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## List of Abbreviations and Acronyms

AECT	Association of Education Communications and Technology
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral [medication]
DART	Development of Antiretroviral Therapy for Africa [drug trial programme]
HEAT	HIV/AIDS in Education Assessment Team [Government of Zimbabwe]
HIV	Human Immunodeficiency Virus
NGO	Non-governmental organisation
OVC	Orphans and Vulnerable Children
PSMAS	Public Service Medical Aid Society
PTUZ	Progressive Teachers' Union of Zimbabwe
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UZ	University of Zimbabwe
WHO	World Health Organisation
ZIMTA	Zimbabwe Teachers Association



# Chapter 1

## *Introduction*

### **Introducing the argument**

In a number of school-based HIV and AIDS education policies and programmes of the Southern Africa region, teachers have been cast as front-line implementers whose task is to facilitate the learning process (Government of Zimbabwe 1993b). As a result, the dominant images of teachers in much of the literature is that of teachers as vehicles for delivering the curriculum to pupils, teachers as mentors and counsellors, teachers as role models for young people, and teachers as guardians of children's rights (Government of The Netherlands 1998; Gachuhi 1999; Seabrooke 2000; Kelly 2002). In Zimbabwe, for example, HIV and AIDS education policy contains powerful images of the end user of the policy – that is, the teacher. The teacher envisaged in the policy document is knowledgeable about HIV and its transmission, is comfortable talking about and teaching sexuality issues to young people, and is a good mentor and counsellor within the school. Most significantly, this teacher is assumed by the HIV document to be HIV-free. And yet there is ample evidence showing that a number of teachers implementing HIV policy are themselves HIV-positive (Zapulla 1997; Muthukrishna 2006; Ramsuran *et al.* 2006.). This (dis)articulation between policy images of teachers implementing HIV policy and the realities of such teachers is the focus of my study.

In researching if these policy images of teachers resonate with how teachers see themselves (*teacher identities*) in the context of HIV and AIDS, a central question is whether it is reasonable to assume that teachers will play the expected key role in the fight against AIDS when their own realities and identities do not resonate with how they are framed in policy. In other words, how do teachers living with AIDS make sense of such a policy and how do they interpret it? Do they faithfully translate the policy into practice or do they transform it first, adapting it to suit their personal

situations and school-level realities? Is the resulting transformation, adaptation or resistance educationally sound or is it problematic? These are some of the questions that shaped my thinking in researching the challenges of implementing HIV policy in Zimbabwean primary schools.

## **Research purpose**

The purpose of my research is two-fold. First, I wish to establish the degree of congruence between policy visions of the ‘ideal teacher’ and the images that teachers have of themselves in the context of HIV/AIDS. Second, I will seek to explain the possible discrepancies between policy ideals about teachers dealing with HIV/AIDS and teacher self-understandings of their roles and identities in relation to the pandemic. Through this study, I will illuminate the experiences of teachers living with HIV/AIDS and how their experiences affect the ways in which they understand and act on government policy.

My hypothesis is that the official images and expectations of teachers, such as captured in government policies on HIV/AIDS, make demands that conflict with teachers’ personal identities of themselves as classroom practitioners. I argue that it is the mismatch between the images of the policy makers and the identities of teachers that has contributed to the challenges in the implementation of HIV/AIDS education policy in Zimbabwe.

## **Research questions**

The following research questions guide this study:

- How do images of the ideal teacher, as reflected in government policy, compare to the self-described identities of teachers in the context of HIV/AIDS?
- How do teachers living with HIV/AIDS experience, respond to and enact government policy on HIV/AIDS in the classroom?

- To what extent can the framework of ‘teachers as emotional actors’ reconcile the differences between policy ideals and teacher understandings of their identities in HIV/AIDS contexts?

## **Background and rationale for doing this research**

With the advent of HIV/AIDS, many countries in Southern Africa introduced school-based HIV/AIDS policies and programmes aimed at harnessing the huge potential of the education sector to prevent HIV infection. The underlying rationale behind school-based HIV/AIDS education was the idea that this would offer the opportunity to start educating children at an early age, before they become sexually active and before they acquire attitudes that are often counter-productive to positive sexual behaviours and attitudes (World Health Organisation [WHO] 1993).

Zimbabwe introduced the HIV/AIDS and Life Skills Policy in schools through the Chief Education Officer’s Circular Number 16 of 1993. Zimbabwe was one of the first countries in the region to introduce Life Skills Education. This policy made the teaching of HIV/AIDS education in all schools from Grade 4 to Form 6 compulsory. In 1999 the National AIDS Policy for the Republic of Zimbabwe was developed, and this also emphasised the integration of HIV/AIDS education into all educational and training curricula. HIV/AIDS and Life Skills was also introduced into the curricula of pre-service and in-service teacher training.

The aim of the HIV/AIDS programme was to develop HIV/AIDS knowledge as well as to promote responsible student behaviour and to maximise protection from sexually transmitted infections, including HIV. The programme was designed to reinforce the urgency of attention to the prevention of HIV/AIDS nationally, and to target the ‘window of hope’ – that is, school-going children and adolescents. It was meant to provide accurate and relevant information and skills to teachers and pupils by using participatory methodologies. In addition, it tried to encompass other aspects of student experiences, community life, basic life skills, human growth and development. All schools were obliged to provide HIV/AIDS preventive education (Government of Zimbabwe 1993a).



The HIV/AIDS and Life Skills policy is now more than fifteen years old and yet its implementation is still fraught with problems. Although the programme had fairly good coverage, an evaluation carried out by Government of The Netherlands in 1998 revealed that there are still some gaps in knowledge on the part of the students (Government of the Netherlands 1998). More significantly, it had not triggered the desired behaviour change among youth. The levels of knowledge about HIV/AIDS and behaviour change remained too low to produce anything approaching an AIDS-free generation (Government of Zimbabwe 2002). This suggested that current HIV/AIDS programmes were having a low impact on the behaviour of young people.

Evaluations of the programme have mainly focused on the impact of the programme in changing students' knowledge, attitude and behaviour. Where they focused on teachers, it was mainly to assess how well they were teaching the content they were supposed to teach. The evaluations concluded that there is clearly a problem in the implementation of the Life Skills Education programme. Across the region, teachers have repeatedly been found to be the weak link in the implementation of school-based programmes. Despite this, there has been very little research to explore the specific challenges that teachers face in implementing HIV programmes.

Research in the region has shown that teachers often lack the curricular time and orientation to address HIV/AIDS issues within the schools (O'Donoghue 1995). In addition, teachers rarely get the information, training and support that they need in order to be able to teach well. Often teachers will provide an overly scientific interpretation of the subject without ensuring that students have a true understanding of the factors that affect transmission of the disease, thus leaving them still unequipped to prevent becoming infected (ActionAid 2004).

But is it reasonable to expect teachers to assume this new role when they themselves are staggering from the impact of the disease? There appears to be an assumption that once teachers are given the right training and support they will become effective vehicles for contributing to the envisioned change (Visser 2004a,b). The reality of teachers is that they are individuals who are also confronted by HIV/AIDS in their daily lives. In her study of HIV-positive teachers, Zapulla (1997) witnessed that HIV-positive teachers struggle with living up to their own images of the ideal teacher, and this often forces them to keep their status a secret while at the same time battling with the many teaching responsibilities.

There is a discrepancy between the levels of responsibility given to teachers in the implementation of school-based HIV/AIDS policies and the recognition of teachers' realities. Clearly lacking is the consideration of teachers, their identities and the contexts in which they do their work. And yet, the way teachers implement a policy directive is affected by their own prior beliefs, knowledge and understanding. McLaughlin (1998) argued that when teachers are presented with changes in curriculum policy, they interpret and enact it through the unique filters of their own experiences, beliefs, personal resources, theories and context. This is supported by Visser (2004a) in her recent study on the impact of individual differences on the willingness of teachers in Mozambique to communicate about HIV/AIDS in schools and communities. Visser found that personal and contextual variables influence teachers' willingness to communicate HIV/AIDS messages in the classroom.

In this study I argue that, in a context with AIDS, there are limits to what education policy can achieve if it remains out of touch with a real world in which school is attended by children and teachers whose bodies are either infected or affected by HIV. The basis for my argument is that while the policy is about bodies and about emotions, it is blind to the bodies and emotions of the teachers implementing it. I highlight the uniqueness of the HIV/AIDS policy and its implementation which, unlike other education policies, calls for resonance between the policy-making and the policy-implementation processes.

(Visser 2004a) maintains that the way teachers understand and interpret a policy directive not only depends on their knowledge of subject matter, but also on their attitudes, beliefs and value systems. Similarly, through the study I show that it does not matter what teachers know (knowledge level) or are able to do (teaching skills); it is their sense of who they are (teacher identity) that ultimately serves as a filter of what they will do (or not do), what aspects of a stated policy they will implement (or not implement).

In this study I propose a relatively new line of inquiry which suggests that the 'policy images' of teachers make demands that conflict with their 'emotional identities' as practitioners. I follow a stream of thinking that suggests that this identity conflict might lie at the heart of the implementation dilemma in the school-based Life Skills programmes.



## Organisation of this thesis

This study focuses on HIV-positive teachers who have the responsibility of teaching HIV/AIDS and Life Skills. I will seek to establish the extent to which the vision of the ideal teacher envisaged in HIV/AIDS and Life Skills policies matches the identities that HIV-positive teachers have of themselves as practitioners. Do the official expectations placed on teachers through policy take account of the realities and identities of teachers in a world with AIDS? Are the images of what ideal teachers should be and how they should conduct themselves consistent with the personal identities of teachers living with HIV and AIDS?

**In Chapter 1**, I introduce the study, providing a background to the HIV/AIDS and Life Skills Policy arena in the region in general and Zimbabwe in particular. I identify the main research questions and provide the intellectual rationale behind the study. I conclude the chapter with an outline and organisation of the thesis.

**In Chapter 2**, I proffer a critical synthesis of the literature on HIV/AIDS and Education, with the aim of highlighting the strengths and shortcomings in the existing knowledge base. I illustrate that there is a paucity of empirical research focused at the micro level, on teachers and schools. I argue that by focusing on teachers living with AIDS, my research seeks to address this gap in scholarship.

**In Chapter 3**, I provide a detailed account of the intellectual and methodological journey that I took in conducting the study. I seek to unpack the connections between my own positionality and the research process. I present a reflexive account of the inquiry, in which I critically reflect on the knowledge produced as well as the process of producing the knowledge.

**In Chapters 4, 5 and 6**, I tell the stories of the teachers Ruva, Gift and Edwin, with the aim of exposing the qualitative contexts in which teaching and learning takes place inside schools and classrooms in Zimbabwe. I seek to give meaning to the day-to-day struggles of teachers to teach, guide, mentor, lead, counsel, manage, negotiate and share their lives inside real school environments.

**In Chapters 7 and 8**, I bring together the stories of the teachers, in an analytic frame with the aim of identifying commonalities and idiosyncrasies that could extend our

understanding of the experiences of teachers living with HIV and AIDS. Chapter 7 responds to the research question: How do images of the ideal teacher, as reflected in government policy, compare to the self-described identities of teachers in the context of HIV/AIDS? Chapter 8 is an analysis of data gathered in response to the question: How do teachers living with HIV/AIDS experience, respond to and enact government policy on HIV/AIDS in the classroom?

Finally in **Chapter 9**, I analyse the research evidence in relation to my conceptual framework. I highlight the ironies and contradictions in which HIV policy is embroiled, which result in teachers being called to implement a policy that is in conflict with their personal situations. I argue that it is this oversight that creates the wide gap between policy intentions and outcomes. I underline the uniqueness of HIV/AIDS policy and its implementation, and argue that, unlike other education policies, the HIV/AIDS policy brings the bodies and the emotions of implementers to the fore. I move on to suggest how education systems ought to be organised – in other words, to outline the implications of my findings for HIV policy and practice. Lastly I propose some unresolved questions which could form the basis for future research.

## Chapter 2

### *What is the status of the existing knowledge base on HIV/AIDS and teachers?*

#### **Introduction**

In this study I will try to establish the extent to which the vision of the ideal teacher envisaged in HIV and AIDS and Life Skills policies matches the identities that teachers have of themselves as practitioners. Do the official expectations placed on teachers through policy take account of the realities and identities of teachers in a world with AIDS? Are the images of what the ideal teacher should be and how they should conduct themselves consistent with the personal identities of teachers as practitioners in a context with AIDS?

This literature review offers a critical analysis of the existing research on HIV/AIDS and teachers. The following questions guided the development of the review:

- What is the status of knowledge on HIV/AIDS and teachers?
- What are the major strengths of the existing research?
- What are the major shortcomings in the existing knowledge base?
- How can my research contribute to and extend this existing knowledge base on HIV/AIDS and teachers?

#### **Organisation of the literature review**

In interrogating the various published and unpublished data sources, I organised the huge volume of literature into categories as substantive themes for further analysis. As a starting point, I carried out a critical synthesis of the general conceptual literature on the role of education in combating the spread of HIV and AIDS. I then reviewed the research on school-based HIV/AIDS prevention studies and teased out

the role and images of teachers as portrayed by research. Next I reviewed the studies that examine the role of teachers in the implementation of school-based HIV/AIDS programmes. Research on the impact of HIV/AIDS on teachers was analysed and, finally, I reviewed those studies that deal with how teachers cope with HIV/AIDS. For all the literature reviewed, I aimed to evaluate its strengths and shortcomings and to illuminate how teachers have been framed in the particular category of literature.

## **The role of education in combating the spread of HIV/AIDS**

Until very recently, the education and social sectors have remained on the periphery of the debates on the impact of HIV and AIDS on their respective sectors (Johnson 2000). A review of literature indicates that research in HIV and AIDS within the education sector has been influenced to a large extent by the dominant discourses within medicine, epidemiology and economics. For the most part, the existing research fails to take into account the social and cultural embeddedness of HIV and AIDS.

Little published research has been undertaken that specifically addresses the potential role of education in combating the spread of HIV and AIDS. It would appear that the available writing tends to focus on conceptualising the impact of HIV/AIDS on education systems and assessing knowledge attitudes and practices on the part of students and teachers (Coombe 2000; Kelly 2000a,b; UNESCO 2001). To its credit, however, this literature has been invaluable in drawing attention to the need for a response, forcing some recognition for action within the echelons of the Ministries of Education (Baxen and Breidlid 2004). For this reason, the review will include some of the existing published and unpublished literature on the subject of HIV/AIDS and education.

In Southern Africa the rapid spread of HIV and AIDS has had enormous consequences for education systems, and for the education process itself. A number of writings on HIV/AIDS and education have alluded to the fact that HIV/AIDS has become the largest management challenge facing education, given the way HIV and AIDS impacts on the education system (Kelly 2000a; Badcock-Walters 2002; World Bank 2002). This has seen a number of policies and programmes across the region

aimed at rescuing the education sector and unleashing the potential of schools to fight the impact of the disease. However, despite a growing level of policy actions and practical interventions in the field of HIV/AIDS and education, there is very little empirical research on the subject.

The conceptual literature on HIV/AIDS and education that I reviewed falls into two categories. First, there is a small literature base that deals with schools as important sites for education about HIV/AIDS and for transforming risk-taking behaviour (WHO 1993; UNAIDS 1999; Helland, Lexow and Carm 1999; Kelly 2002; World Bank 2002). Second, there is the literature that challenges the conception of schools as a convenient location for HIV prevention programmes and as a safe haven for pupils (Kelly 2000a; George 2001; Morrell, Unterhalter, Moletsane and Epstein 2001; Leach and Machakanja 2003). Both categories are reviewed below.

The focus on education as a crucial weapon in the fight against AIDS has been a common theme in most of the conceptual literature around the subject. In his article, aptly titled 'Defeating HIV/AIDS through Education', Kelly (2002) emphasises the need to harness the huge potential of the education sector to prevent further HIV infection, to mobilise the sector to offer care and support to those already infected, and to protect the education sector from the impact of the disease. Kelly (2002) argues that the delay in responses by the international community and the education ministries in the Southern Africa region in the 1990s resulted in the AIDS situation steadily getting worse. According to Kelly, education must play a crucial role in preventing HIV transmission because its principal beneficiaries are young people, ranging in age from infancy to young adulthood. Young people who are in schools, colleges and universities are developing the values, attitudes, knowledge and skills that will serve them subsequently in adult life. Kelly makes a case for the education sector to strengthen its response by focusing not only on prevention but also including care for those already infected.

There has been concern for preventing HIV/AIDS among the 9-14 age group – the so-called 'window of hope'. In their paper 'Education and HIV/AIDS: A Window of Hope', the World Bank (2002) argues that the education of children and youth merits the highest priority in a world afflicted by HIV and AIDS. This is because a good basic education ranks among the most effective – and cost-effective – means of HIV prevention. They assert that education has been proven to prevent HIV/AIDS

because it can equip children and youth to make healthy decisions concerning their own lives, bring about long-term healthy behaviours, and give people the opportunity for economic independence and hope. It is among the most powerful tools for reducing girls' vulnerability. It is highly cost-effective as a prevention mechanism, because the school system brings together students, teachers, parents and the community, and preventing AIDS through education avoids the major AIDS-related costs of health care and additional education supply.

Helland *et al.* (1999) argue that an important challenge for HIV/AIDS awareness programmes is to reach as many people as possible with relevant and correct information. They state that the education sector is a unique tool for HIV prevention, and that schools influence students through what they learn in the curriculum and through the values they receive including respect, gender equality and human rights. If the education sector was effectively used as a channel for promoting HIV/AIDS awareness, one could reach a very large audience because the sector enrolls an ever-increasing number of young people and huge numbers of teachers. According to Helland *et al.* (1999), HIV/AIDS awareness could reach not only teachers, administrators and pupils but also parents and surrounding community members. They argue that use of the education sector as a channel for promoting HIV/AIDS education would be cost-effective compared to other innovations, if there is sound administration and planning.

In their paper titled 'Does Knowledge Equal Change?' Badcock-Walters, Kelly and Gorgens (2004) set out to answer the question; Does HIV/AIDS education, in its widest sense lead to behaviour change? They reviewed a number of studies and analysed their findings in respect of increased knowledge, commitment to behaviour change and evidence of such change. Their review of the body of evidence confirmed that clear links exist between HIV/AIDS education and levels of awareness, and knowledge about HIV and associated risk behaviour. Badcock-Walters *et al.* (2004) argue that the cognitive and literacy skills required to make informed choices in respect of HIV/AIDS risk and behaviour change are substantially based on levels of education and literacy. They conclude that while there is still some ambivalence about the links, we cannot postpone the use of education as a channel while we wait to demonstrate more clearly whether links are present.

A common theme running through this first category of literature is the conception of schools as neutral, safe and rational organisations where interventions based on knowledge, learning the facts or negotiating skills can be deployed (Morrell *et al.* 2001). The assumption is that the learning that takes place in schools will lead to actions that stem the tide of transmission. Learners receiving the messages are viewed as rational and self-controlling agents who will act in accordance with the knowledge that they have been given (Morrell *et al.* 2001). Most of the countries in the region draw on the assumptions of this body of literature in the development of their HIV/AIDS policies and programmes.

And yet, in the literature there is controversy about whether schools can ever go beyond improving knowledge and attitudes to increasing the adoption of safer sexual behaviour (Horizons 2001). Kirby (1999) argues that in developing countries very few programmes have been associated with increases in reported behaviours that protect youth from HIV infection. This is supported by Bennel, Hyde and Swainson (2002) in their three-country study of Botswana, Malawi and Uganda where they found that there is very little hard evidence to show that school-based education has had a major impact on sexual behaviour. They found that while students at the survey schools were well informed about the causes and consequences of HIV/AIDS, it was translating this knowledge into behaviour change that remained the hurdle.

While the above writings see schools as a convenient location for HIV prevention programmes, another shortcoming is that they assume that working through the school system will reach the majority of young people. They fail to acknowledge that there are large numbers of young people who are not in school and who will not be reached by these school-based messages. The articles fail to recommend how out-of-school young people could be reached by HIV/AIDS messages.

Generally much of this writing does not take into account the cultural contexts, but assumes a universalistic language in which sexuality or self-esteem can be described (Ingham 2001). The writing does not acknowledge that learners receive the messages in much more complicated and ambiguous ways mediated by context, personal history and discourses of sexuality, masculinity and femininity (Morrell *et al.* 2001).

While the first category of literature portrays schools as safe havens where pupils are protected from any HIV-related risk, a second category of writings has disputed this view of schools as safe environments for pupils. They have argued that schools are not HIV-free institutions, as they expose children to the possibility of increased sexual activity and consequently HIV infection.

Kelly (2000b) argues that a number of circumstances in the way schools are organised and managed increase the risk of HIV infection for students, teachers and the community in which the school is based. He argues that in many of the developing countries the mixed ages in schools result in classes which contain pupils ranging from the sexually naïve and innocent to the knowledgeable and experienced; thus being at school does not necessarily mean that children are protected. Many primary and secondary school children will already be sexually active, with evidence of considerable sexually activity among street children aged eight or less in Zambia (Kelly 2000b).

A study of South African schools based on extensive interviews with learners, teachers, parents and school administrators in three provinces documents the widespread nature of sexual violence in schools (George 2001). The sexual violence takes place in schools and on the way to school, and girls are learning that sexual violence and abuse are an inescapable part of going to school every day (George 2001). This shows that schools are not simply the safe places of rational learning portrayed by the first category of literature reviewed above.

There is growing concern that significant numbers of African schoolchildren are being infected with HIV by their own teachers. A research study by Leach and Machakanja (2003) into the abuse of secondary school girls in Malawi, Ghana and Zimbabwe reveals that schools are breeding grounds for potentially damaging gendered practices where sexual aggression of girls by male pupils and teachers goes largely unpunished. In a study by Bennell *et al.* (2002), 20-36% of primary school respondents in Botswana, Uganda and Malawi felt that sexual harassment by teachers is a big problem. At secondary schools, higher proportions of both students and teachers see sexual harassment among students as a problem, with students and teachers in Malawi having marginally higher agreement rates (Bennell *et al.* 2002).





A major weakness in both categories of literature is the bias towards preventing HIV and AIDS among students and preserving the window of hope. Although teachers play an important role in teaching HIV/AIDS education, this category of literature does not pay adequate attention to them. The assumption is that teachers can and will be able to teach about deeply private, personal topics within a public space which brings their own sexuality and sexual practices into the spotlight (Baxen and Breidlid 2004). Teachers are portrayed as the vehicles for delivering the curriculum to pupils, and not much emphasis is placed on preserving the teaching workforce so as to achieve the desired goal of preventing HIV/AIDS among the 'Window of Hope'. The second category of literature gives us a view of teachers as the perpetrators of sexual violence in schools; thus we get the image of teachers as potential abusers of schoolchildren.

### **Research on school-based HIV/AIDS prevention**

The literature reveals that many countries in the region responded to the HIV/AIDS challenge by introducing policies and programmes which were to be implemented through the various Ministries of Education (Government of Zambia 1996; Gachuhi 1999; Government of South Africa, Department of Education 1999; Carr Hill, Kataboro and Katahoire 2000; Government of Botswana, Ministry of Education 2000; HIV/AIDS in Education Assessment Team [HEAT] 2002). The school-based programmes were aimed at providing youth with knowledge and skills to protect themselves from infection, and this was to be done under the guidance of adequately trained teachers (Gachuhi 1999).

According to the literature, HIV/AIDS education was introduced using the Life Skills approach (Gachuhi 1999; Boler and Aggleton 2004). This approach has been used for sexual health education at programme and policy level in Africa, Asia and Latin America (Seabrooke, 2000). The World Health Organisation (1993:2) defines life skills as "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". Life Skills Education aims to enhance already positive and healthy pro-social characteristics of the majority of young people and to prevent or reduce risks to health and other aspects of development through reducing myths and misinformation, harmonising negative

or antisocial attitudes and preventing or reducing risky or harmful behaviour (UNICEF 2000).

There is significant literature from developed countries which demonstrates that well-implemented school-based prevention efforts can influence key HIV/AIDS-related risk factors and conditions (Barnett *et al.* 1995; Oakely, Fullerton and Holland 1995; Seabrooke 2000). Research has shown that well-implemented school-based prevention efforts can influence key HIV/AIDS-related risk factors and conditions. They can delay the age of first sex, increase the use of condoms among young people who are sexually active, reduce the number of sexual partners, and increase health, safety and security on school grounds and within the community (Irvin 2000; Smith, Kippax and Aggleton 2000).

However, such evidence from developing countries is scarce and contradictory, partly due to programmes being poorly or incompletely implemented (Kelly 2000b). Sex education programmes have often proved to be incompletely implemented, with certain areas superficially covered. Underpinning these school-based interventions is an assumption that giving knowledge to the students will lead to behaviour change. Baxen and Breidlid (2004) argue that there is a dissociation of the interface between sexual identity, education, and HIV and AIDS. What is left unattended, they argue is the deeply complex nature of the social and cultural discursive field in which youth receive and interpret HIV and AIDS messages.

Klepp *et al.* (1994) found that in Tanzania AIDS education of primary school children had no impact on their attitudes towards sexual intercourse. The Soweto Reproductive Health Programme in South Africa proved to be more effective in changing beliefs related to pregnancy prevention than those related to STI/HIV and sexual behaviours (Meekers, 1998). An evaluation of the Zimbabwe Life Skills Programme by the Government of The Netherlands (1998) revealed that although the programme had fairly good coverage, there were still some gaps in knowledge on the part of the students. More significantly, the programme had not triggered the desired behaviour change among youth. The evaluation concluded that the levels of knowledge about HIV/AIDS and behaviour change remained too low to produce anything approaching an AIDS-free generation. This suggested that current HIV/AIDS programmes had a low impact on behaviour of young people.

The study of Seabrooke (2000), which explored the path from policy to practice of sexual health education in Zimbabwe, was aimed at identifying barriers to programme implementation and key elements for success in the implementation of school-based sexual health programmes. She found that although the programme had been compulsory in schools since 1993, the coverage was low and teacher training had failed to equip teachers with the skills necessary to deliver the lessons.

According to a study by Horizons (2001), while the Zimbabwe AIDS curriculum was very comprehensive in addressing important social, health and gender issues, it proved to be extremely demanding for teachers. It over-estimated the capacity of classroom teachers to be comfortable facilitating frank and open discussions on sex, sexuality, gender relations and HIV/AIDS in a society that still found the topics culturally inappropriate. The curriculum did not address important issues such as student-teacher relationships and how the teacher's own sexual behaviour and HIV status would affect participation by the students. It did not address the possibility of community disapproval of a programme, introduced with little or no prior consultation, that would engage children in discussions on sex and cultural norms and perceptions (Horizons 2001).

In South Africa research done in some schools revealed that the majority of school-based HIV/AIDS initiatives have not been successful. Life Skills programmes have not been implemented in some schools, particularly in rural areas. Where they have been implemented, educators were reluctant to talk openly about sexuality issues (Education Policy Consortium 2001). Research by Bhana, Brookes, Makiwane and Naidoo (2005) on the impact of the Life Orientation on sex, sexuality and HIV/AIDS in Gauteng schools revealed that although principals and teachers reported that all grades had lessons on sex, sexuality and HIV/AIDS, 10.6% of learners reported that they had had no lessons on these topics. In the same study, just over half of the educators reported that they had received some training from the Department of Education in the Life Orientation programme.

Another study in South Africa by Ntuli *et al.* (2000) aimed to review HIV/AIDS and Life Skills Education in secondary schools and to assess the attitudes of teachers and principals towards sexuality. The study revealed that, although teachers were concerned about HIV/AIDS and sexuality, they lacked the skills to deal with the issue at school level. The respondents also felt that the school-based prevention

programmes should be targeted at both students and teachers, as opposed to focusing on students alone.

In 2003 the Medical Research Council of South Africa and the Horizons programme commissioned a study aimed at establishing whether school-based prevention could influence the behaviour of students as well as their knowledge and attitudes. Reddy, James and McCauley (2003) studied the Grade 9 Life Skills curriculum in KwaZulu-Natal province. They concluded that the Life Skills curriculum had had a positive impact on students' knowledge about HIV/AIDS attitudes about abstinence and intentions to use condoms. There was, however, no evidence of increased adoption of such protective behaviours as abstinence and condom use. This was linked to the fact that the teachers did not focus as strongly on the life skills components as on the factual HIV/AIDS information. The study recommended that more attention be placed on helping teachers cover the life skills components.

In Zambia, Malambo (2000) carried out a case study on the views of teachers and pupils with respect to the teaching of HIV/AIDS in basic education. Malambo found that although the Ministry of Education had a clear policy on the integration of HIV/AIDS into school curricula, several problems were faced with the implementation. There were no teaching and learning materials accompanying the policy. Teachers indicated that they had received inadequate training to prepare them for teaching HIV/AIDS. In addition, Malambo found that teachers were shy and were not open when discussing issues on sex. Teachers' shyness and lack of openness was justified by Chiwela and Mwape (1999) as being related to the fact that in Zambian society, it is inappropriate to discuss sex with younger people.

In most of the countries in Southern and Eastern Africa development of HIV/AIDS and education policies and programmes has been largely driven by donors, often with little initiative from the host governments. This is because donors usually have the financial power and influence over government policy. Boler and Aggleton (2004) argue that the lack of implementation of HIV/AIDS policies can be attributed in part to the donor-driven nature of the policies, which results in very little commitment and ownership from the host country. As a result many Ministries of Education may not give the policies sufficient priority in terms of policy development, capacity building or effective implementation. Government will often take on the policy without thinking through the implications, mainly because they

want to be seen to be doing something about the HIV/AIDS situation in their countries.

This assertion is supported by Chilisa (2005) in her paper critiquing HIV/AIDS research in Botswana. She argues that most countries in Southern Africa fail to participate as equal partners in the search for solutions to HIV/AIDS because donor agencies and research funding institutions define the global agendas. The postcolonial critique offered by Chilisa (2005) holds that Western theories and methods obscure and distort African realities and experiences of HIV/AIDS – colonial ways of thinking and agendas that do not resonate with the priorities of the Africans. As a result, she argues, such foreign research frameworks end up alienating the very people they claim to assist. While the article lacks a strong base to support the strong ideological position against the domination of Western thought in developing contexts, it makes a valuable observation about the privileging of teachers in international donor agendas on HIV/AIDS to the exclusion of other equally devastated actors such as poor women. Consequently, teachers are represented in donor policies and programmes as victims of HIV/AIDS for whom some kind of intervention is required.

The research on the impact of school-based programmes has been valuable in determining what works in school-based preventive education for pupils. It has been useful in guiding government response on school-based prevention issues. However, very little of the research has been devoted to the implementation of HIV/AIDS in the classroom. There has been very little focus on what is happening at the chalk-face, in schools and classrooms (Baxen and Breidlid 2004). In the few cases where the research has focused on teachers, it has been to determine what teachers know, on identifying possible misconceptions and on whether they have been teaching the content that they are required to teach.

The majority of research on school-based prevention programmes has failed to look at teachers as persons who are confronted by the disease daily in their personal and professional lives. Some teachers are already infected, some have lost relatives and some have to cope with covering for colleagues who are absent from classes for long periods of time. All this puts considerable strain on teachers who are supposed to be delivering the HIV/AIDS curriculum to their pupils.

The foregoing discussion has elucidated the shortcomings in the research on school-based prevention and has pointed at the crucial role that teachers play in mediating the learning process for students. The discussion has also highlighted a major shortfall of school-based policies and programmes – that they failed to understand teachers’ realities and the influences that shape what goes on in the classroom (McLaughlin 1998).

## **Research on the role of teachers in the implementation of school-based programmes**

A review of studies on the implementation of school-based prevention programmes reveals that since the programmes were introduced more than a decade ago, teachers have often been found to be a weak link in the implementation process (Government of Zimbabwe 1993b; O’Donoghue 1995; Ntuli et al 2000; Seabrooke 2000; Education Policy Consortium 2001).

Uganda was one of the first countries to implement a school-based HIV/AIDS programme in 1987. The programme was designed to complement AIDS prevention issues with other health promotion activities. The underlying principle was that if children were provided with proper information, then behaviour change would follow. O’Donoghue (1995) reported two main problems with the Ugandan project. First, simply providing children with information did not automatically lead to behaviour change. Secondly, it became apparent that teachers proved to be the weakest point in the whole process. They were often untrained, hence uncomfortable dealing with information about HIV/AIDS and other sexually transmitted diseases (STDs). To make up for their discomfort they focused on other health topics and either ignored HIV/AIDS/STDs completely or else dealt with them superficially (O’Donoghue, 1995).

A baseline study carried out in Zimbabwe at the start of the school-based AIDS Education Programme found some knowledge gaps on the part of the teachers (Government of Zimbabwe 1993b). The study found that while teachers were in favour of teaching prevention education, they had mixed feelings about people with AIDS, with one-third of the teachers thinking that AIDS was a disease for promiscuous people. More than 40% of teachers indicated that they were

uncomfortable with the prospect of social contact with people with AIDS. If teachers are to help students develop positive attitudes towards people living with HIV/AIDS then they need to develop positive attitudes themselves (Government of Zimbabwe 1993b).

An evaluation of the second phase of the Zimbabwe HIV/AIDS Life Skills Project, carried out in 2004, found that regardless of the mode of training adopted, the training of teachers did not reach all schools and, where it did, the school-level training was limited. The evaluation argued that inadequate training of teachers contributed to ineffective project implementation and negative attitudes of some teachers (Chavunduka *et al.* 2004).

In a survey carried out in Zambia to ascertain teachers' knowledge, attitudes, practices and skills in the teaching of HIV/AIDS prevention and psychosocial life skills, 25% of the teachers acknowledged that they did not understand HIV/AIDS and psychosocial life skills, and felt unqualified to teach the subject. Approximately 30% of the teachers thought that sex education led to promiscuity among students. Some teachers admitted to worrying about their own HIV/AIDS status, while some (40%) admitted they would like to talk to somebody about their own HIV status (Chiwela and Siamwiza 1999).

A study by ActionAid (2004) in Kenya revealed that about half the country's 240 000 teachers reported not having received any training on HIV/AIDS. Where there has been training, the teacher training programmes have rarely been comprehensive or systematic enough to deliver adequate skills and materials to practising teachers. As a result many teachers feel unprepared to teach HIV/AIDS and Life Skills Education. The ActionAid (2004) study was aimed at elucidating how HIV/AIDS education is implemented and received by schools in India and Kenya. Their major finding was that attempts to deliver HIV/AIDS education in schools is severely constrained by the existing social and cultural restraints in discussing HIV/AIDS, sexual relations and power inequalities. The result was that HIV/AIDS messages are either not communicated at all or are taught selectively. The majority of teachers in both countries reported that they had never been on a training course on HIV/AIDS (ActionAid 2004).



In her study in Mozambique Visser (2004) found that age, personal experience with HIV/AIDS and level taught are among the attributes that have a consistent impact on teachers' intentions to talk about HIV/AIDS. According to Visser (2004) teachers were more likely to talk about AIDS if they consistently used condoms and had a higher perception of personal risk.

In Ghana, World Education commissioned a study aimed at developing an up-to-date picture of the HIV/AIDS knowledge, attitudes and behaviour of teachers participating in HIV/AIDS education programmes (Adamchak 2005). This baseline study explores teacher's willingness to participate in HIV/AIDS programmes in schools, their knowledge and capacity, and the magnitude of their personal risk-taking. The study found that although teachers were willing to help with HIV/AIDS education efforts, not many had been trained to provide HIV/AIDS education. The study also found that teachers were reluctant to talk about and demonstrate the use of condoms, and that they believed that exposure to condoms promoted promiscuity. The study found that teachers expressed ambivalence about interacting with people who might be HIV-positive. Risk-taking among teachers themselves was low but present, and the majority of teachers perceived schools as safe and secure places for students, although a small minority acknowledged inappropriate behaviours such as harassment and abuse (Adamchak 2005).

More than a decade since the inception of school-based programmes, studies still point to the fact that teachers are a weak link in the system. Initial studies recommended training as a way of better equipping teachers to deal with HIV/AIDS; while this has led to some positive changes, it has not substantially improved the quality of school-based programmes.

In education, research has neglected to examine how teachers' attitudes and perceptions of the disease affect their role in teaching HIV/AIDS education. In the developing world, little research has been done to understand the individual and contextual factors that affect the interpretation teachers have of their role in combating HIV/AIDS and how this affects their practice as teachers. There appears to be an assumption in much of the literature that, given enough time, training and curricula space, teachers will be the right vehicles to deliver HIV/AIDS messages to pupils (Visser 2002).



## Research on the impact of HIV/AIDS on teachers

The most prolific studies on HIV/AIDS in developing countries can be described as impact studies. Throughout the region, a number of these studies have been conducted to examine the impact of HIV/AIDS on the education sector (Bennell *et al.* 2002; HEAT 2002; Badcock-Walters *et al.* 2003). Using a range of quantitative methods, these studies offer detailed analysis of how many teachers are infected and affected by the virus, and the educational consequences of such impacts on schools and students.

Most of the impact studies have acknowledged that teachers have been severely affected by HIV and AIDS. According to Kinghorn (2002), teachers will often be personally affected by HIV/AIDS through the incidence of HIV/AIDS among their colleagues and also by fear and uncertainty regarding their own status. He argues that this is an important area for teachers, but it is also an area where they receive very little support.

There are two schools of thought in the literature regarding the vulnerability of teachers to HIV/AIDS as compared to the rest of the population. There is colloquial debate on whether teachers' risk of contracting HIV/AIDS is higher than that of the rest of the population (Bennell 2001; Kelly 2003).

For teachers, higher risk is seen almost exclusively as a result of higher incidence of unsafe sex as compared to the rest of the adult population. Four main explanations for why teachers are more prone to high-risk sex can be found in the literature: high social status, income, mobility and spouse separation (Economic Commission for Africa [ECA] 2000; Kelly 2000b; UNICEF 2000). In her 2000 study, Coombe cites teachers as one of the population groups especially at risk because they are educated, mobile and relatively affluent.

Whereas mobility and spouse separation are occupational specific characteristics, higher status and income are more universal. Both sets of factors are seen to be mutually reinforcing (Bennell *et al.* 2002). Teachers are often separated from their spouses because of lack of suitable accommodation and in some cases the reluctance of spouses to live in remote areas. This might lead to teachers having more sexual

partners than less-mobile population groups. All this is further compounded by the fact that teachers (although not the best-paid of civil servants) usually have more disposable income than other members of the community. This gives them more power in the community and it enables them to engage in high-risk behaviour such as commercial sex (Kelly 2000b; Shisana, Peltzer, Zungu-Dirwayi and Louw 2005).

Teachers enjoy high status, authority and power in the school and in the community. In some cases they will use their position to sexually abuse students, thus increasing their risk profile (Bennell 2001). There are also cases where some students and community members will try to entice teachers into relationships because of their higher income.

In Botswana a study on the impact of HIV/AIDS on primary and secondary education found high mortality rates among teachers. Although the study did not have data on actual prevalence of HIV/AIDS among teaching staff, it found from a variety of sources that deaths among teaching and other Ministry of Education staff accounted for at least one-half the overall adult mortality rates. Mortality rates among male teachers were almost double those of female teachers, and were three to four times higher among primary teachers than secondary teachers. The study found that teacher mortality accounted for one-third of all attrition (Government of Botswana, Ministry of Education 2000)

A study in Zambia showed that the mortality rate among educators in 1996 was 39 per 1 000, 70% higher than that of the 15-49 age group in the general population (Government of Zambia, Ministry of Health 1997). These deaths are equivalent to the loss of two-thirds of the annual output of newly trained teachers from the teacher training institutions in Zambia (Kelly 2000b).

In Zimbabwe, a study on the impact of HIV/AIDS on the education sector concluded that teacher infection levels were very similar to those of other adults (HEAT 2002). The projections suggested that around one-third of all teachers in Zimbabwe were infected with HIV, and this was likely to rise to a plateau of about 40% in the absence of behaviour change among teachers. However, these were only crude projections given the lack of HIV sero-prevalence data for teachers. In addition, no representative data was available on the age, gender and geographic distribution profile of education employees (HEAT 2002). Discussions with teachers during the

fieldwork suggested that teachers are at significant risk. Not all teachers had been targeted by HIV/AIDS prevention programmes and many only had basic knowledge and awareness around HIV/AIDS (HEAT 2002).

Findings from a study by Shisana *et al.* (2005) in South Africa suggest that about 12.7% of educators in that country are affected by HIV/AIDS, and this is a much higher prevalence than in countries such as Senegal, Nigeria and Ghana. This study indicates that the HIV prevalence among South African educators may reflect that of the community in which they live. Throughout the region, educators are responsible for imparting HIV/AIDS knowledge to learners through Life Skills programmes. It is reasonable to expect their HIV prevalence to be lower than that of the general population. However, the fact that educators have a similar if not higher risk of acquiring HIV as the general population suggests that the Life Skills programmes have failed to contribute to sexual behaviour change among educators. It would seem that the knowledge alone is not sufficient to produce behaviour change among teachers (Shisana *et al.* 2005).

In their three-country study of Botswana, Malawi and Uganda, Bennell *et al.* (2002) argue that although the epidemic will seriously impact the teaching profession, there is insufficient hard data to support the assertion that teachers are a high-risk group. They argue that most of the studies treat teachers as a homogeneous group, yet the teaching profession across Sub-Saharan Africa is a very diverse group whose marital status also varies markedly. The difference, according to Bennell *et al.* (2002), is the degree to which it is possible to generalise about their sexual behaviour.

In some studies the higher infection rates found in the teaching profession could be explained by the age and gender profile of teachers, who may have a greater representation of younger and female members than comparison groups (HEAT 2002). In a study in South Africa, gender differences in HIV prevalence were observed among the 25-34 age group, where females had higher prevalence rate than males (Shisana *et al.* 2005). However, this is not always the case; for instance, the Bennell *et al.* (2002) study indicates that mortality rates among male teachers in Tanzania are two to three times higher than among females. It would appear in some instances that male teachers are more likely to engage in high-risk sexual behaviour than their female colleagues.

In a discussion paper on the current approaches to examining the impact of HIV/AIDS on teachers, Boler (2004) argues that there are a number of methodological limitations to the quantitative methods used for impact studies. In some cases the data is unreliable and limited unless it is placed in context, making it difficult to generalise about the exact impact of HIV/AIDS on teachers. It is clear that the impact will be felt differently in different contexts depending on how mature the epidemic is and what wider educational reforms and policies exist to mediate the impact (Boler 2004).

A weakness of the quantitative research on the impact of HIV/AIDS on teachers is that the writings typically lack any qualitative portraits of and insights into the lives of teachers with AIDS. Rather it provides generalised and universal statements of impact on teachers, summarised in statistical formats. Moreover, teachers are presented in such research studies as the targets of HIV/AIDS, as those whom the disease impacts and as involuntary subjects at the end of a viral cycle. We lose the sense of teachers as individuals with feelings and emotions, and as persons who interact with pupils on a daily basis.

In the body of research reviewed there is a stark lack of research that focuses at the micro level, on teachers and schools. Baxen and Breidlid (2004) argue that there is a dearth of research that considers teachers as producers, interpreters and reproducers, mediators and purveyors of knowledge and safe sex messages, who work within fields where this knowledge is considered secret or private. They make the following observation:

*Where teachers have been subjects of research, they have been positioned as deliverers of an uncontested, already negotiated body of HIV/AIDS knowledge within spaces (schools and institutions) that are unproblematic. In this regard, teachers have consequently been targets of training programmes that have largely portrayed them as lacking knowledge and skills to teach life skills or sex education programmes effectively (Baxen and Breidlid 2004:17).*

Embedded in the bulk of the research is the assumption that teachers are HIV-free, and so they are considered as objects in a system rather than as individuals who work in contexts in which they are contributors, negotiators and mediators (Baxen and Breidlid 2004).

## Studies on how teachers cope with HIV/AIDS

In developing countries there is a dearth of studies on how teachers infected and affected by HIV and AIDS cope. In particular, the educational literature has been peculiarly silent about the experience of teachers with AIDS. Few studies have taken into account teachers' lives as a key mediating factor in the teaching of HIV and AIDS education. This section will review the few studies that have looked at how teachers cope with HIV/AIDS.

In Mozambique, a study by Visser (2002) provides personal accounts of the impact of HIV/AIDS on teachers' lives and their work. Teachers emerge as researchers themselves, actively seeking to understand the manner in which HIV/AIDS affects their contexts. In this study teachers reflected on their feelings about HIV/AIDS; these included the following: fear sadness despair, enormity and blame. Teachers in the study suggested that it was important to provide positive examples of people coping with HIV/AIDS through the media (Visser 2002).

A study in Botswana by Garagae (2005) explored ways in which teachers salvage themselves while empowering students. It sought to elucidate the dilemmas that teachers battle with when teaching in an HIV/AIDS context. This study based its theoretical framework on Combs's (1965) concept of the self as an effective teacher, which suggests that a teacher must feel fulfilled or adequate in order to enter into a positive relationship with students. Garagae found that teachers in a context with AIDS are faced with contradictions of whether to become health workers, caregivers or both. This dilemma, he found, is worse when teachers have to take on a dual identity of being sick and being caregivers at the same time (Garagae 2005: 9).

In her study of three HIV-positive teachers, titled *Suffering in Silence*, Zapulla (1997) gives true accounts of HIV-positive teachers who suffer in silence for years for fear of being isolated in their workplaces. She exposes the private ethical conflicts with which teachers struggle as they move between their desire for openness and the fears that drive them into hiding and secrecy. She explores how they struggle with living up to the images of the ideal teacher and how this forces them further to hide their secret. All this places a terrible emotional and psychological burden on the teachers. For the teachers, their personal struggles with AIDS revealed a number of feelings including fear, loneliness, isolation, denial, victimisation, loss of identity,

shame, and judgement. In all three case studies, the image of the teacher as ideal role model and perfect citizen comes out strongly. Their own perception of self as good teachers versus persons affected by AIDS often presents a personal conflict (Zapulla 1997).

## **Teacher images portrayed in public documents**

In this section I will explore how teachers are conceptualised in government policy and programmes through the various policy documents. In order to expose the teacher images portrayed in public documents, I analysed the key policy documents that are of significance in the HIV/AIDS and education policy arena in Zimbabwe (see Appendix Two). This analysis of documentation from the key players in the education sector was important as it proffered an understanding of the expectations placed on teachers by the school community, the government and the international community.

The main document outlining the Ministry of Education, Sport and Culture's policy on HIV/AIDS is the Chief Education Officer's Circular Number 16 of 1993. This policy instruction, which was later cancelled and replaced by the Director's Circular Number 2 of 2003, is complemented by the Director's Circular Number 3 of 2003 and the Secretary's Circular Number 5 of 2000 which deals with the prevention and management of child sexual abuse. These policy documents were selected because they most explicitly describe and prescribe how teachers teaching HIV/AIDS and Life Skills Education should understand their job. Another policy documents of relevance to the education sector is the Zimbabwe National Behavioural Change Strategy for the Prevention of Sexual Transmission of HIV, 2006-2010 (Government of Zimbabwe 2006). It emphasises the role of schools in preventing HIV among pupils.

The policy documents can be understood to reflect the voice of the main political actor within the educational discourse in Zimbabwe – that is, the Ministry of Education, Sport and Culture. They are not in any way representative of the views of other actors within the educational discourse in Zimbabwe. The documents are therefore indicators of the value system operating within the Ministry of Education, Sport and Culture in Zimbabwe and they represent a powerful voice within the

educational discourse where teachers operate. The education policy documents confront teachers with descriptions of functions, regulations and expectations on how to conduct their job. It is these messages from policy makers, which are transmitted through policy, that determine the curricula messages that filter down to the classrooms.

The most significant of the policy documents is the Chief Education Officer's Circular Number 16 of 1993 (Government of Zimbabwe, 1993a). This circular is the first document that introduces the teaching of HIV/AIDS in schools. It emphasises why HIV/AIDS education should be taught in schools, how and when it should be taught, and who should teach it.

This circular and subsequent circulars clearly outline the expectations placed on educators in order for them to fulfil their role as facilitators of the learning process. The documents are punctuated with statements such as, "Teachers are expected to use participatory and learner-centred methodologies..." (Government of Zimbabwe, 1993a:2) and "Heads and teachers are also expected to assist children affected by the pandemic" (Government of Zimbabwe, 2003a:3). Similarly, the Zimbabwe National Behavioural Change Strategy for the Prevention of Sexual Transmission of HIV (2006-2010) places an emphasis on the role of schools in HIV prevention for pupils:

*Schools will therefore be equipped to promote life and negotiation skills as well as educate about all effective HIV prevention methods including abstinence, faithfulness and condom use (Government of Zimbabwe 2006:19).*

The various policy documents clearly pronounce the rights of children, as well as the obligation of teachers to create an AIDS-free generation and to assist children affected by the pandemic. The role of teachers emerges as that of facilitators and mediators of this learning process.

Conspicuous by its absence in most of the documentation is consideration of teachers as a potential target group for the HIV and AIDS interventions. In the few instances where teachers are mentioned, it is in the context of giving them support for professional development (Government of Zimbabwe, 2003a). While the policy proffers an expanded role for teachers in the implementation of the HIV/AIDS education programme, it does not consider how teachers in an AIDS context will



interact with the policy and how this will impact on the policy implementation process.

## **Summary of review**

Through this review, I have traced the trends in research on HIV/AIDS and education over the past two decades. I argue that while the bulk of the research conducted so far has been useful at policy and advocacy level, there has not been adequate investment in a critical examination of the place called 'school' (Jansen 2007). There is little in-depth research that documents fully and vividly life in schools during and through the HIV and AIDS pandemic.

In particular, the studies conducted so far have mostly assumed a positive correlation between knowledge and behaviour. The underlying assumption has been that schools have a captive audience which is assumed to be sexually inactive, especially at primary school level. Consequently, it is mostly high school children who have been the target of interventions. In the same vein, teachers have been assumed to be HIV-free beings who are able to teach private and personal topics without fear or worry about how their own sexuality impacts on the teaching process. And yet it has been reported in a number of studies that teachers have reported embarrassment and ill-preparedness to talk about sex with young children (Chiwela and Mwape 1999; Malambo 2000, Baxen and Breidlid 2004).

The research has neglected the situated context in which messages, knowledge, experience and practice are produced, reproduced and expressed (Baxen and Breidlid 2004). It has left unattended the cultural and social context within which youth receive and interpret the HIV and AIDS messages. In a 2002 article, Cohen describes the context of education programmes; this includes school environments that are not safe and child-friendly, where there are conflicting messages on HIV and AIDS between home and school and where images of masculinity are associated with promiscuity. Consequently, even where knowledge is readily available, it does not necessarily protect young people who are constructing their sexual identities within contexts that produce, reproduce and send conflicting messages (Skinner 2001).



Sexual abuse is yet another dimension of school life that receives little attention in education policy and research. It has been shown by a number of studies that sexual relationships between teachers and students are common, and that they contribute to a very dangerous liaison in the school. As Jansen (2007) argues, HIV/AIDS is not only what infected adults and children bring into the school; it is also a pandemic that recreates itself within the school.

Lastly, few of the studies have considered the qualitative contexts in which teachers do their work or examined teachers' lives as a key mediating factor in the delivery of HIV and AIDS messages to pupils. According to Baxen and Breidlid (2004), it would seem that it is assumed that if teachers have the necessary knowledge and skills, they will want to teach effectively, notwithstanding how they position themselves within the AIDS discourse.

A few studies have considered teachers as professional or social actors in a context with HIV and AIDS, but I did not find any work in a developing country context that looked at teachers as emotional actors in an AIDS context. Furthermore, the literature reviewed was silent on the experiences of teachers infected by HIV and AIDS.

In this study I will make the case that the ideal teacher envisaged in the HIV/ AIDS and Life Skills policies conflicts with the identities of HIV-positive teachers as practitioners. Often the official expectations placed on teachers through the policy documents do not consider the realities and identities of teachers in a world with AIDS. The image of what ideal teachers should be and how they should conduct themselves is very often in conflict with the personal identities of teachers as practitioners (Jansen 2001).

The added value of this study is that I take as my starting point teachers living with AIDS. I wish to explore the qualitative context within which HIV and AIDS policies and programmes are implemented on a day-to-day basis. Through this study I wish to extend the existing research by initiating a line of enquiry that explores how teachers as emotional actors experience, understand and respond to government policy on HIV/AIDS education in schools. I argue that it does not matter what teachers know (knowledge level) or are able to do (teaching skills); rather, it is their sense of who they are (teacher identity) that ultimately serves as a filter of what

they will do (or not do), and what aspects of a stated policy they will implement (or not implement).

## **Conceptual framework**

The aim of this study is to examine the possible discrepancy between policy visions and teacher identities in a context with AIDS. In my attempt to frame this study theoretically, I will explore the two major fields of knowledge that play a key role in defining this study. I will look at policy visions/images of teachers as portrayed by government, donors and communities, and I will explore how this relates to with the self-ascribed identities of teachers living with AIDS. I will argue that it is the discrepancy between policy visions and teacher identities that has contributed to problems in the implementation of HIV/AIDS policy.

## **Policy as ‘shared vision’ (or not)**

Policy occupies the very first stage of the decision-making process where fundamental options or choices are made from a plurality of futures. Harman (1984) defines policy as a position or stance developed in response to a problem or issue and directed towards a particular objective.

Harman’s definition tends to be oversimplified and it has several shortcomings if one considers how policy works in practice. It gives one the impression that there is general agreement when policies are generated and that policy implementation is straightforward and unproblematic. It reflects a functionalist assumption of how society works – that is, that society is underpinned by a value consensus and that the various institutions in society contribute towards the ongoing stability of the whole (Taylor, Rizvi and Lingard 1997).

In contrast to Harman, other authors’ views of society draw on a conflict approach, which sees society as consisting of competing groups having different values and access to power (Taylor *et al.* 1997). They proffer a definition of policy which reflects the political nature of policy as a compromise which contested at all stages by competing interests. They argue that policies are dynamic and interactive, and

that they represent political compromises and conflicting images of how educational change should proceed.

In developing policy there are always competing interests, and sometimes the policy process will represent compromises. Ball (1998) defines policy as the authoritative allocation of values in recognition of the fact that policy is never value-free and that power and control are central to the policy process. There are always debates in the policy process about whose values and visions are allocated in the policy and whose interest the values and visions represent.

Taylor *et al.* (1997) argue that it is the dominant groups in society that are more likely to influence government in their exercise of power. Certain groups will achieve formalised, institutionalised access to policy making. In other words, there will always be political struggles over whose voices will be heard, and whose values and visions will be reflected in policy. This is supported by Ball (1990:22) when he comments, "Policies embody claims to speak with authority, they legitimate and initiate practices in the world, and they privilege certain visions and interests."

The argument of Taylor *et al.* (1997) is in line with the elite/mass model (Hanekom 1987), which assumes that in any society there are a few people who take responsibility for guiding group behaviour. When they enact a policy, the elite purport to represent the masses. However, in reality it is the elite who shape the opinion of the masses. Sutton and Levison (2001) argue that in this model the less powerful actors – teachers, students and parents – are seen as adjusting their expectations, thus challenging the coherence of educational policy.

In most of the countries in Southern and Eastern Africa, the development of HIV/AIDS policies has been largely driven by donors, often with very little initiative from host governments. This is because donors usually have financial power and influence over government policy. Boler and Aggleton (2004) argue that the lack of implementation of HIV/AIDS policies can be attributed in part to the donor-driven nature of the policies, which results in very little commitment and ownership from the host government. As a result many Ministries of Education may not give sufficient priority to policy development, capacity building or effective implementation of certain policies. This assertion is supported by Chilisa (2005) in her paper critiquing HIV/AIDS research in Botswana. She argues that most countries

in the region fail to participate in the search for solutions to HIV/AIDS because donor agencies and research funding institutions define the global agendas. In other words, policy images of teachers in AIDS contexts might very well come from sources external to African countries.

Teachers serve as the medium through which policy results become apparent, because they carry policy into classrooms and deliver it to pupils. In other words, teachers mediate between education policy and practice. However, an analysis of much of the literature on education policy and practice reveals that there appears to be less emphasis on the actual practice than on the policies and systems. Reid, Brain and Bowles (2005) argue that it is obvious that policies are mediated by teachers within their schools, thus indicating the need for an examination of the mediation process. They stress that the successful implementation of policy depends on finding an appropriate strategy or model of policy construction that utilises teachers' professional knowledge, skills and values rather than one that fails to recognise them (Reid *et al.* 2005).

In the development of HIV/AIDS and Life Skills policy, the question to ask is: to what extent have teachers' opinions, feelings and emotions been sufficiently incorporated? If teachers feel that the policy makers represent them sufficiently, or that their opinions and emotions have been sufficiently acknowledged in the policy development process, then they will attach legitimacy to the policy. But do the policy makers acknowledge that teachers are emotional actors? Do they believe that teaching is an emotional act?

HIV/AIDS is an emotional issue, and teaching is more than a mechanical act; it is an intensive human activity, a transmission of values, a meeting point of feelings and an exchange of deep emotions. An understanding of teachers' emotions while implementing reforms can provide a deeper understanding of the ways teachers experience their work and educational change (Van Veen, Slegers and Van de Ven 2005).

For a reform to change the core of teaching and learning, affective meaning-making processes need to occur for teachers (Shmidt and Datnow 2005). Teachers will typically support a reform when they find that their ideologies are consistent with the reform. When teachers feel that their interests, beliefs and values are threatened

by a reform agenda, however, then they may resist the change. Fullan (1993) argues that innovations have a better chance of success when teachers feel some ownership of the change process.

Spillane, Reiser and Reimer (2002) argue that teachers' prior knowledge affects sense making, pointing to how teachers arrive at different interpretations of the same policy messages, sometimes even misunderstanding the policy intent. Values and emotions therefore affect the sense-making process and highlight how teachers are often biased towards policy interpretations that fit (or do not fit) their prior beliefs and values.

Through this study I will underscore the centrality of emotions in teacher action. I will propose that teachers participate in the policy process as whole beings, and that once an aspect of their identity is ignored there is a problem with implementation. Hargreaves (2001) argues that reform efforts seldom address the emotions of teachers. For a reform to change the core of teaching and learning, affective meaning-making processes have to happen for teachers.

Emotions are an overlooked and understudied aspect of the sense-making process of reform (Spillane 2002). This study will further explore the role of emotions in teachers trying to make sense of HIV/AIDS policy. It will seek to illuminate how teachers as emotional actors experience and respond to HIV/AIDS policy and how they understand their capacity to handle the emotional demands placed on them by a policy directive.

HIV/AIDS is a very sensitive issue which can only be partly addressed through legislation and policy. Legislation merely provides a framework for action; on its own it cannot constitute a sufficient basis for full compliance nor can it ensure compliance. HIV/AIDS involves many complex issues, many of which fall in the private sphere, thus often defying policy interventions. While one can legislate or 'police' group behaviour, the same cannot be done for covert behaviour that is buried deep in the minds and emotions of individuals.

## **Teachers as emotional actors: An alternative model for explaining teacher behaviour**

Through this study I will underscore the centrality of emotions in teacher action. I propose that teachers participate in the policy process as whole beings, and that once an aspect of their identity is ignored there will be problems in implementation. Hargreaves (2001) argues that reform efforts seldom fail to address the emotions of teachers. For a reform effort to change the core of teaching and learning, affective meaning-making processes have to happen for teachers.

Most research on teachers' reactions to change displays this in rather cognitive, rational terms that fail to articulate the layers of emotion involved. Van Veen *et al.* (2005) argues that an analysis of emotions should provide deeper insight into the way teachers experience change and the way their identity and commitment is affected by change.

Ketner and Elkman (2000) define emotions as brief, rapid responses involving physiological, experiential and behavioural activity that helps humans respond to survival-related problems and opportunities. Emotions occur in the interaction between the individual and the social environment, and are defined as the product of the appraisal of those environmental events that are perceived as most relevant to the individual's goal and well-being (Oatley 2000). Oatley's perspective provides insights into what individuals have at stake with the environment or in life in general, how they interpret self and world, and how they cope with harm, threats and challenges (Lazarus 1991).

According to Hargreaves (2001), the processes that give rise to emotions are interpersonal and relational. Interpersonal relations are embedded in people's actual remembered and imagined interactions with others (Hargreaves 2001:103). Relational implies that emotions always concern person-environment relations which can change with circumstance over time and so give rise to different emotions.

In this study I draw upon concepts from sociological theory and education to build a framework for understanding how emotions influence teachers' sense-making of reforms. I will base my argument on Blumer's (1969) assertion that human beings act towards things on the basis of the meaning they have constructed for them.

Individual teachers make meaning of their own world in a different ways, often affected by many factors, not the least of which are emotions. Hill (2001) argues that teachers usually attempt to make sense of reforms in terms of their prior practice and what is comfortable for them. This, however, often leads teachers to miss the unfamiliar and more fundamental transformations that are required in reforms (Spillane *et al.* 2002).

Nias (1996) argues that educational reforms can become emotionally debilitating when they undermine or undervalue teachers' own moral purposes. If this happens, reforms pose ethical dilemmas that often lead to deficiencies in the implementation of the reform.

In this study I argue that emotions appear to be an important determinant of teachers' behaviour during policy implementation.. Through the study I will seek to illuminate the extent to which the framework of 'teachers as emotional actors' can reconcile the differences between policy ideals and teachers' understandings of their identities in HIV/AIDS contexts. My conceptual framework has underscored how vital it is that policy visions are in sync with implementer realities if one is to reduce the gap between policy and practice. In addition, it proposes that teachers' emotions are a key ingredient in the implementation of HIV/AIDS policy.

## Chapter 3

# *Walking a mile in the other person's shoes: The method*

### **Introduction**

In this chapter I explain the journey that led to finding, contacting and meeting my research partners. I use the language of research partners to emphasise my aspiration for a collaborative inquiry. I move on to locate myself and the context that shaped my intellectual journey and authorised my point of view. I declare my positionality from the outset because I want to be clear that it is from this standpoint that I embarked on the study. I seek to acknowledge that my values, feelings, culture, history and experience shaped and defined the inquiry (Evans 2002). My purpose is to unpack the connections between my own positionality and the research process. In doing so, I take Code's (1991:55) argument that "knowledge is a construct that bears the marks of its constructors and the more explicit a researcher is about those marks, the more the readers are able to evaluate it fairly".

I argue that the narrative research method is a powerful and suitable tool which aims to understand complex educational processes in which the meaning for those involved is given a central role (Geert 1999). In explaining my choice of narrative inquiry as a research method, I detail my experience with narrative inquiry and my attempts to see life through the eyes of my research partners, assuming a posture of indwelling, or what Maykut and Morehouse (1994) referred to as "walking a mile in the other person's shoes".

I present a reflexive account of the inquiry, critically reflecting on the knowledge produced as well as on the process of knowledge production (Guillemin and Gillam 2004). I make explicit and account for the specific procedures that I used for data collection and analysis. I maintain that I was able to strengthen my research through this methodological explicitness and through acknowledging the role that my



emotions – not separating my ‘human self’ from my ‘researcher self’ (Rager 2005) – had on the process of inquiry.

## **Finding my research partners**

The purpose of my study was to deepen understanding of the dynamics concerning policy – how it is translated at individual and group levels, and how it is translated into action in the real world. I wanted to explore how HIV-positive teachers within a specific social context understand, interpret and act on HIV and Life Skills policy. The aim was to gather subjective accounts that revealed how the world was experienced and constructed by a group of people with similar experiences. The exploratory nature of qualitative research offered me the scope to understand how a particular group of people construct meaning from the way in which they perceive their lives. According to Bogdan and Biklen (2007:43), qualitative researchers seek to grasp the processes by which people construct meaning and to describe what those meanings are. Using qualitative research would enable me not only to see the social world from the point of view of the teachers living with AIDS, but to produce a text that gives voice to the subjects of research: the teachers.

In electing to study the lives of teachers living with HIV and AIDS, I was vaguely aware that I had chosen a very sensitive and emotional subject area. I am now cognisant of the fact that during the research proposal phase I was oblivious of the challenging and emotionally draining task that lay ahead of me. This started becoming clear to me as I progressed with my research, moving beyond the research proposal phase. I began to realise that I might have underestimated the enormity of the challenge that lay ahead, the complex ethical issues involved, and the fact that the research would require a great deal of emotional labour and personal reflection from myself as a researcher and from my research partners.

All the comments from my supervisor and lecturers who read my proposal had carried the warning that I needed to be careful as I was asking people to recount very deep, potentially painful and traumatic events in their lives. At the same time, I was warned that the topic was likely to arouse very deep emotions in myself as the researcher. And it did. I will explore the emotional journey that I took later in this chapter.

Through my readings of various texts on doing research on sensitive topics, I became aware of the need for a careful selection of participants (Lee 1993; Lubbe 2005; Bogdan and Biklen 2007). The respondents had to be prepared to disclose their HIV status and be willing to share their personal experiences, feelings and emotions with a stranger. Given that the interviews took place over three months, the respondents had to be able to afford the time and this called for commitment on their part.

I intended to select my sample from a population of primary school teachers in Zimbabwe. I wanted to look only at primary school teachers because they all have the responsibility to teach HIV/AIDS and Life Skills programmes. At primary school level, each teacher is assigned to one class and they teach all subject areas. At secondary school level, the situation is different, mainly because the teachers are subject-specific. Not all secondary school teachers teach HIV/AIDS and Life Skills. This responsibility is left to guidance teachers only.

Another criterion that I used for the selection of the participants was their accessibility. Because of the intense interactions that were required with the participants, I selected respondents from the Harare region where I could easily reach them. The effect of using this as a selection criterion was that it narrowed the selection of teachers to those primary school teachers working in an urban setting.

I used purposeful snowball sampling for the selection of the participants. I chose this sampling method because I wanted to select information-rich cases for an in-depth study. Patton (1990) defines snowball sampling as an approach designed to identify people with particular knowledge, skills or characteristics; it makes use of community knowledge about those possessing the skills or experiences in question (Patton 1990). In snowball sampling the researcher starts from an initial set of contacts and is then passed on by them to others, who in turn refer to others and so on. Snowball sampling has the advantage that people who form links in the referral chain are known and trusted by the potential respondents, and they are able to vouch for the researcher's bona fides (Lee 1993).

In choosing purposeful snowball sampling, I was fully aware that my sample was not representative of the wider population. I wanted to choose participants, not because they are representative of a population but because they possessed distinctive

characteristics. I was not interested in generalisation; I was interested in participants who could give me rich, in-depth field texts that would give me an insight into the experiences of teachers living with HIV and AIDS.

I was aware that such teachers could be reached through support organisations or networks. I approached the Zimbabwe Teachers Association (ZIMTA), who referred me to one of their members who was living positively with HIV. This teacher, whom I call Hope, belonged to the Development of Antiretroviral Therapy for Africa (DART) programme.

With the contact details I had been given by ZIMTA, I got in touch with Hope. I introduced myself and asked to meet her about some research I was conducting. We agreed to meet in my office the following Saturday morning. I suggested the first meeting in my office because I felt that meeting in her home would be inappropriate at that point as she had not yet consented to take part in research. My office seemed to be a central and neutral location, as opposed to either of our homes. She came in and I introduced myself and the purpose of my research. When she introduced herself, I was immediately confronted with a dilemma because she was a secondary school teacher. In my selection criteria I had wanted to interview primary school teachers only because in Zimbabwe they have the responsibility for teaching the subject HIV/AIDS and Life Skills. Hope told me that she was a Home Economics and English teacher.

Shelving my preferred criteria, I gave her a copy of the consent form (Appendix Three) to read in her own time. I took time to reflect on the situation. I was not sure interviewing Hope would answer the research questions that I had because she was not involved in teaching Life Skills programmes at her school. At the same time, a part of me wanted to interview her in order to explore her experiences with HIV in the school context. While I was not sure this could answer my research questions, I felt that the interview could open up new insights that I had overlooked. After thinking through my dilemma, I decided to go ahead and interview Hope. I made the decision to take her interview as a pilot so that I could refine my research instruments, while at the same time generating data that could illuminate Hope's experiences with HIV in the school.

I kept a personal diary which I completed after each interview session. Having a diary allowed me the space to record my feelings, reflections and observations that I made during the sessions, which could not be captured on the tape recorder. My research diary emerged as a very valuable source of information, as I later struggled to explore and interweave my own story with those of my research partners (see Appendix Four).

I recorded the following in my diary the day I was to meet Hope:

### **HOPE (14-03-06)**

*Today I will have my first interview with Hope and I am nervous. I do not know what to expect. My anxiety increases as the time of the meeting comes closer. My particular anxiety comes from the worry that maybe I have not read and planned for the interview adequately. I feel that I might go through the process and realise that I might be missing essential information.*

*We had arranged that I would pick her up from her school in the morning as she had excused herself from school to go for her monthly visit to the hospital to collect her medication. I would then take her back into town with me after the interview so she could go to the hospital.*

*I have decided to use this first interview as a pilot so I can get a chance to pre-test my data collection instruments. I plan to go through the whole process of interviewing with one participant before I identify the other research participants. I hope I can learn from the pilot and then adjust my data collection tools where necessary.*

*I started off by explaining to her about the research and what she was expected to do and asked her if she had gone through the consent form. She had read it, and she indicated that it was acceptable for her and she was happy to sign it.*

*The first interview was all about knowing more about Hope. I deliberately avoided asking any personal questions because I wanted to establish rapport between us. After her initial nervousness she relaxed as she talked about her family and how she grew up. She shared photographs of her family with me. It was an enjoyable time for both of us. I found talking to Hope very refreshing and, as we finished the first interview, I looked forward to the next one.*

I met Hope for a total of five times between February and April 2006. The interviews varied in length but none exceeded ninety minutes. Each session corresponded to a

category in the interview schedule (see Appendix Two). I used the categories as a road map for the interviews, although I did not strictly adhere to them. I was flexible to the other ways in which she chose to share her story, and I also looked out for other emerging issues. I started each session with a casual conversation to break the ice before we got into the substantive issues. Most of my interviews with Hope took place in her Mabvuku house, and I remember being very nervous before each interview. I was not sure if she would open up to me or whether she would be offended by my line of questioning. I found Hope to be a soft-spoken, gentle person, and she made me feel welcome in her home.

After I completed my interviews with Hope, I had collected very rich contextual data on her life. However, the information she gave me was missing the policy-specific information that I would need to answer my research question on the experiences of HIV-positive teachers in implementing HIV policy. Hope was not involved in the implementation of the HIV/AIDS and Life Skills policy because she taught English and Home Economics at her secondary school. I decided to keep her data and not to exclude her from my sample in case I would need to refer to her interview data.

Interviewing Hope had two advantages. First, it allowed me to reflect on my questionnaires and my own interviewing technique, enabling me to revise my questionnaires after each interview. Second, Hope was able to introduce me to two other teachers living with HIV and AIDS whom she knew through the DART programme. Gift and Ruva were both primary school teachers. I interviewed them over the course of the next six months.

I can describe the six months I spent interviewing Gift and Ruva as the most emotionally intense period of the whole research process. As primary school teachers, I found that their stories touched the nerve of the matter and they adequately described the challenges that they faced in the implementation of the Life Skills policy. Unconsciously I stopped worrying about whether I would get enough data to answer the research questions. Instead I concentrated on the emotions that the process roused in me as a researcher. This is reflected by the entries I made in my diary.

My interviews with Gift took place between April and June 2006. All three interviews took place at the University of Zimbabwe Campus, in Gift's office at the

Student Services Centre. Each interview started with the research formalities and then went on using the interview schedule as guide. Below is a diary excerpt from our second interview:

## **Gift**

### **Interview 2 (30-04-06)**

*Gift went into an emotional state as she chronicled the unfolding of events after Ruth's death. It seemed nothing was going right for him, and this was exacerbated by his own test results coming back positive. By mutual consent, we ended the interview at the point when Gift received his test results. It was an intensely emotional session for both of us. For Gift, telling the story brought back the pain and the feelings of loss. I simply needed a break. I felt emotionally drained. During that second interview I realised that it was not possible for me to go into another person's life story and come out unchanged.*

*After the interview I wanted a way of letting out the emotions bottled inside me. I decided to write down my reflections of the interview. Many questions came to mind: Who gets infected with HIV? Would Gift have been infected if he had made different choices in his life? Who is responsible for what happened in his life? Would his life have been different if he had not grown up in an orphanage? If I had been in his position, how would I have dealt with the situation?*

*As much as I tried to get out of Gift's story and back into my own life, I failed. The emotion I felt was too intense; I kept reflecting on our interview. The more I thought about it, the more I began reflecting on my own place in the research. I felt this dull, nagging concern: Was it my place to peer into the lives of others? Did I have the right to venture into the private spheres of other people lives?*

I met Ruva four times between July and October 2007. Like Hope and Gift, I started with the research formalities and then went on to the interview. I found Ruva very cheerful and willing to share much more information than my interview schedule required. I adopted a flexible stance and allowed her to share her story in the way she chose. Below is an excerpt from my last interview with Ruva:



## Ruva

### Interview 4 (28-10-06)

*Today is my last interview with Ruva. The journey we have been through has been emotional for both of us. Over the weeks of the interviews, I feel we have become close and I am grateful to Ruva for having shared an important part of her life with me. Part of me feels guilty for just being on the receiving end of the relationship. While I have empathised with her, I feel that I have not given anything of myself. I am troubled by this.*

*As Ruva spoke, she sat across the table from me, with her head to one side and her voice lowered. Her eyes had that far-away look of someone remembering past times. I could see pain etched on her features; I could detect it in her voice and from her posture. I felt my own tears burning the back of my throat. As a woman and mother, I could relate to her pain. I understood her worries about her children and their future, her decision to hold back the sad news from her husband. For a brief moment I felt the line between the researcher and the researched become hazy and disappear. In its place was two women united by their love for their children, and by the need to protect their loved ones from pain.*

*As I mull it over in my head I come to the realisation that there is no such thing as being outside of the epidemic; we are all a part of it one way or the other. Ibanez-Carrasco's (1993) words came to mind; he states that, culturally speaking, everyone is at risk and we are all involved because sexuality is a collective phenomenon. I conclude my interview with Ruva filled with admiration for this woman who is very loving, who has managed to bury the past and look to the future. I admire the fact that she is very willing to share her life story 'if will help others in my situation'. Part of me feels sad that my interactions with her are coming to an end. I had started looking forward to our interviews.*

Several months later, when I reread my diary entries, I relived the intense emotion that I had felt during the data collection phase. Fortunately for me, I had come across a number of writings on the effects of conducting emotionally laden research (Maykut and Morehouse 1994; Lather and Smithies 1997; Rager 2005). I also took the time to discuss the personal and emotional impact of the research with one of my supervisors, and this helped enormously.

After completing the interviews with Hope, Ruva and Gift, I realised that I had a more or less homogeneous sample whose attributes were remarkably similar because they all belonged to the same social networks. Continuing with this particular network would tempt one to assume that this selection was a typical



reflection of teachers living with AIDS in Zimbabwe. I knew from my experience working in the field of HIV and AIDS and from talking to critical readers that my sample was biased and that there are teachers living with HIV/AIDS in Zimbabwe who are not part of any social support networks and whose stories would offer different insights to those of Ruva, Gift and Hope.

According to Lee (1993), bias is an inevitable feature of snowball sampling because the networks tend to be homogeneous in their attributes rather than providing linkages to others whose social characteristics are different. In order to increase the variability of my sample, I made a conscious effort to exercise more control over the referral chains. I did this by using other starting points so as to ensure better coverage of the population under study. I followed up referral chains on the basis of their ability to give me a more balanced view on the experiences of teachers living with AIDS. That is what led me to contact Johanna.

I had met Johanna in the days when I worked for the United Nations Educational, Scientific and Cultural Organisation (UNESCO). Towards the end of 2004 I was working as a programme officer with the UNESCO Sub-regional Office in Harare. We hosted a colloquium on HIV/AIDS, and we invited HIV-positive teachers to tell their stories in the presence of key policy makers from the various Ministries of Education from the sub-region. We formed a panel which was moderated by an HIV and AIDS activist. From that panel discussion, there was one female teacher who was very articulate in sharing her experiences, and she talked about how her openness had paved the way for other HIV-positive teachers in her school to open up to her. I took down her contact details as I thought that one day I might want to work with her in my research. I contacted her and she consented to taking part in the research. However, with Johanna I faced the same dilemma I did with Hope, in that she was a secondary school Geography teacher.

Like I did with Hope, I felt an ethical obligation to interview her even if she did not fit the research profile. She was my fourth contact. I met Johanna three times in October 2006, and all our meetings took place in her house.

Next I approached the Progressive Teachers' Union of Zimbabwe (PTUZ) and explained that I was looking for an HIV-positive primary school teacher who was not a member of any support group and who was not getting any support for anti-



retroviral therapy. The officer that I talked to showed an interest in my research. The PTUZ had also been trying to assess how their HIV-positive members were coping with HIV and AIDS. They knew a number of teachers who had come to them asking for help with medication. They agreed to contact them on my behalf to see if any of them were interested in taking part in the research. That is how I met Edwin, who would be my fifth contact.

Getting hold of Edwin proved very difficult as he was frequently away from school because of illness. My frustrations in trying to get an interview with Edwin are reflected in the following diary entry:

### **Edwin (13-11-07)**

*I am hoping to finally meet Edwin today, after weeks of fruitless searches. Edwin's story is different in that it chronicles a lone struggle to cope with HIV/AIDS. It is one of despair and loss of hope compared to that of Gift and Ruva. After interviewing Gift, Ruva and Hope, who are members of support groups and whose stories reflect hope and victory against HIV and AIDS, I realised that this was just one side of the coin. I needed to look at the other side of the coin, at teachers who are fighting and in some cases losing the battle against the disease. I knew such teachers were in the majority, and I also knew that gaining access to them would be difficult for many will not come out in the open, preferring to struggle in silence.*

*As per Ministry of Education, Sport and Culture regulations my first port of call was the school administration block. I went to the headmaster's office, presented my research clearance and explained the purpose of my visit. I requested to see Edwin but was told that Edwin had not reported for duty that Monday. In fact, the school headmaster was worried about Edwin's erratic attendance and the effect it was having on the pupils and other teachers. When I asked for Edwin's home address, I was told that it was against school policy to disclose personal details of staff members. It was clear from the way Mr Musa spoke that Edwin's absenteeism had become an issue of concern in the school. I went back home feeling frustrated but more curious about Edwin.*

*On the whole, interviewing Edwin proved to be a frustrating experience. Understandably, because of his deteriorating health he often did not keep appointments. I was not able to conclude my interviews with him because on the last day we were supposed to meet, he was not at the school. The school head informed me that Edwin had stopped coming to work, and they were not sure what had happened to him. I suspect that he had gone to his rural home to be near his parents, as he had hinted during one of our sessions. During the time of*

*the interviews, Edwin's health had been deteriorating rapidly and his disappearance, while frustrating for my research, is understandable.*

My last contact was Grace, whom I also met through the Progressive Teachers' Union of Zimbabwe. Grace was a secondary school teacher who had encountered so much tragedy in her life that talking to her broke my heart. Grace had lived through the death of her husband and teenage child, and the sickness and paralysis of her son. Although she had tested positive, Grace had not disclosed her status in the workplace for fear of victimisation. She was my sixth and final contact.

The timetable of the contact sessions I had with the teachers is represented in Table 3.1.

I recorded all the interviews on my tape recorder. I found that the tape recorder worked very well in that it allowed me time to listen and ask questions without feeling the pressure to record what was being said. I also found it useful during the data analysis phase, when I could always refer back to the interview to listen to points that I might have missed when doing the transcriptions.

I personally transcribed all the interviews that I recorded, and I tried to finish transcribing each interview before starting another one. I found the process of transcribing very time-consuming. Even when the sound quality of interviews was good it took me about four to five hours to transcribe a one-hour interview, and up to seven hours in cases where the sound quality of interviews was poor. The advantage in making my own transcription is that it made me more familiar with the data. I was able to recall the atmosphere, the events and in some cases the tone of voice that was used by the research participant.

The personal diary which I completed after each interview session allowed me the space to record my feelings, reflections and observations that I made during the sessions and which could not be captured on the tape recorder. My research diary emerged to be a very valuable source of information as I later struggled to explore and interweave my own story with that of my research partners.

After I had completed each set of interviews, I took the stories back to my research partners for member checking. In doing this I was not only interested in checking

the accuracy of the stories; I was also interested in questions of identity. I was interested in whether that was how the teachers saw themselves, and if that was the character they wanted to be when their story was read by others.

**Table 3.1 Timeframe of contact sessions with research participants**

<b>Date</b>	<b>Research Participant</b>	<b>Purpose of Meeting</b>	<b>Venue of Meeting</b>
28 February 2006	Hope	Initial meeting	My office, Five Avenue
14 March 2006	Hope	First interview	Hope's house, Mabvuku
21 March 2006	Hope	Second interview	Hope's house, Mabvuku
28 March 2006	Hope	Third interview	Hope's house, Mabvuku
13 April 2006	Hope	Member checking	My office, Five Avenue
30 April 2006	Gift	First Interview	University of Zimbabwe, Student Services Centre
5 May 2006	Gift	Second Interview	University of Zimbabwe, Student Services Centre
10 May 2006	Gift	Third Interview	University of Zimbabwe, Student Services Centre
4 June 2006	Gift	Member Checking	University of Zimbabwe, Student Services Centre
5 July 2006	Ruva	First interview	Ruva's house, Norton
16 September 2006	Ruva	Second Interview	Ruva's house, Norton
21 September 2006	Ruva	Third Interview	Ruva's house, Norton
28 September 2006	Ruva	Member checking	Ruva's house, Norton
2 October 2006	Johanna	First Interview	Johanna's house, Glen Norah
15 October 2006	Johanna	Second Interview	Johanna's house, Glen Norah
30 October 2006	Johanna	Member checking	Johanna's house, Glen Norah
9 November 2006	Edwin	First Interview	Edwin's school, Epworth
16 November 2006	Edwin	Second Interview	Edwin's home, Hatfield
18 December 2006	Grace	First Interview	Grace's home Marondera
22 January 2007	Grace	Second Interview	Grace's home Marondera
18 February 2007	Grace	Member checking	Grace's home, Marondera

## **Ethical considerations**

In electing to do narrative research on the lives of teachers living with AIDS, I was aware that I would be dealing with intimate material that would carry a high ethical load. Qualitative research in general and narrative research in particular has a clear ethical dimension (Bogdan and Biklen 2007).

As I entered the field I was confronted with my first ethical dilemma in the question of intrusiveness. How deep could I dig into the personal life of the respondents without penetrating their private sphere in an improper way (Geert 1999)? I needed to collect sufficient information to meaningfully reconstruct each teacher's story, while at the same time respecting their privacy. I found myself walking on a very thin line between collecting enough in-depth information and respecting the individual teachers' privacy. I tried to deal with this by relying on my own social sensitivity. I found that in most instances the teachers were willing to share their personal stories without holding anything back. If a respondent was not willing to share personal information, I did not push them; I allowed them to share only as much as they were willing to.

Bogdan and Biklen (2007) advise that the data provided by the respondent has to be handled with discretion. I emphasised to the respondents that the data would be treated anonymously and confidentially, and as a result I made special efforts to ensure that the identity of the respondents would not be released. I asked each of my research partners at the start of our interviews to give me a pseudonym. All teachers selected pseudonyms except Gift, who insisted on using his real name because he wanted his story to be known as his and not to counter his efforts with the Shedding of Stigma Campaign that he was running. We also agreed to use pseudonyms for the other people in their stories – for example, husbands, siblings, children – to protect their anonymity. When I returned the stories for member checking, one of the teachers asked me to remove references to context, places of work and residential locations that could reveal the identity of the respondent or that of the partner and children.

The problem of exploiting the respondents was avoided by informing the participants at the beginning of the study about the aims of the study and the

concrete research procedure (Plummer 1983). By using member checking, I allowed the research partners a chance to control the stories written about them.

The final dilemma arose during the data analysis phase. My initial inclination was to present the stories as given to me by the teachers, to let the raw details be accessible to the reader. At the same time I acknowledged that there were a number of language issues in the texts, since English was not a first language for the teachers. After reading through literature on representing the voices of 'Others' (Alcoff 1991; Lather 1997; Lyons 2001; Sullivan 1996), I made the decision to make modifications so that the stories are coherent and understandable. I came to this decision because I realised that using the exact wording of the participants would make them appear inarticulate, whereas the teachers were very intelligent individuals.

## **Situating myself in the study**

I think it is important to find a place for myself within the parameters of the study because my background and personal interest have been instrumental in my desire to study the lives of teachers living with AIDS. I am a black Zimbabwean woman in my early 30s studying for my doctorate. For the past ten years I have worked as a development worker in the field of HIV and AIDS and education. During these years I developed a particular interest in the area of policy development within the field of HIV and AIDS and education. I followed closely the development of HIV and AIDS policies aimed at harnessing the huge potential of the education sector to prevent HIV infection.

My work as an associate expert with UNESCO from 2002 to 2005 brought me into contact with teachers living with HIV and AIDS through the HIV and AIDS teacher training programmes that I was in charge of. My interactions with the teachers and teacher trainees aroused an interest in the experiences of teachers living with HIV and AIDS. I became interested in exploring the qualitative context within which HIV-positive teachers negotiate meaning in the routines of teaching and learning inside schools and classrooms.

As I reflected on the policy on one hand and the HIV-positive teachers' experiences on the other, a disjuncture between the policy visions and images of teachers, and

the teachers' realities became apparent. There was a discrepancy between the recognition of teachers' reality and the levels of responsibility given to them in the implementation of school-based HIV and AIDS policies. Clearly lacking was the consideration of teachers, their identities and the contexts in which they did their work. I took an interest in this seeming disjuncture between policy intentions and practice of teachers implementing HIV policy. I wanted to explore the extent to which the official images and expectations of teachers, as captured in the education policy on HIV and AIDS, matched HIV-positive teachers' personal identities of themselves as classroom practitioners. Thus I found myself drawn to exploring the experiences of teachers living with HIV and AIDS.

Another factor propelling me to study teachers living with HIV and AIDS was the fact that the research on HIV and AIDS that I had read rarely contained individual voices or stories of those who bear the burden of the disease. A lot of the research reduced and amalgamated the humans in question (pupils, parents, teachers, orphans) into statistics or lumps of data to be studied (Deutsch 2004). I was inspired and challenged by the powerful and disturbing words of Freema Lebaz-Luwisch (2004): How is education possible when there's a body in the middle of the room?

In her view, teaching and learning has to take account of the emotions, fears, vulnerabilities and anger of teachers and students before any dialogue is possible within the classroom about difficult subjects. Moreover, teaching must account for "the body that carries these feelings and experiences" (Lebaz-Luwisch 2004:9). I wanted to do a study that would capture the unique nature of the experiences of the 'body' living with HIV and AIDS. I wanted to enter the meaning-making world of the teachers to see how they made sense of their day-to-day struggles with HIV inside real school environments.

When I developed the first draft of my PhD research proposal, one of my supervisors, while showing interest in my idea, was quick to inject a note of caution; HIV/AIDS is an emotionally charged subject and he wanted to be sure that I knew what lay ahead and that I would be able to handle the emotions that arose during the process. I remember agreeing without hesitation for I felt that the process would engage me personally and professionally, and that the benefits would outweigh any reservations I had on the emotional costs of the subject. As I look back now, I realise

that at that time I was totally unaware of the extent of the emotional and intellectual challenges that would be involved in undertaking such a study for my dissertation.

And so I embarked on my study, unaware of my HIV status, unaware of the impact that my HIV status would have on my interactions with my research participants. I had last had an HIV test in 2003 when I was pregnant with my second child. I did not know at that time that my own HIV status would be an important factor in my positioning in the study. Fortunately, as part of my literature review, I read the work of Lather (1997), who spoke of how her status was a marker of her positioning in the study of women living with HIV/AIDS. My HIV status gradually emerged as one of the issues central to my positioning in the study. I decided to take Lather's advice and get tested for HIV. It took me a long time to bring myself to do it; I did not want to know if I was positive. What would it mean for my study, my family and my future? I realised that a positive test would alter the perspective that I would bring to the study.

The impetus to get tested came after interviewing Hope, the teacher who I used to pilot my research questions. I sat with her for one and a half hours, and for that short time shared her experience with HIV. As I drove home, reflecting on our interview, I began thinking about how brave Hope was. She knew her HIV status and she was doing something about it. This thought kept nagging me until a week later I went to take my own test. As I reflect on this now, I realise that going through the process and through the emotions of testing helped me to enhance my connection with my research participants when they spoke about their own experiences with HIV testing.

If this study is about teachers living with HIV and AIDS, why then did I feel compelled from the outset to share something about myself? Why do I want to reveal a part of my history? The answer came to me after reading Evans (2002), who says that we share something about self because we want to be explicit that it is from this standpoint that we embark on the research project. According to Evans, to reveal these lenses is not to claim a researcher's essentialist qualities but rather to be explicit about the markers that point to a researcher's values, background and experiences. This is taken further by Code (1991), who makes a case for revealing the researcher's context because knowledge is a construct that bears the marks of its



constructors, and the more explicit a researcher is about those marks the more the readers can evaluate it fairly.

In the past, research has failed to acknowledge the researcher's influence on the research process. The assumption has been that researchers can occupy a neutral, unbiased position (Cylwik 2001). And yet Harding (1991) reminds us that, as researchers, our social and political locations affect our research. She argues that our research interests and the research questions we pose, as well as the questions we discard, reveal something about who we are.

Others have suggested that all researchers are positioned but that disclosure of that positionality has not always found its way into the text (Chiseri-Strater 1996; Deutsch 2004). Chiseri-Strater (1996) makes the point that, whether they write about it explicitly or not, all researchers are positioned by virtue of their age, gender, race, class, nationality, institutional affiliation, historical personal circumstance and intellectual predisposition. It is the paradigms under which we train, write or publish which determine the extent to which we reveal the influences on our positioning. The researcher's positionality is also shaped by subjective personal and contextual factors such as personal life history and experiences. The challenge that I faced as a researcher was one of making transparent who I am given that much of my sense of self is taken for granted, and then to use this self-knowledge to show how I enter the field and manage the data that I collect and disseminate.

Finding out that I was HIV-negative awakened in me various emotions. First was joy and then relief that comes from letting go of a heavy burden. However, while I was very happy with the news, I also became more aware of the distance this created between me and my research partners. In my view, I was now confirmed as an outsider. Reading through the work of an HIV-positive gay man, Ibanez-Carrasco (1993), on the lived experiences of men who have sex with men, I became more aware of my outsider status in the study. Because Ibanez-Carrasco was HIV-positive, he could talk about 'us' and not 'them' and he could speak with authority as one who had walked and was walking that road.

As a researcher I came to the inquiry living my own story, with my own experience, history and values. I was not HIV-positive and I had no teaching experience, and this led me to wonder if I could find a point of connection with the teachers living with





HIV/AIDS. I struggled with the question: did I have to be one of them to do the research (Clandinin and Connelly 2000:66). Given my own background, could I meaningfully connect with the teachers? What competencies would I need in order to be able to narrate the lives of others in a more or less unmediated way? My own status as a non-HIV-positive woman led to an internal conflict regarding my own place in the inquiry. Did I have a place in analysing the lives of HIV-positive teachers? Did I have the right? In my mind I was not comfortable with being invasive and with my own role of producing knowledge from other people's life experiences. Like Lather (1997), I was aware that my non-HIV-positive status positioned me as an outsider in the research.

I took time to seriously reflect on my insider/outsider dichotomy, questioning who I am and, by association, whether it was my place to carry out this research. To resolve the question of my positionality, I read the work of others who discussed the issue of being simultaneously an insider and an outsider, and I realised that nobody can be socially marked in only one way (Fine 1994; Bloom 1996; Deustch 2004; Pillay 1995). I found comfort in the words of Bloom (1996) who claims that all human relationships encapsulate multiple subject positions that take on different salience and meaning in various contexts, thus yielding multiple ways in which we can be both part of and excluded from almost any social situation. I stopped concentrating on a fixed identity and I began to interrogate the spaces of interaction between my researcher self and the researched others. It was only as I began to reflect on what I shared (and did not share) with my respondents that I began to let go of my fixed identity of being an outsider to the lives of those living with HIV and AIDS.

While I was aware of the differences that separated me from the teachers, I realised that my position was much more complex – although I was in some respects an outsider, yet I was also an insider in some respects. I found my HIV status to be the most defining characteristic for my outsider status. As I had never worked in the Ministry of Education in any capacity, I also found myself an outsider in that respect. However, being an outsider to the school system meant that I was not in any way a threat to the teachers, so they were able to trust that the information they gave me would not be released to the school authorities.

I considered myself an insider when I began to ask myself: where is the outside of this pandemic (Lather 1997)? Living in a high-prevalence country such as Zimbabwe, I

found it difficult to imagine a space outside of the pandemic; everyone's life, including my own, had been touched by HIV. In this respect I considered myself an insider. Through race and social class I found a point of connection with the participants. As a middle-class black woman and mother of two, I found a point of connection with my female participants.

I followed Clandinin and Connelly (2000) who advocate acknowledging the researcher's own narrative of experience, telling stories of my past that frame my present standpoints. This helped me to deal with questions of who am I in the field and subsequently who am I in the text. I became more aware of the many layers that were at work in the narrative inquiry space (Clandinin and Connelly 2000).

## **Emotions and the research process**

In conducting the research I took the advice of Maykut and Morehouse (1994:2), who advise qualitative researchers to assume a posture of indwelling which they define as "being at one with the persons under investigation or walking a mile in the other person's shoes". By confronting the experiences of the 'Other' I embarked on an emotional journey during which I explored and unveiled my own experiences.

While I was aware at some level of the emotional and intellectual challenges of undertaking to study the lives of teachers living with AIDS for my dissertation, I was not prepared for the emotional journey that I embarked on the moment I entered the field. I remember the twelve months it took me to complete the interviews as being an intensely emotional period. The journey back home after each interview was always troubled as the full impact of the interview hit me. I suffered bouts of depression, anger and helplessness as I played back the interviews in my own mind. I found myself crying during an emotional interview, on my way home and, at times, after I got home. Many times I felt guilty – guilty for invading other people's private lives and guilty for wanting to produce knowledge from other peoples' misfortune.

As a woman and mother of two, I found that I could relate to Ruva, Hope and Grace's pain, not just for their HIV-positive status but for the fate of their children. I felt for Ruva when she talked about asking God what she could have done differently not to have her son be born disabled. I understood the pain she lives with every day for not

being near her son and not knowing his status. I felt Edwin's loneliness each time I interviewed him. To me his story spoke of someone who is alone in a world where no one understands him. In the days that I interviewed him, I started unconsciously following with interest press reports on the availability of anti-retroviral therapy on the Zimbabwean market. I got excited each time I saw a headline with positive news on ARTs, only to be disappointed after reading the fine print, which often talked about the long waiting period for free treatment.

After I finished transcribing all six interviews I felt emotionally drained; I simply needed a break. For over a year I had been immersed in the process of collecting heartbreaking data and engaging intellectually and emotionally with my participants. I was not the same person who had embarked on the study sixteen months earlier; it was simply not possible to come out unchanged after that experience. These feelings and emotions all came back to me during the process of writing up the material. I found that even in the process of writing about another's life, I often found myself overwhelmed with the story.

In the initial stages of my research I struggled to remove my emotionality from the research process, as this seemed to me to be the appropriate action for a researcher. I found myself torn between recognising my own role in the lives of the teachers I was studying and presenting myself as an objective researcher who is detached from the situation. I did not allow space for reflection on the researcher-informant relationship or to include my own subjective reactions to the interviews. Although I was confronted with various emotions in and out of the field, I did not want to acknowledge my emotions for fear that they would contaminate the research; I felt that by acknowledging my emotions I would obscure the experiences of my study participants. Like Deutshe (2004), I was unable to allow the connection between me and my research partners to become a valid site of study and knowledge. I easily stepped back into the role of an observer.

Fortunately, I came across the works of other writers who made me realise that keeping my emotions at bay was not only impossible but also undesirable. These authors advocate for the researchers' awareness of their own subjective experiences in relation to that of their participants as being key to acknowledging the limits of objectivity (Chiseri-Strater 1996; Cylwik 2001; Deutshe 2004; Rager 2005). They stressed the importance of acknowledging the researcher's emotions as being

critical to recognising the bidirectional nature of research. Cylwik (2001) argued that rather than being ignored or marginalised, to be added as an afterthought, emotions should occupy a central position in the research process. Rager (2005) suggested that qualitative researchers should take steps to deal with the stress that can accompany doing research on emotionally laden topics.

Taking a cue from Rager (2005), I actively sought ways to deal with my own emotions that arose during the research process. I found diary writing a useful tool to promote reflexivity. I recorded my thoughts, feelings, anxieties and biases in my diary after every interview. This allowed me the space to step back and take a critical look at the research process and my role in it. These notes became invaluable in the construction of my own story of the experience.

As I progressed with my work, my supervisor became key in ensuring quality of the methodology of my study. Fortunately she had just completed a book using narrative methodology and which was also an emotionally charged venture. I shared with her all my concerns, emotions and stresses of conducting the research, and especially my struggle with my emotions and my own place in the research. She was very supportive, and since she had just gone through a similar experience we found a connection. We established a very good working relationship where we had a mutual understanding of the path the study could take. Working with her I realised personal growth that I had not anticipated with my PhD.

I also engaged my husband, a medical doctor, to be a critical reader of my work – in particular to look at the teachers' stories from a medical perspective. I found this very helpful in that I was able to verify the medical facts with a professional. He also listened sympathetically as I explained my experience with the interviews and recounted how emotionally drained I felt after the interviews. However, because he was trained under the positivist medical paradigm, we always argued about my degree of involvement as a researcher. He advocated maintaining researcher distance and thus objectivity in the research; I argued that removing my own values and empathic reaction from the research process was unnatural in qualitative research and that I needed to turn in upon myself so that I could look subjectively and reflexively at how I was positioned in the study (Chiseri-Strater 1996).

Being with my family while I conducted fieldwork helped me to maintain a balance in life. My husband and children and my sister always helped to keep my spirits up, especially during the period when I was writing up my thesis. By keeping track and taking part in events in their lives, such as supporting my husband through his own Masters dissertation and my sister's departure for the United States, I was able to shift my focus for some time and concentrate on something other than my dissertation.

From my experience in conducting this research I am now aware of the impact on the researcher of conducting emotionally laden research. I found the process of completing my dissertation to be the most intellectually and professionally challenging work that I have done professionally. I realised a level of personal growth that I had not anticipated.

### **My paradigmatic perspective**

As a researcher I am aware that I speak from a particular class, gender, racial, cultural and ethnic community perspective (Denzin and Lincoln 2005). As a result I entered the research scene with my own interpretive frame of reference, my own belief system or world view (paradigmatic perspective). This paradigmatic perspective played an important role in guiding my research. My philosophy of reality (ontology) and how we come to know that reality (epistemology) was an important factor in guiding how I would go about finding out what I believe can be known (methodology).

My epistemological view is that knowledge is a creation of the interaction between the researcher and the researched. I found myself identifying with the constructivist paradigm, which views knowledge as being established through the meaning attached to the phenomena being studied. The theory assumes a relativist ontology which claims that there are multiple realities, thus making each individual's perception of reality valid. The concern of the constructivist paradigm is to discover and understand meanings as they are experienced by those who are subjects of the research. In my study I wanted to explore the teachers' subjective experiences and how these are mediated by their interaction with the reality of their everyday lives, their contexts and their frames of reference (Terre Blanche and Durrheim, 1999).

In my struggle to ascertain my speaking position (whether I would speak *for* others or speak *about* others), I found parallels with feminist theories which emphasise problems with text, its logic and its inability ever to represent fully the world of lived experience. Feminist scholars have long been interested in the politics of speech acts. Speaking about others would be an act of representation while speaking for others would be a process of appropriation. I concluded that what I wanted to do was to participate in the construction of the teachers' subject positions and not to take on aspects of their identity or experience. I was also drawn to feminist methodologies because they acknowledge the role of the researcher's emotions in research. Feminist researchers reject distance and objectivity in the relationship between the researcher and the researched (Rager 2005). I chose narrative inquiry because it would allow me to participate in the construction of the teachers' stories.

### **My journey of/with narrative inquiry**

In this study I wanted to explore people's experiences, and thus *experience* was a key term in my choice of methodology. In line with the constructionist view, I worked on the premise that people's experiences can best be understood by interacting with them and by listening to them. Constructionists assume that individuals actively construe their own social realities and that the researcher is able to understand this by interacting with the interviewee (Lubbe 2005). I wanted to select a method that would allow me to discover and understand meanings as they are experienced by those who are the subjects of the research. I chose the narrative research design because it allowed me to explore and understand the perceptions and complexity of my research partners' experience. Like Lubbe (2005), I found myself drawn to the narrative approach because of its acceptance of pluralism, relativism and the validity of individual subjectivity.

In my literature search I found that even if narrative inquiry is still a relatively new field within the qualitative research tradition, much has already been written about it. I was attracted to the definition used by Clandinin and Connelly (1997) because it related to my own approach to narrative inquiry and it reflected my own epistemological and ontological assumptions. Unlike Polkinghorne (1995), who uses the term narrative inquiry as a covering concept for both analysis of narratives and

narrative analysis, Clandinin and Connelly see narrative inquiry as the study of the ways humans experience the world; it covers the entire research process, including the researcher's narrative or interpretation of the story. Like Clandinin and Connelly, I consider the narrative as a frame of reference, a research method and a way for representing the research study.

According to Creswell (1998), narrative inquiry is a way of understanding experience; it attempts to understand and represent experiences through the stories that individuals live and tell. This is echoed by Clandinin and Connelly (2000), who note that humans are storytelling organisms who individually and collectively lead storied lives; thus the study of narrative is the study of the ways humans experience the world. They argue that people are individuals and they need to be understood as such. However, they cannot be understood only as individuals, for they are always in a social context.

In this study I used narrative inquiry to assist in understanding the subjective world of the teachers and to see how they think about their own experiences. Second, I used it to convey to the reader what it must be like to be a teacher living with HIV and AIDS. Finally, I used it to illuminate the causes and meanings of events, experiences and conditions of the teachers' lives. I try to present the teachers' stories in such a way as to allow the reader some insight into what it is like to be a teacher living with HIV and AIDS. While I focused on the personal experiences of the teachers, I was conscious of the fact that narratives reflect not only the individuals' own meaning making but that of the society they live in.

One of the main characteristics of narrative research is the collaboration process between the researcher and the research participant. For this study I chose to use the term research participant rather than informant or subject, to emphasise my aspiration for a collaborative inquiry. Like Moen (2006), I regarded my research subjects as collaborators rather than informants who would be guided by my research agenda. I elected to adopt a non-judgmental attitude and a sense of equality as I knew this was particularly important in narrative inquiry. Clandinin and Connelly (1990) suggest that the ideal is that the participant and researcher have a joint inter-subjective understanding of the narratives that occur during the research process.



I went into the field with one goal: to record in depth the experiences of teachers living with AIDS. I was not prepared for the reality that awaited me. I became fully involved with my research partners' stories in my quest to truly understand their experience with HIV and AIDS. I was not going to be a sole recorder of someone else's experience because I too had an experience, in that I became part of the experience. But how could I study an experience of which I am a part? How could I step back and see my own story in the inquiry as well as to situate the teachers' stories in the larger landscape in which we all lived? I experienced a dilemma as I tried to move back and forth between full involvement in the teachers' stories and maintaining distance.

### **Narratives and the concern with the 'truth'**

The question about the truth in narratives is a recurring theme within the literature on narrative research (Phillips 1993; Verhesschen 1999; Moen 2006; Hendry 2007; Polkinghorne 2007). Phillips (1993) argues that often (although not in all cases) a narrative must be true to be considered acceptable. For him narratives have to be 'epistemically respectable'. He argues that criteria suggested by Clandinin and Connelly (1990) like 'adequacy', 'plausibility' and 'an engaging plot' are scientifically and epistemically irrelevant (Phillips 1993:7). However, if one takes Phillip's argument that the narrative researcher has the task to tell the truth, one needs to engage with issues of what counts as truth, whose truth, and from what context?

I take the view of Moen (2006) who argues that there is no static and everlasting truth, just different subjective positions from which we experience and interpret the world. Bakhtin (1986) reminds us that there is no single, dominant and static reality but rather a number of realities that are constructed in the process of interactions and dialogues. Narrative research thus aims to understand how humans experience their social circumstances, and it rejects the belief in a potential attainment of an objective reality or truth.

Narrative researchers analyse storied texts for the meanings that they express. The evidence that comes from storied texts differs from that derived from the traditional positivist methods. According to Polkinghorne (2007), this difference is where the strength of narrative lies because it allows for the meaning that life events have for



people. To that end, storied evidence is gathered not to determine if the events actually happened but are about the meaning experienced by people, whether or not the events are accurately described. Thus the truths sought by narrative researchers are 'narrative truths' as opposed to 'historical truths' (Polkinghorne 2007).

I concur with Lubbe (2005) when she argues that narrative is not meant to be read as an exact and quantitatively precise record of what happened, nor is it a mirror of any world out there. Instead of revealing the past as it actually was, narratives give us instead the truth of our experiences. Although the stories of the teachers are personal constructs, Geert (1999) advises that we treat them as personal accounts of how past experiences and events have been perceived and experienced by the narrator. The research does not concern facts as such, but the meaning the facts had for the person involved.

Verhesschen (1999) reminds us that even research that does not belong to the positivist paradigm must still give answers to epistemological concerns. In order to claim the status of 'proper scientific research' narrative research has to account for its methods and procedures. According to Geert (1999), in scientific studies the quality of a study is normally assessed in terms of reliability, validity and generalisability. The question then becomes whether criteria such as validity, reliability and generalisability, traditionally used for positivist research, should be used to criticise narrative research?

Clandinin and Connelly (1990) argue that criteria other than validity, reliability and generalisability should be used in narrative research. They argue that it is important not to squeeze the language of narrative criteria into a language created for other forms of research. Lincoln and Guba (1985) posit that establishing the trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability. They suggest that concepts such as credibility, dependability and transferability be used to describe various aspects of trustworthiness (Lincoln and Guba, 1985).

Jane O'Dea (1994) puts forward a notion of truth which she suggests can help narrative research gain 'epistemic respectability'. She argues that narrative research can gain epistemic respectability if criteria such as an engaging plot are viewed within the context of authenticity. It is by espousing the notion of authenticity that

narrative researchers can speak truths: "... they need to situate their stated criteria clearly within the confines of 'authenticity', connecting them thereby to that notion of truthfulness and honesty that authenticity entails" (O'Dea 1994:169). This is supported by Lincoln and Guba (1985) who state that authenticity is demonstrated if researchers can show that they have represented a range of different realities.

Lincoln and Guba (1985) propose four criteria that they believe should be considered by qualitative researchers in pursuit of a trustworthy study: credibility, transferability, dependability and confirmability. These issues correspond to the criteria of validity, generalisability, reliability and objectivity employed by positivist researchers.

According to Shenton (2004), credibility deals with how congruent the findings are with reality. This is in line with Lincoln and Guba (1985) who argue that ensuring credibility is one of most important factors in establishing trustworthiness. I used member checking to establish credibility of the constructed stories. In member checks, I sought the teachers' views of the credibility of the findings and interpretations of their stories (Miles and Huberman 1994). I took the stories back to the teachers so that they could judge the accuracy and credibility of the accounts. During the writing of the stories I had tried to stay as close as possible to the research partners' spontaneous narrative talk (Geert 1999). In cases where research partners did not agree with the text, we worked together to come up with an alternative formulation. For example, when I took Hope's story back to her, she felt that her mother was not given enough prominence in the story given the role that she had played in her life. She shared with me incidents that she felt could give her mother a more active role in the story, and I inserted this information into the story.

Throughout the inquiry, I used various tactics to help ensure honesty in informants when contributing data. I was aware that the relationship between me as the researcher and my research participants pervaded every aspect of the research, thus determining the quality and quantity of information gathered. I reflected deeply on the verification procedures that I would use to ensure the quality of my study. Moen (2006) stresses the importance of establishing trust with respondents, arguing that only respondents who feel safe and perceive the researcher as trustworthy will be prepared to share their stories. From the outset I explained to my research partners how the process would evolve and what was expected from them. I also took the



time to listen to their stories and to be flexible in allowing them to share their stories. Throughout the process I maintained a reflexive attitude where I critically reflected on the research process and my role in it.

To further enhance credibility, I interviewed every research partner over a period of at least three months. During this relatively long period I was able to collect data in several sittings. In this way I was able to control for reactivity and researcher effects. Besides the lengthy interview period, researcher effects were also controlled through systematic reflection in the research diary (Denzin 1970).

Another factor I used to enhance the credibility of my study was by having frequent debriefing sessions with my supervisors. These sessions served to widen my vision, and my supervisors were able bring my attention to flaws in the proposed course of action. I used the meetings as a sounding board to test developing ideas and interpretations, and they helped me to guard against bias (Shenton 2004).

In quantitative work, the concern often lies in demonstrating that the results of the work at hand can be applied to a wider population. In contrast, findings of a qualitative project are specific to a small number of individuals, and it is not always possible to demonstrate that the findings and conclusions are applicable to other situations and populations. Lincoln and Guba (1985) use the notion of transferability, which refers to the extent to which the findings can be transferred to other settings or groups. To ensure transferability, Goetz and LeCompte (1984) emphasise the importance of clear and detailed description as a means of allowing the decisions about the extent to which findings from one study are applicable to other situations.

I sought to increase the transferability of the study by conveying the scope and the boundaries of the study. As advocated by Shenton (2004), I supplied a substantial amount of information about the teachers and their settings, so that the reader can make a judgement about whether conclusions drawn from my study are useful for understanding other studies. I gave information on the number participants involved in the study, the data collection methods employed, the number and length of data collection sessions, and the time period over which the data was collected. Shenton (2004) advises that, ultimately, the results of any qualitative study must be

understood within the context of the particular characteristics of the people and, perhaps, geographical area in which the fieldwork was carried out.

Denzin (1989) advocates the use of thick description in narrative studies. The narrative has to represent both the context and the web of social relations. Taking my cue from Denzin, I described in detail my research partners and the settings of the study. In this way readers can transfer the information to other settings and they can determine whether the settings can be transferred because of shared characteristics (Creswell 1998).

Lincoln and Guba (1985) propose dependability as a replacement for reliability. Dependability refers to the repeatability of the study and to the degree that the research outcomes are independent of the research procedure. In order to address the dependability issues, I reported the processes within the study in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. Shenton (2004) argues that such in-depth coverage allows the reader to assess the extent to which proper research practices have been followed, and enables readers of the research report to develop a thorough understanding of the methods and their effectiveness.

The concept of confirmability is used to replace the conventional criterion of neutrality or objectivity (Seale 1999). Shenton (2004) advises that steps must be taken to ensure as far as possible that the findings are the result of the experiences and ideas of informants, rather than the characteristics and preferences of the researcher. Miles and Huberman (1994) consider that a key criterion for confirmability is the extent to which the researcher admits his or her own predispositions. As a researcher I was aware that I am the most important research instrument and that my subjectivity was an inherent element in the research. I tried to minimise my researcher subjectivity by systematically documenting the process that I went through. I recorded my activities and my reflections in a research diary. I acknowledged the beliefs underpinning the decisions I made and the methods adopted.

## Data analysis and interpretation

I divided my data analysis into two stages, the first of which was the process which sought to increase understanding of the subjective experiences of teachers living with HIV and AIDS. The second stage of the data analysis sought to explore themes and patterns that would emerge from the teachers' stories. This section describes the data analysis process that I followed.

In order to make sense of the world of teachers living with HIV and AIDS, it seemed logical to represent each teacher's interview transcript in the form of a story. In this way, writing the narratives became part of my analysis as I sought to construct a narrative version of each teacher's story (Lubbe 2005). Using narrative analysis would enable me to organise the various data elements into a coherent story. Polkinghorne (2007) defines narrative analysis as a type of discourse composition that draws together diverse events, happenings and actions of human lives into a thematically unified, goal-directed process. The result of a narrative analysis is an explanation that is retrospective, which links past events together to account for a final outcome.

Following Woods, Priest and Roberts (2002), who describe a procedure that can be used to transcribe interview data to arrive at a story, I read and reread my field notes. I realised I had recorded powerful and moving stories on the lives of teachers living with AIDS. A part of me did not want to touch the stories; I wanted to let the raw details be accessible to the reader. I felt as if in touching them I would be distorting the teachers' experiences. After rereading the interview transcripts, I deleted all interviewer questions and comments and any words that would detract from the key idea of each sentence (Woods *et al.* 2002). I arranged the data chronologically, identifying elements that would contribute to the outcome of the story. As I set out to write the stories, I became conscious of the real power I had as the one wielding the pen. I became aware of the power that Newkirk (1996:3) referred to when he said, "Those who turn other people's lives into texts hold real power."

I realised and sometimes 'feared' this power and authority that I had in constructing the stories. I could decide what to tell and how to tell it, what stories I wished to relate about my research partners and about myself (Lubbe 2005). I was aware of

the fact that my own construction of the narrated events shaped my research partners' stories.

I began questioning my own right to appropriate an 'Other' for the sake of knowledge, and to speak for another without compromising the Other's own powers of representation (Lyons 2001). I searched and read other researchers and authors who write on the subject of 'telling the lives of others' (Alcoff 1991; Sullivan 1996; Lather 1997; Lyons 2001). As I struggled with this "crisis of representation" (Denzin and Lincoln 2005), I found parallels with Sullivan's struggle:

*How could I conceive and reflect the 'Other', the not me, in the process of inquiry such that I would convey otherness in its own terms? How could I adequately transcribe and represent the lived experiences of others in a text that is marked through and through by my own presence (Sullivan 1996:97)?*

It was this intellectual need to bring the Others into account, to understand the Others on their own terms, that situated me in the problematic of subjectivity and representation. I knew that I had to make a conscious and reflective choice about how to represent the teachers as well as myself in the text. Like Geertz (1988), I found it difficult to sort out my own presence in the text. Was I speaking for the teachers (representation) or about them (appropriation)? I found myself struggling to express my own voice in the text. I worried that too loud a voice would run the risk of obscuring the field and participants, while too subtle a voice had the risk of acting as if the text speaks from the point of view of the research participants (Clandinin and Connelly 2000). In my struggle with representation, I also found parallels with Edwards and Ribbens (1998) who emphasise the dilemmas and ambiguities of simultaneously speaking in an academic voice and producing academic public knowledge while retaining the participant's own personal private voices and knowledge.

Given the assumption that reality is socially constructed, it follows that the world is a negotiation between the participants and context. I sought to have a study that would represent the negotiations among the diverse voices, and to describe their interplay and mutual influence (Mortensen and Kirsch 1996). As a researcher, I acknowledge my influence on the study; I wanted my study to be reflexive, to reveal

my own voice and biases as an investigator. As a methodologist writing for other researchers, I wanted to describe an emerging research design (Lubbe 2005).

I wanted to write stories that captured the teachers' experiences while at the same time looking inwards at my own experience during the process of the inquiry. Like Lather (1997), other than only giving voice to the stories of others, I also wanted to tell my story of listening to them and retelling their stories. I made a decision to write the teachers' stories as a paraphrase of the teacher's voices because I wanted to allow Gift, Ruva and Edwin the space to tell their own stories. I did this as a way of drawing them into the telling of their stories. At the same time, using the teachers' voices allowed me to step in and out of the stories.

Following Lather (1997), I decided to split my page into two, making room for a column on the left side of the page where I recorded my inner reactions on how I experienced the experience. Presenting the story in this way allowed me to slide back and forth between the records of the experience under study and my own reflections of the process. I found myself satisfied with this way of presentation because it gave me a voice while capturing the participants' experiences. In gaining a voice and a signature, I realised that I was taking responsibility for the stories and putting my own stamp on my work (Clandinin and Connelly 2000). This way of representation can be found in Chapters 4, 5 and 6.

Many researchers have responded to the crisis of representation by taking steps to place themselves explicitly in their texts. This self-reflexivity has been lauded by postmodern and feminist scholars as an antidote to the issue of representation (Brueggemann 1996; Sullivan 1996; Lather 1997; Tierney 2002). Sullivan (1996) advocates the dispersion of authority across the various voices and points of view encompassed in a text. By calling for self-reflexivity, she argues for the explicit rendering of one's own theoretical and political assumptions and beliefs as well as one's experiences and emotions in the process of fieldwork.

While the proponents of self-reflexivity call for the presence of the author in the text, they also warn against that presence looming too large. Tierney (2002) cautions against the dangers of the author's voice overwhelming the text, while Lather (1997) calls on a decentring of the self to avoid the risk of essentialising the text and the writer. Brueggemann (1996) warns us, "For in being self-reflexive, we turn the lens



back on ourselves, and put ourselves at the centre of representation” (Brueggemann 1996:19).

My reading of the various texts and my own experience suggests that what is required is for the writer to strike a balance between the self and the Other. According to Brueggemann (1996), self-reflection poses the risk of rewriting ourselves to the exclusion of our subjects on the one hand and remaining silent on the other. I interpret this to mean not making myself central in the text but continuously seeking ways of narrowing the gap between the teachers’ voices and my own presence in the text. I realised that I could neither be exclusively participant nor wholly observer. My frames must always be ready to shift, and I should be ready to traverse the terrain of what is happening between participant and observer, what Fine (1994:72) refers to as “working the hyphen”.

In writing the stories I did not want to merely report the facts of the research; I also wanted to construct interpretations. I was interested in finding out what could be extracted from the teacher narratives; in other words I wanted to find out what new knowledge would emerge from the experiences of teachers living with HIV and AIDS. I used inductive analysis to make sense of the field data. Instead of starting with a theory and then seeking data to support the theory, I accumulated data on the teachers’ experiences and then searched for patterns and thematic connections between the respondent cases (Goetz and LeCompte, 1981). In using the inductive approach, I wanted my research findings to emerge from the dominant and significant themes inherent in the raw data without imposing any preconceptions on the data (Thomas 2003). Thomas (2003) argues that one of the purposes of inductive analysis is to establish clear links between research questions and the findings from the raw data and to ensure that the links are both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research).

Before I began the process of inductive coding I closely read my research questions so that they acted as a guide to my analysis. I used generative or open coding to separate the data into groups that share common aspects while missing others (Goetz and LeCompte 1981). The units of analysis in open coding depend entirely on the focus of the study and the data collected. Using open coding, I engaged in an exploration of the data without making any prior assumptions about what themes or



patterns may emerge. I proceeded by closely reading the transcripts while considering the multiple meanings inherent in the text. I then identified specific segments of information that directly responded to the research questions and labelled them to form categories. I also derived more specific categories from multiple readings of the data, a process referred to as “in vivo coding” (Thomas 2003). Strauss (1987) describes in vivo codes as those terms used by the actors in the field which have two main characteristics: analytic usefulness and imagery.

Using the copy and paste function, I manually coded marked text segments into each category (see Appendix 5). I combined categories that had similar meanings and put aside the text that did not seem to fit into any of the categories. I also selected appropriate quotes that conveyed the core theme or essence of a category.

I analysed data from the different data collection instruments to come up with the themes and categories. While the bulk of the data was obtained from interviews with the three teachers, I also used data derived from an extensive desk analysis of the relevant policy documents from the Ministry of Education, Sport and Culture in Zimbabwe.

The outcome of the inductive analysis was the development of categories into a model or framework that summarised the raw data, conveying the key themes and processes. The themes and categories resulting from the coding process are shown in Table 3.2.

**Table 3.2 Summary of themes and related categories**

<b>Theme</b>	<b>1. Conflict between teacher as role model and ideal citizen, and teacher as HIV-positive person</b>	<b>2. The impact of HIV illness</b>	<b>3. Teachers as emotional actors</b>
<b>Category</b>	1.1 Policy images of the ideal teacher	2.1 Absenteeism and the response of the school community	3.1 Dealing with a positive test result
	1.2 Teacher as HIV positive	2.2 Illness and its impact on teaching HIV/AIDS and Life Skills	3.2 Taking into account the body that carries the feelings and emotions
	1.3 Teachers as a high-risk group	2.3 Stigma and discrimination	3.3 Coping with illness and death

In seeking to elucidate the exclusion and inclusion criteria for presenting evidence which emerged from the study, I concentrated on the experiences of teachers living with AIDS. I used data from the teachers' stories and from key policy documents. I deliberately focused on teachers living with AIDS and not on other important stakeholders such as other teachers, parents, pupils and school management. This was done because the purpose of my study is to extend the existing research by exploring how HIV-positive teachers view their role in the implementation of HIV and AIDS policy. I excluded the experiences of school management and pupils, and I also did not differentiate the experiences of the teachers by gender as this was not within the scope of the study.

In order for my findings to be usable, I selected the key aspects of the themes which I assessed to be the most important given my research questions. As I sorted and analysed the data, I was aware that the findings were shaped by my own assumptions and experience, that I had the power to decide what to include or exclude from the data. Aware of the subjectivity inherent in such an approach, I took deliberate steps to enhance the trustworthiness of my findings. In order to increase the trustworthiness of the data analysis process, I openly sought opportunities for other stakeholders to comment on the categories and the interpretations that I made – a process referred to as stakeholder checks (Thomas 2003). I shared my data – including categories, themes and analysed text – with my two supervisors so that they could comment. In order to increase the credibility of my research findings, I shared my findings, interpretations and conclusions with my research partners.

Once I had constructed an outline of the analysis, I moved on to the discussion and interpretation of the data. The outline of the analysis served to remind me of the themes and categories emerging from the data. I used extracts from the transcripts to illustrate the themes and categories that I used. In my discussion and interpretation of the themes and categories, I used experts from the literature that might support or contradict my findings. The discussion and interpretation is contained in Chapter 7.



## Chapter 4

### *Telling the stories (1)*

### *Gift: Finding my joy in theatre and drama*

#### **Introduction**

In Chapters 4, 5 and 6, I seek to expose the qualitative contexts in which teaching and learning takes place inside schools and classrooms in Zimbabwe by looking at the stories of three teachers – Gift, Ruva and Edwin. The teachers' stories are a response to calls for research studies that focus at the micro level, on teachers and pupils. In these three chapters I provide detailed accounts of teachers' lives inside schools and classrooms. In each chapter I allow Gift, Ruva and Edwin the space to tell their stories. They tell their stories in the first person so as to convey a smooth and uninterrupted narrative of the lives of teachers in and around the school. In the side bar, I reflect on my feelings and experiences of the research process.

This chapter tells Gift's story, Chapter 5 tells Ruva's story, and Chapter 6 tells Edwin's story.



## Life in the orphanage

*I first met Gift at the Student Services Centre of the University of Zimbabwe. What immediately struck me about Gift was how soft-spoken and humble he was. He exuded a certain degree of confidence and he seemed to be very much in control of his situation, although I could tell that he was someone who had gone through untold hardships. When I arrived he was working on something with two other students. He explained to me that his meeting was running late. Listening to him talk to fellow students as I waited, I realised that he commanded their respect in his own calm way. I am intrigued by his presence and curious to know more about Gift.*

*To picture Gift, think of a black man in his mid-thirties, with boyish looks and a charming smile.*

It is a beautiful Wednesday afternoon and the sun is shining brightly. I walk out of Mathew Rusike Children's Home with a plastic bag containing the few belongings that I own. I have known all along that this day would come and have been secretly dreading it. I had seen it happen to others when they turned eighteen, and had avoided thinking about my own fate. Having turned eighteen the previous day; I am now considered an adult, beyond the age limit of the orphanage. That's the rule; the orphanage looks after you until you are eighteen. I walk into the surrounding community carrying my whole life with me. In that moment I realise I am on my own.

I was born in Gweru in 1970. My mother was a single parent and she had other children from an earlier marriage. My father also had children from another marriage, and I was the only child from their union. This union did not last long. My mother was working as a housemaid for a white family so I grew up among white people for the first ten years of my life.

After years of working as a housemaid my mother did a Red Cross Nursing Course after which she became a nurse's aide. She got a job at Ruwa Rehabilitation Centre. After some time she started experiencing mental health problems and she had to leave her job. Up to now I do not know what happened to my mother; she just disappeared. My older brother told me that she left for South Africa



*Gift looks frail, possibly as a result of his illness, but he admits during the interview that he has always been underweight, even as a child. He ushers me into a sparsely furnished office in the Student Services Centre. He seems at ease with himself and ready for the interview. Although I might have appeared calm on the outside, inside me there was turbulence. I was overwhelmed with the responsibility of getting the interview right. I worried about leaving the room without getting enough information, about the possibility of offending Gift with my questioning. Inside me I had this fear that I could misrepresent or dishonour my research partners that I so greatly admired for their courage to narrate their lives to a total stranger, to subject their lives to public scrutiny.*

but I never heard from her to this day.

The internationally accepted definition of childhood is a person below the age of 18. For me this age-based definition of childhood is problematic because by the time I was fourteen I was no longer a child, having endured hardships that no one my age should have gone through. My mother became mentally ill when I was twelve. I remember there were times when she would just disappear from the house, leaving me on my own. I had to fend for myself in between periods of looking for her in the high-density suburb where we lived. My search would always end with me finding her looking dirty and dishevelled, with no idea what was happening to her.

The last time my mother disappeared I searched for her with the help of neighbours and her friends from church; our searches proved fruitless. I was taken in by the Department of Social Welfare as a child in difficult circumstances and they placed me in an orphanage, Mathew Rusike Children's Home. I was to continue my schooling at the orphanage with the Department of Social Welfare paying for my living expenses. Life in the orphanage was tough and there was never enough food or blankets to keep us warm in the cold season. In spite of all the hardships, I was happy to be there because I had no one else.

I left the orphanage having achieved seven Ordinary Level passes, and my main concern was to try to survive. Although I was not an exceptional student, I had worked hard to achieve good O-Level passes because I knew my future depended on it. I was determined to leave the orphanage with good passes as that was the only chance I had of making it in the



*As Gift narrates his story of growing up in an orphanage I find myself comparing his background with my own, which now seemed privileged compared to his. Each time he spoke of his mother I could detect pain and maybe regret in his voice. I am left with too many questions. Why would a mother abandon a teenage child? Is she still alive? And if she is, why has she not been in contact with him for all these years?*

real world.

I went into the surrounding rural community where I met other young people who had left the orphanage. Together we formed the Mathew Rusike Children's Association, for which I was secretary. One of our main aims was to try to lobby the orphanage authorities to think about how they could support or at least equip the young people leaving the orphanage with livelihood skills so that they could make it on their own in the real world. It was not easy.

As members of the Mathew Rusike Children's Association we helped and supported each other through the difficult times we faced in the community. We were like a big, extended family. True, we had some happy times, but when I look back now this was a time of great difficulty for us. Through my interest in theatre, we formed the Rusike Theatre Production, made up of young people from the orphanage.

We performed for the community and at times for the members of the orphanage, charging a small fee. The money was shared among the group and it became my source of income, although it was not enough to live on.

As time went on, I realised that I was not going to be able to survive on the small pittance I made through theatre. I also had many people discouraging me to make theatre a profession, given that I had no other forms of support. Theatre in Zimbabwe does not pay well and one needs a means of supplementing one's income. Although I went into teaching, it was



*Given the hardships that Gift has faced, I am surprised that he had the courage and strength to lobby for better conditions on behalf of other young people who are still in the orphanage. I am amazed that he could think of the fate of other young people in the orphanage when he is in dire straits himself. I admire this quality in Gift.*

*As Gift talks about his early teaching years he oscillates between presenting an image of self as 'victim' and self as 'victor'. On the one hand, he felt he was a target of commercial sex workers and other community members, while on the other hand he portrays himself as victor in chasing after the young girls in the community.*

not out of choice as that was not my passion. My interest had always been in theatre and the arts. However, at that time teaching was the only way of escaping the trappings of poverty which I had grown up with all my life, and which worsened after I traded life at the orphanage for life in the real world. In 1989 I applied to the Bulawayo United College of Education and I was accepted to train as a primary school teacher. At the back of my mind I always thought I would leave the teaching field after a few years. I remember the years in college as being particularly tough. I lived on the grant that I got from the government and that was not enough. Not only was it inadequate, it sometimes came very late, which meant that I could go for weeks with no decent meal and sometimes I would miss classes because I was working part-time manual jobs. I really felt that if my mother had been around my situation would have been different. I persevered and three years later I graduated.

### **Playing the 'victim' and the 'victor'**

My first teaching job was at a primary school in Mrewa. I felt young and ready to face the world. For the first time in my life I felt free from the poverty that had always been a part of my life since my mother left. As a teacher I was a respected member of the community. The fact that we had more disposable income than most of the community members put me and other teachers in a position of power.

To the young girls and their mothers, the male





*From the literature a number of studies have postulated that teachers are at a higher risk of contracting HIV than the general population. Kelly (2000a) argues that it is teachers' higher social status and disposable income which gives them more power and enables them to engage in high-risk behaviour.*

*As a young teacher in a rural area, Gift finds himself in a position of power for the first time in his life. As a teacher, he was a respected member of the community and he used this to his advantage in pursuing the young girls in the community.*

*As Gift reflects on his early years, he acknowledges that the multiple sexual relationships that he engaged in during those years possibly exposed him to HIV infection.*

teachers were potential marital candidates. They did their best to bring their daughters to our attention. We were young, single and financially stable, and to the mothers we would be the ideal husbands for their daughters. To the daughters we represented security for the future, and for many we would be their ticket out of poverty. We played the situation to our advantage; we went along but ducked before making a serious commitment. We were not ready to be tied down. We were after a good time. While we pursued the young girls, we were pursued by the ladies of the night. We were targets of transactional sex from the commercial sex workers. They targeted us because we were young and they knew we had cash on us. Even though one tried to resist, at times the influence of alcohol would just make one susceptible to their prowess.

At the school there were incidents of teacher-pupil relationships with the older girls in the school. As bachelors we would ask the girls to perform various household chores at our houses. They would come to clean, wash and cook, and this is usually how it all started. As teachers we had the upper hand and the girls would always obey. To this day I am convinced of the vulnerability of the girl child.

During this time I was young and carefree and I engaged in multiple sexual relationships. At that time there was very little information on HIV/AIDS filtering to the rural areas. The few times that I came across such information I would always think that it would happen to someone else. I was too busy enjoying my youth. It was during this time that I could have been exposed to the virus.



*In a 2001 article, Bennell argues that teachers will sometimes use their higher status, authority and power to abuse students, thus increasing their risk profile.*

*According to Bennell, (2001), in some cases students and community members will try to entice teachers into relationships as they are considered to have higher income.*

I fell in love with a teacher from the nearby secondary school. Her name was Stella and we got married after a year of dating. We had two children in the four years that we were married. They were both girls. For various reasons our marriage did not work out so we decided to go our separate ways. Stella got custody of both children as they were still young. I continued teaching in Mrewa for two more years before moving to Harare.

In Harare I got a job at a primary school in Hatcliffe. At that time Stella decided to take a live-in job as a hostel mistress at a boarding school and as she could no longer look after the children, she brought them to me. I stayed in Hatcliffe with my two daughters.

In Hatcliffe I got involved in a relationship with Fadzai and although we did not get married we had a child together. It was a boy and naturally I was very happy to have a son. At that time I couldn't think of getting married again given the problems I had faced in my first marriage. When my son was about a year old we went our separate ways, and Fadzai now lives in Inyati with my son who is now seven.

### **Pursuing my dream through teaching**

Even though teaching was not my initial passion, I loved my job and I loved interacting with my pupils. Teaching still gave me an opportunity to pursue my love of theatre and drama. In every school that I taught in, I formed a theatre club where we would do traditional dance and drama to educate and



*As my interactions with Gift continue, I realise that one thing that has been consistently present in Gift's life story is his love for theatre and drama. Despite acknowledging the meagre income that he got from theatre and dance, he follows his passion all his life. When he spoke about it I detected a strong passion in his voice, and it is clear to me that even if he did not manage to fulfil his dream of joining the film industry he is happy to have continued to use his talent and love for drama from the time he was in the orphanage through to his days at University.*

entertain the school and surrounding community. It is in theatre and drama where I find my joy.

I am also interested in writing stories and films. It is a pity that the Zimbabwean film industry is in its infancy, as one of my dreams had been to direct films at a national level. My dream was to really make an impact in Zimbabwe in the theatre and film industry. I have always believed that by using theatre I would be able to share my thoughts with the nation and influence the audience. When I became a teacher I used theatre to influence the minds of children on particular issues.

### **Living with my fear**

While I was teaching in Mrewa I started experiencing health problems. I put this down to the fact that the area where I taught was malaria-prone and every now and then I would be down with what I thought was malaria. As I look back now I am conscious of the fact that I could have been HIV-positive even at that time. That was during the late 1990s, and they were coming out about HIV/AIDS in the media. I did not allow myself to think about it. I was underweight, but I had been ever since I was young, and I remember my friends had even nicknamed me 'mosquito'.

In 2001 I decided to give marriage another try and I got married to Ruth. We were living



*In our second interview Gift speaks passionately about his late wife, Ruth. Gift's marriage to Ruth is one of the high points in the story of his life. He spoke of Ruth and their time together with so much passion and yet I could also detect pain and perhaps regret in his voice.*

*Even though he had harbored worries about his own health, he puts these aside as his health improves soon after marrying Ruth. For the first time in his life he is truly happy and he feels a deep sense of belonging.*

*For Gift, who had taken Ruth's child as his own, the loss of the child was a blow. His newfound happiness and sense of security quickly disappeared with the death of Ruth.*

together in Glen Norah and she worked as a housemaid. After a year of dating we decided to get married. Ruth had two children from a previous marriage but her husband and one child had passed away before we got married. Ruth was a beautiful woman with a bubbling personality. She was the sort of person one wanted to be around, always infecting others with her happiness.

The early days of my marriage to Ruth remain memorable in my mind to this day. We were both happy and my health improved very much. I have never been a big man but during those few months even my cheeks started filling out. I felt like I was finally getting my life together, creating a warm home for myself and my daughters. However, our happiness was marred by the death of Ruth's second child a month after we got married. This was really traumatic for both of us. I did not suspect anything when the little boy died. I concentrated my energy on trying to console Ruth on her loss.

After some time we both thought that she was pregnant, and this was very good news. It was as if we felt that the pregnancy could replace the child that we had lost. But when we went to the doctor for a scan we were told that she did not have a baby but she had water in her stomach. They had to drain the water from her stomach. She never recovered from that procedure and two months later she passed away in my arms. I was devastated. The pain of that moment remains real in my mind even to this day.

From the moment Ruth passed away, a lot of things went wrong. It was a living nightmare for me. I had not paid *lobola*, and according to African tradition I



*As Gift spoke, describing the pain that he went through with the deaths and then with his own test result, I tried to understand what he went through, and to empathise with him. In that moment, I realized that I could never understand what Gift went through. I could never relate to the pain of losing a child, a spouse, and receiving an HIV-positive diagnosis within a short space of time. As I listen to Gift's story, I am aware of my own limits. As an outsider, I am cognizant of the fact that I am a mere spectator, in a story which is not mine.*

had to do that even if she had died. Ruth's parents required a huge sum of money and I had to sell off some of my property to raise that money. I had no one to offer me assistance. When I got divorced from my first wife I had lost some of my property, and when Ruth died I lost the property that I had acquired again. This experience was really stressful for me and my health started deteriorating. I started developing opportunistic infections.

After the tragic death of Ruth and her son, coupled with my own illness, I started developing a clear picture of what was happening in my life. Exactly three months after her death I went to get tested for HIV. The results came back positive.

I had just gone through a lot; the experience of the illness and death of Ruth's child followed by Ruth's own death, all in five months, was more than I could take. As such the implication of my own test results did not sink in immediately. I was in denial, in panic mode, and could not accept my situation. I believe that I went through every emotion ever imagined and perhaps some emotions which are yet to be defined. As I look back now, I remember that this was a period of intense fear for me, fear of what was to become of me and my family.

I was still in a period of fear and my mind was not focused solely on my own situation. I had my children to think about and I worried about how my situation was affecting them. I realised that I had to come to terms with my situation before moving on as an individual. On a daily basis, I was now conscious of the fact that I was HIV-positive. I



*Gift went into an emotional state as he chronicled the unfolding of events after Ruth's death. It seemed nothing was going right for him, and this was exacerbated by his own HIV test results coming back positive.*

*By mutual consent, we ended the interview at the point when Gift received his test results. It was an intensely emotional session for both of us. For Gift, telling the story brought back the pain and the feelings of loss.*

*I simply needed a break. I felt emotionally drained. During that second interview I realised that it was not possible for me to go into another person's life story and come out unchanged.*

started trying to make meaning of my own situation.

I do not know if I can say that I have anybody to blame, looking at the life that I have lived before I met Ruth. If she knew her status, she probably assumed she was marrying another HIV-positive person, although we never talked about it. I cannot say I have felt anger or asked myself why this happened to me. No, certainly not in terms of my HIV status; maybe about my background. I grew up with a single mother and she was the only person I was close to and she just disappeared. To this day I have never heard from her. I have gone through difficult times and sometimes I feel that this is what has strengthened me. Sometimes I even wonder at the fact that the fright that other people go through did not happen to me. I feel my experiences have made me a stronger person.

It was tough; I had to depend on my small teachers' salary and I had no family to help me. I was never hospitalised, although I was really ill. I used to frequent private doctors for the opportunistic infections. There are times when I needed to be hospitalised, but I could not leave my children alone. There was no one around to look after them so I had to be there for them.

When I tested positive I started worrying about the health of my children. I had always been concerned about the health of my younger daughter. Since the time she was born she has always had problems with her health, and even her teachers always commented that this affected her performance in school. I am not sure whether she is HIV-positive.



*After the interview I wanted a way of letting out the emotions bottled inside me. I decided to write down my reflections of the interview. Many questions came to mind: Who gets infected with HIV? Would Gift have been infected if he had made different choices in his life? Who is responsible for what happened in his life? Would his life have been different if he had not grown up in an orphanage? If I had been in his position, how would I have dealt with the situation?*

*Through it all I admired Gift for taking full responsibility for his own actions. He did not blame anyone for what happened to him. Even though it was a very difficult time, he still managed to get over it, even though he admits to contemplating suicide.*

Stella refuses to take her for testing because she believes that I became HIV-positive after we separated. She does not want to look at other possibilities. At one time my daughter was admitted to Parirenyatwa Hospital and the doctors did not come out to tell us what they thought was wrong with her. They recommended that we take her for testing. I would like to do this with the full consent of the mother.

### **Alone on the HIV island**

After teaching for two years I transferred from Hatcliffe to a new school in Glen Norah. This is the time when I met Ruth and we moved in together. I had only been teaching in the new school for about two months when Ruth's son died. Soon after the death of her son, she fell ill. Things were definitely not going well for me. When I went into class I could not leave behind my personal problems, they were a part of me. The illness of my wife weighed heavily on my mind. I was in and out of school trying to take her to doctors to get the medical attention she required. I did not get much support from the other teachers because I was new and they did not know me well. I was basically alone with my social problems.

During the time when Ruth was sick, although I had suspicions, I was not aware of my HIV status. I recall that once I punished a pupil, and she went home and told her mother and the mother passed the comment, "That HIV-positive teacher of yours,





*As much as I tried to get out of Gift's story and back into my own life, I failed. The emotion I felt was too intense, I kept reflecting on our interview.*

*The more I thought about it, the more I began reflecting on my own place in the research. I felt this dull nagging concern: Was it my place to peer into the lives of others? Did I have the right to venture into the private spheres of other people's lives?*

why does he take his problems out on pupils?"

The pupil came back and shared the comment with the class, and I remember that this was a difficult moment for me. Because I had my own suspicions regarding my status, comments like that just served to confirm my own suspicions and heighten my anxiety. I knew that my health was not good but I could not afford to get the medical attention that I required.

I started developing opportunistic infections. I remember I developed herpes three times, and at that time I did not have enough information or an understanding of what was happening to me. The problems I faced at school put me under a lot of stress and this must have affected my immune system. Some colleagues would laugh and pass nasty comments about my health. It was quite depressing, and at times I contemplated suicide. What kept me going was the thought that I had to be there for my children.

The time immediately following the death of Ruth was very difficult for me. My own status had now been confirmed. It was a stressful time for me. When I walked in public places I used to get a lot of what has been called 'bus stop diagnosis', where someone can just look at you and diagnose you HIV-positive. There was a lot of whispering behind my back and this used to make me feel very uncomfortable.



## Teaching HIV/AIDS: a constant reminder of my own status

*In school Gift faced a conflict between the image of 'self as role model' and 'self as person infected with HIV/AIDS. He felt that he had fallen short of his own ideal and that of society.*

*As he struggled with his personal problems, Gift found that teaching HIV/AIDS and Life Skills became very difficult. He had not yet come to terms with his own HIV-positive status, and at the same time his wife was ill.*

*He found it difficult to separate 'Gift the husband and father' from 'Gift the teacher'. When he went to class he carried his problems with him.*

I considered myself a good teacher and a role model for the young people under my charge. How could I still live up to this image when I was now confirmed HIV-positive? How could I talk to the children about HIV without thinking about or referring to my own situation? How could I be an HIV-positive person and a good teacher at the same time? I had problems coming to terms with my own situation and I worried about what the school community would think about it.

According to government policy, it is compulsory for all teachers from Grades 4 to 7 to teach HIV/AIDS education to pupils. This is to ensure that young people develop behaviours that will reduce their risk of contracting HIV/AIDS. After I tested positive, I found that teaching HIV/AIDS and Life Skills became a challenge. Talking about the signs and symptoms of HIV and AIDS to a class of pupils was very difficult. In my own mind I felt that the pupils could see some of the symptoms on me. I was in denial and I did not want to be reminded of my own status. When you are in denial all you want to do is forget. Teaching HIV/AIDS and Life Skills meant that I was constantly reminded of my own status.

As a result of my positive status I felt that schools, (through the HIV/AIDS policy), had a strong bias towards prevention. I was struck by the failure to acknowledge the possibility that there would be pupils, teachers and other staff who are infected and affected by HIV/AIDS. Within the school I did not



*Gift found himself alone with his problems. Being new in the school, he had no one to share his problems with. Ruth was sick and her illness deeply affected him. Gift was not able to compartmentalise his life, to separate his personal from his professional life. He found himself carrying his personal problems with him into the classroom.*

*In addition to his wife's illness, Gift had concerns about his own health. His own suspicions regarding his health were confirmed by the comments and reactions of other teachers and pupils in the school.*

*My heart went out to Gift when he narrated his discomfort when he spotted colleagues talking or laughing behind his back. This stigma affected him so much that at times he contemplated suicide.*

find any remarks that were supportive of people living with HIV and AIDS. In my school we had a motto that we used to make pupils recite during school assembly: "AIDS kills; avoid premarital sex."

This message was blind to the fact that there were pupils in the school who could have been born HIV-positive. As educators, what were we saying to them with such a message? How about the male and female teachers who were infected and affected? It was as if we were saying that schools are immune to AIDS, and our main effort as educators is to maintain that status quo. As educators, we have a task of shaping young minds. How then do we let young people see HIV as a curse?

The emotional turmoil that I went through during this time really affected my teaching. I felt that I was not the same person and I had problems coming to terms with my situation. In class sometimes my mind would just drift away and I became a slave of my own thoughts. Most of all, I wondered what would happen to me. It was as if I had a death sentence hanging over me. During this time my pupils suffered because even though I was there physically I was not giving them the attention that they deserved, and I think that my pupils felt and were affected by my situation.

My performance in school was affected. The workload of a teacher is tough; you are talking about young children full of energy who expect the teacher to be always in charge. The level of my engagement with students was really going down. After teaching for a few hours I would feel very tired and had to sit down. I was no longer able to



*Schools are driven by the need to prevent HIV infection at an early age, thus preserving the Window of Hope. As a result most school-based messages are focused on prevention, and do not acknowledge the fact that schools are home to the affected and infected. There is silence around coping with HIV and caring for the affected and infected.*

*Gift found this silence discomforting and it became difficult for him to come out and openly declare his status.*

walk around class looking at my pupils' work or observing them as they did group activities.

When you are HIV-positive you become more aware of the presence of the disease everywhere. I started scrutinising the health of the students. I remember in my class I had pupils who looked unwell, possibly as a result of HIV infection. This really affected me and I felt more and more the impact of the disease. I was in denial about my status and everything that was happening to me. As a result, seeing children who were sick became a constant and painful reminder of my own situation. Even in class, some terms used by pupils kept reminding me of my situation even when they were making innocent statements that were not directed at me.

### **Failing to get support from the school community**

I did not find the school system very supportive when I was sick. Sometimes I just wanted to rest but the system would not allow me to be absent without a letter from a doctor. Because of my financial situation, I was not able to afford doctors' fees. Things were difficult for me. I was a single parent looking after my two daughters and I could barely make ends meet. When I got paid I used to go for a medical check-up and to have my CD4 count measured. In the time following Ruth's death my CD4 count had fallen to 185. The doctor informed me that I had developed AIDS and I had to start taking anti-retroviral therapy.



*The school did not offer Gift the kind of support that he was expecting from his workplace. According to the Public Service Regulations of 2000, a teacher may be granted ninety days' sick leave with full pay and ninety days' sick leave on half pay in one calendar year.*

*After ninety days' leave Gift was still unwell but he could not afford to extend his sick leave, as this meant he would be on half his salary.*

I suffered terrible side effects from the ART medication. I was allowed to take three months off from work. At that time I felt it would have been good to be hospitalised, but this was not possible as I had no one to look after my children. I stayed at home. After the three months' leave I was still not well but I could not get any more time off work without losing my salary. I would just drag myself to school. I remember on very bad days I just used to leave the class in a hurry and would never make it to the men's toilet so I would just vomit outside, in full view of pupils and other teachers. These were side effects from the drugs that I had no control over.

The school counsellor advised me to explain my situation to the headmaster so that I could get time off when I was sick. I faced a brick wall with the headmaster; instead of solving my problems it amplified them. When I went into his office his door was open. I asked him if I could close the door as I wanted to tell him something in confidence. He agreed. After I explained my situation to him his response was, "Is that why you wanted to have the door closed? Well your HIV status is no secret in the school; everyone knows about it, so there was no need to close the door."

To say I was hurt by this statement would be an understatement. I felt violated, exposed and hurt by the lack of confidentiality in the school environment. I was a victim of malicious gossip, and in my heart I was convinced no one deserved the kind of treatment I was being subjected to.



*After three months Gift was still not well but he forced himself to go back to work for fear of losing his salary. This situation was not good for Gift and for his pupils who had to watch their teacher being sick.*

My relationship with the school head had never been good. We had had a number of confrontations. Firstly, it was because I had several episodes of absence as a result of illness when I was still very new in the school. He argued that I was spending too much time away from pupils and threatened to charge me for abusing the sick leave facility. Secondly, I used to challenge a lot of the administrative decisions that he used to make. He did not welcome people challenging his authority and he liked his style of centralised decision making. The way he reacted to my situation was like he was saying it was pay-back time for him. In my case, I really felt that telling him worsened the situation. I had been advised that telling him about my status would make it easier for me to excuse myself each time I went to collect my monthly medication. There would be no need for me to come up with a lie about my illness each time I had to miss class. The disclosure to him really did not help my situation. I am convinced that the response of the school head to teachers living with AIDS is very important in setting the tone on how that teacher is treated within the school.

I remember at one time the school compiled a list of all the orphans and children in difficult circumstances who are entitled to receive assistance through the Basic Education Assistance Module. This is a government programme of support for Orphans and Vulnerable Children (OVCs). In the staffroom, the school head was excitedly saying that he now knew all the children whose parents had died, or were living with HIV and AIDS. He was very happy that he knew their



*Gift forced himself back to school even as he battled with the side effects of the drugs. In my mind I wondered what impact his illness had on the pupils, and how it impacted his relationship with the other teachers in the school.*

HIV status; that is the person that he was. I imagined him saying in the staffroom that he now knew my HIV status, as I had indeed told him about it.

I do not think I had direct confrontations with any of the teachers in the same way that the school head reacted, or that pupils would talk about me and laugh in class. With the other teachers I felt that I was a victim of discrimination. The discrimination was always subtle but I was not blind to it. In my view I felt that I was excluded from a lot of activities that other teachers took part in. For example, I was never nominated to travel on tours with pupils and I was never put in charge of any of the sporting activities.

I was someone who always kept my distance from people, and I spent most of my spare time with the school pupils, working with them in the arts. The fact that I never had close relations with any of the teachers created a gap when I started getting ill. I had no colleagues who were close to me, who would understand my situation and maybe share my burden. In a way I understood the reaction of the other teachers. It is very difficult for someone to establish a relationship with you when you are ill. In a way some maybe saw it as a drain on their resources and it also meant serious commitment in terms of visiting when one is ill.

The person who helped me to come to terms with my situation was the school counsellor. She was the first person within the school that I opened up to. When I was sick she tried to mobilise other teachers to come and visit. She had knowledge





*Heeding advice from the school counselor, Gift decided to disclose his status to the school head. However, the disclosure only served to amplify his problems within the school. Gift, who had never been on good terms with the school head, felt that his disclosure worsened his relationship with him. Gift expressed feelings of hurt at the lack of confidentiality he encountered within the school environment.*

about ART, and she helped me understand that the side effects I was having were normal reaction to the drugs and that they would pass. My relationship with the parents was not badly affected by my illness. In an urban setting teacher-parent relationships are not as close as they would be in a rural area. In rural areas you get all your provisions from the community and you are a member of that community. In Glen Norah Township my interactions with parents were minimal and I did not experience any situations with them. However, during the time when I continuously missed school some parents started to complain to the school head about my absenteeism.

### **Finding the energy to move on**

When I tested positive I went to church and talked to the pastor. We talked, and then he referred me to the Centre, an organisation working with people living with HIV and AIDS. I first went to the Centre in 2001, and the first person I met there was a man living with HIV/AIDS, Elliot Magunje. Today Elliot is my main source of inspiration, even though he is late. I believe I should carry the torch for him because he helped me accept my situation and we shared a common vision.

He later referred me to a support group. I have always enjoyed active work with groups. With the support groups I found the energy to move on. It was a rallying point where people in the same condition move ahead. At that time I was still



*My interactions with Gift bring out various emotions in me. I feel anger, sadness, pain and loss of hope as I listen to his story. Sometimes my anger is directed at schools for being so intolerant of others who possess attributes that differ from others in the community. I always wonder how I would have coped had I been in Gift's situation.*

*At the end of each interview I sit and write down whatever comes to my mind or what I recall thinking about or jotting down during the sessions. I find the process somehow therapeutic.*

teaching and the support I received helped me to move on, especially at school. I met other teachers and together we shared what we went through at school and in the communities.

When the doctor informed me that my CD4 count was going down, he advised me to go on anti-retrovirals (ARVs). As a teacher, buying ARVs on my salary was not possible. I informed the doctor and he helped me to join a programme offering free ARVs that was running at Parirenyatwa Hospital in Harare. I went there at the end of 2003 and they accepted me. On 1 January 2004 I was on medication. Although I suffered serious side effects, after taking the medication for about six months I was feeling much better. Even my CD4 count started going up.

With the new knowledge and strength I was now acquiring I felt better about myself. I was now in a position to help others. My empowerment came as a result of talking to others and attending support groups. I experienced a complete revolution in my teaching. Before testing positive I did not consider HIV/AIDS and Life Skills an important subject, hence I did not give it much emphasis. Our curriculum is examination-driven, so I would mainly focus on the examinable subjects. I changed my way of teaching as I realised how important the subject was to the life of pupils.

At the school where I was teaching, I introduced The AIDS Education Programme as an after-school club. It was aimed at fighting stigma and discrimination within the school. I had many students and members of staff coming to join the



*Today is my last interview with Gift. Together we have gone through the sad, emotional moments of his life. We are having the interview outdoors in the university green because our usual venue is occupied.*

*Throughout the years, I have known many people (male and female) who are living with HIV/AIDS. I have also lost a number of close relatives and friends to AIDS. One thing that I had come to closely associate with the disease was loss of hope.*

*As a result, my assumption before the interviews with Gift was that I would be talking to someone who is sick, probably depressed, or someone who no longer sees a purpose in life.*

club, and our aim was to fight stigma and discrimination in the hope of making the school a friendlier place for those infected and affected by HIV and AIDS. We did, through dramas, poems, songs and awareness campaigns which were targeted at the school and the surrounding community.

Joining a support group really helped me. Now I just look at HIV as yet another challenge in life. I also think that my background prepared me for this. I experienced the hardships of life when I was very young and I think that is why I am able to face challenges head on. The years I spent in the orphanage were also important in building my character. At the present moment I get medication and support from support groups so I am in good health. I am not in a situation where I am overwhelmed. I have problems every now and then, but I take them as they come.

I would like to say the truth; I have been in and out of church. I believe in God and I speak to him every moment and I thank him for what he has done for me. But I have not been really sticking to church, especially after I disclosed my status. When I get into a church I feel the church is still in denial about HIV/AIDS, and I do not feel comfortable. I feel that the church perceives HIV as a punishment from God for sinners.

One thing that has changed in my life is the fact that I am more cautious in my choices in life. I realise now that the kind of life that I used to live really made me vulnerable. As a teacher in a rural area, because of my position in society I used to take



However, through my interactions with Gift I realised that my assumptions had been wrong. Gift saw a very clear purpose for him in life, perhaps more than many HIV-negative people.

In my last interview with Gift, I sensed a change in him. He has moved from the sorrowful, reflexive individual to someone who has conquered his nemesis. As he speaks, there is a glimmer in his eyes and I can detect a fierce determination in his voice.

advantage of a lot of things and get carried away. What I realise now is that I am what I am because of the choices that I made in life. Basically I am no longer a man who would do things without being cautious.

### **A second chance at life**

I feel that I have a second chance to live my life; I have been given the gift of life. My goal in life has always been to have a national impact. It was not really about having material things such as cars, or a big house. I want people to say Gift was in Zimbabwe from 1970 to \_\_\_\_\_, and this is what he did. This vision has now been strengthened. When I look at my HIV status I think that maybe the Lord has given it to me for a purpose. I am now focused on my vision and I know that I can contribute meaningfully to society and make a difference in someone else's life.

Despite the fact that I had progressed to AIDS, I still wanted to pursue and fulfil my dreams. I decided to go to university, and by August 2004 I had enrolled at the University of Zimbabwe for a degree in Sociology. Although I had enjoyed being a teacher, I just felt that I needed more capacity for the vision that I was now carrying. I chose Sociology because it deals with personal relations and life skills, and would enable me to understand and come up with comprehensive strategies for my vision. I did not leave the education field, behind because one needs education to fight stigma and discrimination.



*People make meaning of HIV in their lives in different ways. After coming to terms with his status, Gift reflects on his past life, on the choices that he made and resolves to be more cautious about life's choices.*

*For Gift, testing HIV-positive was a turning point, a wake-up call which made him more cautious about the choices he makes in life.*

*Gift did not allow HIV to dictate the pace and quality of his life. Despite the fact that he had tested positive and progressed to AIDS, Gift felt that he had been given another chance in life. He went on to pursue his dream of enrolling for a Sociology degree at the University of Zimbabwe.*

Before I joined University, I had become very sick. I remember that in 2003 I was really down in terms of health. I needed to further my studies, to attain Advanced Levels as this is a prerequisite for any university degree. I went through hard times trying to read because I wanted to do a degree. My resolve to continue pushed me on. I continued reading even when I was seriously ill. I remember when I wrote my Divinity exam I had a severe bout of diarrhoea, which meant I spent a lot of time out of the exam hall but I continued. I did not want to think of issues of death. I did not allow myself to be overwhelmed by my situation. I wanted to get that degree and I was going to get it at whatever cost.

When I came to University I secured accommodation with relatives who lived close to campus. I lived for free with my uncle and his family. They knew my status. I realised that the family had problems sharing utensils and everything else with me. My uncle was supportive but his wife and children had problems with me and my status. It was difficult for me to live in the house so I decided to move.

I managed to secure accommodation on campus. However, I am not very happy and I am contemplating moving out. Life on campus is very expensive for me and the kind of food that I am getting is not suitable for someone living with AIDS. The canteens are not able to make meals for people with special dietary requirements.



## Finding closure through disclosure

*Gift tries to use his HIV-positive status to help others who might be affected or infected by HIV/AIDS. He sees this as his mission in life, and he feels he has a role to play in his community.*

*Gift found a purpose in life by helping others to cope with HIV. As he moved to University his love for theatre and drama did not wane. He still used it in his campaigns in order to help other students to know more about HIV.*

I decided to disclose my status on campus. For me disclosing meant I would live a realistic life where I would be able to access things that would help me. I did not feel that pretending to be like any of the other students would help me. I was on ARVs, with a chronic disease, and there are certain things that I would require. Doctors had made recommendations for my diet. I needed to strictly adhere to my ARVs, and the situation on campus is not easy. I realised that without help I was not going to be able to complete my university education. I did not want to give up my degree and go back to teaching. So I was in a tight situation where I had to be realistic; otherwise I would not be able to fulfil my dream. At that time I was not living on campus. I had to wake up early, get transport and have my meals on time. That whole routine did not suit me very well, with me being on treatment. I told the authorities about my situation and that I needed help. I was given accommodation on campus.

I told the University Counselling and Advisory Services that I am prepared to go out in the open about myself but there was an outcry from the members of staff. Some even felt we should have a debate: "Is the University of Zimbabwe ready for disclosure?" It was difficult to get them to accept, and there was lots of talk, especially within the Student Services division. Eventually we agreed that we would first visit a small group – for example, the UZ peer educators – and disclose and then move on.



*Twelve years ago, I was a student at the University of Zimbabwe. Like most institutions of higher learning, the response to HIV/AIDS has been rather slow and uncoordinated. During our time, there was not much talk about HIV/AIDS.*

*Listening to Gift talk, I realise that more than a decade later not much has changed. There is still a certain degree of denial if people are proposing to debate on whether the University is ready for disclosure.*

In the end it was a process where we disclosed to small groups until most people knew. I must say the whole experience was actually much better than I expected. It went better than the way I had imagined.

I was the first student to go public about my status. The disclosure was a process; it did not happen overnight. I started disclosing in 2004, and today I think many people on campus are aware of my status. When we started it was because of the coordination I had with people in the student affairs department.

I know that there are other students who are HIV-positive but who are not willing to come forward to get assistance. I am trying to advocate for such students to get help. I think that it is not good for me to just enjoy and not help others who are in my condition.

The way I look at it, there are probably HIV-positive students whose resolve I have strengthened, although they might not come out in the open about their status. At least they can look at me and feel that there is hope. I remember, when I started doing programmes there was hesitation about whether students would join, but the reality is that many students participate and many indicate that they want to continue coming to the programmes. We invite people who have been living with HIV for some time to share their experiences with us. I am of the view that on campus there are many students living with HIV/AIDS and any programme that ignores that is not addressing the reality.





*In my mind I applaud Gift for the decision he made to go public on campus about his status. It is not an easy decision. When I speak to him he makes it clear that his goal is to help others, and not necessarily to have more people disclosing, because disclosure has to be a personal decision.*

At this point in time some lecturers are aware of my status and some are not. The University runs workplace programmes and sometimes I am invited to speak. The University is a large institution, about 15 000 people, but I think that word has gone round that there is a student openly living with HIV, and many try to investigate and come and talk to me. I get a lot of people who ask me about the programme I am doing and when I am finishing my programme. You can see they are looking at me and gauging time to see if I am going to make it to graduation.

### **Fighting stigma on campus**

In general I cannot say that I have experienced many incidents of stigma and discrimination on campus. There are isolated incidents but I try not to let it get to me. I have told myself that I do not have to think that each time I see people looking at me and laughing they are talking about me. I do not have time for that and I do not allow that to affect me.

In class I have been faced with difficult situations. I remember an incident when a lecturer was talking about HIV as if it was death sentence. The way he was explaining about HIV was more like he was trying to instil fear in students, not realising that there might be students in the class who are positive and who might be trying to move on with their lives. After the lecture I went to him and asked him how he could take hope out of students in his class who might be living with HIV/AIDS. I think he got the message.



*Gift has moved beyond the point where he worries about what people think or say about him. His experiences from his teaching days have strengthened him and he does not worry about isolated incidents of stigma. He is now determined to fight stigma on campus, and make campus a better place for other students and staff who might be suffering in silence.*

Together with a few other students and with support from the Deputy Dean, we discovered that we needed a co-ordinated approach, bringing together student clubs and staff to try to create an enabling environment for fighting HIV/AIDS without stigma and discrimination. We started the Shedding off Stigma Campaign. In this campaign many stakeholders within and outside the University are involved in a united approach to fighting off stigma. The aim of the campaign is to fight stigma and to allow HIV-positive members of the University to live positively and get support from campus.

I started forming HIV/AIDS groups where students could get information and psychosocial support. The aim was not solely to get the students to disclose their status but for them to be able to access the services they wanted on campus. We used the Deputy Dean's office, the clinic and the counselling advisory for students as our base. So far no students have openly disclosed their status, but there are students and staff who have disclosed within shared confidentiality. Some students are actually getting help from the University and from the National AIDS Council. I can say that I am really starting to see the fruits of my labour through the Shedding off Stigma Campaign.

## **Looking ahead**

I have learned that for us to move ahead as a nation in the fight against HIV/AIDS, we have to realise that a nation goes through denial, panic and



*Gift takes on the role of a collaborator, facilitating the creation of a friendly environment for those who are living positively. He seeks to give awareness, support and hope to other students and staff who might be affected and infected by HIV/AIDS.*

acceptance, and it differs with situations. Whenever we spend more time in a certain phase, we are doing it to our peril. Personally I view us as a people in panic, although there are still people in denial, and we need to move on. It's been about 25 years since the first AIDS case was discovered and it looks like Zimbabwe has not really made much progress. If I can be able to facilitate one small step for the nation, I will have made an impact.

I finish my degree in 2007 and I do not look forward to getting formally employed. I would like to continue with the advocacy work. I am the founder and director of the Shedding off Stigma Campaign, which is an ongoing programme. It is based at the University of Zimbabwe. It has become a coalition, and so far we have about 29 associate members. We found that it is difficult for one person to ask people to appreciate you and accept you in society. Hence we have taken a multi-sectored approach where we bring together people from the church, youth and non-governmental organisations (NGOs) to form a coalition for shedding off stigma.

We also have the AIDS Education Forum, where students get information on prevention, mitigation, care and support. We have seminars, workshops, videos, talks and edutainment. We also have an outreach programme. I believe in building alliances as opposed to isolating activities. I have realised that within a tertiary institution it is very difficult for people to disclose their status because of the high levels of stigma prevailing in these institutions. It is as if there are no tertiary students who are HIV-positive. And yet if you go to the new start centres



*Tertiary institutions in Zimbabwe are places characterised by high levels of stigma. Gift managed to overcome all that and find a purpose for himself. He dreams of making a national impact, and I believe that in his own way he has made an impact on the university community.*

*Through his love for drama Gift manages to reach out to various groups of people who cross his life path – at the orphanage, in the community, at the schools where he taught, and at university.*

you are told that a lot of their clients come from universities and other tertiary institution.

In the AIDS Education Forum we bring people living with HIV/AIDS to share their experiences. Our focus is not only to get people to come out, but to help those who know their status but are living in confidentiality so that they are able to move on positively. People who can share their experiences with you can help you deal with your own situation. This is what I learned, and this really helped me to move on.



## Chapter 5

### *Telling the stories (2)* *Ruva: The positive self, the ideal other*

*The first teacher that I interviewed, Hope, had led me to Ruva. They were both members in a drug trial programme at Parirenyatwa Hospital, titled the Development of Antiretroviral Therapy for Africa (DART) programme. Hope had spoken to Ruva about my research and she had seemed interested. She had given me Ruva's telephone number. I phoned Ruva and introduced myself and, although she had sounded hesitant on the phone, she agreed to meet me.*

#### **“The results came back positive and I was alone.”**

I am HIV-positive, I am HIV-positive. The doctors' words kept coming back to me. I had come back for my test results and I was told that I tested positive. It was unbelievable; I was devastated. I did not take a taxi home; I walked. Maybe I wanted to burn it out or get time to compose myself. I was angry at my predicament. I started thinking about my son who was only a month old. I could not understand how this could happen when my son was still so young.

It was a Friday and I was on maternity leave in Bulawayo. I had just given birth to my son and second-born child, Farai. I remember waking up that morning to severe pain around my waistline. The previous day I had just been feeling tired and thought I was developing a cold. By the time I took my bath I had developed an angry rash which covered half of my waist. It was so painful I decided to go to the hospital. The doctor who attended to me started talking to me about HIV and suggested that I take the test. At that time I had no clue what was happening or why they wanted to test me for HIV but I accepted anyway.



*I drove to a primary school in Norton, 70 kilometres out of Harare. I walked into the office of the school head and asked to see Ruva. I had not met her before; we had just spoken over the phone. She was called in and we were introduced.*

*'Bubbly, energetic and full of life' is how I would describe Ruva. In the few minutes we took to walk from the school administrative block past the classrooms to the teachers' houses, she chatted with me as if she had known me all her life.*

*She explained to me that she is teaching the morning shift, and she excitedly points out her classroom to me. Along the way we meet school pupils who come to greet us, and I notice that she is very attentive to the pupils.*

The results had come back positive and I was alone, with no one to share my sad news. Daniel, my partner and father of my son, had remained in Gokwe when I went to give birth in Bulawayo. We had agreed that I would give birth in Bulawayo where my sister lived because there were no good hospitals in Gokwe. When I got my test results I knew my sister would be supportive, but I was not ready to share my sad news with her. I needed time to reflect on my situation.

### **"I kept my HIV status a secret."**

I was born in Kwekwe in 1970, the fourth-born in a family of seven girls. I remember that when I grew up our life was marred by the fact that my mother gave birth to only girl children. My father, like all African men, wanted a son. He was a typical African husband, who thought that for him to be respected among society he had to have son. As a result, he did not give us the love and respect that we deserved. I cannot think of a time when I got a chance to talk to my father and relate to him like his daughter. In fact, none of us girls had a relationship with him.

My father was under pressure from the extended family to take on a second wife who would give him sons. The family thought it was a waste of resources to educate girls. Fortunately, my mother was very firm when it came to our education, and her seven daughters got a chance to go to school.

I recall that during the time I was growing up things



*On the outside Ruva's house looks old and in need of paint, like all the other teachers' houses in the compound. On the inside it is perhaps a reflection of Ruva. She has made it into a warm and inviting home. My attention is drawn to a vase with mainly yellow flowers on the small table and the bright orange curtains with a flowery pattern. A set of comfortable, worn-out sofas and a small TV complete the small living room. The living room, although sparsely furnished, is warm, clean and comfortable.*

*Ruva explained that there was no electricity due to a power cut and apologised that it might affect our interview.*

were tough; there was never enough money in the house. My parents firmly believed in sending children to boarding school, and I got my chance to go when I was in Form 3 and when my sisters had completed their O-Level education. In boarding school there was never a time when my father came to visit me the way other fathers used to. It was always my mother visiting me alone, with one excuse after another as to why my father could not make it. I always believed that one day he would come and I would fantasise about that day.

After I completed my O-Levels I got two job offers. One was at Edgars, a local department store, and I was also accepted at the local airline to work as a flight attendant. I was delighted. However, my parents, especially my mother, was not happy for me to go on to a job without formal qualifications. She wanted me to get a college degree or diploma to become a teacher. With my father's assistance I got a job as a temporary teacher in Gokwe, a town which is about 300 kilometres from Harare. [How does she explain this assistance when he did not seem to be interested in educating girls?] In those days it was easier to get into a teacher training college if you had temporary teaching experience.

In 1989 I met Mark at the school where I was working as a temporary teacher. We fell in love. He was great, and I loved being with him. With Mark by my side I enjoyed my temporary teaching days. After a few months of going out I was convinced he was the one I wanted to get married to. We both knew that at some point we were likely to be separated when I went to study for my teaching





*By the time we sat down to start the interview, I felt at home with Ruva. If she felt uncomfortable or curious as to the purpose of my visit, she did not show any signs. The hesitation I had sensed on the phone, I did not detect at any point during our meeting. I introduced myself and explained the purpose of my visit, and she consented to take part in the research.*

*Ruva responded happily to the initial questions I asked her about how she grew up. She seemed happy to talk about her childhood. However, she sounded wistful as she recounted her story of growing up in a family of seven girls in a society that clearly placed more value on the boy child. The lack of love and affection from her father is an issue that hurt Ruva and that she is still bitter about.*

diploma. We were happy and we both agreed that we would face the moment when it came.

In 1990 I got a place at Mary Mount Teacher's College in Mutare to study towards my teacher training diploma. It was only after I had started college that I realised I was pregnant. I was expelled from college and I came back home. At the time, colleges of education did not accept students who were pregnant. I came back home and I got married to Mark. He was happy to have me back and I was also happy to be back. Together we looked forward to our first-born child.

I gave birth to a bouncing baby girl and we named her Josephine. Josephine was a beautiful and happy child and I loved being a mother. My mother kept encouraging me to go back to college for my teaching diploma. While part of me wanted to go, it was hard for me to leave my child behind. I only accepted the proposal when my mother offered to look after Josephine while I was away. With my mother, I knew my child would be in safe hands. I went back to Mary Mount Teachers' College in 1991 and completed my teaching diploma two years later.

I graduated in 1993 and I was happy to finally reunite with my family. The Ministry of Education deployed me to teach in Gokwe, although not at the same school as my husband. I had hoped finally to be together with Mark, but we remained separated. This prolonged separation, which had started when I was in college, proved strenuous for our relationship. I later discovered that during the time I was in college my husband was involved with



*As Ruva spoke about the birth of Farai she sat across the table from me with her head to one side and her voice lowered. Her eyes had that far-away look of someone remembering past times. I could see pain etched on her features; I could detect it in her voice and from her posture. I felt my own tears burning the back of my throat.*

*As a woman and mother I could relate to her pain. I understood her worries about her children and their future, her decision to hold back the sad news from her husband. For a brief moment, I felt the line between the researcher and the researched become hazy and disappear. In its place was two women united by their love for their children, and the need to protect their loved ones from pain.*

someone else and their relationship continued even after I came back. This was the breaking point of our marriage. I found that I could not cope with that situation and we divorced. I got custody of Josephine.

In 1997 I met Daniel and fell madly in love with him. Daniel was running a grocery and liquor business in Gokwe where I was teaching. He was a carefree person who enjoyed having a good time. Daniel did not mind that I had a child from another marriage. He treated Josephine like she was his own child.

Although I fell pregnant early in the relationship we did not want to rush into marriage. When my time was due I went to give birth in Bulawayo where my sister lived. Daniel came to visit me in Bulawayo when Farai was born. He was a very proud father and he doted on Farai. I couldn't have been happier.

Just after Farai was born, I developed herpes zoster<sup>1</sup> and that was when I tested HIV-positive. I went through serious emotional turmoil. I remember waking up and the first thing that would hit me was worry. I worried about what kind of tomorrow I would have. Would I be sick? Would I die? How would my children take it? What was going to happen to them? How were they going to view their lives when they grew up? How were they going to feel in relationships when they grew up knowing that their mother had died of AIDS?



*In the time I sat with Ruva I shared her experience with HIV. In listening to her, I had a glimpse into one HIV-positive woman's life. Concurrently, Ruva was faced with her own illness and that of her child. Just listening to her, I was overwhelmed by her situation, and I could not contain my own emotions.*

*This was not an easy time for Ruva, with Daniel abandoning her when she needed him most. And yet, despite what Daniel put her through, Ruva still referred to him lovingly as "my Daniel". Listening to Ruva, it is clear to me that she is a woman capable of deep love.*

At the end of my maternity leave I returned to Gokwe. I could not bring myself to talk about my status to anyone. I was still in a daze, not fully in control of my situation. I could not bring myself to tell my husband about the HIV test. I needed time to think it through, and I was not sure how he would handle it. I decided to wait for the right moment to tell him about the HIV test.

The right moment never presented itself, because a week after I got back home my son became very ill and he had to be hospitalised. He was diagnosed as having meningitis. Because I was still breastfeeding I had to go into hospital with Farai. The hospital had no accommodation for parents so the nurses made a bed for me on the cold floor so I could be near my son at all times. The cold must have affected me because I also got very sick, so that I ended up being admitted in another ward. I was tested and confirmed positive for tuberculosis, and I was immediately put on treatment. I was away from work for three months.

This time was really difficult for me. I was sick and nursing my sick son who was also admitted in the children's ward. This is one phase of my life that I will never forget. Without anyone else to turn to, I lived by the day. I know that the illness also took its toll on my daughter who was staying at home with my Daniel.

The situation was overwhelming for Daniel; he could not handle it. He had also been put on anti-tuberculosis treatment; he was in a panic. When I was in hospital he could not even get into the ward to see how Farai was doing. He would just wait at



*As Ruva detailed the events leading to the death of Daniel, I experienced various emotions. I felt anger at Daniel for letting her down in a time of need; I blamed him for his refusal to go for testing, and for his failure to take better care of himself when he was ill, and for his premature death which could have been avoided.*

reception and ask the nurses to call me so he could ask after the child. He was disturbed by the fact that all three of us were sick. The doctor suggested that we all be tested. I did not tell them that I had already tested positive for HIV.

Daniel refused to take the test. No matter how much I tried talking to him about it, he did not change his mind. It was as if he was in denial about the whole situation. He started withdrawing from the family and spending most of his time at work. I forced myself to be strong as I was the only one the children had.

While I was in hospital the nurses had alerted me to the fact that my son could have developed a disability. He was now eight months old, yet he seemed not to hear and he could not cry very loudly. Initially the doctors thought he had ankyloglossia<sup>ii</sup> and they performed surgery. When the situation did not improve they asked me to take him to have his speech and hearing tested.

It was just one thing after the other. I felt like the world was collapsing on me. I also realised I was losing Daniel, who was slowly distancing himself from me. His visits to the hospital became more and more infrequent, such that by the time I was discharged from hospital the distance between us had grown. When I mentioned Farai's situation, I was shocked by his response. He clearly told me that there were no disabled people in his family and he was beginning to doubt that he was Farai's father. I was shocked; I never expected to hear this from my Daniel. His response really hurt me, and for the first time since we got together I saw him



*But mostly I felt for Ruva. I felt sorry for her loss. For the second time in her life, she lost her partner and love of her life. I could see tears forming in her eyes. I felt my own tears coming, and I wanted to reach out and touch her and give her words of comfort, but no words came as I was still trying to absorb her story.*

for what he really was – a coward who runs away at the first sign of problems.

The situation between Daniel and me deteriorated; we argued about everything. Daniel still refused to go for HIV testing. I could see that his health was deteriorating but he did not want to confront his situation. Despite being on anti-TB treatment, he continued drinking heavily. In June 1999 he was diagnosed with liver cirrhosis and he died two months later. I was devastated. It felt as if I was on a roller coaster ride. Nothing was going right in my life.

The death of Daniel filled me with a deep sense of regret – regret for what could have been. I knew in my heart that he could have lived longer if he had accepted his situation and taken better care of himself. I understood what people mean when they say it never rains but it pours. The happiness I experienced with the birth of my son was brief compared to the grief that followed. After Daniel died, I lived one day at a time. Every day I thanked the Lord for seeing me through that day. Amidst all this, I still had to come to terms with my own HIV-positive status. I worried about what would happen to me. Each headache, rash or bout of cold had me worried that my end was near. I kept my HIV status a secret that I dared not confront or reveal.

### **“What could I have done differently?”**

When Farai was one year old I took him to Jairos Jiri Children’s Home, where they confirmed that he



*For Ruva the identity of 'Ruva the mother' takes centre stage in her life. She sees herself as an ideal mother, and it is clear from listening to her that she loves her children and she will do anything for them. Ruva is very protective of Farai and she feels the need to shelter him from the world.*

*Ruva suffers from guilt, as she blames herself for her son's disability. She feels that her HIV status changed not just her life but also that of her son.*

was deaf. As a result of his condition, he lacks the sense of hearing and ability to speak.

From Jairos Jiri I was referred to Harare Hospital, where I was advised to attend workshops for children with disabilities. This really helped me to start accepting my son's handicap. When I looked at other children with disabilities who were in the wards, I realised that my son was in a much better position than many of them. The doctors told me that my son's disability was most likely a result of the meningitis that he suffered when he was three months old.

The implications of this were daunting for me. I felt guilty; I felt as if it was my fault that my son was born deaf and mute. I knew that it possibly happened because of my HIV-positive status. In my mind I played over and over how I could have done things differently to avoid this happening to my son. I loved my son wholeheartedly and I always felt this urge to protect him, to shelter him from any more pain and suffering.

I loved my daughter Josephine as well, but I felt that she was stronger and able to face the world on her own compared to my son. I was also aware and still am of the effect on Josephine of her brother's disability. Like me, she also tries her best to shelter her brother from the world. While Josephine is a very strong and independent girl, I sometimes sense her frustration at not getting enough attention from her mother, and she sometimes expresses disappointment at the lack of a father figure in her life. She goes through periods of asking about her father and asking why I never



*Each time Ruva speaks about her son, her whole face lights up. However, I can detect that she is worried about her son, worried about his status. She has not worked up the courage to get her son tested for HIV as she feels that she will not be able to handle a possible positive diagnosis.*

*Given that Farai is already handicapped, it is as if that would be a double blow that she would not be able to handle. While she worries about herself falling ill and dying, her main concern is the fate of her son should she die. Her son is clearly an inspiration and a reason to continue living. As a parent it is difficult for me to listen to Ruva's story and not feel heartache, tears and, at the same time, hope.*

remarried after Daniel's death.

In 2000, when Farai was three, I decided to send him to nursery school. As a mother I yearned for him to have as normal a childhood as was possible. I wanted him to be able to socialise with other children. His initial experience at the school proved frustrating for both of us. The nursery teachers reported that because of his failure to communicate, he tended to become violent if he felt people did not understand him. The other parents started complaining that Farai was violent towards their children. However, the teachers at the school were very supportive and they made sure that Farai was accommodated in the school. As time went by, other parents accepted Farai and the other children understood that he was different. Farai himself seemed more accepting of his situation, although he still had episodes of intense frustration and he would take it out on anyone in close proximity.

In 2001 he was admitted to Emerald Hill School for Children with Disabilities in Harare. Although it was a boarding school, all parents had to take their children for weekends every fortnight. I found this difficult because I was still teaching in Gokwe; travelling to Harare every two weeks was too expensive for me. I requested a transfer to a school in Harare. Getting a transfer proved to be a frustrating experience. I applied using the argument that I needed to be near my son as I could not afford the fortnightly trips from Gokwe to Harare on my teachers' salary. I took countless trips to the Ministry of Education offices in Gokwe





*Focusing my mind on Farai, I am plagued by many questions. Is it morally right for Ruva not to have her son tested? Is it fair to deny him life-saving medication which he might need if he is found to be HIV-positive?*

*At the same time, another voice says to me, who defines what is right? Should she test him even though she is not ready to know the results, even though she will not be able to afford medication for him should the results come out positive?*

*I do not have any answers.*

and Harare, and it was all in vain. I was frustrated almost to the point of giving up. Fortunately, I met an old friend who referred me to someone who could help me. That was how I finally got the transfer. It had taken me two years. In 2002 I moved with my daughter Josephine from Gokwe to Norton, which is about 70 kilometres from Harare. My son was in a school where I knew his needs were being covered. Despite my HIV-positive status, I was in good health and somewhat recovered from the episode in Gokwe. Life was good. I secured accommodation at the school in Norton and so my expenses were minimal. I could afford to visit my son and take him home with me as required by the school. I secured a place for my daughter at a boarding school in Gutu, and she enjoyed it there. I was able to pay her a visit twice every term.

It was during this time that I started thinking of disclosing my status to the rest of my family. I wanted my sisters to know my status so that when I got ill they would be prepared. I went home for my sister's wedding in August 2002, and I made my plan to disclose to them. A day after the wedding we had a chance to sit and catch up with each other's lives. It was fun, just like the old days when we were younger.

When it was my turn to share about my life, I just said plainly, I tested HIV-positive five years ago. There was a deadly silence in the room. Then my older sister from Bulawayo stood up and hugged me, saying it was going to be all right. There were tears and more tears until I assured them that I



*For Ruva a life-threatening illness such as AIDS is more than a medical or biological problem; it is fraught with meaning. Ruva felt that she had lost control of her life and she struggled to make meaning of HIV in her life.*

*To me, Ruva's struggle with AIDS is a poignant reminder of how frail our lives are. I understood the pervasive nature of HIV. It changes everything, from the food she chooses to eat to the friends that remain...*

*Ruva spends some time hiding from her HIV status, dreading the onset of illness up to a point where she realized she just could not keep hiding any more.*

*She has many questions for God and she sees herself as a victim. She knows many people who were promiscuous who did not get AIDS, and asks God why she had to be the one.*

was still in good health and there was no need to worry. Still, I could tell that they were worried about me. We agreed that we would not tell my mother about my status as it would break her heart. All my sisters were very supportive and they always check on me to see how I am coping. I have always been close to my sisters, and in my heart I knew that if I fell ill they would look after my children. I was sure that my daughter would have a loving home to go to. My worry was my son., Farai needs special care and I know that it would be unfair to ask one of my sisters to take him in as they all have their own families.

### **“Dear God, why me and why now?”**

My newfound happiness did not last long. In 2003 I fell sick again. It was not anything specific; it would be a high-grade fever today and diarrhoea tomorrow. Most times I had no appetite, so I lost weight. At school I felt terrible; by break time I would be feeling so tired I couldn't wait for the school day to end.

I started losing weight until I resembled a moving skeleton. I loved my job and I did not want to leave my pupils, but I found it very difficult to continue in my state. I applied for sick leave and it was approved. I was lucky because the school head managed to find a relief teacher to cover my class.

I had many questions for God. I wanted to know why it was all happening to me; what had I done to deserve this? I knew many people who were



*Ruva's asking God **why me** touches my heart. I understand her anger towards God. Part of me feels guilty because of Ruva's situation. Why did it have to be her, why could it not have happened to someone else?*

promiscuous but who seemed not to have been infected, so why me? I tried to avoid worrying as this would make my situation worse, but it was not easy. It was difficult not to get stressed with the state of my health. I had several episodes of thrush and each one was worse than the previous one.

I had been avoiding going to a doctor because I felt I was not ready to confront the demons I had locked up in my closet. I feared to open the can of worms. I had known all along that the illness would come and I had avoided worrying about it. With each new opportunistic infection, I realised there was no way out. I went to a private doctor and told him of my condition and my status. I also informed him that I could not afford expensive medication so he had to prescribe something that I could afford on my teacher's salary. He referred me to an herbalist in Harare.

The herbal treatment made me feel much better and I went back to work after sixty days. Although I also had a prescription for drugs, I could not afford them and so I just concentrated on the more affordable herbs. I had been given a lot of different herbs, some of which I had to take during the school day. I would just take them in the staffroom, often in full view of the other staff members. This caused quite a stir among the teachers, who would be talking behind my back, speculating on the cause of my illness.

My doctor in Norton was a very good doctor and counsellor. When I went to him I was convinced I was dying, but he always managed to instil hope in



*As I drive home I take time to ponder Ruva's story. The question 'who gets AIDS' keeps coming back to me. Is it just those who are promiscuous? Why are some people more susceptible than others?*

me. I did not tell him that I could not afford his prescription for antibiotics; I just took it home and did not buy anything.

I had been advised to eat well and to eat unrefined foods. The problem was that while the food was readily available I could not afford to buy it. I did not want to burden my mother, as she had problems of her own. I was very sick this time, so one of my sisters came to stay with me.

Fortunately, I had my housemaid Thandeka at the time and she looked after me when I was very ill. Thandeka had lost her husband to AIDS, and even though we did not discuss the cause of my illness I think she suspected it. She was very caring and always at my bedside when I needed her. I do not know how we would have managed without her.

After some time I found myself unable to afford the herbs that had been working well; it was now too much for my meagre teachers' salary. I still had to pay school fees for my children and meet other living expenses, so I had no money for medication. I went back to my doctor and we talked about anti-retroviral therapy.<sup>iii</sup> At that time there were very few programmes offering free ART. There was one in Mtoko but this was too far and I knew no one in that area. Another programme was being run in Harare for Harare and Chitungwiza residents; I did not qualify as I lived in Norton, which is out of Harare. My doctor asked me to use a Harare address so that I could at least qualify for the free ARVs in the Harare programme. It also meant I had to be referred by a doctor in Harare.



*In a context of poverty such as Zimbabwe, HIV/AIDS results in considerable suffering for those in need of treatment. It is not possible for Ruva to afford treatment on her teachers' salary, and so schemes such as the DART programme remain one of the very few options available for those in the low-income bracket.*

*For Ruva, joining the programme was a huge achievement; it meant that she could access free anti-retroviral therapy, and have access to support groups where she could meet and socialise with others who are also living with AIDS*

I was referred by my doctor to join a programme in Harare which was offering free anti-retroviral therapy, the DART<sup>iv</sup> programme. To my disappointment I was disqualified because my CD4 count at 295 was still higher than their cut-off point, which is 250. I was expecting to get automatic entry into the programme because of my positive status. I felt I had reached the end of the world. I was devastated. I went back home in a depressed mood. I stayed at home and during this time I almost lost hope. I did not take care of myself well and my health was not good. I still had not managed to buy the prescription for antibiotics that the doctor had given me.

When I went back to my doctor after a month, he was shocked to see how much my health had deteriorated. I explained to him my disappointment at my failure to join the programme. He gave me a note to go again for blood tests. To my surprise and happiness, my CD4 count had gone down. I was happy with this development because it meant I could get on to the programme and receive free ART. In less than four weeks my CD4 count had gone down to 145. This was ironic because normally a reduction in CD4 count is not news to be happy about. This news is normally depressing, but for me it was good as it meant that I now qualified for free ART.

Finally I qualified to join the programme, and I was excited at the prospect of joining. I went early in the morning, started with the counselling, and then they did blood tests. At the end of the chain was where I was supposed to get my medication.



*While Ruva happily shared with me news of her acceptance into the programme, my mind started thinking of the long-term implications. The DART programme is a five-year programme. What happens to people like Ruva, who are on medication for life, when the programme folds?*

*Part of me wants to bring this to Ruva's attention, but another part of me realizes that Ruva is aware of the facts, and in her situation it is better to live for the day and face the challenge of tomorrow when it comes.*

However, the nurse on duty informed me that she was closing for the day. Their next intake would be in two months as they did not recruit on a daily basis.

I was devastated; I was now expecting to get medication. The joy that I had been feeling since that morning evaporated. This really affected me psychologically; I felt helpless. My expectation was that I would just join and get medication without many complications. This really upset me. Fortunately I had established a good relationship with my doctor, who phoned the doctor in charge of the programme. He talked to the nurse, asking her to assist me. I was started on anti-retroviral therapy in May 2003.

I was fortunate that I did not have adverse reactions to the ART, but I was still very sick. When I went back to work I could feel that people were talking about me behind my back because I had lost a lot of weight; I was wasted. I told my school head about my HIV-positive status because I wanted her to know that I would be going to the doctor for my monthly supply of drugs. I disclosed my status to her because I wanted her to understand my situation and allow me time off to seek medical attention when I needed it. I had already taken two months sick leave, and I felt that if I continued taking days off the school administration would find that unacceptable.

The school head was speechless; it was as if she was afraid to say something in case it was not the right thing to say. I was puzzled by her reaction, I had expected her to say something in response, but



*For Ruva, falling sick exposed her to stigmatisation from other teachers in the school.*

*Ervin Goffman (1963) described stigma as an attribute that is deeply discrediting within a particular social interaction.*

*Because of its nature, HIV infection fits the profile of a condition that carries a high level of stigmatisation. In many societies, people living with HIV are often blamed for their condition, with many believing they could have avoided the HIV infection if they had made better moral decisions.*

*Ruva found that because of the support that she received through the DART programme, she was able to stand her ground despite the stigmatisation that she faced from other staff members in the school.*

all she said was thank you for letting me know. As time went on, her health started to deteriorate but she tried to be very secretive about it. She was clearly unwell, but she dragged herself to work and tried to do her duties. When her situation deteriorated even more, she went on medical retirement and she died in her rural home a few months later. It was then that I understood her reaction when I had disclosed my status to her. She must have been struggling to come to terms with her own illness. Somehow a part of me felt guilty, as if there was something I could have done to prevent the situation from happening.

I found that other teachers started moving away from me. Often I heard whispers behind my back. I was showing visible signs of illness and I had become very sensitive to people's reactions. At times I noticed people avoiding me or avoiding eye contact with me. People started moving away from me at a time when all I needed was someone to talk to who would understand my situation. Instead, people moved away.

The counselling that I received during this time helped me to come to terms with my situation. I owe a lot to the counselling that I received from the herbal clinic and the DART programme. Through the counselling, I was able to slowly understand my situation and come to terms with my status. It did not happen overnight. I had days of anger, blame, panic and feeling betrayed. Acceptance came slowly.





*Listening to Ruva' story, one thing is clear to me; Ruva sees herself as an ideal teacher. She enjoys her job, and her love for her pupils is a consistent factor throughout her story.*

I realised that the more confident I felt about myself and my situation, the more people started accepting me. Some colleagues I had been close to withdrew from me but, with my new-found confidence, I did not mind. I just went on with my life. Other teachers would come and ask me indirectly about a cousin or sister who had certain symptoms and what they should do about it. No one would come out in the open and tell me that it was they who had the symptoms; they were always hiding behind someone.

In addition, I think that my background of having a disabled child helped me to quickly accept my situation. Through the counselling that I received then, I learned that God can never give you something that you cannot handle. I learned that instead of questioning why something bad has happened to me, I will have less anguish if I accept my fate and move on. I feel that I am alive today because I know my status. I believe that had Daniel been tested, he would have done something about his status and he would possibly be alive today. I talked to everyone who wanted to talk to me, and in this process I made new friends and lost some old ones. I developed an attitude of not caring what people thought or said about me. I stood my ground and people got used to me. It took a lot to get to that stage, but I owe a lot to the counselling that I received from the herbal clinic and the DART programme.



## “The ideal teacher”

*When HIV came into her life Ruva began to find teaching the subject HIV/AIDS very challenging. She struggled to make meaning of the disease in her life and the effect it has on her pupils. She reported that she resorted to selective teaching of some topics in the syllabus.*

I see myself as the ideal teacher. Looking back to the time before I tested HIV-positive, I can say that I really enjoyed teaching, and found the conditions of service good. I developed bonds with the children that I taught. I taught second grade and the children really looked up to me. I recall one child writing during creative work that when she grew up she wanted to be like me. I was flattered and I remembered that I also used to admire my secondary school English teacher, Mrs Museve. She always came to school looking smart and she was a good teacher. She inspired me, and I always make it a point that whenever I go to work I am well-dressed. To this day the young children I teach love me and they always want to be around me. I miss them when they go on holiday. Some get particularly close, and when they move to other grades they always come back to chat and catch up with me.

Before I tested HIV-positive I did not give much attention to teaching HIV/AIDS and Life Skills. Now HIV affects my teaching space in ways that I never thought possible. I remember that when I was sick I found delivering lessons on HIV/AIDS very tough. When you teach pupils in that state, you worry about how the pupils look at you and how and whether they accept you. Sometimes I ended up avoiding teaching some topics in the syllabus. For example, I would not be comfortable delivering a lesson dealing with the signs and symptoms of HIV and AIDS. It felt like I was opening up and exposing myself to the pupils, and this would make me



*The result is that Ruva faces a conflict between her image of 'self as ideal teacher' and that of 'self as person infected with HIV'. As if being infected herself was not enough, she had to face pupils who were infected and affected by HIV. Ruva expressed frustration at her training, which she feels has not prepared her to deal with such situations in the field.*

uncomfortable.

When I was sick I found that my illness had a negative impact on my teaching. I used to take time off work to go for medical treatment. Sometimes I just felt unwell and wanted to rest. There are also some things I was not able to do because of my illness. For example, when I was unwell I would be forced to deliver lessons from the chair. In cases where I was required to illustrate or demonstrate something, I was not able to do so. I used to react to chalk dust; it gave me a bad cough so I avoided writing on the board. I was not able to take part in sport; I did not have the energy for it. I felt like I was in need of special treatment all the time. I worried about how my illness was impacting on my pupils. Sometimes I would hear my pupils whispering to others that our teacher is sick.

I remember the pain I felt when Robert, one of the pupils in my class, died. He had been sick for some time and was always in need of love and care. I thought Robert was not getting enough support from his family. He was only seven, and he loved school. When he was well, he performed very well in class. He walked a long way to school and by the time he arrived he would be very tired. This really affected me because I had been there and I knew what it was like to be sick like that. I developed a close relationship with him. I wanted to make his mother understand and try to give him more love and maybe give him bus-fare for school on the days when he was ill. Sometimes he would feel too tired to walk back home at the end of the day, so he would just rest in the school grounds. His mother



*At this point in the interview, it becomes very clear to me that there is a silence around HIV/AIDS in our schools. It is as if HIV and AIDS and related illnesses do not exist, and it should be business as usual. In the absence of an HIV/AIDS workplace programme, it is left up to individuals to help each other in situations of illness.*

never came to find out where he was. If he was unable to walk home, I took him to my house to rest and then phoned the mother to come pick him up.

The mother clearly had other problems and could not afford to get him the medical attention he deserved. I was struggling with my own situation and there was not much that I could do to help him. One Monday he just did not turn up for school, and this was rather unusual. I called his house and I remember hearing cries in the background as I waited for his mother to come to the phone. She told me that Robert had died on the Saturday. His death was a very painful experience for me; I felt like I had let him down, that I could have done more for him. The other pupils in the class were also affected by his death, and because they are seven-year-olds I had to break it to them very gently and explain what HAD happened to him. This was not easy for me as I was also trying to come to terms with the death. Nothing in my teacher training had prepared me for moments like this.

I also felt that I was to blame when two teachers at my school died of HIV-related illnesses. I thought that if I had done something to help them, I could have saved their lives. When one of them had been ill, I had talked to her and shared my experiences. I talked about how I had been so ill to the point of losing hope and how ART had saved my life. She was very wasted, and always short of breath, having suffered from tuberculosis for months. I think by the time I talked to her it was too late, for a



*When I focused the interview to look at HIV/AIDS in the school, I noticed that Ruva made a deliberate shift from talking about Ruva the HIV-positive person to Ruva the teacher. Her identity is now centred on being a teacher.*

*I can think of two possible explanations: a) she is simply tired of talking about HIV-positive Ruva; b) perhaps more likely, when she is in class she sees herself as Ruva the teacher and this is the image she reflects back to me.*

week later she died. I feel that if I had been better equipped I should have talked to her earlier and she could have done something before it was too late. For days on end, I carried this guilt with me, and I blamed myself for her death.

The other, male teacher continued coming to school despite being very ill. When I asked, he told me that he had used up his ninety days that he is entitled to for sick leave. If he continued on sick leave, he would lose half his salary. Because he was a widower, he could not afford to survive on half of his salary. He also felt better if he was at school, surrounded by the schoolchildren, than just being at home by himself. And yet one could see that walking to school and spending the day was a struggle for him.

In class I find myself forced to take on the role of a counsellor, mother and sister, and at times I am taken as a confidante. Sometimes a child just comes up to me and cries. I need skills to counsel such a child or to get information from them. Decreasing performance of children in class is usually a pointer that something is wrong. When you really ask the pupil, usually there is something happening at home. Some pupils will not talk; it is only when you ask other pupils that you are told they are staying on their own or are looking after a sick parent.

This always affects me and I have problems distancing myself from the situation. I always find myself getting involved and trying to find solutions for my pupils. I realise that I need different skills to relate to different pupils. When I teach some



*One assumption of the Life Skills policy is that teachers are knowledgeable about HIV and its transmission, and that they are willing to talk about it with their students.*

topics, I know it is important to know the situation of children in my class and to adjust my lesson to include everyone. I remember in one lesson, when I asked pupils to draw their fathers, this little girl just drew circles. When she went home she started demanding to know who her father was and where he was. The mother came to school the next day to find out what was happening and why the child had this sudden need to know her father. The mother informed me that she was a single parent and the pupil had never known her father. While I felt bad for putting them through that situation, part of me just felt helpless because there is no way you can intimately know all the young people you teach.

The classes we teach are large and often I do not find time to give pupils individual attention. My experience is that children with problems are usually withdrawn in class, and it is up to the teacher to find out what is affecting them. I remember a very quiet boy who would never say anything in class. One day we were reading about Jesus and this little boy had a worried expression on his face. When I asked him what was on his mind, he hesitated at first. I kept probing until finally he said, "I know Jesus does not accept me because I am an orphan."

That statement said a lot to me, about how children affected by AIDS feel and how as a teacher I need to be able to talk to my pupils and make them feel accepted, whatever their circumstances.

In class a lot of the young people are in need of support. The HIV syllabus is too factual and it does



*It is apparent to me from interviewing Ruva that she feels that the training she received was inadequate. Furthermore, she worries about not getting any support to deal with her own personal situation.*

*I am struck by the insensitivity of the policy.*

not address psychosocial issues for children who are infected and affected. It does not go into the experiences of those who are affected and infected. In addition, the teacher training that I received did not equip me to deal with children who are infected and affected. A lot of the children we teach are orphaned, and the only adult guidance is what they get at school. I know that as a teacher I do not have the skills to fill the void left by the parents.

According to the HIV/AIDS and Life Skills policy, my role is to impart knowledge, the way I do with Mathematics or Science. I know that one cannot teach HIV/AIDS and Life Skills in that way. We are not empowering pupils for the future by just giving them basic facts about HIV. We need to make them aware of their surroundings and equip them with skills to make better decisions about their lives. HIV/AIDS does not affect only pupils but their teachers as well. How should teachers deal with abused, neglected or orphaned children? It would seem that we have no room for such children in our education system. In our culture, the girl child often finds herself withdrawn from school to nurse sick relatives, but our syllabus does not acknowledge this reality. It does not equip girl children with the skills they need to protect themselves. The syllabus is centred more on facts and it is detached from everyday reality. What is happening on the ground does not match what we read in our school books.

Life Skills has remained very theoretical. We have not created a situation where the children can transfer their skills to the home situation. In the





*I have come to the conclusion that the school is not an easy place to be for those possessing attributes that are out of the norm, such as HIV. What makes the situation difficult for those infected is the silence that still persists round HIV.*

*Ruva's story touches my heart because, despite all the challenges she faced in the school, it seems to me she has been left unmarked by it all. She is a woman who makes the best of her situation.*

early 1990s it might have been adequate, before HIV/AIDS prevalence became too high. Today's children often have little or no parental guidance and are exposed to a lot of influences. As a result quite a number start engaging in sexual activity very early in their lives. Children completing Grade 7 today are not equipped to face life and its challenges.

As a teacher I am expected to be resourceful because I was trained. I am expected to be an all-rounder. And yet I do not get any support to deal with my own situation. The support I get is from outside the school. How can I be there for pupils and effectively teach them when no one is thinking about my own status?

Teachers need to be well-equipped and trained so that they practice what they preach. As long as HIV/AIDS is treated differently from other diseases, we will not see the end of it. In my view, the Ministry of Education, Sport and Culture as our employer is not doing much to help teachers living with HIV and AIDS.

Even though I am on medical insurance, if I exceed my drug allocation I have to start paying cash for my medication. I remember a time when I was sick and I failed to buy medication. I had used up my allocation within the first six months of the year, and for the rest of the year I had to struggle with drug payments.

According to Public Service Policy, when I am sick I am entitled to ninety days' sick leave with full salary. If I exceed this time, I go on leave without full



*Today is my last interview with Ruva. The journey we have been through has been emotional for both of us. Over the weeks of the interview, I feel we have become close and I am grateful to Ruva for having shared an important part of her life. Part of me, however, feels guilty for just being on the receiving end of the relationship. While I have empathised with her, I feel that I have not given anything of myself. I am troubled by this.*

pay. This is frustrating because this is the time when I need the money the most. Teachers who go on medical retirement sometimes die before their funds are released. If the doctor gives me two days' sick leave it will contribute towards my ninety days. At times when you are sick you want to get time away and get treatment. In reality, sick teachers will not take time to rest because they fear they will use up their days, which they might need should their situation get critical. A lot of the human resource issues that affect me as a teacher today are not covered by the policy.

As a teacher, I worry that if I tell my school head about my situation it will affect the way he looks at me and the way we work together. If I fail to do something it is always about my status, even though it could have been a genuine mistake. Each time I ask to go to the doctor people raise eyebrows. They think I am trying to just get some time away from work for other things.

The counselling and support that I have received has made me more confident about myself and my HIV status. Now I take every opportunity that I get to talk to my pupils about HIV and AIDS. While the policy does not stipulate that HIV/AIDS and Life Skills be taught to pupils between Grades 1 and 3, I teach my infant classes about HIV. I know that these children are living with the reality of the disease every day of their lives, and they need to know about it. I always try to break it down in a way I know they will understand. In my view everyone needs to know about HIV/AIDS. Our education system should catch children early so



*As I mull it over in my head I come to the realisation that there is no such thing as being outside of the epidemic; we are all a part of it in one way or the other. Ibanez-Carrasco's (1993) words come to mind; he states that, culturally speaking, everyone is at risk and we are all involved because sexuality is a collective phenomenon.*

that they grow up knowing about it and are able to protect themselves. In my school I have disclosed my status to some of the teachers but not to school children. I am happy that I disclosed. I am now past the stage of feeling anger or blame about my HIV status. I still come across people who blame themselves or others for getting HIV.

They are always pointing fingers, and in some cases they build a wall around themselves. They get offended when people talk about HIV and become too sensitive about their status. I have been through this stage and I know it does not help. Disclosing is good because you open up, share experiences with others and find the strength to move on.

**“Society associates HIV with someone who is sick.”**

This is how society sees me. I am a teacher, I am a mother and I am HIV-free. In most cases I am asked to confirm my status because at the moment I am asymptomatic. The ARVs I have been taking for the past three years have helped me remain asymptomatic.

Society associates HIV with someone who is sick. They cannot believe that someone like me could be HIV-positive. I see myself as a whole person, and the issue of HIV does not come into it. Once in a while I might be reminded of my status but it does not occupy my mind all the time. However, there are times when I look back at lost opportunities with regret and this troubles me. I did not follow



*Listening to Ruva's story I let my mind drift to the other interviews where she chronicles her struggle with illness. I realise that one thing that has helped her to cope is joining support groups. From support groups she has gained information and made friends, and she has become more confident.*

*Like Gift, Ruva has now carved a purpose for herself in life. Through counselling she wants to help others, including pupils who need information, support and counselling on HIV/AIDS. Ruva now uses herself to make others see that there is life after testing positive.*

my dreams because I had lost hope thinking I would not last five years.

In particular, I wanted to further my education. My dream before I was diagnosed was to do a Bachelor of Education degree, but I never enrolled. I had lost hope. In the early days, HIV-positive people were given about five years to live, so I did not see the point. Now when I look back I realise that others who enrolled at that time have since completed their degrees and moved on. During that time I placed more importance on looking after myself, eating well and avoiding stress.

In the beginning I always used to ask God why this happened to me. As human beings we tend to compare ourselves with others. I remember I used to ask why other people who have had multiple sex partners are still alive and healthy. Why was I the unlucky one? What helped me is that I sought help early and the counselling that I received made a difference. I learned to accept that people are different.

One good thing that came out of my experience with illness is that it brought me closer to my children. It has also made me more sensitive to people around me. If I see my children getting sick I worry; when I see someone who is sick I can relate to what they are going through. When my daughter fell sick, what was wrong with her? I did all I could to make sure she received treatment on time. I worried about her and I wanted her pain to end because I know how it feels.

Up to this day I have not taken my son for testing. I



*As I conclude my interview with Ruva I am filled with admiration for this woman who is very loving, who has managed to bury the past and look to the future. I admire the fact that she is willing to share her life story if it will help others in her situation.*

do not think that I can stand knowing his status. I can stand my own sickness, but not the sickness of my children. I try by all means to get him proper medical care. Since the time he got meningitis he has not had any other serious illness. If I see him looking healthy, I thank God; I do not think I am strong enough to deal with the consequences of a positive test result for my son.

I have changed a lot. I am more conscious of myself and my body and what I do. I watch the food I eat; I prefer unrefined foods, lots of vegetables and white meat. I try as much as possible to avoid red meat. I have become more spiritual. I advocate for the empowerment of women so that they can control their own lives. I enjoy reading to get more information about HIV and AIDS.

I do not feel bitter, or feel any blame towards Daniel. Sometimes I think it could have been my first husband. It is normal to look back and blame. But now I realise that if they contracted it from somewhere, maybe they also did not want it. I have stopped that speculation. I am not bitter; I just face the present.

I believe that belonging to a support group has really helped me. I joined a support group because I wanted to find like-minded people to talk to. I feel very comfortable talking to other people in the same situation as myself. At times you give testimonies and at times you share ideas. If you know you are sharing with people who will not judge you, it builds your self-confidence and you do not feel any inhibitions. I know a lot of people who I have met from HIV/AIDS programmes and support



*Part of me feels sad that my interactions with her are coming to an end. I had started looking forward to our interviews.*

groups. If I feel the need to talk to someone, I can call someone from my support group who I am free to talk to, not necessarily about HIV/AIDS. We talk about our families, our lives, our weight, our finances and many things. I know that my friends support me in whatever I want to do.

My dream now is to do a course in systemic counselling because I have realised that I need counselling skills, as there are too many people who are dying not because their time is up but because they have no one to talk to who will understand them.

I think there is a need for a mindset shift, so that we see HIV as any other chronic illness such as high blood pressure or diabetes. As long as HIV is regarded as a disease of promiscuity, then we will not achieve much. People will continue to hide their status because of the stigma surrounding the disease. I talk openly about my status and I always want to share with others who might get inspiration from my story.

We need to create a forum for young people to meet and talk about issues of concern to them. At school we have AIDS clubs, but often children do not want to join for fear of being associated with AIDS. Teachers also need to have opportunities outside the school where we can share our experiences in a non-threatening environment. If we start engaging openly we are likely to see a change in behaviour and attitudes. People need to see the other side of the disease, where people who are living positively and who are healthy can offer hope.



## Chapter 6

### *Telling the stories (3)* *Edwin: Alone in a world where no one understands*

*Today I finally met Edwin, after weeks of fruitless searches. Getting hold of Edwin had not been easy; repeated calls to the school had been futile as he was frequently absent from work because of his illness.*

*Edwin's story is different in that it chronicles a lone struggle to cope with HIV/AIDS. Although he has occasional support from family and a few friends, for the most part his is a lone battle with HIV/AIDS. Unlike that of Gift and Ruva, Edwin's story is one of despair and loss of hope.*

#### **My struggle at school**

I stood outside my classroom door, watching the children play happily in the playground. Inside I was seething with anger. In a way, I wanted that feeling of anger to stay with me. Feeling angry with the school head meant that I would not feel the dull ache in my heart, an ache that had been with me through the months of Susan's illness. With Susan's condition deteriorating, my own health became a major concern. I was aware of the noise coming from my unattended class but I did not want to go indoors. I was angry and I wanted to rebel against the school head, Mr Musa.

That morning I had gone to Mr Musa's office seeking permission to leave school early as I wanted to go to Kwekwe to see my partner, Susan. She had been ill for almost three months and every Friday I made the trip to Kwekwe to be by her bedside. Kwekwe is four hours away from Harare by bus and I had planned to leave around midday so that I could be in Kwekwe before nightfall. Mr Musa refused; he did not want me to leave my classroom unattended for a whole afternoon.





*After I had interviewed three teachers who are members of support groups and whose stories reflect hope and victory against HIV/AIDS, I realised that this is just one side of the coin. I needed to look at the other side of the coin; at teachers who are fighting, and in some cases losing, the battle against the disease. I knew such teachers were the majority and I also knew that gaining access to them would be difficult for many will not come out in the open, preferring to struggle in silence.*

*I approached the Progressive Teachers' Union of Zimbabwe (PTUZ) for names of possible candidates to interview, and they promised to get in touch with me once they found someone.*

Going to Kwekwe on a Friday also meant that I would miss the interschool games that were being held the next day. According to Mr Musa, I had missed too many classes and school events, and other teachers were beginning to complain.

I walked back to my classroom feeling dejected. I felt all alone in a world where no one understood me. I knew Susan was expecting me that weekend and it was now clear that I was not going to make it. The interschool games ended at 4:30 on Saturday and by that time it would be too late to make the trip to Kweke. There was no point in going to Kwekwe on Sunday only to come back the same day. I was frustrated.

## **Who is Edwin?**

I was born on 18 May 1968 in the town of Mutare, the third-born in a family of five. My father was an Executive Officer at the Rural District Council and my mother worked for the Zimbabwe National Family Planning Council as a Programme Officer. When I was growing up, life was good for me. My family was relatively well off in comparison to others in my neighbourhood. We had most of the material things that we wanted and we ate well compared to other children in our school. I was one of the few children in my class who had school shoes and uniforms and who carried a packed lunch to school. I remember my father would drive me and my sisters to school every morning, but we insisted on walking home after school so that we



*I waited to hear from PTUZ for a week but they did not get in touch. A week later, when they had not called, I decided to pay them a visit. The officer apologised for not calling as they had been busy. Of the four teachers that he had contacted, only one had shown any interest in talking to me. His name was Edwin and he was a primary school teacher in Epworth, a peri-urban suburb in Harare.*

*I left PTUZ armed with the phone number of another teacher at the school. Edwin did not have a phone so he had given another teacher as his contact. I was optimistic.*

would have time to play with our friends.

In 1976 the family relocated to Bakwe and later Nyanyadzi when my father changed jobs. I completed my primary schooling in Nyanyadzi and then I did my secondary education at Mutambara High School. I was a very bright pupil but my teachers always remarked that I was a playful boy capable of doing better with more effort. I managed to scrape 5 O-Level subjects, to the surprise of my teachers and parents who thought I would not make it.

After completing my secondary education I joined the Forestry Commission, where I worked as a security officer. After a few months of working I found the job boring and too routine. Although I did not enjoy the job, I liked the money and the security that came from having my own money which I could use as I pleased. Every day after work I liked to go out and drink with the boys, and sometimes we would watch soccer. After a year, I had had enough and I quit my job. I wanted to do something more interesting.

One of my sisters is a teacher and she encouraged me to join the teaching profession. In those days it was easy to join teaching as an untrained or temporary teacher. I worked as a temporary teacher in Rusitu Valley from 1986 to 1989. I found myself enjoying teaching; it gave me immense pleasure. There is a lot of satisfaction that one gets when you teach and your pupils do well. I loved watching the growth in my pupils by the end of the year.



*I phoned the teacher on the contact number given and she told me that Edwin had not been coming to school that week because he was sick. She did not know where he lived. I had to wait for her to contact me when Edwin came back to school.*

*She got in touch after a few days, and for the first time I managed to speak to Edwin. It was a Thursday and we agreed to meet the following Monday.*

*On the phone Edwin did not sound too enthusiastic about our meeting. If anything, he sounded like someone with a lot on his mind. I was just happy that he agreed to meet me.*

There were also a lot of challenges, such as dealing with difficult pupils and fulfilling school duties, but these were part of the job. I enjoyed it because it kept my brain active as I had to keep reading. The hours were not too long and I managed to have time for a drink with the boys every afternoon.

After three years I applied to go for formal teacher training. I joined Morgenster Teachers College in 1990 to study for a Diploma in Education. I thoroughly enjoyed my years in college. We had the freedom and the money to do what we wanted. We studied hard and played harder. Sometimes we started drinking in the morning and the drinking would continue until nightfall. I remember incidents where I was too drunk to attend lectures the next morning. In spite of all this, I managed to pass my diploma and graduate with the rest of the class, much to the surprise of my peers and some lecturers.

After completing my Diploma in Education I was deployed to Beitbridge, where I was assigned to teach at Old Ntuli Primary School. I enjoyed teaching in Beitbridge. As a border town, it was always a hive of activity and I was at home there. I was not in a steady relationship because I had left my girlfriend, Susan, back home in Nyanyadzi. I had multiple casual relationships. In 1996 Martha, one of the girls I was seeing, got pregnant. I was not very happy with that because I was not ready to settle down. After much consideration, I decided to marry her as it seemed to be the proper thing to do at the time. I went ahead with the marriage although I knew deep in my heart that I was still in



*On Monday I was anxious. It would be the first time to meet Edwin and I was not sure how the meeting would go. I drove to Epworth to Edwin's school. We had made an appointment for midday.*

*As per Ministry regulations, my first port of call at the school was the administration block. I went to the headmaster's office, presented my research clearance, and explained the purpose of my visit. I asked to see Edwin but was told that he had not reported for duty.*

*When I asked for Edwin's home address, I was told that it was against school policy to disclose personal details of staff members. It was clear from the way Mr Musa spoke that Edwin's absenteeism had become an issue of concern in the school. I went back home feeling frustrated but more curious about Edwin.*

love with Susan.

Martha and I had a son but we were just not compatible. We were two very different people, brought together by circumstances. We tried for two years, until in 1998 we agreed the marriage was not working out and we went our separate ways. Martha is now married again and our son Brian stays with her mother. I try to keep in touch with my son, sending cards on Christmas and birthdays. In the beginning I used to send child support every month. However, of late I have not been able to send him anything because of my financial situation.

I started having problems with the school administration at Old Ntuli School where I taught. The school head wanted to control all the teachers in the school. It was as if he was an army general and we were his soldiers. And yet it should not be like that according to the Ministry of Education, Sport and Culture's Code of Conduct. What made it worse is that we all lived on the school compound, so he could come and knock on your door whenever he wished. We had no free time; during weekends and school holidays we had to take turns to do school duty. I hated that and I fought with him on several occasions. It was a frustrating time for me. I loved my job but I also wanted to have time to myself outside working hours. I decided to move to Harare in 2002. I knew that in towns conditions of service would be different from the rural areas. In towns things are more relaxed and there is not too much control from the school authorities.



**“I was not ready to know the truth about my HIV status.”**

*The next day I called again and Edwin had not reported for duty. I called every day after that, and finally on Friday he was in and I spoke to him. I asked if I could see him that day, and he agreed to meet me during his lunch break.*

*When I got to the school Edwin was waiting for me in the administration block, and the moment he saw me he introduced himself. I was happy to finally meet him.*

*To picture Edwin, think of a typical black middle-aged male teacher. He is tall, dark in complexion and well-dressed. He has a scar on his left eye and part of his forehead, possibly from herpes zoster.*

During the time I was married to Martha my love for Susan did not wane. She was still in my mind and she had a place in my heart. I had met Susan when I was only eighteen and she was my first love. We never broke up, but I moved to take up my teaching job in Beitbridge. In 2004 I went home to Manicaland to spend time with my parents. While at home I met Susan and it was love all over again. I remember the butterflies I felt in my stomach on seeing her again. I was happy to learn that she was not married, and was staying in Kwekwe with her sister. We resumed our love affair, and we were both happy. Although she lived in Kwekwe and I lived in Harare, we did not mind the distance. We used to talk on the phone every day and tried to see each other at least twice a month.

We started talking of getting married but this did not happen because in January 2005 Susan fell ill. She started losing weight and she had a bad chest. She was diagnosed as having tuberculosis and was put on treatment. Unfortunately, she did not respond well to the treatment and her condition got steadily worse. Every weekend I tried to be by her bedside, and it was painful to watch her die.

This was a very stressful time for me. I was travelling up and down, I was in trouble with the school authorities and I was behind in my work. To complicate matters, I suffered a bout of herpes



*Edwin suggested having the interview in the classroom as the pupils were on lunch break.*

*As we sat down to start the interview, I noticed that he was very tense. He had worry lines that were deeply ingrained on his forehead and he struck me as being someone who did not have much to smile about.*

*I started the interview by introducing myself and the purpose of my visit, in the hope that he would relax and open up to me. Instead, he seemed suspicious of my very presence. I was puzzled by his reaction.*

*It was not an easy interview, also because of the noise coming from the pupils outside. We kept being interrupted every few minutes by pupils coming to talk to him until he locked the classroom door.*

zoster which affected my left eye and forehead. I was at home for two weeks in excruciating pain, and during that time I was unable to visit Susan. We just spoke on the phone but I could tell from her voice that she was giving up the fight. I found the situation overwhelming.

I was happy when one of my sisters came to visit me, I poured out my heart to her. She advised me to get tested and to encourage Susan to also get tested. I decided to take my sister's advice because I could tell that there was something wrong with me. I waited for the lesions on my eye to get better, and then I went to the Public Service Medical Aid Society (PSMAS) Clinic to get an HIV test. Although I received counselling, I think in my mind I was not ready to know the truth. I was in a room with the doctor who was about to tell me my results when his phone rang. He excused himself and went into another room to answer the phone. I took the chance and ran away. Today when I think about it I laugh at myself.

However, I might have run away but this thing was eating me inside. I wasn't getting peace and I was worrying about my status, wondering what was happening to me.

The next weekend I went to Kwekwe to visit Susan. Like I had detected on the phone, she was losing hope. I almost did not recognise her; her cheeks were hollow and her eyes just stared into space with no sign of life in them. She was just skin and bone. I was hurt; we hugged and cried for a long time. She was very concerned when she saw my scars from the herpes zoster, but in my view





*In this first interview I found that it was not easy to get Edwin to open up to me. He only responded to the questions I asked him, and he would not volunteer any information unless I asked. Even then, his answers were always brief.*

*I was very disturbed by this because I really wanted to hear his story. In that first interview, I made the decision not to talk about HIV but to just talk about life – his life in general – as I thought this would get him to relax.*

*At the end of the hour I had some information about Edwin, how he grew up and that was all. I did not think I had gathered enough information in my first session, as I had with the other teachers.*

*I went home and tried to deal with my frustration. I sat down and recorded everything in my diary.*

that was mild compared to her situation.

We spent the whole night talking because she could not sleep. We went back to how we met, the time we were apart and meeting again. I tried encouraging her to talk about our future but she refused, preferring instead to go down memory lane. This was the closest I have ever felt to another human being. Susan did not want to get tested; she argued that in her situation there was no benefit of knowing her status. She would rather struggle with the TB until that battle was lost or won.

When I left for Harare that Sunday, Susan cried and said she did not want me to leave her. I had just been on sick leave and I could not take any more time off given the problems I had been facing with the school authorities. Susan's condition did not improve and she passed away in August 2005. I was away in Harare when I got a call that she had died. Her death was very painful to me. I felt that a part of me had died with her. At the same time, with Susan gone I was now worrying about my own status.

In September, a month after Susan died, I decided to go back to the Public Service Medical Aid Clinic to get tested. I was determined that this time I would leave the clinic knowing my status. I remember that when I went to the PSMAS Clinic I was not feeling too good; I was feeling dizzy and I was really unwell. They administered the necessary tests and the HIV test came back positive. My CD4 count was 58.





*For the second interview we had agreed to meet at the end of the week on a Friday. When I got to the school I asked Edwin if he had an alternative venue where we could meet in a quieter environment without too many disturbances. He proposed that we go to the house where he lived. We got into my car and headed for his house.*

When I went for testing I already suspected that I was positive; still the diagnosis left me paralysed. I did not know what was going to become of me. I felt that I had no purpose in life. Part of me blamed Susan, but when I thought about it I realised that I must have been HIV-positive before my encounters with Susan. Because my CD4 count was very low, I was immediately put on ARVs. In fact, at that time it was not explained to me that the medication I received was ARVs.

### **“My absenteeism became a point of conflict.”**

The time following Susan’s death was very traumatic for me. I was stressed because the headmaster wanted me at work and I had to attend to my health. At times I had to tell the headmaster that my health has to come first, and if I die there will not be anyone to teach my class. I did not want to sit in the classroom when I was feeling unwell. As a result, I had plenty of conflicts with the headmaster when he would not allow me time off to go to see the doctor.

It felt like I was having a series of misfortunes: in June 2005 I developed herpes zoster, in August 2005 Susan passed away, and in September I tested HIV-positive. Throughout all this, I was mourning Susan and trying to deal with my own illness. I started developing opportunistic infections. I would go to work for a few days and then get sick again on and off. I knew this was disturbing for the pupils because there was no



*To my surprise and happiness the moment we exited the school gate Edwin was a happier and more relaxed person. He started recounting his early days at the school and how things had changed since then. He talked about the surrounding community and its relationship with the school. We chatted all the way from school to his home, and I began to get a glimpse into the life of a man called Edwin.*

continuity. At the same time, my absenteeism became a point of conflict with the school authorities. The headmaster felt that it was better for me to go on sick leave because I was missing too many classes.

I took sick leave for the three months, from October to December of 2005. This time away really helped me to start coming to terms with my situation. I had a lot of time to reflect on my situation, and I even attended a few counselling sessions at the PSMAS Clinic. Going for counselling was an eye-opener for me, and it made me change the way that I perceived the disease. I learned that I should view HIV as just another chronic disease, like high blood pressure or diabetes. By the time my three months were coming to an end, I was feeling much better.

I came back to work in January 2006 when schools opened. Then it began again; I started suffering from the side-effects of the ARVs. I was very depressed and I was diagnosed to be suffering from organic psychosis. The doctors said the hallucinations that I had were as a result of the ARVs that I was taking. It was terrible; I did not want to be in front of the pupils in my condition.

My attendance at school became erratic and I had serious problems with the school administration. Almost every fortnight I was applying for sick leave, and they claimed that I was abusing the sick-leave facility. I tried to explain to them that my requests for leave were genuine, but from their point of view it was becoming counter-productive. Parents were bitter about my absenteeism; some phoned the headmaster and some phoned the Ministry of



*Edwin directed me to his home, a cottage at the back of a big old house. We did not go inside, as he suggested having the interview outside. I was comfortable to sit and chat with him outside his cottage.*

*Once we were seated he admitted to me that he had been uncomfortable about my visit as he had worried that I had been sent by the Ministry of Education, Sport and Culture to investigate the reasons for his erratic attendance at school. It was then that I understood his reluctance to meet and talk to me.*

Education offices. Sometimes when I was on sick leave I would get depressed sitting at home by myself and I would go to the local beer hall to take my mind off my illness. When parents would see me there they would be angry that I could go a beer hall when their children had no one teaching them at school. They would go and confront the school head about this, and before I knew it my absenteeism had become a big issue.

The school head reported the matter to the District Education Office and I was charged with abuse of sick leave. The charges have been recorded in my files at the Ministry of Education. All this stress got to me and my health continued to deteriorate. The charges of misconduct came because I had been continually absent from work. The school head was unhappy with my behaviour and he did not offer any support when I was brought before the District Education Officer. On the day of the disciplinary action, I looked so ill that even the District Education Officer showed some sympathy for me. He advised me to go on indefinite sick leave and I got away with a warning.

In February 2006 I went again on indefinite sick leave, which was to end on 28 May 2006. By the end of May I was still sick so I continued into June. I then applied for medical board, and I was granted leave in excess of 90 days which allowed me to be away from work up to 30 June 2006. By the time June came, I had exceeded the mandatory ninety days. I was now a candidate for medical boarding. Because I had taken leave in excess of



*In class Edwin found himself face to face with sick pupils, and this affects him. He admits that being HIV-positive affected the way he taught the subject of HIV and AIDS. Despite his personal situation and the lack of support that he got from the school, Edwin showed concern for the pupils under his care. I am touched by this.*

*I found the situation ironic because Edwin is expected by the policy to care for the young people under his care. But the policy says nothing about caring for Edwin or others in his situation.*

ninety days, I was no longer on the government payroll. I came back to work on 1 July 2006. As I was no longer receiving a salary, I had to go through the formalities again so that I could go back on the payroll. I was told the process would take some time before I was back on the payroll. On the bright side, my health was improving and when I came back to school everyone remarked that I was looking much better. With the ARVs that I was taking, my health had improved greatly.

### **“I just try to teach normally.”**

I have enjoyed my years as a teacher. When I am in front of the class I am the master, and I get immense satisfaction when my students do well. For the five years I have been teaching in Harare, I have taught Grade 4 pupils. In the school I am somewhat of a loner; I don't interact a lot with other members of staff.

As a Grade 4 teacher, the policy stipulates that I should give one HIV/AIDS and Life Skills lesson to my pupils once every week. To my knowledge, it is being implemented by most teachers because at this school the headmaster is very particular about it. In my opinion we give pupils a lot of biological facts around sexual and reproductive health; they need to know about real life and what could be happening to them at home. Children need to be aware of what is happening in their context in relation to HIV.

In addition, I think the 35 minutes allocated to each lesson is not enough; it is something that should be



*According to Zimbabwe Public Service Regulations, teachers have an annual entitlement to ninety days sick leave on full pay in addition to the normal vacation leave. Should illness continue, teachers are entitled to a further ninety days on half pay, which is subject to a medical board opinion on whether a person is able to resume duty. Teachers are also entitled to twelve days special leave on full pay, which is used for urgent private affairs such as funerals.*

*In cases of prolonged illness such as Edwin's case, it becomes difficult for teachers as they now have to survive on a reduced salary at a time when they need the money the most.*

happening continuously. I feel that parents should be sensitised to teach their children about AIDS so that they can also help us teachers. It should begin at home. We should work together with parents; that way we can reinforce the messages and avoid giving young people conflicting messages.

In the school I feel that HIV/AIDS issues are handled in a way that does not consider that there might be some people within the school environment who are infected and affected. Nothing is being done; it is as if there are no HIV-positive people in the school community. No one gets any support within the school, except maybe in the form of counselling.

Being HIV-positive has definitely affected my teaching. When children come to me for counselling on HIV-related issues, I can relate to their pain. I see the pain that I felt long ago reflecting in their eyes. Just this past week a child in my class, Maria, came to me for help. Her father had passed away and her mother is very sick. Being the eldest child she has to look after her mother and her siblings, making sure there is food to eat at home and medication for her mother. So far she had been using the money that her father had left. Now that money was finished and she had no source of income to support the family. This child was one of the brightest in my class and my heart went out to her. At eleven she was already faced with a burden that children her age should not have to face. She confided to me that her situation was forcing her out of school.

My heart went out to Maria. As a school the only support we could give her was a referral letter that she could take to the Department of Social Welfare.



*Edwin's story takes me through the emotional, physiological and physical hardships that he endured as a result of his illness. It reveals his experiences as a victim of fear, loneliness, isolation, judgement and shame. His body tells the story of a body that has been shaken by many bouts of illness. The emaciated frame and the marks on the face and hands tell the story of a body in a constant battle with AIDS.*

*I am touched by Edwin's willingness to let me into his life as a witness to all the hardships he was facing.*

In my heart I felt that I had failed my pupil. Yet at the same time I realised that there was not much more I could do for her. She still attends school, although not regularly, and I know that one day she will disappear and end up on the streets like some of her peers.

In class I feel that the way we teach our HIV/AIDS syllabus does not consider the fact that there might be people in the school environment who are infected or affected by HIV/AIDS. There is silence; it is as if there are no HIV-positive people in the school community. No one (pupils, teachers or other staff members) gets any support. The only support we give pupils is in the form of counselling.

As a teacher, I am expected to teach children regardless of my own personal situation. I do not get any support from the workplace. All teachers are expected to teach children, when some have not dealt with their own personal situations. I feel that something should be done to assist teachers deal with their own issues before they can deal with the children. There is really no support for teachers in the workplace. Personally I feel that there are ways in which my school could help me. Schools can and should do more to assist teachers to deal with their own issues before they can deal with the pupils.

Ever since I tested HIV-positive, I just try teaching normally and I hope that nothing much has changed in my teaching. It is the on-and-off illness that really affects continuity with my class. I am aware that I do not have a good reputation with parents, other teachers and pupils because of my repeated absences at school. I also know that my absence





*As I drive away, mulling over Edwin's story in my head, thinking about his loneliness, about his lack of support in the school, about his battles with the school authorities and about the consequences of his erratic attendance at school, I am left wondering whose rights come first?*

*Is it the rights of the children to an adequate education, or the rights of the teacher to get treatment? What about the rights of the other teachers?*

affects the pass rate of my pupils, because each time I go they are given relief teachers who are sometimes not trained and who do not know how to teach. Now we have a new, challenging syllabus and often they cannot teach this.

I am now finding the whole school environment, from pupils to staff, very stressful. The stress I get from children is mainly because children are playful; at times you need to have a bit of peace and quiet and rest, but they do not allow you to do that. In Grade 4 they are full of energy and sometimes I cannot keep up. When you try to tell them that you need rest, it really gets you worked up. We have double shifts, which we change after a fortnight. Personally I prefer the morning shift so that in the afternoon I can have enough rest. When I come in for the afternoon shift I find it difficult because we finish at 4:00 p.m. At that time I will be hungry and tired and I need to eat something substantial before I take my medication.

The Ministry of Education, Sport and Culture policy does not say anything about teachers living with AIDS. Government has not even considered giving teachers free ARVs, even though teachers pay the AIDS Levy every month. We do not know who is benefiting from this levy but it is certainly not us teachers. Government should do something about the sick-leave policy. Most of the people who are taking ninety days' sick leave are HIV-positive. If the ninety days elapse, the teachers face problems because they will not be able to buy their treatment. I think instead of cutting 100% salary, they should give the teacher 50% of their salary.





*My second interview with Edwin also took place at his house. By now he is more relaxed around me as he talks about the stress that he faces in school and his challenges to source the life-saving medication that he requires.*

*Talking to Edwin, I understand the physical and emotional suffering that AIDS brought him. I understand how in a context such as Zimbabwe Edwin faces major challenges in accessing the medication that he needs.*

The Ministry of Education, Sport and Culture and the Teacher Unions are also not doing enough for us teachers. When I was sick I did not get any sympathy. Instead I got a bad record and I am in bad books with the authorities. I feel that I have been a victim of insensitive policies. One time at the PSMAS Clinic I met a teacher who offered to resign after continued confrontations with the authorities because she was being labelled unproductive.

I agree that as a teacher I am supposed to be productive because I am being paid. However, it is within my right as a teacher to go on leave when I am sick, to access medication and come back to work when I feel better. My experience was that when I came back, the environment was different; I was in bad books with the head teacher. I felt that the other teachers were not very friendly because of the extra load that I gave some of them, teaching my class in my absence.

Coming to work after my illness, I found that the workplace was not the same place anymore. I felt that other staff members did not really accept me, and sometimes I thought the other teachers were laughing at me behind my back. This made it very difficult for me to disclose my status to anyone in the school because I felt that no one would understand.

I was forced to disclose my status to the school head and his deputy when I continued having episodes of illness. I also told two other teachers about my status. They were very supportive and I remember one of them assured me that they



*As I listen to Edwin, I am struck by how lonely he seems. I think of the school, how busy and alive it all seemed when I visited – the children playing happily in the playground, teachers chatting in the sun, while some sat in the staffroom. It was all full of life; it seemed as if there was no room for loneliness.*

*I am amazed by how Edwin could be lonely in the middle of a bustling, energetic place like a school; it hardly seems possible.*

would cover some of my school duties if ever I felt unwell.

I do not regret disclosing my status to the school head and his deputy because I think that since I disclosed they have become more understanding of my situation. Sometimes I think that my disclosure was too late. Maybe I could have avoided all the misunderstandings and the disciplinary hearings had I disclosed early.

**“I am human; at times it gets me down.”**

A lot of things have changed in my life since I was diagnosed. I have a lot of stress and I am having problems coping with my situation. Stress for me usually comes when I fail to get what I want – for example, when I know my drugs are finishing and I don’t have the money to buy the next month’s supply. I cannot cope with buying drugs with the meagre salary that I earn. Drugs cost me around four million Zimbabwe dollars a month (USD40). That was last month’s price, and the price always goes up. You can buy the drugs on medical aid, but you have to pay the cash up front and then claim a percentage of it. Under this system, you never get all your money back.

As it is I am in a tight spot. I have not been getting my salary since July when I went on indefinite sick leave. As of today I am only left with three days’ supply of ARVs, and I need to contact my sister to help me buy medication.



*The next time I went to see Edwin for what was to be our third and final interview, he was not at school. The school head informed me that they suspected he was ill. He had not been coming to work for two days. As he was not contactable by phone, I went to his house. He was not there. A neighbor told me that they had not seen him in two days. Further efforts to follow up with him were fruitless. The school head later informed me that he had received communication from the Ministry that Edwin had applied for medical board, and that Edwin had gone to Manicaland while awaiting the decision of the board.*

When I come to work I get a lot of stress, from the kids and the school management, and that is not good when you are in my condition. I have a lot of problems at work. I know people talk behind my back about my situation. Those attitudes from other people get me down. The way I cope with it is not to think about it. But I am human, and at times it really gets me down.

These days I am on and off, and I was not like this before. I am getting a lot of opportunistic infections. In the early 1990s, once a year I would get a dose of malaria, especially if I go to my home area which is malaria-prone. Now I am more prone to infections, and I run fevers three or four times a month.

My family has been very supportive. They sometimes help me to buy drugs. As far as my friends are concerned, nothing has changed. I have told my two drinking buddies and they have been very supportive. They took me as I am and did not discriminate against me. This somewhat helped me to cope with my situation. When I am in the beer hall, I have developed 'shock absorbers' because people say a lot and I cannot always be getting upset by what people say. At times I encourage my friends to go and get tested. I sometimes see familiar symptoms in friends, and I always try to assist where I can.

I have accepted that this is what God has given me. I grew up in a religious family. Once in a while I go to church but I cannot say that I am very religious. I have been thinking a lot about my future and I have come up with two plans. One



*I am frustrated by the fact that I am unable to complete my interviews with Edwin, but in my heart I wish him well.*

plan is to resign from teaching because I cannot afford ARVs on my salary in Zimbabwe. I would like to relocate to another country where I can freely access medication. I know relocation is not easy, especially given my health.

If the relocation plan fails, I would like to go back home and look for a place to teach in Nyanyadzi, my home area. I would be near my parents where life is slower and cheaper for me. My doctors are supportive of this. My mother would look after me and I would be surrounded by my family. My mother has been giving me a lot of support and encouragement. Sometimes she even sends me money to buy drugs. It will be easier for her to support me when I am living with them.

## Chapter 7

### ***Teacher as role model and ideal citizen versus teacher as HIV-positive person***

#### **Introduction**

In earlier chapters I told the stories of Gift, Ruva and Edwin separately in an endeavour to give space and individual attention to each story. In the following chapters I bring together the three stories in an analytic frame. My aim is to identify commonalities and idiosyncrasies that could extend our understanding of the experiences of teachers living with HIV and AIDS. I seek to expose new knowledge that I believe will bring some depth to understanding the experiences of teachers living with HIV and AIDS. I intend to juxtapose the self-inscribed identities of the HIV positive-teacher against prescribed and inflicted identities, and to analyse how these play out for the HIV-positive teacher within the school context. I use the following three themes that emerged from my data analysis as a guide in answering my research questions:

- the teacher as a role model and ideal citizen versus the teacher as an HIV-positive person;
- the impact of HIV illness on the body of the teacher;
- the teacher as an emotional actor.

In this chapter I follow a line of inquiry which suggests that *policy images* of teachers make demands that conflict with their *personal identities* as practitioners (Jansen 2001). I start the chapter by unpacking the dominant images of teachers embedded in the HIV/AIDS and education policy documents in Zimbabwe. Through a synthesis of the key HIV/AIDS policy documents, I show how the policy narratives construct teacher identity and how policy makers perceive education, teaching and

learning in a context with AIDS. I demonstrate that where policy envisions teachers as role models and ideal citizens, society places expectations on teachers to act as role models for the young people in their care, and the teachers in turn envision themselves as role models. I argue that the moment the teacher tests HIV-positive, the perfect harmony of role models and ideal citizens imagined in policy is overturned. The result is that the HIV-positive teachers see themselves as failures who can no longer be role models, and they face an internal conflict between self as ideal teacher and self as HIV-positive teacher.

I propose a conception of teachers' personal identities that organises them around three categories of analysis – teachers as professional, social and emotional actors. I then suggest a deeper exploration of the personal identity of teachers if one is to understand the identity dilemma they face in high-prevalence countries as they strive to implement HIV/AIDS and Life Skills policy. I suggest that policy should take perceptions of teachers beyond the professional, and not promote prevention at the expense of care and support. I argue that it is through looking beyond prevention that policy can begin to deal with issues of the emotional and personal circumstances of individual teachers. I conclude that the successful implementation of HIV and AIDS policy rests on the degree to which policies and programmes take into account the socio-cultural realities existing in classrooms in HIV/AIDS contexts.

## **Policy images of teachers**

By policy images I mean the official projections through various policy texts of what the ideal teacher looks like (Jansen 2001). The HIV/AIDS and education policy documents that I analysed contain powerful images of the ideal end user of the education policy. They confront teachers with descriptions, regulations and expectations on how to conduct their job and how to see themselves. It is these messages from policy makers, transmitted through policy documents, that determine the curricula messages that filter down to the classrooms. A documentary analysis offers various policy conceptions of the end users of policy – that is, teachers. I will analyse the various policy images of teachers in the next section.

## Teacher as *facilitator* of the learning process

Teacher as facilitator is one of the dominant images in Life Skills Education policy. In this image, teachers move back from taking centre stage to a marginal position in the classroom, where their role is to facilitate the learning process with students taking the lead. This role of teacher as facilitator is a prerequisite for Life Skills Education. According to Gachuhi (1999), life skills are best learned through experiential activities which are learner-centred and designed to help young people gain information, examine attitudes and practice skills. Examples of such activities include discussions, group work, role plays, games and story-telling.

With the participatory method, teachers find that, instead of being the dominant force in the classroom, they are now re-imaged to become facilitators of a new pedagogy (Jansen 2001). The miscalculation with this method is that it does not take into account the reality of classrooms in the developing world. Teachers lacking in subject knowledge and professional confidence will feel challenged if relegated to the margins of an overcrowded classroom (Jansen 2001). Expecting teachers to adopt a different style of teaching within the confines of the same classroom has proved problematic, particularly in Sub-Saharan Africa. In Zimbabwe, as in the rest of the developing world, teaching tends to be didactic, non-participatory and teacher-led, although Life Skills Education is intended to be participatory and responsive. Several evaluations found that the realities of such a formal education system were in conflict with the recommended participatory methodologies (Seabrooke 2000; Baxen and Breidlid 2004; Boler and Aggleton 2004).

The image of teacher as facilitator did not result in new ways of teaching and learning at the classroom level as envisaged by policy. Instead, teachers find themselves reluctant to teach HIV/AIDS and Life Skills, and they often avoid some elements of the curriculum. Ruva reported resorting to selective teaching of topics:

*Sometimes I ended up avoiding teaching some topics in the syllabus. For example, I would not be comfortable delivering a lesson dealing with the signs and symptoms of HIV/AIDS. It felt like I was opening up and exposing myself to the pupils, and this would make me uncomfortable.*

Similarly, Gift found that:





*Talking about the signs and symptoms of HIV and AIDS to a class of pupils was very difficult. In my own mind I felt that the pupils could see some of the symptoms on me.*

The image of teacher as facilitator did not seem to translate neatly into teachers' personal identities because it did not consider teachers as producers, interpreters and mediators of safe sex messages who work within fields where that knowledge may be contested (Baxen and Breidlid 2004). Edwin sums it up well when he says:

*As a teacher, I am expected to teach children regardless of my own personal situation.... something should be done to assist teachers deal with their own issues before they can deal with the children.*

Baxen and Breidlid (2004) argue that it would seem that it is assumed that if teachers have the necessary knowledge about and skills to teach, they will teach, notwithstanding how they position themselves within the HIV/AIDS discourse. The reality is that teachers do make decisions about what knowledge to teach, when and how. This is echoed by Semali (2006), who argues that teacher knowledge is largely surrounded by complex socio-cultural contexts that are at the crossroads of poverty, inadequate infrastructure, a school curriculum that teachers do not own and a devastating epidemic. A deeper exploration and consideration of these realities is essential if HIV/AIDS and Life Skills programmes are to be implemented successfully.

### **Teacher as role model and ideal citizen**

The image of teacher as role model and ideal citizen provides yet another powerful image of what teachers should be like and how they should behave. Parents and others usually see teachers as responsible for fostering much of the overall development of young people so that they might achieve personal fulfilment and become significant members of society (Kelly 2008). Because of this, teachers tend to hold positions of respect and special status in society, even though they may not be recompensed proportionately. As Gift says:

*As a teacher I was a respected member of the community. The fact that we had more disposable income than most of the community members put me and other teachers in a position of power.*

The importance of role models in fostering desired behaviour change is an important component of Bandura's theory of social cognitive learning, which states that new behaviours are learned either by modelling the behaviour of others or by direct experience (Bandura 1994). Society places an ethical and moral obligation on teachers to act as role models for young people in their care by holding teachers accountable not just for imparting knowledge and information but for imparting values (Zapulla 1997). Society expects teachers to have higher standards of behaviour than people in other occupations, a presumption based on the conception of teachers as role models (Strike and Ternasky 1993).

Teachers teaching in an AIDS context play multiple roles, and in most cases these go unacknowledged. Ruva finds herself forced to take on multiple roles in the classroom:

*In class I find myself forced to take the role of a counsellor, mother and sister, and at times I am taken as a confidante.*

Semali (2006) argues that, the roles of leader, elder and sage that classroom teachers fill in educational circles is almost absent in educational policy documents. Little or no attention is paid to the discourse on everyday sexual practices among teachers and how this impacts their role as role models for pupils in an AIDS context.

### **Teacher as *mentor and counsellor***

The image of teacher as mentor and counsellor is implied in HIV/AIDS and Life Skills policy documents, although it is not outlined explicitly. Both policy and curriculum make scant provision for counselling or ministering to the emotional needs of students. Due to poverty and orphan-hood, schools are sometimes the only places where children might expect to find any level of care. Bhana, Morrell, Epstein and Moletsane (2006) argue that the lack of resources, an overloaded curriculum and multiple complex demands on teachers mean that such responsibilities are very difficult and may go unperformed.

In most Zimbabwean schools many of the teachers are in some way or other involved in care work, but the conditions of schools determine the nature and extent of the care work that teachers are called to deliver. Bhana *et al.* (2006) argue that although this work does not fall within the curriculum and cannot easily be measured, it is this work that is cushioning learners from the trauma of loss that many experience. It is thus vital for the well-being of schools, even as it is hidden from public recognition.

At school level the reality is that almost unnoticed teachers are dealing with the consequences of HIV/AIDS in their schools and communities. Teachers are going the extra mile to cater for learners who are either infected or affected, what Bhana *et al.* (2006) referred to as the “hidden work of caring”. That teachers are involved in care work is evidenced by Ruva when she says:

*In class I find myself taking on the role of a counsellor, mother and sister, and at times I am taken as a confidante; I am expected to be an all-rounder.*

Edwin also stated that pupils in his class confided in him when they faced problems in their homes:

*Maria confided in me that her situation was forcing her out of school so she could get an income to support her family.*

However, while many teachers find themselves involved in some form of care work, many have received little or no training and not all teachers have the personal insight and strength to undertake care work. This is illustrated by Ruva when she says:

*I realise that I need different skills to relate to different pupils, but the teacher training that I received did not equip me to deal with children that are infected and affected. A lot of the children we teach are orphaned and the only adult guidance is what they get at school. I know that as a teacher I do not have the skills to fill the void left by the parents.*

While Ruva and Edwin immediately took up care work, feeling that it was their responsibility, Gift responded differently on the matter, as he found that his own personal situation was reducing the attention he gave to pupils:

*The level of my engagement with students was really going down. During this time my pupils suffered because even though I was there physically I was not giving them the attention that they deserved, and I think that my pupils felt and were affected by my situation.*

This suggests that the way teachers act in schools and in classrooms is uneven, depending on their personal aspirations and their expectations, which are determined by their own personal situations. Teachers' personal aspirations and expectations are also in constant negotiation with policy. Hoadley (2002) posits that teachers' work must be viewed against their agency in contesting, negotiating and co-opting broader policy directives.

## **How do teachers see themselves?**

Teachers' identities refer to teachers' sense of self as well as their knowledge and beliefs, dispositions, interests and orientation towards work and change (Spillane 2000). According to Clandinin and Connelly (2000), identities are constructed by the way people relate to the world and to other people, the choices they make, their practices, their use of language, and the narratives they hear and tell about others and themselves. In this study I categorise teacher identities as the way teachers feel about themselves professionally, emotionally and socially.

## **Teachers as professional actors**

Jansen (2001) defines teacher professional identity as the way teachers understand their capacity to teach as a result of their subject matter competence, levels of training and preparation, and formal qualifications. As professionals, the teachers understood their professional role to include imparting knowledge on HIV/AIDS and Life Skills to pupils, in order to facilitate behaviour change. All three teachers considered themselves to be good teachers who had an important role to play in Life Skills Education. However, when the teachers tested HIV-positive, they felt that they had fallen short of this image, as testing positive went against the moral values that they were supposed to pass on to the pupils.

Ruva faces a challenge when HIV comes into her life:

*...now HIV affects my teaching space in ways that I never thought possible.*

The three teachers' stories show how the presence of HIV in their lives dramatically changes their teaching spaces. The changing of teaching space is not just confined to the external but occurs as a result of internal changes. They experience internal changes due to the extensive psychological and emotional turmoil that they undergo. However, this does not remain confined within the self, as it also reshapes the external space of the teachers. In other words, what the teachers feel internally determines how they interact with HIV in the classroom. I argue that this complex interaction between internal and external spaces influences the way teachers contest, negotiate and co-opt policy directives. I further argue that while policy cannot account for these levels of interaction and perceptions that operate in the teaching space, it could strive to create an environment where teachers feel that their internal spaces are catered for. This is evidenced by Edwin when he says:

*Schools [read policy] can and should do more to assist teachers to deal with their own issues before they can deal with the pupils.*

The teachers' dilemma is further complicated by the moralistic discourses around sexuality and HIV/AIDS that prevail in schools. The dominant discourses assume a causal relationship between infection by the HI virus and allegedly immoral, mostly sexual behaviour such as promiscuity and homosexuality (Erevelles 2006). In Gift's school, they used to make pupils recite the motto, "AIDS kills; avoid premarital sex." As Gift says:

*This message was blind to the fact that there were pupils in the school who could have been born HIV-positive. It was as if we were saying schools are immune to AIDS, and our main effort as educators is to maintain that status quo. As educators we have a task of shaping young minds. How then do we let young people see HIV as a curse?*

It is such discourses that feed into the culture of silence around HIV that prevails in schools. HIV/AIDS and Life Skills Education becomes more than just giving biomedical information to students, but also encompasses issues around moral values, sexual knowledge, and the nature of childhood and adolescents. Maile (2004) argues that the HIV-related silence is not natural, but is a creation of individuals, organisations and communities. In general, schools are characterised by a deafening silence, particularly around HIV/AIDS care and support, and this silence is

replicated at the institutional, academic and personal level. Gift illustrates this when he says:

*I was struck by the failure to acknowledge the possibility that there could be pupils, teachers and other staff who are infected and affected by HIV/AIDS.*

Edwin also alludes to the silence:

*There is silence; it is as if there are no HIV-positive people in the school community.*

I suggest that policy's lack of acknowledgement for those living with HIV translates into the dangerous silence and secrecy that surrounds HIV at school level. As policy shades into planning, and planning into implementation, it is evident that the presence of HIV in teachers and pupils remains a reality to be concealed. Perhaps this allows school communities to imagine that they might remain untouched by the disease. Kelly (2001) makes a similar case about universities in Africa when he talks of a thick cloak of silence that surrounds the presence of the disease, a cloak which is amply lined by layers of secrecy, silence, denial, fear of stigmatisation and discrimination.

## **Teachers as social actors**

By teachers as social actors, I refer to how teachers understand their role in society regarding HIV and AIDS. As reflected in policy, society places a moral obligation on teachers to act as ideal citizens and role models, as this is seen to be in the best interests of the children. The image of self as an ideal teacher and role model is an important theme running through all three teachers' stories. All three teachers see themselves as role models, as evidenced by both Ruva and Edwin describing themselves as ideal teachers. Gift illustrates the conception of self as role model when he says:

*I considered myself a good teacher and a role model for the young people under my charge.*

This is echoed by Ruva when she says simply:

*I see myself as an ideal teacher.*

Once they found out that they had AIDS, all three teachers feared that others would think they had fallen short of this ideal. Because of the perception of HIV as an immoral disease, the teachers viewed themselves as flawed, tainted victims. This poses a direct conflict with the teachers' image of self as ideal teachers and role models. This conflict between self as an ideal teacher and role model and self as an infected person is a common theme in the teachers' stories, which is perhaps most explicit in the stories of Gift and Ruva. As Gift laments:

*How could I still live up to this image when I am now confirmed HIV-positive? How could I talk to the children about HIV without thinking and referring to my own situation? How could I be an HIV-positive person and a good teacher at the same time?*

Because they see themselves as ideal teachers, they are aware of society's expectations of them, and they become anxious about how others will see them. They feel that they have fallen short of society's expectations and their own perceptions of self (Zapulla 1997).

Kachingwe *et al.* (2005) identified teachers' personal behaviour as one of the factors impacting on teachers' capacity to be role models. Personal risky behaviour not only increases the risk profile of teachers but also undermines their value as role models. Teachers in Sub-Saharan Africa are often cited as having a higher risk of HIV infection, although credible empirical evidence is often lacking (Bennell 2001). While there is a general lack of statistics to compare teachers' HIV-related morbidity and mortality to that of other professional groups, HIV prevalence rates among teachers remain a cause for concern. Badcock-Walters and Whiteside (1999) suggest that teachers are at greater risk of infection due to higher disposable income, spouse separation and frequent change of stations, all of which encourage multiple sexual relationships. The stories of the three teachers highlight some of the factors that have been cited as leading to increased risky behaviour for teachers. For Ruva, it was the prolonged separation from her husband that eventually led to her divorce:

*The prolonged separation which had started while I was in college proved strenuous for our relationship.*

Edwin found that being a single teacher in a border town was a huge catalyst:



*As a border town, it was always a hive of activity and I was at home there. I was not in a steady relationship because I had left my girlfriend, Susan, back home in Nyanyadzi.... I had multiple sexual relationships.*

As a young teacher in a rural area, Gift found himself in a position of power and he engaged in multiple sexual relationships which increased his risk profile:

*As a teacher, I was a respected member of the community. The fact that we had more disposable income than most of the community members put me and other teachers in a position of power. As teachers we had the upper hand and the school girls would always obey.....*

Teachers enjoy high status, authority and power in the school and in the community. Bennell (2001) argues that teachers sometimes use their status, authority and power to abuse students, thus increasing their own risk profile. Kakoko, Lungoe and Lie (2006) assert that risk factors for HIV infection among teachers are embedded within their working and living conditions as well as their behavioural repertoire. A number of studies have found that some teachers asked their own students for sexual favours (Kelly 2000b; George 2001; Bennell *et al.* 2002; Leach and Machakanja 2003). This is echoed by Naylor (2002) when she asserts that the bodies of students and teachers are often entangled in a deadly embrace. Gift illustrates this when he says:

*At the school there were incidents of teacher-pupil relationships with the older girls in the school. As teachers, we had the upper hand and the girls would always obey. To this day I am convinced of the vulnerability of the girl child.*

It becomes clear that sexual relationships between teachers and students further contribute to a very dangerous liaison in the school. As Jansen (2007) puts it, students are older and teachers are younger, making such liaisons appear reasonable outside of the professional expectations of educators. HIV/AIDS is therefore not only what infected adults and children bring into the school; it is also a pandemic that recreates itself within the school (Jansen 2007).

Teachers play an important role in relation to the pandemic in that they are not only victims at the end of a viral cycle but they also participate in the transmission of infection in and out of the school context. The stories of the three teachers provide

ample demonstration of this. The story of Gift, for example, shows how he moves from being a person of considerable influence and social status in the community to someone almost on the margins of society. Because he was once considered a role model and a source of admiration, he finds it very difficult to reconcile this with the image of a tainted, infected person. This forces him to keep his status secret.

## Teachers as emotional actors

Jansen (2001) defines this as the way teachers understand their capacity to handle the emotional demands placed on them by the policy in the context of existing stresses and pressures. Many aspects of teaching involve the personal dimension of teaching, and yet this dimension is often neglected and overlooked by policy. It is the personal beliefs, attitudes and emotions of teachers which often determine the decisions that they make in their classrooms. Teachers are continually faced with the emotional trauma of HIV/AIDS for themselves and from the pupils who are either infected or affected by the disease. Both Ruva and Edwin admitted to being affected by the problems facing their pupils. Ruva was affected by the illness and death of one of her pupils:

*I remember the pain I felt when Robert, one of the pupils in my class, died. This really affected me because I had been there and I knew what it was like to be sick like that.*

Similarly, Edwin laments:

*When children come to me for counselling on HIV-related issues, I can relate to their pain. I see the pain that I felt long ago reflecting in their eyes.*

There has been protracted debate as to whether teachers are the most appropriate people to transmit HIV/AIDS messages to pupils (Seabrooke 2000, Bennell 2001). The reality is that teachers find themselves taking on a pastoral role in schools, and in most cases this will go unacknowledged. Bhana *et al.* (2005) maintain that there are three quite distinct challenges that HIV and AIDS present to teachers – raising awareness and preventing infection, assisting the infected and affected, and dealing with the trauma of illness and death of significant others. To date much of the research and intervention work has concentrated on the first challenge, with the

other two being ignored or, at best, inadequately addressed. As a result schools have continued to promote prevention at the expense of care and support.

By focusing on prevention while remaining silent on issues of care and support for those infected, schools perpetuate the perception of AIDS as an immoral disease. The AIDS messages in schools are heavily biased towards prevention, and it is as if schools are immune to HIV. This view is shared by all three teachers:

**Ruva:** *The HIV syllabus is too factual and it does not address psychosocial issues for children who are infected and affected. It does not go into the experiences of those who are affected and infected.*

**Edwin:** *In the school I feel that HIV/AIDS issues are handled in a way that does not consider that there might be some people within the school environment who are infected and affected. Nothing is being done; it is as if there are no HIV-positive people in the school community.*

**Gift:** *As a result of my positive status I felt that schools [through the HIV/AIDS policy] had a strong bias towards prevention. I was struck by the failure to acknowledge the possibility that there would be pupils, teachers and other staff who are infected and affected by HIV/AIDS.*

Underpinning this focus on prevention is a downplay of the discursive nature of the pandemic and the social practices in which it is embedded, a portrayal of schools as safe havens where pupils are protected from any HIV-related risk, a presupposition of pupils (in particular primary school pupils) as being asexual, and an assumption that teachers are able to teach deeply private topics in a public space which brings their own sexuality and sexual practices into the spotlight (Baxen and Breidlid 2004). The reality is that schools are not HIV-free institutions, that sexual interactions occur within and outside the school, and that teachers face challenges in dealing with HIV and AIDS in their own lives and in the classroom.

Teachers are expected to counsel and minister to the emotional needs of students, but they are also affected and they face challenges dealing with their own emotions. This is evident in Gift's story when he speaks of carrying his emotional baggage into the classroom:

*When I went into class I could not leave behind my personal problems; they were a part of me.... The emotional turmoil that I went through during this time really affected my teaching.*



Ruva elaborates this point:

*How can I be there for pupils and effectively teach them when no one is thinking about my own status?*

Similarly Edwin says:

*I feel that something should be done to assist teachers deal with their own issues before they can deal with the children.*

The above examples from Ruva and Gift demonstrate that teaching HIV/AIDS does not only demand physical time from the teachers; it also absorbs massive emotional energies from them. It calls upon the personal dimension of teaching, a dimension that is often neglected and overlooked by policy. And yet it is the personal beliefs, attitudes and emotions of teachers which often determine the decisions that teachers make in their classrooms.

## **Conclusion**

In this chapter I have posed as problematic the relationship between policy images and the personal identities of teachers. I have argued that the policy images make demands that conflict with the personal identities of teachers (Jansen 2001). Through the stories of Ruva, Gift and Edwin I have demonstrated that policy images of teachers do not transfer neatly into the teachers' personal identities. I found that all three teachers, while understanding the expectations of policy, felt that they fell short of those expectations because of their HIV-positive status. They did not feel empowered to teach and talk about intimate relationships when their training and orientation merely focused on the biomedical aspects of this disease, but they did feel that policy did not acknowledge the emotional demands they encountered in the school context.

I have shown that teachers live their lives and see themselves in a variety of different roles. They have a personal life and a professional life within the school context, and HIV/AIDS means different things to teachers in each of these roles (Kelly 2008). It becomes important to develop teacher capacity to get in touch with what HIV/AIDS means in teachers' lives, and to examine and deal with the

challenges that being HIV-infected or affected presents for them as persons. Developing this capacity, Kelly (2008) argues, would lead to a more authentic understanding of the epidemic, something that would help teachers take better charge of their own lives in a world with AIDS. It would also equip them better to guide the young people entrusted to them in an ethical, human response to the epidemic.

Throughout, I have followed a stream of thinking that suggests that unless we understand the identity dilemma facing teachers, we cannot begin to unravel the challenges they face in implementing HIV/AIDS and Life Skills Education policy. I propose that policy's assumption of an even, linear and uncomplicated terrain is not only naïve but also undesirable. Policy needs to be cognisant of the complexities on the ground and how these shape and define the outcomes of policy implementation. While it is true that policy cannot account for interactions that occur in the teaching space, it should strive to create an environment in which teachers feel that their personal issues are catered for. I conclude that a deeper exploration of the personal identities of teachers by policy makers is essential if one is to start unpacking the complex problems facing teachers in a context with AIDS.

## Chapter 8

### ***How is education possible when there is a body in the middle of the room?***

#### **Introduction**

In this chapter I analyse the narratives of teachers living with HIV and AIDS in an attempt to offer a detailed exposition of their experiences inside schools. By focusing at the micro level, I seek to provide a window to how real teachers infected and affected by the virus experience life inside real schools. While the previous chapter focused on the disjuncture between policy images and teacher identities, this chapter centres on the classroom experiences of teachers living with AIDS.

I borrow Lebaz-Luwisch's metaphor of the *body* to analyse how teachers affected by HIV and AIDS negotiate their lives in the context of the pandemic (Lebaz-Luwisch 2004). By using the body in this way, I aim to draw attention to the physical, emotional, moral and religious presence of real humans living with AIDS in the school context. I argue that before any meaningful teaching on HIV/AIDS and Life Skills takes place in the classroom it is necessary to take account of the emotions, fears, vulnerabilities and anger of the teacher. Like Lebaz-Luwisch (2004), I underscore the centrality of paying attention to the *body* that carries these feelings and experiences.

I follow this by placing this *body* of the teacher in the midst of the classroom, and exploring the experiences with HIV and AIDS in the classroom and school at large. By considering the *body*, and its experiences and feelings inside schools and classrooms, I am drawn to ask: *how is education possible when there is a body in the middle of the room* (Lebaz-Luwisch 2004)? In using the metaphor of the body, I seek to shift the gaze away from teachers as mere professional actors dealing with

stringent curriculum demands, and acknowledge that HIV/AIDS is a reality that teachers struggle with both inside and outside the school environment.

I concur with Jansen (2007) that teachers are not simply bodies to be counted or targets of behaviour change programmes. They are bodies who demand that their emotions be acknowledged, their illness be accepted, their fears be allayed, their jobs be protected and their humanity be restored. Throughout the chapter I follow a line of inquiry suggesting that there are limits to what education systems can deliver without recognising the complexities of the public place called school and the complexities of the bodies that inhabit such schools. I make the case that simplistic interventions that seek to alter the sexual behaviour of those who occupy schools and classrooms are inadequate, and that they need to be worked through and mediated within the multilayered reality of the school and its inhabitants.

I conclude the chapter by suggesting that in order to reduce the gap between policy and practice in the implementation of HIV/AIDS and Life Skills policy, it is important for policy not to assume normality, defined as healthy teachers and learners (Jansen 2007). It is necessary to imagine a different school to the one currently conceived in policy – a school where teachers, administrators and pupils may be either affected or infected, a school in a community in the midst of HIV and AIDS, where school activities are constantly disrupted as a result of illness and death. For meaningful education to take place, schools will have to be redesigned to be responsive to the pandemic.

## **The body that carries the feelings and the emotions**

When I examined the stories of the three teachers – Gift, Ruva and Edwin – I found the accounts of their lives and work full of bodies. The body was evident in their physical descriptions of themselves, in their articulation of their feelings and emotions, and in their experience with illness. In my mind I am taken back to the body of the teacher as I encountered it during my interviews. First there is Gift – tall, dark and lanky with a face that betrays the hardships that he has gone through in the past. Gift is humble, soft-spoken, with visible signs of illness in his emaciated frame, although his voice is lively and full of passion for life. Then there is Ruva – tall and elegant as a horse. Ruva is bubbly, energetic and full of life, portraying a picture



of good health. Finally there is Edwin – tall, dark and lean, with worry lines etched across his face. He has a dark scar over his left eye and part of his forehead, possibly a result of a previous bout of herpes zoster. As they carried me through their stories I found it impossible to ignore the *body*; it looms large in each teacher's story.

The teacher narratives and my own perceptions evoke visions of the body of the teacher as one carrying intense feelings and emotions brought about by the HIV and AIDS illness. I realise that it is not only undesirable, but impossible to separate the feelings and emotions from the body. It is difficult to conceive of the body without the feelings and emotions it carries. My attention is drawn to the fact that illness, and in particular HIV-related illness, brings with it considerable physical and emotional suffering. The physical manifestation of HIV/AIDS illness forces the reality of its existence on the person. Physical changes on the body attest to the presence of illness, and the illness becomes an intolerable psychological and emotional burden.

A search through the literature reveals that little attention has been given to understanding the emotional well-being of people living with HIV and AIDS. This is so despite the fact that emotions impact on people's sense of purpose and value, and ultimately on their ability and resolve to hold livelihood and family responsibilities together (Thomas 2007). In education, a number of studies have alluded to the centrality of emotions in the teaching and learning process (Hargreaves 2001; Spillane *et al.* 2002; Lebaz-Luwisch 2004; Van Veen *et al.* 2005; Jansen 2007). However, none of the studies focused on emotions and teaching in a context with HIV and AIDS.

For Gift, Ruva and Edwin, the diagnosis of a life-threatening illness brings considerable physical and emotional suffering. The HIV diagnosis marks an important turning point in their lives, where their perception of self and perception of reality changes forever. For all three teachers, the presence of AIDS brings about internal and external changes to the body. Outwardly, the teachers experience physical changes in their bodies due to illness, typically in the form of weight loss, silky hair and loss of energy. These bodily changes become distinguishing marks that separate them from others, and in most cases become a cause for stigma and discrimination. Internally, the body suffers from severe emotional turmoil as the teachers try to come to grips with their situation. The news of a positive HIV

diagnosis produced different emotional reactions at different times for all three teachers. As Ruva says:

*I had days of anger, blame, panic and feeling betrayed. Acceptance came slowly.*

Elizabeth Kübler-Ross (1969) conceptualised five stages that one goes through when faced with terminal illness; these are denial, anger, fear, depression and finally acceptance. She recognised that the stages occur neither with predictable regularity nor in any order, and vary from person to person as detailed below.

### ***Shock/denial***

For Ruva and Edwin the first reaction was shock and disbelief; they could not believe that this was happening to them. Ruva laments:

*It was unbelievable; I was devastated. I could not understand how this could happen when my son was still so young.*

Although Edwin already suspected that he was HIV-positive, he admits that:

*Still, the diagnosis left me paralysed. I did not know what was going to become of me. I felt that I had no purpose in life.*

While Ruva and Edwin were shocked by the diagnosis, Gift's test results came at a time when he was still mourning his wife and child, and as such the implications were not as apparent. Gift was already overwhelmed by his situation and he could not confront the implications of his test result:

*As such, the implication of my own test results did not sink in immediately. I was in denial, in panic mode, and could not accept my situation.*

Kübler-Ross (1969) defines denial as a conscious or unconscious refusal to accept facts or information relating to the situation concerned. In Zimbabwe, denial about HIV and AIDS is not only found at the individual level but is duplicated at all levels of society. No one's life has been untouched by AIDS, yet not many people are willing to discuss it openly. According to Duffy (2005), people still search for every possible reason to explain the high morbidity that is tearing apart families and communities.

Gift, who admits he does not go to church, shares his sentiments on the church in Zimbabwe:

*When I get into a church I feel the church is still in denial about HIV/AIDS, and I do not feel comfortable. I feel that the church perceives HIV as a punishment from God for sinners.*

Throughout history, many serious illnesses have been accorded religious significance (Zapulla 1997). Because of its association with immorality, AIDS is considered a manifestation of evil or wrongdoing. As such, people perceive the disease as a punishment for immoral behaviour and the ill person becomes the culprit and the sinner.

### ***Anger and blame***

Following the initial shock and denial of the diagnosis, all three experienced feelings of anger and a sense of grief for what they were likely to lose. For Ruva, the period after her diagnosis was a period of anger and confusion:

*I was angry at my predicament; I asked God, why me?*

While Gift felt anger because of his positive diagnosis, he took responsibility for it. He did not blame anyone for what had happened to him:

*I do not know if I can say that I have anybody to blame, looking at the life that I have lived before I met Ruth.*

Similarly, although he initially blames Susan, Edwin realises that he could have been infected before they met:

*Part of me blamed Susan, but when I thought about it I realised that I must have been HIV-positive before my encounters with Susan.*

According to Kübler-Ross (1969) the anger can manifest in different ways and can be directed at oneself or at those close to one. Because HIV is a communicable disease, it is easy to direct the anger at one's sexual partner. Gift and Ruva in particular see themselves as victims; this is evident when Gift says:

*... the discrimination you encounter is always subtle but as the victim, I felt it.*

Ruva sees herself as the victim especially because she feels that there are others who could have been infected:

*I wanted to know why it was all happening to me. What had I done to deserve this? I knew many people who were promiscuous but who seemed not to have been infected, so why me?*

### **Fear**

For all three teachers, the fear of death was the most obvious and the most powerful, although they also feared the suffering that they were to endure before they died. In Zimbabwe, life-prolonging antiretroviral therapy is not readily available and a positive diagnosis is commonly associated with prolonged illness and death.

Gift, who had just gone through a difficult period with the death of his wife and child, describes the period as one of fear, where he went through “every imaginable emotion”:

*As I look back now, I remember that this was a period of intense fear for me, fear of what was to become of me and my family.*

In most of the developing world, HIV/AIDS is strongly associated with premature death, and for the teachers the diagnosis most certainly meant an early death. This is evident in Ruva’s story when she says:

*Each headache, rash or bout of cold had me worried that my end was near.*

Similarly, Gift also started anticipating a premature death:

*I felt that I was not the same person and I had problems coming to terms with my situation. It was as if I had a death sentence hanging over me.*

Gift and Ruva in particular fear that they will not live to see their children grow up. As Gift says:

*I had my children to think about and I worried about how my situation was affecting them.*

Ruva's fears quickly turned to worry:

*I worried about what kind of tomorrow I would have. Would I be sick? Would I die? How would my children take it? What was going to happen to them? How were they going to view their lives when they grew up? How were they going to feel in relationships when they grew up knowing that their mother had died of AIDS?*

Fear is also promoted by other community members who worry that they might contract AIDS through contact with the infected person. This sometimes results in isolation of those infected, as evidenced by Ruva when she says:

*I found that other teachers started moving away from me.*

When Edwin came back to work after a period of illness, he found that the workplace was not the same place any more:

*I felt that other staff members did not really accept me, and sometimes I thought the other teachers were laughing at me behind my back.*

A pronouncement of AIDS almost always evokes judgement on the moral character of those afflicted. People with AIDS are subject to moral judgement, and this has a negative impact on their self-image. In the eyes of others, such people are held morally responsible for their condition (Zapulla 1997).

Gift found himself facing remarks from pupils as a result of his health status, and this accelerated his anxiety and emotional turmoil:

*The problems I faced at school put me under a lot of stress, and this must have affected my immune system.*

Ruva was on her own at a time when she needed people around her the most:

*People started moving away from me at a time when all I needed was someone to talk to who would understand my situation.*

Life-threatening illnesses are often fraught with meaning, and AIDS in particular is fraught with moral undertones and values (Zapulla 1997). This is because it is a sexually transmitted, blood-borne disease, and as such it is given meaning that is

invariably moralistic. Like many others infected with HIV, the three teachers endure the burden of illness, physical suffering and the threat of a premature death. They frequently experience the judgment of others, and this only adds to their suffering and fear of rejection by those close to them.

### ***Loneliness/regret***

As a result of their positive diagnosis, all three teachers feel alienated and disconnected from the world. They carry the burden of the diagnosis as a terrible secret that they are unable to share with anyone. Edwin felt that he was alone in a world where no one understood him. Although he had his drinking buddies, the loneliness got to him and he admits:

*...but I am human, and at times it really gets me down.*

Ruva, who was alone when she received news of the diagnosis, describes her grief:

*Being alone with my problems made my situation worse.*

Gift had just moved to a new school and he felt alone on the HIV island, dealing with the illness and then death of his wife and his own positive diagnosis:

*I was basically alone with my social problems.*

Because they fear to disclose their status within the workplace, the teachers suffer in silence, bearing the terrible secret of their illness on their own. The loneliness often fills them with hopelessness and despair.

The various emotions that the teachers experience exert an impact on their bodies. At the same time, the physical illness wears the body down to an extent where the teachers fail to perform their daily functions. It is this same body that walks into the classroom with the expectation of imparting knowledge to pupils. Johnson (2000) proposes that the bodies of human beings are the locus of their complex interactions with their environment, and that our bodily experiences influence the way we are able to understand and know our world, and ourselves as part of that world. This implies that the physical and emotional changes in the body influence the way teachers interact with other players within the school environment.



## The body that lies in the middle of the room

Vanderstraeten and Biesta (2001) conclude that it is not the educator who educates; rather what educates is the educational 'situation' – that is, the in-between space resulting from the difference between educator and student. However, as Lebaz-Luwisch (2004) argues, how is education possible when in between that space lies a body? In an AIDS context, this body carries fear, anxiety, depression, disappointment, guilt, desire, hope and dread. It is this body, with all its physical and emotional changes, that enters the school and classroom to face other teachers and pupils who are also affected and infected by HIV and AIDS.

In the classroom, Gift, Ruva and Edwin found that repeated illnesses impacted on their physical health and ability to perform their teaching duties. They slowly recognised subtle changes in their bodies, their energy levels and their physical strength. They all reported finding it more and more difficult coping with a classroom full of energetic pupils who expect the teacher to be always in charge. With the continuation of illness came guilt and worry about their pupils, who they felt were being disadvantaged.

Ruva reported how her illness affected her teaching duties:

*When I was sick I found that my illness had a negative impact on my teaching. Sometimes I just felt unwell and wanted to rest.*

Gift found his energy levels going down during the time when he was ill:

*My performance in school was affected. The workload of a teacher is tough.... After teaching for a few hours I would feel very tired and had to sit down. I was no longer able to walk around class looking at my pupils' work or observing them as they did group activities.*

For Edwin, coping with his Grade 4 class became a challenge:

*I am now finding the whole school environment from pupils to staff very stressful. The stress I get from children is mainly because children are playful. In Grade 4 they are full of energy and sometimes I cannot keep up.*



Gift expresses his feelings of guilt over his decreasing capacity:

*During this time my pupils suffered because even though I was there physically I was not giving them the attention that they deserved, and I think that my pupils felt and were affected by my situation.*

When symptomatic illness begins to impact on their physical health, this affects the way they perform their duties. The teachers are aware of this and they feel guilty about the impact their decreasing capacity has on their pupils. They also fear the reaction of other members of staff should they find out about their illness. With continuing illness, the teachers find that absenteeism becomes more frequent. At the same time, they start experiencing stigma from other members of the school community.

## **Absenteeism and the response of the school community**

In Zimbabwe absenteeism emanating from ill health is a labour matter regulated by education labour laws and policies (Government of Zimbabwe 2000b). While the instruments protect the employee's job and security, they equally protect the employer to ensure that the business of the employer does not suffer from undue losses. As their illness progressed the teachers found themselves unable to cope and they needed to take time off to recuperate. Their illness becomes noticeable to other staff members, and it became difficult to continue with normal duties.

According to the Zimbabwe Public Service Regulations Statutory Instrument 1 of 2000 (Government of Zimbabwe 2000b), teachers have an annual entitlement of ninety days sick leave on full pay in addition to the normal vacation leave. Should illness continue, teachers are entitled to a further ninety days on half-pay, which is subject to a medical board opinion on whether the person is able to resume duty. Teachers are also entitled to twelve days special leave on full pay, which is to be used for urgent private affairs such as funerals. A public service employee is not allowed to be absent from work for a period of more than three days without a letter from a medical doctor.

After repeated episodes of illness, Edwin found the regulations problematic. After being away for ninety days, the school head did not allow him to take time off as he

had already missed too many classes, thus disadvantaging his pupils. Because of the phase of his illness, he had started developing opportunistic infections so he would go to work for a few days and then get sick again. The situation was frustrating for all concerned:

*I knew this was disturbing for the pupils because there was no continuity. At the same time, my absenteeism became a point of conflict with the school authorities. The headmaster felt that it was better for me to go on sick leave because I was missing too many classes.*

While Gift did not face a similar challenge from his school head, he had problems taking a few days off as he could not afford the doctors' fees required before he could be issued a letter excusing him from work:

*I did not find the school system very supportive when I was sick. Sometimes I just wanted to rest but the system would not allow me to be absent without a letter from a doctor. Because of my financial situation, I was not able to afford doctors' fees.*

While the teachers' on-and-off illnesses disadvantage pupils, they also affect the teacher who in most cases will remain in position when they are already incapacitated. Thus the situation has negative implications for teachers, pupils and colleagues who have to cover for sick teachers. As Edwin's story shows:

*I felt that the other teachers were not very friendly because of the extra load that I gave some of them, teaching my class in my absence.*

The solution for all concerned seemed to be for the affected teacher to go on ninety days' sick leave. For Edwin, this time away helped him to recuperate without worrying about his absenteeism. In situations of regular illness, three months is adequate time for recuperation, but for Gift and Edwin their health had deteriorated to such an extent that they needed more time away. As Gift says:

*After the three months' leave I was still not well but I could not get any more time off work without losing my salary. I would just drag myself to school. I remember, on very bad days I just used to leave the class in a hurry and would never make it to the men's toilet so I would just vomit outside, in full view of pupils and other teachers.*

Similarly, when Edwin came back to work his illness started again:

*I came back to work in January 2006 when schools opened. Then it began again; I started suffering from the side effects of the ARVs.*

It is at this point that the continued illness becomes problematic for all concerned. First, teachers just drag themselves to school because they fear that they will lose their salary at a time when they need it to purchase medication. All three teachers felt that they could not afford to take any more time off as this would affect their salary. Edwin's case was extreme in that, after continued absenteeism, he was struck off the payroll and he had to go through the long process of applying to be reinstated. During this time, pupils lost valuable learning time and parents started complaining about the loss of teaching time. As Edwin says:

*Parents were bitter about my absenteeism. Some phoned the headmaster and some phoned the Ministry of Education offices.*

Similarly, Gift revealed that:

*... during the time when I continuously missed school, some parents had started to complain to the school head about my absenteeism.*

With progressing illness and increasing absenteeism, there is a conflict between the children's right to an adequate education and the rights of the educator to get medical attention. This conflict is well illustrated by Edwin's story:

*I agree that as a teacher I am supposed to be productive because I am being paid. However, it is within my right as a teacher to go on leave when I am sick, to access medication and come back to work when I feel better.*

In all three cases the children's rights to an adequate education is in direct conflict with the rights of the HIV-positive teachers. The school head in each case weighs the teachers' decreasing performance and its impact on the children's performance, and ultimately the rights of the children outweigh those of the teacher. The result is that the sick, emaciated and emotionally exhausted body of the teacher plays second fiddle to that of the pupil.

## Stigma

Stigmatisation is a dynamic process that arises from the perception that there has been a violation of a set of shared attitudes, beliefs and values. This can lead to prejudicial thoughts, behaviours and actions against those perceived to be infected (Zapulla 1997). In many societies, people living with HIV are blamed for their condition, with many believing they could have avoided the HIV infection if they had made better moral decisions. Because of its association with immorality, HIV infection fits the profile of a condition that carries a high level of stigmatisation.

Ervin Goffman (1963) describes stigma as an attribute that is deeply discrediting within a particular social interaction. His definition focuses on the public's attitude towards a person who possesses an attribute that falls short of societal expectations. According to Goffman (1963), the person with the attribute is reduced in our minds from a whole and usual person to a tainted, discounted one. Because the stigmatised person is thus seen as 'not quite human', as substandard, it is easier to discriminate, resulting in reduced opportunities for that person (Goffman 1963). Herek (1999) argues that the discrimination and devaluation of identity associated with HIV-related stigma are created by individuals and communities who mostly generate the stigma as a result of their own fears.

According to UNAIDS (2000), stigma may manifest itself externally or internally and may have different effects. Internal stigma is the shame associated with the fear of people living with HIV/AIDS of being discriminated against. It is usually a survival mechanism to protect oneself from being stigmatised by others and often results in the refusal or reluctance to disclose HIV status and unwillingness to seek help. Internal stigma is characterised by self-exclusion from services, low self-esteem, social withdrawal and fear of disclosure (UNAIDS 2000). All three teachers were victims of internal stigma.

Ruva, who regrets lost opportunities, laments the decision she made not to further her education after she tested positive:

*I did not pursue my dreams because I had lost hope, thinking that I would not survive for another five years.*

For Gift, self-stigma is evident when he says:

*I was not yet comfortable with my own situation. I always felt that if society was thinking in that way then that should be the way for me to think as well. If you have not accepted your situation, you will accept what society is saying.*

UNAIDS (2000) defines external stigma as the actual experience of discrimination, which may include domination, harassment, categorising, accusation, blame, ridicule and resentment. External stigma may sometimes lead to violence towards people living with HIV and AIDS (UNAIDS 2000). External stigma is a common theme in all three stories. As the teachers experience several episodes of illness, it shows in their bodies and they endure comments and suspicions about their health from the school community.

Gift narrates his discomfort from the knowledge that people are talking behind his back:

*After my wife died, I was developing a lot of AIDS-related illnesses. At that time I used to get so many 'bus stop diagnosis' where people can just look at you, diagnose you, then start talking behind your back.*

For Ruva the external stigma she experienced came from colleagues withdrawing from her and talking behind her back:

*In the early days I would overhear them talking behind my back. Some even stopped talking to me.*

Similarly, Edwin found other teachers quite hostile after his illness:

*I felt that other staff members did not really accept me, and sometimes I thought the other teachers were laughing at me behind my back.*

Gift felt that he was a 'victim of discrimination' although the discrimination was always subtle:

*In my view, I felt that I was excluded from a lot of activities that other teachers took part in. For example, I was never nominated to travel on tours with pupils and I was never put in charge of any of the sporting activities.*

Schools are well known for sorting people into all kinds of categories and possibilities, and thriving on difference (Jansen 2007). Inevitably, in a school environment HIV/AIDS will carry the stigma of identification. Because the school environment is intolerant of difference, the stigma, discrimination and resulting isolation mean that people do not easily, if ever, disclose their diagnosis. It appears that within a school the stigma associated with HIV/AIDS is more serious for teachers who, as the supposed moral authority, should have known better (Jansen 2007). The stigmatisation brings with it a corresponding level of denial and secrecy that supports the silence. For all three teachers, the onset of HIV symptoms on the body is a powerful marker of their difference from others, and the more visible the symptoms the harder it becomes for them to keep their status a secret.

## Disclosure

According to the National Policy on HIV/AIDS for the Republic of Zimbabwe (Government of Zimbabwe 1999), an employee is under no obligation to disclose his or her status in the workplace. Should they disclose their status, the person to whom the disclosure is made is legally bound to keep it confidential unless the HIV-positive person concurs. All three teachers felt compelled to disclose their HIV-positive status to the school head. As the leader, the school head is responsible for ensuring the interests and welfare of the school community, including the HIV-positive teacher. By alerting the school head to their situation, they felt that it would be easier to be granted time off when they were sick and when they wanted to collect their medication.

Gift disclosed to the school head on the advice of the school counsellor. However, he reported that the disclosure only served to amplify his problems within the school. He had never been on good terms with the school head and he felt that his disclosure worsened the relationship with him. Gift expressed feelings of hurt at the lack of confidentiality he encountered within the school environment:

*When I told my headmaster about my status he asked, 'Is that why you wanted us to close the door? Well everyone knows about your status here; there was no need to close the door.' I felt hurt by this statement, which to me implied that my status was no secret and so there was no need to talk in private.*

Gift found that his disclosure to the school head served to make life at school more difficult for him. As the representative of the institution, the school head's character plays a significant role in setting the moral tone of the school (Zapulla 1997). His behaviour influences the way the school will react towards those living with HIV and AIDS. Gift felt that he had become a victim of discrimination, excluded from a lot of activities that other teachers took part in:

*... I was never nominated to travel on tours with pupils and I was never put in charge of any of the sporting activities.*

While disclosure did not help Gift's situation, Ruva worried that if she disclosed her status to her current school head it would affect their working relationship. She felt that disclosing her status might disadvantage her and that it might affect the way others in the school saw her:

*If I fail to do something it will always be about my status, even though it could have been a genuine mistake.*

However, by not disclosing she faced challenges in that each time she asked to go to the doctor people raised their eyebrows as they thought she was just trying to get some time away from work for other things. After she received counselling, Ruva felt more confident about her HIV status, and she disclosed to the school head and other teachers in the school. At this point she felt happy about her decision to disclose. Ruva was happy to use her positive status to help other teachers and pupils in the school:

*Disclosing is good because you open up, share experiences with others and find the strength to move on.*

Edwin found that disclosure to school management helped because after his disclosure they became more understanding of his situation. In fact, he wished he had disclosed early to avoid all the misunderstandings he went through with the school authorities:

*Sometimes I think that my disclosure was too late. Maybe I could have avoided all the misunderstandings and the disciplinary hearings had I disclosed early.*



While Ruva and Edwin are ultimately happy with their decision to disclose their status within the school, Gift found that his disclosure facilitated his exclusion from the staff and from other school activities. Although he had never been close to the other teachers, he found that his situation got worse when they became aware of his illness. Gift's disclosure resulted in his isolation within the school and this served to amplify the emotional and physical challenges that his body was facing.

### **Getting the strength to move on**

While all three teachers are aware that accepting one's situation is the key to moving on, Gift and Ruva seemed to have more success moving on with life than Edwin. Although Edwin claims to have accepted that this is what God has given him, he still finds the school environment stressful and his illness overwhelming, such that he plans to relocate to his home area where his parents can take care of him. He also admits to developing shock absorbers to help him cope with people's comments when he is in the beer hall. For Edwin, alcohol seems to be a form of escape from his situation, although alcohol is contraindicated for people on ARV therapy. Being without a family, the beer hall is the one place which he mentions frequently and where he gets support from his drinking buddies, who do not discriminate against him.

Unlike Edwin, both Ruva and Gift go through a period of change which symbolises the beginning of a new life and the shedding of the old ways. As Ruva says:

*I have changed a lot. I am more conscious of myself and my body and what I do. I watch the food I eat; I prefer unrefined foods, lots of vegetables and white meat. I try as much as possible to avoid red meat. I have become more spiritual.*

For Ruva, becoming more conscious of her body and diet represents a change from the old ways to a way of living that will ensure her continued health.

Gift, on the other hand, feels that he has become more cautious about life's choices as he realises that his past life made him vulnerable to HIV infection. With the life-prolonging medication and better health, Gift feels he has been given a second chance at life:

*I feel that I have a second chance to live my life; I have been given the gift of life.*

He now feels that he has a purpose in life and decides to further his studies despite the occasional illness:

*I wanted to get a degree at whatever cost.*

Ruva regrets her decision not to further her studies, and she plans to enrol for a course in systemic counselling so that she can help others in her situation.

Anti-retroviral therapy is the recommended treatment option for effective HIV/AIDS care. If a person is on ART, HIV replication and immune deterioration can be delayed, and survival and quality of life is improved. For Gift and Ruva, ART gives them a new lease on life, where the physical symptoms of illness disappear and their bodies slowly regain their strength. The body's emotional state also improves with better health and the support that they receive from support groups. They feel as if they have been given a second chance, and time becomes an important commodity not to be taken for granted.

## **Support groups**

Gift and Ruva found that belonging to a support group helped them to cope with their situations. They both joined support groups operating outside the school, and this gave them the strength to move on. Ruva talks positively about how she became more confident about herself after joining a support group:

*I believe that belonging to a support group has really helped me. I joined a support group because I wanted to find like-minded people to talk to.*

Similarly, Gift found that the support group gave him the energy to move on:

*... It was a rallying point where people in the same condition move ahead. I met other teachers and together we shared what we went through at school and in the communities.*

Edwin, on the other hand, did not join any support group. Instead he laments the lack of support from the school:



*There is really no support for teachers in the workplace. Personally, I feel that there are ways in which my school could help me. Schools can and should do more to assist teachers to deal with their own issues before they can deal with the pupils.*

While Edwin did not find any support, Ruva and Gift found support groups to be a rallying point where people in the same condition got the strength to move ahead. Because of their experiences with HIV, they wanted to help others going through similar experiences. Ruva uses her knew knowledge to help the young children she teachers to learn about HIV:

*Now I take every opportunity that I get to talk to my pupils about HIV/AIDS. I know that these children are living with the reality of the disease every day of their lives and they need to know about it.*

Gift went on to start a club aimed at fighting stigma and discrimination on campus. He became the first student to disclose his status on campus:

*I know that there are other students on campus who are HIV-positive but who are not willing to come forward to get assistance. I am trying to advocate for such students to get help.*

Through the counselling and support they received from the support groups, the three teachers become more confident about their status and they find a purpose in life – using their positive status to help others in the same situation.

## **Conclusion**

In this chapter I have sought to shed qualitative light on schools as communities within which the bodies of teachers navigate and negotiate their lives in the midst of the HIV/AIDS pandemic. I have detailed true accounts of three teachers' experiences with HIV inside the school in an attempt to answer the research question: *what are the narratives of teachers living with HIV and AIDS?* Through the teachers' stories, I have drawn attention to the suffering, shame, silence and stigma that confront teachers living with HIV and AIDS.

Haddad (1995) observed correctly that misjudging the ease of implementation is probably the most frequent error in policy making. Successful acceptance and implementation of policies often depends on whether the policies are seen as

relevant to context and congruent with the situations of the implementers. The stories of Edwin, Gift and Ruva have highlighted the policy consequences of ignoring the *body* as a critical resource for educational change in HIV and AIDS contexts. I will argue that policy implementation is marked by complexity, and that it is important to understand the situation of the implementers and the context within which policy will be implemented.

I conclude the chapter by suggesting that policy needs to take account of the body in the middle of the classroom in order for education to be possible in a context with AIDS (Lebaz-Luwisch 2004). Policy assumes that teachers will be ready and willing to teach HIV/AIDS and Life Skills. On the contrary, the three teachers' stories reveal that it is impossible for teachers to divorce themselves from their emotions, given that they take part in the teaching process as whole beings. As a result they carry their emotional baggage to the classroom, thus negatively impacting on the teaching process. This implies that policy making and subsequent policy implementation needs to take account of the emotions, fears, vulnerabilities and anger of teachers and students before any dialogue is possible in the classroom.

## Chapter 9

### *Teachers as emotional actors*

#### **Introduction**

In the two previous chapters I examined the themes that emerged from the stories of the three teachers – Gift, Ruva and Edwin. The teachers' stories bring to the fore the reality obtaining in today's schools and classrooms. They tell of school systems which are struggling with a moral discourse of AIDS, sin and immorality. They demonstrate how all three teachers repeatedly confront the belief of others that AIDS is a result of immoral behaviour, and how others hold them personally responsible for their condition. The teachers' stories reveal school systems that have yet to come to grips with the HI virus and its impact on both staff and pupils, systems which are characterised by silence, denial and stigma. They challenge the notion of schools as HIV-free by showing how the virus travels in and out of the school gates every day in the bodies of students and teachers, how the disease of the physical body affects the personal standing of the ill person, and how the person rather than the disease carries the blame. The stories show that teachers are lonely despite being in the middle of the bustling and energetic space called school. At the same time, the teachers' stories speak of hope and new dreams, a second chance to make better life choices, to fulfil dreams, appreciate life and make life better for others living with AIDS (Jansen 2007).

In this final chapter I explore the theoretical positions outlined in my conceptual framework in light of the findings of my study. After an analysis of the various models of policy making in my conceptual framework, I examine the extent of teacher involvement in the development of HIV policy. I then move on to explore the extent to which the identity of teachers as emotional actors can be proposed as an explanation for teacher behaviour during HIV policy implementation.

In this final chapter I will make two central arguments. Firstly, I maintain that in a context with AIDS there are limits to what education policy can achieve if it remains out of touch with a real world in which school is attended by children and teachers whose bodies are either infected or affected by HIV. Secondly, I use the stories of teachers living with AIDS to show that emotions, traditionally considered as private individual feelings, are an inextricable aspect of educational practices and discourses.

In order to demonstrate these two central points, I first examine the idea of HIV policy being out of tune with realities prevailing in schools. Here I highlight the ironies and contradictions embroiled in HIV policy, which result in teachers being called on to implement a policy that conflicts with their personal situations. The thrust of my argument is that while the HIV/AIDS policy is about *bodies* and about *emotions*, it is blind to the bodies and the emotions of those implementing it. I contend that it is this oversight that creates the wide gap between policy intentions and outcomes.

I then examine my second core argument, which focuses on the centrality of emotions in the implementation of HIV policy. I do this by showing the uniqueness of HIV/AIDS policy and its implementation, which, unlike other education policies, brings to the fore the *bodies* and *emotions* of the implementers. I demonstrate how teaching the subject of HIV/AIDS demands an intense amount of emotional labour, and how the teachers' emotional well-being takes a central role when teachers are discharging their duties within the school and the community.

Building on my conceptual framework, I argue that because the policy-making process did not incorporate teachers' opinions and emotions the result was that the images/visions of policy makers did not reflect the personal situations of the front-line implementers. Through the study I have reaffirmed that teachers' emotions are a unique but key ingredient in the implementation of policy on a sensitive topic such as HIV/AIDS and Life Skills.

In describing the three teachers' stories, I attempted to capture episodes and events *as they are* or as they were experienced by the three teachers living with AIDS. However, like Zapulla (1997), it is my aim to take this research a step further and to explore how things ought to be. In essence, describing things as they are becomes a

prelude to an argument as to *how things ought to be*. The task of this chapter, then, becomes two-fold: to analyse the research evidence against my conceptual framework, and to discuss how education systems ought to be organised – in other words, to outline the implications of my findings for HIV policy and practice. Lastly, I propose some unresolved questions which could form the basis for future research.

## **The challenge of policy implementation in a context with HIV and AIDS**

By reiterating the problematic relationship between education policy and practice, I seek to place in doubt the presumed rationality and linearity of the policy-making and policy-implementation process. Revisiting my conceptual framework, I argue that the evidence gleaned from this study contradicts Harman's (1984) definition of policy making as being underpinned by a value consensus. Instead what I found was a policy-making process more in line with Taylor *et al.*'s (1997) elite/mass model of policy making. In this model the dominant groups had more formalised access to the policy-making process and the less powerful actors such as teachers had to adjust their expectations of the policy (Sutton and Levinson 2001). As the stories of Gift, Ruva and Edwin demonstrate, the teachers, with no access to the policy-making process, found that they could not relate to an HIV/AIDS policy that did not speak to their own situations. The result was that implementation of the policy often emerged as a conflict process as teachers tried to reconcile the policy requirements with their own identities.

Through the study I provide an important platform for understanding the limits and possibilities for education policy to initiate change in the context of HIV and AIDS. I argue that the current assumption of policy – that schools are serving healthy learners and teachers who are physically and psychologically well – is out of tune with the realities of today's schools in a context with AIDS.

I highlight the contradiction embroiled in the HIV/AIDS policy, that while the policy is about *bodies* it fails to recognise the *bodies* of those at the implementing end. While the teachers' physical presence is necessary to the implementation process, policy does not acknowledge the physical state of the bodies of the would-be implementers, and this has consequences for the reform process. The three teachers' stories demonstrate that the teachers in the classroom are not simply



statistics to be counted or minds to be changed so that behaviour is altered; they are *bodies* that carry fear, guilt, anxiety, worry, anger, disappointment, hope and desire. These *bodies* enter the classroom to confront the bodies of pupils, some of whom are also sick, and to teach a subject that not only reminds them of the state of their own *bodies* but that also brings their *emotions* to the fore.

In analysing the stories of Gift, Ruva and Edwin, I developed a renewed sense of the implementation dilemma in educational reform (Hargreaves, 1998; Sayed and Jansen, 2001). I found that an important answer to the question “*Why are policies not implemented as planned?*” takes on a new dimension in a context with AIDS. It is difficult for teachers who are HIV-positive to bring themselves to implement a policy that does not acknowledge that schools are home to HIV-positive teachers and pupils, that associates HIV and AIDS with sin and immorality, and that preaches abstinence. It is problematic for them to deal with the demands of policy when staying alive and healthy overshadows every other aspect of their lives. In reality, because of their HIV status the teachers themselves become a contradictory embodiment of the very policy they are called on to implement.

The teachers’ stories demonstrate that the policy images of teachers do not transfer neatly into teachers’ realities. These discordant images and identities of teachers have implications for education reform. The stories of Gift, Ruva and Edwin provide ample demonstration of the distance between policy visions and implementer realities. This dislocation between policy visions and practical realities in schools and classrooms has been well documented in the literature (McLaughlin 1998; Jansen 2001). From the study, policy expected the teachers to guide and counsel the young people under their care. In reality, the teachers were untrained and therefore unprepared for this role; furthermore, they themselves wanted to receive care and support before they could assist the pupils.

I found parallels with McLaughlin’s (1998) Context Centre Research which, by providing different ways of thinking about relationships between macro policy strategies and the micro realities of teachers’ classrooms, suggested that micro was not simply the other end of macro. As this study demonstrated, teachers’ perspectives on teaching and learning at the micro level are rooted in different goals and realities than those of the policy maker at the macro level, and the teachers found that the policy, its demands and expectations were in conflict with their

personal identities as teachers living with AIDS. The resulting identity conflict had implications for the implementation (or lack thereof) of HIV/AIDS policy in Zimbabwean primary schools.

There are also a number of assumptions embroiled in the current HIV/AIDS and Life Skills policy. *Firstly, the policy advances the notion of schools as HIV-free institutions* where sexually innocent teachers transmit vital knowledge about prevention to sexually pure youth to protect them from infection that they might encounter in the real world. And yet, the reality is that the school actors – principals, support staff, teachers and pupils – bring and act out their sexual identities within the school (Jansen 2007). Schools are not HIV-free institutions; they exist in a dynamic relationship with the surrounding communities. As a result of the assumption of schools as HIV-free institutions, the policy focuses on prevention at the expense of care and support. The irony is that while the focus of policy is on prevention, it is often too late for pupils and teachers who are already infected. The prevention mode of policy is then out of sync with the care and support required by those at whom the policy is aimed.

*Secondly, the policy implicitly expects teachers to be morally upright citizens who conform to particular forms of behaviour and morality.* The policy is tacitly and inherently prescriptive in that it assumes a particular and confined understanding of morality. As the teachers' stories have shown, teachers struggle with issues of morality and at times are arguably not the best role models for pupils. Gift's story demonstrates how some teachers had the upper hand in the sexual relationships that they had with the older pupils. In the literature, there are a number of documented studies which have found teachers to be frequent abusers of the young people in their care (George 2001; Bennell *et al.* 2002; Leach and Machakanja 2003). This demonstrates the glaring differences between the prescribed moralities inherent in the policy and the real practice of the teachers. The danger with the policy taking on a moral stance is that it closes itself to the varied and complex moralities of teachers and pupils. In that way it chooses to be blind to the real practices of the very people in is meant to guide.

*Lastly, policy makes the assumption that all classroom teachers have the capacity and will to implement the HIV/AIDS and Life Skills policy regardless of their own personal identities.* In reality, the teachers demonstrated that they needed to have their own

emotions acknowledged and their fears allayed before they could assist pupils to deal with their own situations. The stories reaffirm Comb's (1965:70) concept of self as an effective teacher in arguing that a teacher must feel fulfilled or adequate enough to enter into a relationship with pupils because "it is only when a person feels adequate that self can be transcended and attention given to the needs of others".

It was only when the teachers had come to terms with their HIV status that they were able to talk openly about it and respond to the needs of others. As Ruva showed in the period prior to the acceptance of her own HIV-positive status, she was really affected by the illness of her pupils and she felt inadequately prepared for the role of counselling that she had to undertake.

I conclude this section by asking whether it is realistic to expect a policy conceived at the macro level to take into cognisance the interactions that take place at the micro level. I argue that for the HIV/AIDS policy to be relevant, it needs to be cognisant of the bodies and emotions of teachers, and how these shape and define the outcomes of policy implementation. It is also clear that, unlike other policies, implementing HIV policy for teachers with AIDS is an emotionally laden process that brings into question issues at the very core of teachers' existence. To that end, policies that tacitly assume the presence of perfect and healthy bodies in the classroom are likely to have little chance of being implemented. What this points to is a reconfiguring of the policy development process so that the real bodies and real emotions are written into the policy.

### **To what extent can the framework 'teachers as emotional actors' reconcile the difference between policy ideals and teacher understandings of their identities in HIV/AIDS contexts?**

Through this study I offer the identity of 'teachers as emotional actors' as an alternative model for explaining teacher behaviour during reforms in a context with AIDS. To substantiate this argument, I revisit my conceptual framework and argue that because policy makers did not consider teachers' emotions in the policy-making process, teachers' opinions, feelings and emotions are not reflected in the policy. As a result, the teachers did not attach legitimacy to the policy, with negative

consequences for the policy implementation process. As Van Veen *et al.* (2005) argue, an understanding of teachers' emotions while implementing reforms can provide a deeper understanding of the ways teachers experience their work and educational change.

The study shows how teaching HIV demands an intense amount of emotional labour, and brings to light how the three teachers' emotional well-being affected how they discharged their duties within the school and community. I argue that these teachers struggled to cope with the already existing pressures and stresses which are common features in most third-world classrooms. For the three teachers, HIV and AIDS exacerbated their situation – firstly due to the emotional trauma resulting from their own illness, and secondly that of pupils and other teachers affected by the disease. In his story, Gift sums this up well when he says:

*When I teach HIV/AIDS, it reminds me of myself.*

Since the 1970s there has been blossoming research on emotions, but little of this work has informed current research on teachers and emotions (Sutton and Wheatley 2003). Furthermore, the existing literature has given little attention to understanding the emotional well-being of people living with HIV and AIDS. And yet it has been argued that emotions impact on people's sense of purpose and value, and ultimately their ability and resolve to hold livelihood and family responsibilities together (Thomas 2007).

If one considers teachers to be at the centre of educational change, then it follows that policy needs to be more attuned to the meaning that teachers will attach to it. As this study has reaffirmed, each individual teacher makes meaning of policy in different ways, often dependent on many factors, not the least of which are emotions.

The expectation of the HIV/AIDS policy was that the teachers would transform the policy visions, intentions and goals into real outcomes. However, the teachers found the HIV and AIDS policy to be an insensitive document that did not speak to their needs, priorities and concerns. It was inconceivable for the HIV-positive teachers to faithfully translate into action a policy that does not speak to their own emotions and that required them to pretend to be people they were not.

As a result, when the teachers were confronted with an ‘insensitive’ policy designed to change how they functioned in terms of teaching HIV/AIDS and Life Skills, their emotions took centre stage. The consequence was that the policy was by and large ignored. Instead of putting the policy into practice as was expected, the teachers found themselves initially resisting, then transforming and adapting the policy to suit the school environment and their personal situations. In essence, it was the teachers who ultimately determined what the policy became. For instance, because teaching HIV reminded him of himself, Gift engaged in selective teaching of topics, thus determining what was taught and what was omitted. The consequence was that implementation of the policy unfolded as a conflict process as the teachers tried to reconcile the demands of the policy maker with their own personal identities. While this may be deemed to be a common path for policy, I contend that in the context of HIV-positive teachers teaching about HIV through a policy that is blind to this reality, this could have consequences for lives of pupils. In short, what is at stake is not simply a matter of policy adaptation, but it is about the counting of human lives.

### **Implications for policy**

In this section I aim to outline the implications of my findings for the policy-making process. What does it mean for policy making when HIV/AIDS policy is about emotions and about bodies? Clearly the policy-making process needs to acknowledge the uniqueness of this policy and focus attention on the emotions and bodies of those at the micro level as a first step towards getting closer to the realities of would-be implementers.

The findings of this study have important implications for policy and practice as they point towards a shift from the input-to-output approach to policy implementation to one that is more sensitive to the physical and emotional presence of school-level actors. As Sultana (2008) suggests, lack of consideration for teachers’ situations in the reform process is generally detrimental to implementation, and ignoring teachers leads to ignorance about the conditions and contexts in which the implementation unfolds. I argue for the reconstruction of the policy-making process to inscribe the real bodies and real emotions of the teachers into the policy.

A policy insight from this study is that policy making is far from the scientific and rational exercise that it is touted to be, and implementers try to make sense of the demands made by policy makers by trying to reconcile them with their personal and professional world views. The stories of the teachers living with AIDS suggest that the education system needs to be restructured in order to come to terms with the pandemic. Specifically, it suggests the need for policy to relocate from a purely prevention mode to one that looks at the whole prevention-to-care continuum, acknowledging that a significant majority of school pupils and teachers are infected or affected. Similarly the organisation, content and delivery mode should reflect this reality. Curricula, in particular, will need to be more in tune with the situations of teachers, learners and other school staff.

Fundamentally, in an AIDS context teachers will need support so as to be able to, as Kelly (2000b) puts it, “stand AIDS on its head”. This support would include an acceptance of their illness, the creation of an environment where they can disclose their status, support for accessing life-saving medication, access to counselling services, protection of their jobs and restoration of their dignity. Without these conditions in place, one can expect to see very little positive change in the implementation of HIV/AIDS and Life Skills policy in the classroom. By creating opportunities for teacher input in the reform planning process, policy makers can begin to understand the support that teachers require for them to fulfil their obligations in a context with AIDS. In that way, teachers will become not just consumers of policy but ‘makers of policy’.

This argues for policy development which is organised in such a way that it is responsive to the realities of the HIV and AIDS crisis. Such a policy would recognise the limits of relying on statistical estimates and demographic projections, and acknowledge that schools are micro-ecologies in which real bodies of pupils and teachers navigate and negotiate their lives in the midst of the HIV/AIDS pandemic (Jansen 2007). The policy would work with a clear understanding of the interconnectedness between the school and the community; it would be cognisant of the sexual interchange that occurs between teachers and pupils; it would allow both teachers and pupils to come into the discussion as affected and infected individuals; it would focus on the whole prevention-to-care continuum, acknowledging that schools are already home to pupils and teachers who are infected and affected by AIDS.

## Areas for further research

In this study I have attempted to expose the contexts within which the statistics on HIV and AIDS take on meaning in the daily routines of teaching and learning inside real schools and classrooms. I take an account of teachers' lives as a key mediating factor in the teaching of HIV/AIDS and Life Skills. Through the study I seek to provide a response to Baxen and Breidlid's (2004:24) critique that few studies have looked at what happens at the chalk-face in schools.

While the study has given comprehensive ethnographic accounts of teachers and teaching inside schools and classrooms in an AIDS context, researchers still need to ask different sets of questions in order to develop deeper understandings of a number of key elements which remained unaccounted for in research on HIV/AIDS and education. The questions below have rarely been debated, and yet they remain pertinent to research on HIV/AIDS in the education sector:

- Are schools the best place for HIV and AIDS education to take place?
- Should HIV and AIDS education be part of the work of teachers?
- Why do young people still find themselves unable to negotiate safer sex practices in the midst of readily available information on HIV/AIDS?

## Significance of this research

The main significance of this research is that it is one of a few studies that have focused at the micro level of teaching and learning in a context with AIDS. The study answers Jansen's (2007) call for in-depth and sustained ethnographic research that fully and vividly documents life in school during and through the HIV/AIDS epidemic. Bearing in mind that in most studies on HIV and education teachers have been considered as objects rather than subjects of research, this research extends the knowledge by looking at teachers as individuals who work and live in contexts with HIV and AIDS. While there are a number of published works about AIDS in



schools, the educational literature has been silent about the experiences of teachers with AIDS.

By looking through the eyes of teachers with AIDS, I got a deeper understanding of the challenges they face in implementing the HIV/AIDS and Life Skills policy. In essence, this study provides another perspective as to why policy images rarely translate into the identities of the implementers. By allowing the teachers' stories to speak for themselves about the new kinds of policy, politics and research that should be pursued if education is to have a significant role in countering the pandemic, I sought to initiate debate on what kind of policy-making process should be followed to respond to the unique nature of the HIV/AIDS policy.



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## **Appendix One**

### **Ethical Clearance Certificate**



## Appendix Two

### Data Collection Instruments

#### 1. Summary of Research Questions and Methods

Research Question	Proposition	Methods
How do images of the ideal teacher, as reflected in government policy, compare to the self-described identities of teachers in the context of HIV/AIDS?	The images of the ideal teacher as reflected in government policy often do not consider the realities of teachers, and thus are likely to be in conflict with the images and identities teachers living with HIV/AIDS have of themselves.	<ul style="list-style-type: none"><li>• In-depth document analysis of key government policy instructions on HIV/AIDS and Life Skills, and also donor agency documentation.</li><li>• Key informant interview with the following officials in the Ministry of Education: Director of Planning; HIV/AIDS Unit; District Education Officer- HIV/AIDS; school heads.</li><li>• Interviews with officers in: UNESCO, UNICEF, teacher unions.</li><li>• Narrative interviews with five teachers living with AIDS.</li></ul>
How do the experiences of teachers living with HIV/AIDS affect the way they respond to and enact government policy on HIV/AIDS in the classroom?	Teachers living with HIV/AIDS struggle to cope with their status and the associated burden of illness and its impact on their work. At the same time, they have to face the demands of their job, the stigma and shame associated with the disease, and the need to support other teachers and pupils to cope with the disease. Their own	Narrative interviews with five teachers living with AIDS.



	personal experiences will affect the way they respond to and enact government policy on HIV/AIDS in the classroom.	
To what extent can the framework of 'teachers as emotional actors' reconcile the differences between policy ideals and teacher understandings of their identities in HIV/AIDS contexts?	Policy makers need to consider that HIV/AIDS is an emotional issue and that teaching is more than a mechanical act. It is a highly intensive human activity, a transmission of values, a meeting point of feelings and an exchange of deep emotions. The consideration of teachers as emotional actors might reduce the discrepancy between policy visions and teacher understanding of their roles and identities.	Analysis of the research data on the experiences of teachers against the information on policy ideals gathered through document analysis and interviews with key informants.



## 2. Value of the Chosen Method to the Research

Critical Question	Method	Value
How do images of the ideal teacher, as reflected in government policy compare to the self-described identities of teachers in the context of HIV/AIDS?	Document Analysis Schedule	This will provide me with in-depth information on the image of teachers as reflected in the official documents and the expectations that policy makers, community and donors have of teachers teaching HIV/AIDS and Life Skills. This data will allow me to corroborate and supplement evidence from other sources, such as the interviews.
	Key informant Interview sheet	This will allow me to interact with the key players and get their views on images/visions of ideal teachers vs. the practical realities that teachers, particularly those living with HIV/AIDS, face today.
How do the experiences of teachers living with HIV/AIDS affect the way they respond to and enact government policy on HIV/AIDS in the classroom?	Narrative Interview Schedule	This will bring me into the lives of teachers living with HIV/AIDS, so that I can get an understanding of their experiences with implementation of the HIV/AIDS policy.
	Personal Diary	This will allow me to record the proceedings of any interview soon after it is completed and before I forget the key issues. It allows me to disclose my feelings and reflections on the teachers' experiences.

### 3. Document Analysis

An analysis of the policy documents or policy instructions from government or other key players in the education sector is important to gain an understanding of how teachers are portrayed by the government, the international community and the school community. It also shows how much the official images of teachers have changed over the years with the increasing prevalence of HIV/AIDS.

The following documents will be analysed for this research:

- Ministry of Education Sport and Culture's Policy on HIV/AIDS and Life Skills
- Other policy instructions and administrative circulars issued over the years
- Ministry of Higher and Tertiary Education Policy for Teacher Training Colleges
- Evaluations of the Life Skills programme
- Key documents from teacher unions

The questions below will guide the document analysis:

1. Which organisation produced the document?
2. When was it written?
3. To whom was it written?
4. What were the explicit intentions of the document?
5. What was the central message of the document?
6. How are teachers portrayed in the document?



#### 4. Key Informant Interview Sheet

The purpose of this interview is to get the views of the policy makers and those who have an influence on the policy process. It aims to find out their expectations of teachers teaching HIV/AIDS and Life Skills, and also what visions/images of teachers they hold. Lastly, it will seek to establish whether the policy makers consider the realities of teachers living with HIV/AIDS in their policies.

1. Name of Interviewee: \_\_\_\_\_

2. Organisation: \_\_\_\_\_ Position: \_\_\_\_\_

3. Years in the organisation: \_\_\_\_\_

- What role does your organisation play in the development of HIV/AIDS and Life Skills policy?
- Have you personally been involved in the policy development process?
- What does the policy say about the teaching of HIV/AIDS and Life Skills in school?
- What role are teachers expected to play in policy implementation?
- In your view, what are the shortcomings on the part of the teachers implementing HIV/AIDS and Life Skills policy?
- How can the performance of teachers in this regard be improved?
- What does the policy say about teachers living with HIV/AIDS?
- In your view, do you feel that government support for teachers living with AIDS is adequate?
- What more do you feel should be done for teachers living with HIV/AIDS?



## 5. Narrative Interview Schedule

### ***Schedule A: My Story (narrative biography of each teacher)***

The purpose of this interview is to get to know more about the interviewee, and it is also about establishing a relationship with them. By getting the respondents to talk about their life histories, it is my hope that they will open up to the researcher.

- Tell me about yourself. Who are you?
- When and where were you born?
- How did you grow up?
- Tell me more about your family before you were married – i.e. father, mother, brothers and sisters.
- Do you have a family of your own now? Can you tell me about them?
- Where do you live?
- Tell me about your work. Where do you work? How long have you worked there?
- What do you enjoy doing?

### ***Schedule B: The HIV diagnosis – how I felt after I was diagnosed HIV-positive***

The purpose of this second interview is to get the respondents to start opening up on when they were diagnosed and how they felt after the diagnosis.

Start interview with a summary of the issues from the last interview.

- What were your life and career goals before you were diagnosed?
- When did you learn that you were HIV-positive?
- How did you learn about the diagnosis?
- How did you feel after you were diagnosed?
- What did you do when you learned that you were HIV-positive?
- How do you feel about your diagnosis now?
- How have your goals been affected by the diagnosis?
- What are your plans for the future?
- How are you coping with HIV/AIDS?

***Schedule C: How HIV/AIDS has affected my personal life***

The purpose of the interview is to find out what changes HIV/AIDS has brought to the personal lives of the teachers.

- What changed in your life after the diagnosis?
- How has it affected your health situation, resources, etc.?
- How has HIV/AIDS affected your family life?
- How has it affected your spiritual life?
- How has it affected your relations with your friends and community members?

***Schedule D: How HIV/AIDS affects my life at school***

The purpose of this interview is to understand how HIV/AIDS affected the professional lives of the teachers.

- What made you choose to become a teacher?
- How has HIV/AIDS affected your teaching?
  - *Execution of tasks*
  - *Demands of your work*
  - *Presence at work*
  - *Communication of HIV/AIDS messages to pupils*
  - *Overall performance in school*
- How has HIV/AIDS affected your interactions with students?
- How has HIV/AIDS affected your relationship with other teachers at the school?
- How has HIV/AIDS affected your relationship with your supervisors?
- How has HIV/AIDS affected your relationship with parents and the community?

***Schedule E: How the school community responded to my status***

The purpose of this interview is to get the subjective experiences of the teachers on how the school community responded to the HIV/AIDS diagnosis.

- Have you disclosed your status to anyone in the school community? If not, do you think they are aware of your status?

- If you have disclosed, what has been the response of the headmaster, fellow teachers, parents and pupils?
- How do you feel about your disclosure/non-disclosure?
- Does being HIV-positive affect your interactions with other members of the school community?
- Do you think that disclosing your status has made a difference in your relationships with other members of the school community?

### ***Emotions***

Please describe the different emotions that you went through as a teacher when

- a) you discovered you were HIV-positive.
- b) you tried to reconcile your HIV-positive status with the expectations placed on you by the school and the Ministry through the Life Skills policy.
- c) you could not keep up with your teaching responsibilities.
- d) you felt other teachers were talking about you.
- e) you had to deal with parents and other members of the community.



## 6. Personal Diary

Interviewee: \_\_\_\_\_

Position: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Date of Interview: \_\_\_\_\_ Duration: \_\_\_\_\_

Taped: \_\_\_\_ Yes \_\_\_\_ No

Interviewee was:

Tense	1 2 3 4 5	Relaxed
Holding Back	1 2 3 4 5	Open
Reluctant	1 2 3 4 5	Straightforward

My relationship with the interviewee:

Atmosphere of the Interview:

- What were the main issues or themes that emerged?
- What information did I get ( or fail to get) during each interview?
- Did I gather any new interesting and relevant information?
- What non-verbal communication did I receive?
- What were my concerns regarding this interview?
- What ideas did I gather which might have implications for my research design?

## Appendix Three

### Informed Consent Form

*Research Title:*

“Teachers living with HIV/AIDS”: Underplaying the role of emotions in the implementation of HIV/AIDS policy in Zimbabwean primary schools

**Dear Participant,**

I am inviting you to participate in a research project aimed at exploring the experiences of teachers living with HIV/AIDS, to explore how their experiences affect the ways in which they teach HIV/AIDS and Life Skills. The research seeks to establish whether the official expectations placed on teachers through policy take account of the realities and identities of teachers in a world with AIDS. I will explore whether the images of what ideal teachers should be and how they should conduct themselves are consistent with the personal identities of teachers living with HIV and AIDS.

Your participation in this research project is voluntary and confidential. You will not be asked to reveal any information that will allow your identity to be established, unless you are willing to be contacted for individual follow-up interviews. Should you declare yourself willing to participate in an individual interview, confidentiality will be guaranteed. You may decide to withdraw at any stage should you wish not to continue with an interview.

Accompanying this letter is a document explaining your *role in the research process*.

The results from this study will be used to inform future policy on the realities of teachers in a World with AIDS, and in doing so try to reduce the gap between policy and practice. It is my hope that, through listening to your experiences, we can deepen our understanding of issues facing teachers in a World with AIDS.



If you are willing to participate in this study, please sign this letter as a declaration of your consent – that is, that you participate in this project willingly and that you understand that you may withdraw from the research project at any time. Participation in this phase of the project does not obligate you to participate in follow-up individual interviews; however, should you decide to participate in follow-up interviews your participation is still voluntary and you may withdraw at any time. Under no circumstances will the identity of interview participants be made known to *any parties or organisations that may be involved in the research process and/or which have some form of power over the participants.*

Participant's signature ..... Date: .....

Researcher's signature..... Date: .....

Yours sincerely,

*YOUR NAME*





**Your Role in the research process**

I propose to conduct about five interview sessions with you as a participant, and these will be recorded on audio tape. Each interview will last for a maximum of ninety minutes. I hope to carry out the interviews over a period of up to two months.

The interviews will look at your life story, how the HIV diagnosis has affected your personal and professional life, and how you interact with members of your family and the school community.

The interview will be recorded on audio tape to avoid leaving out any important information and to avoid disrupting the interview process. If you consent to the use of the tape recorder, please sign below.

Participant's signature..... Date .....

## Appendix Four

### Extract from my Research Diary

*Today I begin my research journey. I woke up today with a question nagging me: How do I find my research partners? Researching the lives of HIV-positive teachers is a mammoth task. During the development of the research proposal I was aware of the challenging task that lay ahead of me. As more and more people read my proposal, I realised that I might have underestimated the enormous challenge that lay ahead, the complex ethical issues involved and the fact that this research would require a great deal of emotional labour and introspection/personal reflection from myself as a researcher. All the comments from colleagues and lecturers who read my proposal carried the warning: you need to be careful as this is a process involving asking people to recount very deep and potentially painful /traumatic moments of people's lives.*

*So here am I, ready to start the process of identifying participants. One suggestion from the proposal defence which I took to heart was the need to try to identify as many potential participants as possible, and to try to select the five that I feel will have stories that are interesting, that will add value to my research and that will not contradict each other. I have two starting points. [1]Towards the end of 2004, as I was working as programme specialist H/A with UNESCO, we held a colloquium for the sub-region, where we invited HIV-positive teachers to tell their stories in a panel being moderated by Mr B. Dhliwayo, a consultant who is also living with HIV and AIDS.*

*It was this panel discussion that gave birth to my research proposal idea. This was based on the view that HIV-positive teachers have stories to tell, stories that are powerful and that can actually influence policy, and they need to have their voices heard. The parting words from one of the teachers were, "We need to be part of the solution and not the problem." From that panel discussion I remember there was one female teacher who was very articulate in sharing her experiences, and how she talked about how her openness had paved the way for other HIV-positive teachers to share their stories. I had taken down her contact details as I thought that one day I might want to work with her in my research. She would be my first contact.*



## Appendix Five

### Themes and Categories from the Data Analysis of Ruva's Story

Theme	1. Teacher as Ideal citizen vs Teacher as HIV-positive	2. HIV illness and Job Performance	3. Teachers as emotional actors
Major - categories	<b>1.1 Images of the Ideal Teacher</b>	<b>2.1 Absenteeism and the response of the school community</b>	<b>3.1 Dealing with a positive HIV test result</b>
Sub-categories	<p>1.1.1 Teachers as perfect citizens.</p> <p>1.1.2 Multiple roles of teachers; I am taken as a confidante.</p> <p>1.1.3 Expectations of teachers; I am expected to be an all-rounder.</p> <p>1.1.4 Perception of self as ideal teacher vs. perception as person contaminated with AIDS.</p>	<p>2.1.1 Absenteeism; I would be on and off from work.</p> <p>2.1.2 Parents' attitudes; Some parents do not like their children to be taught by HIV-positive educators. They will not really give reasons as being the teacher's HIV status but they might say it is because the teacher is absent a lot.</p> <p>2.1.3 Ministry's position towards teachers with HIV and AIDS.</p> <p>2.1.4 Unfair sick leave conditions; I did not chose to be sick.</p> <p>2.1.5 The reality is often when teachers are sick they will not go home because they always fear that they will use up their days which they might need when their situation gets critical.</p>	<p>3.1.1 I did not take a taxi home: I walked; maybe I wanted to burn it out or get time to compose myself.</p> <p>3.1.2 I did not understand how this could happen when my son was still so young.</p> <p>3.1.3 Loss of hope.</p> <p>3.1.4 Difficulty; This was a really difficult time for me It was one phase of my life that I will not forget.</p> <p>3.1.5 I lived by the day.</p>



	<p><b>1.2 Teacher as HIV-positive</b></p> <p>1.2.1 <i>Society perceptions of who gets infected by HIV.</i></p> <p>1.2.2 Society associates HIV with someone who is sick.</p> <p>1.2.3 <i>I see myself as a whole person and the issue of HIV and AIDS does not come into it.</i></p> <p>1.2.4 AIDS as a disease of the promiscuous.</p>	<p><b>2.2 Illness and its impact on teaching HIV/AIDS and Life Skills</b></p> <p>2.2.1 <i>Impact on teaching: being positive has negatively impacted on my teaching.</i></p> <p>2.2.2 Sometimes when I am not well I am forced to deliver lessons from the chair.</p> <p>2.2.3 <i>I used to find delivering lessons on HIV very tough.</i></p>	<p><b>3.2 The body that carries the feelings and emotions</b></p> <p>3.2.1 <i>Anger after receiving a positive test.</i></p> <p>3.2.2 <i>I would ask God, why me?</i></p> <p>3.2.3 Going through serious emotional turmoil.</p> <p>3.3.4 <i>Worry; How would my kids take it, what is going to happen to them? How were they going to view their lives when they grew up? How were they going to feel in relationships when they grew up knowing that their mother had died of AIDS?</i></p> <p>3.3.5 Regret.</p> <p>3.3.6 <i>Loneliness.</i></p>
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<sup>i</sup> Herpes Zoster is an acute, localised infection caused by the varicella zoster virus which results in a painful, blistering rash. Also known as shingles, it is caused by the same virus that causes chicken pox. After an episode of chicken pox, the virus becomes dormant in the body. Herpes zoster occurs as a result of the virus re-emerging after many years. It is common in the elderly and in immune-suppressive conditions such as diabetes and HIV/AIDS.

<sup>ii</sup> Ankyloglossia, or tongue tie, is a condition in which the free movement of the tongue is restricted due to abnormal attachment of the base of the tongue towards the tip of the tongue. Children with tongue tie may be unable to protrude the tongue, touch the roof of the mouth or move the tongue from side to side. They are often unable to articulate words.

<sup>iii</sup> Anti-retroviral therapy is the recommended treatment option for HIV and AIDS. Anti-retroviral drugs inhibit the replication of HIV. Different classes of antiretroviral drugs act at different stages of the HIV life cycle. The drugs are broadly classified by the phase of the retrovirus life cycle that the drug inhibits. When drugs are given in combination, HIV replication and immune deterioration can be delayed, and survival and quality of life is improved. In some individuals, hypersensitivity to some drugs may occur although this varies by drug, drug combinations, ethnicity, and individual.

<sup>iv</sup> DART stands for Developing Anti-retroviral Therapy for Africa. The programme is a five-year clinical trial of anti-HIV therapy in 3 300 patients with advanced HIV disease or AIDS in Uganda and Zimbabwe. The trial investigates two questions; 1) Can anti-HIV drugs be given in the absence of routine laboratory tests relying on clinical assessments? 2) Can HIV drugs be given intermittently rather than continuously to provide a similar level of benefit to patients but with less toxicity? The trial aims to assess the most effective strategy for use in resource-poor settings where laboratory capacity is often minimal or non-existent.

