

**EXPLORING WAYS OF ASSISTING LESOTHO EDUCATORS TO  
OFFER CARE AND SUPPORT TO CHILDREN ORPHANED AND  
RENDERED VULNERABLE BY HIV AND AIDS**

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**EXPLORING WAYS OF ASSISTING LESOTHO EDUCATORS TO  
OFFER CARE AND SUPPORT TO CHILDREN ORPHANED AND  
RENDERED VULNERABLE BY HIV AND AIDS**

**BY**

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**Thesis submitted in fulfilment of the requirements for the degree of  
Doctor Philosophiae in the Faculty of Education at the Nelson  
Mandela Metropolitan University**

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**Promoter : Professor Lesley Wood**

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## DECLARATION

I, Grace Makeletso Ntaote, student number 208090594, hereby declare that the thesis for the degree of Doctor Philosophiae (PhD) is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

Signature -----

Date -----

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## ABSTRACT

The HIV and AIDS pandemic has resulted in 14 million children being orphaned worldwide. In Lesotho alone, where this study was carried out, there are about 180 000 of these children (UNAIDS, 2007). Teachers, especially in Lesotho's primary schools need to be equipped to better deal with the challenges that result from having these children in their classrooms.

At the Lesotho College of Education, where I have worked for 12 years as a teacher educator, pre-service and in-service student teachers are not trained to offer care and support to orphans and vulnerable children. They experience problems in the classroom emanating from the needs of these children.

This study followed an action research design to find ways to support teachers to better deal with the issues they face as a result of having orphans and vulnerable children in their classes. Using a qualitative approach, educators perceptions, feelings, attitudes and experiences in dealing with orphans and vulnerable children in their schools were identified, and it became apparent that educators were negatively affected on a personal and professional level.

It was concluded that the development of resilience in educators would help them to better cope with orphans and vulnerable children in their classes. The chosen intervention Resilient Educators Programme (REds) was implemented and evaluated and findings revealed that it was beneficial in increasing educator resilience. Recommendations, based on the findings of the study, were made for future teacher education in this area.

**KEY WORDS:** HIV and AIDS education; teacher training; educator resilience; action research

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## **OVERVIEW OF RESEARCH STUDY**

### **0.1 INTRODUCTION**

The aim of this research overview is to highlight the process that I followed in this study. Since the research design can be quite complicated to explain and describe, due to the different methodologies used at each step of the action research process, I want to provide a clear overview of the study and explain how I tried to simplify the design to make it easier to follow. The overview contains the background to, and the framework for, this study; the purpose and research questions that guided it; and the research design and methodology, and the key concepts used in the context of the study. It concludes with an outline of the research design, presented in diagram form.

### **0.2 CONTEXT OF RESEARCH**

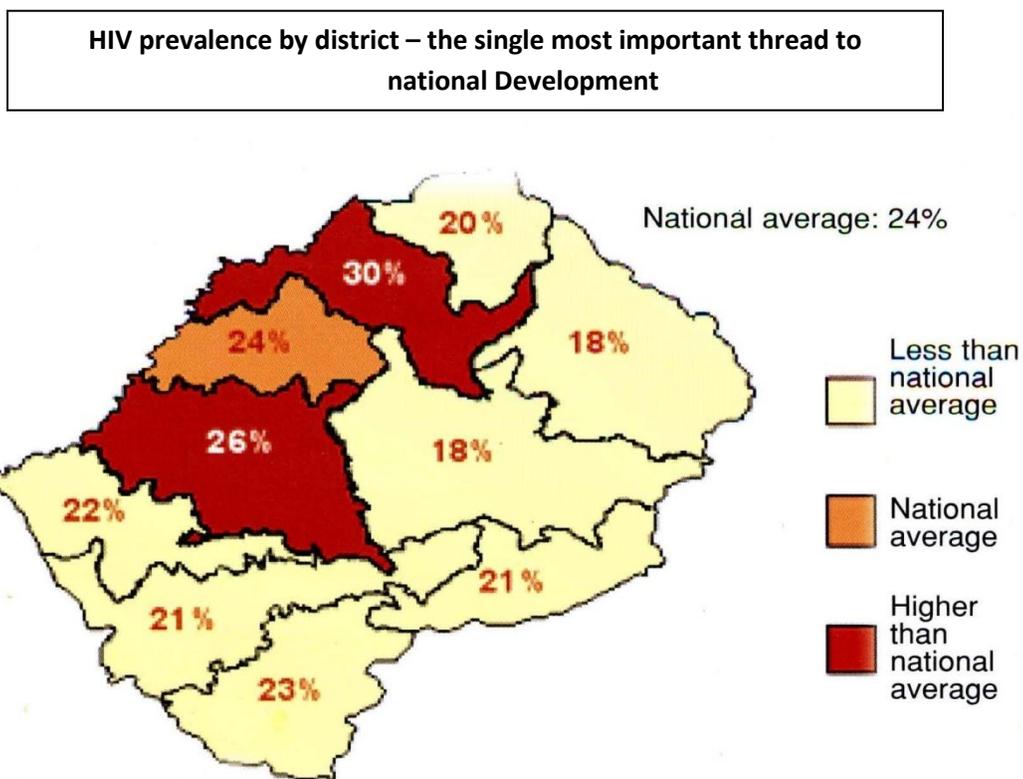
It is estimated that 33,2 million people globally are living with HIV and AIDS (Joint United Nations Programme on HIV/AIDS [UNAIDS] / World Health Organisation [WHO], 2007). Of this number, 22,5 million people are from Sub-Saharan Africa, and about 25% of them live in Lesotho. Since I am a teacher educator at the Lesotho College of Education (LEC), the locality of this study is Lesotho. Lesotho is a small country, completely surrounded by South Africa. The country is just over 30 000 km<sup>2</sup> in size. All the land is over 1 500 m above sea level the only country in the world with this distinction, earning it the name of “the kingdom in the sky”. Its population is just over 2 million. It has a fragile environmental base and, except for water and some diamonds, it has few natural resources (Vilakati, 2001; Bureau of Statistics, 2003; Silase, Morrison and Letsoela, 2004).

Historically, Lesotho’s main export has been labour. It provides South Africa with semi-skilled labour for the mining industry; however, the number of semi-skilled labourers joining the mines from Lesotho has declined over the past 14 years. Despite the

country's relatively few natural resources, the fragile environmental base and the poverty affecting a majority of households, most citizens have access to a variety of social services, such as portable water, education infrastructure, roads and health services (Vilakati, 2001; Silase et al., 2004).

Like many other countries in Sub-Saharan Africa, Lesotho has been seriously affected by the HIV and AIDS pandemic (UNAIDS, 2008). It is one of the six countries in Southern Africa affected by the humanitarian crisis fuelled by poverty, unemployment and the HIV and AIDS pandemic.

**Figure 0.1: Lesotho's HIV prevalence by district**



**Percentage HIV positive among men and women age 15-49: DHS2004**

The HIV and AIDS pandemic is considered to be a leading cause of morbidity and mortality in Lesotho (UNAIDS, 2007). According to UNAIDS, (2008), 18 000 people have died of AIDS and more than 20% of the population is living with HIV. Currently, the

incidence of HIV and AIDS remains high, estimated to be 23,2% (National AIDS Commission [NAC] and UNAIDS, 2008) among the adult population, making Lesotho the country in the world third hardest hit by the pandemic.

HIV and AIDS affects all sectors of the society, however there are many factors which contribute to Lesotho's HIV and AIDS statistics not being accurate. These include misconception about HIV and AIDS and also most people do not want to know their HIV status due to lack of education and the stigma attached to the disease. There is also lack of resources and poor infrastructure. Almost one in four (23.2% [21.9%-24.7%]) adults (15-49 years) were living with HIV in 2005 (UNAIDS, 2007), with infection levels highest in urban areas. Women account for about 57% of people living with HIV, with prevalence among antenatal clinic attendees reaching 38% in the 25-29-years age group in 2005 (Ministry of Health and Social Welfare, Lesotho, 2005 ). Table 0.1 below shows Lesotho's HIV and AIDS statistics.

**Table 0.1: Lesotho's HIV and AIDS statistics (UNAIDS, 2008)**

Indicator	2005	2007	% Variation
Adult prevalence rate	23,2%	23,2%	0
HIV infected people	266 000	270 000	1,5%
Adult HIV incidence rate	2,9%	2,35%	(19%)
Number of new infections	26 000	21 558	(17%)
AIDS mortality	24 000	18 000	(25%)
AIDS related OVCs	97 000	108 700	12%
Projection of ART needs	42 640	81 270	91%

In 2005, the government of Lesotho realised that the AIDS pandemic was not only a health problem, but also a development issue impacting on a broad spectrum of spheres. In response, the government introduced a new AIDS programme. Through joint efforts with community-based organisations and the United Nations, support to orphans and children living with HIV was improved. Groups that are most at risk of being infected include former miners, migrant labourers, factory workers, the unemployed, female sex workers and young people, especially teenage girls (UNAIDS, 2007).

Fewer than 10% of 18 to 19 year old women are HIV positive; however, by the time they turn 22, 30% will be infected, and by age 24, nearly 40% will have HIV, according to UNAIDS (2007). Children are a particularly vulnerable group, because they are infected through mother-to-child transmission, and they are also affected by the loss of a parent to AIDS. According to UNAIDS (2007), 18 000 children under the age of 14 years are infected with HIV. Approximately 97 000 children under the age 18 years have been orphaned by the epidemic. According to Ministry of Health and Social Welfare Lesotho (2005), 34% of the children attending school have lost one or both parents to AIDS.

Moreover, several factors are driving Lesotho's epidemic, including high levels of casual sex, coupled with low levels of condom use. Moreover, an extremely low percentage of the population know their HIV status. Two-thirds of men and one-third of women reported having sex with someone other than their long-term partners in the last 12 months, according to UNAIDS (2007). Less than 50% used condoms. Intergenerational sex is another factor, especially among women aged 14 to 24 years (14.3%) more than two and half times higher than the prevalence rate in men of the same age. Moreover, according to the UNAIDS (2007), in 2007, only 9.2% of men and 14% of women knew their HIV status.

Major risk behaviours that contribute towards rapid and rampant HIV infection in Lesotho include low levels of knowledge, inadequate access to HIV and AIDS

information and services, multiple and concurrent sexual relationships, high levels of unprotected sexual practices, which expose individuals to the risk of STIs and HIV, early sexual activity, alcohol and drug abuse, coercive sex, intergenerational sex and contact with contaminated blood. Contributing socio-cultural factors include income inequality, high levels of poverty, which create situations of risk, unemployment, mobility, gender inequalities and gender based violence, cultural, and traditional beliefs, together with dramatic social, attitudinal and cultural changes (Kimaryo, Okpaku, Shongwe and Feeney, 2004; UNAIDS, 2006). Socially, life expectancy has dropped to 44 years for women and 39 for men. The estimated prevalence rate among the adult population is around 25%, although UNAIDS figures (see Table 01) puts it at 23%. Other estimates have put it at up to 29% (Kimaryo et al., 2004; UNAIDS, 2005; Ministry of Education and Training, Lesotho, n.d.; Kaiser Family Foundation, 2007). Another problem arising from the early deaths of young adults is that elderly people are compelled to care for their grandchildren, at a time in their lives when they could reasonably have expected their children to care for them. Infant mortality has also risen, due to mother-to-child transmission (UNAIDS, 2000; Hosegood, McGrath, Herbst and Timaeus, 2004). The increasing number of HIV and AIDS cases has overburdened health services. Poverty and the unequal distribution of wealth are exacerbated in countries that are hard hit by the HIV and AIDS pandemic, such as Lesotho (Ledward, 1997; United Nations Development Programme [UNDP], 2005).

The HIV and AIDS pandemic is depleting both skilled and unskilled labour in Lesotho. It also erodes traditional coping methods by reducing the capacity of households to produce and purchase food, depleting household assets and exhausting social safety nets. One of the causes of the rapid expansion of the pandemic in Lesotho is the culture of silence around sexuality, and the stigma attached to the pandemic, which results in a broad denial of HIV and AIDS (Kimaryo et al., 2004 ; UNAIDS, 2006).

In many hard-hit countries in Sub-Saharan Africa, people are dying at their most productive ages, because of the HIV and AIDS pandemic (UNAIDS, 2006). Trained people such as educators, farmers, doctors and economists become ill and/or die,

leaving serious gaps in the professional workforce, which hampers future social and economic development (World Food Programme [WFP], 2002; Food and Agricultural Organisation of the United Nations [FAO] /WFP, 2004). For example, if a male or a female farmer dies at the age of 30 years, the national economy loses not only his/her labour force, but also his/her production for the next 20 to 30 years. In other words, during all these years he/she is expected to produce not only for himself/herself, but also a surplus for the market (UNDP, 2005; UNAIDS, 2006). It is estimated that the rate of infection of 10-13% among adults in hard-hit countries could result in a reduction of the national income of up to 30% ( UNDP, 2005 ;UNAIDS, 2006).

With the substantial number of adult deaths, the number of children orphaned by the HIV and AIDS pandemic is increasing dramatically. There are 14 million orphans worldwide. In Lesotho only, there are about 180 000 orphans and vulnerable children, of which 110 000 are believed to have been orphaned by the HIV and AIDS pandemic (United Nations Children's Fund [UNICEF], 2006). In addition to the growing number of orphans, many non orphaned and/or vulnerable children are affected by the pandemic, rendered vulnerable in terms of not having their needs met (UNAIDS IATT, 2004).

The socio-economic impact of HIV and AIDS is threatening the well-being of orphans and vulnerable children in Lesotho. According to Byrne (2002), these children are struggling to survive. They are at risk of malnutrition, illness, abuse, child labour, sexual exploitation, migration, homelessness, and reduced access to education and health care. These children also face stigma, social isolation and discrimination through association with HIV and AIDS. Psychological Problems such as depression, guilt and fear are also prevalent among these children (UNICEF/UNAIDS/WHO, 2002).

These children often experience long periods of absenteeism from school due to their difficult home circumstances and, as a result, they lose out on classroom instruction. More often than not, they may never go back to school, thereby dropping out completely before completing primary education. As many become heads of households or care for their sick parents and other siblings and, as a result, they may have to leave school and

find employment in order to support their families financially (World Bank,2002; Stein, 2003; Kimaryo et al., 2004; Subbarao and Coury, 2004; UNICEF, 2006).

Those who manage to go back to school after their parents' deaths suffer profoundly from psychosocial distress due to the impact of having had to care for their terminally ill and ultimately dying parents (Kimaryo et al., 2004). This situation, if not properly attended to, will affect their performance at school. Because of the trauma of seeing their parents die from HIV and AIDS, many lose the motivation to go back to school (Carr-Hill, Kataro, Katahoire and Oulai, 2002; World Bank, 2002).

Common psychosocial effects of family trauma, such as parental death and the death of a guardian, are anxiety, fear, self-blame and depression in children who witnessed their parents' terminal illness (Mallmann, 2003). Upon parental death, loneliness and the loss of parental love and guidance often compound these emotions. If such children are not provided with quality psychosocial support from families, community members and, most of all, educators during the terminal phase of their parents' illness, they experience many emotions which are usually suppressed and then, later, manifest in destructive ways (Ebersöhn and Eloff, 2002; Mallmann, 2003).

Some children run away from school for fear of being stigmatised and discriminated against by peers and educators. Children whose parents have died due to an HIV and AIDS related illness are often stigmatised by the community, ignorance about the pandemic leads to a stigma being attached to HIV and AIDS. It must be pointed out that even schools and educators may stigmatise children because their parents have died of an HIV and AIDS related illness, albeit unwittingly (UNICEF, 2003; Wood and Webb, 2008). A common misconception is that these children are HIV positive themselves. They are humiliated by educators and their peers, so they may feel very uncomfortable at school and want to drop out (Hepburn, 2001; UNICEF, 2002).

Other factors also contribute to psychological distress. For example, when parents die, children may not be able to access any guidance and counseling, and special care and

support from the school, due in part to, the inability of school educators to provide care through quality psychosocial support (International HIV/AIDS Alliance, 2003). Educators therefore need to be empowered and capacitated in understanding children who are nursing a debilitating parent or parents. They also need to be empowered and capacitated in assisting those who have experienced parental death due to HIV and AIDS (Mallmann, 2003). Surviving relatives sometimes force these children into harmful child labour. Some children are subjected to sexual exploitation by the very same relatives (Brakash, 2005).

Economic hardship is a key factor in influencing the school attendance of orphans and vulnerable children. For example, when parents become sick with an HIV and AIDS related illness or AIDS, the household income decreases and health care expenses increase, forcing the children to drop out of school since they can no longer afford fees or uniforms (Ebersöhn and Elloff, 2002). If these children are able to attend school, they are confronted with additional finances that may be required by the school, despite the Free Primary Education (FPE) initiated by the Lesotho government. Examples of these additional expenses may include transport fares and fees for recreational activities. In many families, any savings are used for medication and treatments, traditional ceremonies and funerals (Hunter and Williamson, 2000; World Bank, 2002).

The abject poverty that these children are subjected to also leads to malnutrition. According to Hunter and Williamson (2000) and Stein (2003), children are at a higher risk of infection by opportunistic infections when they are malnourished. Lack of proper nutrition also affects their inability to concentrate in class and to learn, meaning that even though they may be attending school, little education takes place (World Bank, 2002; Stein, 2003; Human Rights Watch, 2005).

According to Kimaryo et al., (2004), property grabbing is another feature that manifests itself among communities in Lesotho. Many orphans who are forced to move from their homes to live with elder relatives, usually uncles, lose their right to inheritance. The property and other assets that were left to them by their parents are taken from them by

their caretakers or guardians, and never returned. These include money, homes, fields for food production, cars, furniture and clothes. It is also a common practice in Lesotho for relatives to begin to misappropriate the affected children's inheritance from the time when their parents fall ill, that is, even before they die and are buried. These children are then left destitute and in abject poverty (Ministry of Health and Social Welfare, Lesotho, 2001).

The situation is disturbing. In order to address the problems encountered by orphans and vulnerable children in Lesotho, the Government of Lesotho (GoL) has ratified the UN Convention on the Rights of the Child (1989). It has also committed itself to the outcomes of the UN General Assembly Special Session (UNGASS) on HIV and AIDS (May, 2002) and the UNGASS Convention on Children (2002).

Lesotho is a signatory to a number of international agreements dealing with education and the protection of the rights of children. Among these is the Convention on the Rights of the Child (United Nations, 1989); the Salamanca agreement (UNESCO, 1994); the Dakar Framework for Action (UNESCO [United Nations Educational, Scientific and Cultural Organisation]/ Ministry of Education and Science, Spain, 1994); the Dakar Framework for Action (UNESCO/EFA [Education For All Forum],2000) and Standard Rules on the Equality of Opportunities for Persons with Disabilities (UN, 1993), to mention but a few. All these agreements state that education is a fundamental human right for all children, which should be accessed without discrimination. Orphans and vulnerable children are, by definition, included in these educational commitments (UNESCO Inter Agency Task Team on Education, 2003). Specifically, the conventions relating to the pandemic and its effects on children are the U.N. General Assembly Special Session (UNGASS) on HIV and AIDS (UNGASS, 2001) and UNGASS on children (UNGASS, 2002).

Due to the HIV and AIDS pandemic in Lesotho, primary school level enrolment, and indeed at all levels of the education system, is decreasing, despite the signed commitment of the Lesotho government towards the achievement of Education For All

(EFA) goals by 2015 and the Millennium Development Goals (MDGs). In Lesotho, introduction of free primary education (FPE) in 2000 saw 400 000 enroll for Primary 1, but in their last year in primary education, seven years later (Primary 7) only about 50 000 candidates sat for Primary School Leaving Examination (PSLE) (Ministry of Education and Training, Lesotho, n.d.).

According to UNESCO (2008), orphans and vulnerable children in Lesotho's primary schools drop out because their psychosocial needs are not catered for in schools. This would imply that educators have to be trained both at pre-service and in-service levels to address the accumulative psychological, social and economic effects of HIV and AIDS. Although educators may not be able to address the economic factors that contribute to the violation of orphans and vulnerable children's rights, they have a key role to play in addressing their cognitive, emotional, social and psychological needs. There is a dire need for educators to be capacitated with the appropriate knowledge and skills that will facilitate and enable the desired attitudes, values and willingness to deal with, and offer, care and support to orphans and vulnerable children in ways that make them feel as accepted as their non-orphaned counterparts (De Monchy, 2000; Save the children, UK, 1991; World Bank, 2002).

### **0.3 RATIONAL FOR RESEARCH**

The above situation poses a challenge to the government of Lesotho's Ministry of Education and Training (MOET) and, specifically, to the Lesotho College of Education (LCE), a teacher training institution in Lesotho. It is a well-known fact that the core role of teachers is educating children (UNESCO, 2008). However, with the advent of the HIV and AIDS pandemic in Lesotho and, indeed, in many Sub-Saharan African countries, this role has been increasingly complicated by factors, such as the need for counseling and emotional support educators have to give to, specifically, orphans and vulnerable children in their schools (Hall, 2004; Hoadley, 2007; Le Grange, 2008; UNESCO, 2008).

HIV and AIDS are caused by a combination of factors, so there is a need for a multidisciplinary approach to fight the disease (Commonwealth Secretariat, 2002). Educators play a key role in the development of skills and clarification of attitudes and educating children about the disease. If they are properly trained, they can help mitigate HIV infection among young people. Teachers need to be trained in recognising the behavioural problems associated with unresolved grief. A teacher's attitude can do much to promote the acceptance, rejection and/or stigmatisation of an orphan in a classroom (Mallmann, 2003).

The HIV and AIDS pandemic has increased the number of orphans and vulnerable children in Lesotho (Ministry of Education and Training, Lesotho, n.d.; UNICEF, 2007). There has been a corresponding increase in the number of children who may be regarded as having special educational needs, since orphans are especially vulnerable to emotional, social and behavioral problems that are barriers to learning (Ministry of Education and Training, Lesotho, n.d.).

Because of the soaring number of orphans and vulnerable children in Lesotho, the government of Lesotho, through the Ministry of Health and Social Welfare and the Ministry of Education and Training, has adopted policies to ensure that orphans and vulnerable children receive care and support and access to education. However, if such policies are to be implemented, educators need to be empowered and equipped to implement same. The following table outlines the undertakings of the Government of Lesotho to provide structures for support and care to orphans and vulnerable children, and what these undertakings would require from educators.

**Table 02: Lesotho's National Policy on Orphans and Vulnerable Children (UNICEF, 2006)**

<b>Government of Lesotho undertakes to:</b>	<b>Educators in Lesotho would then need to be able to:</b>
<ul style="list-style-type: none"> <li>Promote the establishment of mechanisms to ensure that communities, families and institutions care for orphans and vulnerable children.</li> </ul>	<ul style="list-style-type: none"> <li>Help strengthen the capacity of the school community to protect and care for orphans and vulnerable children.</li> </ul>
<ul style="list-style-type: none"> <li>Ensure that orphans and vulnerable children have access to education.</li> </ul>	<ul style="list-style-type: none"> <li>Offer quality education and provide counseling and support services to help orphans and vulnerable children to remain in school.</li> </ul>
<ul style="list-style-type: none"> <li>Establish a sustainable, non-discriminatory targeting system for orphans and vulnerable children.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that orphans and vulnerable children are able to be identified and supported without provoking stigmatisation, labeling or exclusion.</li> </ul>
<ul style="list-style-type: none"> <li>Establish and maintain a unified, simplified and decentralised registration system at village level for births, deaths and the registration of orphans and vulnerable children.</li> </ul>	<ul style="list-style-type: none"> <li>Identify orphans and vulnerable children at school and ensure that these children are registered.</li> </ul>
<ul style="list-style-type: none"> <li>Provide mechanisms for support and protection of child-headed households to safeguard their best interests.</li> </ul>	<ul style="list-style-type: none"> <li>Create a safe environment for orphans and vulnerable children to reveal their needs and act as mediators between children and support services.</li> </ul>

<ul style="list-style-type: none"> <li>• Develop guidelines and minimum standards for care of orphans and vulnerable children to ensure protection of their inherited property until they attain the age of maturity.</li> </ul>	<ul style="list-style-type: none"> <li>• Educate children about their rights to inheritance and property.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop guidelines and minimum standards of care that would ensure that orphans and vulnerable children are not exploited or abused.</li> </ul>	<ul style="list-style-type: none"> <li>• Protect orphans and vulnerable children against any form of exploitation and abuse.</li> </ul>
<ul style="list-style-type: none"> <li>• Promote and strengthen programmes to safeguard the food security of orphans and vulnerable children and their guardians.</li> </ul>	<ul style="list-style-type: none"> <li>• Make sure that orphans and vulnerable children have access to basic needs such as food, clothing, shelter and basic health services.</li> </ul>
<ul style="list-style-type: none"> <li>• Promote skills training and livelihood opportunities for orphans and vulnerable children (Ministry of Health and Social Welfare, 2005).</li> </ul>	<ul style="list-style-type: none"> <li>• Educate children about HIV and AIDS and life skills and provide access to skills training (Ministry of Education and Training, 2006/7; UNICEF, 2006).</li> </ul>

The care, support and protection of orphans and vulnerable children mandate all stakeholders to participate actively in the national response towards the achievement of Basotho<sup>1</sup> communities that are well informed about HIV and AIDS. School educators are regarded as key persons in addressing issues affecting children affected by HIV and AIDS. This means that educators in the primary schools of Lesotho would consequently need to be equipped in the following content areas in order to be able to respond effectively to the needs of children in their classrooms and to implement the policies formulated by the Ministry of Health and Social Welfare:

- Psychosocial support for attaining the needs of orphans and vulnerable children and basic counseling skills.

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<sup>1</sup> People from Lesotho

- Experiential learning strategies.
- The rights and responsibilities of orphans and vulnerable children
- Effective communication with orphans and vulnerable children.
- Recognition of and dealing with child abuse.
- Facilitation of dialogue between parents and children about illness, death, and future planning and consultation.
- Children's response to death during different stages of development.
- Management of stress in bereaved children.
- Managing educators' stress.
- A holistic approach to assist children living with AIDS.
- Involving communities to address the issues associated with orphans and vulnerable children (International Institute for Educational Planning, 2003; Mallmann, 2003).

The impact of the HIV and AIDS pandemic on education calls for a different approach to teaching as well as a new set of teaching competencies (Poole & Lamb, 2001; Wood, 2008). Since the training of educators at the Lesotho College of Education to date has not really addressed these new demands, it cannot be assumed that most educators in Lesotho are able to offer care and support to orphans and vulnerable children and, because they lack such skills, this makes it difficult for them to handle these children in schools (UNESCO, 2008). It also cannot simply be assumed that educators, who are primarily trained to teach subject content such as Science or Mathematics, History or Economic Sciences, will be able to offer care and support to traumatised children.

Apart from content knowledge and the acquisition of the skills needed to offer care and support, it is also important for educators to have a sound self-understanding and self-knowledge that will allow them to explore, understand and clarify their values, attitudes, inhibitions, prejudices, anxieties and fears around HIV and AIDS and related issues. This will allow them to better function on both intrapersonal and interpersonal levels. In

this way, educators will also be helped to realise their important task as role models for their learners in the context of HIV and AIDS (UNAIDS, 2002). The whole issue of helping educators to deal with issues of HIV and AIDS on a personal level, before asking them to deliver the curriculum to their learners, is increasingly seen to be critical in ensuring the success of any HIV prevention education and in providing care and support (Wood, 2008).

Educators need to be properly prepared for their role as educators in a world affected by HIV and AIDS. Educators themselves have been dramatically affected by HIV and AIDS, which have created major additional problems and challenges in the classroom for them. They require support and skills to promote participatory, gender sensitive and right-based approaches to HIV and AIDS affected and/or infected children. Educators must prepare all their learners, including orphans and vulnerable children, for a life in which they will be protected from contracting HIV and a life that will motivate them to live in a manner that will reduce their risk of infection; help them to contribute to the care, support and treatment of infected learners and play some part in mitigating the damaging effects of sickness and death as a result of HIV and AIDS (Fox, 2001). This kind of training would therefore need to ensure that both pre- service and in-service educators at the Lesotho College of Education (LCE) engage with the pandemic to the level that initiates the educators' transformation into committed, responsible and effective agents of positive social change (Fox, 2001).

From my experience as a teacher educator, I am aware that at the LCE, pre-service and in-service educators are not trained to offer care and support to orphans and vulnerable children. However, in line with the policy of Education For All and the Convention on the Rights of the Child (UN, 1989), educators should help these children to become productive members of society by providing them with quality education, taking care of them and providing them with a safe and healthy environment..

Currently, educators are equipped only with basic knowledge about the prevention of HIV and AIDS, although they are able to pass this on to their learners, prevention education alone is not enough (Coombe, 2000; Coombe, 2003; Hall, et al., 2005; Bennell, 2006; Bhana, Morrell, Epstein and Moletsane, 2006; Schulze and Steyn, 2007; Theron, 2007; Wood, 2008). Educators should be trained to be able to offer both prevention education and care and support. Educators may require guidance on dealing with issues such as confidentiality, identifying and making better use of resources outside educational institutions, including medical, psychological, social and other services. They may also require training in promoting access to counseling, care and prevention in supporting colleagues and learners and in helping schools to deliver the curriculum that the learners need.

Therefore, there is an urgent need for the LCE to expand and improve the current teacher training initiatives to enable future and current educators to not only help meet the basic needs of orphans and vulnerable children, but to also be able to offer psychosocial support and basic counseling services (UNESCO, 2008). By so doing, educators will be able to play a crucial role in improving the prospects of these children, because orphans and vulnerable children need to be assisted holistically (Vandemoortele & Delamonica, 2002; Mallmann, 2003).

Like all children, orphans and vulnerable children have the right to learn and develop in a structured and supportive school environment. Education is vitally important for them, as it is an effective way of reducing both the impact and the spread of the HIV and AIDS pandemic (Vandemoortele & Delamonica, 2002; World Bank, 2002; De Walque, 2004). A good school with a competent teacher can develop the self-esteem of orphans and vulnerable children and also facilitate better job opportunities and economic independence (Save the Children UK, 1991).

However, before any training initiatives or curricula can be developed, it will be necessary to first ascertain the perceptions and needs in relation to orphans and vulnerable children of educators who are currently teaching. It is important to recognise educators as key partners in the care and support of orphans and vulnerable children, because these educators experience major challenges in the classroom emanating from the needs of this specific group of children. Educators need to be part of the challenges identified and the solution thereto, since they are key role players. Only when these problems have been identified, can any effective interventions be developed.

As a teacher educator at the LCE, I chose to carry out research in this field as this will equip me with the knowledge and skills to make recommendations for practical training in order to better ensure that future and current educators can respond to the needs of orphans and vulnerable children.

#### **0.4 PROBLEM STATEMENT**

It is important for the LCE to train both in-service and pre-service educators on ways of better coping with the challenges that result from having orphans and vulnerable children in their classrooms. This would necessarily entail the creation of a physical, social and emotional climate that will enhance quality teaching and learning. Because educators experience challenges and problems in the classroom emanating from the needs of orphans and vulnerable children, it is imperative for the LCE to facilitate the development of skills, knowledge and attitudes to address these challenges facing these educators in providing quality education to learners.

However, educators graduating from the LCE do not possess sufficient and targeted training to offer adequate care and support to orphans and vulnerable children. This is despite the fact that it is stated in the College calendar that the College's mission is to train and produce educators who are competent for the school system of Lesotho and

who are also able to offer necessary services in the community (Lesotho College of Education [LCE] Calendar, 2008:6).

## **0.5 RESEARCH QUESTIONS**

Based on the problem statement above, the following research questions have been formulated to guide the study:

***What are the experiences, perceptions and needs of educators in Lesotho concerning the teaching of orphans and vulnerable children?***

***How can Lesotho educators be helped to better cope with the challenges that result from having orphans and vulnerable children in the classroom?***

## **0.6 PURPOSE OF RESEARCH**

This study aims at determining the lived experiences of educators who are dealing with orphans and vulnerable children in their classrooms. Through the identification of educators' feelings, attitudes and experiences, the needs they have in this regard can be identified and addressed by the provision of practical guidelines and/or the implementation of an intervention.

The primary purpose of this research is, therefore, to find ways of enabling educators in Lesotho to better offer care and support to orphans and vulnerable children. In order to do this, the following objectives have been formulated.

## **0.7 OBJECTIVES OF RESEARCH**

The specific objectives formulated to realise the aims of this research are:

- To investigate the lived experiences and needs of educators as they attempt to offer care and support to orphans and vulnerable children.
- To use the findings to develop guidelines and/or interventions that will help educators to better cope with the challenges that result from having orphans and vulnerable children in their classrooms.
- To pilot these guidelines/intervention with a group of educators in order to evaluate and refine them.

In summary, this research will assess Lesotho primary school educators' perceptions on the teaching of orphans and vulnerable children. The findings will be used to develop guidelines and/or interventions that will enable educators to better cope with the challenges that result from having the children in question. The guidelines, and/or interventions will be piloted, evaluated and refined with a group of educators in selected schools in Lesotho.

## **0.8 CLARIFICATION OF CONCEPTS**

Below is a definition of the key concepts as used in the context of this research.

### **0.8.1 HIV**

HIV stands for human immunodeficiency virus. This is the virus that causes acquired immunodeficiency syndrome (AIDS). HIV is different from most other viruses, because it attacks the immune system. The immune system gives one's body the ability to fight infections. HIV finds and destroys a type of white blood cells (T cells or CD4 cells) that the immune system must have to fight disease. People with HIV are said to have AIDS when they develop certain infections, such as cancer or when their CD 4 count is less than 200. Having HIV does not always mean that one has AIDS. It can take many years for a person with the virus to develop AIDS. HIV cannot be cured. Although people with the virus are likely to die from an AIDS-related illness, there are ways to help people stay healthy and to live longer (Du Preez, 2004; Stine, 2004; Van Dyk, 2005; Soul City: Institute for Health and Development Communication, 2005).

### **0.8.2 AIDS**

AIDS stands for acquired immunodeficiency syndrome. Acquired means that the disease is not hereditary, but that it develops after birth from contact with a disease-causing agent (in this case, HIV). Immunodeficiency means that the disease is characterised by a weakening of the immune system. Diseases, known as opportunistic infections, then attack because the breakdown of the immune system leaves the body vulnerable. Syndrome refers to a group of symptoms that collectively indicate or characterise a disease. AIDS is the final stage of HIV infection. When the CD4 count drops to a low level, a person's ability to fight infection is lost, making the person susceptible to other life threatening infections. In addition, several conditions occur in people with HIV infection with this degree of immune system failure, AIDS defining illnesses. AIDS is diagnosed by a physician using specific clinical or laboratory standards (Ross & Deverell, 2004; Soul City: Institute for Health and Development Communication, 2005; Stedman's Medical Dictionary, 2005; Van Dyk, 2005).

### **0.8.3 Care and support**

According to the Concise Oxford English Dictionary (2000), care is the provision of what is necessary for health, while support means to give assistance or some encouragement. This is a broad term referring to the steps taken to promote and sustain a person's wellbeing through medical, psychosocial, spiritual and other means.

In the context of HIV and AIDS, orphans and vulnerable children need care and support. They need nurturing, access to good accommodation, diet, clean water and medical treatment. These children also need love from family and community members, moral support, acceptance, respect, help from friends, families and the community, as well as supportive laws to protect them against discrimination and stigmatisation. The care that they get from their caregivers helps them develop to their full potential. Care also enables these children to develop a sense of self-worth and belonging, which is essential for them to learn and develop life skills, to participate in society and to have faith for the future (Subbarao, Mattimore and Plangemann, 2001).

Orphans and vulnerable children also need psychosocial support, which can be defined as an ongoing process of meeting their physical, emotional, social and spiritual needs. All of these needs are considered to be essential elements for meaningful and positive human development. Psychosocial support goes beyond the provision of physical or material needs (Richter, 2006). According to Mallmann (2003), such support is essential for orphans and vulnerable children, because it helps them to become resilient. It also helps orphans and vulnerable children to deal with difficult situations and the challenges they are faced with.

#### **0.8.4 Orphan**

The term orphan has different meanings in different contexts. According to UNICEF (2000), an orphan is a child who is under the age of eighteen, and who has lost at least one parent. UNICEF gives examples of different types of orphans, namely:

Paternal orphans: children under the age of eighteen whose fathers have died.

Double orphans: children under the age of eighteen who have lost both parents (UNAIDS/UNICEF/USAID, 2004).

On the other hand, Kimaryo, et al. (2004) state that in Lesotho, and in other parts of Africa, an orphan does not relate to age; anyone who has lost a parent is an orphan. In this research, orphan will be understood to mean a child under the age of eighteen years who has lost at least one parent (UNAIDS/UNICEF/USAID, 2004).

#### **0.8.5 Vulnerable children**

According to Sabbarao, et al. (2001) and Hepburn (2001), vulnerable children are children who belong to high-risk groups and who lack access to basic social facilities. These children's survival, well-being and development are threatened. Sabbarao, et al. (2001) also state that the vulnerability may be caused by specific sets of factors or circumstances in different countries. The main source is HIV and AIDS, as well as conflict. Vulnerable children include street children, children exposed to strenuous labour, children engaged in sex trafficking and commercial sex, and children affected by poverty, war, domestic violence and alcohol abuse by parents.

UNICEF/UNAIDS/USAID (2004) do not use acronyms such as "OVC" for orphans and vulnerable children. The argument is that they are commonly used to identify particular children at community level and that, since children orphaned by HIV and AIDS report that they experience stigma and discrimination on many levels and in all aspects of their

lives, they prefer to be called just “children”. However, the acronym will be used in this study, because it is a commonly accepted terms (UNICEF/UNAIDS/USAID, 2004) to refer to children in school who have been rendered vulnerable as a direct or indirect consequence of HIV and AIDS.

## **0.9 RESEARCH DESIGN**

A research design is a plan or a strategy of how a researcher intends to conduct research in order to address the research question, essentially a plan aimed at enabling answers to be obtained from research questions (Burns 2000; Babbie and Mouton, 2001). Other definitions in the literature support the notion (Creswell, 1998; Cohen, Manion and Morrison, 2000) that a research design is a procedure for collecting, analysing and reporting on research.

According to Newman (2006), three main influential paradigms underpin the research design, namely the positivist approach, the interpretive approach, and the critical approach. In each one of these theories, it is important to determine the ontological, the epistemological and the methodological bases. Ontology specifies form and nature of reality (Guba & Lincoln, 1994); epistemology refers to how the creation of knowledge is theorised; methodology specifies how the researchers go about practically studying whatever they believe can be known (Babbie and Mouton, 2001). Table 3 below outlines the basic differences between these paradigms.

**Table 0.3: Outline of theoretical paradigms**

Theoretical paradigm	Ontology	Epistemology	Methodology
<b>Positivist</b>	A true reality exists, governed by cause/effect laws that can be discovered and generalised. People react in predictable ways.	Knowledge can be created and described using verified hypotheses that can then be taken to be laws to predict behavior.	Empirical, structured designs that can be replicated. Quantitative instruments used to measure. Research is taken to be value-free; research is controlled by researcher.
<b>Interpretivist</b>	Reality is subjective, determined by those involved in various social systems in interaction with each other. People's reactions depend on how they make meaning of their worlds.	Knowledge is socially constructed, therefore it is dynamic and changes according to how people make meaning of their situations; it is fluid and accurate.	Qualitative methodologies to try to understand the "insider" view; values are acknowledged; subjectivity of interpretation allowed for, researcher is co-creator of meaning.
<b>Critical</b>	Governed by structures that can be questioned, reconstructed through intentional critical	Knowledge is constructed by questioning existing power relationships	Participatory methodologies; values are explicit; researcher is

Theoretical paradigm	Ontology	Epistemology	Methodology
	reflection. People are agents of their own change.	within social, economic, political structures in order to distribute that power more equitably.	facilitator to encourage dialogue and raise critical consciousness.

(Guba and Lincoln, 1994; Schwandt, 1994; Newman, 1997; Henning, Van Rensburg and Smit, 2004)

Babbie and Mouton (2001) hold that a paradigm is a model or framework for observation and understanding, which shapes both what we see and how we understand it. A paradigm may be viewed as a set of basic beliefs or worldview that defines how one views the world and one's relationship with it (Guba and Lincoln, 1994). It follows, therefore, that in order for one to carry out research one has to place it within a paradigm, as it is the paradigm that will largely determine the research design chosen and the methodology used in gathering and analysing research data.

The paradigm that will be used to guide this study is based on critical theory. According to Babbie and Mouton (2001), critical theory focuses on a critical understanding of the situation or practice being researched in order to plan for transformative action. Since it provides enlightenment, it is said to be emancipatory or empowering. This is in line my ontological and epistemological beliefs (see Table 3), as I believe that educators have to find a way to free themselves from the currently oppressive situation in which they are teaching, created, to a large extent, by the impact of HIV and AIDS on education.

The *design* chosen for this study is that of action research, since its basic principles are in line with the critical paradigm. The critical research paradigm aims not only at explaining and understanding society; but also at changing it for the better. That is, it

focuses on a critical understanding of the situation or practice being researched, in order to plan for transformative action (Babbie and Mouton, 2001).

A participatory action research design will be followed to help the educators identify their concerns and needs in respect of the care and support of orphans and vulnerable children in order to take action to safeguard their right to a quality education. Participatory action research is a research design in which researchers and participants are equally involved in the research process and take equal responsibility for the outcome of the research (Mouton, 2001; Creswell, 2005). The focus is on the involvement of all roleplayers, including participatory involvement, action and change, encounter and dialectic dialogue (Schurink,1998; Kemmis and McTaggart, 2000; Strydom, 2005; Wadsworth, 2005). Hence, the research and the solutions to concrete problems will occur simultaneously. It is the type of research which is designed to address specific issues identified by local people and the results are directly applied to the problem at hand (Holman, 1987; Pottier, 1993; Schurink, 1998; Babbie and Mouton, 2001 ).

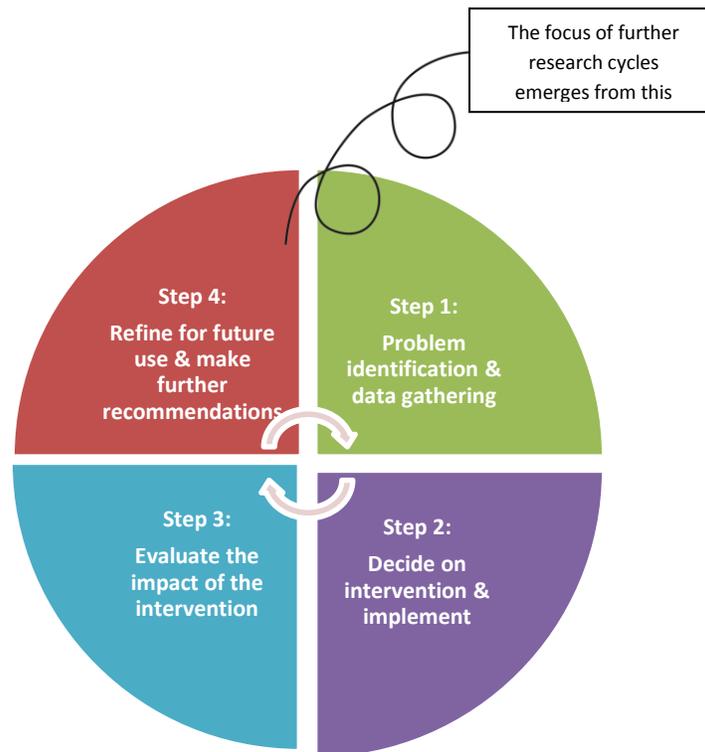
Research design can be either qualitative or quantitative in approach. According to Burns (2000), qualitative research is an enquiry approach useful for exploring and understanding a central phenomenon. Creswell (2003) contends that qualitative research is a field of study that cross-cuts through disciplines and subject matters. It is naturalistic, in that its goal is to understand behavior in a natural setting. Cohen et al, (2000) state that the qualitative research approach uses concepts and clarifications so as to attempt to interpret human behaviours in a way that reflects not only the analyst's view, but also the views of the people whose behavior is being described. The emphasis is on verbal description, as opposed to numerical description. Straus and Corbin (1990) describe qualitative research as a kind of research in which findings are not arrived at by means of statistical procedures. They add that qualitative research is characterised as a methodology that enables in-depth and detailed analysis within the context of a limited number of participants.

In this research, the qualitative approach will be followed, because I want to focus on an understanding of the situation or practice being researched from the perspective of those experiencing the phenomenon, I also want to understand and represent the educators' perceptions, experiences and needs concerning the teaching of orphans and vulnerable children, within the context of which these educators find themselves (Denzin; and Lincoln, 2000; Hammersley, 2000; Creswell, 2005). I have decided on a qualitative approach because it has its roots in social sciences and is more concerned with understanding *why* people behave as they do, and with assessing their knowledge, attitudes, beliefs and behavior, which is commensurate with the first objective of my research.

Another reason why I opted for the qualitative approach is that it allows the subject being studied to give much richer answers to questions put to them by the researcher, and may also give valuable insights that may have been missed by any other methods (Cohen et al, 2000).

Action research is a cyclical process of reflecting, planning, acting and observing (Kemmis and McTaggart, 1988). According to Babbie and Mouton (2001), it proceeds through repeated cycles in which researchers and the participants start with the identification of the major issues, concerns and problems, initiate research, originate action, learn about this action and then proceed to a new research action cycle. The cyclical process is generally not as neat and final as other procedures, because its stages overlap and mutual plans may become obsolete in the light of lessons from experience. It is also likely to be more fluid, open and responsive than other procedures (Denzin and Lincoln, 2000). In this study, therefore, the participating educators will be involved in the problem identification in Step 2 and will actively engage in implementing and evaluating the intervention in Step 3. They will also be facilitated to suggest ways in which they could alter their practice in the future. Figure 0.2 outlines the process followed in the action research design.

**Figure 0.2: Action research design**



The methodology will be explained in detail in the chapters that follow, as I progress through the stages of the action research design.

## **0.10 ETHICAL CONSIDERATIONS**

According to Bell (2003), Mouton (2001) and Bassey (1995), ethical measures include providing the participants with adequate information about the research and assurances of privacy, anonymity, confidentiality, informed consent, dignity, and feedback, and also the assurance that none of the participants will be emotionally or physically harmed.

Bell (2003), Mouton (2001) and Bassey (1995) further point out that a researcher cannot demand access to an institution or a school to carry out research. The researcher must also be aware that prospective participants will be doing him/her a favour if they agree

to participate. It is therefore important for him/her to tell the participants exactly what they will be asked, how much time they will be expected to give, and what use will be made of the information that they will provide.

In this research, all the above ethical research guidelines will be observed. Permission will be sought from the principals of the relevant schools to carry out the research there. The participants will also be made aware of the purpose of the research. The anonymity of the schools will be respected and the confidentiality of participants will be maintained. Written permission to carry out the research will be sought and participant educators who desire to be provided with the research findings, will be given the results. The documents used to attain permission to conduct research and informed consent are appended to this thesis as Appendix A, B and C. The actual measures implemented at each stage of the research will be described in the relevant chapters.

## **0.11 OUTLINE OF RESEARCH**

The research report will be structured as follows:

**Overview of research report:** The overview of the research comprises the background of the research, rationale, problem statement, research questions, purpose and objectives of the research, the clarification of key concepts, an introduction to the research design, consisting of research methodology, measures to increase trustworthiness, ethical considerations, and an outline of the chapters.

**Chapter 1:** This will comprise the first phase of the problem identification process, in which data gathering will be conducted by reviewing existing literature with regard to the threat that HIV and AIDS pose for education and general well-being of children.

**Chapter 2:** This chapter will describe the process and findings of the empirical stage of problem identification, namely the qualitative enquiry undertaken among selected educators in Lesotho.

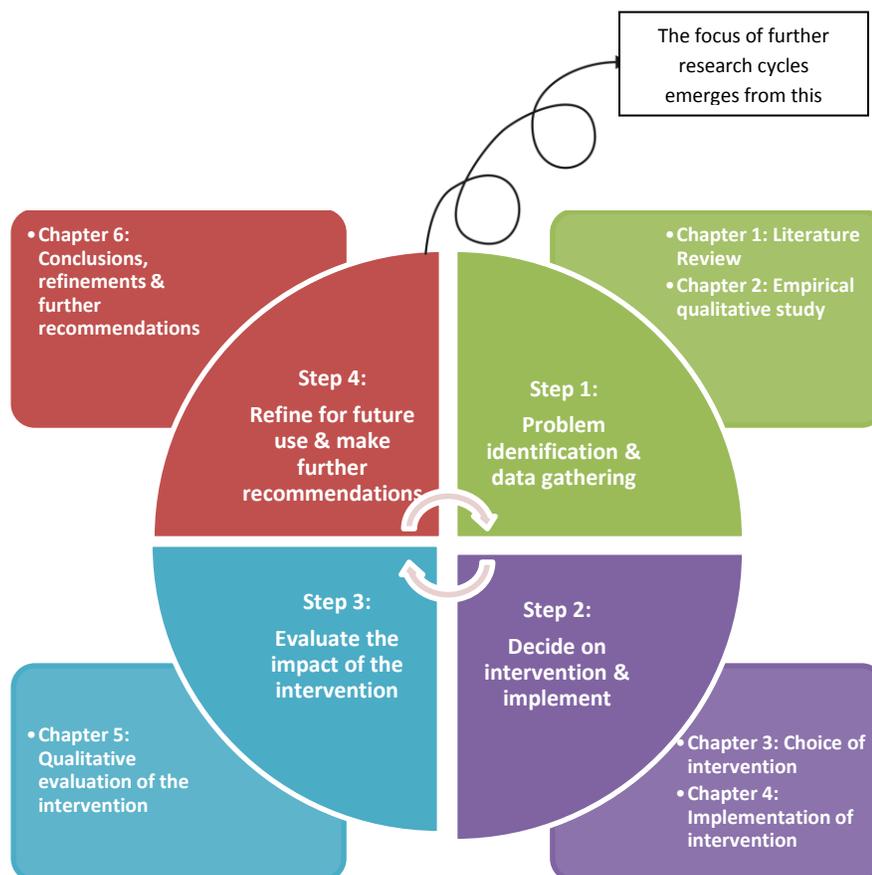
**Chapter 3:** This chapter will introduce, describe and justify the choice of intervention to be used to improve the situation and provide a literature-based overview of resiliency theory in relation to teacher well-being. This will comprise the first part of Step 2 of the action research process.

**Chapter 4:** Continuing with in Step 2 of the action research process, this chapter will describe the implementation of the intervention.

**Chapter 5:** In Step 3 of the action research process, the methodology used to evaluate the implementation of the intervention will be described and the findings discussed in relation to the research question,

**Chapter 6:** This chapter will address the final step of the action research process and will present the research conclusions, recommendations for refinement of the intervention, implications for future cycles of research; recommendations for teacher education and in-service support; and the significance of the study.

**Figure 0.3: Overview of Action Research process as explained in each chapter**



## 0.12 CONCLUSION

In the research overview, I provided the background to the framework for the study, the purpose and the research questions that guided the study. I also introduced the research design and the methodology. I clarified the key concepts used in the context of the study. The following chapter will comprise the first phase of the problem identification process, during which data gathering will be conducted by reviewing existing literature with regard to the threat that HIV and AIDS pose for the education and general well-being of children.

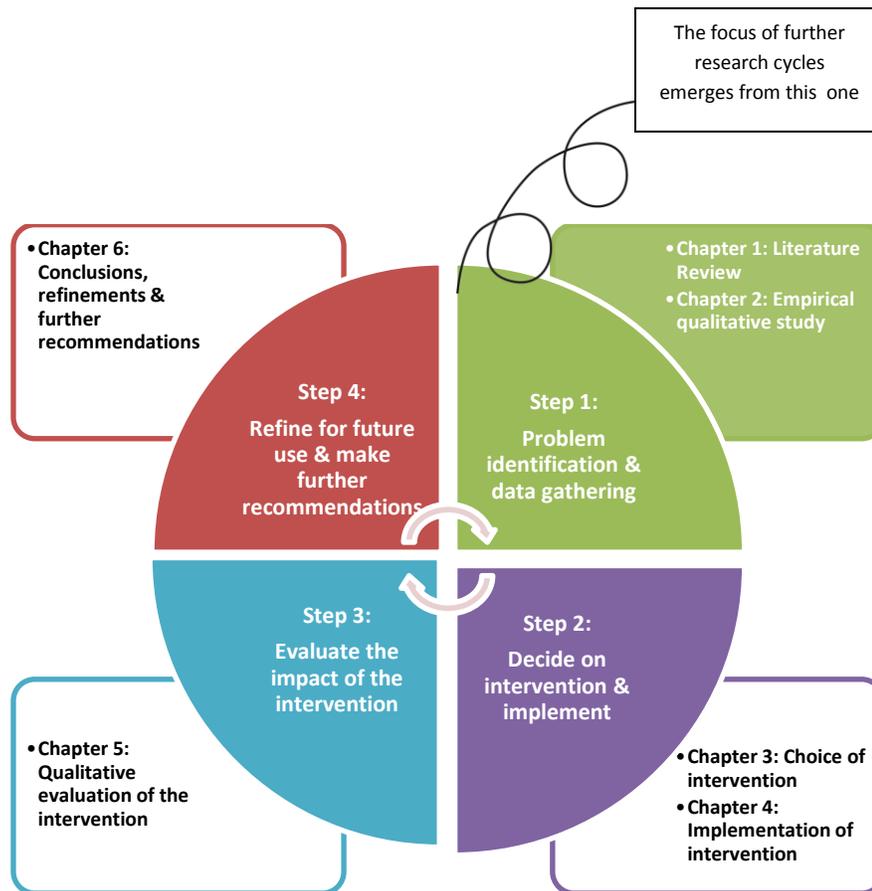
# CHAPTER 1

## LITERATURE REVIEW OF IMPACT OF HIV AND AIDS ON EDUCATION, LEARNERS AND EDUCATORS

### 1.1 INTRODUCTION

In this chapter, literature on the impact of HIV and AIDS on education, learners and educators will be reviewed. This literature review constitutes the first step in the data collection process to identify the problems and challenges that educators face when teaching orphans and vulnerable children. The next chapter will describe the empirical study undertaken to complete the problem identification step (Step 1).

*Figure 1.1: Overview of Action Research Process*



## **1.2 ROLE OF EDUCATION IN HIV AND AIDS ERA**

There are currently more people living with HIV in Sub-Saharan African countries than in any other region in the world (UNESCO, 2007). As a result of the AIDS pandemic, schools need to respond to the changing needs of educators, learners and local communities affected by the pandemic. Schools and other institutions should play a significant role in supporting all the dimensions of a comprehensive response to HIV and AIDS, including prevention, treatment, care and support.

According to Piot, the Director of UNAIDS (2004), education is important in the fight against the spread of the HIV. With the unchecked spread of the HIV, education will be elusive. This is a warning that we cannot afford to ignore. The social inequalities that promote the transmission of HIV and that emerge as a result of a high HIV prevalence rate are built on an entire network of social, political, economic and cultural relations of power (Muthukrishna and Ramsuran, 2005), and it is almost impossible to reduce HIV infection through educational initiatives alone. However, this thesis acknowledges the impact of the pandemic on education; therefore, attention will be centered on that for the purpose of problem identification as a first step in helping teachers to respond to the needs of orphans and vulnerable children.

The opportunity for accessing education is severely limited by the poverty that characterises the lives of the majority of sub-Saharan African peoples. Millions of people living in Sub-Saharan African countries, including Lesotho are poor and have been greatly affected by the pandemic. The majority of the affected are children and women (Jackson, 2002; UNAIDS/UNICEF/USAID, 2004). Poverty is the undeniable background to the HIV and AIDS pandemic, which has deepened the poverty of already vulnerable children. For example, worldwide, one billion children are currently living in abject poverty, 10 million children are dying of preventable diseases and malnutrition annually; and 77 million children are out of school; 44 million of these children are girls in Sub-Saharan African countries (Richter, 2006).

HIV and AIDS pose a real threat to the education sector and to human resources based development. Education is one of the many sectors that are being devastated by the spread of the HIV pandemic in Sub-Saharan Africa (Kelly, 2000; Coombe, 2002; Bennell, 2005; Hall, et al., 2005; Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste and Pillay, 2005; Bhana, et al., 2006; Theron, 2007). Poverty in these countries is associated with inferior educational delivery. The education problems associated with poverty include poor school attendance, low achievement, early school leaving, juvenile crime, violence, and physical and sexual abuse and HIV and AIDS infection (Bezuidenhout, 2004). Since there is no cure or vaccine for HIV and AIDS, the prevention of new infections through educating people is of great importance (UNICEF/UNAIDS/WHO, 2002; World Bank 2002).

Education aims to prepare young people to become responsible and productive citizens. Because children are the future generation, schools have to respond to the HIV-related needs of orphans and vulnerable children as part of their efforts to achieve universal access to HIV prevention programmes, treatment and care (Wood, 2008). Education is also vital because it helps to promote the achievement of the six out of eight Millennium Development Goals (MDGs) which, according to the World Bank (2002) are to:

- reduce poverty
- achieve universal primary education
- improve gender equality
- reduce infant and child mortality
- improve maternal health; and
- lower the prevalence of HIV and AIDS.

Two Education for All goals (EFA) are: ***to achieve universal primary education*** and ***to promote gender equality and empower women*** (World Bank, 2002). These two Millennium Development Goals for Education For All are of great importance, because they make a difference in the fight against HIV and AIDS. They help people to fight

against HIV and AIDS, because education is said to be a “social vaccine” and a “window of hope” against the HIV and AIDS pandemic (UNAIDS, 2002; Vandermootele and Delamonica, 2002).

UNAIDS (2002) has noted that the attainment of the MDGs for education cannot be achieved or attained without urgent attention being given to HIV and AIDS and also that the pandemic weakens the quality of education. Education is important, because if people have a certain level of education, they are able to access information and services that can help reduce the spread of the HIV and AIDS pandemic (Baylies, 2000; Berger, 2005). Education therefore provides individuals with economic, psychosocial and social benefits.

### **1.2.1 Economic benefits**

Education improves access to employment and income security, boosts the status of people, allows people to earn a higher income, and gain access to better health services. It also liberates women from dependence on men, giving women the power to negotiate their sexual practices. When women are healthy, educated and free, they become empowered and independent (Beckman and Rai, 2005).

### **1.2.2 Psychological benefits**

Education is important for the psychological development of young people and children in a number of ways. When people are educated, they develop a sense of self-efficacy, which leads to increased life chances. Educated people have a sense of optimism and hope for the future. They tend to indulge in less risky behaviour, such as substance abuse and unprotected sex (UNAIDS, 2007). Education therefore helps people to make informed decisions, think rationally and choose improved health and life styles (Sabbarao, Mattimore and Plangemann, 2001; Coombe, 2002; Hepburn, 2002; Boler and Aggleton, 2005;).

### **1.2.3 Social benefits**

Education increases integration into the community and promotes the building of supportive networks, such as the development of the knowledge and the ability needed to access social services in times of need. Schools are part of a community, and any HIV response within a school would be strengthened through support from the local community (Campbell, 2003).

Education is vital, because it leads to improved life styles. When people are educated, they are able to access information and services to help mitigate the spread of HIV (Vandemoortele and Delamonica, 2002; Boler and Jellima, 2005). Education could make a real difference by providing orphans and vulnerable children with the necessary information and support around HIV and AIDS, halting the further spread of the pandemic (Kelly, 2002). Boler and Jellema (2005) say that education is a social vaccine because it can help to prevent the transmission of HIV and also offers care and support for people who are already affected or infected (Vandemoortele and Delamonica, 2002). It can be considered a social vaccine against HIV and AIDS, because there is some evidence that the HIV prevalence rate is lower among people with higher levels of education (Cohen, with Epstein, 2005).

Education is important, because it is a major engine of economic and social and development. It plays an important role in preventing HIV and AIDS. It is vital for every country to invest in education, because it promotes the achievement of six of the eight Millennium Development Goals. It is a window of hope that can protect women and children from HIV and AIDS (Fox, 2001).

It may be concluded that education plays a key role in establishing conditions that render the transmission of HIV and AIDS less likely, such as poverty reduction, personal empowerment and gender equity. Education also reduces vulnerability to a variety of factors, such as streetism, prostitution, and the dependency of women on men, which are fertile breeding grounds for the HIV and AIDS infection (Kelly, 2000).

### **1.3 IMPACT OF HIV AND AIDS ON EDUCATION SECTOR**

In the context that HIV and AIDS is affecting many lives around the globe, especially in Sub-Saharan African countries, getting every child into school seems to be one of the best ways to mitigate the impact of HIV and AIDS. However, there is evidence that HIV and AIDS have swamped education sectors, Many children are not accessing education, leaving school before they achieve basic literacy and numeracy skills (Abt Associates and University of Kwazulu Natal, 1999; Kelly, 2000; Coombe, 2002).

The HIV and AIDS pandemic does not attack individuals only, but also systems and all sectors of society (Coombe, 2000; Avert, 2006). As acknowledged earlier (refer to the relevant section), HIV is not only a health issue and cannot be contained by effective health education alone, but requires a multidisciplinary approach (Piot, 2004; Coombe, 2003; Donald, Lazarus and Lolwana, 2006). In Sub-Saharan Africa, education systems, learners and educators and the quality of teaching and learning have all been affected by the HIV and AIDS pandemic, to different degrees (Coombe, 2002; Bennell, 2005; Hall et al., 2005; Shisana et al., 2005; Bhana et al., 2006; Theron, 2007). It is clear that if educators are sick or absent from school or leaving the education profession, the nation stands to lose.

The education systems of most countries in Sub-Saharan Africa are on the brink of disaster due to the HIV and AIDS pandemic (Carr-Hill et al., 2000; Coombe, 2002; Badcock-Walters, Kelly and Gorgens, 2004). For example, school enrolment is shrinking in most African countries; AIDS is undermining the ability of education systems to perform their basic social mandates, as more teachers and administrative staff are lost to the disease (Kelly, 2000, UNAIDS, 2000). The education sector can barely cope with the additional costs associated with training and replacing teachers (Kelly, 2000; UNAIDS, 2000).

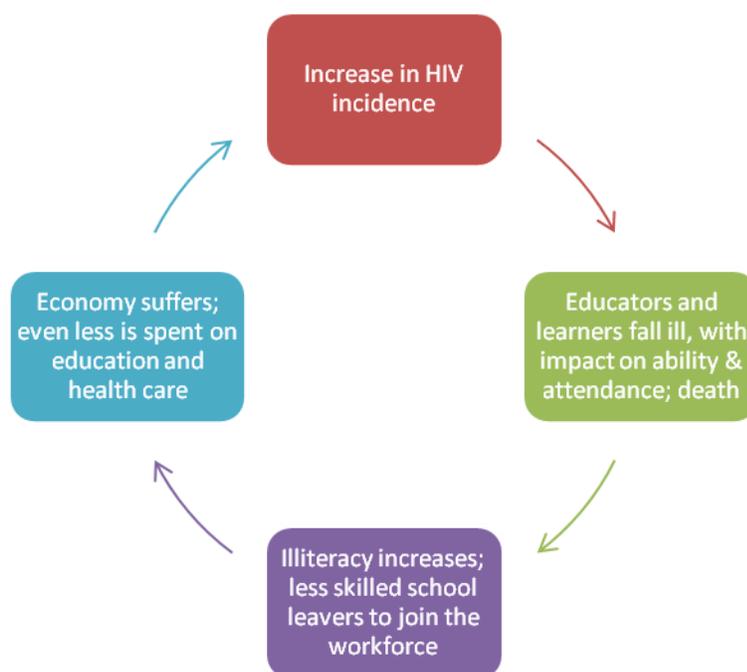
The HIV and AIDS pandemic is sabotaging the supply and demand for and the quality of education. Educators, school managers, education policy makers and children are

sick and dying of the HIV and AIDS pandemic, thus reducing the supply, demand and quality of education. Kelly (2000), Family Health International [FHI], et al., (2002), Coombe (2003) and Wood and Hillman (2008), concur that the relationship between education and HIV and AIDS is complex, dynamic and cumulative. For example, when HIV prevalence increases, it affects the education sector negatively in the sense that institutions, educators and learners are affected and may suffer. The HIV and AIDS pandemic affects the whole education system negatively.

Globally, the education system has begun to experience the loss of inspectors, education officers and planning and management personnel to the HIV and AIDS pandemic and is finding it difficult to attract experienced managers. It must be pointed out that up to now, many school principals have not received sufficient support and training on educational management. Due to the pandemic, the situation will worsen (Coombe, 2000; Kelly, 2000). There will be less qualified teachers, as trained and experienced teachers are replaced with young and less trained teachers (Coombe, 2000; Kelly, 2000). If AIDS continues to take its toll, there will be schools with inexperienced head teachers, and no inspectors of schools. Higher institutions of learning will lose experienced senior lecturers (UNAIDS, 2002). This will have a negative impact on the education system's ability to plan, manage and implement policies and programmes (Coombe, 2000; Kelly, 2000).

In order to stop HIV and AIDS from destroying the education system, there is a dire need for good planning that focuses on the potential outcomes of the pandemic for different education sub-sectors such as higher education, schools and pre-primary schools (Coombe, 2000). Sick educators and learners' absenteeism, as well as the loss of experienced teachers to the HIV and AIDS pandemic, affect the quality of education. It is important to note that supply and quality issues are interrelated. The supply of education has to do with educators being available to teach effectively. In order for quality learning to take place, educators must be available and in a position to offer quality education (Coombe, 2003). Figure 1.2 below illustrates the relationship between HIV and AIDS and education.

**Figure 1.2: The vicious circle of Education and HIV & AIDS**



The HIV and AIDS pandemic undermines the ability of education systems to perform their basic social mandate, as increasing numbers of teachers and administrative staff are lost to the pandemic (Crouch, 2001; Coombe, 2003; Van Wyk and Lemmer, 2007). This reduces the quality of training and education that are provided by institutions, leaves fewer people able to receive the benefits of learning and also causes a serious brain drain of professionals (UNAIDS, 2000). Educators and learners are HIV positive and sick (Hall et al., 2005; Rehle and Shisana, 2005). Educators and learners also often have family members who are sick and dying of the HIV and AIDS pandemic. Consequently, fewer educators are left to teach fewer learners. Some of the learners drop out of school to care for their sick relatives, while some educators leave the teaching profession, because they are depressed and demoralised (Coombe, 2003 ; Bennell, 2005; Hall et al., 2005; Theron, 2005).

Below is a summary of the impact of HIV and AIDS on education, according to Coombe (2000).

- Fewer children will enrol in school because HIV positive mothers die young and children are dying of AIDS complications; children who are ill, impoverished, orphaned, caring for young children or earning and producing, stay out of school.
- There will be increased absenteeism or withdrawal from school to care for others, resulting in lower educational performance, premature termination of education and fewer vocational opportunities.
- Qualified teachers and officials are lost to education through illness and death due to HIV and AIDS pandemic.
- HIV and AIDS will make the management, administration and financial control in an already fragile education system and sustaining the structures necessary to provide formal education of the scope and quality envisioned by the government's policies more difficult.
- Costs of illness, burials, and death benefits along with additional costs for teacher training.
- There will be an incalculable psycho-social trauma, which will overwhelm teachers, children and their families.
- School effectiveness will decline, due to low morale and low levels of concentration among affected children, teachers and officials.
- Difficulty in the attainment of Millennium Development Goals and Education for All.

## **1.4 IMPACT OF HIV AND AIDS ON LEARNERS**

It is difficult to separate orphans from vulnerable children when discussing the impact of HIV and AIDS on their lives because both orphans and vulnerable children belong to high risk groups and are equally affected. These children tend to lack access to basic social facilities and their very survival, well-being and development are threatened. Their vulnerability may have been caused by a number of factors in different countries, the main factors being the HIV and AIDS pandemic and conflict (Subbarao et al., 2001; Richter, Marygold and Phather 2004; REPSSI, 2007).

It is important to mention that the nature of vulnerability is a process; it is not static, but changes with time. Again, the vulnerability of orphans and vulnerable children has increased as a result of HIV and AIDS. Smart (2000), whose description I will adopt for my conceptualisation of an orphan and vulnerable child, as a child below the age of 18 years who fits into one or more of the following categories:

- is orphaned, neglected, destitute or has been abandoned
- has a terminally ill parent or guardian
- is born of a teenager or a single mother
- has lost one or both parents (a maternal, paternal or double orphan)
- is living with a parent or an adult parent or an adult who does not earn any income
- is abused or ill treated by a step-parent or relatives
- is HIV positive; and
- is disabled.

It should be noted that although these children are classified as orphans and vulnerable, research (De Lannoy, 2007) has indicated that they are not necessarily doomed to a bleak future if they can be helped to access the resources necessary to fulfil their needs. Education and educators can play an important role in this. Moreover, education

improves access to employment and security, boosts the status of people and leads to improved health and life styles (Sabbarao et al., 2001; Coombe, 2002; Hepburn, 2002; Boler and Aggleton, 2005).

HIV and AIDS is “the most globalised epidemic in history” (UNAIDS/UNICEF/USAID, 2004). The HIV and AIDS pandemic is one of the biggest challenges in the world, especially in Sub-Saharan African countries, where the pandemic has wreaked its worst damage (UNAIDS, 2007). In countries such as Botswana, Lesotho, Mozambique, Namibia, South Africa, Zambia and Zimbabwe, the HIV and AIDS pandemic has severely violated the basic human rights of many people, in terms of rendering women and children more vulnerable to exploitation and denying many access to basic human needs. The rights to education, health services and freedom from discrimination have been compromised by the pandemic. As Mandela (2007) put it, “AIDS is no longer a disease. It is a human rights issue”. HIV and AIDS have killed one or both parents of over 12 million children in many countries in Sub-Saharan Africa, including Lesotho (Van Dyk, 2005; UNAIDS, 2007). It was estimated that by 2010, there would be approximately 20 million children in Sub-Saharan Africa who would have lost at least one parent to HIV and AIDS (UNAIDS/WHO/UNICEF, 2007). The rate of HIV infection in these countries is increasing at an alarming rate and more people are getting ill and dying from AIDS-related illnesses, increasing the numbers of orphans and vulnerable children globally (UNAIDS, 2007).

The growing population of orphans and vulnerable children is a concern, because, had it not been for the HIV and AIDS pandemic, the global percentage of orphans and vulnerable children would be declining instead of growing (UNAIDS, 2007). Most people in Sub-Saharan Africa who die of HIV and AIDS-related illness are between the ages of 20 and 45 years, when they are supposed to be at their most productive. This has a serious consequence on the economic development of these countries, more especially because they are developing countries (UNAIDS, 2008). It is important for educators to be able to offer care and support to these marginalised children (UNAIDS/WHO/UNICEF, 2007).

Countless children have been affected by the pandemic, in that their parents or primary caregivers have been infected and are consequently more vulnerable to increased ill-health, inability to work and earn a living and increased financial demands to cover the cost of treatment. They also suffer from psychological stress, due to stigmatisation surrounding the disease. Children whose parents or family members are ill or have AIDS feel overwhelmed and helpless (Mallmann, 2003). Cumulative stressors on the children affected by HIV and AIDS can be devastating if these children cannot access their inner resources and do not receive support from the outside (Mallmann, 2003). However, some orphans and vulnerable children have adapted and are coping with the fact that their parents or guardians are HIV positive. In other words, they are resilient (Theron, 2004; Ungar, 2005).

Most orphans and vulnerable children's guardians value education, so they keep these children at school, even though they themselves are poor. For example, a study carried out by Van Blerk and Ansell (2005) on children affected by HIV and AIDS in Lesotho and Malawi has shown that guardians in both countries try everything in their power to make sure that the children under their care have access education. Some of these guardians may go to the extent of selling their assets so that they are able to pay school fees and for other school paraphernalia (Booyesen, Bachman, Matebesi and Meyer, 2001). Some orphans and vulnerable children do their best to remain in school. They work in exchange for school fees (De Lannoy, 2007). Education is important to these children, because it helps them towards a better and more secure future (De Lannoy, 2007).

Orphans and vulnerable children face specific challenges in comparison to their less affected peers. They tend to have less access to education and health care, show more indications of psychosocial distress, suffer economic hardship, experience loss of inheritance and face greater degrees of neglect, abandonment, and abuse (Carr-Hill, Kataboro and Katahoire, 2002; Ebersöhn and Eloff, 2002; Family Health International, 2002; Foster, 2002; Hepburn, 2002; Avert, 2007). They also have to contend with stigmatisation, discrimination, isolation, malnutrition, illness, and an increased risk of

HIV infection (UNAIDS/WHO/UNICEF,2007). The emotional, psychosocial, economic, physical, social and cognitive impacts of HIV and AIDS on orphans and vulnerable children's education will be discussed below.

#### **1.4.1 Emotional impact of HIV and AIDS on learners**

Children's emotional welfare is influenced by a number of factors. These include parents, family, school, community or neighbour-hood, the society and the culture in which the children live (Mallmann, 2003). Due to the HIV and AIDS pandemic, parents may die prematurely, leaving their dependent children without responsible caregivers (UNAIDS/UNICEF/USAID, 2004). Studies conducted have suggested that children whose parents are living with HIV experience adjustment problems such as depression, withdrawal, despair and low self esteem (Ebersöhn and Eloff, 2002 Avert, 2007).

Research has also indicated that there is a relationship between emotional and academic performance. For example, children with emotional disorders attain low grades and have higher dropout and lower graduation rates Hallahan and Kauffman (2000). Again, children whose parents are terminally ill have difficulty in concentrating in the classroom, due to anxiety and depression. They frequently show some learning disabilities (Willemsen and Anscombe, 2001).

Children with emotional problems, such as difficulty in relating appropriately to peers, siblings and teachers and in responding to social tasks that are important parts of schooling; verbal or physical aggression; withdrawal; day dreaming; avoidance of contact with others and extreme shyness, generally do not perform well academically. This is often because their inappropriate behavior negatively affects their academic performance (Hallahan and Kauffman, 2000). It is important to note that most orphans and vulnerable children display higher incidence of emotional, social and behavioural problems, which constitute barriers to learning (Carr-Hill et al., 2002; Ebersöhn and Eloff, 2002; Hepburn, 2002; Avert, 2007).

Orphans and vulnerable children who grow up without parental guidance and support may later develop behavioral problems such as depression, isolation, anxiety, difficulty in making friends, low self-esteem, alcohol and drug abuse (UNICEF, 2000; UNAIDS, 2002). If the emotional problems of such children are not addressed these may manifest themselves in other destructive ways (Carr-Hill, Kataboro , Katahoire and Oulai, 2002 Hepburn, 2002; Mallmann, 2003). All the above factors affect children's ability to learn effectively.

#### **1.4.2 Psychosocial impact of HIV and AIDS on learners**

Children suffer from fear of loss once a parent has been diagnosed with HIV and AIDS as well as the stigma attached to the disease. Most orphans find it difficult to cope with the illness and death of parents or caregivers. After the death of their parents or caregivers, these children often do not receive adequate protection, love, care and support any more (Lyons, 2000; Pivnick and Village, 2000; Bauman, Camacho, Silver, Hudis and Draimin, 2002; Ansell and Van Blerk, 2004; Ansell and Young, 2004; Strydom and Raath, 2005; Woodring, Cancelli, Ponterotto and Keitel, 2005).

Orphans and vulnerable children face challenges such as coping with grief, loss of identity, coping with shame, stigmatisation, fear of being abandoned, rejection and death (Mallmann, 2003). Some literature even suggests that if these children are not helped to overcome these problems, they are unlikely to become fully functioning members of society (Carr-Hill et al., 2002; Hepburn, 2002; REPSSI, 2007).

Due to prolonged parental illness and the death of one or both parents, children experience trauma. These children need counseling to deal with the "trauma", which, according to Mallmann (2003), is a Greek word which means "wound". It is defined as the experience of forceful events, which threaten a person's life or profoundly threatens his/her psychological integrity and overwhelms his or her resources and ability to cope. It is an ongoing process of meeting the social, mental and spiritual needs of, in this context, orphans and vulnerable children, all of which are considered essential elements

of meaningful and positive human development (Richter et al' 2004). It must be pointed out that orphans and vulnerable children face more demands and challenges due to their physiological, psychological, social and economic circumstances ( Mallmann, 2003) than less affected children.

Because of the HIV and AIDS pandemic, most orphans and vulnerable children experience psychological problems. However, according to Foster (2002), the social and economic impact of HIV and AIDS in developing countries has overshadowed concern about the psychological impact of the pandemic on children. This means that the psychological impact on orphans and vulnerable children is often overlooked. For example, in some of these countries, a blanket and food are considered to be more appropriate and more immediate needs than counselling. If these children are not helped to cope with their grief at the loss of family members, their coping ability at school will be severely compromised (Wood, 2008).

#### **1.4.3 Economic impact of HIV and AIDS on learners**

HIV and AIDS deplete families' income. The presence of AIDS in the household and the additional responsibilities and burdens on the family may cause many children to drop out of school. As poverty deepens, school enrolment rates decline (World Bank, 2002; Coombe, 2003; Wood and Hillman, 2008). In countries in Southern Africa there is evidence of declining school enrolments because of lack of school fees and other school paraphernalia, and this is attributed to HIV and AIDS (Kelly, 2000; Abt Associates, 1999).

As parents succumb to the AIDS pandemic, they are less able to provide for their children financially. The little savings they may have, are used to cover medication costs. As a result, children's needs such as school fees, food and clothing are not met (Hepburn, 2002). Children, especially girls, are often forced to drop out of school to care for their ill parents or to help earn an income to contribute to the diminished family livelihood or to seek employment in order to support their families, thus depriving them

of the chance of attending school and accessing a decent education vital for their development and future success in society (Kelly, 2000; ; Makame, Ani and Grantham-Mgregor, 2002; Boler and Carol, 2005; Mishra, Arnolt, Otieno, Cross and Hang, 2005; UNAIDS, 2007; UNICEF, 2007).

The “girl child” is most affected by the pandemic (Sengendo and Nambi, 1997; Makame et al., 2002; UNESCO, 2005; World Bank, 2002). Some children who stay in rural areas may be absent from school because they have to take part in seasonal farming work, while some may become the heads of their families. Most of these learners struggle financially. They cannot afford to buy nutritious food and may suffer from malnutrition(Coombe, 2003; Kimaryo et al., 2004;). Sometimes relatives may take the property and other assets that were left for these children by their parents, leaving these children destitute and in abject poverty (Coombe, 2003; Kimaryo et al, 2004).

#### **1.4.4 Physical impact of HIV and AIDS on learners**

In some instances, children who do not have parents or caregivers to look after their best interests may fall prey to sexual exploitation and child labour in order to meet their needs. Because of the high risk behavior in which they may be forced to engage, they are at risk of contracting HIV (International HIV/AIDS Alliance, 2007). In addition, due to a lack of access to health care, they may be at risk of malnutrition and illness. This situation could affect their learning. Sometimes surviving relatives may even force these children into harmful child labour (UNESCO, 2005). Some children are subjected to sexual exploitation by the very same relatives for cash to obtain protection, shelter and food. Girls are affected in the sense that they may be forced into marriage at a young and fragile age, placing them at risk of contracting HIV and AIDS (Brakarsh, 2004; UNICEF/UNAIDS/WHO, 2004). Due to the loss of a parent or parents to AIDS, orphans and vulnerable children may lack access to basic needs such as shelter, food, clothing, health care and education (Hepburn, 2001).

#### **1.4.5 Social impact of HIV and AIDS on learners**

Orphans and vulnerable children face stigma and discrimination at school. Stigma, the 'undesirable differences' and 'spoiled identities' that HIV and AIDS-related stigma causes, does not naturally exist; it is created by individuals and by communities. Stigmatisation describes this process of devaluation (UNAIDS, 2002). It is important to state that HIV and AIDS-related stigma builds upon, and reinforces existing prejudices. Stigma plays into and strengthens existing social inequalities, especially those of gender, sexuality and race. HIV and AIDS related stigma and discrimination play a key role in producing and reproducing relations of power and control. They cause some groups to be devalued and others to feel that they are superior. In the end, stigma creates and is reinforced by social inequalities (UNAIDS, 2002).

Stigma and discrimination are detrimental, because they can prevent orphans and vulnerable children from accessing education, wellbeing, treatment and care (Strode and Barrett-Grant, 2001; Letteney and Laporte, 2004). There is evidence that children whose parents have died of the AIDS pandemic may experience stigma and discrimination from members of the community, as well as teachers and other children at school, causing them to drop out of school (Foster and Williamson, 2000; Hepburn, 2001; Ogina, 2007).

It must be pointed that stigma and discrimination are caused by ignorance, fear of AIDS in the community, and the moralistic and often judgmental view community members including people with AIDS have about AIDS. Stigma may be external or internal and has different effects on an individual. Internal stigma is the shame associated with the HIV and AIDS pandemic, whereby people who are HIV positive are discriminated against (Change Project, 2005). Internal stigma is characterised by self exclusion from services, low self esteem, social withdrawal and fear of disclosure (UNAIDS, 2000). External stigma is the actual experience of discrimination, which may include domination, harassment, categorising, accusation, blame, ridicule and resentment (UNAIDS, 2000; Nyblade, et al., 2003).

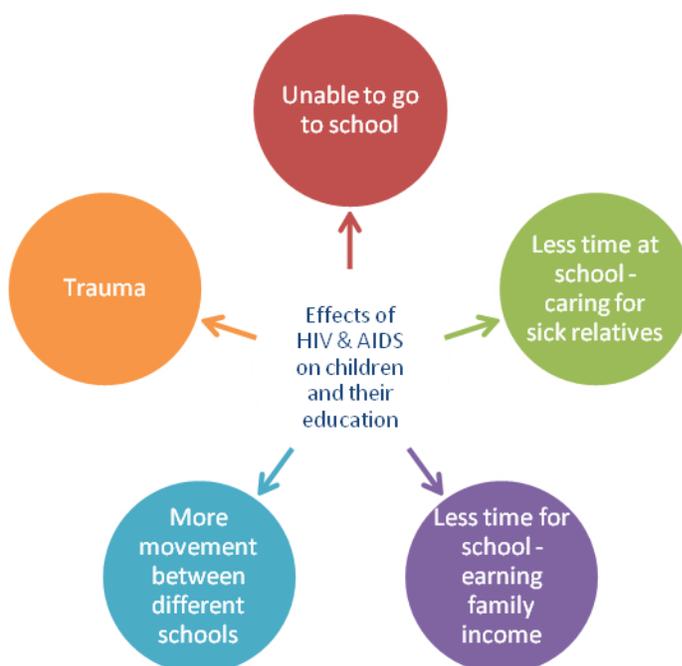
Some affected children may lose their inheritance, because in many countries around the world property and inheritance laws do not protect the rights of orphans, vulnerable children or widows. These children are prohibited from claiming what is rightly theirs. Even though the inheritance laws may be on the books, they are often not enforced (Kimario et al., 2004). Most of these children may have to leave their homes to live in unfamiliar and sometimes unwelcoming places. They may not be readily accepted by their extended family members (UNAIDS, 2000).

#### **1.4.6 Impact of HIV and AIDS on cognitive functioning of learners**

In areas with high HIV prevalence, many children are born HIV positive (Abt Associates, 1999; World Bank, 2002; Bennell, 2005). Most of these children die before they are five years old. Those who survive generally do not perform well academically. Children who are HIV positive generally have poor cognitive functioning and poor adaptive functioning because of the illnesses (Bennell, 2005). Most children who are HIV positive are frequently absent from school due to illness, and because absenteeism is associated with poor learning, this may affect their learning. Their academic performance may deteriorate and they may not be able to learn properly. HIV positive children do not perform well academically due to all the interrelated socio-economic factors discussed above (Ebersöhn and Eloff, 2002; Coombe, 2003; Bennell, 2005).

It can be summarised that the HIV and AIDS pandemic impacts negatively on the demand for education, because it reduces the number of parents in the 20 to 40 years old group, the number of orphaned children increases, poverty deepens, and the school enrolment rates are expected to decline. At the same time, the school drop-out rate due to poverty, illness, lack of motivation and trauma is bound to increase, along with absenteeism among children who are heads of households; those who help supplement the family income, and those who are ill (Coombe, 2000). Figure 1.2 below illustrates the impact of HIV and AIDS on learners.

**Figure 1.3: The effects of HIV & AIDS on orphans and vulnerable children (UNESCO, 2005)**



The diagram above illustrates that, due to the HIV and AIDS pandemic, there will be fewer learners in schools. Many children have dropped out of school, because they cannot afford to pay school fees. Some have to take care of ill parents and earn a family income, some move from one school to the other, and some live with a series of different caregivers. The situation in which these children find themselves traumatises them and affects their learning. Thus HIV and AIDS impact on the orphans and vulnerable children emotionally, psychologically, economically, physically, socially and mentally, hence their ability to learn is affected.

### **1.5 IMPACT OF HIV AND AIDS ON EDUCATORS**

The role of educators is to deliver quality teaching and learning. However, the HIV and AIDS pandemic has a pronounced adverse impact on both the supply and quality of

education. The supply and quality of education has to do with qualified educators being available to deliver quality education to learners at school. The HIV and AIDS pandemic has caused havoc in the education systems, in the sense that it has reduced the supply and quality of education. For example, in Zambia, 2.2% of educators died in 1996 which is more than the number of educators produced by colleges in the same year, and it was estimated that educators' death rates might triple in 2005 ( Abt Association, 1999; World Bank, 2002). In another study, 14 460 educators in Tanzania were estimated to die by 2010, costing US\$21 in replacement training (Save the children UK, 1991). Most educators are reported to be HIV positive, and some are quitting the education profession. There is also trauma in the classrooms, and the educational management finds it difficult to attract skilled managers and educators. All the above factors affect the supply and quality of education (Coombe, 2000; Kelly, 2000; Bennell, 2005).

### **1.5.1 Increased mortality among educators and administrators**

Many educators are ill, absent and/or dying due to the HIV and AIDS pandemic. In a nationwide survey of educators conducted in South Africa in 2005, it was reported that HIV prevalence was the highest (12.7%) among educators in the 25-34 year age group and lowest among those 55 years and older. Again, black educators had the highest prevalence (16.3%), compared to other races (1%), and female educators showed a higher incidence than male educators (Shisana, et al, 2005). Many reasons have been put forward as to why the HIV prevalence rate is higher among black educators compared to other racial groups. Black educators generally have a lower socio-economic position than educators in racial groups. This suggests that the spread of HIV among black educators may have been fuelled by socio-economic factors (Shisana et al., 2005).

In countries such as Botswana, Namibia and South Africa, the annual educator mortality is expected to increase between 2008 and 2012. This will have a serious impact on the education system (Bennell, 2005). If HIV positive educators do not get access to drugs, they may die of infection within ten years (Bennell, 2005). However, due to the

increased availability of antiretroviral drugs, together with behavioural change, the teacher mortality rate has declined in many Southern African countries (Bennell, 2003). One has to point out that HIV and AIDS and its impact on education still adds to high educator attrition and absenteeism rates. This implies that the Department of Education needs to respond effectively to HIV in the education sector. For example, support intervention programmes for educators infected and affected by the HIV and AIDS pandemic should be put in place in order to alleviate the high educator mortality rate.

### **1.5.2 Educator attrition**

HIV and AIDS in most countries in Sub-Saharan Africa has added to the existing high level of attrition in the education service (HEARD, 2008). Factors such as low educator morale and lack of motivation can have an impact on educator attrition. According to Bennell (2003) low pay, poor conditions of service and inept school management play a major role in educators' low morale in countries in Sub-Saharan Africa. Many educators may join the private sector for fear of being infected by HIV and AIDS in the education system (Hall et al., 2005). Due to the HIV and AIDS pandemic, many educators are quitting the education profession, because they are not able to cope with the challenges posed by the pandemic. Schools therefore have to replace the lost staff with novice educators. The education system loses experienced and qualified educators (Coombe, 2000; Kelly, 2000; World Bank, 2002; Wood and Hillmann, 2008).

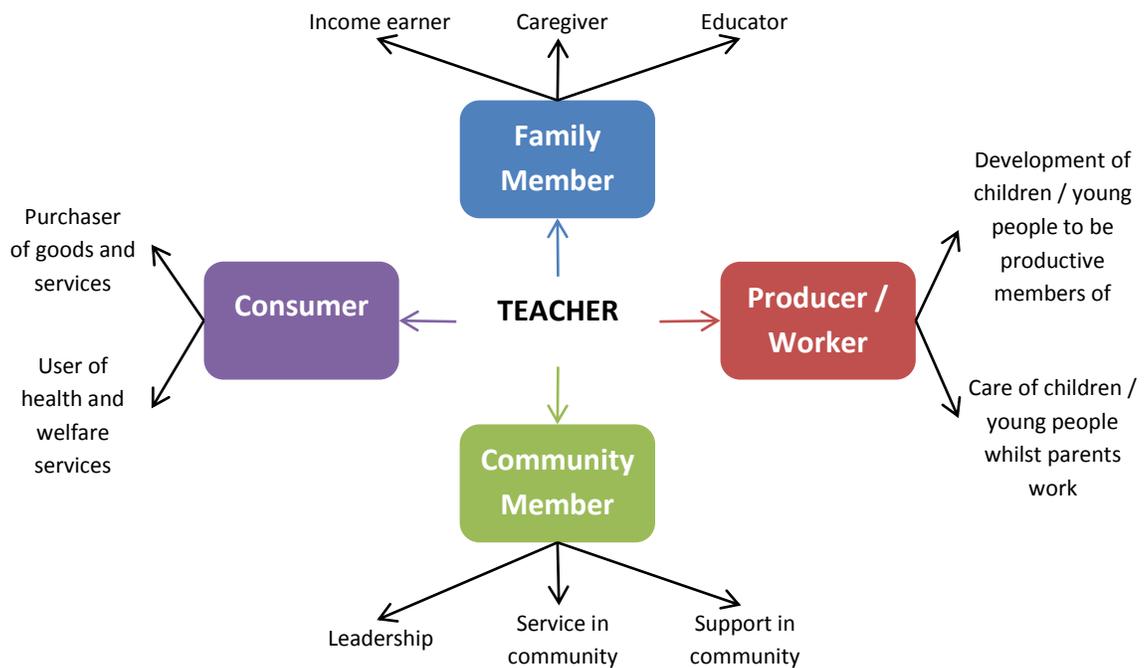
### **1.5.3 Increased stress on educators as a result of HIV and AIDS**

Most educators are infected and/or affected by the HIV and AIDS pandemic. They may be personally or professionally affected. They are personally affected or affected when they are HIV positive themselves or when their loved ones, colleagues and learners are HIV positive. Because they are personally infected or affected, they may experience stress, trauma, anger, depression, loneliness, sleep disturbances and nightmares (Hall et al., 2005; Bennell, 2005; Theron, 2007). When educators are personally infected, they

generally suffer from chronic illnesses, high levels of stress and depression and low morale, hence they are not able to teach or offer quality education to learners (Wood and Hillman, 2008). Again, due to prolonged chronic illnesses, they have increased absenteeism and fewer teaching days. It must be pointed out that in an individual affected teacher, the disease generally develops over a 10-year period and during that period 260 days (10%) of teaching days are lost because of absenteeism. Hence, the supply and quality of education are affected (Bennell, 2005).

Educators who are professionally affected by the HIV and AIDS pandemic may experience lower professional morale and higher stress levels due to the absenteeism of sick colleagues, increased workload, overcrowding and additional professional roles due to the pandemic. All the abovementioned factors affect the quality of education (Coombe, 2003; Kinghorn and Kelly, 2005; Theron, 2005).

**Figure 1.4: The different roles an individual educator plays (adapted from Barnett & Whiteside, 2002:184)**



## 1.6 NEED FOR SUPPORT FOR TEACHERS AFFECTED AND INFECTED BY HIV AND AIDS PANDEMIC

Educators need support so that they can support their colleagues, learners and other members of society affected or infected by the HIV and AIDS pandemic. The HIV and AIDS pandemic has altered the nature of educators' role globally (Hall, 2004). It has altered teaching for educators (Hall, 2004; De Lange, 2008). According to Coombe, (2000), Coombe (2003), Bennell (2005), Bhana et al., (2006) Kinghorn and Kelly (2005), Shisana et al (2005), Simbayi, Skinner, Letlape and Zuma (2005) and Theron (2007), educators are professionally and personally affected by the HIV and AIDS pandemic. They are "*all things to all people*", because of the HIV and AIDS pandemic as Theron (2007) puts it. The educators' role has changed in the HIV and AIDS era. They now serve as HIV and AIDS prevention agents, social workers, counselors, caregivers, advisors, educators and surrogate parents (Bhana et al., 2006; Hoadley, 2007; Theron, 2007). Educators are affected by colleagues, learners, learners' family members. This professional load is taxing (Coombe, 2003; Bhana et al., 2006; Theron, 2007; Theron, 2008). Although this professional load is taxing, little has been done to empower educators in this "*traumatic journey*" (Bennell, 2005).

Because they are the heart of the school, the wellbeing of educators is essential so that they can offer quality education, but it seems that their wellbeing is being eroded by the HIV and AIDS pandemic. It is important for educators to be resilient, because of the challenges posed by the HIV and AIDS pandemic. They may be personally affected or infected themselves (Theron, 2005). Some educators may be ill, while others may be dying of HIV and AIDS. Some may have lost their loved ones or colleagues to HIV and AIDS. This traumatises them, both on personal and professional levels (Theron, 2005). Those who are infected, are absent from school most of the time, due to ill health. Others frequently have to attend the funerals of relatives or friends who have succumbed to the HIV and AIDS pandemic.

The consequences of the HIV pandemic have highlighted the importance of the pastoral role of teachers who are called upon to recognise and deal with the emotional distress that causes problems with children's schoolwork. The role of the educator in this climate is to educate children about the prevention of HIV and encourage openness to promote de-stigmatisation and voluntary testing and counseling. Increasingly, they must also ensure that both infected and affected children can get care, support and treatment, if necessary, by referring them to appropriate agencies (Mallmann, 2003; UNICEF, 2003). Educators have an important role to play in responding to the needs of these children since they act *in loco parentis* and may be the only responsible adults to whom the children can relate. Educators are both legally and morally obliged to offer care and support to orphans and vulnerable children (Department of Education, 2000).

Educators have to think differently about the pandemic and need to know ways of responding to the challenges facing the education system (Coombe, 2002). Educators need support in order for them to be able to offer support to their colleagues, learners and family members affected and infected by the HIV and AIDS pandemic (Boler, 2003; Bhana, et al., 2006). They need to be empowered so as to be able to cope resiliently with the challenges of the HIV and AIDS pandemic.

An asset-based approach offers us some insight into how to support teachers in this untenable situation. This approach is based on the belief that individuals, families and learning contexts have capacities, skills, resources and assets that can make contributions for positive change (Aspinwall, Richer and Hoffmann, 2001; Ebersöhn and Eloff, 2003) if helped to access these. According to the asset-based approach, people should accept that there is an HIV and AIDS pandemic and that they cannot change the situation, but should mobilise their assets to cope better with the situation (Ebersöhn and Eloff, 2003). Although the pandemic is detrimental, people should focus on the things that they can do to manage the pandemic, rather than on the negative aspects that tend to paralyse action. Intrapersonal and community based assets should be mobilised to attain help to address the problem of orphans and vulnerable children in their classrooms. For example, educators can manage the impact of having infected

loved ones by organising home-based care through Hospice. They can also help to address the problem of stigmatisation in their schools by providing people with accurate information about the HIV and AIDS pandemic (Boulton, Pepper, Walters, 1999; Theron, 2007).

In order to address the pandemic, people could connect with others for support, because positive relationships with family members, friends and support groups and accepting support from people who care about others and encourage or reinforce resilience. People can use the pandemic as an opportunity for self-growth. They can learn about the crisis and can grow through the crisis, because growth needs self knowledge. People should remain hopeful; hope is important, because it keeps people strong, realistic and positive. People should also take care of themselves by talking to psychologists or social workers, reading books, using on-line resources and joining support groups (Snyder, Rand and Sigmon, 2005; Theron, 2007; Ebersöhn, 2008; Wood, 2009). The HIV and AIDS pandemic's effects are devastating and in order for people to cope, they need to remain positive and retain hope. According to Gable and Haidt (2005), a positive attitude contributes greatly to people's flourishing or optimal functioning. People who are infected or affected by HIV and AIDS should not be pitied or viewed as inferior, because they still possess innate strengths, resources and abilities.

To summarise, the HIV and AIDS pandemic has a direct impact on the education sector. It has a pronounced adverse impact on the supply, demand and quality of education. It also impacts on educators, personally and professionally, in negative ways. There are many orphans and vulnerable children as a result of the HIV and AIDS pandemic (UNAIDS, 2007). The education systems in Sub-Saharan African countries are deteriorating due to the HIV and AIDS pandemic (Coombe, 2002; Kelly, 2002; Badcock-Walters, Kelly and Gorgen, 2004).

In some cases, the educator may be the only person available to guide these children. Based on the discussion of the needs of orphans and vulnerable children, we are aware

that educators are faced with many challenges in the sense that, apart from teaching these children in the classroom, they often have to assume the roles of counselors, social workers, priests and surrogate parents (Kelly, 2002; Theron, 2005).

Educators are sometimes heartbroken when they see the children under their care who have ability and potential having to drop out of school because they cannot afford to pay school fees (Akintola and Quinlan, 2003) examination fees or simply because their caregivers do not adequately appreciate the value of education. All these problems, especially in the context of the meager salary that teachers get and the pressure to deliver good results at the end of the year, especially for public examinations, can cause a lot of trauma for and stress on the educators (Akintola and Quinlan, 2003; Hepburn, 2001).

It is clear that educators need to be supported to cope with the effects of the HIV and AIDS pandemic. They, too, need psychosocial care and support that will help them to cope with their own grief, fears, stress and worries about the future. They also need psychosocial support to enable them to give the orphans and vulnerable children that they teach the best possible care (International HIV/AIDS Alliance, 2003; Theron, 2005;). Educators also need to be able to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance. By so doing, they will give these children a chance of becoming resilient, productive members of society (Hepburn, 2002; Govender and Farlam, 2004).

From the foregoing, it may be concluded that the HIV and AIDS pandemic is impacting negatively on education. It presents educators, education managers and stakeholders, policy makers and service providers with challenges (Coombe, 2002; Kelly, 2002; Badcock-Walters, Kelly and Gorgens, 2004). Because of the HIV and AIDS pandemic, educators, need to be empowered to become resilient so that they will be able to offer care and support to orphans and vulnerable children. Although educators are expected to function as ecosystemic sources of support in the age of HIV and AIDS, they need support, too.

## 1.7 LITERATURE STUDY

The themes and sources of the relevant literature may be summarised as follows:

### ***The role of education in the HIV and AIDS era:***

Badcock et al, 2004; Baylies, 2000  
Bennell, 2005  
Berger, 2005; Bhana et al, 2006  
Boler and Aggleton, 2005  
Boler and Jellima, 2005  
Campbell, 2003; Cohen with Epstein, 2005; Coombe, 2002  
De Walgue, 2004;  
Hall et al, 2005  
Hepburn, 2002  
Jackson, 2002; Kelly, 2000  
Richter, 2004  
Shisana et al, 2005; Subbarao et al, 2001  
Theron, 2007  
UNAIDS, 2002  
Vandemoortele and Delamonica, 2002  
World Bank, 2002

### ***The impact of HIV and AIDS on the education sector***

Bennell, 2005; Bhana et al, 2006  
Carr-Hill *et al*, 2002  
Coombe, 2000; Coombe, 2002; Coombe, 2003  
Crouch, 2001  
Donald *et al*, 2006  
Family Health International, et al, 2002

Hall *et al*, 2005  
Kelly, 2000  
Piot, 2004  
Shisana, et al, 2005  
Theron, 2007  
Rehle and Shisana, 2005  
UNAIDS, 2000  
Van Wyk and Lemmer, 2007  
Vandemoortele and Delamonica, 2002  
Wood and Hillman, 2008

***The impact of HIV and AIDS on learners***

Ansell and Van Blerk, 2004  
Avert, 2007  
Bauman et al , 2002; Bennell, 2003  
Boler and Aggleton, 2005; Boler and Carol, 2005  
Booyeseen *et al*, 2001  
Brakarsh, 2004  
Carr-Hill *et al*, 2002; Carr- Hill et al, 2003  
Change Project, 2005  
Coombe, 2000; Coombe, 2002; Coombe, 2003  
De Lannoy, 2007  
Ebersöhn and Eloff, 2002  
Family Health International, et al, 2002  
Foster and Williamson, 2000  
Hallahan and Kauffman, 2000  
Hepburn, 2002  
Kelly, 2000; Kimaryo *et al*, 2004  
Lettenery and Laporte, 2004; Lyons, 2000  
Makame *et al*, 2002; Mallmann, 2003;

Mandela, 2007; Mishra *et al*, 2005 Nyblade, 2003  
Nyblade, 2003  
Ogina, 2007 ; Pivnick and Villegas, 2000  
REPSSI, 2007  
Ritcher, et al, 2004; Ritcher, 2006  
Sengendo and Nambi, 1997  
Smart, 2003; Strode and Barret-Grant, 2001  
Strydom and Raath, 2005  
Subbarao *et al*, 2001  
UNAIDS, 2000; UNAIDS, 2002  
UNAIDS, 2007; UNAIDS, 2008  
UNESCO,2005; UNESCO, 2007  
UNICEF, 2000; UNICEF,2007  
Van Bleck and Ansell, 2005; Van Dyk, 2005  
Wood and Hillman, 2008  
Wood, 2008; Woodring *et al*, 2005  
World Bank, 2002

***The impact of HIV and AIDS on educators***

Bennell, 2003; Bennell, 2005  
Coombe, 2000; Coombe, 2003  
Hall et all, 2005 ; Kelly, 2000  
Kinghorn and Kelly, 2005;  
Save the children UK 1991  
Shisana *et al*, 2005  
Theron, 2005; Theron, 2007  
Wood and Hillman, 2008  
World Bank, 2002

## ***The need for support for educators affected and infected by the HIV and AIDS pandemic***

Akintola and Quinlan, 2003

Aspinwall *et al*, 2001

Bennell, 2005; Bhana *et al*, 2006

Boler, 2003; Boulton, *et al*, 1999

Coombe, 2000; Coombe, 2003

De Grange, 2008

Department of Education, 1999

Ebersöhn and Eloff, 2003; Ebersohn and Eloff, 2007

Fox , 2001

Gable and Haidt, 2005; Govender and Farlam, , 2004

Hall, 2004; Hepburn, 2002;

Hoadley, 2007

Kelly, 2000; Kinghorn and Kelly, 2005;

Mallmann, 2003

Shisana *et al*, 2005 ; Simbayi *et al*, 2005;

Theron, 2005; Theron, 2007; Theron, 2008

Wood, 2008

### **1.8 CONCLUSION**

This chapter has discussed the role of education in the HIV and AIDS era and the impact of HIV and AIDS on the education system, learners and on educators. The information gained, offers strong evidence that there are many problems associated with teaching orphans and vulnerable children and that teachers are struggling to cope in the age of HIV and AIDS. In the next chapter, the empirical qualitative study will be discussed in detail and the findings will be analysed to complete the problem identification phase.

## CHAPTER 2

### EMPIRICAL QUALITATIVE STUDY

#### 2.1 INTRODUCTION

In this chapter, the research process and methodology of the empirical qualitative study will be covered in depth. The data analysis findings will also be discussed, completing the problem identification (step1 of the action research cycle), as shown in Figure 2.1 below.

**Figure 2.1: Action Research Process**



## **2.2 STATEMENT OF PROBLEM**

Due to the prevailing HIV and AIDS pandemic, the number of orphans and vulnerable children has increased considerably. According to UNADS (2008), there are about 180 000 orphans and vulnerable children in Lesotho. The country is not able to cope with the needs of these children. Teachers at Lesotho primary schools are overwhelmed by the increasing number of orphans and vulnerable children entering the classroom in schools. They are not able to offer quality education, care and support to these children. They need support and empowerment to be able to offer care and support to these marginalised children.

As a researcher, my interest and background are important in determining the goal of the study. I am a teacher educator at the Lesotho College of Education. I am aware that teachers at Lesotho primary schools lack the required skills to offer care and support to orphans and vulnerable children. This study was motivated by my desire to gain knowledge and skills so as to make recommendations for the practical training of teachers at the Lesotho College of Education in order to ensure that both future and current teachers will be able to respond more effectively to the needs of orphans and vulnerable children in the classroom.

## **2.3 PURPOSE OF RESEARCH STUDY**

The primary purpose of this study is to find ways of enabling teachers in Lesotho to create physical, social and emotional environments that foster quality teaching and learning and provide care and support to orphans and vulnerable children. From the findings, some guidelines and/or interventions that could help teachers to better cope with the challenges that result from having orphans and vulnerable children in their classrooms will be developed, implemented and evaluated.

In order to attain this purpose, the first step is to engage with the teachers and establish, through empirical methods, what their needs and challenges are in dealing

with orphans and vulnerable children. To this end, a literature study was undertaken (see Chapter 1), as well as an empirical qualitative study.

The specific objectives of the empirical study, derived from the purpose, are stated below:

- To investigate the lived experiences and needs of teachers as they attempt to offer care and support to orphans and vulnerable children.
- To use the findings to develop guidelines and/or interventions that will help teachers to better cope with the challenges that result from having orphans and vulnerable children in their classrooms.
- To pilot these guidelines with a group of teachers in order to evaluate and refine them.

## **2.4 PHILOSOPHICAL FOUNDATION OF STUDY**

This section will relate the necessity of placing the research within a philosophical paradigm, the interpretive paradigm. This phase is aimed at exploring the experiences, perceptions and needs of teachers in Lesotho concerning the teaching of orphans and vulnerable children. Qualitative researchers study human action in its natural setting (Moustakas, 1994; Creswell, 1998; Eisner, 1998; Babbie and Mouton, 2001). In this study, I attempted to understand the experiences, perceptions and needs of participating primary school teachers in Lesotho concerning the teaching of orphans and vulnerable children. Since my research is placed within the interpretive paradigm it is appropriate that a brief overview of this paradigm be given.

The paradigm that will be followed in this step of the research is interpretive, since it emphasises the importance of participants' views, the context and the meaning participants hold regarding issues (Creswell, 2005). The interpretive view takes into

account the different contexts, life experiences, expectations and hopes of the informants in the research. It acknowledges that, unlike non-living things, plants and animals, human behaviour is not influenced exclusively by external factors. Humans act on their environment as much as the environment may influence their behaviour (Tesch, 1990; Connole, 1998; Creswell, 1998; Denzin and Lincoln, 2000; Patton, 2002).

The key to interpreting research lies with the idea that meaning is socially constructed by individuals in interaction with their world and that there are multiple constructions and interpretations of reality that are in flux and that change over time (Struwig and Stead, 2001; Patton, 2002; Creswell, 2005). Researchers adopting an interpretive paradigm are therefore interested in understanding what those interpretations are at a particular point in time and in a particular context. Learning how individuals experience and interact with their social world and the meaning it has for them is considered an interpretive qualitative approach (Struwig and Stead, 2001; Patton, 2002; Creswell, 2005).

An interpretive paradigm emphasises the need to see through the eyes of one's subjects and to understand behaviour in its social context (Strelitz, 2005). Since this study aims at determining the *lived experiences* of teachers dealing with orphans and vulnerable children, the interpretive paradigm was adopted.

## **2.5 RESEARCH DESIGN**

According to Babbie and Mouton (2001) and Neuman (2006), a research design is a plan, a protocol or a structured framework of how the researcher intends to conduct the research process so as to solve the research problem or question. The research design therefore describes the nature and the pattern that the research intends to follow and should include aspects such as the research methodology, approach and methods and techniques (Creswell, 1998).

The purpose of the research design is to plan and structure a given research project in such a manner that the eventual validity of the research findings is maximised (Denzin and Lincoln, 2005). It is therefore important for a researcher when developing a

research design to make a series of decisions along the following four dimensions. Firstly, he/she must take into account the purpose of the research; secondly, the theoretical paradigm informing the research; thirdly, the context within which the research is carried out; and finally, the research techniques employed to collect and analyse data (Mouton, 2001). Research design therefore includes the research question, the purpose of the study, what context will answer the research question, strategies appropriate for obtaining it, as well as the philosophical foundation on which it is based (Denzin and Lincoln, 2005).

To investigate the experiences, perceptions and needs concerning the teaching and learning of orphans and vulnerable children, of teachers at Lesotho primary schools, influenced by an interpretive paradigm, I used a qualitative approach.

## **2.6. QUALITATIVE DESIGN**

Different writers of qualitative research texts, such as Creswell (2005), Patton (2002) and Tesch (1990), organised the diversity of forms of qualitative research in various ways. For example, Patton (2002) presented ten orientations of qualitative research according to different kinds of questions that researchers from different disciplines might ask. Creswell (2005) identified five traditions, namely biography, phenomenology, grounded theory, ethnography, and the case study.

Qualitative research designs share similar features. They share a detailed engagement with the object of study; they select a small number of cases to be studied; they use a multi-method approach; and they are also flexible in that they allow the researcher to adapt and make changes to the study, where and when necessary (Babbie and Mouton, 2001; Leedy and Ormrod, 2001). The researcher's choices and actions determine the design. For example, during the research process, the researcher can create research strategies suitable for his/her research.

Creswell (2005) states that qualitative research has an emerging research design. This means that the design plans change as the data is collected, analysed and understood. Burns (2000) and Denzin and Lincoln (2005) contend that qualitative research is an inquiry approach useful for exploring and understanding a central phenomenon. It is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. It is therefore an umbrella covering several forms of inquiries that help us to understand and explain the meaning of social phenomenon with as little disruption to the natural setting as possible (Patton, 2002). According to Denzin and Lincoln (1994), the fundamental assumption of qualitative research is that a profound understanding of the world can be gained through conversation and observation in natural settings rather than through experiment and manipulation under artificial conditions. Each view presented by the participants represents a different view of the world not better, not worse just different.

I have chosen a qualitative approach in this study because this approach can be used to better understand any phenomenon about which little is known, to gain new perspectives on things about which much is already known, and also to gain in-depth information that may be difficult to convey quantitatively (Strauss and Corbin, 1990). I am aware that in qualitative research, the ability to fully describe a phenomenon is an important consideration, not only from the researcher's perspective, but also from the reader's perspective (Lincoln and Guba, 1985).

### **2.6.1 Characteristics of qualitative design**

In qualitative research, the researcher focuses on the social phenomenon under study, observes it completely, then develops a deeper and fuller understanding of the phenomenon. According to Struwig and Stead (2001) and Patton (2002) qualitative research has eight characteristics. However, in this study I looked at the four key characteristics that cut across the various interpretive and critical qualitative research designs, forms or genres, as they are called by various authors such as Patton (2002), Guba and Lincoln (1985) and Creswell (1998). They hold that qualitative research

strives to understand the meaning people have constructed about their world and their experiences. In qualitative research, the researcher is the primary instrument for data collection and data analysis. Qualitative research is inductive and produces rich descriptions.

*The researcher strives to understand the meaning people have constructed about their world and their experiences.*

Qualitative research has an interpretive character, aimed at discovering the meaning events have for the individuals who experience them and the interpretations of those meanings by the researcher (Babbie, and Mouton, 2001). According to Denzin and Lincoln (2005), qualitative research is multi-method in focus, in that it involves an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings and attempt to make sense of or interpret phenomena in terms of the meanings people bring to them. According to Lincoln and Guba (1985), and Patton (2002) and Bogdan and Biklen (2007), qualitative research aims to create understanding through looking closely at people's words, actions, beliefs, history and records within a given context. Therefore, qualitative research is conducted in the natural setting of the social actors.

Qualitative researchers try to understand the meaning people have constructed about their world and experiences; that is, how people make sense of their experiences. They are interested in understanding people's experience in context and see the actual settings as a direct source of rich data. In qualitative research, the participant's perspectives define what is real (Patton, 2002; Denzin and Lincoln, 2005).

For example, I visited selected schools to interview teachers in their own setting. The findings were interpreted from an educational perspective and this helped to contextualise the research (Mouton and Marais, 1994), since all the interviews were conducted in schools, in an educational setting.

*The researcher in qualitative research is the primary instrument*

According to Welman and Kruger (1999) and Kvale (1996), qualitative research places emphasis on humans as the instruments of data collection. That is, in qualitative research, the researcher acts as the primary instrument for data collection and data analysis (Denzin and Lincoln, 2005). The researcher's responsibility is to collect and interpret data. Since qualitative research involves fieldwork, the researcher has to go to the people, settings, sites and institutions in order to observe people's behavior in their natural setting.

Qualitative research is evaluative in nature. The researcher in qualitative research is the key instrument or tool. His/Her expertise and understanding are important elements in the research process. As an observer in the research, the researcher focuses on interests, values, strengths, characteristics, preferences and biases.

Qualitative researcher is close to data and has an "insider" perspective. Because the researcher is the principal data collection instrument, his/her role is to define the problems, select research designs, develop methodologies and collect, analyse and interpret data. He/She collects data through interviews and observations (Lincoln and Guba, 1985; Kvale, 1996; Welman and Kruger, 1999;).

Glaser and Strauss (1967) as well as Strauss and Corbin (1990), talk about the concept of the theoretical sensitivity of the researcher. This concept is useful for evaluating a qualitative researcher's skills and readiness to conduct qualitative research. These include the researcher's qualities such as his/her ability to give meaning to data, his/her capacity to understand, and his/her capability to separate pertinent data from that which is not.

Strauss and Corbin (1990), Eisner (1998) and Patton (2002) believe that theoretical sensitivity comes from a number of sources such as professional literature, professional experiences and the personal experiences of the researcher. They also state that the

credibility of a qualitative research report relies on the confidence that readers have in the researcher's ability to be sensitive to data and to make appropriate decisions in the field. Lincoln and Guba (1985) state that characteristics that make the "*instrument of choice*" for naturalistic research are the researcher's ability to respond to the environment, interact with the situation, collect the information at multiple levels simultaneously, perceive situations holistically, process the data as soon as it becomes available, provide immediate feedback and request verification of the data and, finally, explore atypical or unexpected responses.

It is vital that the qualitative researcher understands the phenomena and is able to interpret the social reality from two perspectives, the *emic* and the *etic*. A mnemonic used to remember these perspectives is *emic* – mine; *etic*- theirs. This simply means that the qualitative researcher tries to understand phenomena through the participants' eyes, then places that understanding within his/her theoretical framework of the phenomena and reconsiders the respondents' perspectives, in order to define, unravel, reveal or explain the world (Gough and Scott, 2000).

As a researcher I was able to expand my understanding through both non-verbal and verbal communication, processed data immediately, clarified and summarised material, checked with participants for accuracy of interpretation and explored unusual or unpredicted responses. In order to overcome shortcomings and biases that might have had an impact on my research I identified and monitored them.

In this research, I was a moderator, working with an assistant. I collected, processed and analysed data with the help of an assistant. I also wrote down the research findings. The assistant did some observations, recorded non-verbal responses and took some field notes, which, together with data collected by myself, were later analysed. My moderation of the data increased its reliability.

Before I interviewed the respondents, I created an atmosphere that encouraged them to talk openly and respond to questions. I listened to their responses and new ideas (Welman and Kruger, 1999; Leedy and Ormrod, 2001). I also asked them simple

questions using simple English and Sesotho language and probed to get clarity on some of the answers received (Kvale, 1996).

### *Qualitative research follows an inductive process*

According to Leedy and Ormrod (2001) and Struwig and Stead (2001), the qualitative research process is inductive in its approach, which results in the generation of new hypotheses and theories. Qualitative researchers do not search out data or evidence to prove or disprove hypotheses they hold before entering the study; rather, the abstractions are built as the particulars that have been gathered, are grouped together. Theory developed in this way emerges from the bottom up rather than from the top down. Lincoln and Guba (1985) state that qualitative researchers begin with an immersion in the natural setting, describing events as they occur, or have occurred, as accurately as possible, while building second-order constructs or a hypothesis and ultimately a theory that will make sense of the observations (Lincoln and Guba 1985; Babbie and Mouton 2001; Leedy and Ormrod, 2001; Struwig and Stead, 2001). In this research, data collected were analysed, and themes, categories and sub-categories were identified, discussed and supported with relevant literature.

### *The product of qualitative inquiry is richly descriptive*

Eisner (1998) and Patton (2002) state that a qualitative research report is descriptive, incorporating expressive language and the presence of voice in the text. According to Anderson and Arsenault (2004) thick description is a term frequently used in qualitative research to describe data that provides a complete description of a phenomenon. The primary aim of qualitative research is in-depth descriptions and an understanding of actions and events. For example, the qualitative research approach demands that the world be examined with the assumption that nothing is trivial, that everything has the potential of being a clue that may unlock a more comprehensive understanding of what is being studied (Struwig and Stead, 2001; Denzin and Lincoln 2005). In qualitative research, things such as gestures, jokes, who does the talking in a conversation, the

decorations on the walls, and the special words participants use, in fact, the entire environment, have some relevance on the qualitative researcher (Wexler, 2000; Bogdan and Biklen 2007).

Qualitative researchers describe the actions of the research participants in detail in order to understand the participants' intended meanings. Qualitative researchers are interested in investigating and responding to descriptive questions such as "*What?*" or "*How?*" because the outcome of any of these studies is not a generalisation of results, but a deeper understanding of experiences from the perspective of the participants selected for the study (Rubin and Babbie, 2001).

Qualitative reports are most effectively presented in a rich narrative, sometimes referred to as a case study. Qualitative research is therefore characterised by a rich description and provides the reader with enough information to determine whether the findings of the study could possibly apply to other settings (Stake, 1995). In this research, I collected data through interviews, and field notes. I developed and analysed the data in detail in order to obtain a high quality final product (Creswell, 2005).

## **2.7 METHODOLOGY**

Methodology refers to the way in which the researcher learns about phenomena. Methodology depends on the subject being investigated and on the researcher's background assumptions (Reichardt and Rallis, 1994). In this step of the action research process (problem identification), research was conducted from a qualitative approach; therefore, methods suited to this approach were selected.

### **2.7.1 Sampling of participants**

The sample and the sampling strategies in qualitative research have to be appropriate. Before I determined the sampling strategies, I considered the four key factors in sampling, namely the sample size, the representativeness and parameters of the

sample, the access to the sample and the sampling strategy to be used (Cohen et al., 2000; Struwig and Stead, 2001). I did not gather data from the whole population of teachers and the results from this research do not claim to be representative of the larger population; neither does it aim to generalise about the larger population. I chose the sample mainly because of the convenience of doing so. For example, financial constraints, accessibility and time considerations greatly determined the size of the sample, its representiveness, parameters and the sampling strategies used.

Lincoln and Guba, (1985), Patton (2002), Creswell (2005) and Neuman (2006) and describe purposive sampling as a method in which the researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult-to-reach population. Cohen, et al., (2000) contend that purposive sampling is the dominant sampling strategy in qualitative research, because qualitative research, seeks to understand the meaning of phenomena from the perspective of the participants. It is therefore important for the researcher to select a sample from which the most can be learned and that qualitative research focuses on information rich cases, which can be studied in depth. In this way, the researcher will build a sample that is appropriate to his/her needs.

Purposive sampling is undertaken with deliberate aims in mind (Leedy and Ormrod, 2001; Creswell, 2005). In purposive sampling, the variability common in any social phenomenon will be represented in data. This is unlike random sampling, which tries to achieve variation through the use of random selection and a large sample size. Cases and sites are selected with certain criteria in mind.

In this study, I used a purposive sampling strategy to select the participants. Lincoln and Guba, (1985); McMillan and Schumacher (2001), Creswell (2005) and Patton (2002) identify different types of purposeful sampling, which include extreme or the deviant case sampling, typical case sampling, maximum variation sampling, snowball or chain sampling, confirming or disconfirming case sampling, politically important case sampling, and convenience sampling. The three most common sampling strategies

used by researchers are stratified purposeful sampling, snowball sampling and criterion sampling. I used the purposive sampling strategy.

In this research, my sample consisted of primary school teachers who were already in the teaching field. They all had orphans and vulnerable children in their classrooms. The participating teachers had a homogeneous background. According to Smith (2004), homogeneity in background rather than in attitude is the goal in selecting participants for observing and interviewing. The participating teachers were selected from twelve (12) primary schools in the three (3) districts of Lesotho, namely Maseru, Leribe and Quthing. The total number of teachers was twelve (12). The participants were all female Basotho teachers, and all had received their training at the Lesotho College of Education. They were chosen according to their knowledge of the research content and their experience in the context studied. The homogeneity is however slightly limited by the range of the ages of the participants. It was hoped that the participants would provide the insights and articulateness needed to attain the desired richness of qualitative data. Table 2.1 below gives the biographic data of research participants.

**Table 2.1: Biographic data of research participants**

<b>Gende</b>	<b>Age</b>	<b>Qualifications</b>	<b>Class taught</b>	<b>Teaching experience</b>	<b>Home Language</b>	<b>School</b>	
Female	30	DEP	Class 5	7 years	Sesotho	A	Primary school
Female	50	PTC	Class 3	30 years	Sesotho	B	Primary school
Female	48	DEP	Class 3	13 years	Sesotho	C	Primary school
Female	35	DEP	Class 1	9 years	Sesotho	D	Primary school
Female	35	DEP	Class 7	14 years	Sesotho	E	Primary school
Female	34	DEP	Class 5	12 years	Sesotho	F	Primary school

Female	42	DEP + BEd	Class 4	8 years	Sesotho	G	Primary school
Female	69	PH/DEP	Class 5	49 years	Sesotho	H	Primary school
Female	64	APTC	Class 1	40 years	Sesotho	I	Primary school
Female	32	PTC+BEd	Class 7	9 years	Sesotho	J	Primary school
Female	30	DEP	Class 5	3 years	Sesotho	K	Primary school
Female	40	PTC	Class 5	7 years	Sesotho	L	Primary school

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### **2.7.2 Techniques and methods of data collection**

Data collection techniques in qualitative research include observations, interviews, documents and audio-visual materials and objects (Leedy and Ormrod, 2001; Patton, 2002, Creswell, 2005). It must, however, be pointed out that the nature of the data and the phenomena to be researched dictate the research method (Burns, 2000). In this research, the data collection techniques used, were phenomenological, unstructured, in-depth, one-on-one interviews with primary school teachers (Leedy and Ormrod, 2001). These techniques are suitable in cases where the researcher wants to understand the respondents' points of view (Creswell, 1998). It is important for researchers to record any useful data thoroughly, accurately and systematically using field notes or any other suitable means.

### **2.7.3 Phenomenological interviews**

According to Burns (2000) and Creswell (2005) interviewing is as popular as observation in qualitative research. Interviews yield a great deal of useful information and are good ways of accessing people's perceptions, meanings, definitions of situations, and constructions of reality (Creswell, 1998; Wellington, 2000; Leedy and Ormrod, 2001). There are three types of qualitative interviews, namely structured interviews, unstructured interviews, and semi-structured interviews (Lincoln and Guba, 1985; Bogdam and Biklen, 2007). An interview is a verbal face-to-face interchange in

which an interviewer/researcher tries to elicit information from another person/participant or interviewee (Burns, 2000). It is a two-person conversation initiated by the interviewer for the specific purpose of obtaining relevant information and a focus on the side of the researcher on content specified by research objectives of systematic description, prediction or explanation (Cohen et al., 2000).

Phenomenological interviews are specific types of in-depth interviews that are used to study the meaning or essence of a lived experience among selected participants. Phenomenological interviews are lengthy and are concerned with capturing rich research information (Kvale, 1996; Leedy and Ormrod, 2001; Groenewald, 2004). Phenomenological interviews are interviews that permit face-to-face contact with respondents, provide opportunity to explore topics in depth, and afford ability to experience the affective as well as cognitive aspects of responses. They allow the interviewer scope to explain or help clarify questions, thereby increasing the likelihood of useful responses. Again, more information can be collected through unstructured interviews than through other methods and, finally, the feedback is immediate (Cohen et al., 2000; Bogdan and Biklen, 2007).

In this study, I used phenomenological interviews in order to investigate the experiences, perceptions and needs of teachers in Lesotho concerning the teaching of orphans and vulnerable children and how teachers can be helped to better cope with the challenges that result from having orphans and vulnerable children in their classrooms. I conducted in-depth, unstructured, phenomenological individual interviews with teachers at Lesotho primary schools who had direct experience of the topic of this research study, because they taught orphans and vulnerable children in their schools (Leedy and Ormrod, 2001) to gain my data.

I used unstructured interviews to collect data, because they are more flexible and more likely to yield information that the researcher had not planned to ask for detailed material that can be used in analysis. Unstructured interviews therefore allow for more flexibility and freedom (Lofland and Lofland, 1995), because there are no strict one-

answer questions. After their initial response to the interviewer's questions, interviewees can ask for clarification, follow-up, probe or change the direction the interview is taking, as demanded by the situation (Creswell, 1998; Bogdan and Biklen, 2007; Babbie and Mouton, 2001).

In unstructured interviews, interviewees talk freely in an informal setting. They are characterised by extensive probing and open-ended questions. The researcher encourages the participants to talk in general about their experiences and then probes into topics that arise. The researcher asks participants open-ended questions, which allow them to give different responses and are conducted with individuals or with a small group of individuals (Bogdan and Biklen, 2007).

However, unstructured interviews do have some disadvantages. For example, one may get different information from different people and may not be able to make comparisons between different interviewees. They are time consuming and expensive if one has to travel long distances to conduct the interview. One also needs well-qualified and highly trained interviewers to conduct interviews. Some interviewees may not feel comfortable about answering questions in a face-to-face situation. Interviewees may distort information through recall error, selective perceptions and the desire to please the interviewer. Flexibility can result in inconsistencies across interviews and, finally, too large a volume of information may be difficult to transcribe and to manage (Cohen et al., 2000; Leedy and Ormrod, 2001).

Kvale (1996) and Leedy and Ormrod (2005) state that an interview should be in the form of a conversation, not in a question and answer form. In order to overcome the above problems, I advised the participants of the aim of the interview and also told them the exact time the interview would last. Participants were all qualified teachers who provided me with accurate, relevant, required information. The two questions that I asked the participants were clear, because I had good questioning skills and listened carefully to their responses.

The central questions that were asked during the interviews were:

What are your experiences, perceptions and needs concerning the teaching of orphan and vulnerable children?

How can you be helped to better cope with the challenges that result from having orphans and vulnerable children in your classroom?

#### **2.7.4 Interviewing process**

Silverman (1993), Eisner (1998) and Creswell (2005), and have formulated some guidelines for conducting a productive interview. According to these authors, the researcher must make sure that the interviewees are representative of the group. This means that the researcher should choose participants that he/she expects will give him/her typical perceptions and perspectives. The researcher must first get written permission to conduct the interview, spend a few minutes establishing rapport with the interviewees, find a relevant and suitable place to conduct the interview, and focus on the actual rather than the abstract. The researcher should not put words in the interviewees' mouths, but must record responses verbatim and keep his/her reactions to him-/herself.

Before the interviews were conducted, I asked for permission from the relevant school principals. I informed the participants of the purpose of the research and the exact time that the interview would take (see appendix B, C and D). I also assured them of anonymity and confidentiality. I assured those participants who confirmed that they would like to be provided with the research findings, that they would be given the results (Bassey, 1995, Berg, 1998; Burns, 2000; Leedy and Ormrod, 2001; Patton, 2002).

## **Recording data**

According to Lincoln and Guba, (1985) and Patton (2002) and data recording is a process that involves the recording of some information using an interview guide or an interview schedule, which is a list of questions. The researcher may rely on written notes or a tape recorder for recording interview data. In this research, I used field notes and a tape recorder to record interview data. An example of the recorded and transcribed interviews are attached to this thesis as appendix H and I.

## **Transcription of interviews**

The data collected through interviews has to be transcribed. Transcribing data means transforming the oral interview into a written structure for analysis purposes (Creswell, 2005). Certain steps must be followed when transcribing interviews. For example, the data collected has to be transcribed verbatim. Before the researcher transcribes the interviews, they have to be tape-recorded; the tape has to be audible. This step is important, as field notes are a written account of what the researcher hears, sees, experiences and thinks in a data collection session (Kvale, 1996; Groenewald, 2004). Field notes are used to back up tapes, and they are an important part of the analysis process. At this stage, it is important for the researcher to see to it that he/she does not prematurely categorise data (Groenewald, 2004). Before I transcribed the interviews, I looked at the field notes to verify the recorded information.

## **Field notes**

Field notes are the researcher's or observer's detailed description of what has been observed. They are a record of the research experience, which includes observations, a reconstruction of dialogue, personal reflections, a physical description of the setting and decisions made that alter or direct the research process (Creswell, 1998; Anderson and Arsenault, 2004). These notes are written on a small note pad, carried by the

researcher. The notes must be written after every event because, according to Anderson and Arsenault (2004), it is appropriate to take notes in certain settings. In this research, notes were taken by my assistant. She took notes during interview sessions, reviewed them to fill in any blanks, fixed up any scribbled information, and added any detail that she might not have had time to note. The records or field notes revealed what happened during the interview process. Leedy and Ormrod (2001) state that the advantages of conducting observations are that the researcher may shift focus as new data comes to light. These authors also state that the researcher should be flexible when conducting observations.

### **Data analysis**

According to Creswell (1998), there are three steps in analysing qualitative data, namely data reduction, constructing data displays, and drawing conclusions. Data reduction entails categorising and coding, theory development, intention, and negative case analysis. Categorisation is the process of coding and labeling sections of the transcripts or images into themes. The categories can be integrated into a theory through the iterative analysis of the data. Data displays entail displaying picture findings or figures so that data can be more easily digested and communicated. After a vigorous iterative process, the researcher can draw conclusions and verify his/her findings. During data verification and conclusion, the researcher establishes the credibility of his/her data analysis.

In this research, I read the recorded and transcribed interviews and my field notes in order to analyse them so as to gain an understanding of the perceptions and experiences of the participants, with the help of my two promoters. Thereafter, we coded the content following Tesch's steps, as mentioned by Creswell (2005). Coding is an interpretive technique that both organises the data and provides a means to introduce the interpretation thereof into certain quantitative methods. Coffery and Atkison (1996) and De Vos (1998) state that coding requires the analyst to read the data and demarcates segments within it. Each segment is labeled with a code, usually a

word or a short phrase that suggests how the associated data segments inform the researcher's objectives. Coffery and Atkison (1996) and De Vos (1998) refer to this as coding, which encompasses organising the data into categories and sub-categories. We also used contrast comparison analysis methods to identify and compare emerging key themes from the data collection process, thus ensuring a more comprehensive and coherent understanding of the data collected (Lincoln and Guba, 1985).

## **2.8 LITERATURE CONTROL**

In carrying out qualitative research, one needs to determine whether or not findings from the research support, refute or supplement existing beliefs on the topic being researched (Creswell, 2005). It is necessary to read as widely as possible existing literature, relevant to the topic being researched. Reading widely provides a framework and a context from within which qualitative research is carried out.

According to Creswell (1998), Leedy and Ormrod, (2001), Neuman (2006) and Bogdan and Biklen, (2007), all researches require literature review. Literature review involves a systematic search of books, journals, reports, libraries and the internet. The purpose of a literature review is to make a case for the practical or theoretical importance of the proposed research. It demonstrates the researcher's understanding of the subject matter and justifies the need for research. It is important that the area of focus is initially defined broadly because this allows the researcher to gain an appreciation of the wider aspects of the research topic (Anderson and Arsenault, 2004; Neuman, 2006).

A comprehensive and a well-integrated literature review is important, because it is an excellent source for selecting and focusing on a research topic. It provides the researcher with a good understanding of the issues and debates in the area in which he/she is working. It also gives the researcher an understanding of current theoretical thinking and definitions, as well as previous studies and their results (Mouton, 2001).

In this research, the literature study was conducted to form a firm theoretical framework for the study, to substantiate the orientation and the rationale for this study, to justify the research design and methodology, and to compare the research results of this study with previous studies in the field (Creswell, 2005). I thoroughly searched for useful and relevant information pertaining to the study, with the aim of gaining knowledge and ideas for other research. I also used documents and records, because they are useful sources of information, as they are always available, stable, cost effective and relevant and can contribute to this study (Lincoln and Guba 1985; Leedy and Ormrod, 2001).

## **2.9 MEASURES TO ENSURE TRUSTWORTHINESS**

All research must respond to principles that act as criteria against which the trustworthiness of the research can be evaluated. Lincoln and Guba (1985) have identified four questions to which all research must respond. These are:

- How trustworthy are the particular findings of the study, and by what criteria can they be judged?
- How applicable are these findings to another setting?
- How can people be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context?
- How can people be sure that the findings are reflective of the participants and the inquiry itself rather than a product of the researcher's biases?

Lincoln and Guba (1985) refer to these questions as establishing the "truth value" of the study, its applicability, its consistency and its neutrality. Since qualitative research requires special criteria to establish trustworthiness, Lincoln and Guba (1985), Jackson (1995) and Patton (2002) have proposed four criteria for judging the soundness of qualitative research.

For these authors, the terms validity and reliability are not suitable for the qualitative method, because they are seen as being aligned with a quantitative approach and therefore impossible to be achieved within qualitative inquiry. The authors feel that their four criteria better reflect the underlying assumptions involved in most qualitative research. These criteria include credibility; transferability; dependability; and confirmability. For them the notion of trustworthiness incorporates the above concepts. So, in this research, the model of Lincoln and Guba (1985) will be employed to ensure the trustworthiness and authenticity of the research.

### **2.9.1 Credibility**

According to Lincoln and Guba (1985), Jackson (1995) and Van Rensburg (2001), credibility involves establishing that the results of qualitative research are credible or believable from the perspective of the participants in the research. These authors point out that from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes, so the participants are the only people who can legitimately judge the creditability of the results. In qualitative research, credibility therefore refers to the researcher's ability to demonstrate that the object of the study is accurately identified and described, based on the way in which the study was conducted.

In order for the researcher to establish credibility, Van Rensburg (2001) proposes triangulation and flexibility. In this research, therefore, I used more than one method to collect data (methodological triangulation); I used interviews and observations. I compared information that I obtained, and these different sources made it possible to promote credibility. I was also aware that my views, feelings, perspectives and biases could influence the interpretation of data, so I was flexible throughout interviews and observations (Lincoln and Guba 1985; Victor, 2000).

### **2.9.2 Transferability**

Lincoln and Guba (1985) coined the term transferability, which refers to the degree to which the results of the qualitative research can be generalised or transferred to other situations, contexts or settings. From a qualitative perspective, transferability is primarily the responsibility of the person doing the generalising. The qualitative researcher therefore can enhance transferability by thoroughly describing the research context and the assumptions that were central to the research.

In order to allow the reader to evaluate the transferability of the research, the researcher is supposed to provide the readers with a thick description of the research findings. In summary, therefore, transferability is the applicability of the results of the research in one context to other similar contexts and also the extent to which the study invites readers to make connections between elements of the study and their own experiences (Lincoln and Guba, 1985).

To ensure the transferability of this study, I used purposive sampling. The participants I chose were all Basotho primary school teachers who had undergone training at the Lesotho College of Education. They were chosen because of their representativeness of the population about which conclusions were made. Again, transferability was ensured through the collection of rich descriptive data, which could be compared to other research (Lincoln and Guba, 1985; Krefting, 1991).

### **2.9.3 Dependability**

The traditional quantitative view of reliability is based on the assumption of replicability or repeatability. Essentially, it is concerned with how much of the findings can be replicated if it were to be repeated in the same context with the same participants. Auditing is also a useful procedure for establishing dependability in qualitative research. A trail is left behind and the trail comprises the tools used for data collection, raw data,

personal notes, memo's and documented procedures for analysing the data and generating theory.

The criterion of dependability in qualitative research therefore emphasises the need for the researcher to account for the ever-changing contexts within which the research occurs. The researcher is responsible for describing the changes that occur in the setting and how these changes affect the way the researcher approaches the study. Dependability means being able to account for changes in the design of the study and the changing conditions surrounding what was studied (Lincoln and Guba, 1985; Krefting, 1991; Eisner, 1998; Mouton, 2001).

In this research, the dependability of data collected, was ensured through triangulation and through asking participants probing questions. The data collected during interviews and observations were tape recorded and kept in the form of field notes for an audit trail. Again, the methodology used was in line with the goals of the research.

#### **2.9.4 Confirmability**

According to Guba and Lincoln (1985), Krefting (1991), and Eisner (1998), qualitative research tends to assume that each researcher brings a unique perspective to the study. Comfirmability therefore refers to the degree to which the results can be confirmed or corroborated by others. A number of strategies exist for enhancing confirmability in qualitative study. The researcher can document the procedures employed for checking and rechecking the data throughout the study. Confirmability builds on audit trails and involves the use of written field notes, memo's, a field diary, personal notes and reflexive journals. Therefore, in qualitative research, another person conducting the same study should confirm the findings of the study.

Confirmability therefore refers to the confirmation of the validity of the data. In this study, experienced coders re-coded and confirmed the data. An audit trail, which included the dates of interviews, the names of participants and schools at which the research was

carried out, letters to schools seeking permission to carry out the research and the notes taken during the interviews were used to facilitate the confirmation of the validity of the data.

## **2.10 DISCUSSION OF FINDINGS**

The fieldwork was carried out between January and February 2009. Interviews were conducted with individual teachers at Lesotho primary schools from three districts in Lesotho, namely Maseru, Leribe and Quthing. A saturation point was reached after twelve (12) interviews had been conducted. All the teachers interviewed, appeared to be interested and excited about the research topic. They were aware that they would benefit from the research and were willing to be equipped with skills to offer care and support to orphans and vulnerable children at Lesotho primary schools.

### **2.10.1 Data interpretation**

In this section, the findings of the interviews conducted with twelve (12) Lesotho primary teachers will be presented. The aim of the interviews was to investigate the lived perceptions, experiences and needs of teachers concerning the teaching of orphans and vulnerable children, to establish how they could be helped to better cope with the challenges that result from having orphans and vulnerable children in their classrooms.

Tesch's (1990) eight steps of data analysis were used to identify the themes below (De Vos, 1998). I identified two themes and differentiated each theme by means of various sub-themes and categories. Each theme will be discussed. The findings will be discussed in a narrative, descriptive format and will be supported by relevant verbatim quotations from the transcribed interviews. The findings will also be compared and supported by field notes and by relevant literature. Table 2.3 below presents a summary of the main research findings, categorised into themes, categories and sub-categories.

**Table 2.2: Themes identified from narratives of participants**

THEMES	SUB-THEMES	CATEGORIES
<p>1. Working with orphans and vulnerable children has a strong impact on the personal and professional contexts of teachers.</p>	<p>1.1 Teaching orphans and vulnerable children impacts on teachers personally.</p>	<p>1.1.1 Teachers feel pain.</p>
		<p>1.1.2 Teachers need personal counseling.</p>
		<p>1.1.3 Teachers feel personally inadequate to offer help to orphans and vulnerable children.</p>
	<p>1.2 Teaching orphans and vulnerable children impacts on teachers professionally.</p>	<p>1.2.1. Teachers feel professionally inadequate to help orphans and vulnerable children.</p>
		<p>1.2.2. Teachers are failing orphans and vulnerable children.</p>
		<p>1.2.3. Teachers need help so that they are able to help orphans and vulnerable children.</p>

THEMES	SUB-THEMES	CATEGORIES
2. Teachers' responses are inappropriate and may even aggravate the situation for orphans and vulnerable children	2.1 Teachers focus primarily on the material needs of orphans and vulnerable children.	2.1.1. Teachers do not focus on the psychosocial needs of orphans and vulnerable children.
		2.1.2. Teachers do not focus on emotional needs of orphans and vulnerable children.
	2.2 Teachers' negative responses aggravate the situation for orphans and vulnerable children.	2.2.1. Teachers respond inappropriately to orphans and vulnerable children.
		2.2.2. Teachers have a negative attitude to orphans and vulnerable children.

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**2.10.1.1 DISCUSSION OF THEME 1. WORKING WITH ORPHANS ANND VULNERABLE CHILDREN HAS A STRONG INMPACT ON THE PERSONAL AND PROFESSIONAL CONTEXT OF TEACHERS**

Teachers are experiencing problems due to the HIV and AIDS pandemic and the rising number of orphans and vulnerable children in schools. Their responsibilities have increased, and this has had a negative impact on the quality of teaching and learning in

the classroom. All the participants interviewed, indicated that the HIV and AIDS pandemic had affected them personally and professionally. They reported that they were overwhelmed by the personal and professional impact of living and teaching in an HIV altered milieu. They indicated that they had many orphans and vulnerable children in their classes and that teaching orphans and vulnerable children affected them personally and professionally.

Some teachers stated:

*“There are so many of these children.”*

*“Teachers are stressed and overwhelmed by the rising numbers of orphans and vulnerable children in primary schools in this country.”*

- **Teaching orphans and vulnerable children impacts on teachers personally**

Educators are overwhelmed by the increasing number of orphans and vulnerable children in their classes. These children turn to educators for help, and many educators become very involved in caring for these children. Some educators neglect themselves in the process and end up feeling burdened. Some participants feel that they had been affected personally because of the increasing number of orphans and vulnerable children. They indicated that this was a very painful experience.

Some teachers stated:

*“One cannot ignore the plight of orphans and vulnerable children.”*

*“Teachers are care-givers in the sense that they look out for these children in their classrooms.”*

This is supported by Govender and Farlan (2004), who point out that the quality of learning and teaching is under threat due to the escalating number of orphans and vulnerable children at schools. The impact of the HIV and AIDS pandemic on the lives of learners affects teachers personally, because they struggle to balance teaching with the additional demands caused by the increased levels of anxiety, limited concentration spans, severe trauma, heightened discrimination and stigma, and increased poverty experienced by learners living in the HIV and AIDS era (Foster and Williamson, 2000; Wood, 2008).

The HIV and AIDS pandemic impacts on teachers personally, because they are equally affected by the pandemic (Theron, 2007). However, their own needs are often neglected while they are supposed to meet the many needs of their learners. Teachers are not able to deliver quality teaching to learners (Wood, 2008), because there is not enough support for educators affected by the HIV and AIDS pandemic (Bennell, 2005; Hall et al., 2005; Kinghorn & Kelly, 2005; Theron, 2007).

It is evident from the above quotations that teachers are facing many challenges, personally and professionally, due to the HIV and AIDS pandemic and the escalating number of orphans and vulnerable children in schools and communities. It is clear that support for educators affected by the HIV and AIDS pandemic is essential so that they will be able to support these children.

### *Teachers feel pain*

The participating teachers felt that the pain experienced by their learners had motivated them to try to provide for their needs, in the absence of a coordinated response from the school. Some teachers expressed their feelings around the impact of HIV and AIDS on them personally as follows:

*“It is really painful.”*

*“It affects me very negatively. It hurts.”*

The contention that many teachers are pained by the orphans and vulnerable children’s situation is supported by Theron (2007), who states that many teachers are engulfed by emotional and distress as these children turn to them for help. Some teachers become intensely involved in caring for these children, to the point of taking them into their own homes (Bhana, et al., 2006). Most teachers reported that orphans and vulnerable children were a major burden on them and that teachers tended to neglect themselves in caring for these children (Theron, 2007).

From the above quotations, it is evident that working with orphans and vulnerable children was a painful experience for the participating teachers. For them, teaching orphans and vulnerable children was a traumatic and taxing experience.

#### *Teachers need personal counselling*

The participating teachers reported that not only the learners had been impacted by the HIV and AIDS pandemic; the teachers themselves were affected on personal and professional levels. They reported that some are affected or infected by the pandemic. They indicated that teachers who were HIV positive themselves or who were severely affected by the pandemic through infected family members were not able to teach properly. Many teachers had infected or affected loved ones, colleagues and learners. These experiences had left them depressed and sad. Seeing loved ones, colleagues and learners ill and dying or suffering was not easy and the experience of burying them left teachers traumatised and grieving. Some participating teachers indicated that they, too, needed counselling and support:

*“Some teachers have actually succumbed to the HIV and AIDS disease ... They really did not get any support from the school.”*

*“Very. We need it – counselling.”*

*“Even amongst ourselves as teachers we need to be able to support each other in cases where some of us are infected.”*

This is supported by ( Coombe, 2003; Hall et al., 2005; Theron, 2007) who point out that many teachers have been affected by the illness and/or the death of loved ones, leaving them with major emotional and financial problems. The HIV and AIDS pandemic affects their ability to function on both personal and professional levels. According to Coombe (2003); Hall et al., (2005); Theron (2007), the role of teachers has changed because of the impact of HIV and AIDS pandemic, which places them under extreme pressure and stress. The participating teachers emphasised the importance of counselling in the form of support so that they were better able to cope with the plight of the orphans and vulnerable children as well as the plight of their colleagues and relatives affected or infected by the HIV and AIDS pandemic.

*Teachers feel personally inadequate to help orphans and vulnerable children*

Children affected by HIV and AIDS have basic needs, such as love, food and security. If these basic needs are not met, quality teaching and learning cannot take place. It is important to mention that the HIV and AIDS pandemic impacts on orphans and vulnerable children on both material and non-material levels. Material issues, according to Richter, et al., (2004), comprise:

Livelihoods (increased poverty, food security and shelter).

Health (nutritional status, increased vulnerability to disease, higher child mortality).

Education (withdrawal from school to care for others and to save costs, increased absenteeism, lower educational performance, premature termination of education, fewer vocational opportunities, and traditional knowledge not passed on).

Non-material issues include protection, welfare and emotional health. The range of potential problems are many and varied, but may include problems caused by decreased adult supervision, decreased affection, increased labour demands, stigma and social isolation, sexual abuse and exploitation, grief and depression (Richter, et al., 2004).

In order for children to perform well at school, all the abovementioned needs must be met. However, the HIV and AIDS pandemic affects orphans and vulnerable children's emotional, physical, social, economic and human rights and also infringes on their basic right to education.

Some participating teachers stated that it was difficult to offer help to orphans and vulnerable children, because they felt personally inadequate to offer such help to these children. For example, most educators interviewed, identified problems encountered by orphans and vulnerable children, but stated clearly that they could not think of effective interventions.

Some participants commented as follows:

*“But as an individual I do not know how I can help them.”*

*“I don't know anything about HIV and AIDS.”*

*“I don't think I am equipped... enough.”*

The contention that the HIV and AIDS pandemic impacts on educators personally is supported by Hall et al., (2005), Theron (2005) and Theron, (2007). These authors state that educators are personally affected when the HIV virus infects or affects their loved ones, colleagues and learners. They become helpless, depressed and sad (Hall et al, 2005) others report a dramatic change in eating habits (Van Dyke, 2005; Theron, 2007) and feel personally inadequate to offer help to orphans and vulnerable children.

Teachers feel helpless in the face of the multiple problems posed by the HIV and AIDS pandemic to orphans and vulnerable children in their communities. They feel personally inadequate to address these children's problems (Hall et al., 2005; Theron, 2005, Theron, 2007) .

It is evident from the above quotations that the participating teachers felt inadequate to help orphans and vulnerable children and needed support on a personal level in order to be able to offer support to their learners.

- **Teaching orphans and vulnerable children impacts on teachers professionally**

According to the participating teachers, most of them were faced with numerous challenges, in the sense that, apart from teaching orphans and vulnerable children in the classroom, they sometimes also had to assume the roles of counsellors, social workers, priests and surrogate parents. The HIV and AIDS pandemic had completely altered their role. Most educators indicated that they had not received any training in how to offer care and support to orphans and vulnerable children affected by the HIV and AIDS pandemic. They indicated that they were not able to offer help to these children and felt that they were not doing justice to these children.

One teacher put it this way:

*“Even myself as a teacher, I don't think I am equipped well enough to help them, I feel like I am not giving them enough.”*

Due to the HIV and AIDS pandemic, educators have become “*all things to all people*”. They are expected to work as social workers, counsellors, caregivers and advisors (Coombe, 2003; Bhana et al., 2006).

They are also expected to teach learners how to prevent the spread of HIV and how to cope with the impacts of HIV and AIDS (Theron, 2007). Most of the participating

teachers indicated that they were not professionally equipped to help orphans and vulnerable children, especially because they had not received any support in the form of training. They therefore felt incompetent to help these children. It is evident from the above quotation that the relevant teacher felt professionally inadequate to help orphans and vulnerable children.

*Teachers feel professionally inadequate to help orphans and vulnerable children*

The participating teachers indicated that the HIV and AIDS pandemic had affected them negatively and that as a result they were functioning less well. They indicated that due to the HIV and AIDS pandemic, they experienced professional stress, associated with growing workloads, overcrowding and the frequent absence of colleagues.

It must be pointed out that there have always been high incidences of orphans and vulnerable children in Africa, as a result of the generally high mortality rates, specifically the high maternal mortality rate. AIDS however, has increased the number of orphans to unprecedented levels, and teachers are struggling to cope with the demand for care and support for these children.

Most orphans and vulnerable children face many challenges compared to other children. For example, some do not perform well academically at school; have poor educational and vocational opportunities; begin working at an early age, have lost their right to land and property; suffer from poor health and nutrition; lack adequate love, care and attention; experience exploitation, physical and sexual abuse; may become HIV positive; lack emotional support to deal with grief and trauma; experience long term psychosocial problems; experience stigma and discrimination; take drugs and other substances; and could become involved in crime.

Teachers have a major role to play in this HIV and AIDS era, which poses many challenges for them. They have to be aware of orphans and vulnerable children's needs and meet these needs, because if they are not met, children may start malfunctioning.

However, most of the teachers who were interviewed, revealed that the HIV and AIDS pandemic had impacted on them professionally and that they felt inadequate to help the orphans and vulnerable children. Some educators who were interviewed stated that they were aware of the problems posed by the HIV and AIDS pandemic and indicated that they were overwhelmed and felt helpless in the face of the HIV and AIDS pandemic:

The participating teachers stated:

*“... really do not know how they can be helped.”*

*“I really do not know how we should help, but my feeling is that we should help.”*

Teachers are impacted by the HIV and AIDS pandemic professionally (Coombe, 2000; Bennell, 2005; Kinghorn & Kelly, 2005; Shisana, et al., 2005; Simbayi et al., 2005; Theron, 2005; Bhana et al., 2006; Theron, 2007). This altered teachers' experience as related to teaching orphans and children made vulnerable by the HIV and AIDS pandemic (Hall et al., 2005).

The presence of learners affected by the HIV and AIDS pandemic has increased educators' workload, resulting in them not having enough time to attend to the academic needs of their learners, thus affecting the quality of education, teaching and learning (Louw, Shisana, Peltzer and Zungu, 2005). Teachers need teaching and learning support in order to cope with the challenges that affected learners have to face at school. Teachers have to nurture, counsel, support and feed these learners. However, many teachers are wearied by these multiple roles and distressed by the plight of their learners (Boler, 2003; Bhana et al., 2006; Hoadley, 2007; Serero, 2008; Ngemtu, 2009).

It is evident from the above quotations that teachers need to be prepared for their role as educators in a world affected by HIV and AIDS. They have a massive role to play, since HIV and AIDS pandemic has created additional challenges for them. They require

support in giving skills to promote a participatory, gender sensitive and right-based approach to HIV and AIDS. They must prepare their learners, including orphans and vulnerable children, for a life that will ensure that these children are protected from contracting HIV and AIDS and that will motivate them to live in a manner that will reduce their risk of infection; help them to contribute to the care, support and treatment of infection; help them to contribute to the care, support and treatment of infected persons; and play some part in mitigating the damaging effects of sickness and death as a result of the HIV and AIDS pandemic.

### *Teachers are failing orphans and vulnerable children*

Many teachers are faced with the increasing burden of teaching children affected by the HIV and AIDS pandemic. Some teachers feel that they are failing these children, because they sometimes call them names, stigmatise them and even discriminate against them. Some of these children experience the emotional hardship of losing parents to the HIV and AIDS pandemic. The children are severely affected by the stigma of the disease, discrimination and isolation from the members of their extended families after the death of their parents. They are teased, bullied and gossiped about by other children and some of their teachers. Stigma and discrimination have a serious effect on orphans and vulnerable children because they make it more difficult for them to deal with the disease and death of their parents.

These children are humiliated by some of the teachers and other children, so they may sometimes feel very uncomfortable at school and want to drop. Most orphans and vulnerable children run away from school for fear of being stigmatised and discriminated against by peers and some teachers, because of the misconception that children orphaned by HIV and AIDS are also HIV positive.

Some of the participating teachers interviewed put it this way:

*“It hurts, but I don’t really like the way these children are treated by some of my colleagues.”*

*“ You might hear a teacher shouting at a child; Hey you, uncared-for thing, come here!”*

*“... when a child is infected, you may find that teachers discriminate against that child or do not want to work with her/him and to help her/him.”*

*“They are impatient with them.”*

*“They become impatient with them.”*

In most areas in Africa, HIV related stigmatisation and discrimination against orphans and vulnerable children is rife. For example, in most schools, children who are either infected or affected by HIV face possible discrimination by fellow pupils and by teachers. This is due to fear, ignorance and moral judgement (Clarke, 2008). Most educators stigmatise and discriminate against children affected by the HIV and AIDS pandemic, whereas they are supposed to play a critical role in helping combating HIV related stigmatisation and discrimination against the children that they teach. HIV related stigmatisation at school exacerbate the educational inequalities and vulnerability of orphans and vulnerable children (Save the Children, 1991). It is important for educators to be trained in how to address HIV related stigmatisation and discrimination.

UNAIDS (2002) states that teachers are supposed to realise that children orphaned by AIDS suffer physical, educational and emotional setbacks from the moment that their parents are diagnosed as HIV positive. Therefore, the earlier emotional support is provided, the better the situation can be handled.

From the above teachers’ quotations, it is evident that stigmatisation is rife in most schools in the country. Teachers are also failing orphans and vulnerable children infected or affected by the pandemic. One must point out that one of the reasons why

teachers stigmatise these children, is ignorance about the HIV and AIDS pandemic, which result in a stigma being attached to HIV and AIDS.

*Teachers need help so that they are able to help orphans and vulnerable children*

Teachers, too, need to be empowered to deal with issues related to orphans and vulnerable children. Some of the teachers indicated that since their roles had changed, in order for them to be able to cope with the teaching of orphans and vulnerable children, they needed empowerment in the form of training.

Most participating teachers stated:

*“... maybe be trained on how we can approach these children, how we can talk to them at their level. As it is, we are operating in the dark.”*

*“We as teachers also need life skills.”*

*“Teachers must be made aware as professionals. They should be given the necessary skills and be taught to have patience when working with orphans and vulnerable children.”*

*“I think it is called psycho-social support. We need to know more about it.”*

*“... We live with it and we must live it.”*

According to Hepburn (2001) and Govender (2008) and the quality of teaching and learning is under severe threat due to the escalating number of orphans and vulnerable children in schools. In this HIV and AIDS era, teachers are facing new demands because of the behavioural, emotional and psychological problems that infected and affected children, especially orphans and vulnerable children, bring into the classroom. They also find that in addition to their teaching work, they are expected to provide

counselling services, act as mentors or offer pastoral care to children who are grieving or are affected by the HIV and AIDS pandemic (Kelly, 2002; Coombe, 2003; Bhana et al., 2006;). Most participating teachers stated that the teaching of orphans and vulnerable children stressed them. Many teachers felt that they were not able to offer help to these children, because they had not been effectively trained to cope with their demands.

The participating teachers indicated that they needed training in the following areas: guidance and counselling, life skills and psychosocial support, and HIV and AIDS. They stated that training in the abovementioned areas would equip them with the knowledge and positive attitude to be able to offer help to orphans and vulnerable children. They indicated that orphans and vulnerable children were vulnerable to emotional and behavioural disorders, which further complicated teaching and learning. The contention that orphans and vulnerable children will not be able to learn properly if all their needs are not met and that they may not be cooperative, is supported by Van Dyk (2005).

Having said this, it is important for teachers to be able to respond to the needs of orphans and vulnerable children. They need to be aware of these needs, be open to responding to these needs, and feel competent to do so. This will require them to have some kind of practical training to be able to address these needs. It should be pointed out that there is no right way of addressing the needs of orphans and vulnerable children, because their psychosocial needs are broad and core elements in psychosocial support are involved such as emotional needs, material needs and spiritual needs (Van Dyk, 2005).

#### **2.10.1.2 DISCUSSION OF THEME 2 – TEACHERS’ RESPONSES TO ORPHANS AND VULNERABLE CHILDREN ARE INAPPROPRIATE AND MAY AGGRAVATE THE SITUATION**

There was a strong feeling among participants that some teachers’ attitude towards orphans and vulnerable children was negative. Most of the teachers were reported to be

impatient with these children, labelling and stigmatising them and discriminating against them. Most teachers indicated that stigmatisation was rife in their schools.

Some of the participating teachers said:

*“... when a child is infected, you may find that teachers discriminate against that child or do not want to help her/him.”*

*“You might hear a teacher shouting at a child: ‘Hey you dirty, uncared-for thing, come here!’”*

*“It hurts, but I really don’t like the way these children are treated by some of my colleagues.”*

According to Hay, Smith and Paulsen (2001), HIV and AIDS affected and infected children experience stigma and discrimination from educators as well as from their peers. Stigmatisation and discrimination towards children and educators is prohibited even though in terms of the National Education Policy Act on HIV and AIDS (DoE [Department of Education, South Africa], 1999). This places them at risk of psychosocial distress due to exclusion and alienation. It must be pointed out that the educator’s attitude will largely determine the acceptance, rejection and/or stigmatisation of an orphan in a classroom (Mallmann, 2003). Therefore, countering stigma and discrimination must be a core part of AIDS related policies and programmes in schools; and training in addressing HIV-related stigmatisation and discrimination needs to be integrated into pre- and in-service education (UNESCO, 2007).

From the above quotations, it is apparent that most participating teachers were stressed and overwhelmed by the escalating number of orphans and vulnerable children in schools due to the HIV and AIDS pandemic and that their responses towards orphans and vulnerable children were aggravating the situation for these children. The participating teacher stated that most teachers discriminate against orphans and

vulnerable children, by calling them names, verbally abusing them and responding inappropriately to them.

- **Teachers focus primarily on material needs of orphans and vulnerable children**

Due to poverty, most orphans and vulnerable children lack food, proper school uniforms, and shelter, which are the basic needs. For example, in the absence of adults to provide food, children from child-headed house holds have to fend for themselves. Most of these children end up becoming street children, looking for hand-outs or begging. Some may have to resort to scavenging while some would visit other children's homes in order to get food.

Some educators are not aware that orphans and vulnerable children need material and non-material needs such as food, clothing, shelter, education, protection, health and psychosocial support. These needs have to be met in order for children to function optimally (Save the Children, 1991).

Some participating teachers stated:

*“Sometimes they will visit my children or any other teacher’s children ...”*

*“Some, it is true, lead a very hard life.”*

The needs of orphans and vulnerable children include both material and non-material needs (Richter and Rama, 2004). It is important for teachers to be aware of these needs, because if these needs are not met, these children may start malfunctioning (Killian, 2003). Richter and Rama (2004) state that the HIV and AIDS pandemic has impacted on orphans and vulnerable children both on material and non-material levels. Table 1.4 below illustrates issues pertaining to material and non-material levels (Richter and Rama, 2004).

**Table 2.3: Issues pertaining to material and non-material levels**

Material issue level	Non-material issues level
<b>Livelihoods:</b> Increased poverty, food security, shelter	<b>Protection:</b> Decreased adult supervision.
<b>Health:</b> Nutritional status, increased vulnerability to disease, higher child mortality.	<b>Welfare:</b> Decreased affection increased labour demands, sexual abuse, stigma, social isolation and exploitation.
<b>Education:</b> Withdrawal from school to care for others and save costs, increased absenteeism, lower educational performance, premature termination of education, fewer vocational opportunities and traditional knowledge not passed on.	<b>Emotional health:</b> Grief and depression.

When asked about their perceptions and experiences of teaching orphans and vulnerable children most teachers responded by referring to material needs only. To some of these teachers, a blanket and food were more appropriate than counselling; yet according to Wood (2008) orphans and vulnerable children need to be helped to cope with grief and the loss of their family members.

- **Teachers do not focus on psychosocial and emotional needs of orphans and vulnerable children**

Children who have lost their parents to HIV and AIDS are extremely vulnerable. They are exposed to many challenges in their lives, because they lack the guidance and counselling as well as support from parents or caregivers as they grow and develop. Some of these challenges impact negatively on these children’s growth and development. As a result, some of them may engage in drug and substance abuse,

enter into unhealthy relationships, indulge in violence and delinquency, and get sexually transmitted infections including the rampant, disastrous HIV and AIDS. As they go through physical, psychological and emotional changes, they become even more vulnerable to these challenges and have many questions with no readily available answers.

Some participating teachers stated that:

*“They do not perform well at all’ – they seek attention.”*

*“They are often rude towards others.”*

Orphans and vulnerable children need psychosocial support, because of the trauma and stress that they have experienced due to parental illness and death because of the HIV and AIDS pandemic (Mallmann, 2003). Psychosocial support is an ongoing process of meeting emotional, social and spiritual needs, which are considered to be essential elements of meaningful and positive human development. It extends beyond meeting children’s physical needs. Psychosocial support places great emphasis on children’s emotional needs and their need for social interaction. Programmes aimed at meeting both the psychosocial and physical needs of children are said to be holistic.

Children need to be loved, to be cared for, to feel accepted and valued by individuals and to have a sense of belonging. They also need psychosocial support, which is support that goes beyond catering for the physical or material needs of an individual, to his/her emotional and social wellbeing, which has a bearing on psychosocial health (Killian, 2003; Subbarao and Coury, 2004). Teachers need to be familiar with the emotional development and needs of orphans and vulnerable children.

It is evident from their responses that most participating teachers focused only on material needs of these children. The teachers mentioned that the children lacked food, school uniform and textbooks. They were severally not aware that the children needed

more than material support, such as clothing, food and shelter, for growth and development.

- **Teachers' negative responses aggravate the situation for orphans and vulnerable children**

According to some of the participating teachers, orphans and vulnerable children generally lack self esteem. They reported that some children were stubborn and very rude towards other children, behaving badly towards them, as if they were embittered. They tended to be antisocial, using that as a defence mechanism. Some of the teachers stated that orphans and vulnerable children had many unresolved issues in their minds. According to some of the participating teachers, these children misbehaved as a result of their caregivers not giving them much support. Some teachers stated that orphans and vulnerable children thought that the loss of a parent or parents spelt the end of life for them, too, and their behaviour became unacceptable. Some teachers pointed out that, academically, some performed well, but others not, because they were more deeply affected by the loss of their parents. They also mentioned that these children were prone to seek attention.

The psychosocial effect of losing a parent to a debilitating illness is severe and could have long-term consequences for orphans and vulnerable children's behavioural development (Hepburn, 2001; Mallmann, 2003;). These children experience anxiety, depression and despair due to lack of parental support and nurturing. This may affect their academic performance (Cohen, with Epstein, 2005). In order to ensure that these children stay on in school, teachers need to provide specialised psychosocial support to address the challenges facing these children. For example, a child who has faced prolonged illness and the death of one or both parents, he or she needs grief counselling in order to deal with the trauma of loss (UNESCO, 2007).

Teachers need to be made aware that if these children are not provided with quality psychosocial support during the terminally ill phase of their parents' illness, they may

experience emotions that are suppressed and then later manifest in destructive ways. Teachers must be empowered and capacitated to understand children who are nursing a debilitating parent or debilitating parents and those who have experienced parental death due to the HIV and AIDS pandemic ( Ebersöhn and Eloff, 2002; Mallmann, 2003). Teachers should be aware that attention-seeking or rude behaviour is a result of the psychological problems experienced by these children due to their parents' illness or death.

Looking at some of the participating teachers' remarks about the behaviour of orphans and vulnerable children, it can be concluded that some teachers responded negatively towards orphans and vulnerable children, which aggravated the situation for these children. These teachers need to be equipped with skills in dealing with children's responses to the death of a parent and grief counselling skills.

#### *Teachers respond inappropriately to orphans and vulnerable children*

The HIV and AIDS pandemic has increased challenges in the special education arena, in the sense that it has greatly increased the number of children who may be regarded as having special educational needs, in that these children are vulnerable to emotional and behavioural disorders. Teachers of orphans and vulnerable children are said to be impatient with them due to their inappropriate or irritating behaviour. Because of these children's antisocial behaviour some of the participating teachers reported that some of their colleagues were impatient with them.

They reported the following:

*"They should accept the situation they find themselves in."*

Teachers' attitude toward orphans and vulnerable children is often poor. They struggle to address the needs of orphans and vulnerable children. They are increasingly distressed by the large number of children made vulnerable by the HIV and AIDS

pandemic (Boler, 2003; Bhana et al., 2006). Consequently, these children often experience unmet needs, besides didactic lessons, which include grief counselling, hunger, accommodation and school fees. They also need support to cope with discrimination, abuse, rejection and their lost childhood (Ebersöhn and Eloff, 2002; Coombe, 2003; Bhana et al., 2006). However, most of the teachers do not give these children any support. One of the reasons may be that teachers feel that they need help to deal with the social problems displayed by orphans and vulnerable children in class.

It seems that teachers are not coping with the multiple roles that they have to play due to the HIV and AIDS pandemic (Coombe, 2003). For example, in this HIV and AIDS era, teachers are social workers, counsellors, caregivers, advisors, surrogate parents, HIV and AIDS prevention agents, as well as educators. This traumatic journey is taxing for them, according to Theron (2007). Some teachers feel stressed and are not able to cope with the teaching of orphans and vulnerable children. Many teachers respond inappropriately to these marginalised children.

*Teachers have a negative attitude towards orphans and vulnerable children*

One of the problems facing the teachers of orphans and vulnerable children is the ability to accept them and offer them care and support. Most teachers are not trained to deal with such children. These children, according to some of the participating teachers, are stubborn and often rude towards other children. They behave badly towards teachers. It is as though they are embittered. They also tend to be anti-social, using that as a defence mechanism. These children have a lot of unresolved issues in their minds. They misbehave, because care-givers are not giving them much support. Some of them seem to think that the loss of a parent or parents has spelt the end of life for them too, and, therefore, they tend to behave in ways in which other children do not behave. Academically, one will find that while some perform well, others do not, because they have been too deeply affected by the loss of their parents. It is for the teacher to help these children. The participating teachers also mentioned that these children tended to seek extra attention.

Some of the participating teachers stated:

*“Some of the orphans and vulnerable children tend to be a bit stubborn.”*

*“Sometimes these orphans are very ill disciplined.”*

*“I don’t know, or is it because they lack self-esteem.”*

From the above quotations we learn that some of the teachers were stressed by orphans and vulnerable children’s issues. They reported that teaching these children created a “lose-lose” situation, because other learners were being deprived of the teacher’s attention (Wood and Goba, 2009). Teachers complain about their professional workload because they have to adopt the roles of mentors, counsellors and welfare workers, which is not an easy task, especially since teachers have not received any kind of training in these areas (Coombe, 2003; Bhana et al., 2006; Theron, 2007). According to some of the teachers interviewed, the professional demand on them by affected or infected teachers and children was taxing. Their tasks include raising HIV and AIDS awareness, teaching HIV and AIDS prevention, aiding infected and affected learners and colleagues, shouldering increased teaching loads as colleagues are increasingly absent, and having to cope with the ordeal of HIV related illnesses, sickness and death in significant others.

It is clear from the participating teachers’ responses that most teachers were challenged by these demands and ended up displaying negative behaviour to children affected by the HIV and AIDS pandemic. The above quotations indicate teachers’ negative attitude towards the teaching of orphans and vulnerable children. Based on the findings, the HIV and AIDS pandemic is clearly impacting negatively on educators. They are experiencing trauma and relentless challenges. Teachers need support to function resiliently in the face of the HIV and AIDS pandemic so that they will be able to help their learners and colleagues affected by the pandemic. In the next chapter, the choice of intervention and justification of the intervention needed for teachers, based on a literature study and a

qualitative study, will be presented. Resilient Educators (REds) and the intervention designed to support educators affected by the pandemic by encouraging resilience as a coping skill will also be explained in detail.

## **2.11 CONCLUSION**

In this chapter, I discussed in detail qualitative empirical study in theory and practice and the findings that emerged from it. It is evident that the HIV and AIDS pandemic impacts negatively on many educators. They are affected both personally and professionally, and this imperils their ability to function properly (Coombe, 2003; Hall et al., 2005; Kinghorn and Kelly, 2005; Theron, 2007). The next chapter will describe and justify the choice and the implementation of a supportive intervention programme for educators affected by the HIV and AIDS pandemic.

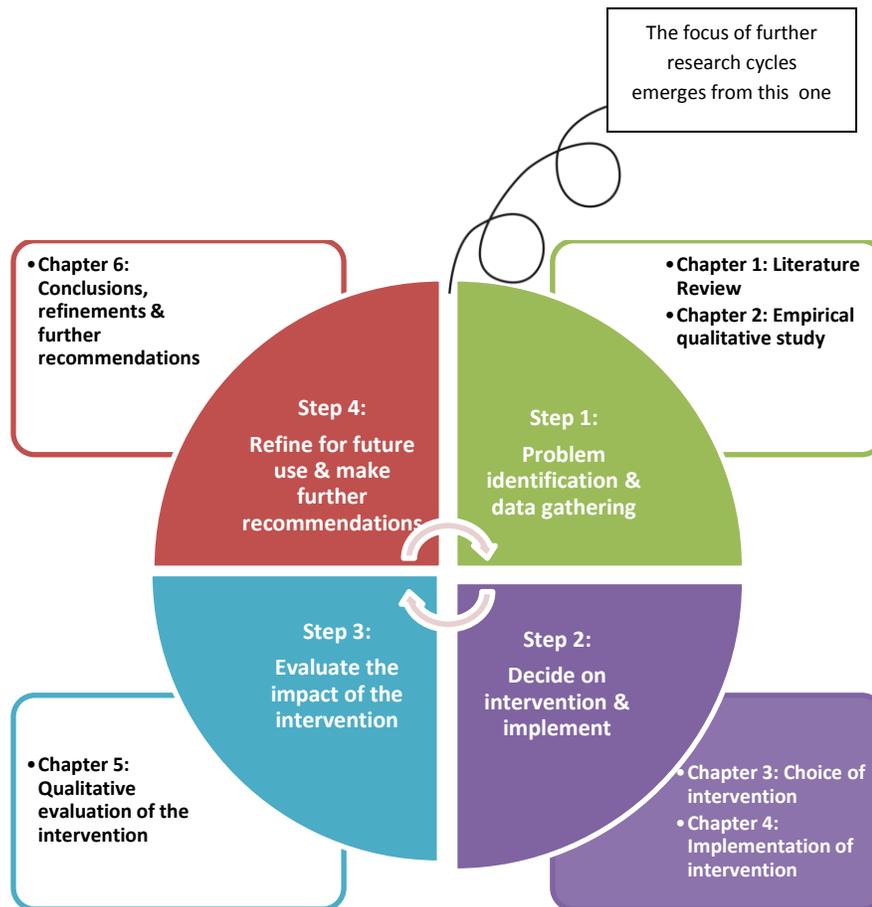
## CHAPTER 3

# RESILIENT EDUCATORS' INTERVENTION SUPPORT PROGRAMME FOR EDUCATORS AFFECTED AND INFECTED BY THE HIV AND AIDS PANDEMIC

### 3.1 INTRODUCTION

This chapter comprises the first stage of the second step of my action research process. The choice and the implementation of a supportive intervention programme for educators affected by the pandemic, based on the findings from the literature and qualitative studies, will be theoretically justified with reference to resilience theory.

**Figure 3.1: Overview of Action Research Process**



The literature study and the qualitative empirical study conducted and reported on in Chapters 1 and 2 respectively, present overwhelming evidence for the perception that educators in Lesotho are suffering both personally and professionally as a result of the HIV and AIDS pandemic. It is unlikely that they will be in a position to help children cope with the effects of the pandemic unless they develop effective ways to deal with the stressful situation in which they find themselves. This chapter will introduce, describe and justify the choice of intervention to be used to improve the situation and provide a literature-based overview of resilience theory in relation to teacher well-being. This will comprise the first phase of Step 2 of the action research process.

### **3.2 ROLES OF EDUCATORS IN THE AGE OF AIDS**

Educators are a vital part of any nation's educational system, and their important task is to protect and promote the quality of education in schools. However, the quality of teaching and learning in Sub-Saharan African schools is under severe threat, due to the HIV and AIDS pandemic (Govender and Farlam, 2004: Hepburn, 2002). The HIV and AIDS pandemic impacts on educators both personally and professionally (UNAIDS Inter Agency Task Team on Education, 2009).

Table 3.1 below summarises the personal and professional impact of HIV and AIDS on educators (UNAIDS Inter Agency Task Team on Education, 2009).

**Table 3.1: Summary of personal and the professional impacts of HIV and AIDS on educators**

<b>Personal impact</b>	<b>Professional impact</b>
Grief	Escalating workloads
Mood disturbances	Large classes
Emotional disorders/problems	Teaching and caring for orphans and vulnerable children
Elevated stress	Interacting with HIV positive colleagues and learners
Fear	Decreased morale
Poor health (e.g. disturbed sleep and poor appetite)	Multiple roles (educator, counselor, confidante, caregiver, social worker and preventive agent)
Attenuated socialisation	
Spiritual doubt	

In order for educators to stay within the education profession and to be able to provide quality education, they need supportive interventions that will help them to cope resiliently with the pandemic (Theron, 2005). Exactly *how* educators are affected, will be discussed in detail below.

Due to the HIV and AIDS pandemic, educators' roles have been affected in a variety of ways. Educators are struggling to cope with the multifaceted nature of the HIV and AIDS pandemic. The HIV and AIDS pandemic has altered their teaching and, according to educators, this is a traumatic journey. HIV and AIDS have become a heavy load and burden that educators have to carry (De Lange, Michell, Moletsane, Stuart and Buthelezi, 2006). Educators state that this heavy load is taxing them (Bhana, Morrell,

Epstein and Moletsane, 2006). Educators are overwhelmed by the professional and personal impact of living and teaching in an HIV and AIDS altered milieu.

From the foregoing, it may be concluded that educators are severely challenged by the need to provide care and support to orphans and vulnerable children, because these children have urgent additional needs, over and above the need to be educated in specific learning material (Coombe, 2003; Hall, Altman, Nkomo, Peltzer and Zuma, 2005; Bhana et al., 2006). Moreover, because of the HIV and AIDS pandemic, many educators feel that they are professionally required to respond to the HIV related needs of the children, yet they have not been professionally trained to address the plight of these children and of their affected and infected colleagues (Coombe, 2003; Hall, Altman, Nkomo, Peltzer and Zuma, 2005; Bhana et al., 2006). Many educators argue that they need a supportive intervention programme in the face of the HIV and AIDS pandemic.

### **3.3 SUPPORT FOR TEACHERS AFFECTED AND INFECTED BY HIV AND AIDS PANDEMIC**

#### **3.3.1 Present support for educators affected and infected by HIV and AIDS pandemic**

Education plays an important role in the prevention and reduction of future HIV infections (Wood and Hillman, 2008). It is also a social vaccine, according to Vandemoortele and Delamonica (2002). There is a need to address the impact of the HIV crisis by multiple roleplayers at all levels of the ecosystem (Coombe, 2003; Theron, 2005; UNESCO, 2008).

Different forms of support could assist educators who are affected or infected by the HIV and AIDS pandemic. These include HIV/AIDS related policies for educators, government support, non-governmental support, faith-based support, community support, educators' workplace support, welfare support, and research initiatives (Donald

et al., 2006). All the aforementioned forms of support for educators affected by the HIV and AIDS pandemic are available in Lesotho; however, most teachers who were interviewed, indicated that due to the multiple challenges posed by the HIV and AIDS pandemic, the support they received was not sufficient and that they needed a programme aimed at enabling affected and infected educators to cope with the pandemic.

I have already established that educators are a very vulnerable group due to the relentless challenges of the HIV and AIDS pandemic; yet relatively little has been done to support them to cope resiliently with the pandemic (Coombe, 2000; Coombe, 2002; Coombe, 2003; Bennell, 2005; Kinghorn and Kelly, 2005; Hall *et al*, 2005; Shisana et al, 2005; Simbayi et al., 2005; Theron, 2005; Bhana et al., 2006; Theron, 2007; Govender, 2008).

Research shows that support is available for people who are infected by HIV and AIDS (Ross and Deverell, 2004). This support includes access to treatment, counseling before and after testing, as well as follow-up counseling. Research indicates that there is less support available for people affected by the HIV pandemic as there is for people who are HIV positive. Researchers such as Coombe (2003), Bennell (2005), Hall *et al* (2005), Kinghorn and Kelly (2005), Shisana et al., (2005), Simbayi et al., (2005) and Theron (2007) strongly advise that educators affected by the HIV pandemic be given formal support; however, literature suggests that affected educators are not well supported. The requested and the recommended support for educators affected by the HIV and AIDS pandemic by various ecosystemic echelons, will be discussed below.

### **3.3.2 Requested support for educators affected and infected by HIV and AIDS pandemic**

Educators affected and infected by the HIV and AIDS pandemic requested that they be provided with support to enable them to function resiliently in the face of the pandemic (Bennell, 2005; Simbayi et al., 2005; Theron, 2006). According to Ngemntu (2009),

Serero (2008) and Wood and Goba, (2009), educators indicated that they needed support from their colleagues, communities, the Department of Education and school management teams. In short, educators asked for support from all levels of their ecosystems. They requested support that would help prevent HIV among both educators and learners, support for ill educators and learners, anti- retroviral support, and support for educator wellness.

Teachers in Lesotho, where this research is based, also indicated that they were personally and professionally inadequate to offer care and support to their colleagues and the orphans and vulnerable children taught by them. They reported that they were not coping with the rising numbers of HIV and AIDS affected and infected children, orphans and vulnerable children in primary schools and that they urgently required support (Coombe, 2003; Kinghorn and Kelly, 2005; MOET, 2006/7; Theron, 2005).

### **3.3.3 Recommended support for educators affected and infected by HIV and AIDS pandemic**

There are many recommendations for enabling affected educators to cope better with the challenges brought by the HIV and AIDS pandemic. These include support for health promotion, social-sector support, support for educators' wellness, legislation and policies, and learner care and ecosystemic compassion (Department of Education, 1999; Peltzer and Promtussananon, 2003; Du Preez, 2004; Ryff and Siner, 2005; Coombe, 2003; Simbayi et al., 2005; Theron, 2006; UNESCO, 2006; Wood, 2008).

Having stated some of the numerous forms of potential support for people infected and affected by the HIV and AIDS pandemic above, one is aware that very little support is specifically designed to emotionally support educators affected by HIV and AIDS. Currently, educators in most Sub-Saharan African countries have been trained regarding the transmission of the HIV virus and preventive measures (Theron, 2005). They have not been trained in how to offer care and support to the orphans and vulnerable children affected by the HIV and AIDS pandemic.

Based on the discussion above, it is clear that educators affected by the HIV and AIDS pandemic do not have access to appropriate and sufficient support. They need psychosocial care and support that will help them to cope with their grief, fears, stress and worries. They also need psychosocial care and support to enable them to give the children that they teach the best possible care (International HIV/AIDS Alliance, 2003; Theron, 2005).

It could be argued that educators need to be supported and empowered so that they are able to cope more *resiliently* in the face of HIV and AIDS realities (Bhana *et al*, 2006; Coombe, 2003; Govender, 2008; Hall et al., 2005; Kinghorn and Kelly, 2005; Theron, 2007). Resilience theory, which offers insight into how educators can develop strengths to cope with adverse situations, will be discussed below.

### **3.4 RESILIENCE THEORY**

In terms of resilience theory, individuals faced with adversity should have access to resources in order to cope effectively and be able to change what they can, or make the best choices regarding the things they cannot change (Ebersöohn and Eloff, 2002). Due to the complex and yet dynamic nature of resilience, different researchers tend to define it in different ways, depending on the specific field of focus. For example, they describe it in specific terms, such as educational resilience, emotional resilience and behavioural resilience (Cicchetti and Garmezy, 1993). Resilience is therefore a subjective concept that is not simple to define, because it is a process that depends on interaction between an individual and his/her environment (Carrey and Ungar, 2007a; Carrey and Ungar, 2007b; Hjemdal, 2007; Leadbeater, et al., 2007; Schoon, 2006).

#### **3.4.1 Evolution of resilience theory**

In simple terms, resilience is the ability to spring back from, and successfully adapt to, adversity. It is the capacity to continue functioning adaptively, despite adversity (Henderson, 1997; Fraser, 1997; Werner and Smith, 1992) and to display positive

functioning under negative circumstances (Haefffel and Grigorenko, 2007; Masten and Reed, 2005). A number of studies done on the concept of resilience agree in principle that the ability of an individual to overcome life's harsh and sometimes incapacitating circumstances and adversities in a sustainable manner, and in such a way that the outcome is positive, explains resilience (Ungar, 2005).

It is important to mention that, due to the shifts in research, the definition of resilience has undergone radical changes. Initially, the definition focused on individuals and their abilities to overcome their problems (Cameron, Ungar and Liebenberg, 2007; Kim-Cohen, 2007; Luthar and Zelazo, 2003; Schoon, 2006). Resilient individuals are said to have strong, lasting and enduring personalities. They are able to employ adaptive, positive coping mechanisms and strategies amidst the deplorable and adverse circumstances that confront them. Such individuals are less likely to resort to maladaptive responses such as denial and/or behavioural avoidance (Kaplan, 1999). For example, due to the HIV and AIDS pandemic, most orphans and vulnerable children in countries hard hit by the pandemic, such as Lesotho, experience many adversities, but not everyone is destroyed or horrifically affected by difficult circumstances and events. Similarly, some teachers have learnt to cope with the pandemic and its challenges. Those who are able to regain strength and shape after going through hardships or adversities, and live a sound and healthy life, are said to be resilient (Killian, 2004; Theron, 2005).

In the second shift, researchers then started to look at the protective factors in the environment that enabled an individual to be resilient and how these buffered the effects that risks would have on an individual. Protective factors and resources that are found in the environment that enhance resilience within an individual may be intrapersonal (found in an individual), or interpersonal (found in the environment). Interpersonal protective resources include protective resources found in families, communities and cultures (Mastern and Reed, 2005). The use of these protective resources that a context can offer to an individual, helps an individual to be resilient.

In the third shift, the emphasis was on an examination of how developmental assets could be developed in individuals and their communities in order for them to be more resilient (Ungar et al., 2008). For example, a resilient individual is able to make use of the protective resources that the context can offer and uses challenges as growth opportunities so that future hardships become more tolerable.

Finally, research on resilience has demonstrated the importance of understanding resilience as a product of both the individual's capacity to navigate his/her way to health resources and the capacity of his/her community to provide him/her with such resources in a culturally meaningful way (Boyden and Mann, 2005; Cameron *et al*, 2007; Kim-Cohen, 2007; Schoon, 2006; Ungar et al., 2008). Resilience is therefore enhanced by the interaction between the protective resources within an individual and his/her ecology. It is a dynamic construct in the sense that as risk and protective factors change, it is challenged (Boyden and Mann, 2006; Haggerty, Sherrod and Rutter, 1994; Scoon, 2006; Wong and Lee, 2005). It is clear that one cannot be expected to be constantly resilient in all areas or at every development stage of functioning. It is also important for one to mention that positive adaptation is not permanent, but is an ongoing process of balancing vulnerability with strengths (Hjemdal, 2001; Leadbeater, et al., 2007).

Because resilience is a dynamic process in which individuals interact with their environment to produce positive results amidst conditions collectively viewed as adverse (Ungar et al., 2008), it is appropriate for me to discuss the two fundamental concepts associated with resiliency, namely risk factors and protective resources.

### **3.4.2 Risk factors and protective resources**

#### *Risk factors*

Risk can be described as anything that threatens one's wellness and leads to negative outcomes. Risk factors are disabling cultural, economic or medical conditions that deny

or minimise opportunities and resources for optimal human development. They are found in individuals, in families and in the environment. If one is faced with many risk factors, the potential for resilience is threatened or weakened (Haefel and Grigorenko, 2007; Leadbeater, Marshall and Banister, 2007). Boyden and Mann (2005), Fergus and Zimmerman (2005), Greene and Conrad (2002), Masten and Reed (2005) and Wermer and Smith (1992) argue that it is not possible to talk about resilience in the absence of adversity or risk. In order for one to function resiliently, one must be able to overcome risk and must function adaptively, despite that risk. For example, adverse conditions such as the HIV and AIDS pandemic, poverty or a dysfunctional family may force one to develop negative patterns of behavior. According to Haefel et al.,(2007) and Leadbeater et al., (2007), people who are able to face multiple risks without developing negative coping skills are said to be resilient.

Resilience does not belong to an individual. It is dynamic; it is a process that depends on interaction between an individual and his/her context or environment. For example, in order for one to be resilient, one needs to negotiate support and gain access to protective resources and make use of them (Carrey and Ungar, 2007; Hjemdal, 2007; Leadbeater et al., 2007; Schoon, 2006).

### *Protective resources*

Protective resources are factors and processes that protect an individual against risk. Protective factors and processes help an individual to manage negative circumstances that may lead to maladaptive outcomes (Leadbeater et al., 2007). There are two types of protective resources that encourage resilience, namely intrapersonal and interpersonal protective resources. Intrapersonal protective resources are found within individuals. These include problem-solving skills; a positive self-concept; having a sense of humour, a good temperament and emotional strength; being autonomous; and being able to adapt to a difficult or a new situation. Interpersonal protective resources are found in one's environment. These include familial, community and cultural protective

factors (Boyden and Mann, 2005; Haggerty, Sherrod, Garmezy and Rutter, 1994; Schoon, 2006; Wong and Lee, 2005).

Protective resources should not be viewed in isolation, but are dependent on dynamic interaction between intrapersonal and interpersonal protective resources. One has to navigate towards and negotiate contextual support. That is, in order for one to become resilient, one needs to make use of the protective resources offered in the context. It is also important to mention that one's personal strength will empower one to use the available resources. Resilience is dynamic in the sense that when risk and protective factors change, it is challenged. In summary, an individual requires protective resources to help him/her cope resiliently with adversities and to make the most of such resources.

### **3.4.3 Strategies to encourage resilience**

Resilience develops through gradual exposure to difficulties and stresses at a manageable level of intensity (Kruger and Prinsloo, 2008). According to Masten and Reed (2005) it is possible and feasible to empower vulnerable people towards resilience. It is important to note that all interventions that promote resilience need to be planned carefully.

Three intervention strategies can be used to encourage resilience functioning. These are the risk-focused strategies, the asset-based strategies, and the process-focused strategies (Masten and Reed, 2005).

#### *Risk-focused strategies*

Risk-focused strategies try to prevent a problem before it materialises in order to develop healthy, positive development outcomes within an individual. These strategies diminish or stop people from being exposed to factors that could promote problematic behaviours (Mastern and Reed, 2005). Poverty, homelessness, the HIV and AIDS pandemic and orphanhood are examples of risk factors associated with poor

adjustment. A multiple of risk factors such as the above may produce negative outcomes.

An example of a risk strategy could be the introduction of policies designed to prevent hardship. In Lesotho, for example, because of an escalating number of orphans and vulnerable children, the Government in April 2009 introduced a Child Grants Programme. These are grants intended for the needy, the poorest of the poor, orphans and most vulnerable children. This Programme is presently being piloted in three communities, namely Mathula (Mafeteng District), Semonkong (Maseru District), and Thaba-Khubelu (Qachas'Nek District) and will be phased to other districts in 2010.

In the pilot phase, approximately 5 000 orphans and vulnerable children living in 1 250 poor households will be reached by this Child Grants Programme. A regular quarterly payment of M360, which is equivalent to R120 per month, will be made to individuals or households who are caring for orphans and vulnerable children to supplement their income. The objective of this Programme is to alleviate chronic poverty by supplementing the income of poor households caring for orphans and vulnerable children, including child-headed households. In most cases, people in these categories have no other income and depend on charity and even begging.

The grants are supposed to be used in the best interests of these children, to increase their school enrolment and attendance, improve their living conditions, ensure that they have access to health care and nutritious food, and to see to it that they are protected from all forms of abuse and exploitation. The programme is coordinated by the Ministry of Health and Social Welfare and a Child Grants Technical Team. It is funded by the European Commission and UNICEF through the government of Lesotho (Ministry of Health and Social Welfare, 2005).

### *Asset-focused strategies*

An asset is a positive feature, an advantage or a source of support (Ebersöhn, Eloff and Ferreira, 2007). Asset-focused strategies expand the number of protective resources. Access to protective resources and the quality of such resources help to encourage adaptive functioning. Asset-focused strategies help build assets that empower people to cope with difficult circumstances (Ebersöhn, et al., 2007). People have to determine the assets that their immediate context and communities have to offer. When people document their local available assets, such a document is called an “asset map”, which is a chart, a diagram or a visual recording of all the existing potential protective resources in the community that could help an individual to remain strong against the challenges of the pandemic. For example, there is a successful project in an informal settlement in the Eastern Cape with a high HIV and AIDS incidence. The project uses an asset-based intervention approach to help the community, including participating educators, and different stakeholders, such as social workers, faith-based leaders, non-governmental organisation representatives, HIV infected community members, school principals and clinic nurses (Ebersöhn, et al., 2007).

The participants were encouraged to identify assets within their community that they could use to help them cope with the challenges posed by the HIV and AIDS pandemic. Participants used many techniques, such as memory box marking, modelling, group discussions and diagramming activities to help them to cope with the pandemic. They were encouraged and empowered to mobilise these assets. The project helped participants to be aware of their traditional coping responses to the pandemic and their strengths. This project has helped the participants to be resilient in the sense that they have become able to stand strong against the challenges of the pandemic (Ebersöhn et al., 2007; Ferreira, 2007).

Three schools based projects have been initiated. The community has a school based garden, an information centre and a support group for people affected and infected by HIV and AIDS in this area (Ferreira, 2007). As a result of this project, the community and the educators who participated, have been empowered. The educators have indicated that they feel empowered and more committed to social upliftment. Community members have become more active in the school, so the school itself has also been empowered (Ebersöhn, Eloff and Ferreira, 2007; Ferreira, 2007).

Research has proved many times over that participants who are encouraged to map their accessible resources become empowered (Ebersöhn, et al., 2007; Mitchell, De Lange, Moletsane, Stuart and Buthelezi, 2005).

### *Process-based strategies*

Process-based strategies improve the processes that encourage resilient functioning. These strategies do not eliminate or add assets; they shape practices or processes that promote resilience. Examples of process-based strategies include supporting cultural beliefs, religious practices and rituals that strengthen adapting and coping (Masten and Reed, 2005). In order to encourage resilience, people need to use a combination of the three strategies. The International Resilient Project (IRP), which is hosting the Negotiating Resilience Project, has identified seven unique clusters that help individuals to develop resilience or to develop positively (Cameron et al., 2007). These include:

- *Access to material resources.* This relates to the availability of financial, educational, medical needs and basic human needs, such as food, clothing and shelter, as well as employment assistance and/or opportunities.
- *Access to supportive relationships.* This relates to a supportive relationship network, that is, good relationships with adults within the family and the community, peers, teachers and mentors.

- *Development of a desirable personal identity.* These are issues pertaining to life purpose, self-appraisal, aspirations and beliefs, as well as to values, including spiritual and religious identification, strengths and weaknesses.
- *Experience of power and control.* A resilient individual is self-reliant and in a position to take care of himself/herself and others and have the ability to effect change in his/her social and physical environment in order to access health material resources.
- *Adherence to cultural traditions.* This relates to one's adherence to and knowledge of global cultural practices, values and beliefs.
- *Experience of social justice.* These experiences relate to finding a meaningful role in a community, which brings with it acceptance and social equality. Though social justice can, and has been, defined in various different ways depending on one's political orientation, religious background and political and social philosophy, social justice has been loosely equated to fairness, equity and equality. Fairness in society is often thought of in terms of distribution of available resources and opportunities afforded to members of a community to realise their potential (Centre for justice, 2001). Social justice has at its heart the idea of human rights regardless of one's religious, social, economic or racial backgrounds or even the persons sexual orientation and/or health status.

The implication of persons living with HIV virus is therefore that their rights as human beings and as members of a given society are not trampled upon. These will include the rights to health care, education, employment opportunities, safety and protection (Daniels, Kennedy and Kawachi, 2000).

- *Experience of a sense of cohesion with others.* This relates to an individual's ability to balance his/her personal interests with a sense of responsibility to the community and to the greater good and feeling a part of something larger than

oneself, both socially and spiritually. It has to do with how a young person engages with others appropriately, according to cultural and community expectations, while at the same time preserving a place for himself/herself (Cameron et al., 2007).

Resilient individuals do not cope well with unusual strains and stressors only, but also tend to view challenges as learning and development opportunities (Ebersöhn and Eloff, 2002). For example, the HIV and AIDS pandemic has changed people's lives. When applied within the context of coping with the consequences of the HIV and AIDS pandemic, resilience could be described as the best way in which people can respond to the pandemic in a positive manner and how they overcome it. They can overcome this challenge by accepting that the HIV and AIDS pandemic exists; see the situation as manageable; connect with others; and use the pandemic as an opportunity for self-growth. People should stay hopeful and take care of themselves. People need to be resilient to be able to cope with the realities of the HIV and AIDS pandemic (Ebersöhn and Eloff, 2002; Theron, 2005).

#### **3.4.4 How can teachers be helped by resilience theory?**

The Resilient Educators (REds) Programme, a supportive intervention, has been proven to enable educators affected by the HIV and AIDS pandemic to bounce back, recover from and adapt in the face of the challenges posed by the pandemic (American Psychological Association, 2006; Boyden and Cooper, 2007; Theron, 2007; Ungar, 2008).

So far, REds has been piloted and implemented in four South African provinces. The results suggest that it has facilitated a degree of educators' resilience (Theron, Esterhuizen and Mabitsela, 2009). I have decided to use the REds Programme because it is a supportive intervention programme intended to buffer the personal and professional impacts of the HIV and AIDS pandemic on teachers to make them become more resilient in the face of the pandemic (Bhana et al., 2006; Coombe, 2003; Hall et

al., 2005; Kinghorn and Kelly, 2005; Theron, 2005). It has been noted that most South African educators who participated in this programme continue to function resiliently despite the negative impacts of the HIV and AIDS pandemic (Theron, 2007).

These educators have indicated that interpersonal protective resources, such as the availability of counselling and collegial support, together with intrapersonal protective resources such as assertiveness skills and religious beliefs, have contributed greatly to their wellness. They have indicated that this, however, does not mean that they were not challenged, disturbed or disheartened; however, they used interpersonal and intrapersonal resources to function adaptively. The REds Programme seems to be a suitable intervention to help teachers cope with the effects of the HIV and AIDS pandemic on their personal and professional lives, so that they will be strong enough to help their learners in turn. I therefore chose to implement this Programme among participating teachers in Lesotho. The process of implementation is discussed in the following chapter.

### **3.5 CONCLUSION**

In this chapter, educators' role in the HIV and AIDS era, the resilience theory and strategies to encourage resilience in teachers were discussed. Current support for educators was discussed, as well as additional and recommended support. The justification for introducing a supportive intervention programme for educators affected and infected by the HIV and AIDS pandemic (REds) was also discussed. The next chapter will focus on the implementation of the REds Programme as an intervention measure, comprising the second phase of Step 2 of the action research process: implementation of action.

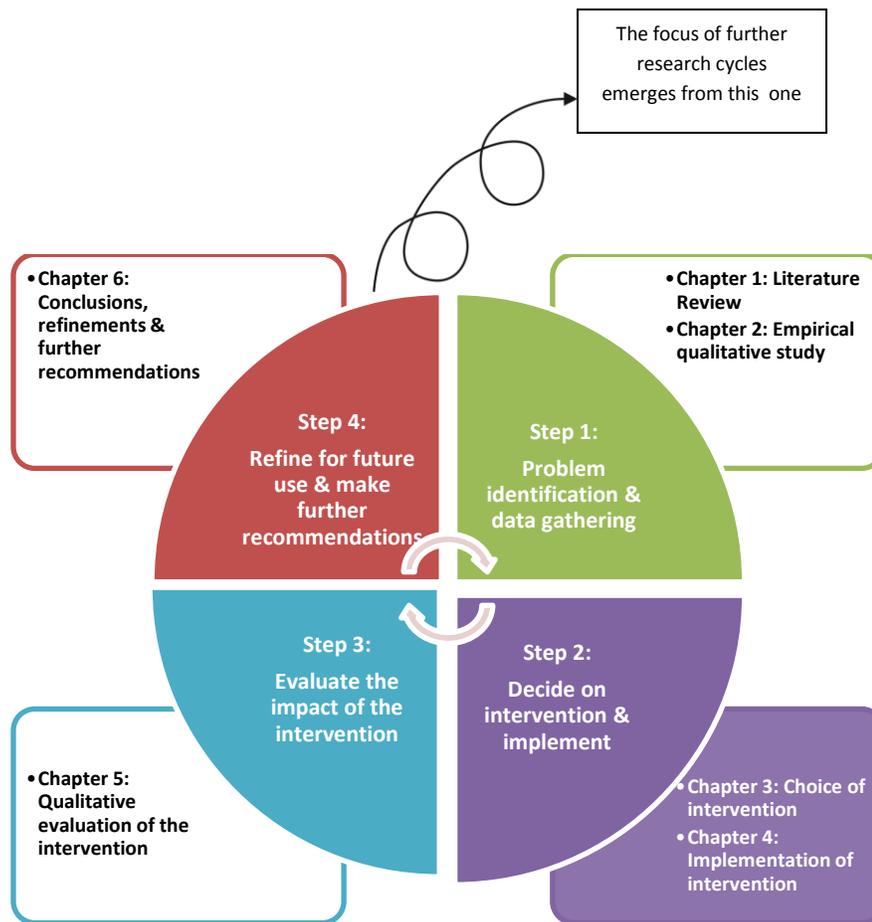
## CHAPTER 4

### PROCESS DESCRIPTION OF IMPLEMENTATION OF REds PROGRAMME

#### 4.1 INTRODUCTION

In this chapter, which covers the second stage of the second step of the action research process, the implementation of the Resilient Educators' Programme (REds) as a support programme for Lesotho educators affected by the HIV and AIDS pandemic, will be discussed.

**Figure 4.1: Overview of Action Research Process**



## **4.2 RESILIENT EDUCATORS' PROGRAMME (REds)**

The empirical study conducted and reported in Chapter 2 and the literature study in Chapter 1 have made it clear that educators are challenged by the HIV and AIDS pandemic and are in need of support. As I stated in these chapters, educators are affected by the HIV and AIDS at both personal and professional levels. For example, educators are personally affected by the HIV and AIDS pandemic when they have loved ones, colleagues or learners who are HIV positive and therefore need extra attention. They are professionally affected when they teach AIDS orphans and children affected by the HIV and AIDS pandemic. According to Theron (2005), when educators are personally or professionally affected by the HIV and AIDS pandemic, the quality of their work and their psychological functioning is imperiled. The quality of education may be threatened when educators are not able to teach effectively and efficiently, or when learners cannot learn effectively. It is important to mention that the HIV and AIDS pandemic is often associated with poor educational results (Ebersöhn and Eloff, 2002).

The Resilient Educators' Programme (REds), which is designed to support educators affected by the pandemic by encouraging resilience as a skill, has produced excellent results in supporting educators. According to Esterhuizen (2007), Theron (2006), Theron, Esterhuizen and Matsibela (2006) and Theron (2008), participant teachers who have completed the REds Programme generally experienced it as worthwhile. The data also indicated that resilience enhancing changes had taken place. For example, after participating in the REds Programme, participants reported feelings and experiences that indicated resilience, such as acceptance, enablement, synergy, greater tolerance, and coping better in an HIV and AIDS dominated environment (Theron, Esterhuizen and Matsibela, 2006). In order to support teachers affected by the HIV and AIDS pandemic in Lesotho, I implemented the REds Programme among a group of teachers in Lesotho primary schools in May 2009. The implementation process will be discussed in detail below.

### **4.3 PROGRAMME DESCRIPTION**

The REds Programme consists of nine interactive, informative and practical modules. These modules were compiled by means of multidisciplinary collaboration, in line with reported educator support needs (Coombe, 2003; Simbayi et al, 2005; Theron, 2005). The Programme includes information gathered from academic resources, including articles and textbooks, and government documents, such as policy documents, legal documents and the South African Constitution. The modules also include some information from NGO publications, the popular press and documented community resources, such as community referral workshops (Coombe, 2003; Theron, 2005; Simbayi et al, 2005).

The REds Programme in general will be discussed under the following headings: target audience; theoretical framework; and participatory and experiential learning approach.

#### **4.3.1 Target audience**

The HIV and AIDS pandemic presents educators with ongoing formidable challenges. In general, educators report high levels of stress due to the HIV and AIDS pandemic (Hay, Smit and Paulsen, 2001; Xaba, 2007; Jackson and Rothmann, 2006; Lessing and De Witt, 2007; Schulze and Steyn, 2007). It is imperative to integrate HIV and AIDS education into the school curriculum; therefore, educators have a critical role to play in ensuring that children and young people acquire essential knowledge, skills and attitudes for the prevention of HIV and AIDS and that in higher prevalence settings, learners infected with and affected by HIV have access to care and support. However, educators face several challenges, including difficult working environments, such as overcrowded classrooms, lack of materials, poor training and the high prevalence rate of the HIV and AIDS pandemic. Other challenges include stigma and discrimination, gender inequalities, concerns around morality, cultural issues and inappropriate relationships between educators and learners that make the environment in which school-based AIDS education occurs highly complex (UNESCO, 2008). Strong focus

must be placed on the situation of the educator in the HIV and AIDS pandemic (Clarke, 2008). The REds Programme is an intervention programme that is specifically aimed at enabling educators affected by the HIV and AIDS pandemic to bounce back and recover from or adapt to the situation (American Psychological Association, 2006; Boyde and Cooper, 2007).

#### **4.3.2 Theoretical framework of REds**

The theoretical framework of REds is resilience theory. In terms of the resilience theory, individuals faced with adversity must have access to resources in order to cope effectively and be able to change what they can, or make the best choices regarding those things they cannot change (Ebersöhn and Eloff, 2002). Resilience is a dynamic process in which an individual interacts with the environment to produce positive results amidst conditions collectively viewed as adverse (Ungar et al, 2008). Resilience is therefore based on an individual's capacity to navigate toward protective resources that are made available to him/her by his/her community in a culturally meaningful way (Cameron et al, 2007; Kim-Cohen, 2007; Schoon, 2006; Ungar et al, 2008). REds is aimed at enabling the affected educators to be able to function more resiliently in the face of the HIV and AIDS pandemic.

#### **4.3.3 Pedagogical approach**

Pedagogical approaches include participatory and experiential learning. These methods are known to encourage participant empowerment, because they allow participants to share their experiences and give them the opportunity to explore, expand and express their feelings, help them develop as individuals, provide an opportunity for them to practise skills, ensure that they are actively involved throughout the learning process, and encourage them to take control of their lives by allowing them to critically connect events in their own lives with their actions (De Lange et al, 2006; Ebersöhn, Eloff and Ferreira, 2007; Mitchell et al, 2005).

Participatory and experiential learning methods recognise that participants always have something to contribute in a teaching and learning process. Participants generate their own learning and because they feel empowered, they are interested and motivated in their own learning (De Lange et al, 2006; Ebersöhn, Eloff and Ferreira, 2007; Mitchell et al, 2005). In the REds Programme, facilitators collaborate with participants in the hope that they will be enabled with the help of REds and that, simultaneously, participants will help them to improve REds. Participants are asked to share their experiences and their knowledge, while facilitators impart knowledge, or reflections on their knowledge. Participants are asked to talk about, think about and use networks in their communities and resources that they are already using to cope.

Participatory activities engaged in the REds Programme include reflections, mapping activities, art therapy, music therapy, gestalt work, role-play, debate and discussion. Participants and researchers share knowledge and experiences, and resilience-enhancing changes are envisaged 'with' participants, rather than 'to' participants (Mullen and Kealy, 2005). As a supportive intervention, REds depends on a small group process. The therapeutic worth of group interaction is limited to a maximum of fifteen participants (Corey and Corey, 2002).

### **Reflections:**

Reflections are important, because they give participants the opportunity to observe, recapture and re-evaluate their experiences. Participants have to work with their experiences to turn these into lasting learning (Rooth, 2005). In all nine REds sessions in this study, participants were given space in which to reflect on their activities in writing in the reflection sheets.

### **Mapping activities:**

The REds Programme employed mapping activities. When people document their local available assets, such a document is called an asset map. Mapping activities in the

context of the HIV and AIDS pandemic involves recording all the existing and potential protective resources in people's community that can help them to be strong against the challenges of the HIV and AIDS pandemic (Ebersöhn, Eloff and Ferreira, 2007; Ferreira, 2007). REds participants identified protective assets, including welfare programmes, local NGOs, accessible counselors, hospitals, clinics; the AIDS help-line and providers of home-based care. Research has proved that where participants have been encouraged to map their protective assets, community empowerment has resulted (Mitchell, De Lange, Moletsane, Stuart and Buthelezi, 2005; Ebersöhn, et al, 2007).

### **Art therapy:**

Art therapy is a form of expressive therapy that uses art materials such as paints, chalk, clay and markers. According to therapists, there lies a healing power in art making and, again, art is a means of symbolic communication (Martin, 2004; Stuart, 2006). For example, drawings, paintings and modeling are helpful in communicating issues, emotions and conflicts. In Session Seven on how to cope with stress, participants were given a piece of clay and asked to model something that symbolised stress. They were given this task, because according to art therapy, playing with clay is a good way of reducing stress (Martin, 1998; Martin, 2006; Stuart, 2006).

### **Music therapy:**

Music therapy is a field of health care that uses music to heal. Today most hospitals use music therapy to help with pain management, to help ward off depression, to promote movement, to calm patients and to ease muscle tension. This is because music affects the body and the mind in many powerful ways. For example, music with a strong beat stimulates brainwaves. Breathing and heart rate can be altered by changes in music. Slower breathing slows the heart rate, which activates the relaxation response, which in turn lowers blood pressure and prevents the damaging effects of stress (David,2000). During REds, participants sang songs to reduce stress (Kruger,1998).

**Gestalt work:**

At the heart of Gestalt therapy lies the promotion of awareness. The individual is encouraged to become aware of his or her own feelings and behaviours, and his/her effect upon his/her environment in the here and now. The objective of Gestalt therapy is to enable the client to become more fully and creatively alive, and to become free from blockages and unfinished business that may diminish satisfaction, fulfillment, and growth. According to Yontef (2005), Gestalt work emphasises that if a person is given the right environment; he or she is able to make use of his/her expertise. For example, during counseling sessions, people are made aware of their strengths, limitations and personal resources and how to pay attention to their emotional and physical responses. In the REEds Programme, affected educators who participated were facilitated by means of Gestalt techniques to cope with the consequences of HIV and AIDS on their lives (Theron, 2005).

**Role play:**

Through role play, participants dramatise a real life situation without having rehearsed it. In the REEds Programme, role play was used in Session 5, on how to cope with stigma. Participants were given a familiar situation in which each participant was assigned a specific role. This role play enabled participants to spontaneously explore different roles and put themselves in other people's situations. It gave participants a chance to analyse some of the difficult interactions that they faced. The other participants observed and took notes to facilitate discussions after the role play (Kruger, 1998; Rooth, 2005).

**Debates:**

During debates, participants argue for two opposing views. Debates are very useful in creating platforms from which complex issues can be critically analysed and discussed (Farrant, 2004; Kruger, 1998; National Curriculum Development Centre, 2006). Debates

encourage critical thinking and public speaking among participants. In this study, participants critically debated different issues in all nine REds sessions.

### **Discussions:**

Group discussions can be held, with or without preceding brainstorming sessions (Kruger, 1998; Farrant, 2004). During all the REds sessions, the participants shared their ideas in a group discussion; talking to each other and trying to reach a solution or conclusion or fulfil the requirements for the topic.

## **4.4 PROGRAMME OUTCOMES AND MODULE CONTENT**

REds is an effective and affordable support programme for educators affected by the HIV and AIDS pandemic. It was compiled in response to the many challenges that educators are faced with due to the HIV and AIDS pandemic, based on the assumption that research should promote social upliftment (Schratz and Walker, 1995) and that structured support programmes can be resilience enhancing (Masten and Reed, 2005). The REds Programme consists of nine interactive, practical modules. Table 4.1 below summarises the contents of the nine REds' sessions.

***Table 4.1: REds' nine sessions cover the following topics***

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<b>Session One</b>	Introduction
<b>Session Two</b>	HIV and AIDS Manual for Educators Part 1 (Biomedical facts of HIV and AIDS; facts about HIV and AIDS; Myths surrounding HIV and AIDS; ways in which Transmission Takes Place; and the Phases of HIV Transmission).
<b>Session Three</b>	How to gain and give support.
<b>Session Four</b>	HIV and AIDS Manual for Educators Parts 2—4 (Care for the sick at

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home; Care for the Dying; and Management of Common AIDS-related Health Problems in the Home)

- Session Five**     How to Cope with Stigma
- Session Six**     How to Cope with Stress
- Session Seven**   Workplace Policies for Educators
- Session Eight**   Resilience in the Pandemic
- Session Nine**     Conclusion
- 

#### **4.5 PARTICIPANTS' INFORMATION**

The participants in this Programme were all Basotho teachers from five primary schools in Lesotho. In this research, I used a purposive sampling strategy to select the participants (Cresswell, 2005; Leedy and Ormrod, 2001). My sample consisted of primary school teachers who were already in the teaching field. The participants were affected by the HIV and AIDS pandemic, because they had loved ones, colleagues or learners who were infected by HIV; they had loved ones, colleagues or learners who had died from AIDS related illnesses; and they taught AIDS orphans and children affected by the HIV and AIDS pandemic.

It is important to mention that the Lesotho education system is the joint responsibility of three partners; the government, the churches and the community. Education is widely regarded as a joint responsibility shared by the government, the churches and the community (MOET, 2006/2007). Teachers who participated in the REds Programme were selected from the churches and community schools. These teachers were selected from five (5) primary schools in the Maseru district in my immediate geographical area. I went to the principals of the five schools and briefed the principals about the REds Programme. I then asked them to help me recruit volunteers to participate in the REds Programme. They agreed and the total number of teachers was

ten (10). The participants were nine (9) female teachers and one (1) male teacher (Table 4.2 below). There were no specific criteria for sampling apart from the fact that the teachers had to consider themselves to be affected by HIV and AIDS.

**Table 4.2: Summary of REds' participants from 5 primary schools in Lesotho**

<b>SCHOOL</b>	<b>GENDER</b>	<b>AGE</b>
Community Primary School	Female	45 years
Community Primary School	Female	46 years
Lesotho Evangelical Church Primary School	Female	34 years
Lesotho Evangelical Church Primary School	Female	35 years
Methodist Church Primary School	Male	64 years
Methodist Church Primary School	Female	34 years
Roman Catholic Church Primary School	Female	47 years
Roman Catholic Church Primary School	Female	55years
Anglican Church Primary School	Female	45 years
Anglican Church Primary School	Female	46 years

## **4.6 OVERVIEW OF PROCESS OF IMPLEMENTATION OF REds: SESSION ONE**

### **4.6.1 Introduction**

Session One was an introduction to the Resilient Educators programme (REds). REds was introduced to participants as a programme for educators affected by HIV and AIDS,

its objective being to support educators to continually cope resiliently in adverse circumstances (Theron, 2006).

The goals of Session One were:

to get to know each other,  
to explore the key concepts related to REs,  
to explore the ethical boundaries governing REs and,  
to determine the group rules for REs.

#### **4.6.2 Overview of Session One**

In Session One, an icebreaker was used to introduce the group members and the Programme. This was done to get the participants to relax, laugh, connect with others and learn while enjoying themselves (Rooth, 2005). The participants then discussed how the HIV and AIDS pandemic had affected them. Concepts such as *affected*, *infected* and *resilience* were explored. The participants and the facilitator then explored the purpose of REs, their mutual expectations of REs, as well as the ethical boundaries of research. Participants read a poem "*I walk the street*" (Covey, 1998:62) (see appendix E) and reflected on the session.

#### **4.6.3 Session notes and participant activities**

In Session One, ten participants attended: nine women and one man. The reason why there were more women than men, may lie in the fact that teachers at primary schools in Lesotho are predominantly female. With this group of ten participants we agreed on the attendance dates and discussed the rules regarding the REs Programme.

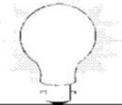
I introduced myself to the participants and they also introduced themselves. We explored the ethical issues governing the REs Programme, as stated in the overview of research of the REs Programme. Because the REs programme involves human

participants it was important for me as a facilitator to be familiar with the ethical issues governing the REds Programme. I observed precautionary measures to ensure that the participants were not endangered in any manner. According to Bell (2003), Mouton (2001) and Bassey (1995), ethical measures include providing the participants with adequate information about the research, assurance of privacy, anonymity, confidentiality, informed consent, dignity, feedback and also the assurance that none of the participants will be emotionally or physically harmed. We discussed the REds rules with the participants to ensure mutual understanding, as advised by Corey and Corey (2002). The participants did not add anything to the rules, but debated the rules that we agreed on.

I also reminded the participants that under the heading ***Help to improve REds***, each participant was expected to write down some notes on how REds could be improved. For example, they were expected to state what was the most helpful and what was least helpful and also write down aspects that they would like to change at the end of every session. To be specific, I explained to them that every participant was supposed to evaluate each session and that that was important, because REds was an intervention programme concerned with the development of an intervention; participants critically commenting on each session content and methods at its close would help to improve the REds programme. The participants completed a symbol worksheet (Saretsky, 1994) to explore the impact of the HIV and AIDS pandemic as an exercise to introduce themselves (see Figure 4.2 below).

**Figure 4.2: Symbol which describes participant best (Saretsky, 1994:15)**

*Handout 1 (Saretsky, 1994)*

	<b>Wheelbarrow</b>	Will only go when pushed.
	<b>Canoe</b>	Has to be paddled.
	<b>Kite</b>	Will fly away unless someone holds tightly to the string.
	<b>Cat</b>	Content only when petted.
	<b>Football</b>	Never know which way it will bounce.
	<b>Balloon</b>	Full of hot air.
	<b>Trailer</b>	Will go wherever pulled.
	<b>Lights</b>	Always go on and off.
	<b>Gold watch</b>	Open-faced, pure as gold, dependable, self-motivated.

Seven participants chose to be like a gold watch. They indicated that they chose to be like a gold watch because of its characteristics, namely being open-faced, dependable and self motivated, and made of pure gold. The other participant chose to be like a cat; she indicated that a cat was a humble pet, while the other two participants chose to be like a wheelbarrow, stating that they chose to be like a wheelbarrow because it was

used in their communities to draw water and carry things. Choosing to be like a gold watch was an indication that these educators were self-motivated; they just needed some support to help them cope with their daily work in the classroom.

We discussed the key concepts of REs *affected*, *support* and *resilience* with the participants. The participants did not have any problem with the two concepts *affected* and *support*. In order for me to clarify the concept of *resilience*, I used a dry twig and a green twig to demonstrate resilience. I bent both twigs; the dry twig bent and broke, but the green twig simply bent; despite the pressure exerted, it did not break, but recovered and returned to its original form and continued with life (Valliant, 1993). The participants were also asked to write down how the HIV and AIDS pandemic had affected them. Table 4.3 below summarises participants' responses.

**Table 4.3: HIV and AIDS pandemic's impact as experienced by participants**

<b>Participant</b>	<b>HIV and AIDS Pandemic</b>
1	<i>"I have lost brothers and sisters to the HIV and AIDS pandemic."</i>
2	<i>"There are many orphans and vulnerable children in my school who need my support because their parents have died of the HIV and AIDS pandemic illnesses."</i>
3	<i>"My workload has increased because teacher X has died of HIV and AIDS related illnesses."</i>
4	<i>"Sometimes I get to school late, because I have to nurse my sister who is HIV positive before I go to school."</i>
5	<i>"I have one learner in my class whose body is infected with sores because he is HIV positive. Other children tease him, and this affects me as an educator."</i>

6 *"My neighbour has disclosed her HIV status to me. I am so depressed."*

7 *"It is difficult to teach in this HIV and AIDS era, because now as educators we have new multiple roles in addition to the normal teaching."*

## Participant HIV and AIDS Pandemic

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- 8 *"Most girls in my class have left school to look after their sick parent/parents. This has affected me negatively."*
- 9 *"I am depressed, because I have just learnt that my sister is HIV positive. She says that she does not want to disclose her HIV status to her children, because she feels hopeless and fear that her children will feel betrayed."*
- 10 *"I have two orphans from my sister and two others belonging to my brother. I have a problem with buying them clothes. They complain a lot."*
- 

I then asked each participant to draw a symbol that came to his/her mind when he/she thought about the HIV and AIDS pandemic. One participant drew a grave; the other drew a sad and crying face; while another drew an emaciated HIV positive person crying for help. All the drawings and the narratives suggested themes of sadness, despair and helplessness resulting from the HIV and AIDS pandemic. This negative representation of the pandemic alerted me to the fact that this might be impacting negatively on their ability to respond resiliently (Bennell, 2005; Car-Hill, 2003; Coombe, 2003; Hall et al, 2005; Theron, 2005; Theron, 2006). This reflection was important, because it acted as a baseline measure for the views of HIV and AIDS held by the participants.

All the participants participated actively; they were not reticent in sharing ideas on how the HIV and AIDS pandemic had affected each one of them. This helped them realise that they were in the same position: all of them were affected by the HIV and AIDS pandemic. Because of its alignment with the tenets of positive psychology, REds was based on the assumption that educators affected by the pandemic had individual and collaborative strengths (Ryff and Singer, 2005; Seligman, 2005), which might be amplified to encourage resilience.

To conclude Session One, we recited a poem “*I walk down the street*” (Covey, 1998:62). The poem was aimed at helping participants relax. The participants indicated that they enjoyed and were very inspired by and excited about this poem. All of them stated that they would teach it to her colleagues and learners. They recited the poem at the top of their voices. I was touched by the fact that they were so relaxed and motivated. They mentioned that they were looking forward to the next session. Most of them indicated that when they first heard about the REds programme, they thought that it would be very formal and demanding, but after attending Session One, they were eager to attend regularly. Table 4.4 below summarises participants’ responses about Session One.

**Table 4.4 Help to improve REds**

<b>Participants’ responses</b>	<b>What was the most helpful about today’s module?</b>	<b>What was the least helpful about today’s module?</b>	<b>What would you change about today’s module before it is presented?</b>
1.	Resilient people bend but do not break.	Nothing.	Nothing.
2.	I learnt people affected by the pandemic need support.	Nothing.	Nothing.
3.	I now know the concept of resilience.	Everything we learnt, was important.	Nothing.
4.	I have to be resilient in the face of the HIV and AIDS pandemic.	None.	Nothing.

5.	Educators need to be resilient.	All what we learnt was important.	Nothing.
<b>Participants' responses</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
6.	We need to support people affected by the HIV and AIDS pandemic.	Nothing.	The session needs more time.
7.	Resilient people bend, but do not break.	None.	Nothing.
8.	The concept of resilience.	None, and I love Reds.	Nothing.
9.	We are all affected by the HIV and AIDS pandemic.	Nothing.	Nothing.
10.	I now know three REs concepts: affected, support and resilience.	The session was okay.	Nothing

I learnt from participants' comments that they were ready to participate actively in the REs Programme and were looking forward to it. Most of them were active, cooperative and ready to share their experiences with the rest of the group. There was one suggestion that this session required more time.

## **4.7 SESSION TWO: MODULE 1: HIV AND AIDS MANUAL FOR EDUCATORS (PART 1)**

### **4.7.1 Goals of Session Two were to help participants**

to be more knowledgeable on the correct facts about the HIV and AIDS pandemic;

to be less afraid of the HIV and AIDS pandemic with regard to the myths about its transmission; and

to feel more confident and comfortable about helping themselves and their family members regarding HIV related health issues.

### **4.7.2 Overview of Session Two**

The educators reported that the HIV and AIDS pandemic affected them in the sense that they had to go beyond the duties of teaching. For example, their resilience was being tested, because they had to provide services, care, advice and guidance under the adverse conditions within which they found themselves. So, educators need to be more knowledgeable about the HIV and AIDS pandemic so as to cope resiliently (Theron, et al, 2008). Module 1 of the REds Programme describes the biomedical facts of the HIV virus and aims to support educators to respond adaptively to a teaching context that demands responses more typical of counselors, social workers or medical personnel trained to prevent HIV (Theron, 2007).

### **4.7.3 Session notes and participants' activities**

I asked participants a few questions about the HIV and AIDS pandemic. I wanted to find out what they already knew about the HIV and AIDS pandemic. I established that most of them had some idea about the pandemic, although some had scant knowledge about the facts. For example, one participant was adamant that HIV was transmitted by

hugging and kissing an HIV positive person on the lips. One participant said she knew a traditional healer who could cure HIV and AIDS. I learnt from some of the participants' responses that some myths regarding the transmission of HIV had persisted. I explained to the participants that the most powerful weapon against the HIV and AIDS pandemic was knowledge and awareness. I therefore had to capitalise on their responses to explain to some of these participants that there was no cure for HIV and AIDS. I explained to them that education was a "social vaccine" according to Vandemoortele and Delamonica (2002), which could help prevent the transmission of HIV and offer care and support for those already infected or affected by the HIV and AIDS pandemic.

At the end of the session, the participants were told more about the next session, which would focus on how to gain and give support to people affected by the HIV and AIDS pandemic. They were excited and indicated that they wanted to learn more about the pandemic. They stated that Session Two had empowered them and were eager to offer help to their family members, colleagues and learners affected by the HIV and AIDS pandemic. This suggested that the participants had been enabled by the REds Programme and its contents. They commented that the REds Programme has empowered them with knowledge so that they would be able to cope with the multifaceted roles that confronted them in the age of HIV and AIDS. Table 4.5 below summarises participants' responses about Session Two.

**Table 4.5: Help to improve Reds**

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
1.	With the information I got from Session Two, I will be able to help people who are affected by the HIV and AIDS pandemic	Nothing.	Duration: the session needs more time.
2.	I have learnt a lot about the phases of HIV infection.	Nothing.	Different teaching aids on HIV phases of HIV transmission.
3.	I now know myths regarding the HIV and AIDS pandemic.	Everything was helpful.	Nothing, really.
4.	I know more about HIV transmission.	Nothing.	Nothing.
5.	My perception about HIV and AIDS has changed.	All what I learnt about in this session was valuable.	Nothing.
6.	I know about myths about HIV transmission.	-	None.
7.	I am empowered to	None.	-

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
	help people affected by the HIV and AIDS pandemic.		
<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
8.	I will be able to help my people affected by the HIV and AIDS.	Nothing.	Nothing.
9.	I am aware that HIV and AIDS pandemic is a reality.	Nothing.	Different teaching aids on phases of HIV infection.
10.	I know the correct facts about the HIV and AIDS pandemic.	None.	Nothing.

There were two suggestions. One participant commented that Session Two needed more time and a second suggested there should be more visual aids, such as posters, showing how the HIV virus was passed from one person to the next for the topic on HIV transmission. We undertook to submit the recommendations.

One participant volunteered to sing a hymn and thereafter, she gave thanks. She did this because in Lesotho, most Basotho are Christians and prayer plays an important

role in their lives. According to the Basotho, God is a source of strength. I learnt that the group was extraordinary and dynamic in the sense that they were versatile and determined to be empowered to be resilient in the face of the HIV and AIDS pandemic. I also noticed that their perception about the HIV and AIDS was beginning to change. For example, they opened up and shared their experiences regarding the HIV and AIDS pandemic. Listening to their experiences, I realised that the group experience was helping them to open up about their individual experiences of the pandemic, because they spoke easily about how they were affected.

#### **4.8 SESSION THREE: MODULE 2: HOW TO GAIN AND GIVE SUPPORT**

##### **4.8.1 Goals of Session Three were to:**

provide participants with information regarding supportive resources for educators affected by the HIV and AIDS pandemic;

provide participants with information regarding supportive resources for orphans and vulnerable children;

provide participants with some grief and bereavement skills; and

provide some grief and bereavement skills for learners to make them able to cope with grief and death.

##### **4.8.2 Overview of Session Three**

An ice-breaker was used to illustrate the importance of support. We discussed support networks for loved ones and orphans and vulnerable children affected by the HIV and AIDS pandemic with the participants. We also discussed possible grief and bereavement skills for learners to cope with grief and death.

### **4.8.3 Session's notes and participants' activities**

I then explained to the participants that Session Three would deal specifically with how to gain and give support to people affected by the HIV and AIDS pandemic. I mentioned that in order to enable educators to be resilient in the face of the HIV and AIDS pandemic, they needed to know about the available support resources and ways of coping with grief and death.

Practical experience and research have shown that educators need support when their loved ones become HIV positive and fall ill (Bhana, Morrell, Epstein and Moletsane, 2006; Coombe, 2003; Hall, Altman, Nkomo, Peltzer and Zuma, 2005; Theron, 2005; Theron, 2007). Since part of this session focused on support networks, I gave participants a list of sources of support for their HIV positive and ill loved ones. All the participants indicated that they were familiar with home-based care as a source of support and highly recommended it. They mentioned that home-based care provided medical and emotional support. It eases the responsibility and burden on the affected person and promotes the formation of a network of relationships (Van Dyk, 2005). I reminded the participants that in Session One, we had discussed the concept of support as offering a helping hand to those in need, receiving external help, giving comfort to other people and also putting oneself in another person's situation (Reber and Reber, 2001; Mullen and Kelly, 2005). In their discussion, I learnt that most participants were affected by the HIV and AIDS pandemic. They expressed their desire to be supported emotionally by all stakeholders, including the school principal, the School Governing Body (SGB), colleagues and the community. They also stated that if the Department of Education (DoE) could offer programmes such as REs to empower them, it would be much appreciated. I asked participants to draw up their own list of supportive resources in their community to establish whether they were aware of such resources. I then added supportive resources to their list.

Participants were given some time to share their feelings, opinions and information. As I observed and listened to their discussions, I learnt that they held the perception that the

support they received from the Department of Education and unions such as the Lesotho Teachers Association (LAT) and the Lesotho Teachers Trade Union (LTTU) was not sufficient. Most participants were aware of support organisations in their own area only, especially the School Based Support Team (SBST), which networks with other community organisations. I learnt that according to some participants, the SBST was the only organisation that offered support to learners and educators living with HIV and AIDS or affected by the pandemic. I then told them that they, too, were capable of giving support to those in need. They were happy to learn about that and indicated that the session had provided them with knowledge about support resources and that they felt empowered.

I then discussed the topic of support for orphans and vulnerable children with the participants. I mentioned to them that there were many resources available for them in order to offer support for orphans and vulnerable children. I made participants aware that if orphans and vulnerable children and loved ones could be supported, they could be supported, too. I issued them with pamphlets which provided them with information regarding support resources for orphans and vulnerable children from the Ministry of Health and Social Welfare (MHSW) in Lesotho. The pamphlets provided them with important, new information regarding orphans and vulnerable children of which they had previously not been aware.

We then discussed ways of supporting grieving learners and colleagues. I asked participants to visualise the appearance of death. I must point out that death is a taboo subject in Sesotho culture, so we needed to discuss it in a sensitive way. I was also aware that there were some participants in the group who were grieving. I asked the participants to draw what they visualised about death. All of them visualised death as a destructive force with power to wound them. Looking at their pictures, I became aware that participants had different pictures of death. For example, some associated death with darkness, some with sadness and fear, while others associated it with hopelessness, anger, punishment from God and shame.

In the Sesotho culture, talking about death is taboo. However, the participants welcomed the opportunity to talk about death and caring for the dying. From the discussion about death, participants realised that they were not alone in the situation and confirmed that it was important to talk about death openly in order to interact with and prepare for the potential loss of loved ones, learners, and colleagues, who were infected and affected by the HIV and AIDS pandemic. They indicated that they felt strengthened by the discussion on this topic and would be able to teach their loved ones and colleagues the importance of preparing for death. It was important for participants to discuss and share some information or resources and skills they knew about, that would help them cope with death. Examples of such resources include grief counselors, social workers, priests and psychologists. We also discussed some basic guidelines for the grieving process.

I explained to participants that it is important for them to explain the concept of death to their learners so that they would be more comfortable with and better able to deal with it when their loved ones were no longer there for them. I also asked participants to help their learners keep memory boxes. According to Mallmann (2003), a memory box can be a shoe box or a real box with special items and messages left behind by a parent for the child after his/her death, such as photographs; recorded tapes with messages; important documents that the children will need, including birth certificates, a will, and the parent's ID card; a diary; letters; or special passages from a spiritual text. A memory box is important, because it helps children come to terms with the loss of a loved one. The participants welcomed the idea of making memory boxes. They indicated that the memory boxes would enable them, their learners and their loved ones to cope with death (Ebersöhn and Eloff, 2006). The participants indicated that although the idea of a memory box was foreign to them, it made sense to them.

One participant was very quiet that day. I learnt from the other participants that she had just received the news that her brother had passed away due to AIDS. She was touched by some of the topics that were discussed that day. I felt bad, because I was not aware

of that. This has taught me to know my participants, understand their feelings, as well as to put myself in their shoes.

Towards the end of the session, participants reported that they were feeling empowered, liberated and enabled by the REds Programme. They mentioned that they felt freer to discuss the issues they could not discuss before they participated in the REds Programme and were ready to help their loved ones, colleagues and learners affected by the HIV and AIDS pandemic. They expressed their desire to learn more from the REds Programme, which they found informative. They stated that they were looking forward to Session Four, which would focus on caring for the ill and dying. Table 4.6 below summarises participants' responses about Session Three.

**Table 4.6: Help to improve REds**

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
1.	I know where to get help for loved ones and learners affected by the HIV and AIDS pandemic.	Nothing.	Nothing.
2.	I have learnt about the importance of the memory box.	Nothing.	Nothing.
3.	The session has taught me to talk openly about death.	None.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
4.	I now know resources where I can refer people affected by the HIV and AIDS pandemic.		Give the session more time.
5.	I can now counsel people who are grieving.	Nothing.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
6.	I am aware that I can also offer support to people affected by the HIV and AIDS pandemic .	None.	Nothing.
7.	I know places where orphans and vulnerable children can get support in my community.	Nothing.	Nothing.
8.	REds has empowered me with grief and	Nothing.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
	bereavement skills.		
9.	I am now aware that it is important to honour the wishes of the ill loved ones.	Nothing.	Nothing.
10.	There are many supportive resources in my area for people affected by the HIV and AIDS pandemic.	Everything was helpful.	It is okay, nothing to change.

One participant commented that the session needed more time, and I took note of that. We agreed that we would recommend that this session receive more time.

#### **4.9 SESSION FOUR: CARE OF SICK AND DYING AT HOME: MODULE 3: HIV AND AIDS MANUAL FOR EDUCATORS (PARTS 2 – 4)**

##### **4.9.1 Goals of Session Four**

- Session Four was the continuation of Session Two. It focused on caring for the ill. At the end of the Session, participants were expected to:
- be less afraid of the HIV and AIDS pandemic regarding care for the sick and infection control at home:

- have the basic principle on the use of medicine;
- have learned to do things that help HIV and AIDS infected and affected people to stay healthy;
- have learned how to care for dying loved ones;
- know how to identify and manage common AIDS related health problems in their homes;
- be able to recognise danger signs, and how to seek more help for themselves and their family members; and
- be more confident and comfortable because they would be able to help themselves and their family members affected by the HIV and AIDS pandemic.

#### **4.9.2 Overview of Session Four**

We used a fictional story to illustrate the HIV infection and how to live well with the infection. We also discussed nutritional guidelines facilitating health precautions, health promotion, the physical care of HIV infected loved ones and home-based management of HIV and AIDS.

#### **4.9.3 Session's notes and participants' activities**

We looked at a fictional story, featuring two characters named Yulia and Mukasa (AIDS Support Organisation, 1993). From the story, we identified four themes dealing with the following topics: ***care for the sick at home; care for the dying; basic use of medicine; and management of common AIDS-related problems in the home.*** The story related how Mukasa contracted HIV through casual sex with a woman in town in 1984. In 1985, he married Yulia, unaware that he was HIV positive; he then passed the

HIV virus to Yulia. In 1986, Yulia gave birth to her first child. In 1988, she had a second child. Unfortunately, the second child was infected with HIV. Yulia took the baby to the doctor, who became concerned about Yulia and the baby's health. The doctor advised Yulia to take an HIV test, but Yulia was scared to break the news to Mukasa and to go and collect her HIV test results. In 1989, their second baby died, and in 1991 Mukasa became ill and died of an AIDS related illness. In 1992, Yulia, too, was diagnosed with AIDS. She accepted the situation and supported people who were affected and infected by the HIV and AIDS pandemic. Yulia died in 1994. The people from her village remembered her good work and spoke about her legacy.

Yulia's story was touching. Some participants even cried when we were discussing the story. They indicated that they put themselves in Yulia's shoes and wondered how they would have coped. Yulia and Mukasa's story helped participants to understand that one step towards resilient functioning is for one to accept a situation that one cannot fight, such as the HIV and AIDS pandemic. In the story, Yulia cared for people who were HIV positive or dying from AIDS-related illnesses, advising them to eat a healthy diet and to practise good hygiene.

Participants learnt that it was important to practise good hygiene, eat a healthy diet and know one's HIV status. Some suggested that people should know their status before they got married. We discussed the symptoms of AIDS, such as a cough that persists for more than a month, dermatitis, shingles, thrush, cold sores, enlarged lymph glands, weight loss, diarrhoea and fever. Most participants were not familiar with all these symptoms.

In our discussion about undergoing an HIV test before marriage, some participants indicated that taking the test before marriage would be difficult for them, due to their culture. For example, according to Sesotho culture, women do not negotiate safe sex with their partners or insist on the use of a condom (Kimaryo, Okpaku, Shongwe & Feeney, 2004; Jackson, 2002). In our discussion, participants mentioned that the cultural practice of men having multiple concurrent partners was still prevalent and that

that was one of the major contributors to HIV infection in Lesotho. Some participants commented that providing in-depth knowledge about the HIV and AIDS pandemic could help to minimise the high rate of HIV infection in Lesotho. I noted that the participants were showing signs of resilience from their comments.

I had a slight problem with the information regarding caring for the dying. In the Sesotho culture, openly talking about death is taboo. In fact, talking openly about death is interpreted as hastening the process of death! The concern is that other people may think that one is happy about the prospect of benefits from the deceased property, such as insurance money or a death gratuity. However, we had to discuss the topic of care for the dying, because one of the Session’s goals was to impart knowledge on how to care for dying loved ones. At first, the participants were not comfortable to talk about death. I explained to them that it was imperative for us to talk about death, because death was a necessary end. After a long debate, the participants agreed to talk about death and caring for the dying. The discussion about caring for dying loved ones changed their perceptions about death. They indicated that the topic was new to them and that they felt strengthened after having discussed death so that they would be in a position to discuss it with their loved ones and colleagues in future. They mentioned that the topic was important because it prepared them for death something they chose not to think about before they participated in the REds Programme. Table 4.7 below summarises participants’ responses about Session Four.

**Table 4.7: Help to improve REds**

<b>Participant</b>	<b>What was the most helpful about today’s module?</b>	<b>What was the least helpful about today’s module?</b>	<b>What would you change about today’s module before it is presented?</b>
1.	I can now take care of my sick sister.	Nothing.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
2.	I have gained a lot of information on how to care for an HIV positive patient.	Nothing.	Nothing.
3.	I can now manage common AIDS related problems at home.	The lesson was superb.	More time.
4.	I have a broad knowledge on how to care for ill loved ones.	Nothing	Since the information in this session is massive. I think this session needs more time – maybe three separate sessions.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
5.	I have learnt that non-compliance to medicine is harmful.	Nothing.	More time.
6.	Diet is important for people living with HIV and AIDS.	-	Nothing.
7.	I need to practise good hygiene.	N/A	Add the topic on ARVs.
8.	I can recognise danger signs of HIV positive people.	Nothing.	Nothing.
9.	The session has empowered me with knowledge on the correct use of medicine.	None.	More time.
10.	I now know how to care for the ill loved ones.	Nothing.	Nothing.

Again, two participants suggested that the session must be given more time, because a lot of information was covered. The other participant commented that the session should include information on ARVs, and I took note of that. There were no negative comments.

## **4.10 SESSION FIVE: MODULE 4: HOW TO COPE WITH STIGMA**

### **4.10.1 Goals of Session Five**

Session Five's goals were:

to explore the concept of stigma;

to explore the various ways of addressing stigma; and

to offer affected educators knowledge and strategies on how to tackle and cope with the stigma surrounding the HIV and AIDS pandemic.

### **4.10.2 Overview of Session Five**

Session five began with an ice-breaker, to introduce stigma as experienced by the participants. The concept of stigma was explored, and different ways of tackling stigma were discussed. The participants also drew a school or community where less stigma existed, listed ways of combating stigma and discussed strategies to cope with stigma. The session was concluded with inspiring thoughts and a reflection on the session.

### **4.10.3 Session' notes and participants' activities**

I asked the participants to role play any situation in which stigma was present and to define stigma in their own words. In the role play, one "actress" was HIV positive. Because she disclosed her HIV status to her employer, she was expelled from work. This person was stigmatised because of her HIV status. It is difficult to eradicate the stigma attached to HIV and AIDS. The stigma associated with HIV and AIDS is rife, so it is important for people to learn to manage the stigma and try to tackle it in their communities.

After watching the role play, we came to the conclusion that the stigma meant a spoiled identity and that to stigmatise was to label someone; to see someone as inferior because of an attribute (Change Project, 2005). I asked the participants to discuss stigma as one of the factors driving or fuelling the HIV pandemic. They mentioned that they were aware that HIV was a sexually transmitted infection associated with death. This caused many fears and prejudice, collectively described as stigma. They also mentioned that stigma in the context of the HIV and AIDS pandemic was largely due to lack of knowledge regarding the pandemic and that stigma increased HIV infection risk. I mentioned that various types of stigma existed, but that in Session Five we would focus on secondary stigma, which manifested itself through social isolation and gossip, specifically about the behavior and the HIV status of people living with HIV and AIDS (PLWHA).

To further help participants understand the concept of stigma, I asked them to discuss how some people behaved towards people living with the HIV and AIDS pandemic (PLWHA). One participant mentioned that she had lost a brother to an AIDS related illness. People from her village stigmatised the entire family; her family experienced physical and social isolation, gossip and judgmental attitudes.

Another participant stated that stigma had serious effects on individuals. She mentioned that when she lost her husband, she was discriminated against by members of the family and her colleagues. They teased, called her names and gossiped about her HIV status. She was no longer welcomed by friends and colleague. According to her family members, she was responsible for her husband's death, because they assumed that she had infected her husband with the HIV virus. The participants concluded that stigma was largely fuelled by lack of knowledge. They mentioned that they were aware that most people who were HIV positive, were in denial, out of fear of stigma and discrimination. They mentioned that in most cases people living with HIV and AIDS were treated with indignity and their human rights were violated.

I then asked the participants to explore other forms of stigma and share their findings and opinions. From our discussion, we came to the conclusion that stigma resulted from fear, stemming from inadequate knowledge, rigid norms and values, as well as lack of recognition of stigmatising behavior or attitudes. Having discussed different forms of stigma, I helped participants to strategise ways to overcome stigma. Table 4.8 below summarises participants' responses about Session Five.

**Table 4.8: Summary of Session five responses**

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
1.	REds has taught me how to break the cycle of stigma and discrimination associated with the HI virus.	Nothing.	Nothing.
2.	That inadequate knowledge about the HIV and AIDS pandemic leads to stigmatising actions.	Nothing.	Nothing.
3.	I now know how to tackle stigma and I know various types of stigma.	None.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
4.	One way of tackling stigma is to involve people living with HIV to address learners.	Nothing.	Nothing.
5.	Stigmatising PLWA is bad.	N/A	Nothing.
6.	Stigma towards PLWA leads to spread of HIV.	Nothing.	Nothing.
7.	I feel better equipped to do something about stigma at my school.	Nothing.	Nothing.
8.	People who stigmatise PLWA are naïve.	Nothing.	To add nothing.
9.	I can now combat stigma at my school.	None.	Nothing to add.
10.	I am well informed on how to deal with stigma at my work place.	Nothing.	Nothing.

There were no suggestions or negative comments in this Session. According to participants, Session Five was very informative, especially because most participants indicated that they had had first-hand experience of stigma. All the participants confidently mentioned that they were now better equipped to deal with stigma in their schools and communities.

#### **4.11      SESSION SIX: MODULE 5: WORKPLACE POLICIES ON HIV AND AIDS: GUIDELINES FOR EDUCATORS**

##### **4.11.1    Goals of Session Six**

Session Six goals were to provide participants with:

up-to-date information on legislation on HIV and AIDS in education;

information on educators' rights with regard to discrimination in the context of the HIV and AIDS pandemic;

up-to-date information about educators' rights with regard to absenteeism and leave;

up-to-date information on their rights with regard to protection at school against the HIV and AIDS pandemic; and

up-to-date information on a supportive school environment in the context of the HIV and AIDS pandemic.

##### **4.11.2    Overview of Session Six**

An ice-breaker was used to introduce the concept of rights. Participants also completed a quiz on discrimination and educators' rights. Participants did an exercise in the form of a checklist to determine whether schools were following certain protective cautionary

measures against the HIV and AIDS pandemic at school. They also rated their schools in terms of providing a supportive school environment for educators. For example, participants determined if their school had a Health Advisory Committee (HAC) and Educator Support Team (EST) in place and, if not, what could be done to establish them. At the end of the session, they read the extract *“Put the glass down”* and then reflected on the session.

#### **4.11.3 Session’s notes and participants’ activities**

As an introduction, I gave each participant a half-full glass of water to hold up in the air and asked them how heavy they thought the glass was. I waited and did not give any instruction to see what they would do. After some time, one participant asked me whether it was in order to put the glass down. I told that participant that it was correct for her to ask me a question, because she had a right to question. Others complained that the glasses were heavy and that they were growing tired, so they put their glasses down; I explained to them that they, too, had the right to decide. I told them that the purpose of the exercise was to illustrate their right and that they had the right to choose to hold the glass or to put it down.

We also discussed a supportive school environment with the participants. Most participants felt that their school environments were not supportive enough. They indicated that at their schools, the rights of People Living with HIV and AIDS were still violated, which contributed to the spread of HIV and the inhumane treatment of these people. They also indicated that most educators reported that the HIV and AIDS pandemic was sapping their energy, because they had to go way beyond the duties of teaching. Their resilience was tested, because they had to provide services, care, advice and guidance, despite the adverse conditions in which they found themselves.

I therefore asked them to identify aspects that they regarded important in the creation of a supportive school environment and what kind of support they would like to be provided with. The participants indicated that the kind of supportive school environment

they would like, was one that addressed human rights and educator stress and assisted educators in dealing with death and grief.

Under the topic of a supportive school environment, I indicated to the participants that the National Policy on HIV and AIDS for Learners and Educators (Section 13) recommended that schools should establish their own Health Advisory Committees (HAC). It is important to mention that Session Six differed from the previous sessions, because most educators were familiar with most goals, because the participants were already knowledgeable about their rights. For example, they were familiar with the National Policy on HIV and AIDS for Learners and Educators. I was happy to realise that the educators were aware of their rights. The participants commented that they found the concept of a supportive school environment valuable. They mentioned that they were also motivated to establish an HAC and an EST in their schools. Table 4.9 below summarises participants' responses about Session Six.

**Table 4.9: Summary of participants' responses to Session Six**

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
1.	I am aware of educators' rights regarding the HIV and AIDS pandemic.	Nothing.	Nothing.
2.	I have learnt about the supportive school environment in the context of HIV and AIDS.	None.	Nothing.
3.	I now know more about the	Nothing.	Nothing.

provisions of legislation on HIV and AIDS in education.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
4.	Educators who are HIV positive are not supposed to be discriminated against.	N/A.	Nothing.
5.	I have learnt about the importance of a supportive environment for employees who are living with HIV and AIDS.	Nothing really.	Nothing.
6.	I now know about universal precautions at	Nothing.	Nothing.
7.	I am aware of the Health Advisory Committee, the School Governing Body and the Educator Support Team's roles in the context of the HIV and AIDS.	Nothing.	Nothing.
8.	I know about the National Policy on HIV and AIDS for educators and learners.	Everything is clear.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
9.	I have learnt about educators' rights with regard to absenteeism and leave in the context of HIV and AIDS.	Nothing.	Nothing.
10.	I am now aware that educators cannot be forced to take an HIV test.	Nothing.	Nothing.

There were no suggestions, which suggested that participants were satisfied with the information they gained from Session Six. We closed the session with a prayer.

#### **4.12 SESSION SEVEN: MODULE 6: HOW TO COPE WITH STRESS**

##### **4.12.1 Goals of Session Seven were:**

to explore the concept of stress; and

to explore coping skills for addressing stress

##### **4.12.2 Overview of Session Seven**

An icebreaker was used to introduce the concept of stress to participants. Mechanisms to manage personal and work stress were also explored. The participants completed a joy list. To conclude the Session, the participants listened to music to relax and release stress.

#### 4.12.3 Session Seven's notes and participants' activities

I gave the participants a piece of clay and asked them to make something out of the clay that symbolised stress. I then asked them to explain their models. This is where I realised that all the participants were experiencing stress. I gave them this task, because I wanted to reduce the stress levels of the participants; because according to art therapy, playing with clay is a good way of reducing stress. The participants enjoyed this activity.

**Figure 4.3: A photo of participants moulding stress in session seven**



I then asked the participants to explain stress in their own words. The participants were asked to identify common stressors in their lives. Their stresses included:

Money problems

HIV and AIDS illnesses

Change in life style

Personal loss due to HIV and AIDS illnesses

Job changes

Fear of retrenchment due to HIV and AIDS

Unwanted pregnancy and HIV infection

Fear of rape and HIV infection

Children leaving school to look after their parents with HIV and AIDS illnesses

## Poverty and unemployment

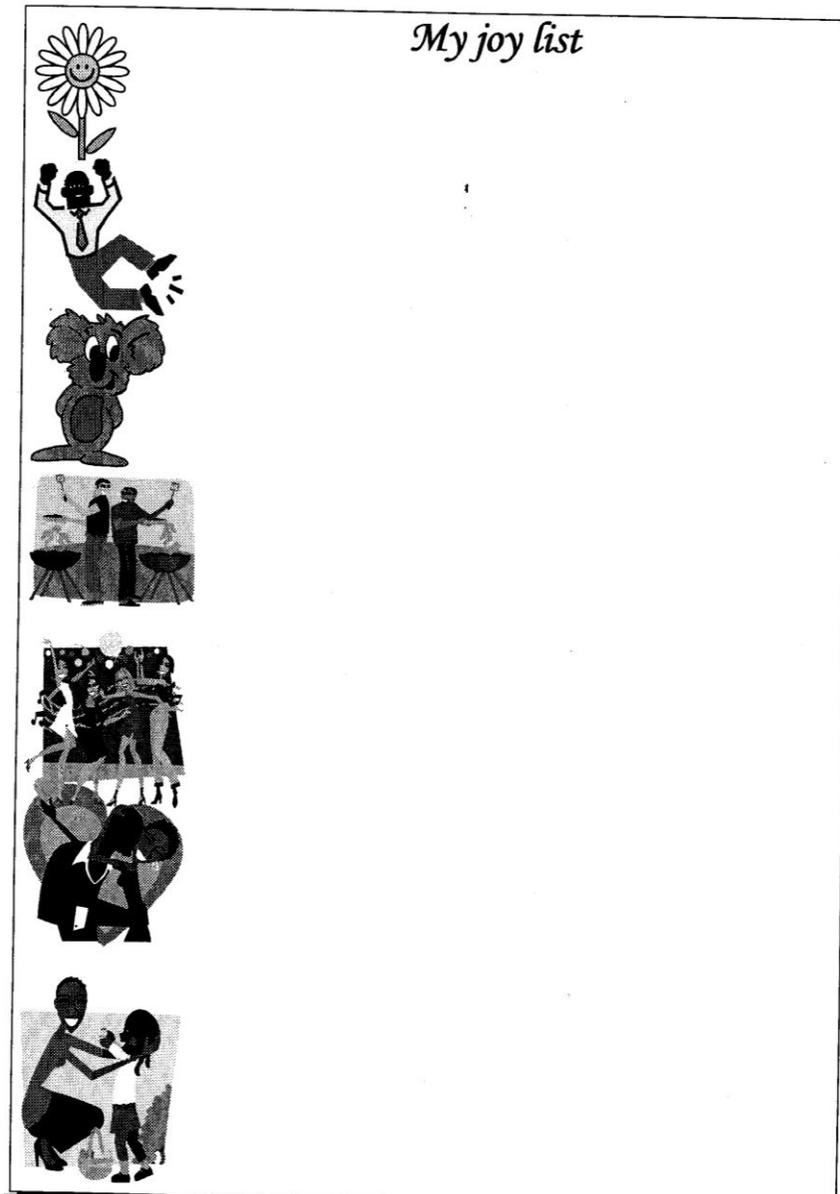
Looking at participants' stressors, I became aware that HIV and AIDS was one of the main stressors. It was evident that the HIV and AIDS pandemic and its risks and negative impacts, played a role in exacerbating their stress levels. Some participants said that they lacked the skills to deal with the death of loved ones, colleagues and learners, and that this lack of knowledge was placing extra stress on them. They indicated that they needed skills to cope with stress.

I asked the participants to choose three main stressors from their list and relate ways of managing those stressors. I asked each participant to share with the group as to how he or she was coping with his/her stressors. I became aware that this was a difficult exercise, because most of the participants struggled. This indicated that they were not sure how to cope with stress. One participant responded by saying that knowing one's stressors was important. This was true, because that knowledge helps one to avoid stressful situations.

We then came to the conclusion that managing stress involved identifying the irrational beliefs that contributed to one's stressors, replacing them with rational ones. I then asked the participants to complete a table on managing stress. They struggled a bit, but in the end they realised what their stressors were and that stress could be managed by countering an irrational thought with a rational argument.

All participants were aware that in order to combat stress, stressors must be understood. They indicated that they had benefitted from this exercise. They stated that before the session, they had no idea how to cope with stress. One participant said that she was aware that in order for one to be able to deal with stress, one should not become overwhelmed, but handle each task as it came, or selectively deal with matters in some priority. The participants completed the "joy list" on pages 117 and 118 of REs and stated that it was important to remember beautiful moments because such

moments were a source of joy and lifted one up and generated feelings of joy. The participants were very happy and delighted while completing their “joy list”.



Towards the end of Session Seven, I played some Sesotho songs to get the participants to relax. They listened and enjoyed the music. I heard one participant saying, “Stress is a fact of life, and everyone has ups and downs. Life would be dull without ups and downs, so the best way to deal with stress is to have a positive attitude towards life”. Another participant stated, “From today onwards, I will be able to identify

my stressors and deal with them positively.” This made me happy, because most participants were now able to identify their stressors and were in a better position to cope with stress. I believe that this session helped participants to cope with stressful situations, such as dealing with the HIV and AIDS pandemic and teaching orphans and vulnerable children. Table 4.10 below summarises participants’ responses about Session Seven.

**Table 4.10: Summary of participants’ responses on Session Seven**

<b>Participant</b>	<b>What was the most helpful about today’s module?</b>	<b>What was the least helpful about today’s module?</b>	<b>What would you change about today’s module before it is presented?</b>
1.	I have learnt ways of dealing with stress.	Nothing.	Nothing.
2.	I can now identify my stressors.	None whatsoever.	Nothing.
3.	I know what to do to manage stress.	None.	Nothing.
4.	In this session I have learnt about symptoms of stress.	Nothing.	Nothing.
5.	I know common stressors.	Nothing.	Nothing.
6.	I have skills to manage stress.	Nothing.	Nothing.
7.	I know what do when I am stressed.	Nothing.	Nothing.

8.	I can write a joy list.	Nothing.	Nothing.
9.	I now know that the only person without stress is a dead person.	Nothing.	Nothing.
10.	I can manage stress.	Nothing.	Nothing.

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There were no comments or suggestions. We said a prayer and dispersed.

#### **4.13 SESSION 8: MODULE 7: RESILIENCE IN THE PANDEMIC**

In Session Eight, we discussed ways of encouraging participants to remain resilient in the face of the HIV and AIDS pandemic, despite difficult circumstances.

##### **4.13.1 Goals of Session Eight**

Goals of session eight were to:

contemplate the concept of resilience;

contemplate further steps towards resilience;

emphasise our connectness to others, including local support networks for the purpose of resilience; and

conclude Reds.

##### **4.13.2 Overview of Session Eight**

We read a fictional story about Yulia and Mukasa as an ice-breaker. We then discussed participants' experience of resilience and steps to becoming more resilient. The

participants were reminded that the following session would be the last. At the end of the session, the participants completed the reflection worksheet.

#### **4.13.3 Session's notes and participants' activities**

The participants mentioned that one of the steps towards resilience functioning was to accept a situation, such as the HIV and AIDS pandemic, as a reality (Bennell, 2005; Hall et al, 2005; Shisana et al, 2005; Simbayi et al 2005; Theron 2007). Some commented on how they thought their resilience had grown as a result of attending REs sessions. For example, some indicated that since they attended the REs Programme, they were professionally empowered to face the HIV and AIDS pandemic.

I then asked the participants to list the things that they could do in their communities to help people affected by the HIV and AIDS pandemic. One participant stated, *"I will encourage people to change their behaviour."* Another participant said, *"I will educate people about the HIV and AIDS pandemic, because I now feel that I am resilient in the face of the HIV and AIDS pandemic."* Most participants indicated that they held positive hope for the future and that they would always support people affected by the HIV and AIDS pandemic.

In our discussion, I mentioned that participants could learn more about the HIV and AIDS pandemic and could grow through the pandemic, because growth needs knowledge (Theron, 2004). To explain the steps to becoming more resilient, I shared with the participants that hope, too, provided people with the energy to keep going. Therefore, the ability to remain hopeful was an important facet of resilience. Again, if one is hopeful, one is able to visualise an alternative to the present reality (Masten and Reed, 2005; Wong and Lee, 2005; Theron, 2006).

Paying attention to oneself is also another important facet of resilience, because if one pays attention to oneself, one will be able to manage stress. I reminded the participants that they could use the guidelines on how to manage stress, discussed in Session

Seven. In addition to that, one could look after oneself by talking to a psychologist or a social worker, getting help or reading books on coping, using an online resource or talking to a 24 hours counselor on Lifeline (0861322322) or the AIDS line (0800-012-322). Participants were advised to find out whether they were on the right track by checking the A-Z of resilience on pages 137 and 138 of REds and monitoring how they were doing. Table 4.11 below summarises participants' responses about Session Eight.

**Table 4.11: Summary of participants' responses on Session Eight**

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
1.	I am resilient in the face of the HIV and AIDS pandemic.	Nothing.	Nothing.
2.	I will bent but not break.	Nothing.	Nothing.
3.	I have learnt to stay strong even under difficult circumstances.	Nothing.	Nothing, really.
4.	I am now resilient.	Nothing.	Nothing.
5.	All the nine sessions from Reds Programme were fruitful to me.	Nothing.	None.
6.	I have learnt to be resilient in the face of the pandemic.	Nothing.	Nothing.

<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
7.	I am now connected with other people for the purpose of resilience.	Nothing.	Nothing.
8.	I am aware that people who cope, who adapt, who go on, are resilient.	Nothing.	Nothing.
<b>Participant</b>	<b>What was the most helpful about today's module?</b>	<b>What was the least helpful about today's module?</b>	<b>What would you change about today's module before it is presented?</b>
9.	I know six steps towards resilience.	Nothing.	Nothing.
10.	I have learnt that resilient people adapt and go on with life.	Nothing.	Nothing.

There were no comments or suggestions. Some of the participants were excited; they indicated that they already felt that they would be able to help their relatives, colleagues and learners affected by the HIV and AIDS pandemic. To me, listening to what the participants were saying, this was a sign of their resilience in the face of the HIV and AIDS pandemic, and that made me very happy.

I observed and listened to the participants' comments. I noticed that they were showing signs of resilience. In their discussions, they mentioned that they believed that they

could make a difference to their families, communities and learners affected by the HIV and AIDS pandemic, because they were now resilient. One participant said, “REds should be adopted by the Lesotho College of Education and the Ministry of Education and Training.” Another said, “I would rather bend than break. REds has taught me to be strong in the face of the HIV and AIDS pandemic.” I was glad that all the participants understood the concepts of resilience. We said a prayer and dispersed.

#### **4.14 SESSION NINE: CONCLUSION**

##### **4.14.1 Goals of Session nine**

Session Nine’s goal was to conclude the REds Programme.

##### **4.14.2 Overview of Session Nine**

The participants were asked to complete the REds questionnaire (Handout 17) (see appendix G). They were also given a list of people they could turn to or would like to swap telephone numbers or/and visit local resources identified in Session Three. Certificates were handed to the participants. At the end of the session, we decided on a convenient time for participants to complete the post-tests.

I asked the participants to list the things that educators could do in their communities to help limit the impact of the HIV and AIDS pandemic. For example, what could each educator do to cope better with the pandemic? And what could each educator keep on doing to cope better with the HIV and AIDS pandemic? All the participants mentioned that since they had gained more knowledge on the HIV and AIDS pandemic and on how to cope with the challenges of the pandemic from the REds Programme, they were going to share their newly required knowledge and information with their schools, friends, families, colleagues and learners.

The participants mentioned that having participated in the nine sessions of REds, they knew what HIV and AIDS entailed, and the stages of the HIV infection and were better equipped to deal with infected loved ones, colleagues and learners. They are also aware of potential sources of support in their communities and schools. They also knew about workplace policies on HIV and AIDS, were able to deal with the stigma and stress related to the HIV and AIDS pandemic, and were more resilient in the face of the pandemic. The participants had become used to the weekly sessions and because this was their last session, they felt sad that we had come to the end of the REds Programme. This was an emotional moment for most of the participants. We discussed some characteristics of a supportive school that were spoken about in Session Seven. I provided each participant with a bookmark with Lifeline and AIDS line, facilitators and counselors' telephone numbers, including Phela and the Ministry of Health and Social Welfare.

Thereafter, we exchanged addresses and telephone numbers. I asked them to decide on the date to write post-tests and delayed post-tests and whether they would like a single session follow-up in three months' time. The second part of the session was a certificate-giving ceremony. I told each participant that his/her certificate was proof of his/her willingness to learn ways to become resilient in the face of the HIV and AIDS pandemic; that each time he/she looked at his/her certificate, he/she should remember Yulia who, for example, "turned the illness into the enemy, not those with the illness .... She turned her anger at the illness into a force in all our lives". I urged them to continue to see the HIV and AIDS pandemic as an enemy and to be resilient in the communities and schools from which they came.

**Figure 4.4: A photo of participants receiving their REds certificates at the end of the programme in session nine**



The participants were happy and indicated that they were going to share the knowledge and information they had gained from the REds Programme with their family members, colleagues and learners. We then sat down together as a group and enjoyed lunch.

#### **4.15 CONCLUSION**

REds' objective is to buffer the personal and professional impact of the HIV and AIDS pandemic by encouraging resilience coping skills among affected educators (Theron, 2005; Theron, 2007). In Chapter 4, I described the process of REds and provide some evidence of how the participants perceived the Programme.

Some participants perceived themselves to be empowered by the Programme. During our discussion with the participants, some mentioned that the REds Programme had been an eye-opener for them, because it altered their perspective about the HIV and AIDS pandemic. Some stated that they were now more tolerant and accommodative of people living with HIV and AIDS. They mentioned that the REds Programme had made them more resilient in the face of the HIV and AIDS pandemic, and that, having participated in the REds Programme, they now realised the importance of a collective effort in the fight against the HIV and AIDS pandemic.

Some indicated that they now felt enabled, because they had acquired a lot of information and skills from the REds Programme. For example, they gained knowledge on the management and prevention of HIV and, according to them, REds provided them with tools and knowledge to fight the pandemic. One participant said, *“REds has helped me to accept and cope with the reality of the pandemic.”* Another participant said, *“Because of the REds Programme, I am going to save many lives, because REds has given me knowledge regarding health care.”*

This did not happen overnight: it was a process. I observed the way in which the participants interacted with one another, how they shared ideas and opinions during all the nine sessions. Towards the end of the Programme, I learnt that their attitudes towards the HIV and AIDS pandemic had changed altogether. I also observed that participants had accepted that the HIV and AIDS pandemic was real and that they were ready to offer care and support to people who were affected and infected by the HIV and AIDS pandemic. This constituted an acceptance of an HIV-altered reality. The REds Programme empowered the participants both personally and professionally. Their knowledge increased, because they now knew about referral networks and the available grants and could cope better with the taxing demands that the HIV crisis is made on them as educators. I have learnt that educators need to be resilient in the face of the HIV and AIDS pandemic and that the REds programme is enabling and life changing, because it has been proven to have contributed and encouraged resilience among educators and others affected by the HIV and AIDS pandemic.

Chapter 4 dealt with an overview of the process of the implementation of the REds programme in Lesotho. In Chapter 5, an empirical evaluation of the impact of intervention in developing resilience in participant Lesotho educators will be done to further explore the effectiveness of the REds Programme for educators affected by the HIV and AIDS pandemic.

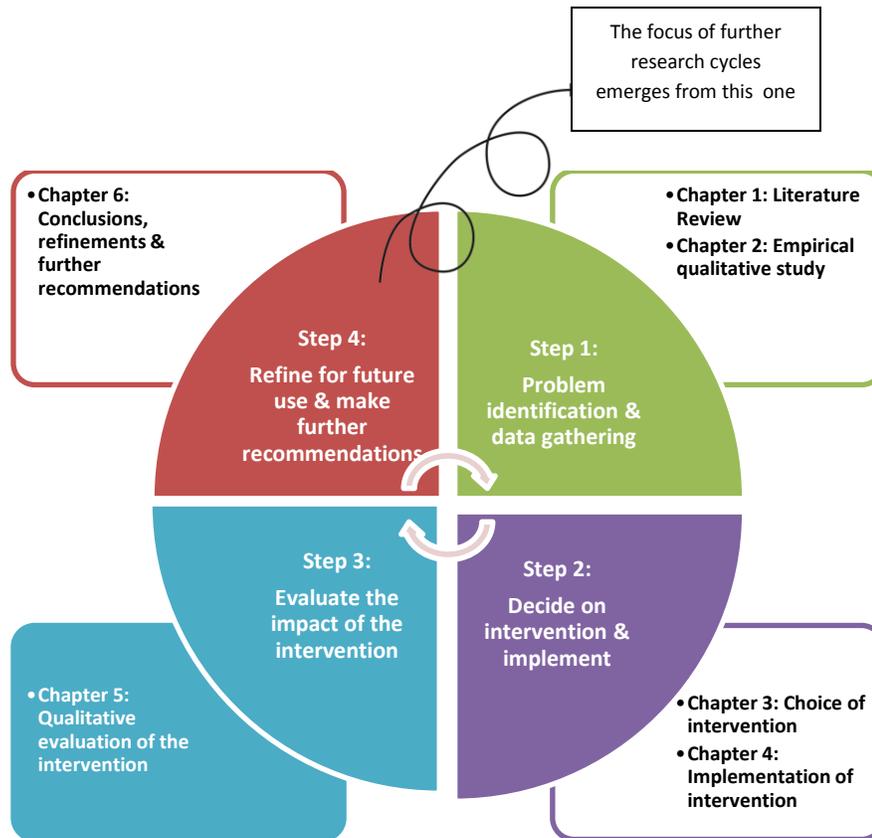
## CHAPTER 5

### EMPIRICAL EVALUATION OF IMPACT OF INTERVENTION IN DEVELOPING RESILIENCE IN PARTICIPANT LESOTHO EDUCATORS

#### 5.1 INTRODUCTION

In this chapter, which presents the third step of the action research cycle (see diagram 5.1 below), the research methodology used to evaluate the development of resilience in the participating educators in the face of the HIV and AIDS pandemic will be discussed and the findings presented.

**Figure 5.1: Overview of Action Research Process**

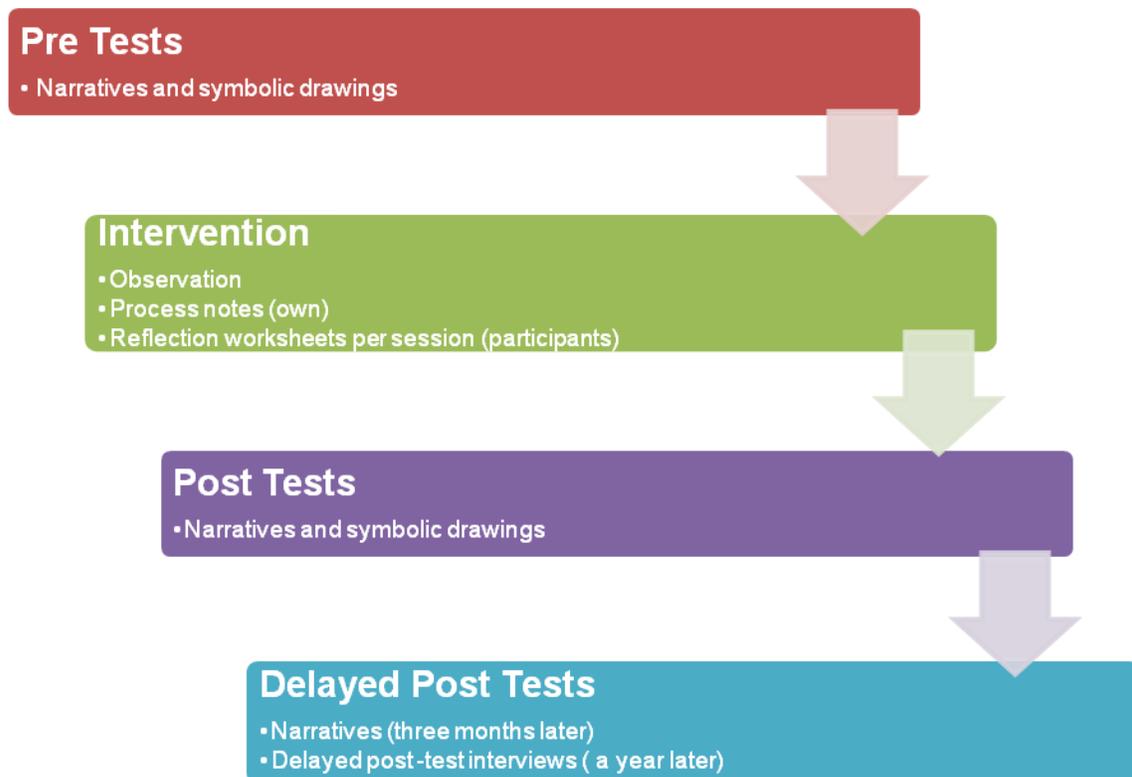


The main aim of this study was to investigate how Lesotho educators could be assisted in coping with the challenges that result from having orphans and vulnerable children in their classrooms. In order to achieve this aim, I conducted a qualitative investigation to identify educators' feelings, attitudes and experiences regarding the teaching of orphans and vulnerable children (Step 1 of the action research cycle). It became apparent upon analysis of this data, that before educators could be expected to provide any kind of support or be effective in overcoming the challenges that HIV and AIDS pose for educators and teaching, they would first have to find ways to cope with their own feelings and needs. Since they were feeling overwhelmed and vulnerable as a result of the impact of the HIV and AIDS pandemic on them both personally and professionally, I realised that my focus would have to be redirected towards first facilitating personal development in the teachers. Based on the findings of the qualitative study, resilience appeared to be a construct that would be useful in achieving this outcome. I chose to implement the Resilient Educators Programme among a group of educators, since it had been shown to be fairly successful when implemented among South Africa with educators working in similar contexts (Step 2 of the action research cycle). In this chapter, which is the third step of the action research cycle, I discuss the methodology and evaluation of the REds intervention among educators affected by the HIV and AIDS pandemic.

## **5.2 EVALUATION DESIGN**

This study employed a pre-test and post-test time-series design (Leedy and Ormrod, 2005). Although the use of pre- and post-tests is usually associated with a more positivistic paradigm (Guba and Lincoln, 1994; Henning, Van Rensburg and Smith, 2004), it was necessary to use these tests in my research, because I wanted to ascertain whether or not the resilience of the participants had increased after having attended the nine REds sessions. Figure 5.2 below outlines the evaluation design followed.

**Figure 5.2: Evaluation design**



### **5.3 SAMPLING**

My sample consisted of primary school educators who were already in the teaching field. Table 4.2 in chapter 4 shows the biographic data of research participants.

### **5.4 DATA COLLECTION**

In this section of the study, I used multiple sources of data collection, as described in the following sections. I collected qualitative data through narratives, symbolic drawings, observations, process notes, reflection sheets and delayed post-test interviews. The use of different sources of data collection increases trustworthiness, since the results of

the multiple sources of data collection can be triangulated (Creswell, 2003; De Vos, 2005; Leedy and Ormrod, 2005; Invankova et al., 2007).

- **Narratives**

Pre- post and delayed post-test data were collected by means of narratives. Narratives are short pieces of writing produced by participants who are asked to write a few lines in response to a prompt. According to many researchers, there is no difference between narratives and stories. In narratives and stories, participants are asked to reflect on their experiences (Moletsane, Mitchell, Smith and Chisholm, 2008). Researchers can therefore collect written accounts of personal experiences through narratives (Nieuwenhuis, 2007).

Over recent years, there have been a number of contributions relating to the use of narratives as a method of qualitative enquiry for exploring areas of education. Narratives are important in educational research, for several reasons. Firstly, they create a sense of community, in the sense that conducting narrative studies establishes a close bond with the participants (Creswell, 2007).

Secondly, narratives engage the reader in the life of the narrator by bringing the reader into the moment of the experience being described. According to Ellis (2004), a well written narrative “shows” rather than “tells”. It also gives the reader a sense of what the narrator is feeling and, by extension, causes him or her to care about the narrator and what happens to him or her. Thirdly, narratives are holistic. For example, life experience is complex and contradictory; narratives are well suited to expressing that complexity and contradiction (Clandinin and Connelly, 2000; Ellis, 2004; Creswell, 2007; Webster and Mertova, 2007).

Finally, narratives can speak a universal language in that they can cross generational and cultural boundaries. They can also offer a common point of entry into experience. For example, since telling stories is a natural part of life, and individuals have stories

about their experiences to tell others, narrative research captures an everyday, normal form of data that is familiar to individuals (Creswell, 2008).

Clandinin and Connelly (2000) explain narrative enquiry as a way of understanding experience through 'stories lived and told, involving collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus'. Narrative enquiry is a research methodology that inquires into or asks questions about and looks for deeper understanding of particular aspects of life experiences (Clandinin, 2007). In this section of the study, each participant was asked to write one and half pages about his/her life in the age of HIV and AIDS, and the narratives were analysed through the lens of resilience theory (see appendix F) .

- **Symbolic drawings**

In this section, pre- and post-test drawings were used to collect visual data. Symbolic drawings are representations in which arbitrary symbols are used to stand for things that are represented (Colman, 2001; Reber and Reber, 2001). This emerging methodology in the social sciences is aimed at exploring sensitive psychosocial and health-related phenomena such as HIV and AIDS (Guillemin, 2004; Martin, 2004; Gillies, Harden, Johnson, Reavey, Strange and Willig, 2005; Lynn & Lea, 2005; De Lange, Mitchell, Moletsane, Stuart & Buthelezi, 2006). Drawings have the potential to enable participants to express themselves even if they have a poor command of English, and this is one reason why I wanted to explore their use among Lesotho educators, who are generally not very literate in English. Drawings also encourage and motivate participants to feel comfortable to make public what needs to be known, in this case, about how the HIV and AIDS pandemic is affecting them (Theron, 2009).

Furthermore, in drawings, people are able to express or air their opinions and beliefs and generate discussion around an issue of interest (Martin, 1998; Stuart, 2006). What people draw and how, as well as the size of the drawing and the placement of objects, can give researchers a starting point from which to ask questions (Schratz and Walker,

1995; Guillemin, 2004). I suspected that this method would be more comfortable than interviewing for the Lesotho educators who, in my experience, often find it difficult to verbally express how they feel about HIV and AIDS, It would also enable me to explore unconscious thoughts and feelings around HIV and AIDS, as depicted in their drawings. In this study, at the pre- and post-test stages, participants were given the following prompt:

*When you think of how the pandemic has affected you, what symbol comes to mind? Draw in the space below (remember it is not about how well you draw, but about what you draw).*

Participants' drawings were accompanied by short written descriptions to explain the essence of the symbol/representation.

- **Observations, reflection sheets and process notes**

In this study, I was a facilitator and an observer. My role was to gain deeper understanding of participants' words and expressions and thereafter to report these (Strydom, 2006). I observed participants' behaviour, reactions, interactions and comments. I recorded my reflections and used them to compile process notes after each session, following the same process as described in an overview of the entire process of the implementation of REs (see paragraph 4.6).

- **Delayed post-test interviews**

A year later, I arranged to interview educators who participated in the REs programme to gain some insight into their experiences in terms of coping with the challenges they had highlighted in the REs Programme. Unstructured interviews as a data gathering tool have been discussed in detail (see paragraph 2.7.2). The same process was followed here.

I asked the participants the following question.

*“Now that a year has passed since concluding REds, how do you feel in terms of being able to cope with orphans and vulnerable children in class”?*

The procedures I used to analyse the data collected are discussed below.

## **5.5 DATA ANALYSIS**

In this phase, the qualitative data were analysed thematically, using resilience theory as a framework. I used Tesch’s 8 steps of data analysis mentioned in Creswell (2005) to identify themes (see paragraph 2.7.4). I was specifically looking for themes that would suggest an increase (or decrease) in resilience and ability for participants to cope with the issues engendered by the HIV and AIDS pandemic, including having orphans and vulnerable children in their classrooms.

## **5.6 TRUSTWORTHINESS IN QUALITATIVE RESEARCH**

In order to ensure the trustworthiness and authenticity of this research, I employed Lincoln and Guba’s (1985) four criteria, which are; credibility, transferability, dependability and confirmability. These have been explained in detail in section 2.9 and their specific use in this stage is explained below.

Credibility in that stage of the study was ensured through the use of triangulation of methods used to collect data pertaining to the resilience of participants. The findings were also checked against the available literature on resilience and there were consultations on the data between myself and my two promoters. The interpretation of the data collected was also done by myself and my two promoters. This further ensured the credibility of the data through triangulation.

Transferability was achieved through the use of purposive sampling, which ensured that participants would be a representative sample of the population, i.e. primary school teachers who had orphans and vulnerable children in their classrooms.

To ensure dependability, all data have been preserved, to create an audit trail. Dates of interviews, letters to schools seeking permission for teachers to participate in REds and the names of teachers who participated in REds, all serve to preserve an audit trail.

Confirmability was also achieved through preserving an audit trail, as well as through the use of experienced coders (my promoters), who re-coded and confirmed the data collected. Now that the evaluation design and methodologies have been explained, the findings will be discussed below.

## **5.7 PRESENTATION AND DISCUSSION OF FINDINGS**

The findings will now be presented and discussed in relation to literature to determine whether REds has enabled the participant educators affected by the HIV and AIDS pandemic to develop resilience. In this section of the study, the qualitative data were analysed through the lens of the resilience theory, and particularly the seven clusters of needs that help an individual to develop resilience (see paragraph 3.3.2). Individuals are said to be resilient if they are able to successfully negotiate for the resolution of all seven clusters of protective resources, so that they are able to cope adaptively with difficult circumstances (Mastern and Reed, 2005; Cameron et al., 2007; Leadbeater et al., 2007; Ungar, 2008).

### **5.7.1 Discussion of pre- and post-test drawings**

Table 5.1 below provides a summary of the pre and post-test symbolic drawings with verbatim explanations, together with indications of whether the seven cluster of needs can be inferred from the drawings. The seven clusters are:

- 1. Access to material resources,**
- 2. positive relationships,**
- 3. positive identity,**
- 4. cohesion,**

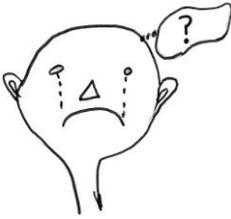
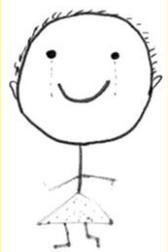
**5. *the experience of power and control***

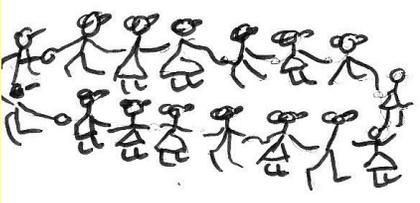
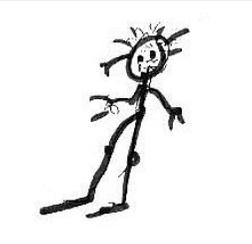
**6. *cultural adherence and***

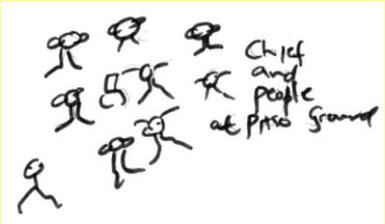
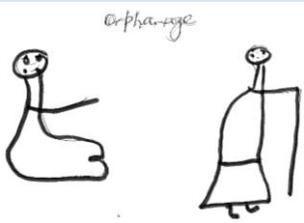
**7. *social justice***

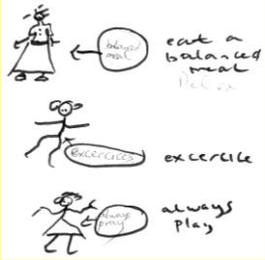
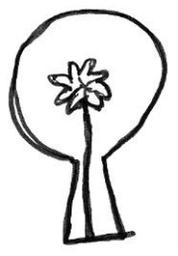
Resilience is the outcome of the successful negotiation of the resolution of all seven clusters. (Cameron et al., 2007). (see paragraph 3.4.3) for explanation of these 7 clusters.

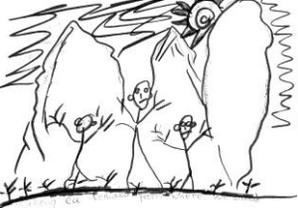
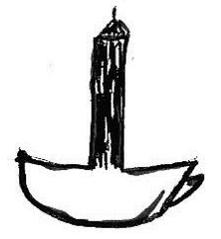
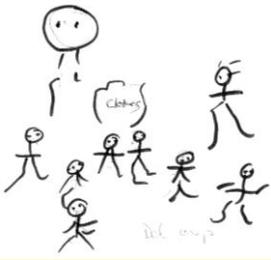
**TABLE 5.1- Analysis of pre and post- test drawings**

8989PRE-TEST DRAWING & EXPLANATIONS	POST TEST DRAWING AND EXPLANATION	INDICATION OF RESILIENCE (CF. 7 CLUSTER OF NEEDS)			EXPLANATION
<p><b>Participant 1</b></p>  <p>Sad face: I am angry, afraid of the HIV and AIDS pandemic. I am very sad.</p>	<p><b>Participant 1</b></p>  <p>HIV affected person: I am affected by the HIV and AIDS pandemic. I am worried and I do not know how to cope with the challenges of the HIV and AIDS pandemic. I also want to know how other people who are affected by the HIV and AIDS pandemic cope.</p>		YES	NO	<p><b>Pre-test drawing:</b> There are feelings of sadness, confusion, fear and anger that show lack of power and control. This shows little signs of resilience.</p> <p><b>Post-test drawing:</b> Although there is still worry and confusion there is also indication that she is aware that she is not alone and is wondering about how others cope, therefore awareness of resources and beginning of a sense of cohesion with others because she empathises with other people affected by the pandemic.</p>
		1		x	
		2		x	
		3		x	
		4	√		
		5		x	
		6		x	
		7		x	
<p><b>Participant 2</b></p>  <p>Sad face: This marks the beginning of miserable days. I shall be crying, thinking about my death, asking myself where I will get help and what people will say.</p>	<p><b>Participant 2</b></p>  <p>HIV-affected person: I am crying for others burdened with the HIV and AIDS pandemic. I fear death.</p>		YES	NO	<p><b>Pre-test drawing:</b> There is misery, worry, sadness, anger and confusion which show a feeling of helplessness. She shows little signs of resilience.</p> <p><b>Post –test drawing:</b> There is sadness, worry and confusion, however she empathises with others who are affected by the HIV and AIDS pandemic. There is a smile on the face of the person, although she is crying which may be indicative of ambivalence. This is an indication of cohesion.</p>
		1		x	
		2		x	
		3		x	
		4	√		
		5		-x	
		6		x	
		7		x	

<p><b>Participant 3</b></p>  <p>Glove and condom: HIV is preventable and manageable. It is no longer a death sentence. If people could use condoms and gloves they could be protected and be saved from the HIV infection.</p>	<p><b>Participant 3</b></p>  <p>Orphans and their carers: Most houses are empty in this village because of the HIV and AIDS pandemic. Orphans are in the hands of other members of the community</p>		<p><b>YES</b></p> <p>1 ✓</p> <p>2 ✓</p> <p>3</p> <p>4 ✓</p> <p>5 ✓</p> <p>6 ✓</p> <p>7 ✓</p>	<p><b>NO</b></p> <p>3 x</p>	<p><b>Pre-test drawing:</b> There is knowledge about the HIV and AIDS pandemic. She is aware that access to material resources such as condoms can help to stop HIV infection. There are signs of resilience in terms of agency, access to material resources and cohesion with others to fight the pandemic.</p> <p><b>Post-test drawing:</b> She is aware that she can access support from community members. This indicates that she has positive relationships with others and support networks and the reference to the needs of children relates to an increased sense of social justice.</p>
<p><b>Participant 4</b></p>  <p>HIV-infected person: I am HIV positive and very ill. I am afraid of death.</p>	<p><b>Participant 4</b></p>  <p>Small sick person: I am sick and weak. I have lost weight, I have swollen limbs and I am also aware that I am HIV positive.</p>		<p><b>YES</b></p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>	<p><b>NO</b></p> <p>1 x</p> <p>2 x</p> <p>3 x</p> <p>4 x</p> <p>5 x</p> <p>6 x</p> <p>7 x</p>	<p><b>Pre-test drawing:</b> There is fear. For her, the HIV and AIDS pandemic is a death sentence. She feels helpless. There are no indicators of resilience at all in these drawings.</p> <p><b>Post- test drawing:</b> This person is sick, weak and helpless due to the HIV and AIDS pandemic. The lack of feet could indicate feeling unstable.</p>

<p><b>Participant 5</b></p>  <p>Sun rising and setting: Everything has a beginning and an ending. People should have hope.</p>	<p><b>Participant 5</b></p>  <p>Gathering: The chief is addressing people about the HIV and AIDS pandemic. Making people aware of the challenges posed by the HIV and AIDS pandemic is important.</p>		<p><b>YES</b></p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>	<p><b>NO</b></p> <p>x</p>	<p><b>Pre-test drawing:</b> There are signs of resilience because in this drawing, the sun symbolises life and hope . It shows that one day there will be a cure for the HIV and AIDS pandemic. There is hope for the future .</p> <p><b>Post-test drawing:</b> There are more signs of resilience. The diagram shows that educating people about the HIV and AIDS pandemic is important because knowledge is power. This shows power and control, together with the chief the people can make decisions; positive relationships are also depicted and a positive sense of self is implied. The mention of the clan system indicates cultural adherence and working together to attain social justice.</p>
<p><b>Participant 6</b></p>  <p>Old people: Orphans are in the hands of old people in this community. Some orphans stay in orphanages.</p>	<p><b>Participant 6</b></p>  <p>The HIV and AIDS ribbon : It shows that each and every person must know about the HIV and AIDS pandemic and must avoid it by not becoming HIV infected.</p>		<p><b>YES</b></p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>	<p><b>NO</b></p> <p>x</p> <p>x</p>	<p><b>Pre-test drawing:</b> Supportive members of the community offer care and support to orphans and vulnerable children, indicating a sense of social justice. There are signs of resilience because she knows about positive relationships within her community, and possibly cultural adherence since this practice is culturally oriented.</p> <p><b>Post-test drawing :</b>The focus has moved from caring to prevention in this drawing, which indicates a feeling of power and agentic experiences. There is a feeling of community in that all must play their part in avoiding infection.</p>

Participant 7	Participant 7		YES	NO	<p><b>Pre-test drawing:</b> There are signs of resilience because according to this symbol, one must have access to material resources, positive relationships in order to be resilient. HIV positive people need care and support. People should join hands to fight against the HIV and AIDS pandemic because unity is power. There are signs of power and control, positive relationships positive identity, cultural adherence and social justice.</p> <p><b>Post-test drawing:</b> There are signs of resilience because resilient individuals know how to negotiate support and gain access to enabling resources.. The drawing indicates a positive sense of self for HIV positive people.</p>
 <p>People holding hands fighting against HIV: People who are HIV positive need knowledge with regard to the pandemic. They also need care and support from all stake holders.</p>	 <p>HIV is manageable: A balanced diet, some exercises, rest and adherence to ARVs are vital. A person can live longer with the HIV virus.</p>	1	√		
		2	√		
		3	√		
		4	√		
		5	√		
		6	√		
		7	√		
		Participant 8	Participant 8		YES
 <p>Light: The HIV and AIDS pandemic had killed many people. However, there is still hope that one day there will be an HIV and AIDS free generation. There is light today because of access to ARVs, and knowledge about the pandemic.</p>	 <p>Children at heart: Orphans and vulnerable children need love care and support.</p>	1	√		
		2	√		
		3	√		
		4	√		
		5	√		
		6		x	
		7	√		

<p><b>Participant 9</b></p>  <p>People below mountains: People have hope that one day there will be cure for HIV. People just need to wait and hope for the best.</p>	<p><b>Participant 9</b></p>  <p>Candle: It is dark in this house. Parents have died of the HIV and AIDS pandemic. Children are left on their own. No parents to care for them.</p>		<p><b>YES</b></p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>	<p><b>NO</b></p> <p>x</p> <p></p> <p></p> <p>x</p> <p>x</p> <p>x</p> <p>x</p>	<p><b>Pre-test drawing:</b> There is hope that there will be a cure for HIV, so, people will overcome the HIV and AIDS pandemic. Hope is important because it keeps people realistic and strong. There are signs of positive relationships (people working together), but little sign of agency here since people are just waiting for help.</p> <p><b>Post-test drawing:</b> In the families whereby children are left on their own, there is no guidance. In these child headed families children encounter problems so, care from adults is vital. The hope seems to have disappeared, therefore one could interpret this as a decrease in resilience. There is an awareness of needs but no indication that they can be met.</p>
<p><b>Participant 10</b></p>  <p>Empty house: There are no parents in this house. Children are hungry. They want to know where they will get the next meal.</p>	<p><b>Participant 10</b></p>  <p>Orphans and vulnerable children get food and clothes from teachers at school: This shows that teachers offer care and support to these children.</p>		<p><b>YES</b></p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>	<p><b>NO</b></p> <p></p> <p></p> <p></p> <p></p> <p>x</p> <p></p>	<p><b>Pre-test drawing:</b> Without parents, children are helpless and miserable. This shows a feeling of helplessness and hopelessness in this house. There is no sense of agency or ability to access material resources and positive relationships.</p> <p><b>Post-test drawing:</b> Orphans and vulnerable children need a material resources and support from supportive relationships that will help them to become functional members of their community. Access to material resources and the forming of positive relationships is evident, the sense of agency of teacher indicates power and a positive sense of self; social justice is implied in the meeting of childrens; needs.</p>

Looking at the pre- and post-test drawings above, one can conclude that the themes of death, destruction, sorrow, despair and reliance on faith that emerged from pre-test drawings suggest that participants were severely affected by the HIV and AIDS pandemic. These themes suggest that the participants experienced themselves as vulnerable, hampering their resilience in the face of the HIV and AIDS pandemic (Kelly, 2000; Coombe, 2003; Hall et al., 2005; Theron, 2007).

The themes of a sense of agency and positive identity that emerged from the post-test drawings suggest that participants in the REds programme had developed more confidence in dealing with the challenges of the HIV and AIDS pandemic. In the case of participant 4, there was no increase in resilience because she was HIV positive, which might have affected her engagement and ability to develop resilience. This participant, in fact, sadly passed away shortly after her participation in the REds Programme.

The results nevertheless show a movement towards resilience, which would have helped participants to cope more positively with the challenges of the HIV and AIDS pandemic. There were signs that they were slowly becoming more resilient in the face of the HIV and AIDS pandemic. For these participants, the experience of completing REds succeeded in lessening the impacts of a stressful situation and provided opportunity for positive education and personal growth (Mastern and Reed, 2005; Leadbeater et al., 2007; Ungar, 2008). In essence, these themes suggest that REds' ultimate goal, which is to empower educators to be resilient in the face of the HIV-altered reality (Theron, Esterhuizen, and Mabitsela, 2009) was attained, to some extent at least. In the next sections, the themes that emerged from pre-test narratives will be discussed.

## **5.8 DISCUSSION OF THEMES EMERGING FROM PRE-TEST NARRATIVES**

In this section of the study, participants were asked to write one and a half pages about their lives in the age of HIV and AIDS. The resultant narratives were analysed from emerging themes in conjunction with my field notes and observations and not

individually for each participant. The following themes emerged from pre-test narratives:

### **5.8.1 The HIV and AIDS pandemic arouses negative emotions**

From my observations and my reflections during REds sessions, I became aware that much of the discourse was focused on the problems posed by the HIV and AIDS pandemic, with no reference as to how and whether the participants perceived themselves able to help. Many of the narratives also focused on how difficult it was to teach under such conditions (*It is difficult for me as a teacher to cope; really, life is not good, teaching is not a nice place now, as I stated, it is too much for me*); and how frightening it was for them to be living and working in contexts where HIV infection was a constant threat (*I am very confused and scared...*); and on the tension between what they knew they should be doing and what they were actually doing (*I am scared to test, because then I won't get the support I need and what will people say about me; I am in danger of being infected by my partner, and I forget to take precautions when dealing with bleeding learners*).

From the above quotations, one may conclude that in most participants, the HIV and AIDS pandemic aroused negative emotions. For example, most participants indicated that they felt very sad when they thought about the HIV and AIDS pandemic. They mentioned that in most cases they experienced stress and depression. Therefore, one would imagine that it would be hard for them to cope with the added stress of dealing with HIV and AIDS and orphans and vulnerable children, as indicated in the literature (Coombe, 2000; Kelly, 2002; Hall et al., 2005; Theron, 2007). Literature supports the assumption that educators react to the emotional pain by isolating themselves from others, feeling morose, lonely, empty and helpless. This affects their wellness and the quality of education negatively, therefore, they cannot cope resiliently (Theron, 2007).

### 5.8.2 Educators are personally affected by the HIV and AIDS pandemic

During REds sessions, my observation and interaction with the participants confirmed the findings of the narratives, that participants were negatively affected by the HIV and AIDS pandemic, due to the illness and or death of family members, colleagues and learners. The narratives indicated that the illness of their loved ones, colleagues and learners left them drained, depressed, helpless and hopeless. For example, most participants mentioned that they were overwhelmed by the problems posed by the HIV and AIDS pandemic. Examples included the following comments:

*“I have experience of living with an HIV positive person.”*

*“I have lost two brothers and three sisters to the HIV and AIDS pandemic.”*

*“Sometimes I get to school very late, because I have to nurse my sister, who is HIV positive.”*

From participants’ narratives, it is evident that they had been personally affected by the HIV and AIDS pandemic. They mentioned that their morale was low and that they found it difficult to concentrate on their work in the face of the illness, death and dislocation of their loved ones, colleagues and learners. As noted in Chapter 1 (Cf.1.5.3), educators who are personally affected by the HIV and AIDS pandemic experience stress, trauma, anger, depression, loneliness, sleep disturbances and nightmares (Theron, 2007; Serero, 2008; Ngemntu, 2009). The above theme suggests that the participating Lesotho educators had the same problems and were finding it difficult to cope professionally due to personal issues (Kelly, 2000; Coombe, 2003; Ross and Deverell, 2004; Hall et al, 2005; Theron, 2007; Serero, 2008; Ngemntu, 2009). In summary, the themes that emerged from pre-test narratives indicated that participants were vulnerable to the stresses and challenges of the HIV and AIDS pandemic.

## **5.9 DISCUSSION OF THEMES EMERGING FROM THE POST-TEST NARRATIVES**

During the implementation of nine REds sessions, as I observed participants, their behaviour and their comments suggested that the process and the content of the Programme enabled and strengthened most of them. I noted with satisfaction that REds was enriching them and helping them to gain knowledge. This led me to believe that REds was helping some of them to cope more resiliently with the challenges of the HIV and AIDS pandemic. In contrast to the negative themes emerging from the pre-test narratives, the post-test narratives were of a more positive nature. The main themes that emerged were that of an emerging sense of agency as a prevention agent and a source of care and support; the ability to care more for their own health and wellbeing; a more positive view of the pandemic; and an increased awareness of the effects of stigma and culture on the success of prevention and care programmes.

### **5.9.1 Educators have an increased sense of agency to help others**

According to some of the Lesotho educators, REds empowered them to help their learners, colleagues and community members. Most participants mentioned that they enjoyed good relationships with the communities within which they lived (*I have positive relationships with my family members, friends and others; I visit the infected people in my community*). Participants also mentioned that they were playing important roles in their communities in the HIV and AIDS era. For example, they served as HIV prevention agents, counsellors, caregivers, advisors, social workers and surrogate parents (*REds has trained us how to approach these problems, we can manage to minimise the situation; I advise them how to live positively and teach others who are not infected how to live with infected ones*). They mentioned that they taught support group members in home-based care, which is care that is given in the home for people who are terminally ill, especially people who are HIV positive (*I teach people from my community how to take care of sick and dying people; I visit the sick in my community*).

It is important to mention that home-based care is the best way to look after people who are HIV positive or terminally ill, because it promotes a holistic approach to care. (Van Dyk, 2005). In addition to teaching community members about home-based care, some participants also initiated vegetable gardens in their communities (*I teach people from my community how to produce vegetables*).

According to this participant, the vegetable gardens that she initiated, supplied communities affected by the HIV and AIDS pandemic with vegetables. Vegetables are very important in the diet of people living with HIV and AIDS. Some of the vegetables were sold to generate income, which helped to alleviate poverty within the communities.

Participants also mentioned that they had empowered people from their communities with livelihood skills, such as handicrafts, in order to help them to be self employed and self reliant, so as to break the cycle of poverty. One participant stated:

*“They can sell their products and make money.”*

Looking at the above quotations, one can conclude that REs had had a positive impact on the participants, because it has helped them to start thinking about how they could help people affected by the HIV and AIDS pandemic in their communities. Rather than being immobilised by negative feelings, as indicated in the pre-tests, they were now able to move to action and focus on helping others, which indicates a more positive identity, sense of agency and the development of helping relationships, all indicators of resilience (Cf. paragraph 3.4.3).

Participants also indicated that they felt confident professionally to help learners, colleagues and community members to address the challenges posed by the HIV and AIDS pandemic: (*As a teacher, I will teach my pupils and people in my community what HIV and AIDS is*). They mentioned that their responsibility as educators was to teach learners to support each other, and to work together to fight against the HIV and AIDS pandemic: (*I will help my learners, comfort them, share ideas with them and support them*). This indicates a sense of community coherence and empathy, both of important indicators of resilience (Cameron et al.,2007).This

shows good interpersonal relationships, suggesting positive social orientation and the ability to derive optimal benefit from social interaction. Individuals who have empathy for others connect with them emotionally, which is a sign of resilience (Brooks and Goldstein, 2004; Donnon and Hammond, 2007; Mills and Donbeck, 2007;Ungar, 2008 ).

Most participants' responses from post-test narratives indicate that they were now moving towards taking more responsibility for helping people affected by the HIV and AIDS pandemic. For example, most participants mentioned that following REds participation, they now knew how to help those who were HIV positive.

*“Following participation in REds, I am able to influence and encourage the community to go for check-ups, offer help, pay visits, educate both the infected and affected about HIV and AIDS, give them food and clothes, help them link with agencies to help, help learners, comfort them and share ideas regarding the HIV and AIDS pandemic.”*

*“Today, I am able to comfort them in times of miserable states.”*

The above quotations imply that participants were coping more resiliently with the challenges of the HIV and AIDS pandemic following the implementation of REds.

### **5.9.2 Educators have developed an ability to care for their own health and wellbeing**

While facilitating REds sessions, I observed and heard some comments from participants, which made me think that some participants had moved from a feeling of fear of the HIV and AIDS pandemic to a feeling of confidence, which might have stemmed from having increased their knowledge around the HIV and AIDS pandemic. This observation was backed up by the narratives, where they reported having become more knowledgeable, having taken HIV tests and becoming able to take responsibility to look after themselves if they were HIV positive. Examples included the following comments:

*“REds has helped me to accept and cope with the situation ...”*

*“I know how to cope positively with it ...”*

From the above quotations, it may be concluded that the participants' sense of agency increased following participation in the REds Programme, because most of them mentioned that REds had capacitated them to cope with the personal and professional challenges of the HIV and AIDS pandemic. This suggests positive change and a move towards resilience. I noticed throughout the sessions that the mood in the group gradually became more cheerful and upbeat. The participants appeared to become more confident about their ability to do something to mitigate the effects of the pandemic on the lives of others and their own. According to Richardson (2002), Theron (2004), Armstrong et al., (2005), Boyden and Mann, (2005), Masten and Reed (2005), Schoon (2006), McMurray et al. (2008), and Ungar, (2008), remaining cheerful and optimistic helps to mitigate the potentiality negative impacts of adverse circumstances.

### **5.9.3 Educators had developed a positive attitude towards the HIV and AIDS pandemic**

Participants stated that their attitudes towards the pandemic had changed, and the post-test narratives seem to support these perceptions. In comparison to the pre-test narratives, participants seemed to have developed a more positive attitude towards the HIV and AIDS pandemic. There was an indication of a movement from avoidance to engagement, to confidence in talking about the HIV and AIDS pandemic, whereas before participating in REds, they avoided talking about the HIV and AIDS pandemic. Now, they saw that HIV and AIDS was preventable and manageable. Furthermore, participants indicated that they could share information about the HIV and AIDS pandemic with others, because REds had helped them to become bold. They were aware that talking about the HIV and AIDS pandemic was no longer shameful and that if people were able to discuss the HIV and AIDS pandemic freely with their families, learners and the community, the pandemic could help them to connect with God and others. Examples included the following comments:

*“I now have enough confidence to talk to them about this virus.”*

*“I am able to face people affected by the HIV and AIDS pandemic, talk to them about the pandemic.”*

*“... But now I have enough confidence to talk to them about this virus.”*

*“REds has helped to talk openly about the HIV and AIDS pandemic.”*

Some participants indicated that they perceived themselves to be empowered, because the REds programme had been an eye-opener to them, in the sense that it altered their experiences, perceptions and needs with regard to the teaching of orphans and vulnerable children. Some indicated that they were more tolerant and accommodative of orphans and vulnerable children in their classrooms (*I am able to help learners, comfort them, I comfort and share ideas with them*). They further stated that they were enabled, had a positive attitude towards the HIV and AIDS pandemic and had been personally and professionally empowered by REds to face the many challenges posed by the HIV and AIDS pandemic (*My life has changed, my perception has improved*); (*REds has trained us how to approach these problems, we can manage to minimise the situation*). This indicates that REds had served to shape and influence participants' attitudes towards the HIV and AIDS pandemic in a positive manner. Participants also indicated that REds had taught them that being HIV positive was not the end of the world and that HIV was not a death sentence, whereas this had been a prominent theme of the pre-test narratives and drawings. They mentioned that because of the information they had received during REds sessions about HIV and AIDS, they were equipped to encourage people affected or infected by the HIV and AIDS pandemic not to lose hope. According to the participants, if a person could take steps to prevent the spread of HIV and educate others about the pandemic, he/she would be able to cope with the challenges of the HIV and AIDS pandemic, and that would give him/her hope to live longer. Some participants put it this way:

*“I will advise my people to remain hopeful.”*

*“I will advise them to live positively with the virus.”*

*“I will teach them that the HIV and AIDS pandemic is not a life sentence.”*

The above quotations suggest that participation in REs had positively influenced participants' hope, as they gained hope that things would improve. Hope is important, because it keeps people strong, realistic and positive (Eberhsöhn and Eloff, 2002). Participants now had a strong, positive outlook on life, because a positive attitude has to do with the ability to remain cheerful and optimistic. According to Donnon and Hammond (2007), people who are optimistic, who have a positive outlook believe in a bright future, have healthy expectancies and are success oriented. In fact, if people have hope they are able to deal better with the challenges of the HIV and AIDS pandemic in a positive way. From my observations and reflections, I realised that the themes that emerged from post-test narratives suggested evidence of a slight increase in participants' resilience functioning and that most participants praised REs for empowering and enabling them to be resilient in the face of the HIV and AIDS pandemic.

#### **5.9.4 Educators are better able to cope with the stigma attached to the HIV and AIDS pandemic and are aware of the importance of culture in prevention and care programmes.**

The participants mentioned that they were aware that HIV was associated with death, due to the stigma attached to the disease. According to the participants, this caused fear and prejudice, collectively described as stigma. They mentioned that the stigma attached to the HIV and AIDS pandemic was due to lack of knowledge regarding the pandemic. They further stated that the stigma leads to denial. According to the participants, most HIV positive people were in denial, based on fear of being stigmatised and discriminated against. In addition to denial, lack of knowledge regarding the HIV and AIDS pandemic also contributed to HIV infection. The participants believed that it was important for people to break the cycle of stigma and discrimination associated with the HIV and AIDS pandemic and that this could be achieved by educating them about the HIV and AIDS pandemic. According to the participants, REs had equipped them with skills on how to deal with stigma

attached to the pandemic in their schools and communities. Examples included the following comments:

*“Inadequate knowledge about the HIV and AIDS pandemic leads to stigmatising actions.”*

*“Stigmatising people living with HIV is bad, therefore we must get rid of it.”*

*“Stigma towards people living with HIV and AIDS leads to the spread of HIV and AIDS.”*

From the above quotations, it is evident that the educators who participated in REds were aware that stigma and discrimination had serious effects on individuals affected by the HIV and AIDS pandemic; this was borne out by their suggestion that more topics about stigmatisation be included in prevention programmes.

The participants also suggested that intervention programmes should be more culturally focused. They emphasised that any prevention programme needed to be culturally appropriate for them to feel comfortable in implementing it and for the learners and community to buy into it (*We need examples or stories in the manuals which are relevant to Sesotho culture ...; I think the music which is culturally appropriate must be used for the programme*).

Culture has to do with the way that people from a given community live their lives, which includes family life, patterns of behavior, beliefs and language (Reber & Reber, 2001; McCubbin and McCubbin, 2005; Robinson, 2007). In addition to this, culture helps individuals to develop a desirable personal identity. Adhering to cultural traditions contributes to an individual’s sense of purpose, aspirations, beliefs and values, as well his or her spiritual and religious identification (Ungar et al., 2008). Cultural heritage also encourages a collective identity and sense of belonging, both important factors for developing resilience (McCubbin and McCubbin, 2005).

According to Fergus and Zimmerman (2005), Cameron et al (2008), and Ungar (2008), being proud of one’s culture and adherence to cultural norms and practices

makes an individual feel grounded. This in turn helps to enhance an individual's resilience or fosters a sense of belonging and resilience. Resilience is a result of the interaction between an individual and his/her ecology that provides him/her with health resources, and opportunities to access these resources in a culturally accepted way. Culture is important, because it provides meaning to an individual living through adversity such as the HIV and AIDS pandemic. Therefore, in order for an individual to be resilient, he /she has to be culturally grounded in knowing where he/she comes from and that he/she is part of a cultural community tradition that is expressed through daily activities. Cultural practices and beliefs also guide individuals and families on how to cope with trauma, such as illness and death (McCubbin and McCubbin, 2005). Spiritual and religious practices also help to build resilience (Dass-Brailsford, 2005) and this spiritual connection helps to build commitment to serving communities, something that was evident in the analysis of the post-test drawings and narratives.

The participating Lesotho teachers had a definite ethnic identity, which also contributed to their social and psychological meaning and sense of belonging. This encouraged a sense of cohesion in the community and guided them to access resources, which enhanced the development of resilience (Cameron et al., 2007). By including culturally relevant music and case studies, therefore, the resilience of participants would probably be increased.

### **5.10 Themes that emerged from delayed post-test narratives**

In this section of the study, the themes that emerged from delayed post-test narratives will be discussed. I arranged to meet the participants three months after the last REds session. Participants were asked to reflect on REds:

*Write about 1 to 1 1/2 pages about your life in the time of AIDS.*

I wanted to find out how they were coping with the teaching of orphans and vulnerable children three months later and if the changes that were identified in the post-test narratives had been sustained or improved on. The following themes emerged from the delayed post-test narratives.

### **5.10.1 Educators still displayed confidence and were initiating action to deal with affected learners and colleagues**

In the delayed post-test narratives, the participants mentioned that although the pandemic was still impacting on them negatively in a personal way, professionally, they were coping better. They mentioned that they were confident and had gained knowledge on how to deal with infected and affected learners and colleagues. They were now able to take the HIV test and encourage others to know their HIV status, which indicates that the fear they professed to feel in the pre-tests had now dissipated. Some of the comments included:

*“I now know my HIV status.”*

*“I have gained more understanding about this virus, and also on how to deal with the affected learners.”*

*“I am confident to deal with sick people.”*

From the above quotations, it is evident that participants' resilience had increased slightly following participation in REs, because most of them mentioned that they were able to cope with the challenges of the HIV and AIDS pandemic. They mentioned that they had a positive sense of self and a collective identity with their community members and the ability to adhere to or oppose prevailing norms (*I am more knowledgeable to work with my community; I know what is right from wrong and can take responsibility to look after HIV positive people from my community*). These are signs that they had developed resilience in the face of the HIV and AIDS pandemic. However, the fact that they mentioned that they were still suffering on a personal level, indicates that a short intervention such as REs may not be sufficient to help them deal with personal issues.

### **5.10.2 Educators still viewed HIV infection more positively**

Following participation in REs, most participants mentioned that they had hope that a cure for HIV and AIDS could be found. They also mentioned that having HIV was

not the end of the world and that it was important for people to take steps to prevent infection and also encourage others not to lose hope.

Some of the comments included: *“REds has helped me to realise that this is not the end of the world.”*

*“REds has given me hope that one day HIV will be cured.”*

The participants' responses suggest that REds had empowered them spiritually. They had developed hope, and hope is associated with resilient functioning (Masten and Reed, 2005). From delayed post-test narratives, it can be concluded that participants' resilience had been sustained over the short term (three months), because their responses implied that they were coping more resiliently with the challenges of the HIV and AIDS pandemic. This is a clear indication that REds had had a positive impact on affected participants, at least on a professional level. In the next paragraph, delayed post-test interviews will be discussed.

### **5.11 Data interpretation for delayed post-test interviews**

I arranged to interview the educators a year later. I wanted to ascertain whether or not the slight increase in resilience that the drawings and narratives had indicated had been sustained over a longer period of time. Interviews were undertaken with educators who participated in REds, apart from one participant who had passed away in the interim. In the interview, I asked the participants the following question:

*“Now that it has been a year since you concluded REds, how do you feel in terms of being able to cope with orphans and vulnerable children in class?”*

The findings are discussed in a narrative, descriptive format and compared and supported by relevant verbatim quotations from the transcribed interviews. They are also compared and supported by relevant literature. (Cf. paragraph 2.7.4).

**Table 5. 2: Themes identified from delayed post- test interviews**

THEME	SUB-THEME
1. Educators still perceive themselves to be coping with the demands of teaching orphans and vulnerable children.	
2. Educators' sense of agency has been sustained.	2.1 Educators perceive themselves as being able to take action to address the needs of orphans and vulnerable children.
	2.2 Educator responses indicate a sustained awareness of social justice issues.
	2.3 Participants reported that they were able to form positive relationships and access material resources.
3. Educators indicated that there was a need for more cultural adaptation of the programme.	

**5.11.1 THEME 1: Educators still perceived themselves to be coping with the demands of teaching orphans and vulnerable children**

As I mentioned in paragraph 1.3, the HIV and AIDS pandemic affects educators and learners negatively. Some of the negative impacts include poor teaching and learning and poor attendance by both educators and learners (Coombe, 2003). Even though the HIV and AIDS pandemic affects educators on both personal and professional levels, some educators who participated in the REds Programme in Lesotho expressed personal relief as no longer being totally overwhelmed by the task of dealing with the HIV and AIDS pandemic in the classroom. They indicated that following the REds Programme, they had become able to deal with the challenges that result from having orphans and vulnerable children in their

classrooms. Their responses indicated that their resilience to cope with the challenges of teaching of orphans and vulnerable children was still sustained a year later. Some put it this way:

*“I am a lucky person who makes change and difference in the lives of orphans and vulnerable children.”*

*“I am feeling great now because I am able to help these children.”*

*“I am now able to identify learners in my class who are affected and infected.”*

When Theron, Mbitsela and Esterhuizen (2006) implemented REs in South Africa, their results also showed that educators perceived themselves to be coping better with the demands of teaching orphans and vulnerable children after completion of the Programme. They indicated that they felt enabled, empowered and functioned resiliently in the face of the HIV and AIDS pandemic. For example, participants mentioned that REs had increased their knowledge and skills, they had a sense of social justice and were able to form positive relationships and access material resources.

Some comments included:

*“I am now able to offer care and support to my learners and colleagues.”*

*“I know which issues should be considered when dealing with these children.”*

*“I am able to cope with orphans and vulnerable children in my classroom.”*

From quotations above, it is evident that participants' responses revealed that most of them were coping resiliently with the challenges that result from having orphans and vulnerable children in their classrooms. This suggests that REs had had a positive impact on the participants and that that impact had had a lasting effect.

### 5.11.2 THEME 2: Educators' sense of agency had been sustained

After participating in REds, most participants' responses indicated that REds had impacted on them in a positive way. Most participants reported that before they participated in REds, they could not talk freely about the HIV and AIDS pandemic with their learners. They were not able to cope with the challenges that result from having orphans and vulnerable children in their classrooms. In fact, they were overwhelmed by the increasing number of orphans and vulnerable children in their classes. However, after participation in REds, most participants mentioned that they now felt better able to take action to address orphans and vulnerable children's related issues, as further explained in the categories below.

- **Educators perceived themselves as being able to take action to address the needs of orphans and vulnerable children**

The participants reported that following REds participation, they felt better to address the needs of orphans and vulnerable children. They mentioned that REds had enabled them to help orphans and vulnerable children.

*"I have informed tactics on how best to guide and counsel orphans and vulnerable children."*

*"REds has equipped me with skills on how to cope professionally."*

From the above quotations, it is evident that educators thought that their sense of agency had been sustained. The educators felt professionally empowered after participating in REds. For example, they thought that they were better able to cope with the demands that the HIV crisis made on them and better able to cope with the challenges that resulted from having orphans and vulnerable children in their classrooms, and they were also more community minded (*I am now able to assist colleagues and other people who are infected by HIV and AIDS in the community and even at school*).

Some of the participants said:

*“I feel strong ...”*

*“REds has equipped me with skill on how to offer care and support.”*

All the above statements show that educators’ sense of agency had been sustained after having participated in REds. The categories below discuss this in more detail.

*“REds has equipped me with skills on how to handle orphans and vulnerable children ...”*

The above statements show that educators’ resilience had increased, because they were able to help orphans and vulnerable children.

- **Educators responses indicated a sustained awareness of social justice issues**

Some educators have stated that they had an increased sense of social justice, because they were able to take action to address stigma and discrimination. According to the participants, the Programme had brought light, because it empowered them. They indicated that REds had increased their sense of social justice.

Some of the comments included:

*“We should also put end to stigma and discrimination.”*

*“Making friendship with those who have the HIV virus, because together we can achieve one goal and say no to discrimination.”*

From the above comments, it may be concluded that REds had increased the participants’ sense of social justice. The participants were aware that people living with HIV and AIDS continued to face stigma and discrimination. According to

UNAIDS (2000), Jackson (2002) and Van Dyk (2005), people affected by the HIV and AIDS pandemic experience feelings of shame and anger. REs therefore equipped participants with knowledge and skills on how to combat and cope with the stigma surrounding the HIV and AIDS pandemic.

- **Participants reported that they were able to form positive relationships and access material resources**

Some participants indicated that REs had enabled them to form positive relationships. They also mentioned that they were able to access material resources. They mentioned that they knew about supportive resources for people affected or infected by the HIV and AIDS pandemic.

*“If we are affected by HIV, we can get help.”*

*“I am now able to assist colleagues and other people who are infected by HIV and AIDS in the community and even at school ...”*

*“I now know how to speak to HIV infected people and tell them where to go for help.”*

*“... in fact we are like a family.”*

Looking at the above comments, one may conclude that the participants now knew how to help HIV positive people. They felt enabled to fight against the disease, work with the community to share knowledge and take steps to prevent the spread of the HIV virus. This shows that REs had impacted on participants positively. Their attitudes towards people living with HIV and AIDS had changed. This finding was confirmed in the evaluation of REs in South Africa (Esterhuizen, 2007; Theron et al., 2009).

### **5.11.3 THEME 3: Educators indicated that there was a need for more cultural adaptation of the programme**

According to the participants, there was a need for more cultural adaptation of the REds programme. For example, the participants suggested that the music and stories used in the REds sessions must be culturally appropriate. They also suggested that the REds content should be relevant to the communities' culture and that it should be disseminated at grassroots levels in the communities. According to the participants, REds should be an ongoing support programme and HIV positive community members should be included in REds sessions when dealing with the issues of stigma and discrimination. Some of the comments included:

*"Music must be more appropriate."*

*"REds should make use of local people, they need to be used in talks."*

*"I think REds should be made more accessible to the larger population."*

*"I would like REds to be an ongoing support programme."*

According to some of the participants, REds should make use of appropriate music and stories, because such stories and music would have a positive effect on the participants' mood. The participants suggested that it was also important to play music suitable for a particular group, and that participants should bring their own music, since this would help participants to relate to the content that was being taught (Rooth, 2005). Culture plays an important role in the process of building resilience, as it helps to build self-efficacy and self-esteem (McCubbin and McCubbin, 2005). Louw, Duncan, Richter and Louw (2007) emphasise that cultural practices and influences provide a variety of protective functions that nurture resilience.

The participants suggested that REds should make use of local people when addressing the topic of dealing with the stigma attached to the HIV and AIDS pandemic. This is because the stigma surrounding the HIV and AIDS pandemic

could be managed by involving people living with the HIV and AIDS pandemic, sometimes referred to as health promoters, village health workers, primary health care workers and rural health assistants. Studies (UNAIDS, 2000) have found that making use of local people who are HIV positive or who know the local situation well, are instrumental in the prevention of the spread of the HIV and AIDS pandemic. These people are trained and expected to “*perform health promotions, education and service delivery*” in the communities within which they live (Department of Education, 1999).

As part of health promotion in the community, they could encourage the use of condoms, abstinence, faithfulness and the necessity of taking medication on a regular basis among people living with HIV. In the case of education and service delivery, they could educate people in the fields of a proper diet, HIV transmission, issues related to stigmatisation, care for HIV infected people and orphans and vulnerable children (Jackson, 2002; Van Dyk, 2005).

The participants also suggested that they needed long-term intervention programmes such as REds, because it had had a positive impact on their personal and professional life and to some extent on their personal life, and they perceived it to be worthwhile. Most training interventions did not last for nine weeks, but were covered in one or two sessions only (Wood and Goba, 2009).

## **5.12 SUMMARY OF EVALUATION**

From the pre-and post-data, I conclude that the REds intervention had developed participants’ resilience in the face of the HIV and AIDS pandemic to some extent. According to the participants, REds should be praised, because most of them thought that they had benefited from the Programme. The visual data and narratives indicated that participants who had attended the nine sessions of REds intervention had experienced an increase in their levels of resilience. They were resilient in the sense that they were able to navigate towards and make effective use of ecologically situated protective resources in culturally relevant ways (Ungar, 2008). REds had helped shape their attitudes more positively and they perceived themselves as agents of change with regard to the HIV and AIDS pandemic.

As a researcher, I am aware that participants' responses in the delayed post-test interviews were more positive and suggestive of increased resilience. On a personal level, the participants reported that they were more resilient in the face of the pandemic, because they no longer experienced negative personal impacts such as depression, sadness, hopelessness, despair, fear, trauma and grief when the HIV virus personally infected or affected their loved ones, colleagues and learners. In addition, they were no longer afraid for their personal safety (Kinhorn and Kelly, 2005). This was a pleasing finding of the delayed post-test interviews, since the previous data analyses had showed that they did not perceive themselves to have benefitted so much on a personal level. It may be concluded that what they learnt from the REds Programme did benefit them over time, once they had processed it over a longer period.

On a professional level, the participants indicated that they could deal better with the HIV and AIDS pandemic. They mentioned that they had developed more tolerant attitudes towards the teaching of orphans and vulnerable children and that they were able to help orphans and vulnerable children, infected learners and colleagues, which had helped ease their professional duties. From the multiple data sources, I conclude that the participants linked all the knowledge and skills they had attained to cope with the HIV and AIDS pandemic to REds. The fact that they mentioned that they were still coping with the challenges of the HIV and AIDS pandemic showed that their resilience had increased to a certain extent and had been sustained a year later.

### **5.13 SIGNIFICANCE OF FINDINGS FOR MY LEARNING AS A TEACHER EDUCATOR**

It is important at this point that I reflect on what the implementation of the REds Programme and my interaction with the participants have taught me, so that I can implement appropriate changes in my work and make recommendations for improving teacher education in the age of HIV and AIDS. I have categorised my learning into methodological insights and training insights.

### **5.13.1 Methodological insights**

During REds sessions, I learnt that the use of drawings, which is relatively novel to South African research, according to Stuart (2007), has the potential to enable participants to express themselves, even where participants have a poor command of English. Symbolic drawings allowed participants who had a language problem to express themselves better. From experience, I am aware that symbolic drawings allow participants with low levels of literacy an opportunity to express themselves richly, even though most participants in this study indicated that they were not good at drawing. I conclude that narratives and symbolic drawings are suitable methods of data gathering when working with teachers who have low literacy levels in English, since they do not have to be expert drawers or be able to write in a formal way.

### **5.13.2 Training insights**

I have also learnt that in the REds Programme cultural barriers were encountered, such as the taboo surrounding talking openly about death. This could affect participants' functioning as HIV educators working with orphans and vulnerable children. However, some participants indicated that as much as talking about death was regarded as taboo, it was an important topic that needed to be discussed, because death was more prevalent now in the lives of their learners and the community members due to the HIV pandemic.

Therefore, teachers need to be encouraged to openly discuss death while still being conscious of the cultural sensitivities of their learners.

In addition to this, participants' reflections suggested that the taped relaxation exercises and classical music used in REds should be replaced by Sesotho music. Stories in REds should also be relevant to the Basotho culture. According to Killian (2007), stories bring alive the substance of a lesson and help participants to learn more. They also allow participants to feel that their personal stories, cultural history and cultural literature are important, and this helps them to create a positive sense of identity and a sense of coherence with a specific culture, both of which increase resilience (Killian, 2007). Therefore, in HIV and AIDS programmes such as this one,

stories used should not just be for the sake of stories, but should be relevant to the substance of the topic and be used to help participants build their understanding.

#### **5.14 CONCLUSION**

Within limitations such as the relatively small samples and limited time, one may tentatively conclude that REds as one of the support programmes for educators affected by the HIV and AIDS pandemic did facilitate an empowerment in the lives of the participating educators by helping them to develop a more resilient response to the adversities they faced in their everyday lives as educators in the age of AIDS. Although it is acknowledged that REds is not the only intervention that can be used to develop teacher resilience, it has proven to be a useful one in this context. The content of REds can be used as a guideline for the development of future interventions to increase teacher resilience. I have learnt useful lessons from implementing REds that will help me, as a teacher educator, to design pre-service and in-service programmes that will help Lesotho educators to become more resilient in the age of HIV and AIDS.

In the next chapter, I will summarise the study, present the conclusions reached in terms of the research questions, and make recommendations as to how Lesotho educators could be supported to be better able to address the issues surrounding orphans and vulnerable children in their teaching.

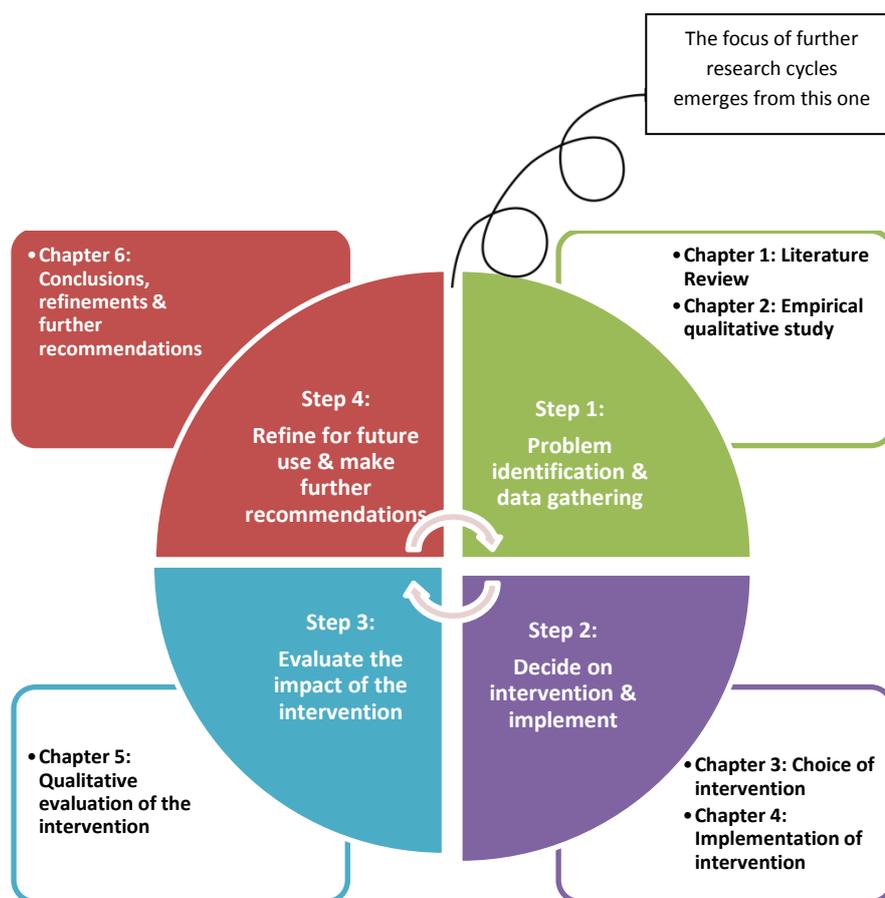
## **CHAPTER 6**

### **SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS FOR FURTHER RESEARCH**

#### **6.1 INTRODUCTION**

In the previous chapter, an empirical evaluation of the impact of the intervention to develop resilience in the participating Lesotho educators and the findings in relation to the research questions were discussed. In this chapter, which constitutes the fourth step of the action research process, I give a brief background of what motivated my choice of topic and what the research sought to discover. I then give a brief synthesis of the problem before addressing my research questions and presenting my conclusions regarding the research questions. I then suggest the potential contribution of my study to research, as well as its limitations. Finally, I offer recommendations for future practice and research, based on the findings of the study.

**Figure 6.1: Overview of Action Research process**



## 6.2 BACKGROUND CONTEXT OF RESEARCH

As a citizen of Lesotho, a country with about 180 000 orphans and vulnerable children due to the HIV and AIDS pandemic (UNAIDS, 2007), and having worked as a teacher educator in this country for the past 12 years, my desire was to do research in this field. I wanted to find out ways in which I could help educators in training and educators in the field deal better with orphans and vulnerable children. It was after consultation with my promoter that the exact field in which I would ultimately carry out the research started taking shape in my mind and, with the help of my promoter, research questions were formulated as follows:

***What are the experiences, perceptions and needs of educators in Lesotho concerning the teaching of orphans and vulnerable children?***

***How can Lesotho educators be helped to better cope with the challenges that result from having orphans and vulnerable children in their classrooms?***

By asking these questions, I wanted to discover Lesotho educators' experiences, perceptions and needs concerning the teaching of orphans and vulnerable children and how they could be helped to cope better with the challenges that result from having orphans and vulnerable children in their classrooms. I wanted to explore and test a possible intervention programme that would help them to cope with the challenges that result from having orphans and vulnerable children in their classrooms. After evaluating their experiences of this programme, I then wanted to make some recommendations for the future training of educators to cope with the challenges that result from having orphans and vulnerable children in their classrooms.

### **6.3 SYNTHESIS OF PROBLEM**

Due to the HIV and AIDS pandemic, orphans and vulnerable children are at risk of dropping out of or never attending school. These children are forced to assume the role of caring for their siblings or terminally ill family members (Avert, 2007). AIDS decreases the opportunity of orphans and vulnerable children to become educated. It is important to state that less education deepens poverty and increases the vulnerability to HIV infection of these children. Educators find themselves ill equipped and not able to cope with the challenges and demands of educating these children. This study undertook to explore ways in which these educators could be helped.

### **6.4 SUMMARY OF RESEARCH PROCESS UNDERTAKEN TO ADDRESS RESEARCH QUESTIONS**

The main purpose of this research was to find ways of enabling educators in Lesotho to cope with the challenges that result from having orphans and vulnerable children

in their classrooms. In order to achieve this purpose, an action research design was adopted, as outlined in Figure 6.1 above.

In the **overview** of the research, I highlighted the process that I followed in this study. I presented the background to, and the framework for, this study. I also specified the purpose and the research questions that guided it, the research design and methodology, the key concepts used in the context of the study, and the ethical considerations. I concluded with an outline of the research design, represented in diagram form. I will now offer a summary of the action research process followed, highlighting the main findings at each stage.

**Figure 6.2: Step one: Problem identification and data gathering**



**Chapter 1** formed the first step in data collection to identify the problems and challenges that educators face when teaching orphans and vulnerable children. It focused on the existing literature with regard to the threat that the HIV and AIDS pandemic posed for education and the general wellbeing of orphans and vulnerable children. In the literature chapter, I discussed the role of education in the HIV and AIDS pandemic era.

I discussed the impact of HIV and AIDS on the education system, on learners and on educators. It became evident from the literature that many problems were associated with the teaching of orphans and vulnerable children and also that educators were struggling to cope with the challenges that resulted from having orphans and vulnerable children in their classrooms. From the literature study, I **concluded** that

educators needed to be helped to better cope with the challenges of having orphans and vulnerable children in their classrooms.

**Chapter 2** explained the empirical study undertaken to complete the problem identification phase of the action research process and to supplement the literature study with knowledge of how Lesotho educators were experiencing the teaching of orphans and vulnerable children. This filled a gap in the existing literature, since most of the previous research had been done in other countries. In this chapter, I covered the research process and methodology of the empirical qualitative study in depth. I also discussed the findings that emerged from the data analysis, to complete the problem identification step 1 of the action research cycle.

From the empirical study, I **concluded** that:

**Working with orphans and vulnerable children has a strong impact on the professional and personal context of educators.**

My research findings revealed that teaching of orphans and vulnerable children impacted on educators personally and professionally. The participating educators mentioned that they felt inadequate to teach orphans and vulnerable children. The educators believed that they, too, needed personal counselling, because they could not function properly, as they are personally affected by infected or affected ill and dying loved ones, colleagues and learners due to the HIV and AIDS pandemic.

The participating educators indicated that they felt *professionally* inadequate to teach orphans and vulnerable children, and that they were not coping with the challenges resulting from having orphans and vulnerable children in their classrooms. The educators reported that they were struggling to cope with the multiple roles expected of them, such as counsellors, caregivers, substitute parents, social workers and preventive agents, noting that they had not been trained to fulfil such roles.

The teaching of orphans and vulnerable children impacts negatively on the participating educators *personally*. They experienced negative emotions such as grief, fear and emotional disorders. The educators had personal experience of the

pandemic, through having relatives being infected or being infected themselves. When they taught orphans and vulnerable children, these negative emotions were brought to the fore.

**Educators' responses to orphans and vulnerable children are inappropriate and may aggravate the situation.**

According to my research findings, the educators' responses to orphans and vulnerable children aggravated the situation. The participants mentioned that working with orphans and vulnerable children caused them to react negatively to the learners in question. For example, they admitted that they tended to be impatient with these children and to stigmatise and discriminate against them. They mentioned that they felt helpless in the face of the problems brought about by teaching orphans and vulnerable children and that they needed support so as to respond in a more appropriate way to the needs of these children.

**Educators focus primarily on the material needs of orphans and vulnerable children.**

According to my research findings, the participating educators focused primarily on the material needs of orphans and vulnerable children. They did not know how to and had not been trained to respond to the psychosocial and emotional needs of orphans and vulnerable children. This was an indication that they, too, needed help to be able to address the psychosocial and emotional needs of orphans and vulnerable children.

The findings from my literature search and empirical study indicated that the participating educators needed to be empowered to better cope with the challenges that result from having orphans and vulnerable children in their classrooms. They lacked skills on how to cope with the challenges that brought about by having these children in their classrooms. I **concluded** that they, too, needed support in the form of an intervention that would help them to better cope with the challenges resulting from having orphans and vulnerable children in their classrooms.

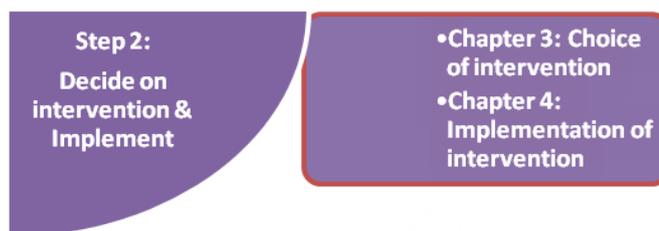
These findings answered the first sub-question of the study, namely:

*What are the experiences, perceptions and needs of educators in Lesotho concerning the teaching of orphans and vulnerable children?*

The knowledge that I gained in Step 1 helped me to critically reflect on what was needed to answer the second research question:

*How can Lesotho educators be helped to better cope with the challenges that result from having orphans and vulnerable children in their classrooms?*

**Figure 6.3: Step two: Decision on the intervention and implementation of the REds programme**

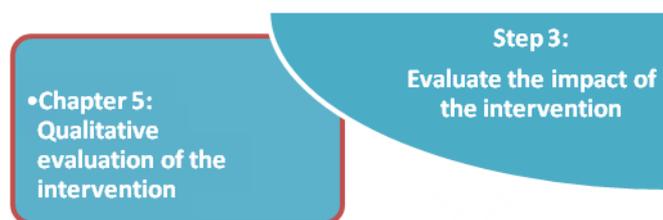


Based on the conclusions reached at the end of the first step of the action research process, I realised that the educators needed help to build their own ability to cope before they could help orphans and vulnerable children. In **Chapter 3**, I discussed educators' roles in the HIV and AIDS era and **concluded** that resilience theory would be a suitable construct to help educators build their strength. I discussed resilience theory and strategies to encourage resilience in the educators. I also highlighted the current support for educators affected by the HIV and AIDS pandemic and the additional requested and recommended support. Finally, I presented a justification for implementing REds for Lesotho educators. REds is a supportive intervention programme for educators affected by the HIV and AIDS pandemic.

**Chapter 4** focused on the overview of the process of the implementation of the REds Programme for educators affected by the HIV and AIDS pandemic in Lesotho. This formed the second stage of the second step of the action research process.

In order to help educators in Lesotho to better cope with the challenges that result from having orphans and vulnerable children in their classrooms, the REds programme was implemented among a group of educators in Lesotho affected by the HIV and AIDS pandemic in Lesotho (see paragraph 4.6). From my reflective process notes and the evaluation forms filled in by educators, I **concluded** that the educators enjoyed the sessions and that they benefitted from them. Most of them mentioned that REds had empowered and enabled them to cope with the challenges of the HIV and AIDS pandemic. They stated that it had also enriched their knowledge about the HIV and AIDS pandemic and that their attitude towards the HIV and AIDS pandemic had changed in a positive way.

**Figure 6.4: Step three: Evaluation of the impact of the intervention**



**In Chapter 5**, which is the third step of action research cycle, an empirical evaluation of the impact of the intervention to develop resilience in the participating Lesotho educators and the findings in relation to the research questions were discussed. I reported and interpreted the findings to determine the extent to which REds had been successful in enabling Lesotho participants affected by the HIV and AIDS pandemic to function resiliently with the HIV and AIDS pandemic challenges. This was done to further explore the effectiveness of the REds Programme for educators affected by the HIV and AIDS pandemic.

I evaluated the programme with a pre-post-test time series design, using multiple sources of data collection, namely drawings, narratives, interviews and observation by means of field notes. I **concluded** the following:

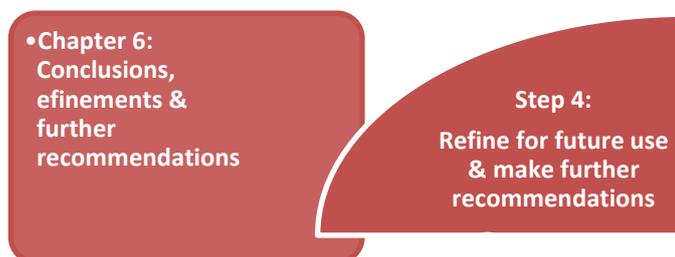
The participating educators showed signs of increased resilience, particularly on a professional level. Personally, they still needed to be assisted to develop resilience, although the delayed post-test interviews indicated that they had become more resilient in this area a year after completing REs.

The delayed post-test interviews revealed that changes in the educators' sense of agency, ability to cope on personal and professional levels with the demands of teaching orphans and vulnerable children, ability to take action in addressing the needs of same, awareness of social justice issues, formation of positive relationships and ability to access material resources had all been sustained after a period of one year. Participants also felt that REs needed to be made more relevant to the Lesotho context.

**REs needs to be adapted for the Lesotho context to make it more culturally relevant.**

REs, which was found to be fairly successful when implemented in South Africa, will need to be adapted to the different cultural contexts of a country or community it may be implemented in. The participants in this study were of the opinion that some aspects of REs such as music, stories and topic about death needed to be made more culturally applicable to the Lesotho situation and for the Basotho culture.

**Figure 6.5: Step four: Conclusions, refinements and further recommendations**



In conclusion, this research has provided very detailed and rich data, which resulted in a number of findings. The findings and conclusions reached at each stage of the action research process have been summarised above. In the next section, I will

concentrate on **recommendations** arising from these conclusions and also reflect on my own learning from the study.

## **6.5 PERSONAL REFLECTION ON MY OWN LEARNING**

Personally, as a result of the readings I have undertaken in the writing up of this research, I now know that I have a better understanding of educators' experiences, perceptions and needs concerning the teaching of orphans and vulnerable children. I am now aware that most educators have been teaching orphans and vulnerable without being able to identify, contain and address their own needs in this regard.

The findings from this study will help me to attend to these needs when designing my learning material for pre- and in-service educators in Lesotho.

I also learnt that the use of symbolic drawings by educators helped them to better express themselves with regard to the impact of the HIV and AIDS pandemic. They were better able to express themselves, because through the use of drawings, they could represent symbolically what they might have felt uncomfortable talking about or were unable to express in words. This insight will also help me in my work with educators in the future.

The narratives, reflections and interviews carried out with them also encouraged them to express in words things they had experienced with regard to the challenges of the HIV and AIDS pandemic and the challenges that result from having orphans and vulnerable children in their classrooms. The narratives, reflections and interviews had a therapeutic effect on them, in that for many of them, this was the first time they had talked about their feelings with regard to the personal and professional impact of the pandemic. These methods of data gathering also helped them to see the problems of orphans and vulnerable children from a different perspective, as there was a sharing of ideas and open discussions on their experiences as educators of orphans and vulnerable children.

I must mention that the time I spent and interacted with educators in the field is a potential strength, because I came across new realities regarding the challenges that

result from having orphans and vulnerable children in the classroom. This is information that I would not have come across in the literature, since there was a gap regarding Lesotho educators' experiences of teaching orphans and vulnerable children. The information I elicited from educators was authentic and believable. Again, as a teacher educator, the skills I acquired in working with these educators have benefitted my facilitation of interviews and participatory activities. I can say that I was able to conduct my study in a professional manner; that is, there was a spirit of harmony, cooperation and respect during interviews between myself and educators who were interviewed (Bassey, 1995).

## **6.6 RECOMMENDATIONS EMERGING FROM THE CONCLUSIONS**

This study has revealed educators' experiences, perceptions and needs with regard to the teaching of orphans and vulnerable children. It has also revealed how educators can be helped to better cope with the challenges that result from having orphans and vulnerable children in their classrooms. The recommendations that I present in this chapter are based on the findings of the study in Chapters 2 and 5 respectively. They are also based on the literature that appears in Chapters 1 and 3. I need to point out that even though these recommendations are stated separately, they overlap.

### **Recommendations for in-service training of educators:**

The study revealed that dealing with orphans and vulnerable children has a considerable negative impact on educators' emotions and wellbeing, therefore it is **recommended** that:

- The Lesotho Ministry of Education and Training (MOET) makes counselling available for educators working with orphans and vulnerable children and arranges for the training of counselling staff to work with these educators.
- MOET makes provision for regular visits by counsellors to schools to offer psychosocial and emotional support to these educators.

- MOET develops programmes to encourage resilience in educators, similar to the one adopted in this study. However, the material and content should be adapted to be more suitable for the Lesotho context.
- MOET should provide educators with workbooks and other printed material on possible ways of dealing with situations that may arise affecting orphans and vulnerable children.

### **Recommendations for pre-service training of educators.**

Since the study revealed that educators had not received training to deal with the impact of the HIV and AIDS pandemic in their initial training, and since the reality of orphans and vulnerable children is likely to be present for many years to come, it is **recommended** that:

- More emphasis should be placed on the development of resilience in the training of educators at the Lesotho College of Education.
- Teacher trainees on internship should also be exposed to those schools with a high number of orphans and vulnerable children during their internship year, to equip them for the reality of working in a context characterised by HIV and AIDS.

### **Recommendations for education research/ further research**

The study revealed that REs was not considered to be culturally sensitive; therefore, it is **recommended** that further research be carried out on the socio-cultural sensitivity of REs in Lesotho, in which this study was carried out.

The study also revealed problems around the material support, medical support, social support and family support of orphans and vulnerable children. It is therefore **recommended** that future research could explore:

- The educational financing of affected children.
- Availability of medical facilities for HIV and AIDS infected children at schools.
- The extent and impact of stigmatisation of these children in schools and on their academic performance.
- The integration of suitable prevention and care programmes at schools into the curriculum.

## **6.7 LIMITATIONS OF STUDY**

I am aware that there are some easily discernible weaknesses in the research in this study. For example, I noted the following limitations:

- Firstly, the study covers only a small fraction of the number of potential participants of the study. This limits the claim of representativeness. However, it is not the intention of this research to assemble representative data: its aim is to assemble data which would shed light on how Lesotho educators can be helped to better cope with the challenges that result from having orphans and vulnerable children in the classroom. Also, it applies to primary schools in Lesotho only.
- Secondly, related to the limitation concerning the quality of the interviews and, by implication, data emerging from these, is the fact that the interviews were, to a large extent, carried out in Sesotho and translated into English during transcription. Some meaning and nuances may have been lost in the translation.
- Finally, some infected and/or affected educators were reluctant to be involved in the interviews and in the REds Programme for fear of being

stigmatised, therefore, this study may not have accessed those most in need of help.

## 6.8 POTENTIAL CONTRIBUTION OF MY STUDY

To the **theory**, the study will not only add to the literature already existing on resilience of educators working with orphans and vulnerable children, but will, more importantly in my view, do so in a way that is specifically contextualised to the circumstances peculiar to Lesotho. In my readings, at the literature review stage of the research, I never once came across literature pertaining to resilience amongst educators working with orphans and vulnerable children in Lesotho. Such a study has never before been carried out in Lesotho and none of the participants in my study had ever heard of the REds Programme. The study then will greatly contribute to the existing literature and offer new insights into the problems from another perspective for future research. The finding that REds could be improved to make it more culturally relevant, makes an important contribution towards the design of future programmes to develop resilience in educators in Lesotho.

To **practice**, as a teacher educator at the Lesotho College of Education, this study has also helped me gain skills and knowledge that I can pass on to teacher trainees at the Lesotho College of Education. I can make recommendations to the College that will result in REds or other intervention programmes being essential courses offered by the College to its trainees. This would result in future educators graduating from the College being able to deal with orphans and vulnerable children's issues. I will also be able to use the knowledge gained in this study to assist my colleagues in developing suitable programmes, thereby contributing to staff development.

The study has contributed to knowledge about **research methodology** for working with groups who are not very literate in English and who experience difficulty in orally explaining their thoughts and feelings. For example, I found the combined use of symbolic drawings, narratives, reflections and interviews very appropriate for collecting the kind of data I needed to collect. Future researchers in this field could replicate the methods I used in this study for working with similar groups.

## **6.9 CONCLUSION**

In this chapter, I have summarised the study, presented the conclusions reached in terms of the research questions, and made recommendations as to how Lesotho educators could be supported to be better able to address orphans and vulnerable children issues in their teaching. I have also outlined how my study has made a contribution to knowledge and practice. It is important to mention that I am satisfied that I have attained the goals of my study and, moreover, I have experienced significant personal development during this journey, which can only benefit my future work with educators in Lesotho.

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## **APPENDIX A**

### **AN APPROVAL FORM FROM: NMMU RESEARCH ETHICS COMMITTEE (HUMAN) TO UNDERTAKE A RESEARCH**

## **APPENDIX B**

### **REQUEST FOR PERMISSION FROM PRINCIPALS TO CONDUCT RESEARCH IN THE SCHOOL**

Lesotho College of Education

P.O Box 1393

Maseru 100

Lesotho

19 January 2009

The Principal

Dear Sir/ Madam

I am employed as a Lecturer at the Lesotho College of Education ( LCE).

I am presently on study leave studying for a doctoral degree in education with Nelson Mandela Metropolitan University. As a requirement for this degree, I have to carry out some research.

It is in this regard that I am writing this letter to you, to ask for your permission to carry out said research at your school.

My research will lead to my writing up guidelines to assist, mainly teachers in Lesotho to offer care and support to orphans and vulnerable children.

I therefore wish to ask for permission to meet with a view of interviewing two teachers from your school who work with, or have worked with, orphans and vulnerable children.

The interview will be carried out outside the normal teaching hours to ensure that classes are not disrupted. I estimate that the interview will last for about 45 minutes.

Teachers who shall agree to be interviewed are assured of anonymity. No information they shall divulge shall be directly ascribed to or used against, them in any way. The name of your school shall also not be divulged to anyone.

The interview shall be recorded and the readings transcribed at a later date.

To confirm accuracy of the information collected, the transcribed interview shall be referred back for the interviewed teachers' consideration.

Thanking you in advance for your kind consideration, I am,

Yours truly

Grace Makeletso Ntaote

## APPENDIX C

### REQUEST FOR PERMISSION FROM PARTICIPANTS TO TAKE PART IN THE RESEARCH

Lesotho College of Education

P.O. Box 1393

Maseru. 100

Lesotho

22 February, 2009

The principal

Dear Sir/ Madam

I wish to sincerely thank you and your staff for the assistance you accorded me in January and February 2009 when I was carrying out my research towards the fulfillment of a Doctoral degree with the Nelson Mandela Metropolitan University.

The information I received from your staff was invaluable, I could not have done without their assistance. I thank you and I thank them all for their time and input.

Wishing you and your learners a fruitful academic year, I am,

Yours truly,

(Grace Makeletso Ntaote )

## **APPENDIX D**

### **A LETTER THANKING THE PRINCIPAL FOR ALLOWING ME TO INTERVIEW TEACHERS FROM HER/ HIS SCHOOL**

## APPENDIX E

### POEM “ *I walk down the street*”

## **APPENDIX F**

### **SAMPLE OF A NARRATIVE**

## **APPENDIX G**

### **HANDOUT 17 (Please tell us what you think)**

## APPENDIX H

### SAMPLE OF INTERVIEW TRANSCRIPTS (1)

#### INTERVIEW SCHOOL 1

**I** Thank you very much for having agreed to be part of this research, which is aimed at enabling primary school teachers in Lesotho to offer care and support to orphans and vulnerable children. The questions I ask and the answers you give will help me very much in writing up my research. My first question is: Do you have any orphans and vulnerable children at this school?

**R** Yes, we do have some orphans and vulnerable children. Some have lost just one parent – the father or the mother – while others have lost both parents.

**I** Okay, so you have paternal, maternal and double orphans?

**R** Yes, we have them.

**I** In your class, Class 4, do you have any?

**R** Yes, I do have some in Class 4. Do you want to know how many?

**I** Well, no, it doesn't matter much. Now, what are your experiences, perceptions and needs concerning the teaching of these children? Do they perform as well as the other children?

**R** At first they were not performing well. I have been with them since they were in Class 1 and at that time, I could realise that they had problems. Even though they were young, I tried to encourage them, to make them realise that being without parents was not the end of their lives. I would try to get to their level of understanding and gave them examples of other children who had lot their parents but who persevered, went to school and, today, hold important positions in society. I would try to motivate them in this way and I could see that it worked. They got motivated and as they went on, I realised that their performance improved.

**I** Yes, after you had spoken to them and so on, their performance improved?

- R** Yes. After I had spoken to them and showed them that I cared enough and I would also try to meet whatever needs they had, whenever I could.
- I** Okay. Now, as a teacher, what would you like to see happening that would be of benefit to these children?
- R** There is something that does not sit very well with me. Yes, you may find that these children come to school and are given books, but then they have transportation problems. Also, the food they get, is not adequate. You will find that some of them even faint, because they have not had anything to eat. Sometimes they do not come to school, because they have no money. At times, the caregiver has no money and cannot help. Their needs are not really being met. Even myself as a teacher, I don't think I am equipped well enough to help them – I feel like I am not giving them enough.
- I** Now coming to you as teachers, how can you be helped to better cope with the challenges that result from having these children in your classroom? How do you think you can be assisted to be better able to help these children?
- R** I am presently studying Psychology, which is something I have wanted to do for some time so as to learn about ways and means of approaching and counseling these children. Even though I am only in my first year, I am slowly equipping myself with some skills and am growing to understand how these children feel. My approach now is slightly different from before when I had no information at all as to how I could approach these children. But I am learning, and I hope finally I will be better enabled to help these children.
- I** What sort of things would you like to be trained in?
- R** The way I see it, that is, regarding teachers in general, teachers are not able to appreciate the circumstances these children find themselves in. They become impatient with them; for example, when a child comes to school hungry, a teacher may not take time to consider how best to help that child. They become impatient; not that they discriminate against them, but ... the fact that you become impatient with the child who is in that situation, affects that child's life. Another thing is that sometimes some of these children are also infected and you may find that they develop sores if they do not get helped. You may find that the teachers do not take an active role towards helping that child, they fear that they will also get infected. It is one of those things which happen, but shouldn't. It really hurts.
- I** Yes, they need some training. They should know what precautions they can take to avoid infection.

- R** True. They need to be trained. Though they always hear about HIV and AIDS, it is like they don't really understand it. They do not really understand how it can be transmitted. It is true that the school does not have any surgical gloves and we may find ourselves attending to these children without gloves. It hurts, but I don't really like the way these children are treated by some of my colleagues.
- I** Yes, they need to be trained. To be informed on how AIDS can be transmitted so that they are not afraid to help these children.
- R** True. They have very little knowledge of HIV transmission.
- I** What else do you think can be done to help these teachers?
- R** The teachers?
- I** Yes. How can they be enabled to help these children?
- R** They need to know ..., I mean if you are a parent raising a child, you want what is best for that child, so you should also feel for the next child and wish the best for the other child, too. You should know that in the same way you wish for a bright future for your child, even orphans and vulnerable children also wish for that bright future, and you should wish it for them, too.
- I** So, as teachers you need to be trained, to be made able to accept these children, not to discriminate against them and to know how you can best help should one sustain an injury?
- R** True. Not to just stand aside and watch a child bleeding and not help, because you don't have gloves, to say: "I don't have gloves", and then just stand aside and watch a child bleeding. It is really painful. It is a challenge, because we have a number of children who passed away as a result of being infected, but still, we have to cherish them. They were flesh and blood and we, too, will ultimately pass on but, we still need to protect ourselves. There are instances where I find that I cannot just stand aside and watch. It could be that even I myself have been infected while helping one such child. I cannot just stand aside and watch. Sometimes, maybe two years later, someone will come and tell me: "That child you were helping, was HIV positive." I might have done this a number of times, but I always tell myself "I don't care, as long as I have done the correct thing, because at that moment that child needed my help." I don't have any argument with that. I have seen it a number of times where a child would be bleeding heavily and no one would want to touch that child, I would tell myself that "no, I have to do something".

I Yes, to help this child.

R To have God in me.

I Are there any orphans and vulnerable children you have tried to counsel? And, have you found that after trying to counsel them, there has been some change in them?

R Yes, they change – they change a lot. I like it because they become happier people – they become happier people. As a teacher you should not always put on a stern face. You should try to make your classes fun and make these children laugh and enjoy themselves. It makes them comfortable and when they have problems, they are able to come to you with their problems. You should show them that you care for them?

I Thank you very much for your time.

**END OF THE INTERVIEW**

## APPENDIX I

### SAMPLE OF INTERVIEWS TRANSCRIPTS (DELAYED POST-TEST INTERVIEWS)

**Code: I = interviewer**

**R= respondent**

#### TEACHER 1

I - Thank you very much for having agreed to be part of this interview, which is aimed at finding out how you feel in terms of coping with orphans and vulnerable children now that you have concluded the REds programme. The questions I ask and the answers you give will help me very much in writing up my research. My first question is:

I-You participated in REds programme in May 2009, If so, now that you have concluded REds, how do you feel in terms of being able to cope with the challenges that result from having orphans and vulnerable children in your classroom?

R-Let me see, oh! REds has really improved my life.

I-Can you please explain to me how it has improved your life.

R- (Pause): Let me see... Okay, before I participated in REds, I was even afraid to mention the word HIV. I have now realized that this was brought about by my ignorance. Now I am no longer afraid of the HIV and AIDS pandemic because REds has empowered me. I am resilient in the sense that I know how to cope positively with it and I know where to seek help. Let me tell you this, you know what ?, at first I could not cope with the large numbers of orphans and vulnerable children in my class but now that I have concluded REds, I feel confident and my attitude has also changed drastically. I can now cope and deal with orphans and vulnerable children in my classroom. I have informed tactics on how best I can guide and counsel orphans

and vulnerable children. Okay, I can now address them individually and in groups. I can also sensitize them with life skills that can help them to build their self esteem. I am also able to face all the challenges regarding the HIV and AIDS pandemic. For example, I am tolerant and accommodative. I am now able to help orphans and vulnerable children and my colleagues who are affected or infected by the HIV and AIDS.

I- How do you face some of these challenges that you are talking about, can you please give me examples, or how do you help learners and colleagues affected or infected by the HIV and AIDS?

R- (Laughing) for example, I have learnt to deal with learners and colleagues with problems caused by the HIV and AIDS. REds has equipped me with skills on how to cope professionally with the work. I am now able to help learners who are affected by HIV and AIDS. It has helped me professionally because I spent most time with these children everyday, so I have developed a positive attitude that assists me to identify orphans and vulnerable children and I now know which issues should be considered when dealing with these children. I help my co-workers, I give them advise on how to implement good methods of approach and to find out the motive behind a certain behaviour of their pupils. We work together to find the solution to problems pertaining to recognized behavior of such children. I also invite their next of kin to come up with the best help. I am now able to assist colleagues and other people who are infected by HIV and AIDS in the community and even at school.

I-What else can you say about REds program?

R- Okay, REds has taught me to be able to offer care and support to my learners and colleagues who are affected or infected by the HIV and AIDS pandemic. For example, I know ways in which HIV virus is transmitted, I know all the precautions with regard to the HIV and AIDS pandemic.

I-Having said this, then what else can you say about REds?

R- Oh! REds programme is a very good programme. I think we need regular workshops at the local and national levels. I think it needs more teaching aids so that people will understand more about the HIV and AIDS pandemic.

I-Okay workshops, which group of people should be trained on REds?

R-I think that all people need REds programme because we are all affected if not infected by the HIV and AIDS pandemic. For example, in Lesotho we burry people who have died due to the HIV and AIDS pandemic everyday.

I-During REds training, in the pre, post and delayed post test you were asked to draw a symbol that came to your mind when you thought about the HIV and ADS pandemic, what is the difference between your first, second and third drawing?

R-Yes, the first drawing shows the first miserable days of the person when she learnt about her HIV status. In the second drawing, the picture shows the woman's understanding about the disease and she feels better, she is no longer miserable and she now knows that she can get help somewhere. The third picture shows that the woman now knows about the HIV and AIDS pandemic, she also sympathizes with other people who are affected by the HIV and AIDS pandemic.

I-Why did you draw this symbol and what does it mean?

R-Let me think. Oh! Yes. I drew this symbol to show people who are affected by the HIV and AIDS pandemic to know that it is normal for a person to be miserable when she learns about her HIV positive status, but as time goes on, one can accept her status and get help from local health centers and clinics. The symbol therefore means that we must act positively if we are affected by the HIV and AIDS pandemic because we can get help. We have to tell other people who are infected or affected by the HIV and AIDS pandemic, help and sympathize with others people who are HIV positive.

I-I see. Thank you very much for your time.

**END OF INTERVIEW**