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

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Abstract
This is a research-based article outlining how HIV/AIDS affects men's and women's adjustment to positive living. It explores issues of challenge, survival and sexuality and offers culturally appropriate and sensitive life skills that may be adopted in schools, families and communities. Life skills education for risk reduction and living positively with HIV and AIDS needs to be carefully planned and executed, or else it runs the risk of increasing risk taking behaviour (Visser 2005), an important consideration that this article heeds.

Context
HIV/AIDS in South Africa
HIV and AIDS in South Africa is embedded in a complex context of poverty, family disintegration, food insecurity (Ahmed *et al.* 2009; Kasiram 2011) non adherence to treatment, sexual violence and cultural complexities that appear to promote risky sexual conduct (Kelly 2002).

Cultural complexities in themselves are difficult to isolate as contributors to sexual risk taking as they are largely intertwined with religion, spirituality, morality and values (Smith 2002). Moral 'regeneration' was a popular term since its inception as a movement in 2003 (PMG, Parliamentary Monitoring Group 2010) and includes not only Life Orientation to address HIV/AIDS in South African schools but a host of

other concerns such as violence against women and corruption that flout morality in its broadest sense. Indeed, in the document: Chapter 6: Challenges Facing the Moral Regeneration campaign, nation building is cited as the evolving aim of the campaign (www.iss.co.za/pubs/monographs/N0114). This article recommends research-based life skills, with the term life skills being used in its broadest sense.

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

The third study focused on sexuality, dating and intimacy concerns among men and women with HIV/AIDS. In South Africa, sexuality and intimacy are both taboo topics, more so when there is HIV and AIDS. There is a need to appreciate sexuality and dating challenges and experiences of men and women who are HIV positive, because this is a much neglected area and little is known about the full range of sexual adaptations HIV-infected individuals choose (Schiltz & Sandfort 2000). Kasiram *et al.* (2003:9) highlight interaction and intimacy among HIV positive persons 'as a neglected area' that warrants research, and Painter (2001), that couple relationships for infected persons have been insufficiently attended.

Both HIV/AIDS in women and sexuality and dating among HIV positive men and women are concerns that may be addressed early whilst youngsters are still at school, with results of these studies pointing to how life skills programmes may be planned and implemented.

Life Skills

Since HIV and AIDS has reached epidemic proportions in South Africa, with far reaching consequences to the individual, family, community and country,

it has become necessary for prevention, planning, remedy and general management of the pandemic by multiple stakeholders. Life skills, the subject of this article is one such programme in South African schools, aimed at preventing HIV and AIDS, and offered since 1995 (Visser 2005).

Research studies on these programmes have shown that although knowledge levels may have increased, this did not translate to behavior change with regards to sexual risk taking (James *et al.* 2006; Kelly 2002; Visser 2005) post the programme's implementation. Magnani *et al.* (2005) however found in their study of 2222 youth in KwaZulu Natal, that there was overall modest change in self efficacy and increased condom use reported by the youth after the implementation of the programme. Differences in these results are attributed to poor and inconsistent implementation of the programme (Magnani *et al* 2005; Visser 2005), real long term benefits being too early to gauge since the programme's inception in 1995 and other extraneous factors that may have promoted behaviour change that the studies could not control.

Literature reviewed on best practice life skills education suggests careful planning and implementation that must consider all of the following issues:

Policy and Planning: Top-down policies on life skills for sexual risk taking do not work, even with the best intentions and committees that plan these programmes (Kelly 2002, Visser, 2005). The suggestion is for including parents and young people themselves (Kelly 2002) as well as for marketing, liaising and coordinating to formulate and then sell the life skills product (Visser 2005). These suggestions make sense considering the time, effort and finances expended in aiming for desirable outcomes.

The school management team together with community support, form core contextual ingredients for a successful programme. In this regard, Visser (2005) and James *et al.* (2006) caution that without funding, management support and a context that offers space, time and import to the programme, it is doomed to failure.

Who: Life skills education in schools should be undertaken by educators who are thoroughly prepared and trained (Pick *et al.* 2007; Ahmed *et al.* 2009), skilled, committed, good role models and should understand which

cultural norms are being violated through the programme in order to address them (Kelly 2002). In addition the suggestion is to include young people themselves, target audience members (Visser *et al.* 2004), community members (Visser 2005), traditional healers, faith-based organizations, peers, untrained teachers and senior students (Coombe & Kelly 2001) as persons who could be involved in teaching, training and life skills education.

Visser (2005) recognizes the importance of relationship as the vehicle through which sensitive information is taught and learnt and thus exhorts teachers and learners to share a trusting relationship.

What: James *et al.* (2006) research the Life Skills and HIV/AIDS Education Programme of the KwaZulu Natal Department of Education (2000). The programme includes the following ingredients: **facts** about HIV and AIDS, modes of transmission, the immune system, progression of HIV to AIDS and how to keep the body safe and healthy. This was followed by **skills** on preventing HIV and AIDS that include attitudes to condom use, gender norms and sexual behavior. James *et al.* (2006) note that specific information on what attitudes need change and suggestions on best practice methods for accomplishing such change was not offered. The findings were that behavior change did not occur, this being attributed to the programme lacking input on addressing 'self efficacy beliefs and skills related to actual condom use' and **'**internalization' of the information, communication, negotiation and refusal skills (James *et al.* 2006:292-3). Efficacy and control and re-negotiating sexual identity were also cited as important to good life skills programmes by Visser *et al.* (2004).

A higher order level of engagement with learners, using multiple communication channels and media is clearly necessary in aiming at behavior change (Coates *et al.* 2008). To this end, Visser *et al.* (2004) suggest interrogating meanings and beliefs surrounding HIV and AIDS, beliefs about change, critical assessment of personal risk, self awareness, decision making, assertiveness and developing a positive attitude towards persons with HIV and AIDS in order to interact with them without prejudice.

Researchers agree on moving beyond the mechanistic (factual) aspects of HIV and AIDS, focusing on the context of the learner's own developing sexuality, engaging on issues of witchcraft, sorcery and black magic and engaging with traditional healers (Coombe & Kelly 2002; Kelly

2002; Visser 2005; James *et al.* 2006). In South Africa, people may be too afraid to challenge issues of sorcery, witchcraft, cultural and traditional beliefs which may significantly control sexual risk taking behavior, hence the need to include these topics and involve relevant 'experts'.

HIV and AIDS do not occur in a vacuum as explained earlier. In accord with ecosystems theory, broader socio-economic issues affect risk taking and HIV and AIDS (Visser *et al.* 2004; Ahmed *et al.* 2009). Unemployment and financial need can significantly impact women's risk taking behavior and promote HIV infection and re-infection (Kasiram *et al.* 2011). In appreciating the multiple, reciprocal influences in which HIV and AIDS thrives (ecosystems theory), Coombe and Kelly (2001) caution that programmes need community backup, so that there are no conflicts between what is taught/learnt and what is expected and supported in the home and community. Similarly Visser *et al.* (2004:263) advise on 'developing a community context for supporting sexual behavior change' whilst assessing the capacity of the community to change.

Notwithstanding, community capacity to change, it is incumbent on education and skilling to direct effort at some socio-cultural change (Coombe & Kelly 2001). In this regard, societal expectations of women (social constructionism) could be changed to help with their empowerment, thereby reducing their sexual risk taking. Kelly (2002) suggests interrogation of gender-based violence, associated rights, responsibilities and respect, aspects that also feature in moral regeneration campaign (Challenges Facing the Moral Regeneration campaign, undated) while Mitchell and Smith (2001) suggests promotion of the female condom to give women greater personal control in sexual relationships.

Kelly (2002) suggests that if the programme elicits group support for abstinence as 'cool', the chances for adopting such behavior increases. Recognizing this group pressure dynamic, Visser (2005) similarly suggests that condom use be marketed as popular, to realize attitude and behavior change. Such marketing needs to be large-scale, involve multiple role players such as the school, faith-based organization, family, community and government, to have the desired impact.

Kelly (2002), Pick *et al.* (2007) and Ahmed *et al.* (2009) suggest that life skills be included in larger programmes on health care and promotion (Ahmed *et al.* 2009), targeting younger learners and then continue as they

progress to later years to discuss more difficult/sensitive topics such as sexual and reproductive health (Pick *et al.* 2007). The advantage of commencing early in this fashion is including life skills on promoting creativity, self esteem, problem solving, negotiating and expressing feelings from a young age as discussed by Pick *et al.* (2007). That the programme should be sustained and progress in level of intensity, difficulty and sensitivity is also suggested by Visser (2005) and Ahmed *et al.* (2009). Indeed, there is also a suggestion for the programme to have an examinable component in order that it is taken seriously and enjoys dedicated time and effort in the curriculum.

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

In addition, Magnani *et al.* (2005) and James *et al.* (2006) suggest full and consistent implementation in schools by a committed and varied team of educators.

Research Methodology

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

All three studies in the project utilized the qualitative paradigm as this allowed us to glean rich, in depth and new understandings of experiences of HIV and AIDS (Rubin & Babbie 2005). The research designs used were a

combination of exploratory and descriptive designs as some of the data was new to the area such as exploring survival issues although challenges have already been the subject of research interest. Further, sexual experiences of HIV positive people have not been determined using positive persons themselves, hence the exploratory design being mainly used in this study. It was also necessary to describe experiences in detail, to produce information pertinent to the meaning behind these experiences (Royse 2004), hence employment of the descriptive design to complement the exploratory design.

The sample used in the project was as follows:

Project 1: survival stories of 7 HIV positive women, using a convenience sample of women who received therapy at the University-based family therapy service learning unit where the authors offered services.

Project 2: challenges and survival stories of 15 HIV positive women, using convenience sampling, at the health centre where one of the authors is employed.

Project 3: sexuality and intimacy experiences of 12 HIV positive men and women, using available and then snowball sampling procedures.
The research instrument was the semi-structured individual interview that contained themes for guiding the interview. Having this guide to structure the interview was essential since the topic was sensitive and sometimes painful, necessitating fieldworker input, therapy and referral that could have derailed the research component of the interview.

Since this was a qualitative project, reliability was less of a concern than was trustworthiness. Data had to be credible, with researchers ensuring that participants did not offer socially acceptable responses or responses that would compromise their status as clients receiving social work services. Hence, social work skills in assuring them of confidentiality, a non-judgmental attitude, discussing termination of the interview without penalty were some of the measures used in promoting credibility of data. Data was also dependable, in that themes were derived from a thorough literature search, along with allowing for open discussion so that authentic,

comprehensive accounts were received from participants. Tape recorders were also used after securing participant permission, ensuring confirmability of data.

Ethical issues such as confidentiality, anonymity, explanation of the research project, securing informed consent and offering ongoing services or referring participants for further assistance was respected in all three projects. Further, all 3 projects secured ethical clearance from the University under whose auspices they were undertaken.

Three theory frames were used in grounding this project viz. narrative, to explore the full narratives of participants' experiences, all the plots, the dominant discourses along with the alternate stories. The ecosystems perspective was used to ensure that due consideration was afforded to the multiple systems that reciprocally influence each other in the face of HIV and AIDS. Not only do these different factors influence HIV risk, but in reciprocally exchanging with each other, they create new scenarios that equally affect risk and/or adjustment to HIV and AIDS. Finally social constructionism was useful since it emphasizes the role of culture and society in shaping the experience of illness, especially in relation to gender and chronic illness, in this study in relation to HIV and AIDS as life-long diseases (Conrad & Barker 2010). Urdang (2006) explains that pre-existing socio-cultural norms reinforce the role of women as reproductive agents with little ability to negotiate safe sex, and hence the theory's relevance.

Results and Discussion of Life Skills

In presenting the results of the three studies, reference is made to the theory frames used to ground this project and to the literature reviewed on life skills programmes. In addition, results are discussed specifically in relation to life skills education for the purposes of this particle, with the literature review providing the data source from which life skills related to the results are derived.

Because Project 1 and 2 were closely related, their results are jointly presented since challenges that are overcome become 'survival' stories of participants. In addition, results are presented briefly as themes, in order to focus more attention on the life skills, the subject of this article. Life skills

were also supported with discussion of results where necessary, in order to appropriately contextualize the choice of particular life skills.

Suggestions for specific life skills to address themes and participant responses are made and more fully explained where necessary. The life skills are initially discussed in depth, but as they become relevant to other findings and responses, the authors refer to them briefly to avoid undue repetition.

Project 1: Challenges and Survival of HIV Positive Women

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

Theme 1: Non Acceptance/Acceptance: Allocate Finite Time

Denial, guilt, loss, grief and shock mainly accompanied a positive diagnosis. However, when the women allocated a finite time for grieving, recognizing that life has to continue '*for the sake of the children*', they could forward plan and live positively. Life skills for this theme include:

a. Strengths based work to improve self esteem, as loss of confidence and other negative emotional responses were commonly experienced when receiving news of a positive diagnosis (as suggested by Pick *et al.* 2007).

b. Change socio-cultural beliefs- since women were made to believe that they carried the responsibility of bringing the disease into the home as noted by Coombe & Kelly (2001) and Kelly (2002) in accord with social constructionism.

c. Trauma, death and dying education- to appreciate stages of grieving and realize that crossing these stages brings one closer to the acceptance stage.

d. Externalizing - in separating the problem from the person as discussed by

narrative theorists so that the identity of the individual is not infused with being only HIV positive to facilitate the development of healthier, alternate identities (narrative theory). This is also suggested by Visser *et al.* (2004).

e. Assertiveness and problem solving- to help women negotiate safe sex and to not be afraid that that this may result in them losing the relationship in the face of having sex more safely or not at all. This was also advocated by James *et al.* (2006) and Visser *et al.* (2004).

f. Value living optimally/positively- to commence early as part of a wider programme on health promotion, achievable if youngsters are taught to value life and live it fully and positively as discussed by Pick *et al.* (2007) and Ahmed *et al.* (2009).

Theme 2: Disclosure / Non Disclosure/ Selective Disclosure, and Consequences to Family

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

a. Negotiation and refusal skills- necessary where women wish to prevent re-infection (also see 1e).

b. Assertive training and problem solving- essential for honest disclosure and dealing with consequences of disclosure (also see 1e).

c. Right living within a life orientation programme- also necessary for promoting honesty in the relationship and family (also see 1f).

d. Trust building-instead of women fearing their partners, they could be helped to build trusting relationships, achievable through early life

orientation and health promotion programmes that could commence early in the learner's school life as discussed above (also see 1f).

Theme 3: Loss of Self, Loss of Sexual Intimacy

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

a. Strengths based work, to help identify the multiple identities and strengths that reside in us all, to be nurtured from childhood. In addition, because identity loss is largely prompted by societal constructs of women, socio-cultural change is necessary (social constructionism; also see 1a), with the school providing a helpful door for entering the community and society.

b. Externalization – to detangle the identities of the these women and help with healing (narrative theory; also see 1d)

Theme 4: Rejection, Stigma and Isolation

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

a. Value social connection and wrap around networking- this life skill may be also be taught early to the child in developing a sense of community connection, essential for nurturing fight and survival in all human beings (ecosystems theory; Rojano 2005).

b. E networking – today e communication makes connection so simple, but it is important to remember that just as we may rely on faceless

networking, we must also nurture face to face relations, to experience the full benefit of 'wrap around networking'. These suggestions were not found in the literature review, but may have been implied in suggestions to use the 'group' dynamic (Visser 2005) in goal setting and risk reducing behaviour.

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

Factual understanding about the disease, its transmission and preventing re-infection was often limited among most participants and contributed to further risk taking such as having '*neviropine babies*' since women did not transfer the virus to their babies because of treatment at antenatal clinics. Only a few of the women were well informed, so much so that they were able to become 'AIDS Counselors' themselves, serving others in their community. Life skills indicated for this result include:

a. Update/improve knowledge, attitude, skills by accessing/ synthesizing knowledge from multiple sources, critical thinking and making informed decisions (James *et al.* 2006). However, synthesizing the information and making informed choices has to happen outside the boundaries of didactic teaching, in small groups where interaction and groupwork allows the many dimensions of these issues to be openly and liberally interrogated (Visser 2005; Ahmed *et al.* 2009).

b. Address myths about male supremacy, correction rape- also see 1b.

c. Address issues of witchcraft, sorcery, curses, black magic – also see 1b.

d. Assertive skills to question e.g. medical staff regarding best options in treatment–also see 1e; 2b.

Theme 6: Ensuring Financial Security

More than being HIV positive was the fear of not being financially able to

provide for themselves and their families. This concern was all consuming for most of the women, and in the survival stories, their efforts and successes were lauded. Many of the women had food gardens that allowed gave them '*daily exercise, food for themselves and families and a little extra for selling*'. However, when they were ill, it was difficult to maintain their gardens, suggesting the dire need for other sources to be tapped for everyday survival, in the form of the following life skills:

a. Handwork, sewing, gardening, baking, craftwork- could be taught as part of a larger skills initiative drive to change the focus from pure academics to alternate but necessary creative arts. These could later be used to source an income or could re-instill a sense of accomplishment in women (and men). This suggestion is also made in the literature by Pick *et al.* (2007).

b. Value education/qualification- in a context where money is scarce, it is not always possible to promote education as this may take away potential earnings, albeit meager. However, it is necessary for young learners to know the value of education, ongoing education and qualification, so that where possible and feasible, they may pursue studies for a better quality life. These self same values for education must also be instilled in the community, since without such community backup (Coombe & Kelly 2001; Visser *et al.* 2004), such ideals will not reach fruition because of the reciprocal influences at play of non support for education in communities (ecosystems theory).

Theme 7: Support Network for Self and Others: Wrap around Service

The need for networking was evident earlier in the theme of rejection and isolation. Here, women mentioned the value of being supported when surrounding themselves with others who cared for and nurtured their spirits. The women's survival was inspiring, in that sources of support were simple, did not involve financial resources and were easily available to them if they

reached out. Such simplicity sometimes has also to be taught and grown, as in examples of the following life skills:

a. Recognizing/managing negative influences and problem solving- also see 2a; 2b.

b. Recognizing value of connection and e links- also see 4b.

c. Valuing/nurturing nature, friendships –also see 6a.

d. Promoting spiritual regeneration, prayer, meditation- also see 6a.

e. Promoting self healing/creativity- song, reading, walking, dancing, drama, journaling-include in curriculum –also see 6a.

Theme 8: 'UBUNTU'

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

Project 2: Sexuality and Intimacy Experiences of HIV Positive Men and Women

This study was conducted with 6 men and 6 women who were HIV positive, the rationale for this focus having been clarified earlier in this article. Several findings emerged and are represented in the themes discussed hereunder. Overlap of both results and related life skills with the first and second study on experiences of challenges/survival of women were evident. Hence, life

skills are not demarcated separately, but incorporated into the explanation of the theme, to prevent undue repetition.

Theme 1: 'I am dirty', Poor Self Esteem, Fear of Rejection/ Loss of Relationship upon Disclosure, Guilt at Living

These findings highlight the sense of worthlessness in HIV positive persons and their all-consuming fear of disclosure. They did not believe that deserved intimacy, pleasure or happiness. Life skills pertinent to these findings overlap largely with what has been mentioned in results and life skills of women with HIV and AIDS. They include externalization skills in order to develop a strong self identity that is separate from a positive diagnosis, nurturing strengths and creativity and using youth-popular media.

Theme 2: No Future Goals, Fearing the Unknown and Inability to Solve Relationship Problems

These concerns for the future found a corollary in participants' negative mind set and inability to make informed decisions about their current life or future living. Life skills pertinent to these results again show similarity to earlier results. Being positive, looking to a future, nurturing communication skills and being able to problem solve about relationships must, as mentioned earlier, commence early, in general life orientation programmes at school, with sensitive topics such as intimacy being added later as and when appropriate.

Theme 3: 'I can't have childre'

This theme is very similar to the afore-mentioned regarding concerns for the future. Here it is specifically related to unborn children, and originates from inadequate knowledge about HIV, transmission, infection and re-infection, all of which could be addressed through knowledge acquisition. However, in order to result in beliefs and behavior change, teaching/learning must be learner-centred, age-appropriate and culture and context specific through

interactive teaching/learning means as outlined in the literature (Kelly 2002; Visser *et al.* 2004; James *et al.* 2006; Bozalek 2007).

Theme 4: ARV's Make People Reckless

This result referred to HIV positive persons not caring about infecting others and about their own re-infection. In the case of women, there was a sense that they could behave in any way, and even if they became pregnant, ARV's would prevent transmission to the children. Again, updating knowledge about HIV, treatment, STI's, pregnancy and contraception is imperative. The suggestion is to link such education with current health clinic policy in order to arm people with all possible information, in order to reduce risk of infection and re-infection to themselves, their partners and their children.

Summary and Recommendations

True to ecosystems theory, general health promotion and HIV risk taking are influenced by a range of factors. Results therefore pointed to a wide range of life skills that could be included in the school curriculum to prepare youngsters for HIV and AIDS prevention and/or management. Not only is it important to consider planning the **content** of the programme with care, but the socio-cultural **context** within which the programme will be implemented must also be afforded attention (in accordance with social constructionism).

Results suggested empowerment through knowledge, attitude and skill acquisition, for both males and females, for personal and sexual identities to be delinked from having a positive diagnosis (narrative theory) and for dominant societal discourses such as females being responsible for bringing the virus to the family (social constructionism) to be the simultaneous target of change in order that the receiving context may embrace the objectives of the life skills programme. For women who are at greater HIV risk than their male counterparts, the female condom is advocated to claim locus of control during sexual encounters. Of course, this contraceptive and HIV prevention device being expensive, needs governmental support and funding, and its promotion included in life skills

programmes. Faith-based organizations could also support this initiative, alongside their efforts to promote sex within the institution of marriage.

Results suggest the following life skills for empowering youth with **knowledge** about a range of issues surrounding HIV such as infection, transmission, re-infection, STI's and safe sex and myths related to these topics such as 'correction rape'. Related to this knowledge about the disease, is **understanding** and **attitude change and skills** for building relationships, building trust, communication and assertiveness skills, problem-solving and negotiation skills, identity and self esteem building, self care and healing, healthy living, morality, right living, serving others, being positive, value of connection, trauma, death and dying education and the creative arts. Including non academic matters such as nurturing talents is aimed at developing alternate, empowered identities (narrative theory) that can be enhanced to showcase strengths to defy diminishing of self in the face of the disease. These skills may begin early in the family, being based on values/ culture/ religion that then strengthened at schools and in communities. In addition, together with talent building, accountancy and profit-loss understanding is suggested so that young people can address possible food insecurity and poverty related concerns that usually accompany HIV and AIDS.

As discussed in the literature review, the authors **recommend** that knowledge must be accompanied by attitude changes and changes in beliefs in order that behaviour is accordingly adjusted. The programme should be part of an ongoing one that promotes healthy and responsible living; it should also focus on highlighting the importance of community service and '*ubuntu',* indeed nation building as stipulated in the PMG (2010), in order to secure far reaching benefits. Small group teaching and learning using a creative range of 'educators', a variety of educative sources that include traditional healers, faith-based organizations and youth-popular media (such as e networks and entertainment education-Mitchell & Smith, 2001)) should be employed to penetrate the AIDS information-saturated scene. In addition, in countries such as South Africa where the community may not backup plans for such life skills programmes, community engagement is essential, in preparing for a context that embraces rather than opposes/fights changes. This may mean addressing issues of witchcraft, sorcery and the like multivariously, pointing to life skills programmes not being a top-down approach, but always including relevant stakeholders, continuously and consistently.

The authors suggest that aspects of the life skills programmes become examinable so that the programme is afforded due consideration and seriousness. There should be balance in the degree to which the guidelines are specific versus general, relating to the programme's content and implementation since both depth/detail and liberty to creatively engage with and interpret the programme are considered essential in promoting local relevance. We also suggest that the programme is supported by policy and funding and that it is continuously evaluated and adjusted to suit the changing landscape within which HIV and AIDS thrives. Finally, we suggest that the nation dedicate a date to 'wellness' and declare this a public holiday, focusing on the country's most valuable asset, its people's health!

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