UNIVERSITEIT VAN PRETORIA
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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

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V Odendaal Date

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.

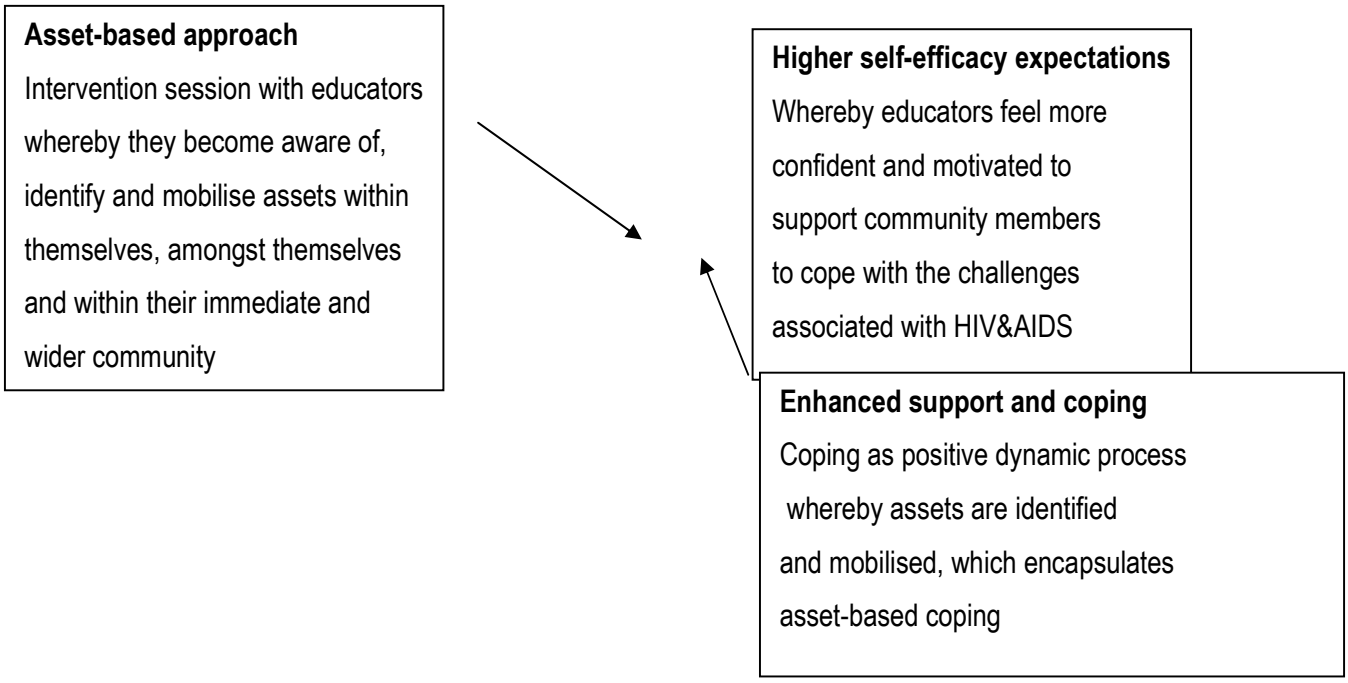


Figure 2.1 : Conceptual framework of this study

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-

[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.

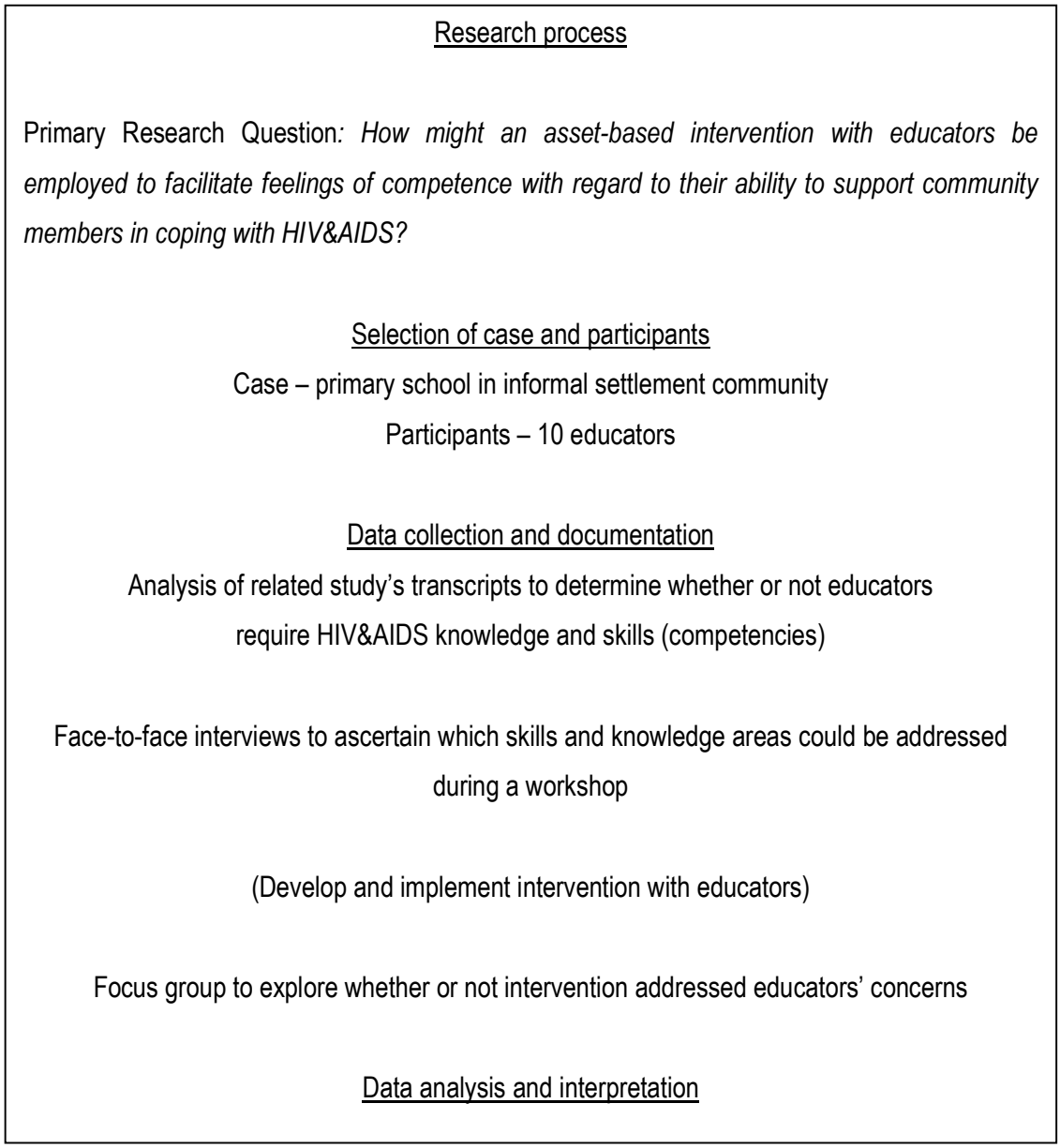


Figure 3.1: Research process

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 conceptualisation 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).

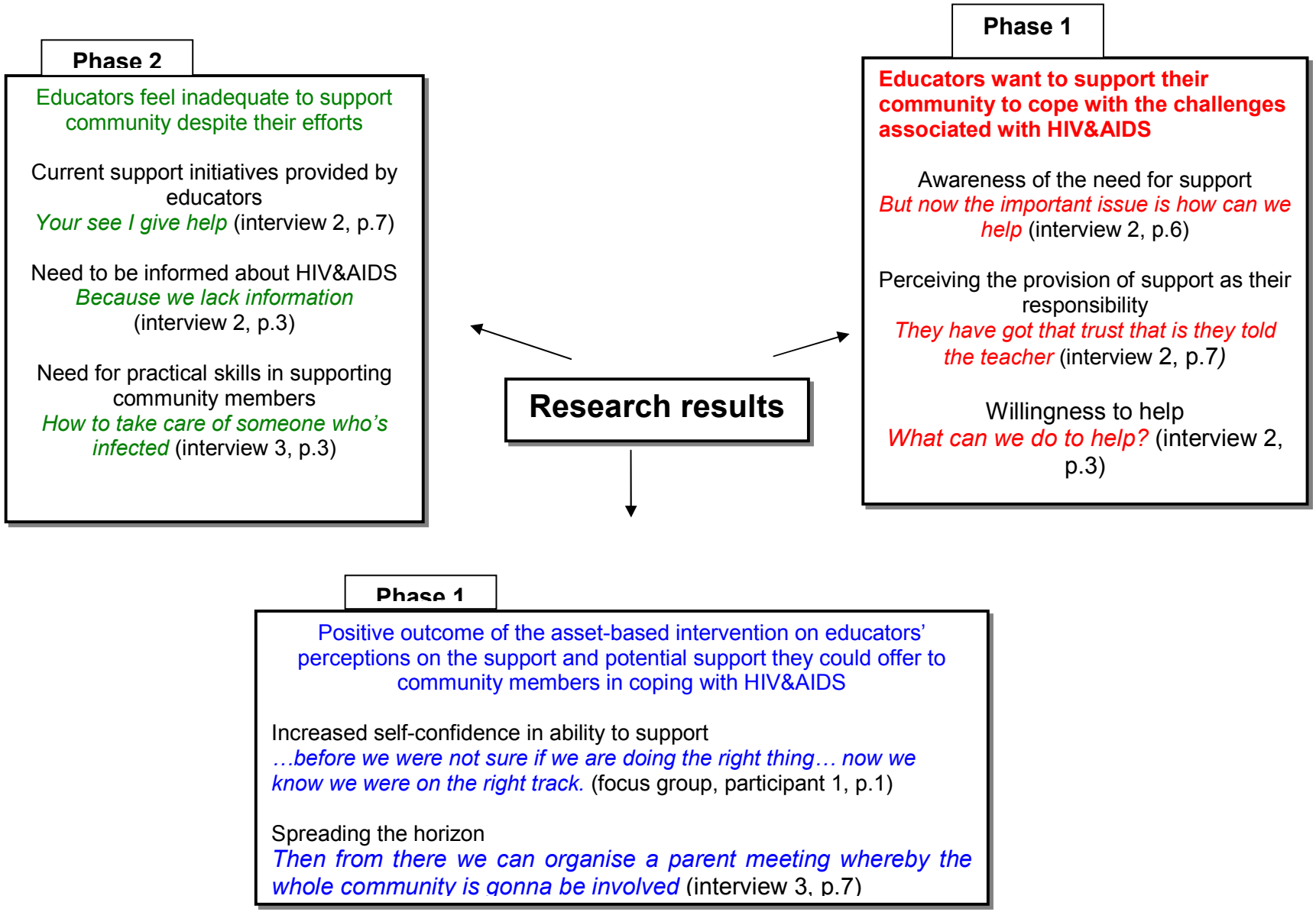
During individual interviews I was guided by the following interview protocol themes, which emerged from my analysis of the transcripts of Ferreira's (2006) initial field work, as well as the theoretical framework of the asset-based approach: the various resources (assets) the educators (participants) 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] Interview 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

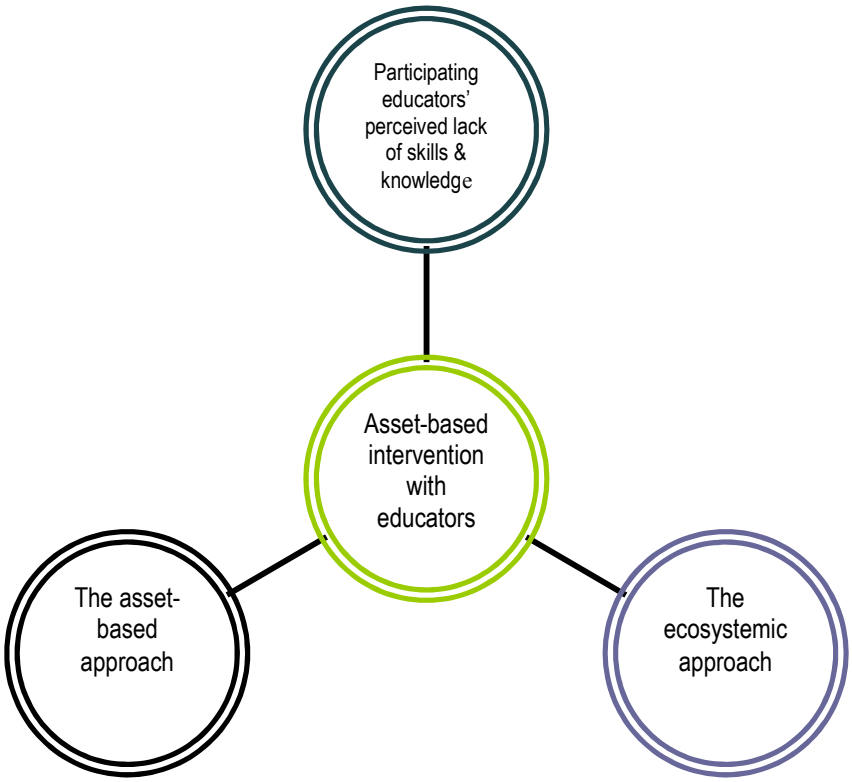


Figure 4.2: Framework for the development of the asset-based intervention

- 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

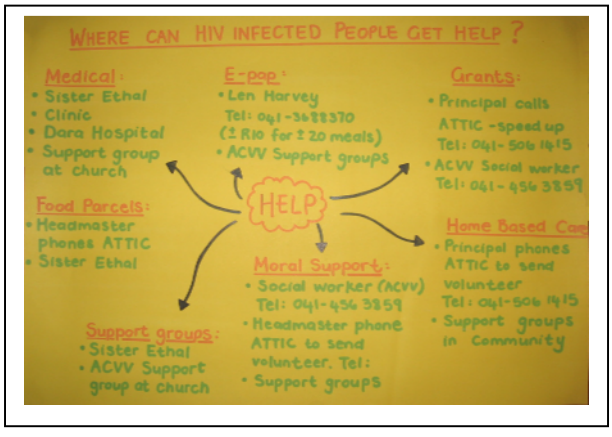
[9] Please note that this theme refers to physical care but in the spirit of Interpretivism I chose to use the words of the participants.

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.

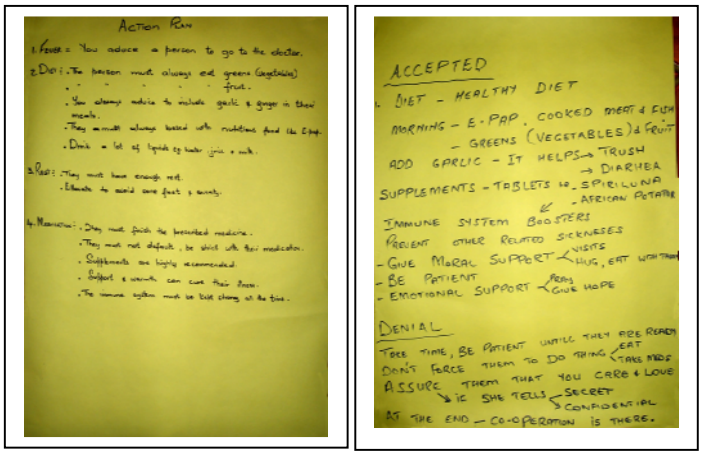


Figure 4.4: Visual representation of the action plans posters made by participants

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.

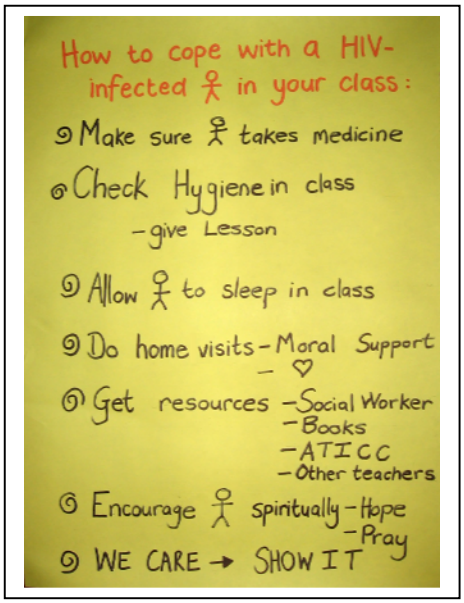


Figure 4.5: Visual presentation of integrated poster on coping with an infected child in a classroom

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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