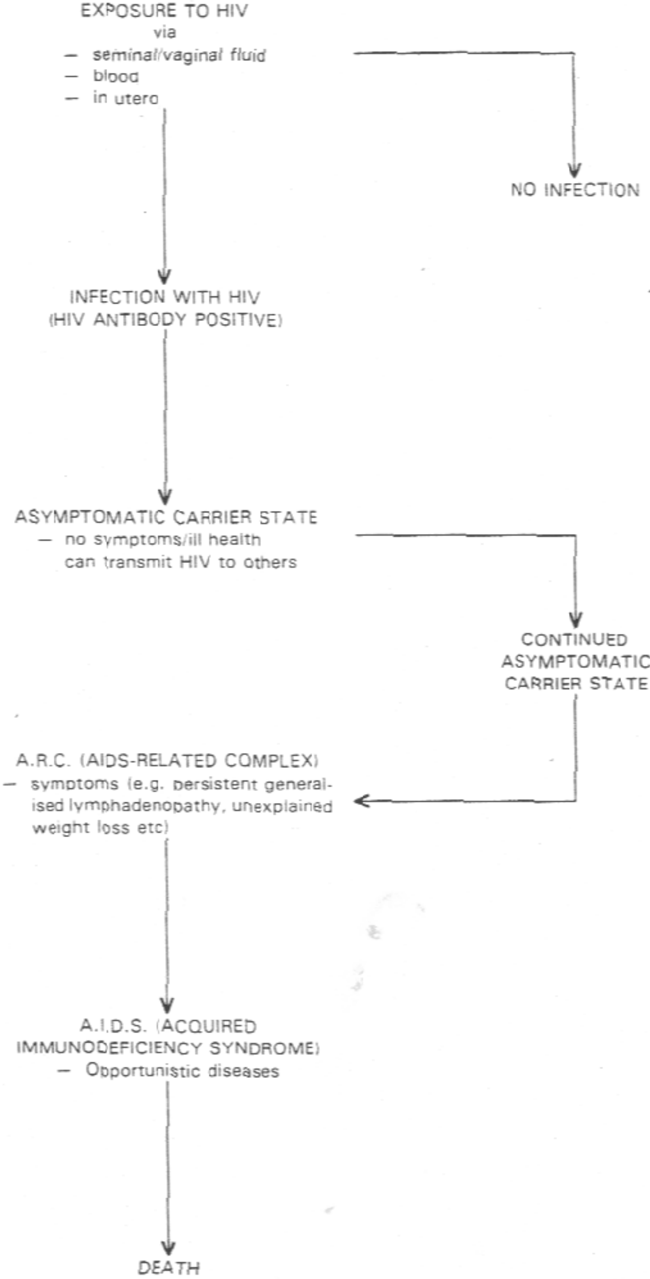
THE NATURAL COURSE OF HIV INFECTIONS



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A.I.D.S.

THE DISEASE

CAUSE: The H.I.V. virus (Human Immunodeficient Virus) — a Retrovirus

TRANSMISSION: By:
1. Sexual Intercourse
2. Infected Blood
3. From an infected mother to her unborn child.

Because the virus can be present in semen and vaginal fluid, this means, for most people, the only real danger comes through having sexual intercourse with an infected person. This means **ANAL** or **VAGINAL** sex. It could also be that **ORAL** sex can be risky.

So the virus can be passed from man to man, man to woman, and woman to man. For those **DRUG ADDICTS** who inject drugs there is the **ADDED RISK FROM SHARING NEEDLES** with someone who is infected. Finally, **BABIES BORN TO MOTHERS WHO ARE INFECTED** have a 50% chance of being born with the virus.

STAGE I

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WHA[illegible] H.I.V. + CARRIER?

This [illegible]son who has been infected as described above and now carries the H.I.V. virus in his/her body fluids. After confi[illegible]y blood tests have been carried out this person is now a proven H.I.V. + carrier.

HOW [illegible] DOES IT TAKE TO CONVERT TO A H.I.V. + AFTER BEING INFECTED?

From six to twelve weeks on average, rarely longer.

STAGE II

WHAT HAPPENS NOW?:

Often they remain healthy, but carry the deadly virus in their bloodstream, enabling them to infect more victims. In these cases the virus is dormant — resting, so to speak. Experts differ — some say 30% — 50% H.I.V. + carriers will develop **A.I.D.S.** Some say in years to come an even higher percentage of carriers will develop **A.I.D.S.** as the disease "ages". The incubation period — meaning the time from becoming infected until taking ill — can vary from up to ten years or shorter.

STAGE III

P.G.L.: This stands for Persistent Generalized Lymphadenopathy (or enlarged lymph glands). It must involve two or more lymph glands **NOT** situated in the groin region for more than three months without an obvious cause. Usually these patients are free of symptoms but some have 'flu-like aches, pains and fevers.

STAGE IV

A.R.C.: This stands for **A.I.D.S.**-related complex.

SIGNS & SYMPTOMS

- Fever of unknown origin for two months
- Chronic diarrhoea
- Mass loss of 10% body mass or more
- Weakness and tiredness
- Persistently enlarged lymph glands
- Enlarged spleen and/or liver
- Minor oral infections — thrush, viral or a white deposit (leucoplakia)

In Central Africa it is called **"SLIMS DISEASE"** due to the marked weight loss. This often includes P.G.L. and may progress to **A.I.D.S.** It is often difficult to distinguish between the different stages and they can overlap.

STAGE V

A.I.D.S. The signs and symptoms are the same as for A.R.C. but they mostly present with an atypical pneumonia P.C.P. or pneumocystis carinii pneumonia and/or a rare skin cancer, Kaposi's Sarcoma — purple blotches on the skin or in the mouth.

DIAGNOSIS:
(1) H.I.V. + Blood Test
(2) Immuno Deficient Blood — low T4 cells
(3) One of the opportunistic infections

AIDS IN INFANCY: Only after 18 months can H.I.V. tests be accurate — maternal antibodies will only then not be a factor in H.I.V. testing.

20 — 40% of babies will be affected.

Usually starts within six months after birth.

70% will die within 18 months.

Normal immunization procedures carry a risk but the chance has to be taken.

Do Blood T4 cell counts as an indicator.

These patients are ill and waste away. The **A.I.D.S.** patient may develop:

A. *MALIGNANCIES:* Kaposi's Sarcoma and B. Cell Lymphomas of glands.

B. *OPPORTUNISTIC INFECTIONS:*

- PROTOZOAL INFECTIONS: P.C.P. pneumonia, Cryptosporidiosis
- FUNGAL INFECTIONS: Thrush, Cryptococcocis
- BACTERIAL INFECTIONS: Tuberculosis, Salmonella, Legionella
- VIRAL INFECTIONS: Herpes virus; Cytomegalus virus; E.B. virus

These conditions in the young should arouse suspicion.

One of the most tragic results is an infection of the brain which could be caused by many of the abovementioned organisms. Cancer may also result.

POSSIBLE PRE-DISPOSING FACTORS:

(1) The presence of other Sexually Transmitted Diseases and especially genital sores or ulcers.

(2) Non-circumcision

(3) Pregnancy — often there is more rapid progression through the different stages to fully developed A.I.D.S.

(4) Immuno suppression, e.g. steroid use or organ transplantation

(5) Tuberculosis

(6) Drug and alcohol abuse coupled or not with malnutrition.

DIAGNOSIS: Suspicious lifestyle
Clinical evaluation
Blood tests – the patient must give consent and be counselled before being tested.

BLOOD TESTS: 5cc – 10cc clotted blood – plain tube
2 ELISA Tests (Enzyme Linked Immuno Sollubie Assay)
IFA (Immuno Fluorescent Assay) or Western Blot Tests (3 – 10 days)

COST OF TESTS:

ELISA TEST	=	R32.40
WESTERN BLOT	=	R52.00
I.F.A. TEST	=	R23.60

The tests are 99.0% accurate

PROGNOSIS: No one has yet been cured. At present 60% of all cases in the Republic of South Africa have died

TREATMENT: At present, only AZT is available. It costs R2 000 per month and it is very toxic. It does not cure permanently.

SAFER SEX – NO SAFE SEX

Abstention
Monogamy NOT promiscuity
Track record of sexual partner
Condoms / KY – Surgilube / Delfin Foam
Pr[illegible]al tests – H.I.V. blood tests

S[illegible] Therapy: Opportunistic infections
Blood Transfusions
AZT (Retrovir): Dextran Sulphate
Immune Builder from France

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PREVENTION IS THE ONLY CURE

GUILTY CONSCIENCE?? WORRIED?? FEELING ILL??

FOR MORE INFORMATION CONTACT US AT EMERGENCY TELEPHONE NUMBER (041) 55-2541
OR OUR DEPARTMENT

GUIDELINES FOR SAFER SEX
PROTECT YOUR OWN BODY, AND YOUR PARTNER

SAFE

Abstinence or celibacy
Monogamy / faithful one partner relationship
Body-to-body rubbing
Masturbating alone
Masturbating together
(use hands to orgasm)
Massage
Hugging & cuddling
Dry kissing – provided there are no sores or ulcers in/on mouth and lips

POSSIBLY SAFE

Intercourse (oral/anal/vaginal) using a condom plus spermicide (Delfin Foam)
or lubricant (K-Y Jelly) or Surgilube
Oral sex when the penis is withdrawn before climax

UNKNOWN RISK

Mouth to mouth kissing
Saliva as a lubricant

UNSAFE

Intercourse without a condom especially anal intercourse
Oral sex carried out to climax
Semen, vaginal fluid, blood, menstrual blood or urine in the
mouth/vagina/anus/any sores or broken skin
Any anal sexual involvement
Excessive use of drugs or alcohol that inhibit judgement and impair the
immune system
Using semen as a lubricant or at any time rubbing it onto the
penis/anus/vagina/any broken skin

MANY WOMEN ARE BUYING CONDOMS NOW. ONLY YOU ARE RESPONSIBLE FOR TAKING CARE OF YOUR OWN BODY!

FOR FURTHER INFORMATION PHONE THE AIDS TRAINING AND INFORMATION CENTRE
AT 041-5061911.

CONDOMS

1. KNOW WHAT YOU BUY OR GET
2. STORAGE
3. HOW AND WHERE TO BUY / GET
4. GUIDELINES FOR SAFE AND CORRECT USE OF CONDOMS

1. KNOW WHAT YOU BUY OR GET

You get TWO types — Animal (sheep's gut) or Latex rubber condoms.

Always ask / look for latex rubber condoms. "DUREX" and "CREPE DE CHINE" are popular makes.

Che ry date on package.

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2. STORAGE

Kee cool dry place like a bedroom cupboard NOT in a warm, moist bathroom cabinet.

3. HOW AND WHERE TO BUY OR GET

Ask for CONDOMS, F.L.'s, EFFIES, RUBBERS, JOHNNIES, PROPHYLLACTICS or PROTECTION.

Buy from pharmacies, hypermarkets, cafes or condom vending machines — buy "rubber latex".

Family Planning Clinics, S.T.D. Clinics and Community Health or Youth Clinics should have them available — preferably from easy to see and easy to reach self-help dispensers to avoid embarrassment.

4. GUIDELINES FOR SAFE AND CORRECT USE OF CONDOMS

Demonstrate condom application to group using broomstick model.

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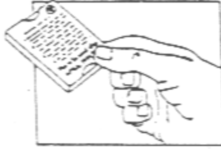
GUIDELINES FOR SAFE AND CORRECT USE OF CONDOMS

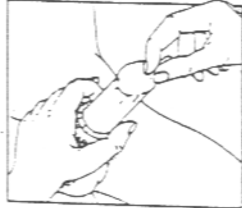
SO HAVE FUN SAFELY!

1. Use a new condom every time you make love, and don't use it after the expiry date on the packet.



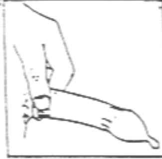
2. Open the foil carefully so there is no danger of tearing the condom inside. Remove it carefully.

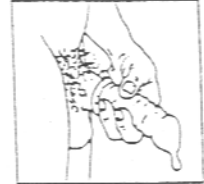
3. Put on the condom as soon as the penis is hard and erect but before any sexual contact, as sperm may be re-released before ejaculation ("coming"). Squeeze the closed end of the condom to expel surplus air and make sure the condom will unroll the right way.



4. Still squeezing the closed end between thumb and forefinger, unroll gently down the full length of the penis. Make sure the condom is not damaged by sharp fingernails or rings.

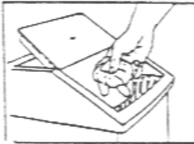
5. After making love, SLOWLY withdraw the penis BEFORE it goes soft, holding the condom firmly in place at the base of the penis.





6. Ease it off the penis taking care not to spill any semen and keep both penis and condom clear of the woman's body.

7. Wrap the condom in a tissue and dispose of it hygienically.



Throw the condom into a coal stove or fire, or into a pit privy, or wrap it in toilet paper and flush it in the toilet.

USE A NEW CONDOM EACH TIME YOU HAVE SEX
YOU CANNOT USE A CONDOM MORE THAN ONCE.

AS SOON AS THE MAN EJACULATED HE MUST WITHDRAW FROM THE WOMAN'S BODY. HE CAN ALWAYS WASH AWAY THE SPERM AND THEN TAKE A NEW CONDOM AND START AGAIN.

FOR FURTHER INFORMATION CONTACT THE AIDS TRAINING AND INFORMATION CENTRE
TEL.: **041 - 5061911**

EDUCATION

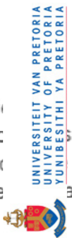
GENERAL APPROACH

1. People cannot concentrate for more than 15 to 20 minutes.
2. Maintain good eye contact with the audience – keep moving – ask questions – speak clearly, audibly and slowly.

THE BAD NEWS

A.I.D.S. IS FATAL

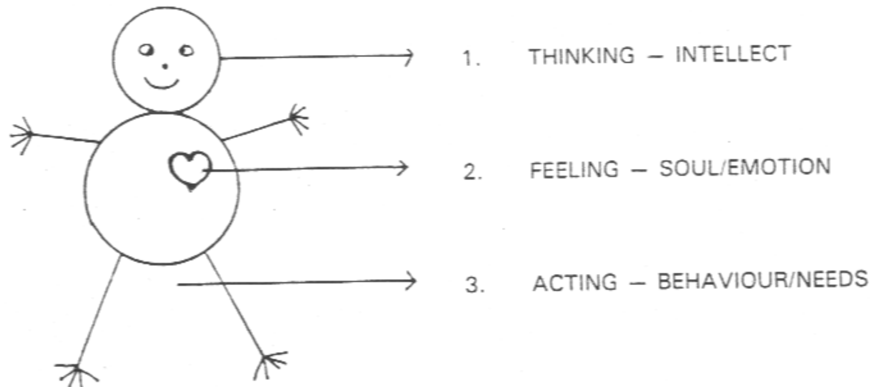
THE GOOD NEWS



Saf[illegible] can prevent it.
Avc[illegible] safe sexual practices.
Ign[illegible] and fear must be exchanged for knowledge regarding A.I.D.S.
The [illegible]an Sexual Drive is one of mankind's basic needs.

HOW DOES ONE CHANGE SEXUAL BEHAVIOUR???

THREE ASPECTS OF FEELING:



1. THINKING – INTELLECT
2. FEELING – SOUL/EMOTION
3. ACTING – BEHAVIOUR/NEEDS

THREE EDUCATIONAL EXPERIENCES

O → OOOO ONE WAY (DIDACTIC)

O ⇄ OOOO TWO WAY (INTERFACE)

O ⇄ OOOO EXPERIENTAL (ROLE/PLAY)

YOU DEAL WITH *FOUR* PERSONALITY TYPES:

1. FATALIST – What must be must be
2. AVOIDER – Does not want to listen – turns a deaf ear
3. INVULNERABLE – Believe they will never get it
4. DILIGENT – They listen, learn and believe – they will change thei[r] attitude.

and unfortunately also

THE WORRIED WELL – The over-anxious and neurotic, possibly with a guilty conscience as well.

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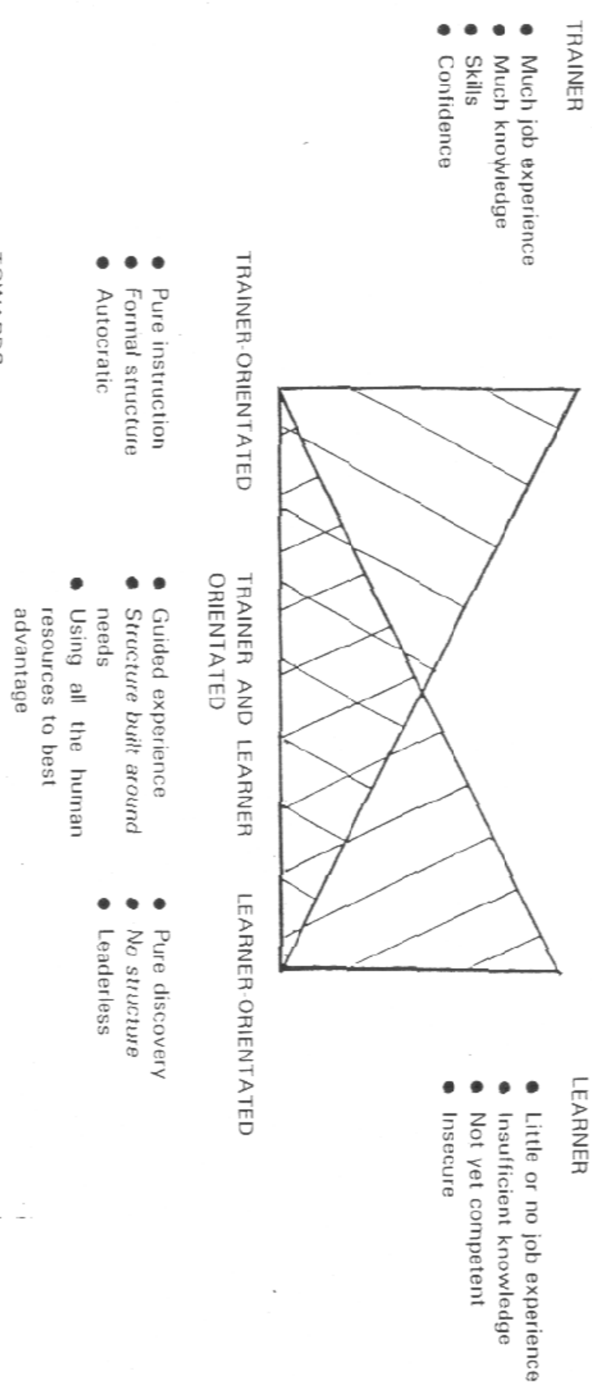
LEARNING/TEACHING STYLES



MRS. MUSA ZAZAYOKWE

SOME BARRIERS TO EDUCATION ABOUT AIDS IN THE BLACK COMMUNITY

AIDS TRAINING AND INFORMATION CENTRE

SOUTH AFRICAN INSTITUTE FOR MEDICAL RESEARCH

The focus of this paper will be on educational *barriers in the black community. Since most of these obstacles may* lead to failure in AIDS education, there is a need to identify and address them so that learning can take place. Each obstacle will be discussed in turn and possible solutions will be highlighted. The following ten barriers have been encountered in the course of our work with educating and counselling people about AIDS.

1. The first important obstacle is the tendency of people to BLAME AIDS ON OTHERS. For instance, there is the belief that AIDS is a gay disease or a disease which affects only intravenous drug users and prostitutes. People are also inclined to see *AIDS as a disease of migrant workers from central Africa, in particular mineworkers.* Some people perceive AIDS as a form of punishment from God for homosexuality and promiscuity. People who do not engage in high risk behaviour fail to see themselves as vulnerable. For example, a black man who is married yet has other established girlfriends does not consider himself promiscuous. It is important to stress that AIDS is not prejudiced. Everybody who is sexually active could become infected. The danger is even greater when one has more than one sexual partner.

2. *Another pertinent barrier is the MEDIA COVERAGE ON AIDS. Most reports on AIDS are dramatised* and distorted, which is unfortunate because this information is more readily accessible to the general public. The sensationalism, misconception and fear provoking media information on AIDS is a difficult barrier to overcome because the inclination of a lot of people is to cling steadfastly to what has been heard or seen prior to getting factual information. Thus, there is the strong need to emphasise the facts so that people are able to critically evaluate what they read in the press see on TV or hear on the radio.

3. *A third potential barrier in AIDS education is that traditional* black people DO NOT UNDERSTAND THE DISEASE CONCEPT in terms of western medicine i.e. – as caused by a virus. To them illness is either due to being bewitched by a person with sorcery powers or due to the wrath of ancestral spirits who may cast evil spirits of anger which causes illness. There are two possible ways to address this problem. One way is to accommodate existing beliefs and work within them. For instance, to tell the person that they know where it has come from but you know what it is doing in their body. Secondly, to emphasise factual knowledge about AIDS by using adequate and clear explanations with the assistance of visual aids. In our experience this has proved to be very *helpful. They must use new or sterilized blades/instruments* for scarification or circumcision procedures.

4. In most cultures SEX IS NOT OPENLY DISCUSSED and is considered for a taboo subject. This poses problems when discussing sex related topics such as AIDS. To promote participation it is essential to address same-sexed and same-aged groups so that members may feel less inhibited and possibly contribute to discussion by asking questions.

5. '*Age is an additional consideration* when talking about AIDS to Blacks. Because WISDOM IS ASSOCIATED WITH INCREASING AGE, adults may disapprove of being addressed by a young person. Similarly, males may dislike being addressed by a female who is usually considered to be a perpetual minor. Thus, for one to earn credibility before a group, it is advisable to wear a uniform or trademark of profession or authority to help overcome discrimination against age.

6. LANGUAGE MAY RESULT IN A SERIOUS COMMUNICATION BREAKDOWN in AIDS education. In particular, some *elementary words such as* 'condom', 'virus' and 'immunity' do not exist in any Black language. To overcome possible miscommunication, the use of relevant analogies with visual aids has proved to be useful. For example, the immune system is compared to an army which defends the body against invaders like HIV. Draw comparison between AIDS virus and a thief invading a healthy body and the T-4 cells, the policemen, that protect the body. Moreover the word 'germ' can be used in place of 'virus' and *several terms can be used to describe a condom.* Terms like rubber, french letter, Johnny, etc. are often easily understood for condom.

7. EDUCATIONAL BACKGROUND can also result in a variety of learning problems. For example, some females do not encourage their partners to use condoms simply because they lack adequate knowledge about the human anatomy. They believe that death may result from a condom that has accidentally slipped off. One woman in our training session actually mentioned that she feared she could be suffocated if the condom strayed to her lungs or to some major life-supporting *blood vessel. A visual aid illustrating the reproductive system of a female can*

help to alleviate ignorant reactions to using a condom for safer sex.

8. Another profound barrier is the dichotomy between indigenous and western healing. Any skin piercing acitivity is at risk of transmitting the virus. Traditional healers may use razor blades to inoculate a drug through an incision of the skin but do not always sterilise blades between use on patients. It was deemed important to host seminars to educate sangomas and nyangas about the transmission and prevention of AIDS. This equips traditional healers to be a source of information to their patients and also to practise infection control like cleaning instruments in between use.

9. A CONDOM PRESENTS SEVERAL DIFFICULTIES for use with Black people. Although some people would like to use condoms they lack the means of buying them. People have to be advised about places that freely provide condoms. Since some people are shy to ask for condoms some form of self service system should be organised at places like clinics, factories, etc.

Condoms have to be promoted because migrant labour is responsible for a lot of promiscuity and prostitution. This means that both men and women may be at high risk for becoming infected from extramarital sex, and safer sex must be encouraged. A condom is the most available safer sex practice. However, condoms are traditionally associated with the prevention of gonorrhoea, syphillis and other sexually transmitted diseases. Thus, couples are sometimes reluctant to insist on the use of a condom since this tends to lable their partner. One way of trying to overcome this is by practising ways of communicating to a potential sexual partner the need to use a condom for protection on both sides. This can be achieved through role-plays.

Another problem that is associated with condoms is that most people tend to believe that they minimise sexual excitement. Men are not keen to use them and women may not put enough pressure on men because they are afraid of losing their loved one who may be tempted to resort to someone else who does not insist that a condom is used. This is difficult to overcome because the final decision rests with one's value for health. Hopefully, with adequate knowledge about the nature of this disease, wise discussion and behaviour can ensue.

Quite often the condom is received with suspicion in that it could be meant to promote birth control and decrease the black population. Occasionally one is suspected to be the government's mouth piece and is asked about the department for which one is working. To help solve this problem, it is important to explain what may be done when the[illegible] wish to have a baby. In other words, couples who are planning a family need to be made aware that a c[illegible]s for protection only. If they wish to get married or start a family and want to stop using a condom, the[illegible]e advised to have an HIV antibody test.

Eve[illegible]ple agree to use condoms they have to be informed that it does not provide 100% protection and are use[illegible]safer-sex'' only. It should not be taken for granted that people know how to use condoms properly. In ord[illegible]nefit from a condom one must know what to do. Thus, it is necessary to practically demonstrate how to [illegible]ondom when teaching about AIDS.

10. A f[illegible]cational barrier that deserves mention is that preaching to all black people about monogamy is often futi[illegible] some people still practise polygamy. Instead, loyalty between husband and more than one wife may be [illegible]d to promote prevention of infection outside of marriage. This is workable as long as all wives and husband are not infected in the first place!

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CONCLUSION

Target your audience correctly and ''pitch'' your talk accordingly.

General experience from our AIDS education has revealed that it is a great mistake to perceive the black population as a homogenous group; even more so during the latter part of this century. Variations are mainly based on ethnic grouping, geographical location and/or educational standards and material well being. These days black people have been exposed to a variety of cultural influences. For instance, urbanisation has resulted in the convergence of different ethnic groups and racial groups. A lot of cultural diffusion and cultural lag is taking place among blacks at present; a process of cultural transition so to speak. There is also a tendency of discarding or ignoring traditional cultural values and norms even before understanding what is being adopted to replace traditional values or norms. When comparing the past and present black population significant structural changes are present. Migrant labour has contributed to depleting the family structure which was once the functional unit of the community and was overly responsible for educating the new generation. In its place, social class recognition is now based on one's social position. It may happen that both traditional and modern class characteristics can be found together in a group of persons.

With such a diffuse social background it becomes evident that one may have to address a group that is predominantly traditional or modernised, or both. The educational difficulties that are encountered will thus vary in proportion to the nature of the group. It is also necessary to be aware and to accept the fact that some barriers may fall beyond the efforts of individual educators. At a symposium the following three reasons were mentioned as possible causes of failure of AIDS education:

1. Some men regard S.T.D. aś a male/macho symbol.
2. In normal S.T.D. the cause/effect is understandable Gonorrhoea – 24 to 48 hours / Syphylis 3 – 6 weeks / AIDS – no lesions – long time lapse – no cause/effect relationship.
3. AIDS regarded like TB or Cancer – a curse – no cause/effect relationship.

COUNSELLING

A. OBJECTIVES

1. To EDUCATE the patient as to what an H.I.V. – Blood Test means and all the implications of possibly having, or developing, A.I.D.S.
2. To SUPPORT the patient in his/her crisis in dealing with reality.

B. WHO SHOULD CONDUCT COUNSELLING

The person who conducts the counselling must have extensive knowledge of the H.I.V. + state, A.I.D.S. and the psychological aspects of counselling a patient with a potentially fatal condition and must be prepared to carry on counselling the same patient to maintain continuity.

For this reason a psychologist and/or a medical doctor with counselling experience or specially trained nursing personnel should be responsible for this task.

I have the greatest respect for the Nursing profession and they will most often be tentatively approached by worried patients. Because of possible legal implications and lack of technical or counselling experience the patient should always be referred to a Specialised A.I.D.S. Counselling facility manned by a psychologist and/or medical doctor or specially trained nursing personnel.

Do not be drawn into innocently offering or promoting the H.I.V. Blood Test or talk idly about A.I.D.S. – the patient may turn on you and sue your for accusing him/her of possibly having A.I.D.S.

It is absolutely essential that if possible only specially trained staff should conduct counselling.

C. HOW AND WHERE IT SHOULD BE DONE

Avoid telephone counselling . . . try to gain the confidence of the caller and arrange for a personal interview and tell the caller that an hour will be set aside for this purpose and that it will be absolutely CONFIDENTIAL. Telephone counsellors should be specially trained as well.

The venue should be a quiet clinic, anonymous or preferably a specialised unit like the A.I.D.S. Centre in Johannesburg.

D. PRE-TEST COUNSELLING

Why is the patient worried? Let them speak. Do not offer test or mention A.I.D.S. Let the patient ask for it. One can mention the H.I.V. test as being one of the ways of establishing a positive diagnosis.

The counsellor must be absolutely knowledgable regarding all aspects of the H.I.V. test – the accuracy, the time lapse before a result can be expected and the cost thereof.

The counsellor must have a thorough knowledge of all aspects of A.I.D.S. – the physical, political, legal, social, sexual, economic, ethical and emotional aspects.

Before the H.I.V. blood test is done MOST IMPORTANT, INFORMED CONSENT MUST BE OBTAINED from the patient to execute the test – preferably in writing.

The patient must be prepared for the possibility of a positive result and that this does not automatically mean that the patient has, or will develop A.I.D.S..

The advantages and disadvantages of being diagnosed as a positive H.I.V. carrier should be explained to the patient.

It must be remembered that the patient may experience problems in the work situation, problems regarding life insurance, ostracism possibly at work, at home or by medical and dental professionals.

The patient should be counselled on adopting a healthier lifestyle, safer sex practices and rather to abstain until the result is known.

The patient should also be made aware of the importance of his/her previous sexual history and contacts.

The patient should be advised who to confide in if the result is positive, at home, the workplace and preferably his doctor and dentist — the choice, however, is entirely left to the patient.

These should be touched on briefly because in all probability the patient will be so anxious about the test result that most of this will probably be forgotten.

Above all, the counsellor must be a caring listener.

Re-assure the patient regarding the confidentiality of the interview.

Arrange for the follow-up meeting in ten days and make allowance for one hour. Tell the patient that a friend or relative is welcome at the interview, for support.

E. POST-TEST COUNSELLING

This is a very specialised exercise and should be conducted by an A.I.D.S. trained psychologist and/or a medical doctor with specialised A.I.D.S. counselling training/expertise. Specially trained nursing personnel can be utilised too.

Professor J.P.P. Fullard of the Department of Psychology, University of Port Elizabeth is in charge of this aspect of our programme and will conduct counselling courses for specialised selected personnel.

Attached is a list of emotions which may be experienced by patients — For information only.

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SAFETY PRECAUTIONS TO BE TAKEN BY EVERY H.I.V. + CARRIER

to donate blood, semen and organs or other tissue for transplant operations.

avoid activities which may put their partners or sexual contacts at risk, i.e. to avoid exchange of body fluids — od, saliva or semen. In this regard, the USE OF CONDOMS is recommended as a barrier to the exchange of ain body fluids.

avoid sharing of toothbrushes, razors and other implements that could become contaminated with blood.

- To inform their sexual contacts that the A.I.D.S. antibody test has been positive and to recommend that they be evaluated medically.
- To inform their doctors or dentists of the results of the tests so that they can take the necessary precautions.

If you feel you may be at risk for developing A.I.D.S., you should see your doctor who will arrange a blood test.

TABLE 1. EMOTIONAL REACTIONS OF PEOPLE WITH HIV AND AIDS

SHOCK

- from loss of hope for good news.
- from diagnosis and possible death.

ANGER

- at being infected.
- at past high-risk lifestyle and activities.
- at inability to overcome the virus.
- at new and involuntary health/lifestyle restrictions.

GUILT

- over past high-risk behaviour.
- over illness as punishment.
- over possibly having spread infection to others.

ANXIETY

- about reactions of others.
- *about isolation, abandonment and rejection.*
- about risk of infecting others and being infected by them.
- about partner's ability to cope with their infection.
- about loss of cognitive, physical, social, and work abilities.
- about uncertain prognosis and course of illness.
- about effects of medication and treatment.
- about disfigurement and disability.

DEPRESSION

- helplessness over physical decline
- hopelessness of no cure
- virus in control of life
- limits imposed by ill health
- reduced quality of life in all spheres
- self-blame and recrimination for past behaviour
- loss of self-esteem

OBSESSIVE DISORDERS

- persistent probing for explanations
- relentless searching for new diagnostic evidence on body
- pre-occupation with death and decline
- faddism over health and diets

THE RISKS OF H.I.V. ANTIBODY TESTING

1. Severe psychological reactions — anxiety, nightmares, sleep disturbance, depression and suicidal behaviour.

2. Disrupted interpersonal relations including potential rage reactions and violence.

3. Social ostracism and self-imposed social withdrawal.

4. Relationship problems.

5. Stigmatization and discrimination if positive status is made public.

6. Difficulty with Employment and Insurance.

7. [illegible]ccupation with bodily symptoms.

8. [illegible]e security and denial of risk if test result is negative — continues high risk behaviour.

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THE BENEFITS OF H.I.V. ANTIBODY TESTING

1. To assist in a medical diagnosis in persons who exhibit suspicious symptoms.

2. To challenge and reduce anxiety in persons assessed Low risk but who have high anxiety.

3. To motivate persons who practice high risk behaviour and who feel a positive result may help to reduce these behaviours.

4. To protect recipients of blood, donated semen, tissue and organs.

5. To assist high-risk persons in decisions related to having children.

6. To assist high-risk women in decisions related to breast feeding and inoculations produced from live virus.

7. To assist decisions related to participation in experimental treatment programmes.

8. To assist couples entering a monogamous relationship in decisions related to permissable sex practices.

Appendix B

Pamphlet obtained during field work: XXX Care Centre

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CARE CENTRE

The growth of a miracle

It took root as a humble backyard Mission. It branched out to become a vital life-line for severely deprived people. With your help, it will continue to grow. Without your help, it will die.

Taking root

Sister [redacted], a member of the Little Company of Mary Congregation came to Port Elizabeth in 1988 with the hope of being able to share the compassion of Christ with the poor, relieving their misery and deprivation by whatever means she could use.

Her work in [redacted] began under a backyard tree "given" to her by [redacted], a local resident who played a vital role in helping Sister [redacted] understand the dire needs of the community.

Under this tree, day after day, Sister [redacted] taught and played with the little children and rendered basic health care to the sick.

A visit from the Urban Foundation later that year resulted in three small rooms being set up. These rooms marked the humble beginnings of the [redacted] Care Centre. Used as a classroom and clinic during the day, the rooms continued serving the community after hours by way of craft training and other self-help projects – such as holistic health hygiene, alcohol and chemical abuse, counseling, literacy classes and a senior citizens club.

Contributions from local companies and organizations in the months that followed enabled Sister [redacted] to establish the basis of a clinic, nutrition unit and classrooms.

In the months and years that followed:
1988 – The visit of Mother Theresa

1989 – Sr. [redacted] recognized as Woman of the Year by the Union of Jewish Women.

1990 - Sr. [redacted] was chosen citizen of the year.

1995 – The visit of Queen Elizabeth. She singled out Sister [redacted] and paid tribute to the wonderful work she does in her traditional Christmas message to the nation.

2001 – Sister [redacted] received and Honorary Doctorate from the University of Port Elizabeth.

Branching out.

But the services offered there were far exceeded by the increasing demands of the [redacted] community and it was soon evident that the facilities had to be upgraded.

In July 1992 the first phase of present Care Centre was officially opened with the help of Shatterprufe, 3M and Delta Motor Corporation, hoasting a fully equipped clinic, a nutrition unit, library and admin. offices.

Later was added through hard-acquired donations, a Primary/ Pre-primary School and a Community Hall, which is used daily for Adult Education and Community projects.

Spiritual nourishment is much needed to give strength to endure the suffering and some years ago the people requested a place of prayer. Sr. [redacted] sourced most of the funding from overseas, and on March 21st 2002 the church for the people [redacted] was blessed and opened. It is a sanctuary of prayer and peace where the essence of the people's lives can be nourished.

Today the playground of the [redacted] Centre is a bright collage of happy faces belonging to children who would otherwise be deprived of the education that is vital to change their future and to give them a head start in life.

At the Clinic health care is rendered which was previously inaccessible to the residents of [redacted]

The Nutrition unit cares for families that would otherwise go hungry and the people bring recycling material to help pay for the bread and soup. Meals are cooked from there for the children attending school.

The Self-Help projects, the Garden and the Skills Training along with every other aspect of the centre play a vital role in uplifting the quality of life for these people, giving them a new sense of pride and the opportunity to better themselves.

We have a special Resonator program for people suffering from HIV/AIDS and other illnesses to boost their immune systems. They are provided with a weekly food parcel.

The progress and the success of this Care Centre can not be measured in terms of buildings and facilities, but rather by the tangible aura of joy surrounding the people who work and learn there, the deep inner contentment of people who previously had no sense of direction or belonging.

eed to grow

revailing tragedy however, is that [redacted] currently accommodates more than 100 000 in conditions of dire poverty and without basic facilities. Malnutrition, tuberculosis and re rife.

emands for health care and welfare facilities far outweigh the resources available at the Centre.

To continue providing [redacted] with a scale of help commensurate with the daily increasing needs we are calling for financial support from concerned companies and individuals.

Since its inception, the Care Centre has survived only because of generous support from people like yourself who care enough to make a difference. Our immediate, most pressing needs are that of financial assistance, food and donations of clothing and blankets.

Every single contribution, no matter how small – given in cash or in kind, helps to provide the physical, mental and spiritual nourishment so vital to improving the quality of life for [redacted]'s disadvantaged people.

Thank you for taking the time to visit us, and for reading this. Your generosity is vital in terms of finance, or sharing of skills in order that people who are so disadvantaged may live a human life.

[redacted] CARE CENTRE MISSION STATEMENT

PURPOSE

TO IMPROVE THE QUALITY OF LIFE OF THE PEOPLE OF [redacted] THROUGH CONSULTATION, PARTICIPATION AND SELF DEVELOPMENT

GOALS

TO PROVIDE AN ESSENTIAL HEALTH , SOCIAL AND SPRIRITUAL SERVICE

TO PROVIDE PRE-PRIMARY AND PRIMARY SCHOOL EDUCATION AND OTHER FORMS OF EDUCATIONAL DEVELOPMENT

TO PROMOTE A STABLE AND HARMONIOUS HOME AND COMMUNITY ENVIRONMENT

TO DEVELOP A SENSE OF PRIDE AND OWNERSHIP AMONGST THE PEOPLE OF [redacted]

WHO DOES THE CARE CENTRE SERVE?

1. PRE-PRIMARY AND PRIMARY SCHOOL CHILDREN AND ILLITERATE ADULTS
2. PEOPLE SUFFERING,FROM MALNUTRITION AND ITS CAUSES
3. PEOPLE WHO NEED MEDICAL CARE
4. MOTHER/BABY CARE
5. ALCOHOLICS AND SUBSTANCE ABUSE
6. PEOPLE NEEDING SPIRITUAL GUIDANCE
7. PEOPLE NEEDING SOCIAL/PSYCHOLOGICAL CARE
8. SENIOR CITIZENS

We respond to the many needs of the people in the circumstances they live in.

Tel:
Fax:
E-mail: o.za

Port Elizabeth
6005
South Africa

CARE CENTRE

STATISTICS FOR 2003

At our nutrition unit we cook and prepare meals for our primary and pre-primary school children. They get a breakfast, a mid-day snack and a cooked meal from Monday to Friday.

121 070 Heads per family received a half a loaf of bread and a cup of dried powdered soup. In 2002 we had 106 433.

17 084 families infected and affected by HIV/AIDS and related illnesses received food parcels. In 2002 = 13 434

623 families were clothed from our warehouse compared to last year's 547.

Father Christmas handed out 4500 gifts to all the children in

Patients seen at the clinic – until November 2003

T.B = 11 356

Under 5 years old and babies = 4 722

5 yrs old to adults = 32 466

We thank all those who have believed in the people of down the years and we know that as we endeavor to make them self reliant, and to sustain the long term service of education in various forms that you will be with us. The specter of AIDS overshadow everything, and sadly it is the Mothers who is the cornerstone of any household that suffers the most here as her life fades into eternity leaving her children to their Grand Parents.

May 2004 be good to you, and may the generosity of God be with you.

I am sincerely grateful to you, and that gratitude is expressed daily in prayer.

Dr.

BOARD OF TRUSTEES: Sr (Director) • (Chairperson)
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• • • n

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Appendix C

Visual presentation of informal settlement community in which the selected primary school is situated

Visual presentation of informal settlement community in which the selected primary school is situated

Appendix D

Analysis of related study's transcripts

Analysis of transcripts – initial stages of Ferreira's 2006 study

Field visit 1 -14 November 2003

Focus group 1 – 11 Participants

Researcher: the talk that there was… somebody was stoned and there is a fear of being harmed when you disclose and that keeps them from disclosing and then other people that do disclose – it's easier to support them. But then also I think there was the idea that… how do you support somebody with HIV/AIDS? What can you do? What can you do physically? What can you do emotionally? And also what can you do…uhm… probably for social support to link people? So I don't know if there are…

Participant 9: Okay… what I know if you have information, let's say you have an *advanced* – you must know what you are going to talk about… the information… because sometimes they will ask questions and you must know that you are going to answer all those questions. And if you don't know, if you don't know a question – you must tell them, no I don't know this – otherwise I will be caught out and find out… And you must be patient and you must be organized… You must be flexible. Because most of them are very touchable, you see. If they are very touchable, sometimes they don't want to talk about this. They don't know that you know that they know… even my brother he is HIV positive and his girlfriend and by the time they heard the news, he was so surprised and so worried, but after that he don't want to talk about that – he forgot about that… we told ourselves life must go on… and they don't want to talk about it all the time, because by the time you are talking about this all the time, you get scared – it is as if you are scared then.. You see, and if… the way that you are going to support them is the way they must take care of themselves. Because if you know the

Need to be informed

Need to be sure of advice to give to community members

diet, I like you to eat is… But if you support them in a group situation, let's say here at school… I can't just give the child, let's say food, spinach / special food - here at school they are eating bread and milk, sometimes bread and jam. But I can't just give them special food, because there will be stigma. They will ask – why are they eating special foods? We want to give them the support, but how are we going to give them the support?

How to cope with Learner infected with HIV

Willingness to support but lack confidence

Researcher: The children specifically?

Participant 9: Yes, the children specifically. Even in the community… even in the community if you can go to give them food parcel… Why those houses?

Participant 2: The other people will eventually find out and ask - Why are you just giving those people this? Why aren't you giving other people also? Why are doing this?

Researcher: It is also the concern that you don't want to label children and families by treating them differently.

Participant 9: Yes, yes. We want to support them, but we don't know the way to support others.

Willingness to support but lack confidence

Participant 4:I want to say that, let's say my brother or my sister is HIV Positive – we as a family don't have to give him or her something different – we must eat the same thing at the same time, knowing that it is okay for his or her condition and not something different from us…

Participant 3: I like to differ from them, because even if you've got diabetic… even if you've got cancer – the menu, even in hospital, are

different because you are ill. You know the situation, you can not put yourself at risk. Even those HIV people, if I know that someone in my house, say my husband is HIV positive and I'm not HIV - I have to cater for him… Even the children that is HIV, you have to cater for him… Unless the problem is where there is a denial. As long as they are not going to disclose it, they are going to suffer. Because I cannot suffer giving my child the diabetic food because I'm diabetic…

Participant 10: my child… This evening he is with my mother. My mother is a diabetic. We cater for… because the porridge he is suppose to eat, must give him energy, supplements…

participant 10: So, it must be totally different – not unless you are making a full meal for the whole family… otherwise, you go an extra mile for the HIV people. Because they must get the supplements and all the vitamins they can get, because you want them to survive. If you are going to give them whatever, whatever, you are not prolonging their lives…

Researcher: But I'm also hearing two things. I'm hearing one that is in a family, so within a family where there is already disclosure, but there can be differences because the family knows. But maybe in a school, or in the community, where you like to be there for the people, but you don't want to label them to be different…

Participant 10: But I think even here at school, my idea that I want to share with my colleagues here, is… Like if the mother of the child, or the people concerned, can come to us and say - okay, my child has AIDS… That people wants the child to be given support… So we must, if we are going to give the support, we must also say to that parent…

See community as in need of support
Willingness to support

we must change our attitudes here at school. If we are going to cook, maybe maize, we give them with soap… Those little ones… because in a classroom situation they will see that this one is suffering…

Researcher: They know…

Participant: They will know that this one is suffering. So we must…. (*kan nie hoor*) here at school… But the consent must be given to us.

Participant 3: Sorry – can I get in? Okay. If we can see, this whole situation is revolving back to disclosure… And if there is someone, like you have said, some who didn't come out with this, it is difficult to give them help, but those who talk about it – it is easy for anyone to help. To show that the most that got denial, the only thing that we know is what we heard other people talking about them and you see them in clinics, you can see the symptoms of this because we are all educated. You could see the symptoms and know that this one is suffering from this. Even though you cannot tell them, that is the denial situation. Some of them… like a woman in our church – she is dying because we cannot give help to her because each and every time we go there to visit and pray, you see… What is the use of praying for something… Because I'm sure that if she's in denial with us, I'm sure she's in denial with God… If you say God help me with this, you must tell what it is you need help in… Then what is happening – you could see the symptoms. All of the symptoms were there….. Is the fever… Even in the working situation, there are some colleagues. We heard about them….. We cannot go to them, they are not yet ready to talk about it. Because they know their fears. Even if they can die, we cannot say that they are dying of this, because it could be TB… Even if we are able to help them, we cannot.. The only people that I see most

insecure in providing support

of them that are talking, are those who are illiterate… Because I've got a parent in my classroom, but nobody knows – it's only myself, there is a child who has been raped… And I could see the symptoms to a child, but I couldn't say anything. But the parents came to my classroom saying that the symptoms were coming like this and when I asked them when are you taking the child to the clinic – they said: For what? The child was raped. You understand now it hurts me… And they prayed and they prayed and they prayed. Because I said: Oh Lord, this is a child. She didn't do nothing – please help her. As a result now, she is doing very well now. It's like I know… Because that's why I have to go outside and ask for help for that child, so that I can help that… And the second person who disclosed to myself, and nobody knows about it, is a parent whom I had a child to, and you could see the parent is very sick, the symptoms… And the parent said Maim, I don't have to hide anything, I've gone through to some of those groups and you could see myself … And I said to him pray because you have strength and I'm sure you are going to be okay, because I can see that you have faith and you are strong. But what I am going to do, I will take care of your kid.

Participant 9: Okay, I'm going to talk about myself, about my home. As I told you, my brother is HIV positive and practically it is not easy if you are staying with that person, you see… He told us that he is HIV positive, but as I told you that, after that we are not talking about that, you see… We are not everything, we are not going to talk about that. Even if I have HIV, I won't say: why this person is not disclosed? Because this person did not disclose him or herself. Because I know that if it comes to me, it will not be easy – because we have fears if they are going to chase me out, you see… out of their lives. It is not easy, it is not easy to talk about this, but in the family you have to tell them.

What I am saying is that people are different, people are differing. My brother is very angry. He is a… what can I say… he is not one that will say don't do this because I am ill, he will say: Hey! Leave me alone! I'm living my life! You see, leave me alone! It's not easy. You want to help, but you can't help because of his anger. If you are talking to them, if you are talking to him – he will say: leave me alone! I'm living my life. I will say, no I'm going to die, though we are all going to die. It is not easy to say: don't do this, do this and this. And sometimes, and sometimes they are getting that payment, they are getting that grant, that *R780* – with that money, they go out and spend it. In liquor – they are enjoying themselves with that money.

Researcher: What grant is that? A disability grant or what?

Participant 9: But that R780 is too much. That is supposed to be enough to buy food…, but they are misusing it, you see. Because they say: it is my money and I am going to do with whatever I like to do with it. And some people now, they are looking for the HIV person so that they can share the blood, because of that money. Do you understand now what is really the problem? That is why I say to them it is like a joke, you see… And now they are sharing the blood, you see…

Researcher: So they say, if I understand right, that they also want to be infected so that they can also get the money?

Participant 9: And then when you ask them what did you do with your money, they will say why don't you get HIV – this is my money, I'm HIV… Why don't you get HIV, this is my money!

Researcher: So he says it's my AIDS, it's my money…

Participant 9: yes… it's my AIDS – it's my money…

Researcher: This is new information for me now. That you can get a disability grant now if you have HIV/AIDS…

Participant 9: And I'm sure the government can change the style and give them a full bursary of money… and they will abuse that money…

Participant 7: The government…that they could support themselves… (*sukkel om te hoor)* so that they can get the food they should get…

Participant 9: It would be better if the government could make food parcels… and that R780 is enough for that… not to give them money – they can buy anything they would like to buy…

Participant 11: I would also like to add on that. Sometimes the reason for the disclose is because of the money. They disclose… but has not yet accepted … And then someway somehow the government will get confuse because of the statistics. Because now what happens – if I'm HIV positive and I go to…… with my blood and I give… so that everybody can get… And now the numbers are going up, but it's only one person that is HIV positive…

Researcher: But why do they want to test so many times, if…

Participant 11: … to get the grant…

Researcher: Now I'm totally confused. One blood? But can't they see…

Researcher: But don't they ask for an ID or something?

Participant 11: No… so that is what is happening

Researcher: So you are actually saying that the statistics is wrong…

Participant 11: That is the reason why they disclose…

Participant 10: The clinics are not following the procedures correct; because they are suppose to get full detail of that person…

Researcher: And ID number…

Participant10: Yes, and ID number… and they are not doing that.

Participant 11: As a result now, what is happening now with this grant… sometime in October it was stopped because the numbers exceeded the… And they see this fresh person, waiting to get the money…

Participant 10: But now I just want to say that once I was saying that they are afraid in their homes, to talk about this thing. If you are strong… if you are strong and you are counseled, you are suppose to talk about it so that that person must belong to you…

Participant 9: Aa-a – I want to correct you. No, no… I want to correct her on something I said… In my house we don't want to talk about it, because my brother becomes angry, he becomes angry. If he is not angry, we can talk about it, but when you correct him to do this, he will say to me: leave me alone! I'll do what I want to do.

Participant 10: That is why I am saying that the whole family must go for counseling so that they can see that I am not at school anymore but

my family is supporting me. For if you don't, if you don't talk about something that is eating you in your family - what are you doing? You are supposed to talk about it, even if it is going to hurt somebody in your family, you must talk about it…

Researcher: You mustn't try to avoid conflict?

Participant 10: Yes. Because, my brother too – sometimes he becomes angry and he is taking medicines from somebody we don't know. Then we ask him what is this medicine for and he say somebody said: it helped me, it helped me. But then I say to him: no, what you are going to take is the medicine that the doctor say you must take. Not everything that somebody said is helping him. If somebody is giving you the medicine, saying this has helped him, come to us and show it to us – we want… So if you are strong and you are counseled…

Researcher: Where do you go for counseling?

Participant 9: Unlike my brother, unlike my brother – my brother is an heavy weight… I don't want to be kicked by him…

Researcher: So every family will be different…

Participant 2: Even if your brother becomes angry at you and say leave me alone – that's also a form of denial… That is something you must talk about.

Researcher: There's also a personality…

Participant 8: That's right. You have to change the diet. But if you want to give a special dish for him, he won't eat it. You have to change the…

Researcher: The lifestyle?

Participant 8: Yes, the lifestyle…

Participant 10: Sometimes you have to eat the food… even if you don't want to…

Participant 1: There is something that I've noticed… in funerals, they don't want to talk about this. They don't want to say this person has died because of this or this… As a result, if maybe someone have just said that he was HIV positive, maybe other people… don't want to say it at funerals. They will just say it was something from TB or something else… That is … It is not easy to talk about this, to say this…

Participant 10: That means that we must change our community, we must change the communities.

Wiliness to support

Participant 7: Here at school, we don't want to say they have it. I had a parent in my class who died. I called her and she came in. She was very sick – she said she had… or she had flu and that she doesn't want to go to the doctor. I said you must go to the doctor and you have to be tested. She said no, I have been tested. There's nothing wrong – it's just this flu. She said no, I'm going to be fine – but she was sick and as a result she died. Not having gone to the doctor. But this is the problem… but her child is still in her class – she is still alright.

Researcher: And who is taking care of the child?

Participant 7: There are aunts and uncles that are taking care of her… they don't want to go and take the tests – even if the child is sick now. They don't want us to get in, because if we get in, then we see and we can help and advice… Then I'm sure we could make a difference, but they don't want us in… Because they will not tell us if there is a problem and come forward…

Willingness to support

Participant 2: They don't tell us… they don't disclose and their health goes down, because they don't tell anybody that they are HIV positive… And then they don't eat right, because some of the people they don't want to disclose and go for help and find out more about the disease, you know… Like what must I eat to boost the immune systems and things like that… That's why they don't want to disclose, they just go on for a couple of years…

Participant 1: There is a teacher here at our school, she is having a child in her class. She could see that the child was suffering, she know that this child was sick… Until that child was admitted to hospital and then the parents came and said that she was HIV positive - that is why I am saying that parents don't want to come and tell us what is happening…

Participant 5: Another thing is.. what I am seeing, is that the kids needs counseling – for they need to go for different sessions. Even with us educated people, we seldom see psychologists – we believe in general practitioners. When we get ill, we must go to the doctor. We don't use psychologists. The only time that they get the counseling, a little bit, is when they are told about the results… Then, before they are told, they get just a little bit of group counseling… Another things is,

with the doctors now, they are making use of this grant. They are doing what they say is … in order for them to get expensive medicine. You know what it frustrates one more is when it is said that no, …….. is too low then even this medication is …. killing this person. This is number one. Number two – in some areas it is said that you have to be on a certain stage in order for you to get that grant. You just… let's say I've been tested and I am HIV positive, I won't get that grant – not unless I'm just nearly to be fully blown. Then I will be able to.

Researcher: So, you have to be very sick to be able to get the grant?

Participant 5: Exactly. You must have a history of you going to the clinic, seeing that you are at this stage then this stage and then it is quick with the clinic. But if you go to the doctor, ugh… And that medication is dam expensive and the unemployment rate is too high – they cannot afford it.

Researcher: Where do the people go for counseling? Because L, you spoke about counseling for families, but you say there is not a lot of counseling and E there said there is also a need for counseling.

Participant 10: Okay, let me help her. If you want to go for counseling, if you are a family… you don't want to listen to people. You take your money and go for counseling or you go to a clinic… Because before the tests you get the prior counseling and then, after the test, the whole family is included. Because that is why I say you are going to be strong if you are going for counseling.

Researcher: So that is actually – the counseling we are talking about, is situated in the clinics by the nurses. And the social worker you spoke about the other day? Does she give counseling?

Participant 10: If you are using medical aid, or you can go and pay money…

Researcher: Did any of you have training in counseling?

Participant 10: No, not in counseling.

Researcher: Had any one of you have training in HIV/AIDS information?

Participant 11: Yes, I have.

Researcher: By the Department of Education?

Participant 11: Yes, by the Department of Education.

Researcher: Okay. And is there something special you have to do in the school then, based with that HIV/AIDS knowledge? Is there a special task assigned?

Participant 11: I am supposed to teach the gr6 – gr7 …

Researcher: So it is a life-skills training?

Participant 10: But it's not just about that – there's more to it…

Participant 11: It's not just training…

Researcher: Yes.

Participant 3: Okay, what I want to say is: As long as there is going to be denial, because the counseling is done before you get… prior, before you get your results. But if you don't have a denial problem, it is easy for the doctor, your own doctor, to help you. Because if you can get to our GP's, it is written boldly that if you've got this and this is this… So you've got the chance to talk to your doctor. How can your doctor smell… How can the doctor smell that you are HIV? It is up to you to tell the doctor – Doctor, I've got this problem. Then the doctor can tell… can take you to do all those things where you find out that you have got HIV. It is your duty to tell your doctor. Even if you don't tell, you are not ready to tell your family. Somebody who is going to counsel you – yourself, you see… People doesn't know about this, especially those who are illiterate. To come to the denial situation. If… Let's go back to what I've said about the parents. If the literate, the people who are educated, have got a denial problem, what will happen to those who are not educated? So we cannot say that the parents they don't say anything – it happens even to us, those who can understand this things. So it will be difficult for them, unless we people who understand about this things, accepting them. Then it is easy for them. You can go to that parents - look, I've got this problem. You think I'm educated, we are all educated in this room about HIV. I'm HIV. Talk to me so that I can help you. Is doesn't happen to those who are educated. What about those who are not educated? We mustn't take blame to the parents. And the parents sometimes can see you… on your attitude to what you are talking about. So you must check even the attitude… It's like when I talked to her about her brother who is aggressive. It's a symptom of denial that aggressiveness, because he is not yet ready. He has not yet been counseled, you see – that's why he is so… One day here at school,

there was a lady – a lady who was working with... He came to school with another lady who was HIV infected. He called us at staff and that lady, **** had a nice body, … is almost dead now having that virus. She has got a child, but you cannot say anything about ****. **** was going to be sick for a long time, unless she got counseling and was told about her eating habits. And when ****addressed the kids, she asked the kids what can you say about myself? And the kids said: nothing – you look beautiful, you are pretty. She said there's nothing I don't know about myself – I'm HIV positive. And ****- I'm sure God is going to bless **** and she is still going to have 20 years - she is still working there and there are many more. If you can switch the radio, you can hear about this. Coming to the disclosure at the funeral - you cannot talk about death certificate, because at any funeral there are not a death certificate. Let's put the death certificate aside. The doctors said, like you said in the beginning, you've got pneumonia, you've got TB, when you see the symptoms. It's up to the family, and even the family – there are two things that make them not to disclose. It is difficult to disclose on a funeral situation, once the wife is left behind. Because now I have to disclose upon my husband and I'm not yet ready – we are married. Then my husband died and then, on his funeral, I cannot disclose if I'm not ready. Because it will to affect me worse. You can disclose about your child, knowing that he is not married so that you can teach other kids, but it differ on how you take it to strange…

Researcher: That's right.

Participant 10: That's why I say that the community workers must be well trained – they must talk about this. If the community… The community is about parents, it's about everybody. If the community is well groomed in this, even in the funerals – you

Need for training of community workers (educators)

can just say this one died of AIDS. Whether it is my husband or whoever, as long as we have courage in this.

Lack confidence to support community

Participant 2: The problem now is that the one who stays behind, is going to be labeled by his own people, do you understand?

Participant 10: No, what I'm saying is that before this happens or whatever, we must as a community educate ourselves about this, then there will be no stigma.

Need to be educated

Researcher: And where will the education come from?

Participant 10: Education must come from people who are trained.

Participant 4: Coming to that, I think that we as a school, as teachers, it is our responsibility to call the community to train…

want to educate the community

Researcher: If I just hear what you are saying already, you are pretty much trained. I can see where you say that it sounds like some counseling skills are needed. But you are all well informed, you know about lifestyle supports and all sorts of things – you are already well trained in HIV/AIDS.

Participant 3: To get back to what I've just said. I've jumped to them. It was 2002 when I got pregnant. Then I got to the gyno, then I went to the gyno. Because when you are pregnant at the 8th month you've got to go for a blood test. But I couldn't remember myself taking blood test during those 8th month. But I do remember myself, when I was close to 8th month, the doctor gave me a list that I must go to 4th floor. And I told my colleagues. Then I took this list – I like to read. Because what I remember, when a teacher in the olden days could give you a letter,

you will take it to another one and she will spank you. When I took this, I was so pregnant. Then I took this letter from the doctor and I was going to the 4th floor and something said: Read the letter! And when I read the letter – HIV! And what strike me was my husband who had the affair. And when I got to the lifts, I stopped there and asked myself to which floor am I going to? 4th floor. And this thing I was holding like this. And you know the doctors write lists like these – HIV… So what are they going to do with this big tummy? And about myself? Why didn't he tell me earlier? But now look how… And when I got into the door, I could see a very thin nurse with a small face - a lady with legs that are just like sticks. And I said to myself: is she going to counsel me now? And they looked and said why didn't you…? And I said to her: This, what does this mean? And I point to the HIV. So they said no, no – you've already done this. So now you come for the booking, for your bed. And the nurse said; Do you see myself like this? No, I got sick – that's why I am like this. I don't have HIV, but I'm like this. And when I talked to *S…* and others, they said no, they know that nurse is like this. She is sick, that's why she looks like that. So, I just want to tell you that it is not easy for the first time.

Researcher: Yes, and even you are an educated person.

Participant 3: What happened when I got home, I was relieved. And they said I must give him this letter. And my husband was teaching them. And I said: Look what you did with that girl that you got? I'm HIV now. I'm HIV. And my husband said: no, no! And I said: That's what you did! Because I want him to get shocked too, because I got shocked. So it was his turn now, whereas I knew about it. And then I could see tears and I said: I told you, I told you! And he said he will go to the doctor tomorrow and I said to him: Beware of what you are doing

beside me – be faithful! Because I also nearly died. So, that's what happened.

Participant 9: So now, if you are taking that life cover… I don't want to go and do that blood test, I'll rather leave that life cover. I don't want to do the blood test. For the time being now, I'm still fresh. If it is something that will take me to the blood test, I will say no. Because I'm still fresh and there's nothing wrong. And even for those people who are sick, even for those people who are HIV positive – if they are still fresh and healthy, they will say leave me alone I'm still alright. But when they are very sick, they can do everything because they are… – you can do whatever you want to do. You can give them a weak porridge because they are sick. But when they are still fresh, when they are still healthy, when they are still strong – they don't care. They can do whatever, they can eat whatever. They will be serious when they are very sick. Do you understand what I mean? For those who are strong, the life is still there.

Researcher: But do you see - I just want to understand something. If you are… I've also been for testing and I'm healthy and all of that, but I think it is in our country necessary to go for testing and find out your status so that you can know. How should I be with other people? What should I do? But now you say that you don't want to go for testing.

Participant 9: No, no. No, I don't want to go for testing. I don't want to know my status.

Participant 1: I want to tell about my brother. This is how it happened now. I was phoned by my sister to let me know that my younger brother was sick. I asked them did you go to the doctor and they said

that my brother didn't want to go to the doctor. I told them they must come and we can arrange for a doctor that will be able to help him. For my brother's sake because he was in a bad condition. And then I phoned him and ask him how does he feel and he said: Sissy, I don't want to go to the doctor, but I was forced because now I can see with my condition I need to go. He was tested. He told me he was sitting in the passage… I was shivering, I was laughing of fear - because the way I was scared to hear the results. I was shivering because I thought the results are going to be positive.

Participant 5: He's a teacher…

Participant 1: Yes, he's a teacher. But fortunately the results were negative. That is why I am saying – It is not easy, even if you feel that you are sick, to go for the test.

Researcher: But there's a sense… Why do you think one should go for testing, even if you are healthy? Why is it necessary?

Participant1: Because sometimes when you think you are healthy, you've got this. You must go.

PARTICIPANT 9: Most of the ladies know their condition when they are pregnant. Because they are forced to be are tested. Do you understand what I mean? I don't want to hear while I'm still alright. I will be forced to go there to be tested.

Participant 10: That's why I want to come back to what I've said. If we educate a community, then no one will be afraid to be tested.

Participant 11: But how are you going to do that?

Researcher: Okay, let's talk about that, because that is a very good question

Participant 11: We are supposed to lead by example. Because what will happen is this, and what the government has already started, is for teachers to be tested. We are suppose to be the ones who are first to say I've already done it. And the reason why this thing is going up and up, is because everything is always done late and then I'm already HIV positive. We have to start by educating people – what are the causes of HIV/AIDS, what happens after you find out. And we are supposed to be ones doing that. Once I was told that, I was watching out and I was telling myself I was failing my community. And after that I tried to talk to them. But the problem is – people are not serious. And what we have been saying about people not disclosing at funerals – there are no need to disclose that. Because you see, even in this place, AIDS is not a disease, so you won't say that person died of AIDS. They will say it was TB… But what you are supposed to do, is to try and persuade the people to change their lifestyles. That is the best thing to do.

Researcher: Yes, and you can even do if from here. How can you as educators, here at school… Some examples?

Participant 10: If we are not suppose to get permission somewhere… if we are not suppose to get permission from somewhere, we can do this. We can do this. Like I think we must contact health workers first to come here – we must contact health workers to come and help us here at school. From there, the principal or the management of the school, are suppose to make means that we can use our school as a center.

Researcher: Yes? Explain – that sounds interesting.

Participant 10: The management must allow us to use the school to reach this. The community must not see us as educated people, they must see us as people that want to help the community.

Researcher: And also friends who want to help the community, but also people who have infected families and also knows someone that are infected with HIV/AIDS. Some even being infected themselves. So, not to be strange outsiders…

Participant 10: Because we are affected here. Mrs ……….. is having a child, mrs…….. is having a child. The teachers, the school is having these people, you know. And this in affecting us. In order to support these people, we want to help you as a community. I think we must all go and do this.

Researcher: Yes, and I like your idea of getting the department of health… to get your school as a center of health and I love the idea of getting… Who else can you also get involve at school? So it is you, community members, it's health… Who else?

Participant 11: ATTIC

Researcher: ATTIC – what's that?

Participant 10:AIDS Training …

Researcher: I will search it on the internet. The NGO's, and who else?

Participant 11: The workshops that the department always invites us to attend… at the NGO's…

Researcher: Okay. And what NGO's are there in this community?

Participant 9: I don't know. We are not sure. It's only the counselors…

Researcher: The counselors.

Participant 10: But I think we can get the people who own shops here as our… If you can go and talk to them, because the people's needs – they cannot manage them on their own. Because they have got the money, they can help the community to get to those needs. I think so.

Researcher: And what about faith organizations?

Participant 3: Even if we are doing this thing, it was said on the television that we must also include the reverends and the priests and all those people, because this is where most of the people meet like at the churches. Because the problem with the churches is they hide these things as if they are not happening. But they are still there. Because they don't want to talk about sex. They must invite nurses, like at our church we invite nurses to talk about AIDS. We invite nurses to talk about the diseases, like herpes and all those things. It is very important that the churches must also be involved. Coming to what she has said, before doing anything, we also need workshops. Because when we are going to these people, we must be able to answer. We must be able to help, to say this, this and this. This is the way to do this, this is the way to do one and two, or one and three. Because this people don't know nothing about this.

Need for workshop on HIV&AIDS

Want to provide accurate advice to community

Researcher: I just want to understand something. Do you mean that you as teachers want to give those workshops, or do you want to receive the workshops?

Participant 3: We want to receive the workshops first, so that we can give.

Need for workshop on HIV&AIDS

Researcher: And who do you think should provide the workshop training for you?

Participant 3: Okay. If the ATTIC or the department, not to take one teacher from the school, but to take all the teachers. And at the workshop it will be so nice to talk about these things, because it is going to happen in our schools… They've been to…

Researcher: *Cosatu?*

Participant 3: *USAPT– Union of South African Provincial Teachers* It is two different parties – both are for teachers. What is happening, they went to those… Now they came back and as a result, the day when they made the report it was like a workshop. As a result now, they said every teacher should receive these workshops. It is so nice to deal with this, because they make everything so clear for me when we were there. But it was a short time. They said they are going to make more workshops so that we can go the communities and apply back what we have learned.

Workshops also support by Union

Educators what clarity of information

Researcher: Now I also want to know, we have actually spoken a bit about the children and we have spoken a lot about adults. The bit we spoke about children was while you said that you want to be careful in your classes, you don't want to distinguish this child from the other

children. And the other one was that sometimes the parent comes, it doesn't sound like always, but sometimes the parent comes and discloses the status. What else do you think… In your school at the moment, is there a system to identify the child who has HIV/AIDS or…

Participant 3: No, no. What that lady was saying about the food that was taking place, we heard of another school – that's why he raised that point.

Researcher: With the growing of vegetables?

Participant 3: What they were doing at ………, they… those people who have HIV/AIDS, they are giving them a special diet. They are doing everything for them, and as a result they are well… That's what we heard about them.

Researcher: But what about… I remember, B I think it was you that said on Friday, that there was a child that collapsed from hunger in your class. So what about the idea of not only providing nutrition for HIV/AIDS children, but for most of the school, because most children will benefit from nutritional food.

Participant 2: But all those children get food, it's just the brown bread.

Researcher: But that's why I am saying – the brown bread is one kind of nutrition. How about having a vegetable garden and then most of the children…

Participant 2:… can get something from it.

Researcher: Yes. In our country unemployment is such a problem. If there's no work, there's no money, there's no food, you get hungry children in the schools. So if we cannot only distinguish children who have HIV/AIDS, or who are orphans… If we can work with all our children and say many of our children are vulnerable – let's not label some. Let's try and…

Participant 10: I think you are a blessing in disguise by coming here and give us talks about this, because I think the management of the school must change its policy from today. Because here at school, the pupils that are getting the feeding are the gr1's up the grade 3's, while the whole school are suffering.

Participant 2: It's the policy of the department to say only those children should receive…

Participant 10: But what about internal?

Participant 2: Yes, that can maybe happen.

Researcher: Sorry, what are you saying M?

Participant 2: I am saying that the management must… No, the departmental policy cannot change, but now she is saying that maybe we can do something internally, here at school.

Participant 1: I was sent to a meeting, because I'm… and it was said that from next year, no… As a result we are having a certain lady who is coming here, she is going to see management. She is going to do some facilitation about this issue.

Participant 11: Not to the management?

Participant 1: No, she has come to the management first. She will invite others to… I'm trying to say that from next year it's not only going to be bread…

Researcher: And also as from next year, it will also not be the Department of Social Development who helps with the provision scheme, from next year it will be the Department of Education. It has shifted from the one department to the other department. But what I'm also hearing here is that 1) there's the confines, or the boundaries of what government says and what the school policies are. But I'm also hearing about this other school you spoke about (What's their name?) – they say that policy says this, but what can we in the school do? And maybe when you said we must also get community members in, or this person who stays in the house who can help with the garden. If there is so much unemployment in the community, to get the children and the community to work with that garden.

Participant 2: Some of these children, they just come to school to get a piece of bread because there's nothing at home. Because there is nothing at home.

Participant 10: And sometimes they cannot help for not having money, we must use them to help in the garden. Instead of taking their kids away, we must tell the parents to do work for us.

Researcher: Those who can't pay school fees…

Participant 10: They must rent their services here…

Participant 3: I want to get in here. Those vegetable garden – it's only the seeds that are needed. Rain are coming from Above to make that to grow, you see. So everything that is happening, God is happening by purpose. Because there are this disease, and most of the people… this virus are depending on *greens.* Greens are coming from soil, soil that can be done by people who are illiterate. So what we need to do is to motivate, because if we can go outside there is a lot that we can do, but you can see a lot of grass and weeds. Instead they will see the cabbage, or the spinach, or the vegetables. The parents need to be motivated. And the other thing that I want to highlight to you – do you know what is killing our nation? Is the confidentiality of this thing, this *pandemic* - being HIV positive. Because ever since it was told that it is confidential, because no one knows about my status… And you can see I'm a bit fat and fit, and any man could see a fit person out of myself. But because of confidentiality, knowing my status, I could easily accept your proposal – knowing that I'm HIV positive. Knowing that it is wrong. Because what is happening, even in our community - people are so stupid sometimes. Because why is this thing easy now – it is easy to go to you and sleep with you. Why don't you strike in your mind why is it easy now? Even those people who are still okay, it is easy for them to say yes, yes, yes. Yes is like good morning, good morning, good morning. Knowing that at the end of the day, they will be 10 like this who will die – knowing that I will not die alone. That is a thing that is killing our nation, that I am not going to die alone.

Participant 10: Okay, on that issue. That is why people who find out that one has AIDS, and accepted my proposal and slept with me, become angry. Because you know your status, you are suppose to say that I'm infected. Say I love you, but let's use condoms. I want you to be responsible – that's why people are killing each other

because they don't want to be responsible. I don't want you to have this.

Participant 2: They say I don't want to sleep with her with a rubber on…

Participant 3: They say: do you eat a sweet with a paper or do you want to eat a banana with the peel on? So they want me to meet and that's where the problem lies. Even if you know your status, you have one particular responsibility of condomizing. Even I have to be honest enough to tell you take it or leave it - I'm HIV positive. If you want me, put a condom on – if you don't want me… If you could see on the TV – a man that has got an affair and that women, her parents told her you can't go on like this. They have got 5 years – the man is HIV positive and the women negative. Because they were honest with each other.

Participant 5: I also want to say that it also goes back with us to our culture. In our culture it is said that a man can't sleep to one person. And it will be difficult for myself after twenty years saying to my husband – let's use a condom. The very first thing is: Why? So it is easy for me to be infected. Even if I can be as faithful as... It is not so easy…

Researcher: So you are saying that in your culture it is okay for a man to have more than one partner?

Participant 5: Yes.

Researcher: Although some have spoken about it, it is a no. So you can be in a marriage for twenty years and now suddenly if you say

listen I want to use a condom and he says why, you'll have to stick by this tendency…

Participant 5: It also leads to something else…

Researcher: And one is also trying to stay away from that conflict.

Participant 10: If the man has come to the push where he is unfaithful, you must separate – because I don't want to die. I want to see my kid when they grow. You must go separate - you can't just get the disease for nothing.

Participant 3: To add on what she is saying, but it is not an issue, it is not an excuse. It is an excuse because it will not happen to… The married man know he is married. But even if you could see your husband is not faithful, it is alright to say no - let's check again. It's coming back to: why don't you go for the test again? To those people who are unmarried, they are doing it purposely. Because if you are not married, it is your duty to say take it or leave it. To the little ones who are still at school, it is their responsibility to say take it or leave it. It is ABC – its either you Abstain, or you Condomize or B, I don't know the B…

Researcher: Be faithful

Participant 3: Be faithful, yes. So, it all comes back to us. I cannot say I know my husband is moving around and I say okay, take it. No, I must tell him: no, my life is also in danger.

Researcher: Are you also saying that women should learn to be more assertive?

Participant: Yes.

Researcher: I also want to know…

Participant 9: I wonder how many of us here are saying to the young ones: no, let's use this. Because you are not ready at that time to… you know… If you say to your husband okay, let's use a condom. We always say so, but we are forced not to use it. But you know that he will go out, you are not ready in your marriage… You are not ready for a fight and you are not ready that your marriage are going to fall apart. You give him what he wants, because he is your husband.

Participant 10: But what about the consequences?

Participant 9: You will suffer, you will suffer. And you are not yet ready for your marriage to fall apart. How many of us… how many of us here use the condoms?

Participant 1: I want to reply by saying right enough; it is not easy to say you want a condom. But now if you can see that your husband he is unfaithful, now you have got the right to say that you want it. It is your right!

Participant 7: I want to talk about this denial. I have a friend, who is married and has HIV, and the husband doesn't want to use the condom and now she is HIV. I'm sure the husband is also HIV now. She tells me he does that.

Researcher: What about we talk about the woman who doesn't want to, or it's difficult for a woman to ask for a condom and to be assertive with other things, because we don't want to cause trouble in the

marriage. But what about… I'm thinking about the children and (*almal praat gelyk*)…………….. And these children are going to stay with the aunties and uncles, "ouma's and oupa's". What do we tell our children in communities when we are HIV/AIDS? Do you know if parents talk to their children about HIV/AIDS? Do they talk to them about when they are going to die, and about where they are going to live? Who will look after you when I die? Will you get this house? Do the parents share information?

Everybody: No.

Researcher: Okay, let's take one at a time.

Participant 9: Let's come to point of this – Why HIV positive woman become pregnant although they know that they are HIV? And they don't want to terminate the pregnancy. Although they know it will… Everyday we are talking about the orphans – a lot of orphans, but they still become pregnant although they know that they are HIV positive. Do you understand what I mean?

Researcher: Yes, I do.

Participant 9: Why they don't accept to terminate the pregnancy?

Participant 10: I think the answer there is this – they want to proof a point. They want to proof a point. You know what? If you are HIV positive, and you said to that one or even if you didn't say it to him – you want other person to know that, even if they see how tired are you, you want them to know that I am not HIV. I am going to proof a point that I am going to be pregnant and you will see my child, although the consequences will follow.

Researcher: So it is denial?

Participant 10: It's denial, its denial!

Participant 11: I am also going to say that they don't get pregnant to proof a point… (*almal praat gelyk)* And secondly, it's against the law to terminate a pregnancy……….. It is not that they want to get pregnant to……. (*almal praat gelyk)*

Participant 1: It is not a question of …….

Participant 10: Even then, even then if you are not HIV and then you become pregnant, you are tested and you know your status now is…, you can terminate the pregnancy because you are not going to… It is not okay to see when a child is sick. If you go to this hospitals, their parents are dead already and now the child is suffering. But again, because I'm not responsible or I don't want to be responsible, I get pregnant. Why? It's denial.

Participant 5: Again to what you are saying. I'm going back again to say cultures play an important role, because our parents don't talk with us about sex first of all. They don't even tell what are the consequences. They are still continuing with that. Even with us here, right here, we don't even know if our parents had the will or what… The only thing that is happening is that we fight when they are dead. We fight about the house, because nothing is being said to the children – absolutely nothing. You just go out and find out yourselves.

Researcher: I just want to find out something. Is it that most parents do not speak with their children about HIV/AIDS or death?

Participant 10: But I think there is no need, there is no need.

Participant 3: What is happening now, is that we are taking the blame to our parents. Now the parents are us. I've got a 16-year old, she's got a 21-year old. This century is another century, being us as parents. What are we as parents going to do with our children? Because most of our parents died long ago.

Researcher: Do you talk about sex with your children?

Participant 9: Yes, but not in a… For instance, I've got 2 children - the one is a 21-year old and the other one is 18. When I am talking about sex, I said to them… I talk like this: If you have many girls… You see, I shout - I don't talk to them in a formal way. I say: if you have many girlfriends, you will see my dear, you will have HIV – you will have AIDS. I will be out of that, you will see. That is the way we are talking to them, we don't sit down and talk to them in a formal way with detail. I am talking about me.

Participant 4: My children are still like this and this, the one is 5 years (*showing small)…*

Researcher: I want to tell you something that happened to me. This is also a disclosure from me. We had a daughter, and we thought we want her to be aware of things in life from a small age. We talked about everything and we call everything – we say a penis, and a vagina and so on… So that she can know that this is what happens. Because what do we do? We say: my child, this is your tummy, this is your hips and we skip… Then once we were at Kwazulu Natal for a holiday and my daughter wants to go and play with the "maatjies" next door. And she said: mommy I want to go play next door. But we thought no, we

don't know the people. And we want her to be careful, so we told her to be careful and not to do this, and this and this… And at the end I said to her, okay – you can go and play there, but nobody touches your vagina. And she runs out of the door and she screamed: mommy said I can come and play but nobody touches my vagina! And I was so embarrassed! But now I know that my daughter is 5 years old but she knows. So 5 years is old enough. We don't start at 14 or 35…

Participant 9: If I have condoms, I just go to their rooms and put it in their *wardrobes*. I don't tell them here at the condoms, I just take the condoms and… I don't want to know what they are doing when they are busy, you know. But what I did – I just take the condoms and put it in their *wardrobes*.

Researcher: So it is still a secret?

Participant 9: Yes. I can talk with other kids, but not to mine.

Researcher: And what do you do?

Participant 1: I just talk to them when they start showing, then I'll say you must talk with them.

Researcher: And then, what do you tell them?

Participant 1: I just tell them that if you go with a man, you can get pregnant (*praat baie onduidelik)*

Participant 10: They are saying that communication is the best policy for our homes, but we don't do that. But now, a word of advice. Kids are seeing these things on TV, but they are naughty because they want

to proof it on their own bodies. And its carelessness - even if you talk, they just want to do it.

Participant 2: You know, even here at school we have sex education. But we are not trained on how to answer these children's questions, and I understand there are teachers for that. So I think we need to get some… how to approach these kids at school, because all that we know is ……. what we hear and things like that.

Need for training

Want certainty regarding HIV&AIDS

Participant 1: I was for training………. But you know, you can't even look at them….. She didn't want to explain it. So it's for us to be trained.

Need for taining

Participant 11: I just want to know. In……….. we've got different age groups. We've got the little ones, then around 10 and then the bigger ones. So, some of the information is catered for the older ones, so you cannot just give it to all of them.

Researcher: Yes, it has to suit the age group.

Participant 9: And even……. And I will give lessons to a specific age group, because these younger children like to go to their homes and say mrs…….. has done this and this and this.

Researcher: Okay, so you also need the parent's consent?

Participant 10: Yes, you need the consent.

Researcher: It's a good thing we are coming in January, because there's so many things we have not talked about…

Participant 3: I just want to say. Like my daughter asked me one day. She was 14 years, now she is 16. She asked me when is the right time to get involved. And I asked her where did you hear that. And I said, okay one day will…. Uh!! One day? One day is too far! And I asked her why do you ask such question. And she said that I got a form from school that I have to fill in and discuss everything. And I said to her show me your form. And she answered the form and wrote that age 16 is right to get involved. And she answered that herself, you see. And that shows that even at school they are talking about it, you see. Even us as parents, we have to ask them why, so that you can be involved. Like what you were doing by talking about the vagina and the penis – it's not like this with us. Even when we are washing, our kids used to look…

Researcher: No, but it's the same with us. My daughter has a hard time at school - the teachers called me in to say do I know that my daughter are saying these words. And I said I know and I will tell the other children also. So it's something that many cultures struggle with. We don't want to talk about it.

Participant 3: What we were saying - we as blacks… We said to a vagina is a cow. But how can it be a cow if it's between your thighs? We want to make a child a fool. But they think how a cow with horns put his head between your thighs? So then we they talk about men they say *puti* – you don't tell him, but when he ask you say all men have got this. Because look at the 3-year old when she saw the 8-year old – "my, my – come and look at this", and was pulling… Because she could she that hers was not like his. And we didn't say anything about it, but she could see it was not like hers.

Participant 10: I think when you come back again, you will see the difference.

Researcher: Now, that sounds interesting…

Participant 10: Because we will be up to the principal to… What is going to happen? We want to save the community.

Researcher: And also you can't leave everything for the poor principal.

Participant 9: No, in our school it is like this. The parents, the community, came to our school before and asked the principal if they can plant there and we can have the veggies, everything, you see. But the principal said no. So that's why… So we are going back to the principal now and ask him to accept those parents to come back and plant here at school, because it will help the teachers.

Researcher: And then it must be in the interest of…

Researcher: And you must remember this must then be for the school and not for themselves.

Participant 9: No, even if it is for themselves, it will be fine. They will give us… We.. they will donate what they plant, you see. We will get something from them.

Researcher: But it must be first for the school and then… That is what I'm thinking. Because maybe if the parents will feel that they are doing something for their children, it will make sense to them.

Participant 9: No, if we say they can plant for us here at school, they will come and steal. They will come and steal. But if you say they can plant for them and then we'll get something, maybe a quarter…

Researcher: I understand what you are saying.

Participant 9: Then they will not come and steal, because then they will steal their. Maybe if they will come here and plant for the school, they will steal.

Researcher: Okay, I think we need to wrap this up so that we can go on. And thank you – I think we will definitely continue this discussion in January.

Participant 9: Are we finish now?

Researcher: No, we are not finish for today. We are still going to do the posters. But I just wanted to say thank you for this information that you shared. And I think you didn't only share information. I think you got some ideas of what you are going to do. And that's excellent.

Participant 10: If it wasn't for you, we wouldn't get the ideas…

Researcher: We did it together. I think we can take a break for 5 minutes and then come back.

Appendix E

Analysis of face-to-face interviews

Participant: with the shock first of all, with the shock

Field visit 1 - 18 February 2004

Interview 1- 1

Participant: First of all they must know what you are talking about so that if they ask questions you can answer them. If you don't know you can say no I don't know, and come later with an answer, you don't just talk talk talk. You must have got a full information – first of all. What I like, the importance of spiritual in holistic care, emotional and spiritual – you have to give them emotional support. You can give them spiritual support because when they can help you into the trauma for the family and for themselves

Researcher: okay, but you are saying that you feel, to train the teachers on how to deal with this trauma, of assisting the person that's been identified

Participant: yes

Researcher: okay

Participant: you know when a person come to you, for example if your friend come to you telling you the first time he hears the news, or she hears the news, what are you going to do, are you going to cry, what help are you going to do, in other words what are you going to do

Researcher: so the initial, assisting with the shock

Need to be informed

Desire to provide emotional & spiritual support

(Member checking)

Desire to provide emotional support

Researcher: with the shock first of all, train teachers to help say parents and to the community members and even children?

Need for training

Participant: yes

Researcher: on how to deal with the shock

Participant: for instance in my classroom I've got a child, XXX, 8 year old girl, I must give .., when I am at home I always think about here, I want to give her hope, I want to give the support spiritually and emotionally. She likes to cry, she likes to demand something you know. Sometimes early in the morning she doesn't feel well, she doesn't want to work, as a teacher what must I do

Desire to provide emotional & spiritual support

How to cope with HIV infected learner in classroom

Researcher: so how to handle it when the child is infected, so how to handle the infected child in the classroom

(member checking)

Participant: and that last trauma

Researcher: how to cope with it on a daily basis

Participant: for instance the pupils in your classroom you treat them as your own children, like a member of my family because he's a child of my heart of the children in my classroom, so that's why I said the child that is in your classroom, treat them as your own and now even when I'm at home I felt there's more that I can do, I want to do more. You see I want to do more, what can I do today for XXX, you know

Desire to offer more support

Sense of urgency to support

Researcher: and you don't know how?

Insufficient skill & knowledge hamper support efforts

Already supporting

Participant: yes but I felt there's a lot I can do but I don't know what, but at the school I just went to the principal and told the principal that I saw this child, and I want to call her parents, her aunt because her mother is already died and father. And I went to the principal, the principal wants to see XXX, so that she can know what is happening at school you see, as an infected child, I want to know about the grant, about the social worker and I hear that they've moved.

Need guidance on referring

Researcher: just now before you forget, it's better for if the mother and the father of the child has died already, it's better to apply for the grant for HIV care than it is to apply for the grant to adopt the child, through foster care, because with the HIV kid care you get more money, so it's important that those, the care takers, not the parents, the caretakers must not apply for the foster care, not apply for the grant, they must apply for the HIV grant. You must tell the guardian that because the HIV grant she's going to get R700 with the foster care grant she's only going to get R400 so you must tell her that she applies for the HIV and disability grant, then they will test XXX and they will see she's HIV positive and she'll get the R700 grant. It's a little bit more money than the R400 so you must tell her that

Participant: okay, what she did, thank you for that, and that is what she wants to know, that is why we want to go to her house, we've been told that we can know, what she did *(the social worker)*, there are some people that you can phone and tell them the problems you see. What .., it was last week or that week, when the social workers came to XXX's home and they bring food and they

Educators organised a social worker – already supporting community

tell us XXX can get a grant you see, an HIV grant, that's the disability grant. So this was last week when they said they must go, her aunt must go and get the grant, maybe the grant is already there. I feel happy of what I did you know, what we did as a whole, not me alone and the principal like all these ladies. But what about the other children and it feels a bit little we've got a lot of children here that are infected, and now we are moving here with, we are going to deal with .., we are going to deal with so much sick, as I told you that if your child is infected or whatever or what .. or a member, you are traumatic too, you feel traumatic, it's a trauma, you live in the trauma that is why I said you must know everything .., the importance of spiritual support and what you want to know, HIV and the meals and how it is and it's not because sometimes it can happen like that. If you have the time you will not want her to come next to you, do you understand what I mean, you don't know and now we must know that we must help all the children but this is confidential a disease like this, but that child is in the classroom, there are a lot of children that is next to her. What are the children going to do with the children in the classroom because the child is in the classroom, you see and now you have to teach other children what they must do and not to do, you see, not that you are going to tell them that so and so is infected

Educators are emotionally affected by HIV&AIDS

Need to be informed

How to cope with learner infected with HIV

Researcher: if you are, I understand it – do you want to take it to be changed so they can tell .., teach the children in their class what causes it, if they have a child in the class or a friend on how to handle that

(member checking)

Participant: how to handle it, how to handle it you know, and all the time they must know the disease, this disease you see and how

it is and it's not spread, you know, even us teachers we are not really sure what we know you see. You see sometimes you can feel scared you see.

Do not possess sufficient knowledge

Researcher: because you're unsure

Participant: yes, it is like that and there's a diet

Need practical information

Researcher: so information on what type of diet HIV people should follow

(member checking)

Participant: yes and the role play counselling, as a teacher you are a counsellor, with this you must know how to do it

what to provide emotional support

Researcher: okay, would you like any training to do include a session on the role play of doing counselling?

(member checking)

Participant: yes because sometimes you are not going .., it can be not easy to go and get psychologist you know, you as a teacher you must have a role play in counselling you see, because you are here now you see.

Identifies me as asset they could utilise to enhance their skills

Researcher: you are in this situation and they trust you and you must be able to mobilise

Participant: yes, that's what I want to know, you see how to do ..(unclear) and to make, more especially in youngsters, the myth of HIV, you see there are a lot of myths you see. Some as I told you before, the time you were here that there are so many myths that HIV is not something that is real, you see

Researcher: and there's still people believing it

Participant: yes, they like to sangomas and do this and this, they like to say there is a calling of ancestors, it's a myth, there's a lot of myths about it, you must know how to feel, how to tell them that HIV is here, ja

Feel that they ought to spread correct information

Researcher: one other myth I've heard about is that they say that you're bewitched, they say that you're bewitched

Participant: it's true yes

Researcher: and how to handle somebody that tells you, but I don't have Aids I'm only bewitched

Participant: yes they like to say so and more especially in youth. More especially in youth and now here at school there's a lot youth, you see, you must teach them HIV Aids is real you see

Researcher: so in the classrooms almost breaking through the myths

(member checking)

Participant: yes

Researcher: to train the teachers to do, for example, classroom debates so that you can spread the right information and break through the myths.

Participant: yes, you know, and I told you the way in which HIV is not transmitted, physical, close tough, and look like you are bewitched, they are treated like this but we must know, that is what

we want to know, how HIV infection can be prevented, prevention of HIV and also how to do support like you must be patient, you must know, you must know everything because they are going to teach, don't rush them, don't rush them because it's easy for them to be emotional, to become emotional you see, you must know what you must say and not to say you see, the way of teaching them.

Ought to spread correct information
Offer emotional support

Researcher: so do you mean how to train the teachers how to teach about Aids?

(member checking)

Participant: yes

Researcher: or about general in the classroom with all the children and some children being HIV

Participant: yes, for instance, for instance, there is a foundation phase, and in a foundation phase there are some things that you are not going to say

Educating learner on HIV&AIDS issues

Researcher: to say to the child, okay

Participant: though you want them to know, but it's difficult to say it for the children

Researcher: how are you going to get the message across?

Participant: yes, and then it will be better in intermediate, and it will be more better later, you see and what else we want to know, the resource relief of organisations involved in HIV in PE, you see, a resurrection haven, like all these places but when you talk to

Need for guidance on referring

them you must help them with those organisations, they don't know. Most of them they don't know where to go.

Already supporting by referring community members

Researcher: okay, so you want information on resources available?

(member checking)

Participant: yes, resources ja, in this area, ja in PE, so that you can send them there, what illnesses take advantage of the Aids virus, there are some TB, and they must know all of these illnesses, you know they can take advantage of the Aids virus. They say with preparation of food and maintaining good production you see, sometimes they haven't got the diets, what they must do you see. You see sometimes it's difficult to go and buy, they can plant veggies in the garden so that they can get a veg to improvise you know, because it's not easy to go and buy, you see, sometime there is no one who is getting a grant it and it will take time to get a grant, it's not easy but if they can plant veggies, you see so it can help, do you understand what I mean. So that we as the teachers we want to know

Need for practical guidance to support

Identify tangible assets

Need to be informed

Researcher: what other possibilities

Participant: yes, what other possibilities

Researcher: or to give people access through a diet

Participant: and what you can do as a community, what we can do as teachers to help that family you see. For instance some of the teachers bring fruit for XXX, some a banana for the day, or whatever, sometimes we give that child something is not good

Wiliness to support

Already supporting

because we don't know. The other thing that I need, maybe I will bring grapes, XXX to you can have this, I think I'm helping but it's not good for her, it's not a good diet for her. The other one would bring a cheese and bread with cheese, but maybe the cheese is not good for her, but we want to help but we don't know what if it is right or wrong do you understand. So that is why I say the diet, they must know the diet because I can bring a lunch for the child, but maybe the lunch is not good for her, do you understand.

Lack on knowledge is hampering support efforts

Researcher: ja, also teach the parents and the caregivers on what type of food must have

Participant: yes, and what else,we are the care givers, we are the care givers because most of the time those children are here at school, from 8 o'clock to 2 o'clock, most of the time they are here with us, they understand, we are care givers too. Not only the family, not only the family or the neighbours, we are the care givers too because most of the time they are with us

Provision of support their responsibility too

Researcher: you look after them?

Participant: yes, that is why it is a trauma even to us, but we are not going to cry, we must be bold, we must be strong for them you see, and the family too because most of the parents here in this community, they are illiterate, they don't know you see, so if you call them you must know what is there you see. And the home care, the home care for instance there's this visit to those home that are having a problems you see, not that to say at home, to say I'm stay, my family stay, you can go and visit them and bring anything that you can help, anything, to show that you are with

Educators are emotionally affected

Support is their responsibility

them, you are with them because you don't know what will happen tomorrow in your home, don't say I'm safe, my family is safe, so you can help in there, you feel you can do whatever, visit them, talk to them you see. It's something that I felt we must know from each other and help in the community you know. But we can think that we know, but we don't know because I'm not trained properly you see, we are not trained and we haven't got any gloves in our classes so that if the child here is bleeding you can help him, you see, you can help with gloves you know

Need to be informed & trained

Researcher: maybe they should work out numbers that you get, try and find out if there's no organisation that will be able to donate gloves to your school

Participant: ja so that we can – about planning of the teaching, you know I want to teach them, maybe the community, the parents about the teaching of the community or of the families. I must know the priority topics, you see, not just to talk, you know, the priority topic

Ought to spread correct information

Researcher: when speaking to the parents.

Participant: yes, the priority topic, hence those to feel comfortable, the way of teaching you know, you must help them to feel comfortable so that they will be free, so they can be free, encourage them to ask questions and talk – some they don't want to talk, they just want to ask any question, so you must encourage them, the family

Researcher: the family, okay, get the family to get involved in it, okay

Participant: yes, if you understand what I mean, it's not that we are going to teach in the school alone, even the community

Snowballing: spreading the correct information

because we like to call the parents of the infected children here you see, we must encourage them to talk, some they are shy, they don't want to ask too many questions, so we must have the ways of encouraging them to speak, to ask questions and remember whatever, do you understand what I mean, you see to make sure you find out the family and the sick person knows, you must know what the family or the sick person know or believe by asking questions, but we must be sure these questions are not going to make them angry, you see

Researcher: okay

Participant: It's a way of teaching

Researcher: the way of interacting with infected and affected families?

(member checking)

Participant: yes

Researcher: okay

Participant: too much information all at once is confusing. You must say okay today I will give this thing

Researcher: like you said like priority topics

Participant: yes, priority topics for the day, you know too much information is confusing sometimes, but we must know as teachers, we must know as teachers, you must know as a teacher that today I must make this priority of what I want to know, the priority topic you see, the information that you want to know, what it is, because they will become confused

Researcher: XXX tell me have you ever received any Aids training?

Participant: no

Researcher: so the information you have on Aids where did you get it?

Participant: it's only because, I told Ronel and Lizelle that my brother, I've got a brother who is HIV

Researcher: so the knowledge you have HIV comes from your brother or where did it come from?

Participant: no, I just have it, because I'm the part of SADTU, I'm part of SADTU, I stay with my brother, now I have to know, I knew what they don't like, do you understand what I mean?

Researcher: yes

Participant: I know what they don't like, I know how I felt by the time I received the news, as a family

Researcher: so you've almost experienced it?

Participant: yes, experienced that I am there

Researcher: and the things about diet, and the things, where did you learn that?

Participant: the diet, sometimes to listen from the radio

Researcher: okay, media

Participant: yes, media, radio, television, pamphlets and so on. But we haven't got .. I know that, I'm praying for that workshop, there's a lot more I have to know, even to help

Researcher: how long have you been with the school?

Participant: nine years now, as from 1995

Researcher: so you've walked quite a long road with the school?

Participant: yes

Researcher: thank you so much for all the information

Participant: okay, thank you

Researcher: I will now go back, I had interviews with 4 people and now I am going to plan a programme and then in April or May I will come and give the programme to you. Then I have been working with and then you can teach the other teachers, then you can go into the communities with your knowledge, so that's what I am

Field visit 1 - 18 February 2004

Interview 2 - Participant 2

Researcher: Last time you where working with Ronel you decided that there is a need for the teacher to be trained on HIV. What I want to know is what do you expect form training? I want to go home and I want to see if I can develop a program and come back to the school and to present it to 10 teachers. So that's what I want to study. And because it's research, everything you, we say is confidential

Participant: ja

Researcher: will not mention your name of the school's name. and you don't have to do this if you don't want to. I'm not forcing you and you can tell me if you don't what to do this any more. So I'm going to give you a form, that you can read and if you what to you can sign it. This form is to say that I told you it's confidential and that you don't have to do it and you can leave anytime you feel that you don't what to do it anymore.

Participant: Ja

Researcher: I want to start by asking you, you said yesterday when we spoke that you know about the children that are HIV positive, how do you know they are positive?

Participant: Okay, I'm so much fortunate, because I have a child, I would start with, it was last year, this parent had got a child with her, but the child was no longer with family then this parent came to

me and told me ‘ let my child sleep, I got sick and now I’m not the way I used to be, so you mustn’t mind of the child has got problems here at school, you must know that I also got some time’ and I said ‘ why don’t you go to the teacher that child is with now,’ but she said ‘ you know, mam I am HIV positive that is why I told you that I’m sick’. She said to me ‘ I have got nothing with me and there is no way I can get help but I have been diagnosed with HIV’. Then I said ‘ I know the teacher of that child, she is the one who’s going to take care of you kid, if you have got a problem you can go to the present teacher , but confidential’. I also told her that if I can get help I will be able to help you but I had nothing that I could do for her at that moment in time. I also told her that I wish we could get help for her. Then she went to the teacher of that child and talked to her, so that she can understand if the child is not well. Then the other child, that’s why I say I am very much fortunate. I got this child, his parent came to me and said that he is going to the social worker. I didn’t know that they were sick, but I suspected that, and the reason why I suspected that is when she told me, otherwise I could see the sores. So she told me, and he had to take the child to the social worker, so the child was absent in the classroom, so she wanted me to know what caused the absenteeism is caused by that

Willingness to support

Researcher: Alright, you are saying that you only now when people disclose. But you saw the sores, and …

Respondant: ja, I saw the sores, like the other one had. But when she told me about it, I could not see that’s why the child falls asleep. She doesn’t want to say,,, but certainly I do notice them, but could you take a means of letting the kid to sleep in the class, but after knowing that it’s when I took care of her, in a way to make so that the class can not suspect why the teacher now loves XXX,

Coping with learner infected with HIV in classroom

why when XXX feels like sleeping she lets XXX sleep. So I say 'okay XXX you have to do work for homework'. And I say ' if you don't feeling well tomorrow, tell you mum to take you to clinic. So that they have that little bit of help. I don't know whether its help or advice, but I used to do that.

Already supporting

Researcher: so it's the way you handle it in you class

Respondant: ja I treat them all the same but the other mustn't suspect that there's something wrong with her. You know the other kid they tell you 'I didn't sleep well last night but this one they do not speak. There is this other boy he is doing grade 2, grade 4 now. I asked the boy ' why do you to sleep, each and every time, especially in the morning?' and he said ' I have to watch for the witches when they are coming at night, so that they cannot come and fetch me and my grandfather said I must watch for them'. Now when the time comes for school it's the time for him to sleep. Then I spoke to the grandfather, the grandfather then explained the same thing even to me. It is difficult to control the situation.

Researcher: have you received any training on AIDS

Participant: no

Researcher: but you seem to know a lot with the sores and things, where did you get the information from.

Participant: the information I get from the, I like to use the … each and every book and even the programmes on TV. As a result at home my kids, I won't sleep if there would be a talk on HIV. They

Assets utilised in media

would say “mommy you are so anxious of HIV and AIDS” and I said “ leave me alone I know what I’m doing”. The programmes on TV helped me a lot, the books. There was a book that the department gave us, the department distributed it to all teachers. I used that book. I read it a lot.

Assets in media utilised

Researcher: I would like to know, if you have to design an AIDS programme, how would you do it?

Participant: through a workshop, what is it all about, know what you have to do, the second one, what can we do to help, if there’s someone infected, how can that person be helped, at home, at school or at work, how can you help that person.

Willingness to support

Researcher: You mean things that you can do to support them?

(Member checking)

Participant: yes, counselling. I want to attend a course, but the department could not send me, because I wanted especially for counselling. I know that I can do that. The other thing is education, so that some people had got the right information. As I told you …I may invite that woman …of the woman’s union. What happened is that we had a woman, she is not married, but they are allowed to make prayers with them, to do those things with her, now what happened she got the HIV – so she had a denial. The symptoms they found on her, all the symptoms were there… but I had to say to her “I could see that you just cry”, but when you talk to her, she’s away from what you could see on her. Because I use to bring her prayers there, three or four woman would go there and pray for her. She would complain of the cold.

Desire to be trained
What to provide emotional support

What to spread correct information

Already supporting on spiritual level

Researcher: so cold is one of the …….

Participant: ja, that I've got a cold here and I took this cold by using Gin and lemon. You see if you say Gin, because it is liquor, it's taking the out the cold. The second thing that she complained about, she would say to me or even others, "I'm okay but you could see that she is not okay. But the problem is this cough, she would say if this cough can go away I will be okay". You could see something was wrong she used to ear a dress size 46 but it was clear that she was wearing a size 32. So those symptoms. I told her that ' how about using …we heard from other people that they were helped by Spirulina, the immune booster, I asked her to buy Spirulina so that she can boost her immune system". But I didn't say that the symptoms were telling me that she needs to boost her immunity. She was admitted to the hospital, she would even there at the hospital, she would cough but she was better that the others.

Already supporting on practical level

Already supporting on practical level

Researcher: but she thinks….

Participant: she would say if this thing can run away I will be fine, but that is denial. So those symptoms helped us a lot because what I was about to do now is to ask I had already asked the wife of my neighbour, she had been too, she had been to counselling and got medicines that can help the flu that when you got cold you can use this – she knows that when your cold you can use this and that but I don't know that because she has been to the workshop and all these. So I asked her, because she's working at P.E., why don't you go to the clinic. Because you are alone when you go there. Then she promised that "okay I will go their and I will give her something that is helping but she passed away.

Assessing asset in closer community

Desire to be trained

Researcher: she passed away

Participant: she passed away, if she was strong enough she would have got her some sort of help.

Researcher: so you think the symptoms are important?

Participant: ja, they are very important

Researcher: and how…

Participant: you know the minute, the causes yes, they are very much important but not that much. Like I can get…even if the… and honest woman, staying at home having one husband, but I don't know what my husband is doing, the cause might be my husband being naughty or sometimes you get sick because you went to the hospital long ago. Now what I've concentrated on now is what can help them because it's there.

Sense of urgency to support

Researcher: and the..

Participant: because it is already there, we cannot take it away, because sometimes we preach and preach for preventing but we still have the problem, because the very ways that it comes to you it's the way that the people are, even though they know it's dangerous, but now you cannot make it go away. What can we do now that we are here?

Sense of urgency to support

Researcher: so you are saying that you would rather spend you energy on supporting and …

(Member checking)

Participant: ja, but at the very same time, going back to those young children, to give them educations, they are going to do

it, they must say that I did it knowing very well what the risks are. We cannot run away from the importance of it. They go together, but now the important issue is how can we help.

Researcher: so you are saying that if you teach the little ones, give them the information so that they can teach it to the little children, and also to support others. What can be done to support…

Participant: and to add more that, education is very important, you mustn't underestimate these kids. We are supposed to teach them on their level because when you think at it, if you are going to make it as a subject, let's say you were going to make it and according to the level, that will understand them and come with the information, the good that they gives us, they've got levels of information on it means if you can study at Grade 1, in a school and the subject that will in a long run, I feel there is a low rate of HIV.

Educate learner and spread correct or understandable information

Researcher: so you feel it should be almost like a subject with different levels for different ages

Participant: ja, even if it is just 30min a week. You can teach them. You know what there was a lady that came to school. She was brought to school by a gentleman who's dealing with HIV and AIDS. Those ladies were infected, and they talked about the sex. It worked. I said to my friends, those ladies are not educated, those ladies were the ladies who dot infected –anyone who may be capable or who had got AIDS educations can help. That's why people are becoming activists, those who are infected, so that we can see from them.

Researcher: so the knowledge can either come from training or experience.
Participant: but what's important at the end of the day is a good someone

Researcher: and what will you do with that training, you will support the people, the parent and the children?

Participant: you know. Like now we are trying to help, but helping is like going to a cousin to know that if you have a wound, I must put this leg like this, so that you know, but if I don't know that I have to put this leg like this, I will just make everything worse. So if you have a child I can keep on talking to her, nothing will help, but if I come with ..”okay why don't you use garlic” so that your child can be helped. You see I give help, that's the thing, but if I don't know nothing about those things how can I give help.

Already supporting

Support hampered by lack on skill & knowledge

Researcher: so you want all the teacher to know how to help?

Participant: yes, because we are dealing with kids and the parents. Because some times they are illiterate, they know nothing, but you know something and when they come to that the teacher knows everything. They've got that trust that if they told the teacher something. But now you feel angry when you cannot help because even now when they come to me, I say I will organise a social worker, well they know that social workers know something about this AIDS, why don't you….it's a little bit of advise. But if I knew more I would have given her more than an advise. ‘okay now you've got sores, why don't you wear gloves and put something that will help the sores. The help, literally help that you van give

Community trust them to support

Sense of urgency & emotionally affected

Asset identification & utilisation

Willingness to support despite lack on knowledge & skill

her, physical things that you can give her, not just talk. You can give them advise but you need to do more. Like even if we are giving them advice, the advise must be a good one, not the think that you think can help. But if you know something, suggest " why don't you have a small garden so that you can plant things" that's good advise because you know that she's going to plant vegetables. But if you say I don't know what they are using, they are talking about nevaropine, it isn't that easy to get. The problem is now. What can she use now. What they need now is what is important, sometimes that is going to help her immune system.

Need for practical skills to support

Already supporting on practical level

Sense of urgency to offer support

Researcher: I've talked to you many times; you are doing quite a lot. You are constantly watching out for the children and watching out for the parents, your friends and family, when you know that there's a person in need you help them. And you also said last time that sometimes you give them food parcels and you say that you pray for the people and that you visit them. What else do you do to help people cope?

Participant: that is what I wanted. I wanted to do more, so I said to myself, if I can get educated about this, like a workshop on what can we do more. I'm sure the people who know can give us more. Like if I've got sores what can I use, if I've got thrush what can I use, because I cannot give them advise because I know nothing about those things, although I heard about them but I need somebody who can give me surety, when we go to a workshop, you know that this thing has helped, now it's going to help. It is not something that I can take out of my mind and take chances with people's lives. I only help that I give is to give support to them, support, advice but it's not enough for me.

Desire to offer more support

Desire to be trained on offering practical support

Training will provide confidence

Desire to offer more support

Researcher: to support the children and others. And give them advice on what to do?

Participant: ja

Researcher: how will you tell others what you have learned from the workshop, what is the possibility of that?

Participant: of what?

Researcher: of taking what you've learnt from the workshop and that surety of the knowledge, telling the other people about it?

Participant: it's easier for us. I am like this, if I can go to a workshop, even for me to tell them the way I was told, I'm just like that. Even if I can go to a meeting, when I come back form the meeting, when you listen to me you will think we were in that meeting, I'm somebody like that, and I'm so glad for God gave me that gift. So I won't have a problem even if you can train us and they will learn more. You won't be wasting you time by giving me or the other teachers training, it's where we can help, especially like that, I like to talk and if you can't stop, I will talk continuously, I'm truly like that, I like talking

Would transmit knowledge from workshop to others

Researcher: you like to share

Participant: ja, I like to share, I like to do all those things, especially if it relates to talking.

Researcher: apart form helping the community and getting advice and knowing what to do, why do you think all teacher should be training?

Participant: because here at school, you know the squatter area. If you can think at the courses of HIV and AIDS they are coming almost from a areas like these, there's poverty, unemployment and those things. But if you can teach that earlier because these kids are going to be a community of the area are going to be the future generation of this area, so they will do better than the present generation. They are like this because they don't know, but the little one's will be advanced, they will have better knowledge that the older ones.

Researcher: when designing the program maybe you can think of a way to teach other teachers and then it can spread like that?

Participant: that will be good. Thank you

Researcher: thank you also very much for you time and everything you do for us driving with us in the community so that we don't get lost and everything is to help others. You have a great heart.

Field visit 1 - 19 February 2004

Interview 3 - Participant 3

Researcher: First of all I want to ask you what type of training you have received before.

Participant: Well, first of all we got a circular from the department and we attended a workshop on HIV&AIDS …

Researcher: okay, tell me the teacher training on AIDS that you have had, who presented the training?

Participant: ish it was many people ATTIC was one of them, but it's not ATTIC alone, but it was the community but ATTIC was organising the first week, so the first week we gonna have ATTIC and then the others picked up for the department of education

Researcher: and the training you received there, what was the format, was it a workshop or discussions or ..?

Participant: it was a workshop, there were lots of handouts too, like one's of being infected, like how far do you know of the virus, and our first day, he asked us what we want to know concerning HIV&AIDS. What do you know as now, up to this stage, what do you know? What do you want to know or more. Then from there they took us from there, then the introduction then they fill in the thing, then they started.

Researcher: tell me, you are in contact with a lot of HIV & AIDS people in the community. How do you know those people are HIV positive?

Participant: I don't know them, but I've got one friend, that was 2002 neh, like he was saying, now he does confirm to me otherwise, otherwise some of them it's difficult to know up until someone comes me and disclose. But, most of them don't look alright or maybe you don't know.

Researcher: so you only see a person as HIV person once the person has disclosed? You don't look for symptoms and say this one I don't know?

Participant: like I couldn't believe it, because he was normal as I am, healthy all the time, but to a certain stage whereby like the problem of him neh, he doesn't know where to go to look for help, like in terms of getting a treatment, like eating even a proper nutrition, doesn't know where to go. Most of the people that's the problem, they don't know about those things, they get sick, they don't know about where to go, now you are in this stage, a doctor has told me that you are HIV positive, but even most of the doctors they don't even do like the free counselling and even the explaining – they just say we going to take your blood, you going to go for blood test, you don't know what is going to be tested and all that stuff, and of which they are looking for HIV and when they get it they just tell them you are HIV positive. And they let you go.

Community member need practical support, advice on referrals

Researcher: what I'm hearing is because the government said that they must get free counselling, social grants and food parcels they still don't get it if they go to a doctor. So what I'm hearing is that the idea is although it is policy that they do the pre-counselling it doesn't really happen in reality?

Participant: ja, it's like I don't know what is happening with the doctors, but I doubt if all of them do it.

Researcher: I want to talk about the teacher training to support the community like we spoke earlier. If you can design a feature programme for teacher on AIDS what would be the content, what information would you put in that package of the training?

Participant: basically all the things that I would speak of would be around coping through if someone is infected was, that is what is lacking mostly; they don't know how to cope and the caring if someone is infected because most of the time it seems nobody accepts it, they don't know what to do, all of them whether you are infected or affected, coping to both of them because whether it's not you, but you're also part it of direct or indirect

A need for skills on providing support to cope

Researcher: are you talking of coping?

Participant: say for instance, okay I'm gonna go out of this one, but it's the same thing. If you take, if someone dies in your family, maybe it's your mother and she's a bread winner and that I'm the child, I'm learning at school and then that happens and then the first thing, that is my problem who's going to help me to buy the coffin, and what happens because of that loss I ended up going in the streets because I don't know where to go, who to contact, who's gonna help me now, who's gonna look after me. That's why we've got sometimes there's lots of street kids, I'm not going to say it's a short way but at that stage I ended up committing suicide because of this, he can't cope with trauma, death, dying, your mother has died and for instance now, most of the kids they are in school like to keep this off, people dying with HIV and AIDS neh, you know when they look at this, they don't know what

Need to provide emotional support

to do, or how to handle it, some may sometimes .., they feel like assisting but they don't know and the risk involved. So, my training would like be around those things, and then the others I would just take them but initially I will focus on this coping through, and they know that they must know what is it, how to cope with it, how to care for someone who's infected or if he's like you are the one who's infected how to care, how to take care of yourself, but it's because .., they are just .., even if, if you go like people are buying sometimes some vegetables, just buy some medicine in here.

Educators support efforts are hampered by lack of knowledge

Need for practical guidance

Researcher: how is your friend coping, the friend that is ..?

Participant: he died

Researcher: oh he passed away?

Participant: he died 2002 he died

Researcher: and you supported him during the time that he was sick?

Participant: no it was a problem then, it's like when his family, most of his brothers and sisters were not, they were no longer going to school but like even now, so he was the only one who was interested, he was a school going person at that time and he didn't have a father, they were only looking for a mother who was also getting sick looking for a job, oh there is a job that today I'm gonna come with R50 or R100 tomorrow, they don't know, if they get something to eat they don't know what is going to happen tomorrow

Researcher: tomorrow

Participant: so those things all add up.

Researcher: so the more stress a person experiences while they are actually infected the quicker the symptoms?

Participant: ja, I can agree with those people because in any tragic the best thing is the mind. You do whatever you want to do, so if you are positive, in your mind you think positive, and then the better, the longer you can be healthy, but the thing with HIV and AIDS, the minute the people they hear that I've got it now, so they turn to negative saying I'm gonna die, that's why others they use the drugs, like you hear in papers they say "I'm not going to die alone" because those feel like they have denial, those infected but they need like some sort of education – there is to say if you've got like you hear the news that you got, you have to accept it. I mean they must .., there's nothing wrong with denial, I had, but the basic thing is you have to know how to cope with it because you can't change, when it comes they say you've got it, you can't kill it, as you say we have to accept

Community member need to be educated on HIV&AIDS

Researcher: In this training programme, who would you like to present the programme? We are thinking that I will initially do the first one, but in the future who do you think must present this programme?

Participant: like a presenter?

Researcher: ja, but how

Participant: it's like their work, they divide into sections, if you are dealing for instance with bereavement, that is a section for your course in bereavement, it is dying, or if all the three of them you gonna have a book, say okay you gonna present that stuff. So if I'm gonna give

people living with HIV today, I have to deal with that bunch only, if you are dealing with nutrition you have to deal with nutrition only. So for me, it's .., if I can have at least a bit of which, which are we gonna go to like I was gonna have to touch, we have to touch here and then, because they're specialising, not just specialising, but they are specialist, but they are specialising when they are .., because I've got one that is .., the one that is, specialising with special diet in the last section we doing medicine now, that person was also doing that one, so anything set on the specialist he's the one who's presenting

Researcher: so I get the feeling you're saying the person who has specialised with a specialised knowledge must present that specific thing

Participant: ja, that specific thing. For instance otherwise, it's not a problem, even someone if can be able, I'm saying in terms of, if he's confident of presenting, you see, because my fear, not to say I've got a fear but my fear sometimes is for someone to present something, then there comes a question, if each and every question you've been asked and then you cannot be able to answer, say okay I'm gonna look for .., like I'm not sure about this but .., but I think always giving his or her own knowledge and that other than that saying I will try and then to come back to you, maybe I'm gonna find it, like I will go out then make a research what it is, you know that stuff. At least 90% of your presentation you must be able to cover it, not to say everything

Would like to have confidence in person presenting training (for it to generate confidence in participants)

Researcher: who do you think must, on the teachers must attend this programme from the school, parents, one of the parents or something and also be a part of it?

Participant: preferably the parents can be like attend, but I know it's gonna be difficult to organise and so I would prefer actually like to meet the teachers alone and you present it to the teachers only or even if it's not the teachers only, they have parent members, the parent components they can also join as teachers and then the presentation it can happen that with that group only, Then from there we can organise a parent meeting whereby the whole community is gonna be involved. So, to me making the job easy for the presenters because if now we have a parent component, we are dealing with the whole parents, this place here is full parents, they read the questions but it doesn't directly like, it doesn't necessarily need your response. But if for instance if you gonna meet all of us, each and every question you have to answer, but in that case we can even share, they can ask the question and then I will be able to come up and answer it.

Snowballing reaching wider community

Identify colleagues as assets

Researcher: ja, so you think the participants in the training must be a group of people in the same, the same people, but either teachers or parents, not teachers and parents if I'm hearing you correctly?

(member checking)

Participant: like I was saying on the first one, just a small group of teachers and a few parents because they will see those ones can join us. And then others that organise a parents meeting whereby even these ones are going to preach at the hospital that we've got some good news from these people, otherwise there's a meeting that they've organised, let's go to one and talk, so we gonna make use of .., divide and then make like a smaller group it's a bit of more weight if someone is saying ' I got this at a teacher workshop.

Snowballing reaching wider community

Workshop might provide confidence

Researcher: okay. Anything else that you can think of, I want to know you said your friend disclosed to you, but very often people don't disclose, why don't they disclose?

Participant: like, in the first place I didn't know. It's only now that I was able .., like myself and as friends, there were few things man that we don't tell each other, but I, it's like I used to hear people would say it's better– not knowing that if someone next to me can have it and all that stuff. But we were just now talking about it, then there were a lot of people getting in there, we were busy talking talking and then, like on a dream then somewhere somehow, there's something I want to tell you about my girlfriend and I said what's wrong, aren't you gonna go to the lady, are you in a cold feet now, problem again. He said no it's not a problem, they used to fight now and again, every week, every weekend, every weekend they fight and fight. I said no man what is it now? Otherwise most of their problems I used to take all of them, to take down and they say no man don't worry but I couldn't see by that time. I said this one is joking and really they were not even looking sick and then when the doctor they couldn't see what is it. He obviously didn't go to the same doctor, and I didn't even like bother myself to ask which doctor did you go to and then, who told you that you are HIV positive, which doctor, I didn't even have to go that far, I said go away there's no such. He said serious, let's go, let's go and then we went home. I couldn't take it, it's only after I do the thing, he said no I've accept it and I admitted it. But I was busy, I once go there like one time, and he is sick, how are you, he said I've got chest pains at last they say he must be taken for medicine, I mean he's healthy there's nothing wrong with him. And the thing that he said that has already gone in my head but I took everything lightly man, you don't, I wasn't serious, it's just to say you put your mind in it. I asked do you still remember me, he said mmm, you said you are you see that's fine you didn't put yourself, you didn't focus negatively

Emotionally affected

Researcher: was it because you thought it was something that's far away?

Participant: ja, the thing now, we've got this now, most of us, unlike you read now, but it's only after. It's on the other side you know what they're heading for, but you are sure of yourself that I know, I'm doing only this thing the one that I won from a cousin, that was the only naughty thing that I've done in my life, nothing else. So it can't happen with that one, only one, no it can't happen. So the people like us, they need to be educated otherwise they don't know their status, and they don't have that knowledge

Sense of urgency

Researcher: but do you think the community, this community surrounding the school, are they still in a lot of denial?

Participant: it's worse this community here, around, it's not very healthy, because the thing here, like the basic factors that is the problem, that is like their basic problems, most of them they are not working, unemployment, and a lot of poverty which means they can do anything to get something to eat for himself like a parent or for both them and for the kids. Meaning if we can go from door to door here, maybe about this community, or 30% of the infected because there are some kids that used to report to me that my sister died or their mother died but now it seems everyone is sick and then how do you cope at all?

Participant: so if you're saying that there are many sick people, so there's a lot that needs to be done around this community

Researcher: and very often the people won't acknowledge it, they won't come out and say I'm HIV positive?

Participant: no it will take time

Researcher: they keep it a secret?

Participant: ja, they keep it a secret

Researcher: why do they keep it a secret?

Participant: nobody knows, no one wants to think about it, because if you go there everyone is going to say "oh that one is HIV positive", that is the main thing. It depends who you are, because the people, the thing is, they don't accept it. It's worse with these one, they are not educated, besides the unemployment and poverty but they are not educated. So you speak of HIV and Aids you have to explain what is it, how one can get it, how it cannot all that stuff but the next day that thing is gone to most of them so you have to speak it again, it mustn't be a once off thing, it must go on, it must continue, ongoing process. I even gave them, some of them the brochure, but no one came back as to say this book is good and show an appreciation of some sort, no one up to now. But the kids they are showing a positive mind because they are so interested. And they tell me like most of the kids in that place that is it not right for the parents to have sex in front of the kids, but the parents are drinking so anytime they want, any time is tea time, if they want to have it now they take it. Some of them they've only got one room the kids are exposed to most of the things, so that's why I want for them to know how can they be infected and how they must take care of themselves even if their kids are there in it.

Educating the community

Already supporting community

Researcher: which subjects do you teach again? life orientation and ..?

Participant: life skills and natural science and English

Researcher: and the training that you went to, so you only applied in the life skills here?

Participant: ja, only in the life skills of the other Grades because not in my Grade of life skills subjects, I don't do AIDS in life skills it's someone else who's teaching it. But I once told the principal, he's a nice man, for me I would feel much better if I was also giving AIDS life skills because most of the things that they get now, they are just a flesh, the kids need to get more, so for me in a sense I would like to take life skills and AIDS as the same subject, make up my own subject, out of the two, unlike now I'm dealing with my life skills and doing this according to the programme but if it was one thing that I was doing, there was no need, there's no need for someone to go look for an advance, but the years, maybe sometime somewhere they are going to change it

Researcher: tell me how long have you being in this school?

Participant: since 1997

Researcher: thank you so much for your time. Thank you so much

Participant: no problem

Field visit 1 - 20 February 2004

Interview 4 - Participant 4

Researcher: I want to know, we spoke about HIV&AIDS training…

Participant: I know a little bit.

Researcher: okay, the information you have on AIDS where do you get it?

Participant: it's through friends you know, it's through friends when we are discussing the issue of HIV and find out what is it that maybe you can say that has happened to help and you find that people want to help, it depends then maybe some are shy.

Utilising assets in closer community

Researcher: okay, so the friends you speak to…

Participant: we talk about this because others doesn't talk about it

Researcher: and tell me, if you had to design training, what information would you like to be part of the training?

Participant: well, I think the information that should be part of the training is the way in which we can make people to understand that you need to know your status, you know some people are very scared to know, I think they must tell other people that they are positive status you know, also there are people, for an example here working at the hospital, she told me that, an old mother was positive and we were shocked because we don't, I don't see my mother being HIV positive you know, and say that so even for that

Spreading information to eliminate stigma

grade there is something that, that mother did that is naughty but she you don't know maybe she has been raped, even with other ways not only the rape and sex, there are other ways that lady is old enough to have grandchildren

Researcher: Tell me if I'm missing a point. You saying that if people know exactly what is causing AIDS, that it would be easier to disclose?

(Member checking)

Participant: yes, because they don't want to disclose because they say it's because they say it's because I'm going to be taken as if I was going out being naughty but it's not true.

Awareness of HIV&AIDS issues

Researcher: Other things you would like in the content of the training?

Participant: other things say like treating the sores and all those that are sick and also say you know the diet and all these things, sometimes somebody will get an accident with blood so people must be told that it's like that, you must take cloves and you can even die today, don't think that if you are not HIV positive you are safe, anyone can die even if she does take care if they can be counselled with that thing, and made to understand that death is everywhere

Need for guidance regarding practical support

Researcher: and for teachers specific, what do you think because the training will be for teachers?

Participant: you know for teachers because, here for an example, we do have learners that have got Aids, some parents have come forward, some didn't, so for teachers I think I want for them to be

trained, to take the classes equally, irrespective of you know that there's a child who is positive they must then change now to be very kind to that child because maybe that child will take that, and if you are shouting you will make the child even more sick. So because we don't know all of them, maybe there's a child who would find others have done that thing we need to treat these learners kindly now – you know, because we used to get parent dying and all these things. Now they must come and ask the last child the one looking sick or the one that is talking to his heart the whole day and say with him, "can you call your parents, I want to know if there are problems, because even these learners, you can even identify that the child is not well

Coping with learner infected/affected

Researcher: so you can see when a child is not well

Participant: for an example, there is this boy, I don't like that child, in fact not that I don't like him, I don't like the way he is and the manner in which his is dirty always, to come to him because even if he wants to go and take a walk and say your son is a nice boy and change the mother thinking to take better care of him it is then that the mother will start to talk, I think so.

Building relationship to enhance support to families

Researcher: so you want the teacher to teach all the learners equally and treat them with a kind heart?

(Member checking)

Participant: yes that will be good. All the teachers, and also I don't know, some teachers make a big mistake, by if she/he has identified that child, take that child with special treatment, now that child also gets embarrassed, you must not show them. As a result we were talking about it at school that they are treated equally, but it would be very nice for the department to develop another

How to cope with learners infected/affected in classroom

program but also if we can start our own, so that they've got good nutrition, not the teachers who take their lunches and give them lunch

Id. Assets amongst themselves & tangible
Already supporting on practical level

Researcher: so teachers give learners their lunches

(Member checking)

Participant: I believe it's being like that if there's nothing that you can assist with, because it's going to be helping that child if it's taken

Researcher: okay, the knowledge you have on Aids do you incorporate that in your class?

Participant: yes because it interprets in communication and culture, I mean arts and culture because sometimes you will come across a lesson where I'm going to talk about our culture, how we got married in our culture and how other people married, the way we were compared to the Ndebele so with that you can speak about having one partner and avoid becoming infected. So even in arts and culture you do interface with it, as we want, in our culture you were just taken by that husband of yours, whether you know him or not as long as the family communicated and then said we like your daughter and then you are just sent to that husband, you don't know how he is now, it's not wise now to go to a man whom you don't know because he could be positive and have naughty habits so those are things that we talk about in class.

Incorporating AIDS info in different subjects

Researcher: which class do you teach?

Participant: grade 7

Researcher: this AIDS programme or training, what format do you think it must be, do you think it must be a discussion group or workshop, how would you like it to be presented ?

Participant: I think it needs both because we lacking information, what you may just know is that AIDS knowledge and also at the same time it needs a discussion of that but it's because some teachers have ideas that can help others, you need to talk like this, so to get information even from teachers, teachers know better than I know. Some are having some information maybe as we are going, there are things that they can give, but it needs also the knowledge and how to deal with it in a form of a workshop and in the form of a discussion

Id asset amongst themselves

Need for accurate information

Researcher: and who do you think must present the training in future, the training that I will present first is a workshop, but who would you like to see presenting it in future?

Participant: qualified people, those that are very much qualified because when you want to know something you want people who are going to tell us exactly what is happening, not myself, I cannot, as long as you do a workshop because there are sessions that I'm able to offer

Want qualified presenter with accurate information

Id. assets within themselves

Researcher: and if you receive the training, say you receive the training, say we plan to do the training in April or May and to give you a workshop of AIDS do you think you may be able to give information to the other teachers?

Participant: this is being done, for an example now, I go to a workshop representing teachers on my way back I have to come

and tell what I heard about it, as well as with the teachers centre training there, people that are there trained first and workshopped and then we come to facilitate, it is like that. So there's no problem for me, if I'm workshopped to go back and workshop, as long as I have information and every pamphlets, it is not, I cannot say because you are in Pretoria you must train me, at the same time although I'm here at in P.E. I cannot workshop these people that I think will have to come again, if you have just taken that book, then you tell them what to do, that group can workshop others

Would transmit knowledge to others

Researcher: and who do you think should be trained, all the teachers, only some, what do you think, if ..(unclear) gives the programme?

Participant: I think everybody must be trained, ..(unclear) and ..(unclear) then they just reported also ..(unclear) but everybody needs to be trained because, for an example now, there is this people are going to go out, some are going to get in, so that information that you have can be easy to assist you and what we want is everybody to expand, they should go and then tell others, not only at the school.

Want to transmit knowledge to others

Researcher: Is there certain people outside the community who would be able to come and talk to you?

Participant: it's because we ..(unclear) it's not easy to call someone outside because what we usually do, when you come across that person and then you just talk and talk, especially that maybe you had heard that he is having AIDS, even if he didn't tell you, just to talk and ..(unclear) that's where they are going to say that there's something that I want to tell you, that is how now

..(unclear) it can assist. But there are sometimes here, we hear sometimes the community calling people and saying there are people who are going to come for their project for HIV and AIDS, even those that are affected, those that have AIDS and accepted it, to come and say here I am, I'm HIV positive and we will really cherish and appreciate that thing.

Researcher: like a community support thing?

Participant: you know some, even one, even one who to come and say, if one can come I'm going to tell the community that I'm HIV positive , but for us as teachers it's not easy to call the community unless you are belonging to a certain group outside or community project. But we usually call parents, to come to the school to say I'm back at work, we have been to training then they are going to tell the learners about this and this and this because some work there, maybe parents who would like their kids to be told, so we usually call the parents and say our learners are going to be told– so I can say therefore, for doing that, also parents get something out of the discussions.

Researcher: ..(unclear) shared with the rest of the teachers,..

Participant: I think it is enough, you know to hear a thing from the horse's mouth it's much better than hearing from others, why I'm saying yes, I think every teacher need to be trained by you and then our teachers, can do training in the community

Participant: it's too short for a person who's been gone for a week, that is why we saying it's not enough, maybe there are activities that are done as well as in groups

Researcher: so would you like the programme to have activities in groups as well

Participant: yes

Researcher: okay, thank you so much for your time and efforts. I will ask XXX to let you know when we will be back to do the workshop.

Participant: yes, that will be good.

Appendix F

Analysis of focus group discussion

Field visit 2 - 8 June 2004

Focus group discussion

Researcher: I don't know who has been able to go through this (booklet) but you might have noticed that........ any page look at the nutrition.

Participant 1: I like this page.

Researcher: why

Participant 1 : you know when you are ..uhm.. uhm.. looking after a person and you are washing the linen. This tells you what to do. what can you do you know about the washing.

Researcher: you know what I have put it in the book…. If somebody soils the linen, you must wash the linen with bleach. 1:10 concentrate with bleach, to get everything out. And it is very important that you must wear gloves. I think with her (Tilda), she is also going to work with action plans, maybe that you must get gloves for the school. When you are caring for somebody with AIDS it is very important that you should be wearing gloves.

Participant 1: we have gotten some for the AIDS.

Researcher: that is wonderful. Now I would like to talk about what you have said to me about diet. If you look at this page it says exactly the same.

Researcher: it says exactly the same as what you have said, and I have done this before you have said this to me.

Participant 3: okay, okay. (all in agreement)

Researcher: so I what to know, from Thursday up until now…. How do you feel about having to cope with AIDS? Do you feel the workshop has……

Participant 3: open, open it opened us

Researcher: do you feel that the workshop has given you opens to talk about HIV, has it given you confidence?

Participant 1: it has give us confidence, before we where not sure if we are doing the right thing. Now we have shared a lot of information. Now we know we were on the right track.

Gained confidence in their abilities
Utilise assets amongst themselves – share info

Researcher: you where on the right track… (agreement) what you didn't know Thursday, Sunday, you know you were on the right track.

Participant 1: yes, yes.

Researcher: XXX how do you feel about it?

Participant 5: I feel very,….very confident. Because what I know is what you know. What you know is what I know and then I add more on what I have on what you have.

Gained confidence, competencies were affirmed

Active participation – ownership?

Researcher: a very important thing you just mentioned. This is the universal one. Everybody around the world with AIDS, those problems are the universal ones. But this community has got special gifts and if has special needs. And you have added that something special, you have added that to this. (booklet)

Participant 5: thank you too.

Researcher: XXX ?

Participant 6: okay. Something that I like most is.. Because I like to be involved in helping the community and other people. As a result by you coming here, I have been involved in many things and I have been exposed to many situations. Some of the situations I was able to help. I thank you that. Because If I haven't met you I should have not been as far as I am by knowing what HIV and AIDS is. I have also heard in our church even here at school. A lot of people how have gained something form me. Whilst I gain something from you. So I met somebody how is taking the help with me myself. (cellphone rang)

Enhanced support provided

Transmit knowledge

Researcher: how do you feel from Thursday up to now?

Participant 6: form Thursday up to now I feel very much confident. More confident. I know what I am doing is right. I can stand up and say to the parents this is right, this is not right (uhm, uhm.. in agreement in background). So I am totally confident.

Gained confidence

Sense of empowerment

Researcher: XXX what have you gained form Thursday?

Participant 7: form this workshop?

Researcher: the ones that I presented. In other words the one on Thursday and the one today? I also what you to think back on what you expectations where? You heard I was going to do a workshop. Try to bring in you expectations, do you feel you gained or do you feel you have not gained anything?

Participant 7: you know that soon we are going to sing the same song. (uhm, uhm.. in agreement in background) otherwise you know. What I was thinking was the question of HIV and AIDS that was also for social workers and nurses not for us as teachers, but since you came here you have given us the assurance that we are also social workers and we are also nurses, because we are dealing with kids.

Enhance collaboration amongst educators

Their role as expanded

Researcher : you pastoral role

Participant 7: now we are not afraid, to assist anyone who come and disclose. We are not afraid really. We do know what to say and what to tell that person. So..for you coming here, as I have said the other day it is very much fortunate for us to have some people like you. We are confident

Decreased levels of anxiety

Gained confidence

Researcher: and do you remember the interview we had in you office, (ye..ye) on what you expected from training. Do you feel that what you expected you got?

Participant 7: I think there is no point in even for workshops because we said; we need to have workshops as a staff, but we can, we can conduct workshops. Especial that now you have given this documentation everything is here. I have paged through here and it is really what we know as Mrs XXX said. And everything you are telling us is here and everything we said is here. We are confident. We are confident of saying it.

Gained confidence in their own abilities

Gained confidence/sense of empowerment

Researcher: so this gives you like the safely blanket (yes …yes.. in background) because I gave it earlier on you said, we are not sure what to tell the parents. Now you tell them because you know you have the backup.

Participant 1: yes we do have it, and we know now where to refer to. Because if we sometimes have a problem, we are free to phone you and ask you: what can we do.

Still feels outside help will be required, view me as asset

Researcher: and the thing (poster) you made over there.

Participant 1: yes that thing it just accommodates everything.

Researcher: XXX what do think I didn't have the interview with you, I only had it with a few teachers. but as I said this a few of the things that came out. Do you feel that you got

what you thought you were going to get.

Participant 8: firstly when we sit here and we are being told that there are people coming from Pretoria. To come and conduct a workshop I was so curious. It is just that, then I really was thinking what is it that we are going to do because, what is it exactly because I was in a mind that you people are going to tell us. But I found it out that we are actively involved. (Uhm…uhm ..agreement I background). It is our thing it is you people together with us. And as from Thursday up to now, it has changed. It has made me and I can say us, stand firm on our feet and be sure. Because we are 10 we have 2 people that only trained by the department. If we can stand there and conduct a workshop, they will be sorry for going there instead of coming here. Because we also… when I look at this document, by just paging through there are also HIV&AIDS related symptoms, it can be also easy for you to treat those. Even the preventions and things, even so it is a long lasting skill.

Sense of empowerment & enhanced sense of ownership

Gained confidence & sense of collaboration amongst educators

Researcher: it is something you can… it's not only with AIDS. If a person any person has diarrhoea they don't have to be HIV then you can still treat them. (Ja, ja it also helps) , so you feel…

Participant 8: it is something universal. Ja, I feel strong and confident. I can stand on my feet.

Sense of empowerment
Gained confidence

Researcher: do you honestly think that I came and I told you something you don't know?

Participant 8: you added, there where things that I didn't know but I know now you have added something by letting us talk about it. What you have done is just like a stamp on an envelope, to let it go.

Active participation

Gained confidence in own abilities & empowerment

Researcher: so you feel confident now.

Participant 8: yes you have added a little bit here and there.

Participant 2: you feel you know everything and you can do it, the confidence

Sense of empowerment & gained confidence

Researcher: XXX what do you think, from Thursday up to now, since before we came?

Participant 1: okay, before you came, we were not sure, sure what we must do and what we must not do. But now since you have came, we have found out that, there are many things that we know but we didn't know that we know them then. But now we are sure that we know them. You see most of the things that you know, they are clear now to us. Another thing is that you know this workshop gives us motivation to open even to ourselves of the HIV/AIDS you see. (uhm..uhm in the background)

Own skills & knowledge affirmed

Addressed own insecurities *via* intervention

Participant 3: everybody here is saying exactly what we are going to say. But before you came really we didn't know that we know so much. I am very happy. I once asked mrs…. What are you doing here, this that they are doing, coming for us? She said that you are going to workshop us. Surely everything should come from you and then we are capacitated. I expected that is what you are here for, but up to now we know a lot and we can do everything possible.
(Laughter and agreement in background)

Affirming their abilities

Confidence

Participant 3: there are cases that we will be able to face alone. We know what to do and we know what to say. We are really confident of everything.

Confidence gained

Participants (talking together): we are capacitated (unclear) what came from the group. But now we are free. (Talk about language issue –their second languages ours too) If you start with a pen and paper and you are correcting… (Laughter)….

Researcher: and XXX what do you think, what do you feel, what have you gained.

Participant 3: from what has been done from Thursday afternoon. I think I have learned a lot. There was this (*klink soos* absentness) not being sure if I am right or not. Now I am sure what to say what to ask or what to do when the thing comes.

Researcher: you have mentioned something very important. I have listened to the tape of Thursday. And I mentioned the expectations I have picked up from the previous session and everything. And I said lets brainstorm on this or that and there where 4 seconds of quietness where nobody said anything because you thought that I was going to come and tell you everything (uhm, Uhm, agreement) and you came and you spoke.

Participant 7: you have mentioned 9 different roles of a teacher but you just mentioned one. I think I have… the pastoral role. But what are the others?

Researcher: I will get that document for you

Researcher: we just wanted to link the pastoral role to the moral support you give people. It is something you need to do, you have to do it.

Participant 5: you know what we are going to help other teachers. because you see, we know a lot, we know a lot. And today we know that we know a lot. And we are going to tell others.

Information sharing

Gained confidence

Researcher: that is what we are going to work on with Tilda. On Monday and Tuesday, what are you going to do from here? Now you have all the self-confidence and knowledge and now we are going to ask ourselves what now. How can you now go into the community and spread this good work. That is what Tilda is going to do tomorrow and Tuesday. We are going to put some action plans on

the floor and then in two months time we are going to come and see if you are doing the plans.

Participant 5: and just the way you conduct the workshop, you make us feel free, you know. You workshop is not that much, it is not that much, it is not heavy we are free

anxiety lessened

Researcher: can we talk about that. About the format of the workshop. **** said she liked the format of the workshop. What to the others of you feel? Do you think we should have done something differently?

Participant 5: no, no, no, you will spoil the whole thing.

Researcher: don't you think there is something, say..cause I am going to write up what I did here and I am going to write that you gave me positive feedback (Uhm…uhm..agreement) but what was bad, what must we do different the next time we do it.

Participant 6: sorry the thing that you taught badly was the thing that it helped us to be good. Because when you came here like …….said we thought that we are going to be passive. But it didn't happen like that. The thing you taught us is that what you are living the everyday living. That is what is with us, so you get something from us and that is where you found out that these people know everything. So let us make them sure that they are on the right track. Now that it is over we see that It is 10% from

active participation and contribution

realisation that they possessed capacities before intervention

you and 90% from us because we are living in this community and we know everything. We thought that we know nothing. So you take something you see, knowing that you've got treasure. But we didn't know that we have treasure.

Enhanced ownership, competencies affirmed

Id themselves as assets

Participant 7: another thing that I think was we supported you about is the question of organizing from the local community. We must send you an e-mail or send you a sms for you advice but we didn't

Researcher: you know what XXX in every group people have different roles. And it was XXX 's role to take the lead and organise all the meetings, but you played an important role with us as well, every time we had a meeting she offered her office. When we needed it she just moved out of her office that we can us it.

Participant 5 : you know when you came here I thought what the …. (laugh)

Researcher: I saw you were very disappointed not to see Liesel, I saw..

Participant 5: but Ronel you choice is good

Ronel: XXX I am sure you are worried about her (Tilda) now! (laughter) But after Wednesday you will also say this about her. You know what XXX I train them they are my students, so from little I tell them this and that……

Appendix G

Field notes and research journal:
compiling a research book

Field visit 1

Field notes:

Interview 1, Participant 1 – 18 February 2004

We (Ronel and I) entered the school on a windy, sunny day. It was break-time. The children came running towards us. They seemed too small even for grade one. Their eyes were big with even bigger smiles; their uniforms were crisply clean with shinny school shoes. The principal could only wave to us from behind his desk staked with papers. A pleasant woman with a smallish frame came towards us. I did not realise that this was deputy principal and the first participant I would have an interview with. She was wearing a navy blue pencil skirt, and white blouse with black sandals. She took us to her office, a small room with posters on the walls with slogans such as – “you don’t have to crazy to work here, but it helps”. There were also newspaper clippings on the wall – it seemed to relate to some insistent at a local school. Her files were neatly, covered in blue paper with yellow stickers stating the contents.

There were three chairs put out for us in front of her desk. We made small talk, about the wind, where we are staying in P.E. and Ronel talked about her previous visit. I joined in, not quite knowing how to move forward. She excused herself for a minute, came back and sat down, with calm anticipation, leaning forward with her hands on her lap, looking for clues to begin.

She spoke in a soft voice, her posture was relaxed, tilting her head and crossing her legs, rocking one leg in the air. Although our discussion covered emotion-provoking issues ("are we going to cry, what help are we going to do") yet she kept her calm demeanour. At a stage two little girls interrupted us, their eyes were turned toward the ground but they made fleeting eye contact accompanied with faint smiles. The participant turned towards them speaking suddenly very loudly but the message seemed positive. Once the girls left she turned to us with the same calmness in her voice and we continued the interview.

Research Journal:
Interview 1, Participant 1 - 18 February 2004

Arriving at the school for the first time as researcher I felt nervous and excited. The Principal was too busy to see us; our interview was with the deputy principal.

I instantly liked her. Why? I think it relates to her calmness in a seemingly overwhelming situation. She seems to be in control and the challenges of coping with HIV&AIDS in the community is not throwing her. Yet she spoke about the "trauma". Maybe as a deputy principal she remains calm and collective to lead other educators, I don't know.

She seemed to be an information rich participant and openly talked about what she would like to have in an HIV&AIDS workshop. There seems to be a great desire to support the community to cope with HIV&AIDS as she

Willingness to support

stated this type of sentiment a few times during our interview.

Field notes:

Interview 2, Participant 2 – 18 February

We (Ronel and I) left the school and returned 2 hours later. Although break was over three boys were washing the principal's car? The deputy principal did not seem so calm anymore. The school is busy preparing for the opening of their computer centre and time seemed to be running out. The deputy principal asked one of the children to call the teacher we were going to have an interview with, I saw her the previous day while I was acting as field worker for Ronel, but we have not been introduced.

Participant 2 is a bigger woman, she walked toward us at quite a pace and with a big smile she introduced herself. She instantaneously talked to Ronel as if they were old friends. They were talking about her previous visit.
She had an enthusiastic, loud laugh, and would through her head back when she laughed, and regularly touched Ronel's shoulder.

We went to the deputy principal's office, the three chairs was still were we left them. Participant 2 sat down with a sigh, leaning forward. She was wearing Jeans and a flowery blouse with gold sandals.

Her voice was loud with a high pitch and her eyes grew bigger when we talked about what educators should do

emotionally affected by HIV&AIDS

regarding a learner infected with HIV&AIDS and the emotional support they would like to provide.

She started to rub her hands, wiped sweat of her upper lip while making a fist with one hand, during discussions relating to educators should do something NOW to help community members.

Emotionally affected

Research Journal:
Interview 2, Participant 2 - 18 February

The interview was held deputy principal's office, which seemed too small to contain a woman with this amount of passion. At a stage during the interview when I looked at her and saw the frustration in her demeanour, I though to myself : how can I possibly perceive what it is like to stand in her shoes? (emic perspective) I will never come close!![1]

I share her frustration or do I ? Insider/outsider?

She talked a lot and although I initially though 'wow'. I realise now that a lot of what she said was repeating herself and engaged in emotional talk. I wonder how her emotional talk will influence the results of this interview. Yet during the interview I was unaware of her emotional talk, Ronel pointed it out to me. I have to watch myself that I do not get swept up in emotional talk and should focus on informational talk – I am doing research and not therapy!!!! I will validate and acknowledge what participants say but I must return to data gathering. Yet, on the other hand, the challenges of coping with HIV&AIDS is an emotional issue,

Roles of researcher

[1] Reflection on my research methology

I work interpretivistic and qualitative, I can acknowledge the emotional issues from a research point of view.

<u>Field notes:</u>

<u>Interview 3, Participant 3 – 19 February 2004</u>

The interview was held in the participating educator's classroom after teaching hours. A big room with two backboards next to each other, the children's desk were neatly line up in rows with the chairs pushed in. Posters on the wall had slogans such as: reading opens up the world.

Participant 3 is a young man I suspect in his twenties. He was wearing dark green trousers, a white shirt and a tie with cartoon characters on it. He walked, swinging his arms. With a smile and what seemed to be a joke, he instructed the children still in his classroom to excuse us. He went to his desk and put on his glasses, while Ronel and I were standing around not quite knowing where to sit.

He invited us to sit on the learner's desk near the front of the classroom and we began the interview. With his hands on his lap and one leg supporting himself on the floor he seemed relax. His voice seemed even toned and composed and when he laughed he would bend forward and slap his knee with one hand.

When he was talking about a friend who got infected his demeanour changed. He stared giggling, bending his head down and shuffled on the desk he was sitting on.

emotionally affected on personal level

Research Journal:

Interview 3, Participant 3 - 19 February

Today I have an interview with the only male participant in the study. He is also the only one who has received HIV&AIDS training. I wonder how the data will differ from other interviews? It there is a difference does it reflect the fact that he has received training of will it reflect the fact that he is male?

credibility of findings??

His voice seemed apathic and lacked the enthusiasm of the previous participant. A feeling on frustration kept on coming up in me during the interview. I now realise that this man has what the other teachers want – HIV&AIDS training. The other two participants indicated that they want to support their community although they have not received formal training. But it seemed that participant 3 did not share the same sentiments. He did talk about supporting the community but referred to 'they '(as the other teachers) would support the community and 'they' (other teacher) do not know how to do it. I realise now that I share some of her (participant 2) frustration, how can people just lift their shoulders and walk on by when you can help someone in need?

I am emotionally affected by what seems to be his don't care attitude, he has what other want yet he does not use it.

emic perspective??

Field notes:

Interview 4, Participant 4 – 20 February 2004

The opening of the computer centre is tomorrow and the whole school is running around. A little girl with yellow ribbons in her two ponies is washing the floor on her hands and knees. Other girls are washing the windows and dusting filing cabinets. There are boys sweeping the passages. Teachers are shouting instructions and the children are running towards the gates. It seems as if nobody is in their classes although it not break-time. The principal is not at school.

Our interview was held in the deputy principal's office. Participant 4 came into the room apologising that she has kept us waiting. She is a plump woman in her late (I guess) 40's. She was still drying her hands and rearranged her peach skirt as she sat down. We talked about the opening of the computer centre she was busy cleaning the library. I asked if we should reschedule but she said something in the line of 'this thing of AIDS is too imported'.

a sense of urgency or responsibility maybe?

Her voice was high pitched with excitement when we initially stared our interview but after 10 minutes I realised that her demeanour has changed. Her shoulders started to hang and she did not speak so loudly anymore.

emotionally affected

Research Journal:

Interview 4, Participant 4 - 20 February

I was worried about the quality of information I would be able to obtain today as it seemed as though everyone was on a buzz to get ready for tomorrow. I was pleasantly surprised that participant 4 insisted that we carry on with the interview. It might reflect that fact that these educators are serious about the support they want to provide to the community and the training they want, to be able to support their community. Yet they are already supporting.

I believe that the greatest asset in this community is the educators' wiliness and motivation to support their community. It is something in their character, Ubuntu maybe? Yet why did participant 3 not display this tendency? Maybe a male female thing, nurturance traditionally comes from woman?

willingness to support

is wiliness/ eagerness to support a gender based issue or an aged based issue, maybe a bit of both??

FIELD VISIT 2

Field notes:

Asset-based intervention - 3, 6 June 2004

- 8 Participants
- 1 researcher
- 2 co-researchers

The workshop and focus group were held in the staffroom. A large room with white walls and blue and white check curtains on the windows, facing the fence of the school. We assembled tables in such a fashion that we would be sitting in a circle. As participants arrived we offered them cold drinks and biscuits. We made small talk referring to the little girl in who's memory the computer centre was named, I did not realise that she was one of the little girls I met during our previous visit when I acted as field worker for Ronel.

Participants soon settled around the table they seemed eager to begin with the intervention. I got up and gave feedback regarding the four themes, which emerged from the interviews, and that we will be addressing during the intervention, participants nodded their heads saying 'ja' and 'uh'. some participants reshuffled themselves on their chairs and leaned forward.

participants agreed with the themes I derived at from analysis of the interview data.

I introduced the first theme ***Where can HIV infected people get help***? and informed participants that we were going to have a group discussion on it. After approximately

60 seconds one of the participants hesitantly asked, "must we talk now?"

Participants seemed hesitant to start and I encouraged them to share with one another what they know and referred back to one of the interviews where participants said that some of the teachers have good ideas, which they should share, at the workshop. One by one the participants become more talkative, adding to each other's ideas. One participant even got a phonebook to search for telephone numbers that they needed. The participants divided themselves into two groups and the two less talkative participants was instructed to write the actions plans down. I moved towards the two note-keepers and encouraged them to add to what they were discussing. XXX turned to me and gave me a tiny smile, while writing.

Active involvement

I asked the group to divide in two groups and make posters on ***How can I cope with a HIV infected child in my classroom?*** While I moved between the two groups, participants started talking softer and covered their poster with their handbags.

During the group discussion on ***How can HIV infected people be physically supported*** (physical care), Participants really contributed with practical advice and added to each other's ideas and contributions. Although participants were talking a lot with high-pitched voices they still provided each member of the group to contribute by quietly waiting for a participant to contribute before others added to contribution.

enthusiasm

Our first session was concluded and we started on Sunday with the final theme ***How can HIV infected people be emotionally supported by teachers***? Although participants seemed eager to contribute as they talked loudly and indicated they would like to speak by slightly lifting their hand, they waited their turn and did not interrupt other participants.

Enthusiasm

Once this theme were concluded I revised each theme and present the combined posters I made to participants. While I was busy with this activity participants nodded their heads and one participants said something in the line of ' that's the way it is', in agreement to what I was presenting.

Research Journal:

Asset-base intervention – 3, 6 June 2004

The 60 second silence after I opened the floor for a discussion on our first themes ***Where can HIV infected people get help*?** was wonderful. The participants really expected me to inform them – deficit model. They were somewhat uneasy to start of with but soon got the just of what we were doing, they are the experts and they have the knowledge and skill. Participant's eagerness to support their community was evident in their eagerness to participate and contribute to the discussions.

asset-based approuch

willingness and motivation to provide support

During the creation of poster on ***how can I cope with a HIV infected child in my classroom?*** As I moved

between the two groups, I realised that a game has emerged and that the one group did not want the other group to know what they were writing on their poster. I did not anticipate this rivalry but I though to myself that it is part of group work. I anticipated that the rivalry will diminish once the groups presented their posters to each other. I also emphasised the similarities in their presentations aiming to unify the group as one.

I was worried about the quality of contributions/advice that participants would make regarding ***How can HIV infected people be physically supported***. I soon realised that the contributions (advice) they made were accurate and represented in the information booklet I compiled. As soon as I realised that I was worried regarding participants' contributions I was shocked. Being concerned, did I truly believe that participants possess the competencies to support their community effectively!! What is going on here??? I am falling back into the needs-based approach making myself the expert and participants the needy, who require advice. I have to watch myself, I truly though I believed that participants are the experts and I 'live' the asset-based approach everyday. Maybe participants insecurities regarding their ability to support was rubbing of on me???

questioning my assumptions and the asset-based approach

During the discussion on ***How can HIV infected people be emotionally supported by teachers?*** I was somewhat surprised in the restrain some of the participants displayed and the amount of respect they had for the other

participants as no one interrupted each other while they were making their contribution despite the fact that there seemed to be an air of excitement amongst participants.

enhanced feelings of empowerment

I feel that the intervention was a success. The participant's contributions support the asset-based approach. The fact That participants were also actively involved kept them engaged and motivated to continue to contribute despite the fact that they seemed to have been tired on the first day of our workshop as this session commenced after school hours during a very busy week at the school

advantage of asset-based approach

Field notes:

Focus group discussion - 6 June 2004

- 8 Participants
- 1 researcher
- 2 co-researchers

The focus group was held in the staff room directly after the asset-based intervention has commenced. We shared lunch and had cold drinks before we started with the focus group. During our lunch educators made jokes regarding the fact that none of the researcher had children. Once we finished eating participants would not allow us to through the chicken bones away as they were going to cook it and put it over their dogs' food.

We stated the session and I explained informed consent and confidentiality. Our discussion commenced and I requested participants to provide feedback regarding the

workshop. The Dictaphone was placed in the middle of the table. Participants wanted to know it they should speak into the Dictaphone or if they were speaking loud enough to have their voice recorded. I played a section of the tape back to them so that we could hear their voices. Some participants sad back in their chairs and crossed their arms, while smiling.

confident

While I asked participants what they though of the intervention again participants did not interrupt each other and as one participant contributed others quietly nodded their heads, smiling.

consensus amongst participants

Research Journal:
Focus group discussion - 6 June 2004

Lunch was very nice and I truly felt that we just a group of woman laughing and making jokes. At one stage I become somewhat concerned that the focus group might be too informal to really obtain credible information. What would the influence of a very informal discussion be on the research results? Should I try and make it more formal? Why do I think formal equals more credibility? These are just some of the concerns that crossed my mind when participants started washing their hands to indicate that lunch was coming to an end.

refection on research methodology

I placed the Dictaphone in the middle of the table and it seemed that participants became very aware of the Dictaphone. Our discussion became more formal with the presence of the Dictaphone. Participants seemed relaxed

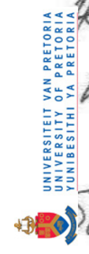
and satisfied with the fact that their voices could be heard. Once again participants did not interrupt each other while others were contributing. They truly show great respect for their colleagues. At one stage I got the feeling that participants were reluctant to share their thoughts on the asset-based intervention. I realised that participants were unable to contribute anything new to the conversation. One participant even said, " you know I am going to say what they have all been saying". As researcher, I though is this what data saturation looks like? I tried to obtain more information and turned the discussion towards their expectation and what they have now experienced during the intervention. This seemed to work and shed more light on the asset-based approach and group intervention.

I became concerned, as it seemed that data saturation occurred quite quickly and I planned to move the discussion to a close, and just as I was thinking this one participant provided what I now call the golden quotation:

> *we thought that we are going to be passive. But it didn't happen like that… That is what is with us, so you get something from us and that is where you found out that these people know everything... Now that it is over we see that it is 10% from you and 90% from us because we are living in this community and we know everything. We thought that we know nothing. So you take something you see knowing that you've got treasure. But we didn't know that we have treasure* (Focus group, participant 6 p.5).

Leaving the school for the last time I felt depressed. The

participants in my study shared so many things with me, they truly allowed me to view the world they live in through their eyes and yet I know in my heart I will probably never see them again. It felt as though I left a piece of myself behind in that small dusty school in P.E.



Interview 3.

Fieldnotes

Big Classroom – 2 Black Boards.

So neat! – Chairs & Tables in Rows.

– Posters – "Reading opens the world."

Confident Walk – Swing arms (Hip in sy step).

He went to put on Glassess before we started with interview ??

Standing around

Confident & Relaxed with interview – hands on lap

Swinging his leg

Friend infected – Seems uncomfortable

– Shuffles around on desk

Research Journal (Reflections)

I felt uncomfortable and irritated by him – He was so smooth.

↳ Why ??

Only man ? – May Reflect gender or Age issue (Younger than rest of participants)

→ He engages in "othering" – they .... them... does not include himself in support issue

↳ I feel frustrated. – He has the knowledge other teachers want, but he is not helping/supporting community → Insider view ??

Ronel's interview upset me – saw parents (Caregivers) of HIV infected Children – orphaned – Raped.

tiny Little girl!! – I want to scream.

CRUEL cruel World

Appendix H

Visual presentation of activities during asset-based intervention

Visual Presentation of activities during workshop

Participant involvement

Facilitating group interaction amongst participants

Facilitating group interaction amongst participants

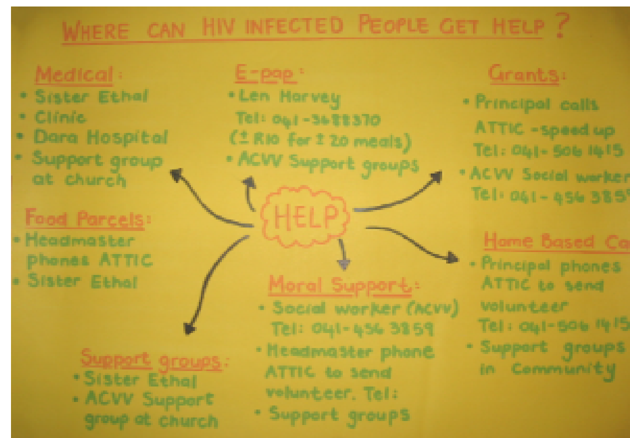
Participants working in small groups

Participant presenting her group's presentation to other participants

Participants working on posters and presentations

Certificate ceremony at the end of the asset-based intervention

Posters made during intervention



Summarised poster of first theme

Poster of action plans made by participants

Poster of action plans made by participants

What can you do if you suspect a child is HIV-infected?

1. Call a colleague into your classroom. Ask their opinion.
2. Call the parent → describe child's behaviour, ask if they have noticed it. Suggest parent take child to doctor.
3. Make a case study: Has someone else in family recently passed away.
4. Get parent to come to school – get feedback on what the hospital said.
5. If parent disclose pos. HIV status of child or themselves → encourage parent to disclose to principal.
6. Call ATTIC → They send volunteer to give foodparcels and grant.

Summarised presentation of action plans

ACTION PLAN

Denial:

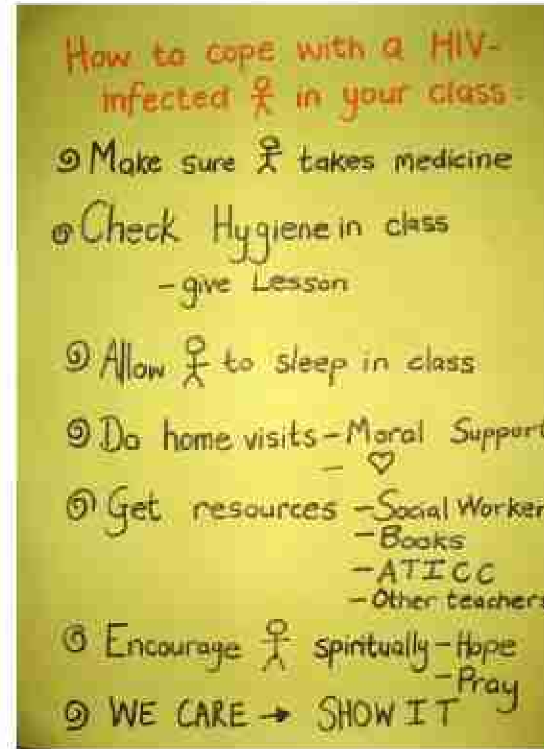
- → Be patient, until they are ready
- → You can't force them to eat / take medic.
- → Make them understand → Confidentiality
- → Assure them that you care + ♡ them
- → They can get help if they disclose → grant, food, support, home care

Accepted:

- Diet → healthy diet
  - (pap, butter, fruit, veggies)
  - → Add garlic, vegetable oil, ginger
  - → Drink lots of liquids
  - → Supplements to prevent sickness (Spirulina, african potato)
- Physical Support → fever, → diarrhoea, → pain, → coughs, → TB, → tiredness, → anorexia, → mouth problems
- Emotional Support

Summarised presentation of action plans

Helping hand of support



Summarised poster on coping with an HIV infected learner in the classroom

CERTIFICATE OF ATTENDANCE

FOR A WORKSHOP PRESENTED AT CEBELIHLE PRIMARY SCHOOL
ON

HIV/AIDS

DELEGATE'S NAME : Galano

DATE : 6 JUNE 2003

WORKSHOP PRESENTED BY
MED (EDUCATIONAL PSYCHOLOGY)
UNIVERSITY OF PRETORIA

Workshop sponsored by
ETDP SETA

How To cope with HIV-infected ♀ in your class:

- Treatment, medicine with food – early in morning arrange with parents.
- Let ♀ sleep: explain other why the ♀ is sleeping ~~et~~ bv: he has a head~~ache~~ ache
- Classmates aware that the ♀ sometimes get sick
  ↓
  Maybe other children can help her, call teacher when ♀ is not feeling well. learners help Teacher)
- Aid HIV-child to sweep floors cause of dust
- Absent ♀ from school: Tell children ~~th~~ that ♀ went to clinic (inform)
- Provide homework / worksheets for ♀ who missed school
  ↓
  Still part of schoolwork.
  Stay on track – dont left behind
- Homevisits: Moral Support + ♡
  We care!
  ~~Tea~~ Not only classteacher – but as a group.

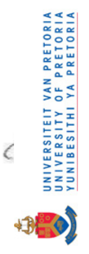
- Encourage ♀ to be involved in extra-mural activities
  Do not stigmatized!
- Check ♀'s lunch → diet + healthy food
  Inform parents + call them
- Give info for parents
  Say: "I don't know – I will find out"
  Go ~~to people who know~~ and get info: Resources
  - newspapers / books.
  - ATTIC
  - Sister
  - Other teachers
  - Social worker
- Tell parents to have a watchful eye on ♀
  eg. → what did ♀ eat?
- Encourage ♀ spiritually
  → giving hope
  → Praying
  → God ♡'s you
- Guard against:
  → 2 much attention (May take advantage of it)
- Traing children in class.
  Teachers duty to educate ♀dren
  Change lives
-

How to cope with a HIV-Infected in your class

- ~~Contact - parent~~
- Arrange with the parent to change the medication time.
- encourage the child to bring the medicine.
- If we had a sick room - would suggest he - goes there when feel sleepy
- Careful not to give too much attention to her/him -
* class - aware.
- Be willing to improvise for the child - when feeling to eat what she/he does not have from home eg. [illegible], juice etc.
- [illegible] to contact Parent to know if they (have/afford - have) healthy food.
* Monitoring - eat in the class - check what happens after eating - 10 minutes before - be official.

HOW TO COPE WITH HIV INFECTED CHILD IN YOUR CLASS.

1. ~~AFTER~~ TREATMENT → ENCOURAGE PARENT TO GIVE THEM AFTER SCHOOL
   WHY - DURING MORNING → CAUSE DROWSINESS
2. IF GIVEN IN THE MORNING → HAVE PORRIDGE FIRST. IF NOTICE DROWSINESS - LET HER/HIM SLEEP
   EXPLAIN TO LEARNERS THAT - SHE/HE HAS GOT HEADACHE
3. LET THE CLASSMATES BE AWARE THAT SHE SOMETIME GET SICK. WHY THEY CAN BE ABLE TO ASSIST THE TEACHER → TELLING EDUCATOR THAT HE/SHE IS NOT WELL.
4. HE/SHE MUST AVOID DUST WHEN IS SWEEPING TIME → WHY = COUGH
5. ABSENTEEISM → ~~HIS~~ CLINIC VISITS / SICK
6. → PROVIDE HOMEWORK/WORKSHEET TO WORK AT HOME
   → ASSURE HIM/HER THAT YOU UNDERSTAND HER ABS
6. → HOME VISIT - EDUCATOR → SHOW CARE → NOT LET HER HIM PANIC
7. ENCOURAGE THEM TO BE INVOLVED EXTRA MU[illegible]
8. CHECK FOR LUNCH IF ~~NOT~~ THERE THERE IS NOT PROVID[illegible]
   IF SOMETHING NOT SUITABLE IN THE LUNCH → CALL PARENT FOR [illegible]
9. WATCH THE DIET WHY REACTION [illegible]

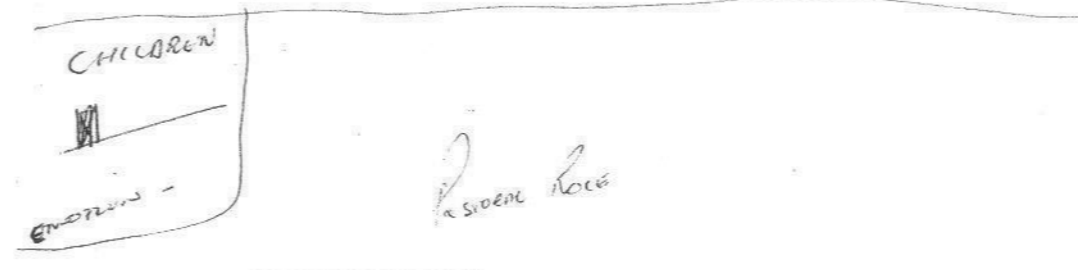


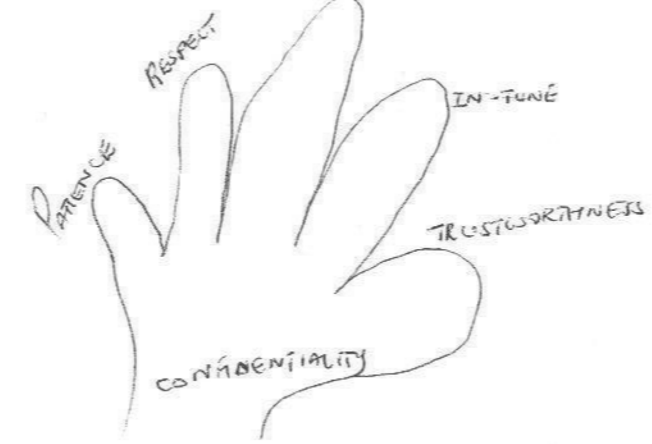
Emotional Support - guide lines

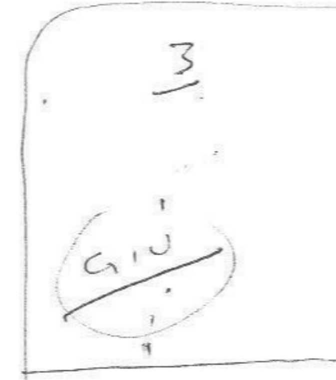
- Thumb ⇒ trust
- Index finger - in tune
- middle finger - got Message
- Ring finger - Respect
- Pinkie - Patience
- Bracelet - Confident

diff. roles - a teacher has to fulfil - S.A.

(10) RESEARCH - GO TO NURSES.
SCRIPTURE READING - VERSE ⇒ GIVE HOPE
SPIRITUAL & DEVELOPMENT ALL LEARNERS







Appendix I

Asset-based intervention preparation document

Intervention/Workshop Preparation session 1

Welcoming;

- Sit around the table
- Introduce ourselves
- Talk about the purpose of workshop
- Talk about Informed consent; ask if they are willing to complete informed consent forms
- Eating

Orientation:

- Give feedback on the interview we had at school – aiming to establish the expectations they have regarding a HIV/AIDS workshop.
- Four main themes arose
    - Where can HIV infected people get help – with regards to things like the grants, food parcels, medication, social support (social workers), Sister Ethel (the services she provides at clinic).
    - How to deal with child in classroom. If a teacher would like to give a child food but does not what to let the others in the classroom realize what is going on. Or if the child is feeling sleepy.
    - How can we support HIV infected people - Physically
    - How can we support HIV infected people - Emotionally

Theme 1 - Where can HIV infected people get help?

Min.

Focus group discussion – share with one another where can help be found

- give phone numbers of relevant people (have telephone directory available.
- Draft action plans

Action plan 1 – if suspect child is HIV positive

Action plan 2 – if parents are infected } *make sure your have a*

Action plan 3 – if both child and parent(s) are infected *summary of action plans*

(get the note form the relevant person combine it into a poster which will be presented at the follow-up session)

Social worker: tel -

Sisters: tel –

Dept of Pensions: tel. –

Theme 2 – How can you deal with a HIV infected child in the classroom?

Min.

- Divide in two group of 4 each
- Each group receives a A2 cardboard which they will use to make a presentation to the other group (or to write down their ideas)
- Encourage them to brainstorm how to treat the child without making it obvious that child in infected. *Min.*

(ideas: if you want to give the child food, if the child feels ill or tried, when the child is absent)

- Allow each group to present their poster/information to the other group.

Min.

(collect posters and combine them into one poster to be presented on the day of feedback)

Theme 3 – How can HIV infected people be physically supported?

Min.

- In the format of a focus group encourage the teachers to share with one another what they have done up to now (or what they have heard) to help HIV infected people. *Min.*

- Things to keep in mind regarding the treatment of symptoms:

Directly ask the group what can be done regarding

- Fewer – try to cool the body, stop dehydration
- Diarrhoea – dehydration
- Pain
- Cough and difficulty breathing

- Tuberculosis
- Skin problems, eg., rashes, itching or sores
- Soreness in the mouth and throat causing
- Tiredness & weakness
- Depression
- Anaemia – blood deficiency (reduced amount of blood in circulation)

- Things to keep in mind regarding nutrition:

- 3 types of food

  - Energy giving food = rice, sugar, honey, bread, pap, cooking oil, sweet potatoes

  - Body building food = meat, fish, beans, eggs, chicken

  - Protective food = citrus fruits, mangoes, dark green leave vegetables eg., spinach or 'marogo'

- eat small amount of food often
- add sunflower oil to food
- drink lots of juices
- eat a variety of food
- give soft food if it becomes difficult to chew and swallow.

Everything we have spoken about will also be covert in the manual. If you feel you would like to add to something we spoke of now you can write it in the manual – each receive a copy + copy of additional notes made during the focus group on the day we give feedback.

<u>Theme 4 – How can we support HIV infected people emotionally?</u>

Min.

- In a group discussion generate some of the important things to consider when interacting with a person experiencing problems. *Min. Ronel or Tilda can make notes on A4.*

- Summarise on 6 A3 poster each representing a category relating to; trustworthiness & honesty, tuning in to person with non-verbal behaviour (eg.

leaning towards person), active listening (eg. are you getting the message the person is trying to convey), displaying respect, confidentiality).

- Once they have generated ideas, provide heading for posters and introduce *helping hand of support* poster
  - Thumb = Trustworthiness & honesty
  - Index finger = In tune to what the person is saying (SOLER + Mind + ears)
  - Middle finger = message what is the message this person is trying to convey – active listening.
  - Ring finger = respect & compassion for the person sitting in front of you
  - Pinkie finger – (actually called a little or small finger, but for this purpose call it a pinkie)

    = Patients
  - Remember the bracelet of confidentiality.

- Divide group into pairs and practice the *helping hand of support* in role play.

1. Role play where one person is a child or a member of community having a general problem, eg., the other children do not want to play with this child or the parent feels frustrated because child does not want to learn. Min.
2. Ask volunteers to tell they how this felt. What worked well? What could have been done better? Could you see the 5 fingers of support in the person listening to your problem?
   Min
3. Switch roles, the person complaining has an HIV/AIDS related problem, eg,. fewer or someone close to you recently found out they are HIV positive. Min.
4. Ask volunteer to give feedback again. Min.

- Draw their attention to the fact that counsellors use these guidelines. They are teacher and being a teacher one needs to support the community (pastoral role of teachers). By attending this workshop they are not counsellors but teacher

with the knowledge to use some of the counselling skills used by counsellors in the field.

- I will leave a copy of the formal manual which I used to collect this information with the deputy principal anyone whom wishes to educate themselves in counselling are welcome to borrow the manual.

Give certificates and gifts (a framed photograph of handing over of certificate taken on day one)

Resource required for the workshop:

- Lunch (sandwiches)
- A3 Cardboard × 11
- A2 paper for notes
- 12 manuals: *Care Giving & Nutrition of HIV Infected People*
- 1 manual: *The Basic guidelines on AIDS counselling*
- Certificates rolled up with red ribbon X 8

Intervention/workshop preparation, session 2

- Welcoming
- Cover the themes we did not get to on day one (I suspect we will only be able to cover 3 of the abovementioned themes)
- Provide lunch
- Feedback, focus group (regarding whether they feel their expectations has been met and do they feel more confidant when being faced with HIV/AIDS in their classrooms and community.

Appendix J

Information booklet

The Support of HIV Infected People

A practical guide

Workshop : HIV/AIDS

JUNE 2004

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Action plan – If parent(s) are infected p. 20

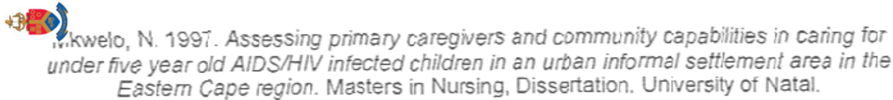
Action plan – If both child and parent(s) are infected p. 21

How can you best deal with a HIV infected child in your classroom? p. 22

Please note: The information and pictures presented in this practical guideline has be obtained form:

Zimba, E.W. 2000. *The Knowledge and Practices of Primary Caregivers Regarding Home Based Care of HIV/AIDS Children in Malawi.* Masters of Science in Nursing, Dissertation. University of the Witwatersrand.

As well as



Mkwelo, N. 1997. *Assessing primary caregivers and community capabilities in caring for under five year old AIDS/HIV infected children in an urban informal settlement area in the Eastern Cape region.* Masters in Nursing, Dissertation. University of Natal.

Basic HIV/AIDS information:

HIV is the acronym for *Human immuno-deficiency virus.* This virus is spread via unprotected sexual intercourse or through direct contact with the blood of a person infected with the HIV virus. The HIV virus causes AIDS, an acronym for *Acquired immuno-deficiency syndrome.* AIDS is seen as a severe and fatal range of diseases to which the human body has lost it ability to resist (Donald *et al*, 2002: 256).

Once the human is infected by the HIV virus it may take up to 12 weeks for the body to produce anti-bodies freighting against the HIV virus. These initial weeks are called the window-period. Going for an AIDS test during the window-period is unreliable. The test will not be able to tell the person that they are infected by the HIV-virus.

After the HIV virus has infected the body the person carrying the virus is still healthy for a long time. This period is called the incubation period. It is only when the body's immune system is so impaired that other infections and virus can not be resisted that the person has AIDS.

How is HIV spread?

- Having sex without using a condom
- Being in contact with HIV infected blood or bodily fluid
- The unborn Child of an infected mother, the infection might occur during pregnancy, delivery and/or breast feeding

How is HIV not spread?

- Sharing cutlery and crockery
- Having a haircut
- Shaking hands
- Wearing second-hand clothes
- Sharing a bathroom
- Playing
- Having a meal together
- Mosquito bites
- Swimming in the same pool or river.

Is their cure for HIV/AIDS?

At the present time there is neither a vaccine against nor a cure for HIV/AIDS. Some healers might proclaim to have the cure for HIV/AIDS but this refers only to the lessening of other conditions caused by AIDS such as diarrhoea. Medicine such as AZT and anti-viral treatments are used in the fight against AIDS but it can not rid the body of the HIV virus.

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AIDS related conditions and the management there of at home:

Fever:

Fever is a condition whereby the body temperature is to high. High fevers can cause confusion in Adults and fits in children. The threat of dehydration is also present.

What to do:

- Give a cool bath
- Increase fluid intake
- Wipe person's body with a wet cloth
- Keep the person clean and exposed to cool fresh air
- For adults give: 2 paracetemols or 2 aspirins every 4 hours with meals until fever disappears

When do I take a person to a health professional?

- The fever does not disappear with the above treatments
- The person shows
  - Stiff neck
  - Fits
  - Yellow eyes
  - Unconsciousness
  - Severe and sudden diarrhoea
  - Sever body pains
- If a pregnant woman develops fever.

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Chronic Diarrhoea:

Passing 3 or more watery or loose stools per day can be seen as diarrhoea. The great danger of diarrhoea is dehydration in both children and adults.

What to do:

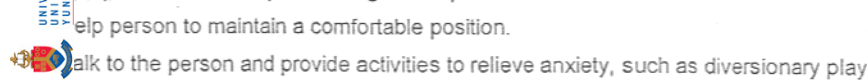
- Drink lots of fluid. A re-hydration mixture made up of – 8 litres of boiled (then cooled) water, 8 teaspoons of sugar and ½ teaspoon of salt, can be administered 1 hour after a water stool. Other fluids such as Energade or Game can also be provide.
- Make sure the person washes his/her hands after using the bathroom and before eating.
- Infected waste must be properly disposed. If toilets are at a distance, a hole can be dug away form the house to dispose the waste. The waste should be covered with soil.
- Soiled linen should be soaked in a solution of bleach 1:10.
- Eat nutritious food frequently, for example, rice, bananas, pawpaw and mangoes.
- Care givers are to wear cloves if exposed to bloody diarrhoea or bleeding episodes
- Check for severe dehydration by examining the skin elasticity (see picture)

When do I take a person to a health professional?

- If severe dehydration has occurred
- If Persistent diarrhoea
- If the person is to weak to eat or develops a fever
- When bloody stool occurs

Pain:

Some of the conditions related to AIDS cause sever pain.



W do:

- ently message sore muscles.
- pply hot or cold compress and give the person a warm bath.
- elp person to maintain a comfortable position.
- alk to the person and provide activities to relieve anxiety, such as diversionary play with AIDS child.
- Show patients, love and understanding.
- For adults: give 2 paracetemols or 2 aspirin 4 times a day with meals.
- For children give: paracetemol syrup (NB: read the dosage information before administering the medicine as children of different ages have different dosages).

(Please note that children may also use aspirin but read the dosage information before administering the medicine as children of different ages have different dosages)

When do I take a person to a health professional?

- If the pain becomes severe.
- When new symptoms such as headaches, necks stiffness and fever occur in association with the pain.

Coughs and difficulty breathing:

Persons with AIDS might show sighs of lung infections, might have difficulty breathing and display a chronic cough.

What to do:

- Place the person in a well ventilated room.
- Sit with the person and give emotional support. Difficulty breathing might causes great anxiety.
- Provide support for the person to sit up to ease his/her difficult breathing.
- Give adequate fluids.
- Give a throat remedies, for example, I teaspoon of honey 3 time a day
- Encourage person to cover their mouth while coughing.
- Discard of bodily fluids by burying it or throwing it in the toilet.
- For adults give: 2 paracetemols or 2 aspirin 4 times a day with meals.
- For children give: paracetemol syrup (NB: read the dosage information before administering the medicine as children of different ages have different dosages).

(please note that children may also use aspirin but read the dosage information before administering the medicine as children of different ages have different dosages)

When do I take a person to a health professional?

- If a sudden high fever develops
- When the person suffers from severe pain in the chest
- If the person becomes breathless
- When the coughing of blood occurs
- If foul smelling phlegm
- If the person does not respond to the above treatments

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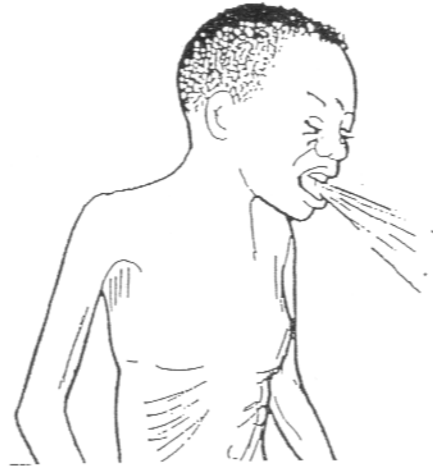
Tuberculosis (TB):

This is a chronic infectious disease affecting lungs resulting in a sever cough. In sever cases a person might cough up blood.



Symptoms of TB include:

- A sever cough for more than 3 weeks
- Weight loss
- Night fevers
- Chest pains
- Loss of appetite

What to do:

- Encourage the person to seek early assessment by a health professional.
- Encourage them to cover their mouth when they cough.
- Provide adequate fluids and nutritious food.
- Ensure that the person is not smoking or using alcohol.
- Encourage the person to take treatment medication regularly and completing the treatment.
- Provide support for the person to sit up.
- Encourage the person to refrain from excessive work.
- Discard of bodily fluids by burying it or throwing it in the toilet.

When do I take a person to a health professional?

- If the person shows a reaction such as, itching and skin rash caused by the TB medication.
- When the person is not taking the medication.
- If the persons shows no sighs of improvement
- In the cases where there is a TB relaps.

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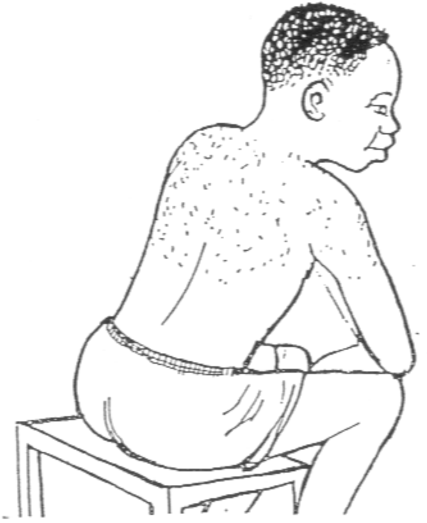
Skin Problems:

A person living with AIDS often shows rashes, painful sores and itching skin.



Want can be done:

- Bathe the person with warm water and soap.
- Daily clean open wounds with mild salty water and place new dressing on wound.
- Apply the appropriate prescribed skin lotion.
- Provide the person with nutritious food.
- Encourage the person be out of bed as much as possible. In cases of very ill persons or babies make sure that their positions are often changed to prevent pressure sores.
- For adults give: 2 paracetemols or 2 aspirin 4 times a day with meals.
- For children give: paracetemol syrup (NB: read the dosage information before administering the medicine as children of different ages have different dosages).

(Please note that older children may also use aspirin but read the dosage information before administering the medicine as children of different ages have different dosages.)

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When do I take a person to a health professional?

- If wounds become infected (swollen and hot), the pain worsens or if a fever occurs.
- When the wounds bleed.
- If the abovementioned treatment is ineffective.

Tiredness and Weakness

AIDS can make a person very weak and tired.

What to do:

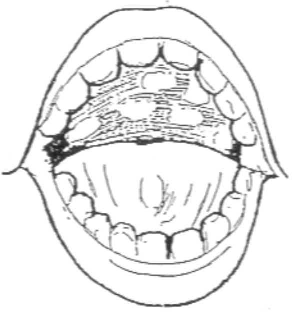
- Help the person with eating, bathing and getting in and out of bed.
- Encourage the person to use a walking stick if he/she has difficulty walking.
- If the person is to weak to get out of bed, gently move their limbs several times a day.
- Turn the person from side to side and gently massage pressure areas, to avoid pressure sores.
- Provide and encourage the person to eat nutritious food (especially energy giving food)
- Keep the person company

When do I take a person to a health professional?

- If the person does not improve

Mouth and throat problems:

Sores in the mouth and throat cause pain and this makes it difficult for the person to chew and swallow.



...o do:

- Provide the person with soft nutritious food
- Increase fluid intake
- Obtain treatment for thrush (Candida = white patches in mouth)
- Clean the person's mouth with warm salty water or gargle with dissolved aspirin.
- For adults give: 2 paracetemols or 2 aspirin 4 times a day with meals.
- For children give paracetemol syrup (NB: read the dosage information before administering the medicine as children of different ages have different dosages).

(Please note that older children may also use aspirin but read the dosage information before administering the medicine as children of different ages have different dosages)

When do I take a person to a health professional?

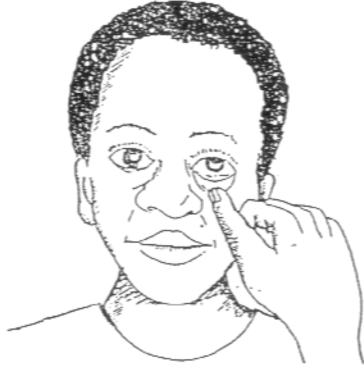
- If the person is unable to swallow or breathe properly
- When the person is dehydrated
- When the person develops a fever
- If the abovementioned treatment is ineffective

Anaemia:

A reduced about of blood in the circulation causes tiredness, weakness, heart palpitations, swelling of feet, dizziness and breathlessness.

The presence of anaemia can be investigated by looking at the colour of

- Membranes on the inner layer of the eyelid (see picture)
- Tongue
- Colour of the palms and nail bed



What to do:

- Try to control any superficially bleeding by applying pressure (remember to wear gloves)
- Provide lots if nutritious food especially green leafy vegetables.
- Encourage the person to take prescribed medication such as iron supplements
- Assist person when they are weak and tired (see tiredness and weakness section)

When do I take a person to a health professional?

- If the person become very weak
- When the person experience difficulty breathing
- If there is no sign of improvement

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Nutrition

Possible nutritious food items include:

- Energy giving food : rice, sugar, honey, bread, cooking oil, pap and sweat potatoes
- Body building food : meat, fish, beans, milk, nuts, chicken and eggs
- Protective food : citrus food, guava, mangoes, dark leafy vegetables e.g., spinach and marogo

Points to remember:

- Nutrition is important for maintaining a healthy immune system, thus healthy food improves the general condition of the person
- Hygiene should be exercised when preparing food, and utensils and grocery should be thoroughly washed

Eat small amount of food often
Drink lots of juices
Eat a variety of food
Add vegetable oil or nuts to food
Eat soft food when experiencing difficulty chewing and swallowing

Emotional support

People with AIDS tend to have mood disturbances such as depression and may be experiencing a sense of loss and grieving due to their anticipated death. Other people's reaction toward them may also lead to their moods being affected. They might be experiencing guilt as to how the infection occurred.

The 5 finger support plan:

- Thumb = Trustworthiness & honesty
- Index finger = In-tune to what the person is saying (body + mind + ears)
- Middle finger = Message, what is the this person trying to say to you – active listening.
- Ring finger = respect & compassion for the person sitting in front of you
- Pinkie finger = Patients (actually called a little or small finger, but for this purpose call it a pinkie)
- Remember the bracelet of confidentiality.

What to do:

- Provide a 'safe' environment for the person, where they feel loved and cared for.
- Regularly chat to the person and encourage friends to visit them
- Encourage the person to talk about their worries
- Where possible encourage the person to be involved in daily activities
- If the person shows the need pray with them

When do I take a person to a health professional (counsellor)?

- If the person withdraws completely
- When the person refuses to eat
- If the person shows suicidal tendencies

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Action plan – If you suspect that a child might be infected

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Action plan – If a parent(s) is infected

How can you best deal with a HIV infected child in your classroom?

Appendix K

Cut-and-paste analysis of interviews and focus group discussion

Cut- and-paste analysis of Face- to- Face Interviews

Educators feel they do not know how to cope with a HIV infected learner

- Sometimes early in the morning she doesn't feel well, she doesn't want to work, as a teacher what must I do (Interview 1 p. 2)[1]
- we must help all the children but this is confidential a disease like this, but that child is in the classroom, there are a lot of children that is next to her. What are the children going to do with the children in the classroom (referring to the stigma attached to HIV, Interview 1, p.3)
- So that we as the teachers we want to know (Interview 1p.7)
- you take a means of letting the kid to sleep in the class, but after knowing that it's when I took care of her, in a way to make so that the class can not suspect why the teacher now loves XXX, why when XXX feels like sleeping she lets XXX sleep. (Interview 2 p.2) *referring to confidentiality of HIV status and disclosure*)[2]
- for teachers I think I want for them to be trained, to take the classes equally, irrespective of you know that there's a child who is positive they must then change now to be very kind to that child because maybe that child will take that, and if you are shouting you will make the child even more sick. (Interview 4 p.3)
- I don't know, some teachers make a big mistake, by if she/he has identified that child, take that child with special treatment, now that child also gets embarrassed (Interview 4 p. 4)

Educators perceived that they do not have sufficient knowledge on HIV&AIDS

- First of all they must know what you are talking about so that if they ask questions you can answer them. If you don't know you can say no I don't know, and come later with an answer, you don't just talk talk talk. You must have got a full information (Interview 1, p.1)
- even us teachers we are not really sure what we know you see. You see sometimes you can feel scared you see (Interview 1 p.4)

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[1] Interview 1 = participant 1, interview 2 = participant 2, interview 2 = participant 2 and interview 4 = participant 4

[2] I made notes for myself to remember the context in which participant made statements/make further interpretations.

- The other one would bring a cheese and bread with cheese, but maybe the cheese is not good for her, but we want to help but we don't know what if it is right or wrong do you understand. (Interview 1p.7)
- But we can think that we know, but we don't know because I'm not trained properly you see (self-efficacy expectations, Interview 1 p.8)
- The other thing is education, so that some people had got the right information. (Interview 2 p.3)
- . But if I knew more I would have given her more than an advise (Interview 2 p7)
- although I heard about them but I need somebody who can give me surety, when we go to a workshop, you know that this thing has helped, now it's going to help (Interview 2 p.8)
- basically all the things that I would speak of would be around coping ……they don't know how to cope and the caring if someone is infected because most of the time it seems nobody accepts it, they don't know what to do, all of them whether you are infected or affected, coping to both of them (Interview 3 p3) (referring to coping skills that educators can utilise to support infected and affected community members)
- is the way in which we can make people to understand that you need to know your status (Interview 4 p.2) (referring to educating the community so that they go for testing and disclose their status)
- because we lacking information (Interview 4 p3)

Educators would like to have surety in the knowledge they have/obtain from a workshop

- because my fear, not to say I've got a fear but my fear sometimes is for someone to present something, then there comes a question, if each and every question you've been asked and then you cannot be able to answer, say okay I'm gonna look for .., like I'm not sure about this but .., but I think always giving his or her own knowledge and that other than that saying I will try and then to come back to you, maybe I'm gonna find it, like I will go out then make a research what it is, you know that stuff. At least 90% of your presentation you must be able to cover it, not to say everything (Interview 3 p.6)
- it's a bit of more weight if someone is saying ' I got this at a teacher workshop (Interview 3 p.7).

- I will and will be happy because what I don't want to do is to stand in front of people saying something that I'm not sure of, I want to be sure of myself, (Interview 2 p.10)
- you know to hear a thing from the horses mouth it's much better than hearing from others (Interview 4 p.7)

Educators would like to provide emotional support

- you have to give them emotional support. You can give them spiritual support because when they can help you into the trauma for the family and for themselves (Interview 1, p1)
- you know when a person come to you, for example if your friend come to you telling you the first time he hears the news, or she hears the news, what are you going to do, are you going to cry, what help are you going to do, in other words what are you going to do (Interview 1, p1)
- I want to give her hope, I want to give the support spiritually and emotionally (Interview 1, p.2)
- and the role play counselling, as a teacher you are a counsellor, with this you must know how to do it (Interview 1 p.4)
- we need to treat these learners kindly now – you know, because we used to get parent dying and all these things (Interview 4 p.3)

Educators indicate that they would like to support learners/families infected with and affected by HIV&AIDS

- I want to do more. You see I want to do more, what can I do today for XXX, you know (Interview 1 p 2)
- what we can do as teachers to help that family you see (Interview 1p.7)
- Now what I've concentrated on now is what can help them because it's there. (Interview 2 p.5)
- what can we do to help, if there's someone infected, how can that person be helped, at home, at school or at work, how can you help that person. (Interview 2 p.3)
- I also told her that if I can get help I will be able to help you but I had nothing that I could do for her at that moment in time (Interview 2 p.2)
- but now the important issue is how can we help (Interview 2 p.6)
- But now you feel angry when you cannot help (Interview 2 p.7)

- for me I would feel much better if I was also giving AIDS life skills because most of the things that they get now, they are just a flesh, the kids need to get more (Interview 3 p.10)
- Now they must come and ask the last child the one looking sick or the one that is talking to his heart the whole day and say with him, "can you call your parents, I want to know if there are problems, because even these learners, you can even identify that the child is not well (Interview 4 p.3)
- it would be very nice for the department to develop another program but also if we can start our own, so that they've got good nutrition, not the teachers who take their lunches and give them lunch (Interview 4 p.4)

Educators indicated that they would like to have (assess to asset in community) practical guidance to support community members

- I want to know about the grant, about the social worker (Interview 1 p. 2)
- what else we want to know, the resource relief of organisations involved in HIV in PE, (Interview 1, p.6)
- sometimes they haven't got the diets, what they must do you see (Interview 1 p. 6)
- So if you have a child I can keep on talking to her, nothing will help, but if I come with ..."okay why don't you use garlic" (Interview 2 p.7)
- 'okay now you've got sores, why don't you wear gloves and put something that will help the sores. The help, literally help that you van give her, physical things that you can give her, not just talk (Interview 2 p.7)
- how to care for someone who's infected (Interview 3 p.3)
- like treating the sores and all those that are sick and also say you know the diet and all these things, sometimes somebody will get an accident with blood so people must be told that it's like that, you must take cloves (Interview 4 p.2)

Educators can identify and utilise assets

- you as a teacher you must have a role play in counselling you see, because you are here now you see (Interview 1p.4)

- You see sometimes it's difficult to go and buy, they can plant veggies in the garden so that they can get a veg to improvise you know, (Interview 1 p.6)
- The programmes on TV helped me a lot, the books. There was a book that the department gave us, the department distributed it to all teachers. I used that book. I read it a lot. (Interview 2 p.3)
- they asked someone to come to our church, a lady who was dealing with these issues, ………….. she can help me too when I'm dealing with these kids and parents (Interview 2 p.10)
- it's through friends you know, it's through friends when we are discussing the issue of HIV and find out what is it that maybe you can say that has happened to help and you find that people want to help it depends then maybe some are shy. (Interview 4 p.1)
- it would be very nice for the department to develop another program but also if we can start our own, so that they've got good nutrition, not the teachers who take their lunches and give them lunch (interview 3 p. 6)
- also at the same time it needs a discussion of that but it's because some teachers have ideas that can help others, you need to talk like this, so to get information even from teachers, teachers know better than I know. (Interview 4 p.4)

Educators already support community members

- I feel happy of what I did you know, what we did as a whole, not me alone and the principal like all these ladies. (Interview 1, p3)
- you see and now you have to teach other children what they must do and not to do (referring to educating other learners in classroom on the ways in which HIV in spread trying to minimise stigma (Interview 1 p.3)
- some of the teachers bring fruit for XXX, (Interview 1 p.7)
- I asked her to buy Spirulina so that she can boost her immune system" (Interview 2 p.4)
- Because I use to bring her prayers there, three or four woman would go there and pray for her.(2 p.4)

- it would be very nice for the department to develop another program but also if we can start our own, so that they've got good nutrition, not the teachers who take their lunches and give them lunch (Interview 4 p.4)
- So that they have that little bit of help. I don't know whether it's help or advise, but I used to do that (Interview 2 p.2)
- You see I give help, that's the thing, but if I don't know nothing about those things how can I give help. (Interview 2 p.7)
- I say I will organise a social worker (Interview 2 p7)
- Now they must come and ask the last child the one looking sick or the one that is talking to his heart the whole day and say with him, "can you call your parents, I want to know if there are problems, because even these learners, you can even identify that the child is not well (Interview 4 p.3)
- suggest " shy don't you have a small garden so that you can plant things" that's good advise because you know that she's going to plant vegetables. (Interview 2 p.8)
- I only help that I give is to give support to them, support, advise but it's not enough for me (Interview 2 p.8)
- I even gave them, some of them the brochure (Interview 3 p.9)

Educators feel traumatised by HIV&AIDS in community

- But what about the other children and it feels a bit little we've got a lot of children here that are infected, and now we are moving here with, we are going to deal with .., we are going to deal with so much sick, as I told you that if your child is infected or whatever or what .. or a member, you are traumatic too, you feel traumatic, it's a trauma, you live in the trauma (Interview 1. p3)
- that is why it is a trauma even to us, but we are not going to cry, we must be bold, we must be strong for them you see (Interview 1 p.8)
- It is not something that I can take out of my mind and take chances with people's lives (Interview 2 p.8)
- I couldn't take it (Interview 3 p.8) (referring to a friend's disclosure)

Educators feel that they should spread/teach the correct information on HIV&AIDS

- you must know what you must say and not to say you see, the way of teaching them. (Interview 1 p.5)
- you know I want to teach them, maybe the community, the parents about the teaching of the community or of the families. I must know the priority topics, you see, not just to talk, you know, the priority topic (Interview 1 p.8)
- you must help them to feel comfortable so that they will be free, so they can be free, encourage them to ask questions and talk (Interview 1 p.8)
- it's not that we are going to teach in the school alone, even the community because we like to call the parents of the infected children here you see (Interview 1 p.8)
- The other thing is education, so that some people had got the right information. (Interview 2 p.3)
- to give them educations, even though they are going to do it, they must say that I did it knowing very well what the risks are. We cannot run away from the importance of it. (Interview 2 p.6) (referring to educating the young learners)
- We are supposed to teach them ………….. if you are going to make it as a subject………it means if you can study at Grade 1, in a school and the subject that will in a long run, I feel there is a low rate of HIV. (Interview 2 p.6)
- if you are positive, in your mind you think positive, and then the better, the longer you can be healthy, but the thing with HIV and Aids, the minute the people they hear that I've got it now, so they turn to negative saying I'm gonna die, that's why others they use the drugs, like you hear in papers they say "I'm not going to die alone" because those feel like they have denial, those infected but they need like some sort of education (Interview 3 p.5)
- so that's why I want for them to know how can they be infected and how they must take care of themselves (Interview 3 p.10)
- if they can be counselled with that thing, and made to understand that death is everywhere (referring to educating community members to use gloves when in contact with blood) (Interview 4 p. 2)

Educators feel that the community trust them and that they should support the community (they see themselves as asset in community)

- Because some times they are illiterate, they know nothing, but you know something and when they come to that the teacher knows everything. They've got that trust that if they told the teacher something. But now you feel angry when you cannot help because even now when they come to me, I say I will organise a social worker, well they know that social workers know something about this AIDS, why don't you (interview * p.*).

Educators seems to indicate a sense of urgency with regards to supporting their community

- But if you say I don't know what they are using, they are talking about nevaropine, it isn't that easy to get. The problem is now. What can she use now. What they need now is what is important, sometimes that is going to help her immune system (Interview 2 p.8)
- It is not something that I can take out of my mind and take chances with people's lives (Interview 2 p.8)
- the thing now, we've got this now…… So the people like us, they need to be educated otherwise they don't know their status, and they don't have that knowledge (Interview 3 p.8)

Educators indicated that they would transmit the knowledge obtain from an intervention workshop to others

- I am like this, if I can go to a workshop, even for me to tell them the way I was told, I'm just like that (Interview 2 p.9)
- Then from there we can organise a parent meeting whereby the whole community is gonna be involved (Interview 3 p.7)
- It's worse with these one, they are not educated, besides the unemployment and poverty but they are not educated. So you speak of HIV and Aids you have to explain what is it, how one can get it, how it cannot all that stuff but the next day that thing is gone to most of them so you have to speak it again, it mustn't be a once off thing, it must go on, it must continue, ongoing process. (Interview 3 p.9)

- So there's no problem for me, if I'm workshopped to go back and workshop ……. and what we want is everybody to expand, they should go and then tell others, not only at the school (Interview 4 p. 5)

Educators indicate a goal of community upliftment

- But if you can teach that earlier because these kids are going to be a community of the area are going to be the future generation of this area, so they will do better than the present generation. (Interview 2 p.9)
- Then from there we can organise a parent meeting whereby the whole community is gonna be involved (Interview 3 p.7)
- Meaning if we can go from door to door here, maybe about this community, or 30% of the infected (Interview 3 p.9) (referring to the educating people to disclose so that they can get help)

Educators build relationship with parent to support the family and the learners
for an example, there is this boy, I don't like that child, in fact not that I don't like him, I don't like the way he is and the manner in which his is dirty always, to come to him because even if he wants to go and take a walk and say your son is a nice boy and change the mother thinking to take better care of him it is then that the mother will start to talk, I think so (Interview 4 p.3) (reaching out to the parents in order to support learner and family)

Cut-and-paste analysis of focus group discussion

Confidence Gained

- it has give us confidence (participant 1, p. 2)
- if feel very,….very confident (participant 5, p. 2)
- now I feel very much confident (participant 6 p. 2)
- now we are not afraid, to assist anyone how come and disclose(participant 7 p. 4)
- We are confident. We are confident of saying it (participant 7 p.4)
- stand firm on our feet and be sure (participant 8 p. 6)
- there are cases that we will be able to face alone. We are really confident of everything (participant 3, p.8)
- Now I am sure what to say what to ask or what to do when the thing comes (participant 3, p.8)

Seems that they were uncertain of there abilities before workshop – now affirmed

- before we where not sure if we are doing the right thing………. Now we know we were on the right track (participant 1, p. 2)
- More confident. I know what I am doing is right (participant 6, p. 3)
- not being sure if I am right or not. Now I am sure (participant 3, p.8)

How do they view workshop – describing workshop

- Now we have shared a lot of information (participant 1, p.2)
- What you know is what I know and then I add more on what I have on what you have (participant 5, p. 2)
- Because If I haven't met you I should have not been as far as I am by knowing what HIV and AIDS is (participant 6, p.3)
- Whilst I gain something form you. So I met somebody how is taking the help with me myself (participant 6, p.3)

- because I was in a mind that you people are going to tell us. But I found it out that we are actively involved. (Uhm…uhm ..agreement I background). It is our thing it is you people together with us (participant 8, p.6)
- you added, there where things that I didn't know but I know now you have add. What you have done is just like a stamp on an envelope, to let it go.
- you have added bit here and there (participant 8, p.6)
- But now since you have came, we have found out that, there are many things that we know but we didn't know that we know them then. But now we are sure that we know them (participant 1, p. 7)
- She said that you are going to workshop us. Surely everything should come from you and then we are capacitated. I expected that is what you are here for, but up to now we know a lot and we can do everything possible (participant 1, p.7)
- and just the way you conduct the workshop, you make us feel free, you know. Your workshop is not that much, it is not that much, it is not heavy we are free (participant 5, p 10)
- sorry the thing that you taught badly was the thing that it helped us to be good. Because when you came here like …….said we thought that we are going to be passive. But it didn't happen like that. The thing you taught us is that what you are living the everyday living. That is what is with us, so you get something from us and that is where you found out that these people know everything. So let us make them sure that they are on the right track. Now that it is over we see that It is 10% from you and 90% from us because we are living in this community and we know everything. We thought that we know nothing. So you take something you see knowing that you've got treasure. But we didn't know that we have treasure (participant 6, p.10)

Validation of their knowledge occurred

- Because what I know is what you know (participant 5, p.2)
- I think there is no point in even for workshops because we said, we need to have workshops as a staff. But we can, we can conduct workshops (participant 7, p. 5)
- But before you came really we didn't know that we know so much (participant
- there are many things that you know, bit we didn't know that we know them (participant 1, p.7)

Reaching out to wider community

- I like most is.. Because I like to be involved in helping the community and other people. As a result by you coming here, I have been involved in many things and I have been exposed to many situations. Some of the situations I was able to help (participant 6 p. 3)
- A lot of people how have gained something form me (participant 6, p.2)

- **Parents**

- I can stand up and say to the parents this is right, this is not right (partcicpant 6, p. 3)

- **Reaching other teachers**

you know what we are going to help other teachers. because you see, we know a lot, we know a lot. And today we know that we know a lot. And we are going to tell others(participant 5, p.9)

- **Feels group stand together & positive affect**

- you know that soon we are going to sing the same song (participant 7, p.4)
- It has made me and I can say us, stand firm on our feet and be sure (participant 8, p.6)
- I am very happy (participant 3, p.8)
- we can do everything possible

- **Feels their Role has expanded in community**

- What I was thinking was the question of HIV and AIDS that was also for social workers and nurses not for us as teachers. but since you came here you have given us the assurance that we are also social workers and we are also nurses (participant 7, p.4)

Sees facilitator as asset

- and we know now where to refer to. Because if we sometimes have a problem, we are free to phone you and ask you what can we do (participant 1, p.3)
- So,.for you coming here, as I have said the other day it is very much fortunate for us to have some people like you. We are confident (participant 8, p.3)

Ownership partnership and collaboration

- It is our thing it is you people together with us (participant 8, p.3)
- you know that soon we are going to sing the same song (participant 7, p.4)

Addressed their own insecurities surrounding AIDS

- gives us motivation to open even to ourselves of the HIV/AIDS you see. (uhm..uhm in the background) (participant 1, p.7)

Appendix L

Faculty of Education Research Committee guidelines and ethical clearance

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ETHICS AND RESEARCH STATEMENT

FACULTY OF EDUCATION
UNIVERSITY OF PRETORIA

While research has produced many positive social and educational outcomes, it has also raised disturbing questions about the conduct of researchers with respect to ethics, values and community. The purpose of ethical review, therefore, is to ensure that human respondents participate in research freely and without unreasonable risk. Where there is some degree of risk, the process of ethical review has to ensure that the potential benefits outweigh the risk and that the participation of human respondents enjoys the full and informed consent of these respondents.

The broader goals of the ethical review of research proposals in the Faculty of Education are the following:

1. to develop among students and researchers are a high standard of ethics and ethical practice in the conceptualisation and conduct of educational research.
2. to cultivate an ethical consciousness among scholars especially in research involving human respondents.
3. to promote among researchers a respect for the human rights and dignity of human respondents in the research process.

The ethical review process is guided by the following principles common to research involving human respondents:

1. the principle of *voluntary participation* in research, implying that the participants might withdraw from the research at any time.
2. the principle of *informed consent*, meaning that research participants must at all times be fully informed about the research process and purposes, and must given consent to their participation in the research.
3. the principle of *safety in participation*; put differently, that the human respondents must not be placed at risk or harm of any kind e.g., research with young children.
4. the principle of *privacy*, meaning that the *confidentiality* and *anonymity* of human respondents must be protected at all times.
5. the principle of *trust*, which implies that human respondents will not be respondent to any acts of deception or betrayal in the research process or its published outcomes.

The process of ethical review is not intended to add bureaucratic burden to the research process. Rather, this process is intended to protect the researcher as well as the participating human respondents. At a higher level, the process is also intended to elevate the quality of research in the Faculty of Education—where research is conceived not simply as a set of techniques, but as a well-considered, ethically grounded process that builds values such as trust, respect, empathy and dignity among both the researcher and

the researched. In such a process, participants are treated as authentic "respondents" in the research endeavour and not simply as "objects" to be studied.

UNIVERSITEIT VAN PRETORIA
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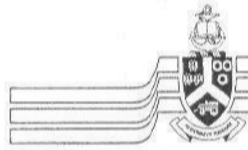
ANNEXURE D



UNIVERSITY OF PRETORIA

FACULTY OF EDUCATION

RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE	**CLEARANCE NUMBER : EP06/06/01**
DEGREE AND PROJECT	M.Ed Educational Psychology Exploring eablement of educators by raising awareness of asset-based trends in coping with HIV/AIDS
INVESTIGATOR(S)	Viona Odendaal
DEPARTMENT	Educational Psychology
DATE CONSIDERED	1 June 2006
DECISION OF THE COMMITTEE	APPROVED

This ethical clearance is valid for 2 *years from the date of consideration and may be renewed upon application*

CHAIRPERSON OF ETHICS COMMITTEE	Dr C Lubbe
DATE	1 June 2006
CC	Ms Ronél Ferreira Dr Liesel Ebersöhn Mrs Jeannie Beukes

This ethical clearance certificate is issued subject to the following conditions:

1. A signed personal declaration of responsibility
2. If the research question changes significantly so as to alter the nature of the study, a new application for ethical clearance must be submitted
3. It remains the students' responsibility to ensure that all the necessary forms for informed consent are kept for future queries.

Please quote the clearance number in all enquiries.

Appendix M

Permission to do research and informed consent letters

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Mr. XXXX

The Principal: XXXX Primary School

XXXX Street

XXXX Township

Port Elizabeth

6001

Department of Educational Psychology

University of Pretoria

Dear Mr, XXXX

REQUEST TO CONDUCT RESEARCH AT XXXX PRIMARY SCHOOL

I am a Master's student at the University of Pretoria. I am currently conducting a research study on enablement of educators to support communities in coping with HIV/AIDS. The aim of my study is to develop and present a HIV/AIDS workshop to educators in order to support them to become more confident, empowered and feel enabled when coping with HIV/AIDS in the community.

The aim of my study is to develop and present an asset-based HIV/AIDS workshop for educators. For this purpose, I have selected your community as participant in the study. The study will take place during 2004.

For this purpose, I kindly request your permission to conduct discussions and workshops with for selected staff members of your school. All information provided will be treated confidentially and anonymously. Any participant will also be free to withdraw from the project at any stage should he/ she wish to do so.

If you are willing to assist me, please complete the form attached and return it to me.

Kind regards

Viona Odendaal
Tel : 082 741 2088

UNIVERSITEIT VAN PRETORIA
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YUNIBESITHI YA PRETORIA

PERMISSION TO CONDUCT RESEARCH AT XXX PRIMARY SCHOOL

Dear Ms Viona Fourie

Having read the letter attached, I hereby grant / ~~do not grant~~ you permission to do research at XXX Primary School, by conducting workshops and facilitating discussions with some of the staff members at my school.

Signature ....

Date 17-02-2004

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

REQUEST FOR INFORMED CONSENT

17 February 2004

Dear Sir/Madam

I am a Masters student at the University of Pretoria. I am undertaking a research study on sustainable HIV/AIDS training for educators. The aim of my study is to develop and implement a HIV/AIDS training program for educators in order to enable them to support the community in coping with HIV/AIDS.

Data collection for the study will be done through a process of semi-structured interviews, as well as one or two workshops. I kindly request your assistance, by participating in these discussions and workshops, that will take place during February, March and April of 2004. The identities of the participants and the information obtained during the project will be dealt with confidentially and anonymously. Participants are also free to withdraw from the study at any time.

If you are willing to participate in the discussions and workshops, please complete the bottom section of this page.

Thank you
Viona Odendaal

I understand the above and undertake to participate in the discussions and workshops that will be held during the next few months. I understand that all information will be treated confidentially and that I may withdraw from the study at any stage.

20/02/04
DATE

SIGNATURE

Appendix N

Face-to-face interview protocol

Interview protocol

- Where do you get HIV&AIDS information from?
- If people come and disclose their HIV positive status or if you suspect someone is infected with HIV, what have you done in the past?
- Do you think it is necessary for teachers to have training on HIV&AIDS and how to support their community?
- If you attend an HIV&AIDS session what kind of information would you like to talk about?
- Which format do you think such an HIV&AIDS session should take on, a discussion, a workshop or what do you think?
- When you receive HIV&AIDS training, what kind of exercises would you like to practice?