Life Skills for Positive Living in the Face of HIV and AIDS

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Abstract
This article is based on a research project involving three related studies on challenges and adjustments made in the face of HIV/AIDS. The authors were interested in establishing how findings of these studies could inform life skills education, this being the backdrop against which recommendations are made for positive living.

Keywords: life skills, HIV/AIDS, positive living

Introduction
The article commences with a description of the context and background related to the topic, this being divided into HIV/AIDS as it occurs in South Africa followed by a literature review of life skills education. Following on from this, the authors proceed to discuss the three research studies, results thereof and recommendations for positive living using life skills as a frame of reference and theoretical grounding.

Context
HIV/AIDS in South Africa
HIV and AIDS in South Africa is embedded in a complex context of poverty, family disintegration, food insecurity (Ahmed *et al.* 2009; Kasiram 2011),

non adherence to treatment, sexual violence and cultural complexities that appear to promote risky sexual conduct (Kelly 2002).

Cultural complexities in themselves are difficult to attribute to sexual risk taking as they are largely intertwined with religion, spirituality, morality and values (Smith, 2002). Moral 'regeneration' was popular at its inception as a movement in 2003 (PMG, Parliamentary Monitoring Group 2010) and included both Life Orientation to address HIV/AIDS in South African schools as well as related concerns such as violence against women, which this article addresses. On the identified need for 'Life Orientation', the document: Challenges Facing the Moral Regeneration campaign (Chapter 6, www.iss.co.za/pubs/monographs/N0114) cites nation building as key to addressing decreasing morality levels in the country, this perhaps promoting community conscientizing about HIV and AIDS. Clearly then, HIV/AIDS has a complex context within which it must be understood and within which related concerns must be addressed alongside the obvious ones of health promotion and sexual empowerment (Ngcobo 2011, Mulqueeny & Kasiram 2013).

Two of the three studies in this paper focused on women because women are more vulnerable to HIV and AIDS than their male counterparts (Ngcobo 2011). Statistics between 1997 and 2004 in South Africa reveal that death rates to AIDS among men aged 30-39 more than doubled, while among women aged 25-34, it more than quadrupled (Statistics South Africa 2006). In 2009, it was found that almost 1 in 3 South African women aged 25-29 as compared to 1 in 4 men aged 30 – 34 were living with HIV (HSRC 2009). HIV among pregnant women is also a concern with antenatal clinics run by the Department of Health showing an increase from 25.8% in 2001 to 29.4% in 2009 (Avert 2010). Thus it is apparent that the context of increased risk of HIV and AIDS among women needs to be addressed.

The third study focused on sexuality, dating and intimacy concerns among men and women with HIV/AIDS. In South Africa, sexuality and intimacy are both taboo topics, more so when there is HIV and AIDS (Schiltz & Sandfort 2000). Kasiram *et al.* (2003) and Mulqueeny and Kasiram (2013) highlight interaction and intimacy among HIV positive persons as a neglected area that warrants research, and Painter (2001), that couple relationships for infected persons have been insufficiently attended. The article (and the studies) addresses this gap of sexuality and dating among

HIV positive persons, with a view to recommending changes for positive living through life skills.

HIV/AIDS in women and sexuality and dating among HIV positive men and women, are concerns that may be addressed timeously through life skills for youngsters at school.

Life Skills

Since HIV and AIDS has reached epidemic proportions in South Africa, with far reaching consequences to the individual, family, community and country, it has become necessary for multiple stakeholders to offer prevention, remedy and support (Den Hollander 2009). Life skills, the subject of this article is one such programme offered by the education sector in South Africa and was aimed at preventing HIV and AIDS since 1995 (Visser 2005).

Research studies on these programmes have demonstrated that although knowledge levels have increased, behavior change with regards to sexual risk taking did not follow (James *et al.* 2006; Kelly, 2002; Visser, 2005). Magnani *et al.* (2005) however found in their study of 2222 youth in KwaZulu-Natal, that there was modest change in self efficacy and increased condom use amongst their participants. Differences in these results are attributed to poor and inconsistent implementation of the programme (Magnani *et al.* 2005; Visser 2005) and real long term benefits being too early to gauge.

Literature reviewed on effective life skills education suggests meticulous planning and implementation that must consider the following components (divided by authors into categories where some overlap is inevitable):

Policy and Planning: Top-down policies on life skills for sexual risk taking do not work, even with the best intentions and committees that plan these programmes (Kelly 2002; Visser, 2005). The suggestion is to include parents as well as young people themselves (Kelly 2002) and then to co-ordinate and market the programme well (Visser 2005). In addition, the school management team should harness community support, ensure funding, adequate space and time for the programme (Visser 2005; James *et al.* 2006).

Who: Life skills education in schools should be implemented by educators who are thoroughly prepared and trained (Pick *et al.* 2007; Ahmed *et al.* 2009) skilled, committed, good role models, understand which related cultural norms are controversial and address these (Kelly 2002). Again the suggestion is to include young people themselves in presenting the programme in addition to audience members (Visser *et al.* 2004), community members (Visser 2005), traditional healers, faith-based organizations (Den Hollander 2009), untrained teachers and senior students (Coombe & Kelly, 2001). However, a good relationship with these stakeholders is important as it is the vehicle through which sensitive information is taught and learnt in a climate of trust and respect (Visser 2005).

What: James *et al.* (2006) review the Life Skills and HIV/AIDS Education Programme of the KwaZulu-Natal Department of Education (2000) that did not result in behavior change. The programme included: **facts** about HIV and AIDS, modes of transmission, the immune system, progression of HIV to AIDS and how to keep the body safe and healthy. This was followed by **skills** on preventing HIV and AIDS that included attitudes to condom use, gender norms and sexual behavior. James *et al.* (2006) lament the absence of specific information on attitudes that need change and how improvement in self efficacy and control and re-negotiating sexual identity may be accomplished (Visser *et al.* 2004).

What is needed is: high level engagement with learners, use of multiple and creative communication channels and media (Coates *et al.* 2008) interrogating meanings and beliefs surrounding HIV and AIDS, beliefs about change, critical assessment of personal risk, self awareness, decision making, assertiveness and developing a positive, non judgmental attitude towards persons with HIV and AIDS (Visser *et al.* 2004; Den Hollander 2009). In addition to this, the learner's own developing sexuality and beliefs about witchcraft, sorcery and black magic (Coombe & Kelly 2002; Kelly 2002; Visser 2005; James *et al.* 2006) must be addressed via the programme.

Other wider socio-political considerations for the programme include unemployment and financial constraints impacting women's risk taking behavior (Kasiram *et al.* 2011; Ngcobo 2011), gender-based violence (Kelly 2002) and the female condom to give women greater personal control in sexual relationships (Mitchell & Smith 2001).

What is also necessary is for abstinence to be marketed as 'cool' (Kelly, 2002) and condom use popular (Visser 2005). Such marketing needs to be large-scale, involve multiple role players such as the school, faith-based organization, family, community and government, to have the desired impact. Kelly (2002), Pick *et al.* (2007) and Ahmed *et al.* (2009) suggest that life skills be included in larger programmes on health care and promotion (Ahmed *et al.* 2009), targeting younger learners first and be incrementally made complex to embrace age-appropriate understanding (Visser 2005; Ahmed *et al.* 2009).

How: Coates *et al.* (2008) and James *et al.* (2006) advocate best practice in life skills education to include a combination of methods and multi-level approaches**:** didactic, role plays, interactive discussion and groupwork employing a range of people, institutions and networks. Participatory methods, using non formal education are suggested by Kelly (2002) and Ahmed *et al.* (2009). Visser (2005) discusses the importance of using the group process and dynamics of group pressure for facilitating a leaner-centred pedagogy (Bozalek 2007) to change beliefs and behavior. Entertainment education (Mitchell & Smith 2001) is also considered essential to penetrate the 'AIDS fatigue barrier' so that the life skills package is made attractive for recipients. Finally, Magnani *et al.* (2005) and James *et al.* (2006) suggest full and consistent implementation in schools by a committed and varied team of educators.

Research Methodology

The overall research project sought to understand the experiences (challenges and survival) of women who were HIV positive and to explore the sexual and intimacy issues confronting both men and women who were HIV positive.

All three studies in the project utilized the qualitative paradigm as this allowed us to glean rich, in depth and new understandings of experiences of HIV and AIDS (Rubin & Babbie 2005). The research designs used were a combination of exploratory and descriptive designs (Terre Blanche *et al.* 2006) as some of the data was new such as exploring survival, sexuality and dating and richly described in the in depth interviews (Royse 2004).

The research instrument was the semi-structured individual interview in all three instances with themes to guide the interview (Terre Blanche *et al.* 2006). Having this guide to structure the interview was essential since the topic was sensitive and sometimes painful, necessitating fieldworker input, therapy and referral that could have derailed the research component of the interview.

The samples used in the project were as follows.

Project 1: survival stories of HIV positive women, using a convenience sample of women who received therapy at the University-based family therapy service learning unit where the authors offered services. Altogether seven women participated in this study, the authors-researchers having reached data saturation (Terre Blanche *et al.* 2006) after interviewing these seven women

Project 2: challenges and survival stories of HIV positive women, using convenience and availability sampling, at the health centre where one of the authors was employed. The first 15 women with HIV/AIDS who were willing to share their experiences with the researcher participated in this study.

Project 3: sexuality and intimacy experiences of HIV positive men and women, using available and then snowball sampling procedures until a sample of 12 participants was secured and until data saturation was reached. The initial sample was known to the researcher (available, convenience sample) but thereafter snowballing had to be used to reach the remaining number.

Since this was a qualitative project, reliability was less of a concern than was trustworthiness. Data had to be credible, with researchers ensuring that participants did not offer socially acceptable responses or responses that would compromise their status as clients receiving social work services. Hence, social work skills in assuring them of confidentiality, a non judgmental attitude, discussing termination of the interview without penalty were some of the measures used in promoting credibility of data. Data was

also dependable, in that themes were derived from a thorough literature search, along with allowing for open discussion so that authentic, comprehensive accounts were received from participants. Tape recorders were also used after securing participant permission, ensuring confirmability of data.

Ethical issues such as confidentiality, anonymity, explanation of the research project, securing informed consent and offering ongoing services or referring participants for further assistance was respected in all three projects. Further, all three projects secured ethical clearance from the University under whose auspices they were undertaken.

Results and Discussion

Results of the three studies are discussed using the literature reviewed on life skills programmes. The distinction between findings in each of the studies is not considered important in furthering the discussion on life skills education, hence only partial reference is made to the different study results.

Study 1 and 2 results are jointly presented since they both dealt with women and a common focus (challenges and survival) whilst study 3 results on sexuality and dating are presented separately thereafter. In all instances themes which emerged after data analysis (Terre Blanche *et al.* 2006) are offered alongside pertinent life skills that derive from the earlier literature review.

Life skills are initially presented in detail, but as they become relevant to other findings and responses, the authors refer to them briefly to avoid undue repetition.

Study 1 and 2: Challenges and Survival of HIV Positive Women

Results of seven (7) HIV positive women's survival stories and fifteen (15) HIV positive women's stories of challenge and survival are presented hereunder.

Theme 1: Non Acceptance/ Acceptance: Allocate Finite Time

Denial, Guilt, Loss, Grief and Shock mainly accompanied a positive diagnosis. However, when the women allocated a finite time for grieving,

recognizing that life has to continue '*for the sake of the children*', they could forward plan and live positively. Life skills that directly or indirectly address this theme include:

a. Strengths based work to improve self esteem (women said they were '*devastated, depressed*'). Improving self esteem is suggested by Pick *et al.* 2007) to improve confidence and address some of the related negative emotional responses shared by participants, upon receipt of a positive diagnosis.

b. Interrogate and adjust dysfunctional socio-cultural beliefs (Coombe & Kelly 2001; Kelly 2002) as women were riddled with guilt believing that they carried the responsibility for bringing the disease into the home.

c. Trauma, death and dying education- to appreciate stages of grieving and realize that crossing these stages brings one closer to the acceptance stage. This is related to participants suggesting '*finite periods for grieving*', perhaps realizing that stages of grief have to be passed with some professional help.

d. Externalizing- the need is to separate the problem from the person ('*I am not AIDS*; *I am bigger than AIDS'*) as discussed by narrative theorists (Morgan 2000) so that the identity of the individual is not infused with being only HIV positive. This will facilitate the development of healthier, alternate identities (Visser *et al.* 2004).

e. Assertiveness and problem solving- to help women address the many responses of non acceptance of a positive diagnosis (one participant referred to '*giving others for your own growth*' as part of her assertiveness and taking charge of her life). Assertiveness and problem solving skills will also help women negotiate safe sex as advocated by James *et al.* (2006) and Visser *et al.* (2004).

f. Value living optimally/positively ('*I have to look forward*') to commence early as part of a wider programme on health promotion in schools as discussed by Pick *et al.* (2007) and Ahmed *et al.* (2009).

Theme 2: Disclosure / Non Disclosure/ Selective Disclosure

There were varying responses in relation to disclosure, with some women feeling '*completely liberated*' upon disclosure whilst others were '*scared*', fearing reprisal and censure from partners (who may have infected them in the first place), family members and their children. To better manage disclosure, the following life skills are indicated:

a. Negotiation and refusal skills as outlined from in the words of a participant in study '*1 need to bring my husband so that he can hear from the counsellor*'- necessary where women wish to prevent re-infection (also see 1e).

b. Assertive training and problem solving as discussed by a participant in '*doing motivational talks to teach others*' and living authentically- essential for honest disclosure and dealing with consequences of disclosure (also see 1e).

c. Right and righteous living as women often felt *'judged, guilty and afraid*' to disclose to family and friends- this promotes honesty in relationships (compare 1f).

d. Trust building-instead of women fearing their partners ('*after I told my husband, he said nothing will change, he still loves me'*). Women could be helped to build trusting relationships, achievable through early life orientation and health promotion programmes in school (also see 1f).

Theme 3: Loss of Self, Loss of Sexual Intimacy

Women often bemoaned '*loss of identity*', believing they were '*worthless*' and did not deserve love and intimacy. Their identities were inseparable from that of being an HIV positive person. To this end, the life skills programme could include:

a. Strengths based work, to help identify the multiple identities ('*I ask – who is in charge today- the AIDS or me*') and strengths that reside in us all, to be nurtured from childhood. In addition, because identity loss is

largely prompted by socio-cultural determinants, addressing these factors (see 1a) via the school which allows access to the neighbourhood and community, is necessary.

b. Externalization which is supported by strength-based work (see 1d).

Theme 4: Rejection, Stigma and Isolation

These emotional responses were very similar to the reactions discussed under theme 1, except that here, women did not discuss ever '*coming to terms with societal prejudices*'. Hence many of the life skills suggested under theme 1 are relevant here as well. In addition, the following life skills would help accommodate responses mentioned in this theme:

a. Value social connection and wrap around networking- (one said: '*I serve in my church*'; another the women in her neighbourhood) - this life skill may be also be taught early to the child with the aim of developing a sense of community connection (Rojano 2005).

b. Promoting spiritual regeneration, prayer, meditation and appreciation of nature *('I walk'; 'I enjoy nature'; 'I pray 3 times a day'*).

c. E networking – today e communication makes connection so simple, but it is important to remember that just as we may rely on faceless networking, we must also nurture face to face relations, to experience the full benefit of 'wrap around networking'. These suggestions were not found in the literature review, but may have been implied in suggestions to use the 'group' dynamic (Visser 2005) in goal setting and risk reducing behaviour.

Theme 5: Empowerment via Knowledge and Understanding of Rape, HIV/AIDS, Treatment, Re-infection

Factual understanding about the disease, its transmission and preventing re-infection was often limited among most participants and contributed to further risk taking such as having '*neviropine babies*' since women did not

transfer the virus to their babies because of treatment at antenatal clinics. Only a few of the women were well informed, so much so that they were able to become 'AIDS Counselors' themselves, serving others in their community. Life skills indicated for this result include:

a. Update/improve knowledge, attitude, skills by accessing/ synthesizing knowledge from multiple sources ('*don't take what the Doctor says for granted'; 'find out as much as possible yourself'*) to help make informed decisions (James *et al.* 2006). However, synthesizing the information and making informed choices has to happen outside the boundaries of didactic teaching, in small groups where interaction and groupwork may allow issues to be openly and liberally interrogated (Visser 2005; Ahmed *et al.* 2009).

b. Address myths about male supremacy, gender-based violence ('*both my daughters were raped-there is much violent crime in my area'*) and correction rape- also see 1b.

c. Address issues of witchcraft, sorcery, curses, black magic ('*I must beat this curse of AIDS*') – also see 1b.

d. Assertive skills-refer to 5a,1e and 2b.

Theme 6: Ensuring Financial Security

More than being HIV positive was the fear of not being financially able to provide for themselves and their families. This concern was all consuming for most of the women. Many of the women had food gardens that gave them '*daily exercise, food for themselves and families and a little extra for selling*'. However, when they were ill, it was difficult to maintain their gardens, suggesting the dire need for other sources to be tapped for everyday survival, in the form of the following life skills:

a. Handwork, sewing, gardening, baking, craftwork- could be taught as part of a larger skills initiative drive to change the focus from pure academics to alternate but necessary creative arts. These could later be used to source an income or could re-instill a sense of accomplishment in women

(and men). This suggestion is also made by Pick *et al.* (2007).

b. Instil value for education/qualification- in a context where money is scarce, it is not always possible to promote education as this may take away potential earnings, albeit meager. However, it is necessary for young learners to know the value of education, ongoing education and qualification. These self same values for education must also be instilled in the community, since without such community backup (Coombe & Kelly 2001; Visser *et al.* 2004), such ideals will not come to fruition.

Theme 7: 'UBUNTU'

This theme formed a circle of comfort, offering many women respite from the knowledge of having a positive diagnosis, whilst also promoting the notion of helping and serving others. The term '*ubuntu*' a South African word meaning '*we are who we are because of others*' was an apt summary to the survival stories of many women in the studies. Life skills emanating from this result include promoting a culture of service ('*you grow when you give*') with Kelly (2002) even suggesting that this aspect become examinable, to ensure that it is afforded seriousness.

Study 3: Sexuality and Intimacy Experiences of HIV Positive Men and Women

Six men and six women participated in this study on sexuality, dating and intimacy. Overlap with results from the first and second study with women, was evident. Accordingly, life skills discussed earlier were also relevant here, and reference is made to these to avoid undue repetition.

Theme 1: Poor Self Esteem, Fear of Rejection upon Disclosure, Guilt at Living

This finding highlights the sense of worthlessness as discussed in studies 1 and 2 and acutely experienced in relation to disclosure. Participants did not believe that they deserved intimacy ('*I stopped having sex after my*

diagnosis'), pleasure or happiness. Life skills pertinent to these findings overlap with those from studies 1 and 2 and include externalization in order to develop a strong self identity that is separate from a positive diagnosis, nurturing strengths and creativity and using youth-popular media.

Theme 2: Poor Relationships and Fearing the Future

Fear and poor relationships seem to be related to each other (*'I decided not to have sex with my wife, for fear of infecting her...I think she was scared of being infected too')* and is linked to participants' negative mind set. Life skills pertinent to these results again show similarity to earlier results. Being positive, looking to the future, nurturing communication skills and being able to problem solve about relationships must commence early, in general life orientation programmes at school, with sensitive topics such as intimacy being added later as and when appropriate.

Theme 3: 'I can't have children'

This theme is very similar to the afore-mentioned regarding concerns for the future. Here it is specifically related to unborn children, and originates from inadequate knowledge about HIV, transmission, infection and re-infection, all of which could be addressed through knowledge acquisition. However, in order to result in behavior change, teaching/learning must be learner-centred, age-appropriate and culture and context specific through interactive teaching/learning means as outlined in the literature (Kelly 2002; Visser *et al.* 2004; James *et al.* 2006; Bozalek 2007).

Theme 4: ARV's Make People Reckless

This result referred to HIV positive persons not caring about infecting others and about their own re-infection. In the case of women, there was a sense that they could behave in any way, and even if they became pregnant, ARV's would prevent transmission to the children ('*I will have my neviropene baby*'). Again, updating knowledge about HIV, treatment, STI's, pregnancy and contraception is imperative.

Summary and Recommendations

Results pointed to a wide range of life skills that could be included in the school curriculum to prepare youngsters for HIV and AIDS prevention, management and positive living. Not only is it important to consider planning the **content** of the programme with care, but the socio-cultural **context** within which the programme will be implemented must also be afforded attention.

Life skills should include empowerment through knowledge, attitude and skill acquisition, for both males and females, for personal and sexual identities to be delinked from having a positive diagnosis and for dominant societal discourses such as females being responsible for bringing the virus to the family to be challenged through the programme. For women who are at greater HIV risk than their male counterparts, the female condom is advocated to claim locus of control during sexual encounters. This contraceptive and HIV prevention device being expensive, needs governmental support and funding, and its use promoted in life skills programmes. Faith-based organizations could also support this initiative, alongside their efforts to promote sex within the institution of marriage.

Life skills for empowering youth with **knowledge** about a range of issues surrounding HIV such as infection, transmission, re-infection, STI's and safe sex and myths related to these topics such as 'correction rape' were also deemed necessary. Related to this knowledge about the disease, is **understanding** and **attitude change and skills** for building relationships, building trust, communication and assertiveness skills, problem-solving and negotiation skills, identity and self esteem building, self care and healing, healthy living, morality, right living, serving others, being positive, value of connection, trauma, death and dying education and the creative arts. These skills may be nurtured early in the family, being based on values/culture/religion and then further developed at schools and in communities. In addition, together with talent building, accountancy and profit-loss understanding should be included to address food insecurity and poverty later in life.

In addition, the programme should be part of an ongoing one that promotes healthy and responsible living; it should also focus on highlighting the importance of community service and '*ubuntu'*. Small group teaching and

learning using a creative range of 'educators', a variety of educational sources that include traditional healers, faith-based organizations and youth-popular media (such as e networks and entertainment education-Mitchell & Smith, 2001) should be employed to penetrate the problem of AIDS saturation. In addition, in countries such as South Africa where the community may not backup plans for such life skills programmes, community engagement is essential, in preparing for a context that embraces rather than opposes/fights changes.

Finally, the programme needs to be supported by policy and funding and should be continuously evaluated and adjusted to suit the changing landscape within which HIV and AIDS thrives.

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