Coping in an HIV/AIDS-dominated context: teachers promoting resilience in schools

Liesel Ebersohn1* and Ronél Ferreira2

1Unit for Education Research in AIDS and 2Department of Educational Psychology, Faculty of Education, University of Pretoria, Pretoria 0002, South Africa

*Correspondence to: L. Ebersohn. E-mail: liesel.ebersohn@up.ac.za

Received on March 12, 2010; accepted on February 20, 2011

Abstract

This paper explains how teachers in schools function as resources to buoy resilience in the face of human immunodeficiency virus/acquired immune deficiency syndrome-compounded adversities. We draw on participatory reflection and action data from a longitudinal study with teachers (n = 57, 5 males, 52 females) from six schools in three South African provinces. The study tracks the psychosocial support offered by teachers following their participation in the Supportive Teachers, Assets and Resilience project. Verbatim interview transcriptions were thematically analysed and three themes (as well as subthemes and categories) emerged: (i) Teachers use resources to promote resilience in schools [teachers use (a) systems and (b) neighbourhood health and social development services to identify and refer vulnerable cases]; (ii) Teachers form partnerships to promote resilience in schools [teacher partnerships include (a) children and families, (b) community volunteers and (c) community organizations, businesses and government] and (iii) School-based support is offered to vulnerable individuals [by means of (a) vegetable gardens, (b) emotional and health support and (c) capacity development opportunities]. We conclude that teachers can promote resilience in schools by establishing networks with service providers that function across systems to support vulnerable groups. We theorize that the core of systemic networks is relationships, that relationship-driven support networks mitigate the effects of cumulative risk and school-based networks can enable schools to function as resilience-promoting resources.

Introduction

Teachers and schools are as part of a child’s world as is playing, learning and growing. But when children experience adversity [as is the case with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)], teachers and schools play an even more indispensable role. Ordinarily, children (just by virtue of being children) would enjoy a range of advantages offered by schools. However, in HIV/AIDS circumstances, the benefits of school life are limited as children become burdened with bereavement, stigma, additional care responsibilities and compound effects of poverty. How can teachers and schools enable children affected by HIV/AIDS to access recreation, education and development despite the presence of HIV/AIDS-related barriers? How can teachers promote resilience in schools in HIV/AIDS settings?

Various researchers propose that schools can serve as access points for the delivery of care and support to the vulnerable members of communities [1, 2, 3, 4]. Policy and research arenas [1, 5, 6, 7] have earmarked psychosocial support as a way for
Teachers and schools to promote resilience. Although the latest South African teacher training curricula include psychosocial support competencies [8], this was not the case during the training of most teachers who are currently in practice [6]. Our aim was to determine how teachers can promote resilience in schools after participation in a strength-based intervention (STAR, Supportive Teachers, Assets and Resilience). In this study, ‘strength-based’ indicates approaches that emphasize available internal and external resources without negating risk [9]. Psychosocial support refers to actions that target vulnerable individuals so as to enable well-being.

From baseline data [10], it was apparent that teachers had not identified and used community resources prior to their involvement in the STAR study. Before they participated in STAR, teachers arrived at schools in the morning to teach and left in the afternoons to take care of their families and homes in communities far away from the schools in which they worked. All the teachers expressed concern about levels of poverty, illness, absenteeism and fear related to HIV/AIDS in the respective school communities. What was apparent, however, was the sense of teachers being overwhelmed by the magnitude of needs. Teachers admitted to being weighed down by the hardship they saw in schools. They felt powerless and incompetent to do anything about the situation. In this paper, we provide evidence of how, subsequent to their participation in STAR, teachers started to devote themselves to alleviating the effects of HIV/AIDS so as to promote resilience in schools [11].

The guiding question of the current research is as follows: How do teachers (working with children who are significantly affected by HIV/AIDS) promote resilience by implementing what they have learned from a strength-based intervention? The objectives are to (i) describe how teachers provide support following a strength-based intervention and (ii) to determine how these teacher strategies may promote resilience. We explain how teachers assess risk, map protective resources and establish protective mechanisms to buffer the impact of multiple risks in an HIV/AIDS-related school setting. Based on a review of relevant literature, we formulated three theoretical assumptions:

- Children are made vulnerable by compounded risk factors characteristic of contexts dominated by HIV/AIDS.
- Teachers are able to implement psychosocial support strategies subsequent to their participation in STAR.
- Teacher-initiated psychosocial support is a catalyst for schools to function as protective resources where children’s vulnerability to risk can be reduced.

Understanding resilience

Resilience refers to the tendency to rebound, bounce back or recover in response to adversity [12, 13]. From a resilience perspective [14, 15, 16, 17], individuals become vulnerable because they face multiple adversities (risk factors) that serve as barriers to their resilience [18–21]. For individuals to bounce back from adversity, various resilience-promoting resources come into play, thereby indicating resilience as both outcome and process [22].

In the current study, we focus on resilience as a process. This process-oriented view of resilience implies scrutinizing the dynamic interaction between risk factors and protective resources. This interaction modifies the effects of adversity [23]—in this instance, cumulative risk that is typical of HIV/AIDS-characterized settings. Poverty is one barrier related to HIV/AIDS cumulative risk. Whereas socioeconomic status impacts both resilience and vulnerability [22], studies have indicated how supportive communities can promote resilience in the presence of increased socioeconomic risk.

Dynamic interaction (also referred to as transactional relationships; 13) between levels of resources indicates resilience as an ecological phenomenon [24]. With regard to children, resources that promote resilience can be found within systems of individuals, families and the broader society. Other
than dynamic interaction in the form of protective processes, interaction also implies engagement between risk processes and protective processes. Recent studies have also shown distinctly cultural forms of resilience. Cultural understandings of resilience [25] caution that local knowledge about aspects of resilience need to be privileged. Furthermore, resilience implies intervention that not only engages simultaneous multiple forums but also assists individuals in navigating towards health resources. These resilience-promoting resources are of course not exhaustive.

The presence of bonding, attachment and connectedness promotes resilience [26]. Hence, social cohesion—indicated by exposure to warm, caring and supportive environments—is significant in the process of resilience [27].

**Schools and teachers as resources to mediate HIV/AIDS risk**

Like others [28–32], we conceptualize schools as institutions that have the potential to be positive psychological pillars to shield children against the various risk factors that are synonymous with the HIV/AIDS landscape. In our opinion, an important prerequisite for schools to function as resilience-promoting resources is that teachers act as protective resources to provide psychosocial support [14, 33]. Conceptually, psychosocial support becomes a method that teachers can use to buffer the challenges faced by children and to facilitate resilience in schools [21, 34, 35].

Ecological perspectives on resilience [13, 22] argue that not only individual and family resources promote resilience but also resources outside of the family. Hence, schools’ function as such a resource has lately been central to resilience discourses [12, 24, 36]. Recent studies have highlighted the significance of incorporating resilience-building efforts in schools by structuring school environments to strengthen resilience. Such structuring typically involves the cultivation of positive environmental contexts to avert risks in children’s lives [24].

Vulnerable children view both teachers and schools as resources that can buoy their resilience [18–21, 37–40]. Specific socioenvironmental resources in the school environment include supportive peers, positive teacher influences and academic success [22]. Thus, schools can be meaningful settings in which protective resources can be enhanced and risk factors reduced [24]. Characteristics that are common to health-promoting schools include community participation, a supportive physical and social environment, good school–community relations, as well as access to health services and well-defined health policies [27].

Of specific relevance to this study is the view of caring and support as a strategy to promote resilience in schools [36]. Educational psychologists function systemically to ensure that schools are friendly spaces in which vulnerable children may feel welcome [12]. When considering stigma and discrimination discourses related to HIV/AIDS, the school as a safe and caring space has a central place in related literature [33].

**The intersection of HIV/AIDS-related risk and schools**

Because HIV/AIDS renders children and families vulnerable [41, 42], schools seem an obvious potential resource to strengthen resilience [24, 36]. Also, HIV/AIDS usually occurs simultaneously with many other stressors such as poverty, stigma, discrimination, increased depression and anxiety [4, 43]. Coping with these stressors in an appropriate way calls for resilience, as well as for mechanisms to support resilience. A review of children’s resilience [22] in a variety of studies indicates a linear relationship between the number of risk factors in a child’s life world and the number of psychosocial problems during adolescence. Significantly, for HIV/AIDS-dominated settings, the effect of cumulative risk can be exponential as an increase in risk factors leads to increased opportunity for interaction between risk factors. Conversely, the same exponential effect bears true for resilience [13]. In this regard, children living in institutionalized care in an environment affected by HIV/AIDS risk experience resilience on a continuum [38].
HIV/AIDS-related challenges force teachers to confront vulnerability in schools [4, 18, 20, 21, 44, 45]. Besides the children in their classrooms and schools, teachers also encounter numerous community members who have to cope with HIV/AIDS and overcome the barriers that the disease imposes [11, 21]. Teachers see sick children in classrooms and on playgrounds, hear grieving children who have lost their parents, know of children who take care of ailing parents, are concerned about adult-like children who head their households and worry about children who live in income-poor households due to job loss. At the same time, teachers interact with community members who live in a vulnerability-saturated world. Teachers meet parents who are concerned about the future care of their children and engage with unemployed caregivers who struggle to provide for the basic needs of their households. Often, teachers themselves are infected with HIV and face the stigma and dilemma of disclosing their status [46]. They also worry about their future health, employment and caregiving responsibilities. In many other instances, teachers care for loved ones afflicted with AIDS-related illnesses or fill in for colleagues who are unable to teach due to HIV/AIDS-related absences from work [47]. Accordingly, teachers’ lives are entwined with numerous risks related to HIV/AIDS.

We acknowledge that not all teachers necessarily are (or want to be) instruments of social support. However, potentially some teachers may, either by nature or need, administer certain tasks (psychosocial support) across various systems [35].

**STAR intervention: school-based intervention with teachers to promote resilience**

**STAR: intervention and resilience**

For intervention purposes, resilience studies have indicated specific processes within various systems that can reduce the impact of risk settings (one of which is schools). Traditionally, school-based resilience interventions may be either outcome oriented [48] or process oriented [49] or they may combine outcome and process foci [24]. In addition, school-based resilience interventions may target children or youths (e.g. social competence in terms of life skills and social skill interventions; 24, 26, 48, 50), teachers (e.g. promoting resilience in teachers and staff; 24, 51, 52) or school systems [48]. Regarding HIV/AIDS, schools more often than not serve as forum to engage with youth in school-based programmes to address health risk behaviours [53, 54].

Since schools cannot serve as effective resilience-building environments unless they enable school personnel to function at an optimal level [24], we developed STAR as a resilience intervention for the training and development of teachers [36]. STAR embraces conceptions of resilience as contextual, cultural and process oriented. STAR specifically builds on the idea of enabling teachers to use schools as an organizational base to mobilize linkages with other protective resources [24] and to develop schools as safe environments and a buffer against adversity.

**STAR: conceptualization, purpose and target audience**

When we conceptualized STAR, we posited that a strength-based approach enhances the likelihood of sustainable psychosocial support [55]. STAR is a school-based intervention [22] that emphasizes capacity development to facilitate the successful negotiation of high-risk environments. A core premise is that individual adaptation to adversity depends on a wide-ranging assessment of available resources on various levels, as well as the mapping of risk. This strength-based orientation implies that teachers

- use available resources, capacity and assets to address existing needs, barriers and deficiencies,
- determine which resources are available in school communities,
- identify risks that need to be addressed and
- mobilize accessible assets to mitigate prioritized risk.

Central to STAR is the notion of collaboration and partnerships to establish psychosocial support networks.

STAR is implemented in four 2-day intervention sessions, preferably on the school premises itself.
Sessions take place in 3-month cycles over the course of a year. During the first session, teachers map their communities (visually and textually) to identify both assets and barriers. They then decide which assets are already used and which are latent. They indicate which assets can be used to address barriers. In the second session, teachers prioritize the barriers they want to address. They also decide on action plans to address these barriers by using identified resources. The action plans include responsible role players, time lines and means to monitor and evaluate progress. Teachers next start implementing action plans to provide support. During the third session, they reflect on the progress they have made and discuss how to adjust their plans. They also learn how to use memory box making and body mapping as techniques to provide counselling. In the final session, teachers again report on progress and reflect on their supportive role in the community. They may use the generic asset-based competencies that underpin the sessions to prioritize activities that will promote resilience based on needs that are specific to their school context.

**STAR: development, piloting and format**

The current study is part of our participatory reflection and action (PRA) study [56] that was initiated in a single school in an informal settlement community in 2003. This subsequently evolved into the ongoing STAR investigation that currently involves 11 schools situated in three provinces in South Africa. The development and piloting of STAR was participatory and iterative, characteristic of PRA (see Table I for the different STAR intervention research phases). This article reports on the initial four schools (40 teacher participants) involved in the development/pilot phase (2003–6), as well as on the first two schools (17 teacher participants) involved in determining the fidelity of STAR (2007–9)—six schools and 57 teacher participants in total.

As stated above, the development/pilot phase occurred in four schools between 2003 and 2006 and involved a total of 40 teachers ($n = 40$, 2 males and 38 females). We implemented STAR in four purposefully selected schools and invited volunteers from the teacher corps so as to identify 10 teachers from each school to participate in the study.

STAR spanned six 8-hour PRA intervention sessions (36 sessions in all) with teachers. The implementation took place on the premises of participating schools. Following the intervention, teachers had the option to implement initiatives that would provide psychosocial support to vulnerable children in their schools.

**STAR: monitoring, evaluation and implementation fidelity**

Typical of PRA, monitoring and evaluation occurred throughout the intervention study. Continuous monitoring and evaluation occurred during each site visit to schools’ settings and took the form of observation, as well as focus group and individual interviews. Table I reflects details of monitoring and evaluation activities. Currently (since 2007), STAR is in a dissemination research phase to investigate implementation fidelity. This phase involves seven additional schools in three provinces. In the dissemination research phase, teachers who were involved in the first phase of the study were trained as STAR facilitators. STAR teacher facilitators subsequently implemented STAR with teachers in neighbouring schools.

---

**Methods**

**Paradigms, research design and selection of participants**

Interpretivism constitutes the basis of our PRA intervention study. This has afforded us the opportunity to conduct research with teachers in their natural environments and to understand how they promote resilience [57]. We viewed participants as partners and experts throughout the research process and encouraged them to not only share their knowledge but also co-create and co-determine the progress and processes of the research. We supported participants in taking action when challenges were mentioned during discussions and in facilitating positive change in the community [58]. Consequently, by applying PRA principles in STAR, the
focus on ‘finding and solving problems’ was replaced by a focus on ‘facilitating change’.

We employed purposive sampling to select schools and identified potentially information-rich cases, to be able to gain a deep understanding of the focus of our investigation [59–61]. A selection criterion was that schools had to be located in settings signifying HIV/AIDS-related risk. Because of HIV/AIDS-related stigma, the disclosure of infection by parents and children was a scarce phenomenon in all the participating school communities. However, the presence of HIV/AIDS in these school communities was indicated inter alia by references to prolonged illness, deaths, children being orphaned or cared for by individuals other than their parents, absenteeism in order to take care of sick family members and requests for knowledge on nutrition, medical treatment, as well as access to funding with regard to HIV/AIDS. Similarly, poverty was obvious in various ways. In all the schools, the majority of parents or caregivers was unemployed and families did not access grants to supplement household incomes. Teachers reported children to be malnourished, hungry and sleepy in classrooms. Generally, parents were unable to pay school fees and to supply children with requisite school uniforms and stationary.

We entered each school via a contact person or key role player, such as a school principal, who assisted us in identifying teachers to participate (see Table II for an overview of the participating schools and teachers). Contrary to the initial school where the principal selected 10 teachers, an open invitation was put to teachers at other schools to voluntarily become involved. Participating teachers were not limited to specific learning areas or areas of expertise. Teachers involved in STAR were responsible for a variety of grades (foundation phase and secondary education) and specialization areas (science, business economics, early childhood education and agricultural studies). We relied on teacher participants to select other community members and stakeholders for additional individual interviews—a data source not part of the current study.

**Data collection, documentation and analysis**

We used multiple data collection methods (crystallization; 62) to reflect different nuances and present a refined view of reality. Data were collected as part of various phases, spanning baseline up to dissemination research phases. Table I provides a summary of data collection and documentation procedures. Primary data collection strategies that were used were focus groups combined with PRA-interactive activities (involving teachers), as well as individual interviews [both informal, conversational

---

**Table I. STAR intervention research phases and data collection**

<table>
<thead>
<tr>
<th>Data collection activity</th>
<th>Number</th>
<th>Participants and time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus groups for baseline data purposes</td>
<td>6 (1 in each school)</td>
<td>Teachers, six schools 2003–9</td>
</tr>
<tr>
<td>Focus groups for the purpose of data collection/monitoring and evaluation</td>
<td>39</td>
<td>Teachers, six schools 2004–9</td>
</tr>
<tr>
<td>Informal conversational interviews</td>
<td>41</td>
<td>Teachers and other school setting stakeholders, six schools 2003–9</td>
</tr>
<tr>
<td>Semi-structured interviews</td>
<td>19</td>
<td>Teachers and other school setting stakeholders, six schools 2003–9</td>
</tr>
<tr>
<td>Presentations at two seminars</td>
<td>10</td>
<td>Teachers 2008–9</td>
</tr>
<tr>
<td>Observation-as-context-of-interaction</td>
<td>Ongoing</td>
<td>Researchers, teachers and contexts of six school settings 2003–9</td>
</tr>
</tbody>
</table>
and semi-structured interviews with teachers and other stakeholders in the school setting, e.g. social workers, nurses, non-governmental organizations (NGOs) and faith-based organizations [61, 63].

Research activities focused on obtaining baseline data in each school (observation and focus group on first site visit), the implementation of STAR, data collection to explore the promotion of resilience, member checking of data analysis and monitoring and evaluation. Along with the theoretical assumptions of the study, focus groups, interviews and observations were guided by the following questions:

- What risks can be identified in the school/community?
- What resources can be identified in the school/community?
- How do teachers reduce risk by relying on the identified resources?
- How and by whom is teacher-initiated school-based support used?

In addition to the data collection and documentation procedures mentioned, the teachers attended two seminars (November 2008 and March 2009) as part of the STAR project, where they presented their psychosocial support initiatives (10 one-hour teacher presentations in total).

Although focus group discussions and interviews were supported by observation-as-context-of-interaction [64] and documented by means of field notes, reflective journals and visual data-capturing techniques [61], the data sources for this article are limited to verbatim transcriptions of focus group discussions and interviews. As our background and culture as researchers differed from those of the participants, field workers and other stakeholders were requested to assist us in interpreting communication when the need arose.

Data collection and analysis was participatory and iterative. During thematic analysis of verbatim transcriptions, we identified initial categories. We followed up initial analysis with final analysis by focusing on a comparison of different categories of themes and concepts, by identifying variations and connections between them and ultimately by integrating the various themes and concepts [57, 65]. We used a colour-coded word processor method [66] during data analysis.

### Table II. Participating schools

<table>
<thead>
<tr>
<th>School</th>
<th>Participants</th>
<th>Primary/secondary</th>
<th>Urban/ural</th>
<th>Province</th>
<th>Pilot phase</th>
<th>Dissemination phase</th>
<th>Participation time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N = 10</td>
<td>Primary</td>
<td>Urban, informal settlement</td>
<td>a</td>
<td>Yes</td>
<td>Facilitated STAR to two schools</td>
<td>2003–</td>
</tr>
<tr>
<td></td>
<td>All females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>N = 10</td>
<td>Secondary</td>
<td>Rural</td>
<td>b</td>
<td>Yes</td>
<td>Trained as STAR facilitators</td>
<td>2005–</td>
</tr>
<tr>
<td></td>
<td>Females = 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males = 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>N = 10</td>
<td>Primary</td>
<td>Urban</td>
<td>c</td>
<td>Yes</td>
<td>Trained as STAR facilitators</td>
<td>2005–</td>
</tr>
<tr>
<td></td>
<td>Females = 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males = 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>N = 10</td>
<td>Primary</td>
<td>Urban</td>
<td>c</td>
<td>Yes</td>
<td>Discontinued</td>
<td>2005–</td>
</tr>
<tr>
<td></td>
<td>Females = 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males = 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>N = 15</td>
<td>Primary</td>
<td>Urban, informal settlement</td>
<td>a</td>
<td>No</td>
<td>Trained in STAR by School 1</td>
<td>2008–</td>
</tr>
<tr>
<td></td>
<td>All females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>N = 2</td>
<td>Primary</td>
<td>Urban, informal settlement</td>
<td>a</td>
<td>No</td>
<td>Trained in STAR by School 1</td>
<td>2008–</td>
</tr>
<tr>
<td></td>
<td>All females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trustworthiness of the study
Due to the fact that meanings vary across different contexts of human interaction, and based on our selected paradigm of interpretivism, we did not seek generalizable findings. We did, however, attempt to obtain transferable and credible findings by producing rich and detailed descriptions of crystallized data [62]. We entered the research field as white, Afrikaans, graduate females, which implied researcher bias in respect of subjectivity and prejudice. To account for this challenge and increase credibility, we clarified uncertainties with participants, as multiple meanings could be ascribed to ‘reality’ [61, 67]. We strove to present dependable findings by documenting procedures that occurred as reported. By providing a balanced perspective of the various views, perceptions and beliefs of participants in various school sites, we aimed to present authentic findings [57, 67].

Regarding the core criteria for rigorous qualitative research [68], we addressed inter-subject comprehensibility by documenting the research process in detail, relying on interpretations in groups, member checking and peer debriefing and discussing our project with co-researchers and colleagues in the research arena. The study was considered relevant and meaningful due to the practical application value of the PRA study and a contribution to existing theory on resilience and the potential role of teachers and schools to promote resilience.

Ethical considerations
Prior to entering research sites, we obtained the necessary permission to conduct research from relevant South African education authorities (i.e. Eastern Cape, Mpumalanga and Gauteng) and from the principals of the schools concerned, as well as voluntary informed consent from participants. We explained the nature, purpose and process of our study, stipulating activities and the expected participant involvement. Participants were assured of the confidentiality, privacy and anonymity of any information obtained. We did, however, indicate that we could not guarantee the confidentiality of information shared during focus group discussions and urged all other participants to treat shared information as confidential and private. We took the necessary steps to protect confidentiality by altering identifying information on photographs and transcripts of interviews and by keeping data sources in a secure place [59, 69]. We monitored possible adverse effects to ensure that participants did not experience any form of distress. Participants remained informed during the research process and knew they were entitled to withdraw from the study at any time. For representation ethics, we relied on member checking and consulted with participants to ensure that the study’s findings reflected their voices and perceptions [60, 70].

Limitations
Findings in the current study need to be interpreted with some caution, given the limitation of the small sample size. In addition, the bias of the teachers who participate in STAR needs to be taken into account. These teachers’ willingness to participate in the intervention conceivably denotes high levels of commitment and compassion, which in and of itself served as individual-level resources together with that of the intervention. Teacher willingness to offer support cannot be viewed as a consequence of STAR only but must also be related to teachers’ intrapersonal characteristics. Most significantly, given the design of the study, the link between STAR and teachers’ supportive behaviours is tentative and currently being investigated as part of a longitudinal study.

Results
Table III reflects the themes, subthemes and categories that emerged from focus group and individual interview transcriptions. The first two themes involved ways in which teachers provided support following a strength-based intervention. In this regard, teachers provided support by using resources (identifying and referring children and gaining access to health and social development services) and by forming partnerships (with children, families,
community volunteers, community organizations, businesses and government). Theme 3 elaborates on the second objective by explaining how teachers’ support seemed to promote resilience. Individuals accessed the support offered by teachers to alleviate the effects of adversity (using vegetable gardens, availing themselves of health and social development services, as well as developing their capacity).

**Theme 1: teachers use resources to promote resilience in schools**

The first theme describes how teachers used the existing resources in school settings to promote resilience. They did not only use systems of identification and referral to provide support to vulnerable children (and their families) but also accessed the available health and social development services as resources to promote resilience.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers use resources to promote resilience in schools</td>
<td>Teachers use systems of identification and referral to provide support to vulnerable children (and their families).</td>
<td>Systems of identification. Systems of referral.</td>
</tr>
<tr>
<td></td>
<td>Teachers use health and social development services as resources to promote resilience in schools.</td>
<td>Teachers disseminate information on HIV/AIDS-related health issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teachers assist children and their families to access health and social development services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teachers target nutrition as a priority health issue.</td>
</tr>
<tr>
<td></td>
<td>Teacher partnerships with children and families.</td>
<td>Teachers promote resilience in family-centred way.</td>
</tr>
<tr>
<td></td>
<td>Teacher partnerships with community volunteers.</td>
<td>Teachers, children and families partner in feeding schemes.</td>
</tr>
<tr>
<td></td>
<td>Teacher partnerships with community organizations, businesses and government.</td>
<td></td>
</tr>
<tr>
<td>The use of school-based support to promote resilience in schools</td>
<td>Making use of vegetable gardens.</td>
<td>Parents supplement household provisions, cultivate gardens and become part of schools.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community members collect produce.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children receive food.</td>
</tr>
<tr>
<td></td>
<td>Accessing health and emotional support.</td>
<td>Children, parents and families access health services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents and families use emotional support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children access emotional and behavioural support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Using available support connects parents to schools.</td>
</tr>
<tr>
<td></td>
<td>Using support to develop capacity.</td>
<td>Capacity development of parents.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning support and extramural activities for children.</td>
</tr>
</tbody>
</table>
Subtheme 1.1: systems to identify and refer vulnerable cases

Teachers developed and used systems to identify vulnerable children and their families and to refer identified individuals to appropriate services. Systems for identification and referral function within larger school settings as a way to link vulnerable individuals with available resources (e.g. classrooms, playgrounds, neighbourhoods, clinics and faith-based organizations).

Teachers in all participating schools used school plans to establish, implement and monitor systems for identification and referral. They developed and implemented checklists to identify vulnerability based on behaviour change (drowsiness in classes, withdrawal from activities and expressions of anger, sadness and anxiety), as well as appearance (unkempt and absence of school uniform) and health (increased hunger, lack of concentration, blisters and sores on faces). ‘So it is really paining to see a child not wearing shoes in winter and so on—some coming here you can see they are from poverty, you can see that they are not properly fed because of their physique, their uniform is in tatters and that pains you and gives you the motivation to help’ (Female teacher, School 3).

Teachers directed the identification and referral initiatives, as one teacher noted: ‘You know, I … start with myself as link, as a coordinator of the … project here at school’ (Female teacher, School 5). Another teacher stated that ‘as educators, … it is possible that we can go an extra mile helping other people out there as long as we have ideas and as long as we communicate and as long as we form groups’ (Male teacher, School 2).

Other than systems of identification, teachers also used systems of referral. Teachers referred children and their families to relevant social development stakeholders to access grant information, apply for grants and monitor the progress of their applications. Teachers also tapped into relationships with service partners to monitor and evaluate the progress of referrals: ‘So, if the child reports that I have a parent who is very ill, I just pick up the phone and call Sister X. She comes to our school, we go to the place and then she does the rest. Admission is done by her’ (Female teacher, School 3).

Subtheme 1.2: health and social development services as resources to promote resilience in schools

Teachers used health services to promote resilience. They disseminated information on HIV/AIDS-related health issues, assisted children and their families to access health and social development services and targeted nutrition as a priority social issue.

Teachers shared information on *inter alia* HIV/AIDS prevention, care and support: ‘We invite them (parents) to come and listen, … so that they can hear and maybe spread to other members of the community. Like during the HIV and AIDS thing, the specialists who are invited to the school, we invite even the parents to come and listen so that … they can discuss … in their social clubs’ (Male teacher, School 3). To disseminate information on existing health services, teachers in one school (School 1) even established a school-based clinic in partnership with a local doctor, nurse and clinic.

In all but one school (School 4), teachers established links with the local clinic and/or hospital for voluntary testing and counselling: ‘then we are here to encourage clinics … they must go to the clinic because this is where they are going to get help, then to get medication, then to organise caregivers’ (Female teacher, School 1).

In four of the schools (Schools 1, 3, 5 and 6), social grant information was shared via networks: ‘So we’re all the time busy doing all these things, like we have children that we put in for foster care, we give support’ (Female teacher, School 6). Teachers distributed application forms to supplement household incomes. They also helped adult caregivers to complete grant forms.

All schools targeted feeding and nutrition as a support priority and established vegetable gardens. Produce from vegetable gardens was used to supplement food from the Department of Education’s feeding scheme: ‘the department don’t provide us with vegetables, only maize, soya and all
that stuff, and we do the extra’ (Female teacher, School 5). Produce from vegetable gardens were supplemented by donations (including clothing) from businesses in the neighbourhood: ‘At that moment we had various stakeholders, they managed to give us support and food parcels’ (Female teacher, School 1). ‘And then we’ve got X who is running a Pick ‘n Pay … every month end he … sends parcels to the school so that they can take home to go and eat. We have a vegetable garden, every Friday they get spinach and tomatoes from our … and then during winter time Checkers brings a lorry to our school with soup and bread. During breaks they eat bread and soup, they never get cold, our kids are never cold in winter’ (Female teacher, School 3).

The following quote captures the essence of teachers’ views on nutrition and HIV/AIDS: ‘for example people who are infected and affected by the epidemic virus. We thought that maybe if we could just have a small garden where we could plant vegetables so that the people around the community will not go and buy the green stuff from the market. They can just plant and come and have the vegetables in the garden’ (Female teacher, School 2).

**Theme 2: teachers formed partnerships to promote resilience in schools**

In an attempt to promote resilience in schools, teachers formed partnerships with children and their families. In addition, teachers partnered with unemployed volunteer community members.

**Subtheme 2.1: teacher partnerships with children and families**

Teachers adopted a family-centred approach by partnering with whole families and not only with identified vulnerable children. Children and their parents (or caregivers) cultivated vegetable gardens as part of the school-based feeding schemes introduced by teachers.

Teachers did not view children in isolation when promoting resilience but included the families from which they originate: ‘that was our goal: to support the many needy families’ (Female teacher, School 4); ‘helping especially the poverty stricken families that we are working with here in this community’ (Female teacher, School 5).

Parents (or caregivers) were also partners in teachers’ nutrition efforts by working in school-based vegetable gardens. In some schools (Schools 1 and 2), children also participated in tending vegetable gardens. Children either worked during school hours in a curriculum-integrated manner, after-school hours and/or during break-times: ‘X maintains the garden, especially the natural science group. They maintain the garden, look after the garden … they’re in charge of the garden’ (Male teacher, School 2).

Parents also volunteered to act as partners in other forms of support, in this instance a school initiative of home-based care: ‘Their willingness, their positive attitude towards the project; … they responded positively and they indicated and they showed that they were really interested in the (home-based care) project’ (Male teacher, School 1).

**Subtheme 2.2: teacher partnerships with community volunteers**

Teachers partnered with unemployed members of the community to cultivate school-based vegetable gardens: ‘a person comes with a spade, a fork and rake of their own and cut whatever site of land he wants’ (Female teacher, School 5). In two of the schools (Schools 1 and 5), parents (or caregivers) sold surplus produce to generate household income: ‘Most people are unemployed in this area. We were seeing that with the gardening project it will be easier for these people to get something into their pockets in a long run because they will be selling the vegetables to the outside world’ (Female teacher, School 5).

**Subtheme 2.3: teacher partnerships with community organizations, businesses and government**

Teachers furthermore promoted resilience by forming and maintaining partnerships with neighbourhood, municipal and government institutions, especially with community organizations, the business sector as well as government departments.
Schools 1 and 3 provided after-school care to children by collaborating with community organizations and NGOs. Three of the schools (Schools 1, 3 and 5) established collaborative systems with businesses and NGOs and managed to provide children with school uniforms and other clothing. In two of the schools (Schools 1 and 3), food parcels to vulnerable families included produce from the vegetable garden, as well as donations from businesses: ‘our learners were getting food parcels, they were receiving clothes, school shoes and uniform from other people’ (Female teacher, School 1). In addition, School 1 established a counselling centre on site. This centre was funded by a bank, based on an application made by the school principal.

School 1 initiated home-based visits by teachers in the form of a support group that collaborated with faith-based organizations. Later on, community volunteers (trained and paid a honorarium by the Department of Education) took over this role.

Theme 3: vulnerable individuals using school-based support

This theme provides evidence of the awareness and use of school-based support rendered by teachers. Children, parents, families and neighbourhood members made use of the vegetable gardens, accessed health and emotional support provided at schools and took advantage of opportunities to develop capacity.

Subtheme 3.1: making use of vegetable gardens

School-based vegetable gardens were used widely by children, parents and community members. Parents used the vegetable gardens to receive food to supplement household provisions: ‘And they come in large numbers and I’ve got a lot of them … there are lots of parents and we find out that they are so interested … because each and every day they must come and have a look at their garden’ (Female teacher, School 1). In addition, while parents benefited from the vegetable garden, they gradually also took shared ownership of the school premises: ‘What is happening with the vegetable garden, what I’ve seen so far, it helps a lot with the community because … the parents are taking care of the school, they don’t want the gate to remain open, they don’t want any animals to come in because they are keen, they are looking out for the vegetable garden’ (Female teacher, School 1).

Not only parents but also members of the neighbourhood community collected food from the school-based vegetable gardens. In each of the schools, a specific protocol was established to manage the distribution of food to individuals requesting support: ‘And anyone from the community can feel free if they need any vegetables … we monitor that, because they don’t just come in, they come to the office and they ask and if there’s any we will provide them with whatever is available … You don’t just come in and pick here, you come, you ask, you first see the principal, we like to follow procedures’ (Male teacher, School 4).

Children in particular benefited from the vegetable gardens by receiving food. Teachers distributed the produce from vegetable gardens: ‘When we harvest we will give the vegetables to the orphans, we have so many’ (Female teacher, School 3), ‘The greens from the garden, we use to prepare food for our needy learners. We’ve (also) got a feeding scheme at school, the spinach, the cabbage and tomatoes we get from the garden and we cook it for them’ (Female teacher, School 4).

Subtheme 3.2: accessing health and emotional support

Besides health and social development support (as apparent in subtheme 1.2), parents and extended families also approached teachers for emotional support: ‘I would like to emphasise that the support group is working because the uncle of the one, he came this morning to thank the support group for the good work that they are doing’ (Female teacher, School 1), ‘Also this (STAR) project brought the parents together—you know sometimes it’s difficult for them just to come to the school but with this project we saw them coming when we started’ (Female teacher, School 2). The fact that support was available thus drew people in need to come to the schools: ‘You see more people come to school
to disclose their status ... they can get food, help you see from the school ... support will get people’ (Female teacher, School 1).

The children themselves also took advantage of emotional support, as was clear from their use of the support offered by social workers: ‘Every Friday when the kids leave the place where they are staying, they first go to the social workers, and then there they discuss different ... programmes and topics’ (Male teacher, School 3). Children who experienced behavioural problems also targeted teachers for support: ‘There are children who are dealing with drugs; they come to the office and are given advice because we are working hand in glove with Child Line’ (Female teacher, School 1).

Subtheme 3.3: using support to develop capacity

Parents and children went even further and made use of support opportunities to develop their own capacity. During supportive discussions, parents often requested teachers to provide them with information: ‘that one of working with people who are affected ... it was very interesting for me to ... explain some of the things and ... why do we have to have projects in around the community’ (Female teacher, School 2). Parents at School 1 used a training opportunity provided by various school partners: ‘those parents were trained in various aspects, ... they were trained on HIV/AIDS and counselling ... in parenting empowerment ... in trauma ... These 22 parents also were trained ... from the Department of Health’ (Female teacher, School 1).

Children accessed opportunities for learning support and for participating in extramural activities: ‘They come four days a week, Monday to Thursday, they have a place where they can do homework, they see the learners and they have a computer programme for the learners’ (Female teacher, School 4). Also, ‘on the side of HIV support group, we managed to organise a pastor for us who can assist us with a group of people. There are kids who ... , after school every day, they go to a place of safety where ... they pray and they play some games’ (Female teacher, School 3).

Discussion

The discussion that follows concerns the ways in which teachers provided support to promote resilience in terms of our theoretical assumptions. The teachers implemented plans that they had devised themselves by making use of the asset-based competencies that underpin the STAR project.

Children are made vulnerable by the compounded risk factors that are characteristic of HIV/AIDS-dominated contexts

Teachers provided support in respect of a range of vulnerabilities in the HIV/AIDS-affected school settings. Their psychosocial support initiatives included assistance to children who experienced extreme poverty in HIV/AIDS-inundated settings as manifested by hunger, ill health and neglect and to the families of vulnerable children. As with other studies [20, 71], this finding indicates that resilience in terms of HIV/AIDS cuts across vulnerabilities, supporting our assumption that children are made vulnerable by compounded risk factors (one of which is HIV/AIDS). As argued elsewhere [15, 16, 37], efforts at buoying resilience therefore cannot be targeted at HIV/AIDS in isolation but need to take compounded risk into account.

With regard to HIV/AIDS, teacher-initiated protective processes favoured specific priorities. First, teacher support involved the identification and referral of vulnerable children, specifically to health and social grant services. Second, teachers’ risk (and resource) assessments targeted children as part of families. Third, teacher support gave preference to providing for basic needs (food, school uniforms and social grants for household incomes). In this, the current study (like others; 15, 16, 33) supports the relatedness of children and families when adversity is identified and when schools are structured to reduce the effects of such risk [24].

Promoting collective resilience [72] is one strategy to use in settings that are prone to HIV/AIDS risk. In the current study, collective resilience was indicated by local people engaged by teachers to
mitigate risk, teachers creating organizational linkages and teachers boosting social supports. Reducing risk and resource inequities is an aspect of collective resilience that is absent in the current study and that merits future policy-related enquiry.

As maintained by others [24] and demonstrated in this study regarding HIV/AIDS risk, a key to promoting resilience in distressed neighbourhoods is the ability to access formal and informal social supports. Although the relevance of access to health services for resilience has been documented [26], the current study demonstrates that enabling social capital (or networks) in education and health policy, as well as in practice frameworks is meaningful to promote resilience in HIV/AIDS-saturated settings.

**Teachers are able to implement psychosocial support strategies subsequent to participation in the STAR project**

Teachers opted to establish mechanisms and processes that function to modify the effect of an HIV/AIDS risk setting. Protective processes that teachers instituted to mitigate adversity on the one hand assessed the risk that enhanced children’s response to adversities (rendering them more vulnerable) and on the other hand assessed available resources (structures for reducing risk). The *modus operandi* adopted by teachers following intervention by means of the STAR project was to

- identify available assets and relevant risks,
- initiate partnerships with people related to these assets in order to provide psychosocial support,
- establish school-based community systems to identify vulnerability,
- refer children and families for support to pertinent partners in the community systems and
- maintain and monitor partnerships.

These teacher actions support the assumption that the STAR study facilitates teacher implementation of psychosocial support strategies.

Neighbourhoods have been identified as an influential environmental resource [24], and the current study supports the role that teachers can play in identifying, mobilizing and linking resources to promote resilience through networks. Characteristic of ecological perspectives on resilience [13, 24], the networks were systemically integrated and collaborative, and they referred vulnerable individuals to either community systems or on-site networks at schools.

Teachers expanded a resilience web by introducing partnerships in the community [22, 24, 26]. They used partnerships to link individual-level resources (teacher compassion and commitment), social-level resources (parents’ willingness to cultivate gardens) and societal-level resources (school leadership, small businessmen, clinics and social workers). This finding corresponds with those of other development studies [17, 73, 74, 75], which suggest that networks, collaboration and partnerships are central to strength-based interventions. It does, however, seem somewhat ironic that it is precisely these networks that again ‘liberate’ teachers to function in their primary role as facilitators of teaching and learning, while teachers continue to support resilience in collaboration with partners, via networks.

In the current study, relationships were central to teacher support. Teachers used relationships to access and mobilize identified resources through which they could address the identified needs and to establish and maintain networks. We contend that relationships are resilience-promoting resources that teachers use in their efforts to promote resilience. This finding echoes that of other studies [17, 74, 76] and indicates that relationships are essential for strength-based capacity development.

Partnerships, networks and relationships signal social capital. As indicated by others [22, 27, 51], the current study hints at the further investigation of social capital (prominent in studies of public health and social epidemiology) within the realm of resilience, specifically pertaining to teachers and schools as protective resources.
Teacher-initiated psychosocial support is a catalyst for schools to function as protective resources for reducing children’s vulnerability to risk

Teachers and schools can reduce risk in HIV/AIDS-influenced environments. Among other factors (including teacher disposition and available resources), teachers’ provision of psychosocial support is a catalyst for schools to potentially function as resilience-promoting resources. Significantly, children, youths and families made use of available support, thereby demonstrating reciprocity and the value of protective resources. This finding supports several studies [14, 16, 17, 77] and shows that available resources can be mobilized and accessed to promote resilience.

School community collaboration has been indicated as a significant factor in promoting resilience [24]. The current study indicates how teachers use schools (as a social environment resource) to establish supportive communities, through partnerships. Significantly, the current study found that in HIV/AIDS-stressed settings, teachers used partnerships to establish school-linked services and to situate social and health services for children and their families at school sites. In this way, teachers and school-level resources are expanded as resilience experiences in the form of supportive peers, positive teacher influences and success experiences—as previously found [22].

When schools become caring, safe and friendly spaces, the extended school family (children, their families and teachers) feels more at ease to disclose vulnerability and, importantly in terms of HIV/AIDS, to be referred for health services (or to access socioeconomic security by means of grants). In this regard, safe and caring schools have been linked to an increased sense of community [24], as well as a sense of belonging [48]. The potential role of schools as spaces of community and belonging to reduce the effects of stigma and discrimination related to HIV/AIDS warrants closer scrutiny.

Although only one rural secondary school formed part of the study, it appears that the implementation of support was more challenging in this context. The effects of a stringent secondary school curriculum, as well as of rurality [78, 79, 80] on teachers’ ability to provide psychosocial support by means of networks thus seem to merit further investigation. Other areas for future research include establishing similarities and differences in teacher support related to gender, as well as examining factors that are related to sustained school-based support.

Conclusion

Although it remains contested whether or not teachers should provide psychosocial support [4, 81], teachers can play a significant role in promoting resilience. Teachers promote resilience by making the most of social capital in identifying and harnessing community resources, thereby buoying vulnerable children. These relationship-driven support networks mitigate the effects of cumulative risk. We theorize that relationships constitute the core of such systemic networks. We postulate that these school-based networks by teachers in partnership with others enable schools to function as resilience-promoting resources. We argue that a strength-based approach can enable teachers to establish and sustain networks across systems.

As for the near future, HIV/AIDS signals a source of risk that cannot easily be resolved. Insights from the current study provide pragmatic strategies teachers may follow to promote resilience in children’s immediate environments. Although resilience is not a cure for HIV/AIDS risk, societal mechanisms and policy structures continue to be pivotal to buoy resilience processes.

Funding

University of Pretoria’s Department of Community Engagement; Foschini Group; ABSA Foundation.

Acknowledgements

We acknowledge the contributions of teachers and schools participating in STAR, as well as co-researchers Tilda Loots and Hermien Olivier.
Teachers promoting resilience in HIV/AIDS dominated contexts

**Conflict of interest statement**

None declared.

**References**


