CHAPTER FOUR
OVERVIEW OF THE REEds PROCESS (PROCESS NOTES)

4.1 INTRODUCTION
The focus of this chapter is on providing a session by session description of the REEds process. This description is based on my reflections and observation notes, the notes of the observer and the reflection worksheets completed by the participants. I used direct quotes at times, and my reflections at the other times, to describe how the participants responded to REEds. I do not indicate a data source for these as they all came from my written process notes, which includes the observer’s notes too. I also include (per session) a section entitled ‘Participant Feedback’. These sections are based on the participants’ completed reflection worksheets. My description focuses on how the contents, methods and language of REEds need to be refined and on observations that indicate where REEds enabled participants (because such observations would mean that these parts of REEds do not need to change).

4.2 THE PROCESS OF REEdS
The process of REEds will be discussed session by session. There were nine sessions in total. For each session I will provide the aim (as per the REEds programme)\(^2\) and then focus on my/the observer’s observations and reflections relating to how REEds enabled participants and to how REEds needs to be refined. I must stress that I was not only looking for ways in which REEds enabled the participants. I was also careful to observe ways in which REEds might fail to enable them. I end each session with a summary of the participants’ feedback on that session, as written in their reflection worksheets.

\(^2\) I have not included more than the aim because REEds is freely available. Copies can be obtained from Linda Theron (Linda.Theron@nwu.ac.za).
4.2.1 Session One

In session one the aims were:

- To get to know each other.
- To explore the key concepts related to REds (including resilience and what it means to be affected).
- To explore the ethical boundaries governing REds.
- To determine group rules for REds.

My initial observations were that all the participants had loved ones, colleagues or learners who were either infected or affected by the HIV/AIDS pandemic. Participants shared their experiences on how HIV/AIDS had affected them emotionally, psychologically, spiritually and physically. It seemed that they were generally negatively affected. For example, one participant sadly shared her emotional experience and said, ‘I didn’t believe that HIV/AIDS is real, but after taking care of my ill brother and preparing for his funeral, it was then I believed and I am still angry for this terrible disease’. The stories shared by the other participants had similar sad themes.

When we talked about the aim of REds (i.e. enabling affected educators to cope resiliently with the challenges of the pandemic), it became clear that they were not familiar with the word ‘resilient’. I used a concrete object to demonstrate to the participants what resilience is by using a fresh green twig and old dry twig. Pressure was applied to the old dry twig, causing it to break. However, when pressure was applied to the green twig, it bent, but curved back to its original form and would even be able to blossom again. The fresh green twig is a resilient twig: although it has been bent and is hurting, it will recover and carry on living (Vaillant, 1993:284).

After this illustration the concept “resilience” was clearly understood by the participants and one participant related to this by saying, ‘I am responsible for the orphan project, Farm school hostel project, learners experiencing barriers to learning and development and sports. I am also expected to teach four Learning Areas in different classes in different grades. I was complaining to
the principal, but from now on I am going to be like a green twig, even in hardship I will work hard and produce good results'. I noted that it was the practical demonstration of resilience that had helped participants to understand what we would be focusing on during the next eight sessions. There is no word for resilience in Sesotho, so this demonstration was important for the aim and title of REds to make sense to the participants.

We agreed on basic group rules including regular attendance of all sessions, providing honest feedback and listening while someone is talking. We revisited the ethical boundaries that had been discussed when each participant completed the informed consent procedure. I observed that the participants were comfortable and there were no further questions about rules or ethics. I came to the conclusion that it is a good idea to take time to decide on group rules and that future REds should adhere to this.

The session was concluded by reading the poem 'There is a hole in my side walk' by Portia Nelson (Covey, 1998: 62). The poem is about someone who learns to be resilient and to avoid life's pitfalls. All participants were quiet; one participant remarked that: 'It is high time that we do something about HIV/AIDS, if we say it's not our fault about the OVCs, really, we are going nowhere'. To me it seemed that this participant had understood the message of the poem, namely that it is possible to make choices that allow us to avoid getting hurt even more and hurting others. I think it is a good idea to include simple poetry in the contents of REds because it links well to the culture of African participants. The Sesotho people often tell stories to be able to explain something. This poem is similar to a story because it explains how a woman learnt to be resilient.

The participants completed the reflection worksheet and they chose to pray because in their culture, after each and every occasion they pray to thank God for being alive and for having the opportunity to receive the correct information to change their lives.
When I think back on Session One, I conclude from my notes and the observer's notes that it seemed that the participants came with stories of sadness and stress, because of AIDS-related losses and because of HIV-related difficulties. But they also came with a willingness to listen and, it seemed to me, a hunger to be empowered. This gave me a good feeling about the sessions that would follow.

4.2.1.1 Participants' feedback on Session One

The participants' reflections on the first session were encouraging. They were satisfied about the information they received. They made remarks like: 'This module has helped me to care for and support infected and affected people in different ways, e.g. socially, emotionally, spiritually and psychologically.' One participant noted that 'this session made me feel at home and this workshop will empower us'.

There were no suggestions for change.

4.2.2 Session Two

In Session Two the aim was to provide participants with the biomedical facts of HIV and AIDS and teach them basic care-giving skills, so that they could be better informed and better able to take care of people who were HIV-positive. This included:

- Being knowledgeable on the correct facts about HIV and AIDS.
- Being less afraid of HIV and AIDS regarding:
  - The myths about the transmission of HIV.
  - Taking care of the sick at home.
  - Infection control at home.
  - Use of medicine.
  - Learning to do things which will help the infected and affected to stay healthy.
  - Learning how to care for the dying.
Knowing how to identify and manage common AIDS-related health problems in their homes.

Learning to recognise danger signs, and learning when and how to seek more help.

Feeling more confident and comfortable because they would be more able to help themselves and their family members.

Because there was more information than could be covered in the time allotted to a session, we decided to divide this session into two sessions and participants came to an agreement on which topics they felt needed to be addressed. They chose Part 2: Taking care of the sick at home, Part 3: Taking care of the dying and Part 4: Management of common AIDS-related problems in the home. They decided they would read Part 1: Facts about HIV/AIDS on their own.

As recorded in my process notes, my initial observations and those of the observer were that the participants knew what HIV/AIDS was. They also had information on when a person becomes infected with HIV and when a person starts to develop the symptoms of AIDS (the stages of infection). Although they had this knowledge, they learned for the first time that once a person’s immune system is too weak to fight off germs, they have gone from being infected with HIV to being sick with AIDS. They did not seem to have a lot of knowledge on how HIV is transmitted. I am not so sure that it is a good idea to conduct Session Two without first checking how much knowledge the participants have and how accurate their knowledge is. If they have sufficient knowledge, it might not be necessary to focus on the basic facts of HIV, especially as there is lot information to absorb in this session as it is.

The ways in which HIV is transmitted were discussed (e.g. through unprotected sexual intercourse with an infected person, from an infected mother to her unborn or new-born child through breast-feeding and through contact with infected blood like transfusion of infected blood (sharing needles that are not sterile). In our culture the mother has to breast-feed; it is a
common belief that breast-milk is very good. Women with little information about HIV transmission are confused about when to breast-feed and when not to. One big mistake is that some pregnant women do not tell their in-laws or their family members about their HIV status. This leads to complications when they choose not to breast-feed and they come into conflict with their families, who insist that they breast-feed. The participants said this was excellent information as they now knew the correct facts about HIV and AIDS, and were better equipped to deal with contentious issues like breast-feeding.

We discussed the myths about HIV transmission and this information enabled the participants to have clear and correct information on this aspect. There would be no more myths about the transmission of HIV/AIDS and this was enabling for them. I think it is especially important to focus on the myths of HIV transmission when REds is being presented in rural areas, because many people in rural areas lack up-to-date information on HIV and AIDS (UNAIDS 2009). This is true of the Thabo Mofutsanyana (QwaQwa) area as well and so the participants appreciated this information.

The story of Yulia and Mukasa (World Health Organisation, 1993) is included in REds so that participants can gain a better understanding of the social realities that often lead to HIV infection and what the consequences are for a family and a community. The story was read by one participant and the others listened attentively. The story in a nutshell is as follows: In a certain community there was a beautiful girl by the name of Yulia who would soon finish her studies. Her parents were proud of Yulia; her boyfriend (Mukasa) was also successful in his business and intended to marry Yulia. Mukasa was not aware that he had become infected during his stay in the city and that he would pass the virus on to others. He felt well and was happy to marry Yulia. They got married and were blessed with a healthy son by the name of Yokaana. Yokaana was not infected. Everything went well until the birth of their second child. The new baby was infected. Yulia tried everything to find a cure for her baby, but nothing helped. The baby died and the family was unhappy. Mukasa started to get sick often and received treatment for AIDS symptoms. It was hard for Yulia to take care of a sick person, Yokaana and look after the business. Yulia felt well but she knew that her family was under
attack from HIV/AIDS. Mukasa died and Yulia decided to take action about what was happening to her family. She visited the clinic for a blood test and the result was positive. Nevertheless, she did not give up. She took a training course offered by an AIDS organisation on how to take care of and provide help to infected and affected people in her community. Yulia and her son are now doing home visits, offering help to the sick, watching over children and playing with them. Yulia learnt to take care of herself and of others.

The participants’ reaction was emotional because they related to the contents of the story, especially how the impact of HIV is weakening families. They were afraid that the same might happen in their families. One participant summarised the whole story in this manner: ‘It is very easy to be infected by HIV and it is difficult to know when and how you were infected and by whom. It is painful to us as we are sending our kids to universities, trying to give them a better future, but only to find that after their completion they only work for two years and become ill and they die. It means we are educating them to be better-educated corpses. When they marry or start working, they just live for two to three years; after that they die. Nowadays we celebrate funerals rather than weddings. We are all affected by HIV/AIDS in many ways’.

I shared my sad story about what happened in 2004 when my younger sister died of HIV/AIDS. She was very young, beautiful and worked hard at her studies. She went to university and completed her studies. We were proud of her and knew she would have a good life. She was happy because soon she would marry the man she loved. However, after six months she died and two years later her boyfriend also died.

Our sharing of stories helped the group to feel closer. We all seemed to have known sadness, helplessness and loss that relate to HIV/AIDS. In my reflections on this session, I noted that using the story of Yulia and Mukasa worked well for a number of reasons. As noted with the poem in Session One, stories fit in well with African tradition (Bouwer, 2004). The use of this story allowed participants (and me) to tell their stories and I observed that this helped the group to bond. It also worked well because the story provides
hope: it is possible to have HIV, but still to make a positive difference in your community.

I also reflected that using a group format for REds was well suited to African participants. African culture generally defines and understands a person in relation to other people (Mkhize, 2004: 4-24). This means that African people feel comfortable being part of a community and I observed this within the REds project as well.

However, after telling our stories, our focus as a group did not stay on sadness. We went on to discuss ways in which to care for those who were HIV-positive. Although the participants were touched by the sad stories, they were also happy about the information they received because they reported that nowadays, when you take a sick person to the hospital, the nurses or doctors will just check him/her and give medication, and then the doctors suggest that the sick person be taken care of at home. So the information on caring for the sick at home was important to the participants. Some of the participants felt that it was important to know your HIV status and disclose your results to your family members in order to get support and the best medication.

We then discussed preventing HIV transmission in the home, avoiding other infections and good hygiene. The participants added that to play safe, the rules of hygiene (like avoiding contact with body fluids, keeping wounds covered and not sharing sharp instruments, toothbrushes and needles) must be applied to every person, whether ill or healthy.

This discussion enabled the participants; they said simple good health practices and proper hygiene in the home could minimise infection. I got the impression (as did the observer) that they felt strengthened because they now knew what they could do that would help lessen their risk of contracting HIV. For this reason, I believe it is important that future REds programmes continue to teach about prevention of HIV in the home.
In summary, the session contributed to the participants feeling stronger because they learnt about common myths and received knowledge that enabled them to change their minds with regard to how people get infected. They also learnt about guidelines and procedures that would enable them to care and support people who were HIV-positive without stigmatising them or placing themselves at risk. As a facilitator it was not difficult for me to talk about HIV transmission in a group that had men and women. I observed that REDs needs to take place in mixed gender groups to have views from different perspectives concerning subjects that are not often or easily talked about.

4.2.2.1 Participants’ Feedback on Session Two

The participants reported that the information on facts about HIV/AIDS, myths about AIDS and how the virus grows inside the body and infection control at home was very informative. They felt capacitated by the information regarding how to care for ill loved ones at home and management of common AIDS-related health problems in the home. For example, one participant wrote: “... simple good health practices; good hygiene in the home can minimise the infection”.

There was no criticism or any suggestion for change

4.2.3 Session Three

In Session Three the aims were:

- To provide information regarding supportive resources for educators.
- To provide information regarding supportive resources for OVCs.
- To provide some grief and bereavement skills.
- To provide some grief and bereavement skills for learners coping with grief and death.

In this session I observed that some participants found it hard to trust one another before trustworthiness was proven. This was observed during the performance of the ice-breaker, where group members stood in a circle and
one participant who volunteered stood in the middle, blindfolded. The group members were asked to gently push the blindfolded participant backwards and forwards without letting him fall. The blindfolded participant had to trust the group members not to let him fall. At first he was unsure but the group members were confident enough that they would not let him fall. They urged him to relax and to trust them. After two minutes, when the participant realised that the group members were supporting him not to fall, he started to trust them.

After this activity we discussed what the participants had observed and learnt. One participant said, ‘It is easy to support someone who trusts you or who has confidence in you. We must respect other people; trust them so that they will have trust in us’. It was important for us to talk about the links between respect, trust and support because this session focused on helping participants identify supportive resources in their schools and communities that could be used to help them and their affected learners cope with the challenges of the pandemic. I noted the importance of including practical activities (like this ice-breaker) that allow participants to participate actively and to learn through doing. I think they experienced how important trust is and this practical exercise was more effective than merely talking about trust. If communities must cope with HIV/AIDS, they need to rely on one another and have trust. Other South African research projects have also reported that it is important for participants to be actively involved (Ferreira, 2007: 386-387).

Once again, participants shared their experiences and concerns about how HIV/AIDS was affecting them and their learners. All the participants were affected by HIV/AIDS at school, at home and in the community. They spoke openly about their need for support, especially because they teach an increasing number of learners who are orphaned and made vulnerable by HIV/AIDS. We shifted the focus of our discussion to possible sources of support, especially ones that could be found in the community from which the participants came. In the end the participants compiled a group list of local support in their community. The list as indicated in Table 4.1 included:
Table 4.1: Local support services

<table>
<thead>
<tr>
<th>Local Support Service</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Kizito (Roman Catholic)</td>
<td>Mr. Mabuya Khehla (058-7898438/0839617235)</td>
<td>Providing educational support.</td>
</tr>
<tr>
<td>ATTIC</td>
<td>Me Malimabe (058-7132572)</td>
<td>Voluntary counselling and HIV antibody testing, Ongoing counselling and support.</td>
</tr>
<tr>
<td>Tshwaranang</td>
<td>Mrs. Jackie (058-6221799)</td>
<td>Supporting OVCs.</td>
</tr>
<tr>
<td>Maluti Child Care</td>
<td>Barbra (0721538199)</td>
<td>Feeding OVCs (hot meals).</td>
</tr>
<tr>
<td>Save the Children (UK)</td>
<td>Mr. Etienne Bramney (058-7182960)</td>
<td>Care and support for OVCs at schools and in the community.</td>
</tr>
<tr>
<td>Pheke Ka Kopanelo (Uniting for cure)</td>
<td>Pastor Mary Crockett (084 272806/058-7135685/058 7133128)</td>
<td>Hospice.</td>
</tr>
</tbody>
</table>

I observed that their expressions changed while they were compiling this list. To me it seemed that writing down the names of people and organisations that could be called on to help reminded the participants that they were not alone and that there were opportunities for support. Future REs must continue to encourage participants to list (or even map) local sources of support, especially as access to information and supportive resources are associated with resilient teachers (Cf. Table 1.2)

We also discussed possibilities of support for AIDS orphans and vulnerable learners (OVCs). I provided many examples of potential sources of support (this included nutritional support, educational support, economic support, psychosocial support, home visits, helping learners with homework, home-
based care, care and support for OVCs at schools and in the community (including food parcels, donations of clothes and school uniforms). It was not hard for me to provide examples because I come from the same broader area as the participants and because my work in the Department of Education had helped me to become aware of various possibilities of support for OVCs. When I compared the listed resources that the participants had listed (Cf. Table 4.1) with available resources (Cf. Table 3.2), it became clear that the participants were not aware of all the resources. REds facilitators need to be familiar with local supportive resources. If they are not, the contents of REds will not include enough local information.

The participants were in high spirits about the information because they had not been aware of all the helpful sources of support in their community to which they could refer their learners and their loved ones in need of help.

The discussion further enabled the participants, as they had not been aware that there was a local hospice in their community and they were eager to visit it. I gave the detailed information on where and whom to contact in regard to supporting OVCs. Again, both the observer and I noted that these concrete details (like contact numbers) seemed to help the participants to feel stronger because this made them feel less alone in supporting loved ones and learners who were affected and infected by HIV/AIDS.

We had a good discussion about how to cope with grief and how teachers could assist grieving learners. The participants added to the guidelines on coping with grief presented in the REds manual. They thought it was important to teach children and adults that it helps to have a good cry. One participant commented that crying is one of the healing processes. The participants shared their experiences relating to the preparation of funerals, ill-treatment by in-laws if a spouse died of AIDS, and cultural practices like wearing only black clothes after the funeral (and how the period for wearing black clothes differs among ethnic groups). These cultural practices surrounding death sometimes mean that it can take someone longer to heal from the pain of loss.
This discussion made me realise that REds needs to do more to encourage participants to share their cultural experiences of grief, grieving and loss.

A lengthy discussion took place about the creation of memory boxes (in REds, memory boxes are suggested as one way of aiding learners who are grieving for parents who are dying or who have already passed away). All participants commented that memory boxes could be important and valuable to orphaned learners. However, the problem is that in our culture the belongings of the deceased are shared among the adult relatives and nothing is left for the children. There is no clear reason for this. In the light of this, the participants thought that it would be important to hold parents' meetings and advice parents and other community members about the importance of a memory box and how it could be meaningful to a child or young person. A memory box would provide the child with a concrete link to parents that have passed on, as well as an attachment with and a history of their family, should they be placed in children's home or have to live with foster parents, or even with extended family who may not have known their parents well.

Because it is hard to assist learners to deal with death if an educator is not comfortable with death, we focused on death for a while. Four participants were positive and comfortable when talking about death. They freely shared their experiences and ideas on what happened to them when someone died in their families. Seven participants were not comfortable. One of them told us that his grandmother had passed away and he had to organise a car to take the body to the mortuary, but he was afraid to touch and wrap the body. He asked a senior male family member to do that for him and he paid him. In our culture, the families (especially the elders) are responsible for doing everything before and after the funeral. During these discussions the participants were supporting each other and gave different advice. Although initially most of them had been hesitant to talk about death, they eventually opened up. In the end they felt that this discussion would enable them to have a better relationship with their families and neighbours, also with regard to death. They seemed to think that they would need to play a vital role in hard times like these.
Both the discussion on memory boxes and death reminded me and the observer that REds deals with sensitive issues that can be made more complex by culture. I think that when REds facilitators are trained, they need to be reminded often that they must be familiar with the culture of their participants and that they should actually first discuss the contents with representatives from the community before REds is implemented. Depending on the feedback from the community, parts of the contents may need to be revised so that they are compatible with the participants' culture.

During the discussion on sources of support and death, the participants were relieved to learn about additional sources of support that they could turn to when they were stressed, like consulting with a counsellor, a social worker, a psychologist, a priest or a telephone counsellor. Most participants thought they would opt for a telephone counsellor, because they were afraid of stigma and that their information might be divulged to all and sundry if they spoke to somebody local (they feared a lack of confidentiality). Their truthfulness about rather using telephonic support reinforced the whole idea of HIV stigma as still being overwhelming in our community.

The story of the pressure cooker was read. In this story the pressure cooker is a metaphor for what happens when someone bottles up things inside, and participants understood it very well. This was clear when one participant commented that during the introduction of Outcomes-based Education (OBE), he nearly took a package because he was frustrated about the changes in the education system. He did not understand it but he was afraid to ask help or tell his colleagues because they might have laughed at him. However, under difficult circumstances he attended training classes and took extra time to read widely on the OBE curriculum. He commented, 'Please, friends, don't be shy if you undergo a difficult time like myself, stand up and find help, otherwise you will explode'. His message related to difficulties with OBE, which suggested that the participants were not stressed by HIV/AIDS alone. Literature (Besthorn, 2005: 122-123) suggests that when a person faces multiple risks, the chances of a resilient response to these risks are poorer than when only one risk is faced.
At the end of the session, the participants completed the reflection work sheet and concluded the session by praying. My overall observation (and that of the observer) was that participants had benefited from this session; they seemed to have found relief in knowing that there were local supports they could turn to that would help care for OVCs and loved ones and that there were telephonic counselling services they could use to support themselves. Their open sharing about death and their experiences and fears relating to death had also seemed to free the participants to be more supportive of their families and learners in this regard. I was pleased that the participants had thought of a solution to make it possible to include memory boxes as support for bereaved learners. This suggested not only that they were open to what they were learning, but also that they were not blind to possible obstacles to implementing what they had learned.

We took longer than the suggested two hours (Theron et al., 2008: 84-85) in this session.

4.2.3.1 Participants’ feedback on Session Three

Participants learned different skills on how to deal with people who are grieving, especially because REds did not approach this session from a Sesotho perspective. One participant commented that ‘I have learned that we do not grieve in the same manner’. Participants commented that the development of a memory box was a good idea and would be important and valuable to orphaned learners, but that it might not be compatible with the culture of dividing the deceased’s belongings among adults. For this reason they recommended that future REds programmes include a workshop for parents and community members so that they can also understand these new ways of helping grieving children to remember their parents. Participants commented positively on being made aware of supportive resources in their communities.
4.2.4 Session Four

The aims of Session Four duplicated those of Session Two. In this session we continued with the aims that we did not get around to covering in Session Two. This included:

- Taking care of the sick at home.
- Learning to do things which will help the infected and affected to stay healthy.
- Learning how to care for the dying.
- Knowing how to identify and manage common AIDS-related health problems in their homes.
- Learning to recognise danger signs, and learning when and how to seek more help.

In this session we focused a lot on information concerning nutrition for people who are HIV-positive, caring for ill people at home and general guidelines on the use of medicines, and healthy foods.

Participants were made aware of food that can contribute to health (like bodybuilding food, energy-giving food and food that protects the body from infection). I got the impression that the participants appreciated the information on two levels – firstly, it again gave them a hands-on skill (they learned what kinds of food they could feed people who were ill in order to build up their strength) and secondly, they were grateful for the knowledge because they believed it would help them sustain their own health.

We then focused on care for the dying. The aim of this topic is to keep dying persons as comfortable as possible and to maintain their dignity. This is called palliative care (REds, 2010: 50). Just as with the discussion on death in Session Three, some of the participants were not used to talking about death and caring for those who are dying. The participants commented that it was difficult to talk about death to a sick person because the patient might be worried about finances, loved ones who would be left behind or even be afraid of dying. One participant shared his sad story about how his father had died at
home and how difficult this was for him to cope with. It seemed that at the time he was unable to talk to his father about the fact that he was dying and when he passed away, he was overwhelmed by all the funeral responsibilities. In our discussion, participants began to understand that, despite all these difficulties, it is necessary and often brings relief to talk about death, and that arrangements can be made for children who are left behind. The participant who had spoken about his father commented that he felt differently now and he believed he would be able to talk to someone who was dying about his/her death and help others in positions similar to the one he had been in. I think it is important that REDs continues to encourage participants to think and talk about death, especially in cultures (like those of the participants) where death is not spoken about easily.

The participants discussed (and in the end most agreed) that giving a patient comfort and encouraging communication about death would allow the patient to be independent and prepare for death. They also realised that it is an opportunity to hear what the dying person would prefer and that it is important to listen to the wishes of the patient. The participants also thought that helping the family after death is important, that this works better if you are part of the family and have good relations with them. If not, family members might think that such involvement and support were linked to wanting to benefit from the belongings of the dead person. Their comments highlighted that they were once again weighing up what they were learning against their cultural context and refining what was being suggested to suit their context. To me this meant that they were participating actively.

The participants commented that our discussion on caring for those who were dying would help them to support others in the community who were taking care for the sick, or in arranging funerals. They felt capacitated by receiving skills and knowledge on how and when to help in times of sorrow. I was encouraged by this, because it suggested to me that their ability was growing to cope resiliently with the many challenges of the pandemic.
We also discussed management of common Aids-related health problems in the home (like anxiety, constipation, coughing, depression, diarrhoea, dizziness, fever, forgetfulness, fatigue, nausea). When we were being trained as REds facilitators, we were encouraged to invite a knowledgeable nurse from a local clinic or someone from Hospice to help present the sections on illness management. I was unable to do so due to a strike at that time, and so I had to prepare myself well to present the information to the participants. When I think back, I am glad that things worked out this way because in the end I was enabled by all the new knowledge I gained. I feel (and still feel) confident that I would be able to manage illnesses associated with HIV and AIDS. The participants were happy about this information as well: they reported that it enabled them to help care for and assist their loved ones at home. At the end of the session the participants looked relaxed and satisfied.

In summary, this session contributed a lot to the participants as they received knowledge and skills that would enable them to be brave and less stressed to take care of sick and dying persons. They also developed skills on how to manage common Aids-related health problems in the home. I observed that this helped them towards resilience, as the knowledge, skills and awareness gained in this session meant there were many more things they could do for the ill, the dying and people in their community who were also caring for ill and dying relatives. This meant that the participants felt less helpless.

4.2.4.1 Participants’ feedback on Session Four

Participants commented that this session had empowered them by giving them information on how to care for the dying, information on nutrition and HIV/AIDS, tips on general hygiene (personal and environmental), infection control at home, and general guidelines on the use of medicines. They realised the importance of making a will in order to give the person in charge responsibility to care for children and to prevent family problems after death. They also commented that it was important to think about ways that they could put their knowledge to use without offending their cultural practices (e.g. taking care of someone who was ill without letting others think you were after
Many participants commented that this session enabled them. In the words of one: ‘I can be able to cope’.

4.2.5 Session Five

In Session Five the aim was:

• To explore the concept of stigma.
• To explore options for addressing stigma.
• To explore some coping skills regarding stigma.

In this session the observer and I noted that stigma was a big problem for the participants. This was clear when they discussed what they believed was happening in the group of pictures. Participants decided to discuss instead of role-play because they were free to talk and it was easy to relate the pictures to real-life situations. All the pictures related to stigma and for this part we chatted in Sesotho because there were words difficult to explain, like negative attitudes, prejudices, gossiping, isolation, discrimination, rejection and misinterpretation of facts. The participants agreed that the pictures showed an environment that was not safe, where human rights were violated, where there was no respect for others, where people’s lives were not valued and where there was a lack of understanding of the pandemic. One participant remarked that this was happening in their school and they did not know how to address it. He hoped the session would help them with skills on how to reduce stigma. All participants shared his opinion and hope.

The participants were asked to identify ideas which might work to reduce stigma or to comment on what was already in place in their community that helped reduce stigma. This was done to encourage more positive values towards People Living with AIDS (PLWAs). They could identify a number of ideas that were already being implemented in their school in this regard, including:

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3 REde gives participants the choice to talk about or roleplay stigma.
• They used to have parents meeting and talk to parents about HIV/AIDS, but they realised that it was important to involve the community in order to have different ideas on what to do about HIV/AIDS in the community.

• Vulnerable households (e.g. child/orphan-headed households, grandparents-headed households) were already identified and were receiving regular support.

• Bana Pele was implemented in order to help families to obtain exemption for school fees.

• Clothing banks and food donations were established in their school. They received supplies of seeds from the Department of Agriculture to grow vegetables and there was a school vegetable garden.

• Love Life was providing/helping to organise piece work for adolescent orphans.

• Fundraising was being done in the school to generate income to support vulnerable households.

• The Department of Education had agreed to establish the provision of hot meals in their schools.

This list meant that the participants came from a school that seemed to actively support families and children who could easily have been stigmatised.

The participants also thought that there needed to be an association of school families, neighbours and church groups to deal with HIV, but that was not in place. One participant offered to establish such an association in her school. A regular system of visiting HIV-affected households was in place in the participants’ school, but it was implemented by the School Based Support Team (SBST) members only. All participants agreed to start visiting these households when the school re-opened. Their willingness to engage in activities that would include and support families and children who were negatively affected by HIV/AIDS suggested to me (and to the observer) that the participants were moving away from being just distressed about the challenges of the pandemic and taking steps to address these challenges in a resilient way.

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In addition to focusing on what activities could be undertaken to include and care for people who could easily be stigmatised by HIV/AIDS, the participants were encouraged to discuss what they could do personally to cope with stigma. None of the participants thought that stigma was something to joke about as they were not sure about their own status. Although most thought they would go public about their status, three would not. As a group they considered the advantages and disadvantages of various coping skills (like avoiding situations that could evoke stigma, talking to friends about experiences of stigma, joining a support group, withdrawing and so on). Although they did not agree on any one way, their detailed discussion gave them much to think about and about some of alternatives for coping with stigma. One participant remarked that this session served as an eye-opener for her because she was not aware of some coping skills regarding stigma. The others concurred.

Reflecting on this session, I thought that its contents and methods (discussion) worked well. In the REDs manual, facilitators are given the option to let participants role-play situations in which stigma is hurtful to others or to discuss such situations as depicted in a series of pictures (as mentioned above). My participants chose to discuss (not role-play). I think it is important not to force rural teachers to role-play, because often they are conservative and do not like to be the focus of attention. Discussion and debate fits in well with African tradition.

The contents of Session Five worked well because they were based on the participants' knowledge of what worked in their communities. I think this made them realise that their community was already working quite hard to fight stigma. This encouraged the participants to be even more active in putting an end to HIV-linked discrimination, which in turn can be linked to tolerance and acceptance (that are associated with teachers who are resilient to the challenges of the pandemic – Cf. Table 1.2).

We took longer to complete this session than the suggested time of two hours (Theron et al., 2008: 84-85).
4.2.5.1 Participants' feedback on Session Five

The participants were positive about the focal point of this session being how to address stigma. Participants were pleased about vast knowledge and strategies they had obtained. One participant wrote, 'I understood what stigma is, I always did stigmatise other people but I will not do it any more'. This means that participation in this REDs session seemed to enable participants towards awareness of stigmatising others and a willingness to change their attitude in that regard. There were no negative remarks or suggestions for change.

4.2.6 Session Six

In Session Six the aims were:

- To explore the concept of stress.
- To explore coping skills for addressing stress (both personal and work-related stress).

In this session I was again reminded that all the participants were being challenged by stress. They identified a lack of money as causing major stress. They spoke about how the pandemic was making money-related stress worse. They spent money to care for ill persons at home and to take care of OVCs at school (like providing them with food or clothing). Many of the participants were or had become their family's bread-winner and they found it difficult to take all this responsibility upon their shoulders. However, they felt they had no other choice: their circumstances had forced them to do this, as in African culture sharing within the family is essential. Their stresses were worsened by HIV/AIDS because in some instances their siblings had passed away from AIDS-related illness and left their children to be cared for. Other siblings were not working due to ill health. Their focus on money made me wonder whether REDs should not invite local stakeholders (at participants' request or when it is clear that participants would benefit from additional information) like financial advisors to encourage the development of skills that may help them cope better with challenges of this nature. In this sense, the REDs programme needs to be more flexible and maybe ahead of this session determine what the chief stressors of the participants are. If these are
practical issues (like managing finances) then it might be worthwhile to extend the REEds contents for that group of participants and invite a local expert in that field to help them develop relevant skills.

Two participants compared stress to a monster because when they were stressed, they had distressing feelings (they felt like running away, were anxious and/or depressed). All the participants thought stress to be a horrible thing. Their description of stress and their experiences of stress that led them to want to run away, suggested to me that the participants were generally not coping resiliently with the difficulties they faced.

I suggested that we focus on stress management and the participants were eager to obtain more information on stress and how they could find solutions for their stressors. In addition to discussing general steps to manage stress as outlined in the REEds manual (REEds, 2006), the participants talked about things that they had tried in order to decrease stress. Most participants had good strategies to deal with stress, like taking care of their bodies and taking time to relax, but they did not apply them. One participant commented that we have to walk the extra mile and be prepared to cope with stress. He said, "My supervisor usually instructs me like a child, he used to give me a lot of work within a short period and when I complained he said "You must prioritise this; it is a department thing and it's needed this afternoon". In the end this participant did that: he prioritised the new task and attended to the matter. This story illustrates that it is possible to cope better when people accept that there is no option and that all they have control of is their attitude. Other participants agreed that even in hard times this would make it possible to cope with stress, but they emphasised that through proper planning stress can be reduced.

This discussion was of assistance to the participants in that they realised that all of them had stress and they could learn from others how to deal with it in different situations. As noted in other sessions, I think it is valuable to encourage participants to share their experiences. Again, this relates well to African culture of sharing within a community (Mkhize, 2004: 4-24).
We also discussed irrational beliefs that encourage stress. Participants made a list of the irrational thoughts that made them feel stressed. This activity was enjoyed by the participants as most of the irrational beliefs they were discussing were practical examples from their personal experience at their school, e.g. "My supervisor is not greeting me because I bought new car and I am wearing smart clothes". or: "They do not like to share food with me because my husband died of HIV/AIDS and I am taking care of my ill brother." It was good that participants could identify these irrational thoughts, because it allowed them to laugh together at how their own thoughts contributed to their stress. In future they would be more aware that if they changed their thinking they would be more in control of their stress.

The participants developed similar insights about time management. They realised that they could not really control time but they could manage themselves. They drew up time management guidelines by putting forward at least one tip on how they could manage their time. They also drew up a 'to-do-list', which they seemed to enjoy (I observed many smiles and they worked eagerly). They divided their list into must, should and want to do's. In the course of this activity they spoke about procrastination and how it is one of the major signs of poor time management, especially at work (e.g. smoking before going to class). The participants realised the importance of deadlines.

All participants mentioned that there was one educator who frequently came to school late and that they had tried their level best to support her but she did not change. They thought that REWs would help her if she was included. Since she had not volunteered to participate they decided that they were not going to give up and they would spread the good news (i.e. time management skills they had now learnt) to her. Their willingness to share their new skill suggested to me (and to the observer) that what they had learnt had let them feel more in control of their circumstances. This was also an example of assertiveness associated with resilient educators (Cf. Table 1.2).

In conclusion, the participants realised that if you feel the pain of being overloaded, it is important to put down the burdens, which includes asking for
help and not agreeing to do everything. If this was not possible, they had learnt that they could manage what they thought and felt and how much time they devoted to something. In the end they danced to relaxation music and were very cheerful. Their determination to help their colleague who had not attended REds and their cheerfulness left me with the impression that they felt enabled by this session. They no longer seemed to want to run away.

4.2.6.1 Participants’ feedback on Session Six

The participants commented constructively on the contents of this session and wrote that they had learned a lot about how to manage/avoid stress, time management, and self-management and how to relieve stress, being able to identify their stressors. One participant wrote, "This module helped me to cope better with my stress. It teaches me to plan and prioritise and reminds me that time management is important".

There were no negative remarks or indications for change relating to the session.

4.2.7 Session Seven

In Session Seven the aims were:

- To encourage awareness of legislation on HIV/AIDS in education.
- To inform about educator rights with regard to discrimination in the context of HIV/AIDS.
- To inform about educator rights with regard to absenteeism and leave in the context of HIV/AIDS.
- To inform about educator rights with regard to protection at school against HIV/AIDS.
- To establish a supportive school environment within the context of HIV/AIDS.

In this session I observed that some participants were not aware of the policies governing their rights as educators in the age of HIV/AIDS. This first became clear during the ice-breaker where participants were asked to hold a
glass full of water in the air. They were puzzled while they waited for further instructions. One participant whispered to the one next to her, ‘Why are we doing this? I am tired now’. This participant was standing up for her rights and disliked having to do what she did not like or understand. She was demonstrating the right to question. Other participants were holding their glasses in the air without complaining. It had not occurred to them that they had the right to question. I used the reaction of the one participant who whispered to illustrate that we have rights. In response, the participants said they did not think critically enough and they related this to what was happening in their school situation and their custom to accept instructions (especially from the headmaster) without question. As noted with other practical activities and ice-breakers in REds, this worked well because it allowed participants a chance to experience what rights are all about.

From this discussion we turned to the idea that teachers and their learners have certain rights in this age of HIV/AIDS. I observed that the participants were quite knowledgeable about their rights relating to tolerance and leave. As noted in Session Two, it might have been better to first check and see what knowledge the participants had before focusing on their rights and those of their learners. I think the REds programme assumes lack of knowledge which might not be true of all participants.

Despite these rights, participants felt that discrimination still existed in their community even though they did not experience any sign of HIV-related discrimination at their school. All participants felt that there was a need to educate the community on how to reduce discrimination around the issue of HIV/AIDS, also with regard to how teachers and learners who are affected get treated. The fact that they were protected against discrimination within their school was an asset (Ferreira, 2007: 382) that probably helped these educators to cope with the challenges of the pandemic. Again, their reference to the community made me reflect that REds should probably be presented to educators as well as to community representatives. To really enable educators, their communities need to have similar knowledge and understanding.
To ensure that educators understood the concept of a supportive school environment (as one possible way to encourage resilience), I asked participants to explain what they understood under a supportive school environment. They said a supportive school environment was an environment where learners were happy, where educators took care and supported each other, learners and community members, where educators were motivated and happy to work under circumstances that discouraged stigma and discrimination.

This discussion helped make participants more deeply aware that if they support and respect each other at school, they will be more likely to cope with the challenges of the pandemic. Although the participants came from a school that encouraged staff to have positive relationships with learners, they now realised that this needed to be extended so that educators were also supportive of their fellow-educators.

My observation was that the participants ended the session determined to assert their own rights, but also to respect the rights of others and support them. This made me hopeful, because educators who are assertive and community-minded cope better with the challenges of the pandemic (Theron, 2008b: 94) (see Table 1.2).

4.2.7.1 Participants' feedback on Session Seven

Participants were knowledgeable about their rights regarding disclosure and absenteeism due to ill health. They suggested that the information regarding safety measures be unpacked to parents and learners. They commented that this session was educative and informative and they became aware that the pandemic threatens human rights in many ways, e.g. discrimination, stigmatisation and violating the rights of others. The schools must have accessible first aid kits. They did not suggest that the contents of this session be changed. However, their recommendation that safety measures be explained to parents and learners suggests that maybe REds should have parallel programmes for communities and learners, rather than just for
teachers. The way forward might be a different, multi-faceted programme, REPCOM (Resilient Educators, Parents and Community).

4.2.8 Session Eight

In Session Eight the aims were:

- To contemplate resilience.
- To contemplate (further) steps towards resilience.
- To emphasise our connectedness to others (including local support networks) for the purpose of resilience.

At the beginning of this session one participant commented that she wished for ongoing support from me as the REds facilitator (like future refresher sessions or opportunities later on to evaluate how they were all coping). She did not want REds to be a once-off thing. Some of the others agreed. This suggested to me that the REds programme had been experienced as having value, but also that the new knowledge, added skills and feelings of being stronger needed to be sustained. To me this fitted with the resilience theory which states that resilience is dynamic (Theron, 2008b: 93) and should not be considered as necessarily lasting.

Because the focus of this session was resilience, I repeated the illustration of resilience being like a green twig (as in Session One).

We then discussed steps towards resilience and the participants were spontaneous in adding to these. This included:

1. **Accept the situation:** The participants felt that it was a waste of time to fight with the changes and challenges of life, e.g. the statistics of infected people and OVCs are rising all the time and we cannot change them. However, for the participants this meant that we have to support one another and life must go on. They seemed to have accepted the reality that we are all affected by the pandemic and that focus now had to be on finding ways of coping with this reality. Because my participants were African, they emphasised that coping is aided by relying on one another (Mkhize, 2004: 4-27).
2. **See the situation as manageable:** The participants agreed that the pandemic is a bad state of affairs but it is manageable. They again emphasised that we cannot change the reality of the pandemic, but we can change how we think about it and how we respond to it (when they said this I heard echoes of the skills they had learnt in Session Six on how to cope with stress). Again, the participants felt that to be able to manage the situation we must not be gloomy and we need to seek help from other people.

3. **Connect with others:** The participants agreed that a circle of support was needed to manage the pandemic. This circle included positive relationships with family members, friends, colleagues, learners and others from their community. The resource list in their community had to be utilised in order to get care and support to enhance resilience. *(Cf. Table 3.2)*

4. **Use the pandemic for self-growth:** The participants indicated that the information they had received and made their own in the course of REEds had helped them to learn about themselves (like their own personal thoughts that led to stress and how they related to death). They added that this had not only led to their own growth but that it would make a difference to their families and learners as they applied what they had learnt for the benefit of others.

5. **Stay hopeful:** The ability to remain hopeful is an important facet of resilience because it provides energy to keep going even in really difficult times *(Cf. Table 1.2)*. The participants indicated that they were now able to feel hopeful about a number of things (like a cure eventually being found) but they emphasised that their hope was linked to their faith in God. Right from the beginning of REEds it was clear to me that the participants were strengthened by their religious faith (e.g. they chose to end each session with prayer).
6. Self-care: The participants understood that they needed to look after themselves so that they would not burn out or give up. They indicated that they would use the guidelines discussed in previous sessions (e.g. how to manage stress, being aware of their rights, talking to a psychologist or social worker (preferably via a telephone counselling line), reading books on coping, joining a support group), to take care of themselves.

In comparison with the first few sessions, the observer and I noticed that the participants were more focused on what they could do to look after themselves and others than on their experiences of loss or on fears linked to the pandemic. In reflecting on this session, their reliance on community and on one another made sense to me as it fits the African philosophy of humans as inter-connected and inter-dependent (Mkhize, 2004: 4.23-4.27). Because REds focuses on making participants aware of the supportive resources in their communities and encourages them to rely on and support one another, its contents are well suited to African participants. At the close of this session the participants wished that REds could be available to the whole staff because of the value of the information, knowledge and skills they had gained. They wanted other educators to share in this enabling experience.

4.2.8.1 Participants’ feedback on Session Eight

Participants learned more about the process of being resilient and developed a clearer understanding of what resilience is and how to encourage their own resilience. One participant wrote, ‘I have gained skills on how to cope, adapt and to go on even in hard times’. One participant suggested that ‘More time must be given as the module is interesting and helpful’. She explained that she wasn’t just talking about the session on resilience, but about the whole programme, suggesting therefore that the REds programme should be promoted more broadly. There was a feeling that Reds should be implemented in all schools and among community members to empower more people with resilience.
4.2.9 Session Nine

Session Nine was devoted to closure in the form of handing out attendance certificates sponsored by the North-West University to confirm the participants' involvement in the programme. This session was also about celebrating resilience.

In this session I observed that participants were happy and felt empowered. Once again, they talked about the skills they had learnt, especially on how to support affected educators and learners affected and infected by HIV/AIDS.

As part of the closure of REds, a parent meeting was organised by the School Management Team (SMT) of the school, where parents would be brought on board about what was happening in the school and about the REds programme and its aim. The participants had requested that the observer and I speak on their behalf because they felt parents would listen to us as REds facilitators. We spoke about:

- Facts about HIV/AIDS.
- Myths about HIV/AIDS.
- The Importance of the memory box
- Stigma.
- Circles of support.
- Tips on how to care for the ill person at home.

Parents were encouraged to make use of support structures in their community and to talk to their children about the information they have received. Parents were allowed to ask questions if they needed more clarity. One parent pointed out that they were afraid to talk about this pandemic because other people in the community would laugh at them. The parents also viewed the issue of the memory box as important but they had not been aware of it. We spoke about stigma. Stigma will take a long time to be erased from most people's minds and it always needs to be addressed when there is
a meeting so that they can come to grips with it. The parents were happy to receive the information.

This meeting encouraged parent enablement as they reacted positively to the information they had received and they will work together with the educators to support the OVCs. One parent indicated that this meeting served as an eye-opener and he was happy because his children were in a caring school, where educators were resilient.

REds participants were excited and thrilled about the certificate ceremony. The certificates were awarded to the participants in the presence of the parents to confirm their participation in the programme. The participants were proud, happy and motivated to go out to their homes, community and school to make a difference. They felt empowered and willing to share their experiences with other educators in neighbouring schools. I made them aware that they would come together after three months to review their progress.

In summary, the participants were enabled by having parents present during this ceremony, to show them that they as educators were caring for their children who were affected by HIV/AIDS. Therefore, involving parents emphasised the connectedness to others, including the community, for the purpose of resilience. As mentioned in other sessions, this is a failing of REds in its current form: it also needs to reach out to community members (e.g. parents). This will help to enable teachers further.

4.2.9.1 Participants' feedback on Session Nine

The participants were pleased that this session had included parents due to their belief that parents and the community also need to be empowered to be resilient. Learners spend most of their time with community members who do not understand what is happening at school and who do not always encourage resilience, because they may not understand it. As we say, charity begins at home; therefore there should be mutual support between home, community and school. The community who has understanding and
knowledge that is consistent with that of the educators will help the learners and educators to be more resilient.

4.3 CONCLUSION

Chapter Four focused on the implementation process of the REds programme. It also discussed the actions and experiences of the participants and myself towards the programme. The purpose of recording my observations of the REds process was to comment on how REds seemed to contribute to the enablement of the participants and to make suggestions for refinement.

In summary, I observed the following about the contents of REds:

- After Session Two, the participants were more familiar with good health practices and understood that good hygiene in the home could minimise infection. I got the impression (as did the observer) that they felt strengthened because they now knew what they could do to help minimise their risk of HIV (Cf. Session Two, 4.2.2). I specially noted that participants benefited from discussing myths. When REds is presented in future (especially in rural communities) myths must be emphasized.

- At the end of Session Four, I observed that the knowledge and skills the participants had gained regarding care of the ill and dying helped them towards resilience. This session meant there were many more things they could do for the ill, the dying and people in their community who were also caring for ill and dying relatives. This meant that the participants felt less helpless. (Cf. Session Four, 4.2.4).

- In Session Five, the participants considered the advantages and disadvantages of various ways of coping with stigma (like avoiding situations that could evoke stigma, talking to friends about experiences of stigma, joining a support group, withdrawing and so on). Their discussions around stigma provided them with a number of alternatives for coping with stigma. In the end participants were aware that stigma could be reduced by ensuring the correct knowledge and caring for those infected and affected (Cf. Session Five, 4.2.5). This appeared to enable them.
• The participants realised the importance of identifying their stressors and attending to stress in Session Six. If you feel the pain of being overloaded, it is important to ask for help and not agree to do everything – this was one skill they learnt. Their determination to help their colleague who had not attended REds and their cheerfulness made me believe that they felt enabled by this session (Cf. Session Six 4.2.6).

• Following Session Seven, the participants were determined to maintain leave-related-policies, individual school-based plans for coping, support for stressed educators, a supportive climate and their own rights, but also to respect the rights of others. This made me hopeful, because educators who are assertive and community-minded cope better with the challenges of the pandemic as noted in Table 1.2 (Cf. Session Seven, 4.2.7).

• After Session Eight, the observer and I noticed that the participants were more focused on what they could do to look after themselves and others than on their experiences of loss or on fears linked to the pandemic (as they typically had in the first few sessions) (Cf. Session Eight, 4.2.8). It seemed to me that the contents of REds had encouraged them towards new understanding and hope.

All of the above are examples of positive reflections on the contents of REds. I think these contents should be included in future REds, with the following cautious note:

It was often evident (see Session Three, Session Five and Session Seven) that the contents needed to be matched with participants' culture and beliefs. In other words, future use of REds contents should not just be done without aligning the contents respectfully with participants' culture.

The contents of REds also need to be adapted to suit the specific additional needs of the participants (in my study, this related to financial planning skills as noted in Session Six). Again, although most of the contents seem to be well-suited to future use, facilitators must check if the contents match the needs of educators affected by HIV/AIDS, in the same way that they should verify contents matching participants' culture.
In conclusion, my implementation of REds allowed me to observe the following about its language:

- The language should mostly stay the same and where difficult words are encountered, code switching should be done. For example, the following words which are not well-known English terms to rural people, might need code switching:
  - Negative attitudes
  - Prejudice
  - Gossiping
  - Isolation
  - Discrimination
  - Rejection
  - Stigma
  - Memory box

The REds manual for facilitators needs to include more practical examples that illustrate difficult concepts to help participants understand them better. For example, my participants understood resilience, when saying resilient people are like a green twig - they bend as they experience pressure; but they don't break. This practical illustration (which I demonstrated) helped them understand an abstract concept.

In conclusion, during my implementation of REds I observed the following about the presentation of the programme:

- REds facilitators must be familiar with local resources before presenting REds so that they can actively help participants become aware of local resources. Participants in my study were not aware of all the services available in their communities that could help them cope with the challenges of HIV. By the end of Session Three they were making posters to educate their school communities about what resources were available. This suggested that they had been enabled to know what was available and to use this to enable others and they found this gratifying. I must add
that my role as facilitator was important here. Because I know the area well and am familiar with a number of the supportive resources, we could work together to broaden the resources the participants were aware of. This means that REds facilitators must be instructed to familiarise themselves with local assets before presenting REds so that they can actively help participants become aware of local, available resources. (Cf. Session Three, 4.2.3).

- It would be useful to involve health care workers or specialists in sessions dealing with health matters and policies in the way forward. Speakers from Hospices or PLWAs could be invited to participate as they have practical insights that will enable participants’ further. In other words, future presentations must actively include community members.

- REds facilitators must allow participants to feel free to share their experiences with HIV/AIDS (Cf. Session One, 4.2.1) as this will help them to come to terms with some of their negative HIV-related experiences. This means that REds facilitators need to be comfortable with their own sexuality and with HIV/AIDS.

- Using stories (e.g. of Yulia) as well as poems worked well. I concluded that future REds presentations should continue to use stories and poems especially with Black participants because these fit well with African culture (Mkhize, 2004).

- Facilitators should first check with participants to determine their level of prior knowledge before presenting all the contents of REds (Cf. Session Two and Session Seven).

- It worked well to have a group format and activities that encouraged participants to share and open up (see Session Two and Session Three). Future presentation of REds should retain a group format that encourages discussion. (My assumption regarding participants being shy to speak was therefore wrong – see 1.4).

- It worked well to have a group that included both genders (see Session Two). Here my initial assumption (see 1.4) was wrong too. We often extended our session time and so future presentations need to allocate more time per session.
• I noticed that the participants were enabled to have parents present during the awarding of certificates. The aim was to show the parents that they were caring for their children who were affected by HIV/AIDS, and also to bring the parents on board about what was happening at school. Therefore, involving the parents emphasised the connectedness to others, including the community, for the purpose of resilience (Cf. Session Nine, 4.2.9).

In conclusion, when I compared my observations recorded in this chapter to Table 1.2 (see Table 4.2 below for this comparison), the participants seemed to have grown towards being more resilient during their participation.

Table 4.2: Resilience indicators noticed in implementation of REds

<table>
<thead>
<tr>
<th>Resilience-promoting factors (Cf. Table 1.2)</th>
<th>Observations that suggest resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong faith / Religious practices</strong></td>
<td>Some participants indicated that they had become more religious and that they prayed much more. (Cf. Session Eight 4.2.8). All sessions were concluded in prayer.</td>
</tr>
<tr>
<td><strong>Access to information</strong></td>
<td>Participants commented positively on being made aware of supportive resources in their communities (Cf. Session Three 4.2.3.1). They could list a few resources and our Session Three enabled them to know about more.</td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td>Participants showed empathy when they referred to feeling burdened by AIDS orphans and vulnerable children in their classes and wanting to assist them (Cf. Session One 4.2.1.1).</td>
</tr>
<tr>
<td><strong>Hope</strong></td>
<td>Participants had hope that one day God will hear our prayers and help all people who are affected</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td>Seeing self as strong</td>
<td>Participants were determined to assert their own rights, but also to respect the rights of others and support them (Cf. Session Seven, 4.2.7).</td>
</tr>
<tr>
<td>Acceptance and tolerance</td>
<td>Participants accepted the reality that we are all affected by the pandemic and that focus now has to be on finding ways of coping with this reality (Cf. Session Eight 4.2.8).</td>
</tr>
<tr>
<td>Willingness to be a health promoter</td>
<td>Participants believed that the information they received will not only lead to their own growth but that it will make a difference to their families and learners as they apply what they learned for the benefit of others (Cf. Session Eight 4.2.8). They wanted to help a colleague too (Cf. Session Six, 4.2.6).</td>
</tr>
<tr>
<td>Talking openly about the pandemic</td>
<td>Participants were provided with a number of alternatives for coping with stigma and at the end they were aware that stigma could be reduced by ensuring the correct knowledge and caring for those infected and affected. They could talk about the pandemic openly (Cf. Session Five, 4.2.5). They were happy for parents to interact with them and know about REds (Cf. Session Nine).</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>Participants were hopeful, assertive and community-minded to cope better with the challenges of the pandemic (Cf. Session Seven, 4.2.7).</td>
</tr>
</tbody>
</table>
| Positive attitude                         | Participants realised that they should encourage staff to have positive relationships with learners, educators and community members to promote a
Supportive school environment (Cf. Session Seven, 4.2.7 and Session Nine, 4.2.9).

| Supportive resources | They were more aware of supportive community resources (Cf. Session Three 4.2.3). |

I am aware that my observations (and the observer’s) could be biased and so I revisited my comparison to Table 1.2 in Chapter Five using additional data.

In the concluding chapter of this study I use the above conclusions to suggest how REds needs to be refined (Cf. Chapter 6, 6.4). Data analysis of the pre-test and post-test qualitative data will be discussed in Chapter Five to comment on how the resilience of the participants improved following participation. I use this to comment further on how REds needs to be refined.