VIEWS OF A RURAL COMMUNITY ON THE IMPACT OF HIV/AIDS ON THE CHILDREN OF INFECTED PARENTS: INTERVENTION GUIDELINES

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VIEWS OF A RURAL COMMUNITY ON THE IMPACT OF HIV/AIDS ON THE CHILDREN OF INFECTED PARENTS: INTERVENTION GUIDELINES

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SUMMARY

The impact of HIV/AIDS extends beyond those living with the virus, as each infection affects the lives of the family, friends and communities surrounding an infected person. Those most affected by HIV/AIDS are the children.

The aim of this study was to examine the views of a rural community concerning the impact of HIV/AIDS status of the parents on their children and to provide intervention guidelines to address the problem. From the research study it was clear that the inhabitants of Heuningvlei village were mostly unemployed and unable to generate income due to lack of skills, training and other opportunities. There was vast evidence of poverty in the community. The community is of opinion that children are negatively affected educationally, socially, economically and health-wise when their parents have HIV/AIDS. They saw family support and material and financial resources as a priority to assist these children through caring and providing food parcels and social grants. Due to poverty in the community and the increase in the numbers of children affected by HIV/AIDS, the caring capacities of families are reduced and children are often left to care for themselves. The community views the role of the social worker as very important. Therefore guidelines are essential for social workers to help communities care for children affected by HIV/AIDS.

OPSOMMING

Die uitwerking van MIV/VIGS strek veel verder as diegene wat met die virus lewe, aangesien elke infeksie die lewens van die familie, vriende en gemeenskappe wat die geïnfekteerde persoon omring, beïnvloed. Diegene wat die meeste deur MIV/VIGS geaffekteer word, is die kinders.

Die doel van hierdie studie was om die opvattings van 'n landelike gemeenskap rakende die uitwerking van die MIV/VIGS status van die ouers op hul kinders te ondersoek en intervensie-riglyne te voorsien wat die probleem onder die loep neem. Uit die navorsing is dit duidelik dat die inwoners van die dorpie Heuningvlei meestal werkloos is en nie daartoe in staat is om 'n inkomste te genereer nie weens 'n gebrek aan vaardighede, opleiding en ander geleenthede. Daar was oorvloedige getuienis van armoede in die gemeenskap. Die gemeenskap is van mening dat kinders opvoedkundig, sosiaal, ekonomies en gesondheidsgewys negatief geraak word wanneer hul ouers MIV/VIGS het. Hulle het gesinsondersteuning en materiële en finansiële hulpbronne beskou as 'n prioriteit om hierdie kinders te help deur versorging en die voorsiening van kospakkies en maatskaplike toelae. Weens die armoede in die gemeenskap en die styging in die aantal kinders wat deur MIV/VIGS geaffekteer is, is die versorgingskapasiteit van families beperk, en kinders word dikwels aan hulleself oorgelaat vir versorging. Die gemeenskap beskou die rol van die maatskaplike werker as besonder belangrik. Riglyne vir maatskaplike werkers is dus noodsaaklik sodat hulle gemeenskappe kan help om vir kinders wat deur MIV/VIGS geaffekteer is, te sorg.

FOREWORD

The article format has been chosen in accordance with Regulations A.11.2.5 for the degree MA (SW). The article will comply with the requirements of one of the journals in Social Work, titled Social Work/Maatskaplike Werk. This article comprises 10 percent of the total mark of the course.

INSTRUCTIONS TO AUTHORS

The Social Work/Maatskaplike Werk publishes articles, short communications, book reviews and commentary on articles already published from any field of Social Work. Contributions relevant to Social Work from other disciplines will also be considered. Contributions may be written in English or Afrikaans. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Commentary on articles already published in the Journal must be submitted with appropriate captions, the name(s) and address (es) of the author(s) and preferably not exceed 5 pages. The whole manuscript plus one clear copy as well as a diskette with all the text, preferably in MS Windows (Word or WordPerfect) or ASCII must be submitted. Manuscripts must be typed double spaced on one side of A4 paper only. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or armaments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "..." (Berger, 1967:12). More details about sources referred to in the text should appear at the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors.

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1. INTRODUCTION

The HIV/AIDS pandemic is a great threat to society as a whole. The infection rate is increasing despite all the intervention strategies which are put in place. The children are the one's who are most affected by this disease, either directly or indirectly. In order to provide for the needs of these children, intervention strategies should be developed.

This article focuses on the living conditions of a rural community, the community's views on the impact of HIV/AIDS on the children of infected parents and its views on the available resources to address these children's problems. The findings of the study will be discussed and finally intervention guidelines will be proposed to address the needs of these children.

2. PROBLEM STATEMENT

The researcher is part of the Tshwaragano project. The primary aim of this project is to investigate the strengths in families and to empower them to play a more supportive role in the care of dependent and vulnerable family members.

According to the Department of Social Development (2001:7), South Africa has the highest number of people living with the disease in the world, amounting to about 6 million adults and children. The HIV/AIDS pandemic is the principal challenge facing South Africa and it will have an enormous impact on the children. In the North West Province alone, 26,151 HIV-infected people have already died since 1996 (Ferreira, 2002:4). As the North West

Province is mainly rural, most of these deaths were in rural areas where no support systems exist. Rural areas are especially affected by the HIV/AIDS pandemic (Ferreira, 2002:4).

HIV/AIDS is fast becoming one of the largest humanitarian and developmental challenges the world has ever seen. The pandemic is increasing poverty and inequality and reversing decades of improvements in health, education and life expectancy. It is also leaving millions of children orphaned and living in situations of acute vulnerability (Pharaoh & Weiss, 2005:1). It is estimated that 8% of South Africa's children are AIDS orphans and the Medical Research Council predicts that at least 5,7 million children would have lost one or both parents by 2015 (Green, 2004:7). South Africa's child welfare system is under huge pressure to provide for the number of children orphaned by HIV/AIDS and seeking foster care.

Vulnerable families care for vulnerable children and one of the consequences of this loss of income and support is that the affected poor sink even deeper into more poverty and neglect (Department of Social Development, 2001: 7).

Although South Africans have better access to health care and an improved quality of life, the number of people who die before they reach the age of 50 has almost doubled over the past ten years (Strydom, 2002:346). Life expectancy in South Africa (the number of years the average person will live) was expected to have dropped from around 60 years in 1994 to just over 47,7 years in 2005 (United Nations Population Division, 2003). Infant mortality rates are hugely affected by the pandemic, and the gains made in child survival will disappear in the 34 worst affected countries (Dunn, 2005:11). Most of the people dying from AIDS are women between ages 30 and 50. This means that the most vulnerable groups are women of child-rearing and working years. This will badly affect our society as a whole (Education Training Unit, 2005:74).

The economy is vastly affected, because AIDS kills people in the prime of their working and parenting lives, and it represents a grave threat to development. This is caused by reducing growth, weakening governance, destroying human capital, discouraging investments and eroding productivity. When the breadwinner ends up losing income due to illness the family is further impoverished. Other family members have to devote more time and effort away from income-generating activities to take care of the ill. In rural areas, for

example, they depend on agricultural activities. Mostly women are the ones remaining at home and ploughing the fields while the husbands are working in mines and other sectors where they do not stay with family end up bringing the disease home (Education Training Unit, 2005:56).

HIV/AIDS creates a different type of family. It robs children of their childhood and forces them to assume adult responsibilities. This means that an extra burden is forced onto the children as well as onto elderly grandparents, both of whom are economically dependent on the state (Department of Social Development, 2002:10). According to the Education Training Unit (2005:56), the toll of HIV/AIDS affects the family life adversely. It is often the poorest who are mostly vulnerable to the disease and to whom the consequences are most devastating. The presence of AIDS means the household will dissolve, since parents die and the children are taken in by relatives for upbringing and care. When the husband is ill, he comes home to be taken care of by the wife who is not even aware of the illness she is treating her husband for (Education Training Unit, 2005:56).

In South Africa, very young children impacted by HIV/AIDS may lose their inheritance rights, family land and property. As they grow older they will be forced to migrate to cities and towns where they are likely to become prostitutes, child labourers and street children and turn to crime (Dunn, 2005:10). The HIV/AIDS pandemic has created thousands of households headed by children as young as 6 to 11 years. These young children cannot provide adequate emotional, nutritional or financial support to their siblings and themselves. Many of these children will feel the effects of a parent's illness long before their death when they shoulder new responsibilities such as caring for younger siblings, taking on additional domestic chores and generating income for the family. Common consequences of orphaning include growing up in poverty, the loss of parental affection, reduced level of care, stigma and the psychosocial implications of repeated personal and material losses such as trauma, stress, depression and a loss of social connectivity (Pharoah & Weiss, 2005:2). Girls are more likely to be adversely affected than boys, because traditional roles of care-giving and subordination are played out in the families and communities. Girls are not only at risk of HIV/AIDS infection through exploitative situations, but also have the burden of responsibility of caring for affected families. This can affect their opportunities of access to formal education which can lead them to be less able to respond to prevention strategies (Dunn, 2005:15).

The grandparents are the primary caregivers, mostly maternal ones seeing that they are concerned about the well-being of their grandchildren. Most of the time grandparents are unable to cope and also provide for the basic needs of these children with their pension funds. It is an extra financial burden. At the same time they lose the financial support they might have been receiving from their dead children. Sibling separation is another impact experienced by these children. Children are split among relatives as it is economically difficult to care for all the children. When family resources are stretched to accommodate new additions, these children sometimes have to do domestic work or become prostitutes to supplement the income of the relatives. These children may also be subjected to impersonal and abusive child care and treatment (Education Training Unit, 2005:79).

The social stigma attached to HIV/AIDS prevents people from being open and increases the isolation of people in families affected by the disease. Not only do they have to deal with their own grief and emotional suffering; it is also aggravated if the community treats them badly. In the rural community there is still denial of HIV/AIDS existence. This is evident as people will not indicate that deaths were caused by HIV/AIDS (Miller & Murray, 1999:291).

After a parental death, children's needs for love, support and care are enormous. Meeting their basic physical and emotional needs is a necessary precondition to permit mourning. If these needs are not met, mourning may be inhibited because anxiety leads them to deny the loss. The children worry about who will care for them and adequately meet their basic needs for food, physical care and safety. Bereaved children need an environment in which they feel free to communicate their thoughts and fantasies about a parent's death. Children's adjustment to parental death has been found to be less difficult when families tolerated open expression of anger, guilt, sadness, loss, including shared information and feelings about the loss. The children need grief counselling and to be assured that they will be provided for by the family (Education Training Unit, 2005 :81).

Gilbert (2001:14) maintains that a strategy which is being implemented is advocacy, which includes educating teachers and school administrators about the needs of HIV-affected children. It is important to ensure that the children are accurately assessed when behavioural conduct problems underlying AIDS-related grief or anxiety are presented. The advocacy

includes implementing and supporting school programmes to reduce AIDS-related stigma. The fight against HIV/AIDS takes place on two fronts of prevention; care and support. To stop the spread of HIV/AIDS, it is important to educate communities on how to prevent infection. The Department of Social Development provides food parcels to orphans and vulnerable children and infected people through home-based care programmes (Department of Social Development, 2001:10). Caregivers are people who volunteer to look after ill people and are provided with first aid kids by the Department of Health and funded by Department of Social Development. Volunteers are responsible for assisting children in obtaining birth certificates and identity documents and applying for the necessary grants.

In 2003, the South African government approved a comprehensive National Plan on HIV/AIDS care, management and treatment. Among other things, this aims at providing access to antiretroviral treatment to more than 1,4 million South Africans by the year 2008 (Education Training Unit, 2005:74). The government also provides a number of different grants to people infected and affected, such as child support grant for children up to the age of 14 years, foster care grants for orphans and vulnerable children, disability grant for the infected and disabled, care dependency for those looking after ill family members, as they are unable to be left alone without constant care (Education Training Unit, 2005:75). These grants serve as income for those vulnerable groups to survive.

However, these strategies have not been successful in addressing the impact of the HIV/AIDS of parents on their children. Experience shows that communities have particular or occasionally strong views on HIV/AIDS-related problems. Families suffering from HIV/AIDS will thus be affected by the attitudes of the community. It is therefore appropriate that any intervention programme for HIV/AIDS must consider the views of the community. Natural support for families suffering from HIV/AIDS-related problems should come from the community's views, and in this case those from a deep rural community.

With regard to this study, the researcher will attempt to find answers to the following questions:

- What are the living conditions of a deep rural community?
- What are the views of the rural community on the impact of the parents' HIV/AIDS status on children?

- What is the view of the community on the services to address the HIV/AIDS issue in the area?
- What intervention strategies could be implemented to address the problem?

3. AIM AND OBJECTIVES

3.1. AIM

The aim of this research is to engage in an exploratory and descriptive investigation on the views of a rural community concerning the impact of HIV/AIDS on the children of infected parents in order to provide guidelines to address the problem.

3.2. OBJECTIVES

The research has the following objectives:

- To determine the living conditions of a deep rural community
- To examine the views of the community on the impact of the parents HIV/AIDS status on the children.
- To determine the views of the community regarding services to address HIV/AIDS issues.
- To provide guidelines based on the views of the community to address the problem.

4. THEORETICAL ASSUMPTION

The HIV/AIDS condition of parents has a negative effect on the children and needs to be investigated with a view to develop guidelines for intervention.

5. RESEARCH METHODOLOGY

Newman (1997:38) points out that methodology refers to the techniques a particular discipline uses to manipulate data and acquire knowledge. The method of research will consist of a literature study and empirical survey.

5.1 LITERATURE REVIEW

A literature study is aimed at contributing towards a clear understanding of the nature and meaning of the identified problem (Fouché & Delport, 2005:123). A researcher can plan in a scientifically valid and meaningful way after having performed a thorough relevant literature study on the topic.

The researcher reviewed literature relating to HIV/AIDS. It is well documented in the literature that the HIV/AIDS pandemic is a serious threat to the South African people at all levels. The researcher wished to find out more about the consequences of the pandemic on the lives of children whose parents have HIV/AIDS. She especially wanted to examine the problem in a rural area. Literature relating to existing strategies to deal with the problem was also examined.

The data bases which were utilized for a systematic library search were the following: EBSCOHost, Internet and Ferdikat. A selection of overseas and South African journals, social science journals, books, articles and government publications was also consulted.

5.2 EMPIRICAL RESEARCH

5.2.1 Research design

The research design is a blueprint of a research or the initial planning of a research. It is the arrangement of conditions for collection and analysis of data (Anderson, 2002:10). The study design was exploratory and descriptive so that the researcher could gain insight into the views of a rural community concerning the impact of HIV/AIDS on the children of infected parents. (Bless and Highson- Smith, 1995:42).

Although much has been written on HIV/AIDS, there is still a need to gain further insight regarding the impact of the pandemic on children whose parents have HIV/AIDS. The researcher also explored intervention strategies that could be implemented to address the problem. This was a quantitative study (Schurink, 1998:241).

5.2.2 Research participants

The population consisted of the 700 households in the village Heuningvlei in a deep rural area in the North West Province. A random sample was taken from the study population. A random sample is that method of drawing a portion of a population so that each member of the population stands an equal chance of being selected (Kerlinger, 1986:110). To make sure that an error of not larger than 5% occurred for the population, the sample should have been 285 houses. The sample was taken from the population by starting at a random point (house). From there on, every third house was included. The head of the household or the next in charge had to answer the questions in the schedule. If there was no one home at a

specific house, the researcher went to the house to the left of the one chosen. The sample was taken from the entire community because it was not possible to identify which household was affected due to the nature of the topic. The researcher wanted to gain the opinion of the whole community.

Unfortunately, due to extreme weather conditions and a language barrier, only 230 schedules were completed. However, because of the precision with which the randomness was built in, the statistician, Mrs Wilma Breytenbach of the Statistical Consultation Servicess did not consider it a major problem. This means that the sample is a fairly good representation of the entire study population.

5.2.3 Measuring instrument

For purposes of this study, a survey was conducted. Data was collected by means of a personal schedule. A schedule is a set of questions on a form which is completed by the interviewer in respect of a research project (New Dictionary of Social Work, 1995:55). The schedule contained mostly closed questions. It was compiled after examining similar schedules (Raath, 2001:Addendum A; Strydom, 2002:395-399;Makhubele, 2004:184-192;; Van Rensburg, 2006:Addendum A). One comprehensive measuring instrument was used for the whole project, but for purposes of this research only relevant information was extracted from the data. The Statistical Consultation Services of the Potchefstroom Campus, North-West University helped with the validity and reliability of the research project.

5.2.4 Procedures

The researcher is a member of the Tshwaragano project. During December 2005, the project leader visited the identified rural area where the empirical research was done. Permission to conduct the research was obtained from the tribal Chief, Mr Bareki. The schedule was compiled by the team of researchers in English, and was pilot-tested. A consent form 9 addendum B) was designed by the team of researchers and each participant signed one. Interpreters were utilized whenever a language barrier occurred. The schedules were personally completed by the team of researchers, comprising two lecturers, two doctoral students and four masters students. The students were trained to complete the questionnaires.

5.2.5 Ethical aspects

The proposal for the Tshwaragano project was submitted to the Ethics Committee of the North-West University, Potchefstroom Campus. Written permission was granted and the registration number of the project is as follows: Tshwaragano Project number 06k07.

- The principle of confidentiality was observed. All confidential information was dealt with as such. No identification particulars were required. Babbie (1995:450) states in this regard that the clearest concern in the protection of the interest and well-being of the participants is the protection of their identity.

- Strydom (1998:25) advocates that the researcher has to protect subjects against any form of physical discomfort which may emerge from the research project within reasonable limits. In the study, the researchers informed the respondents about the length of the interview in advance and made sure they were comfortable.

- In this study the issue of informed consent was regarded as important. During a meeting, participants were informed about the goals of the research and procedures that would be followed. It was important for them to realize that the research would lead to the empowerment of all and that the findings would assist the entire community. Each participant completed a consent form.

- In this study the researchers respected each respondent's right to privacy by ensuring that the questionnaire was completed in private and information kept as such.

- The respondents were debriefed after the research to take them where they were before the research.

- Once a schedule was completed, that specific household received a 2 kg packet of Soya meal as a token of appreciation.

5.2.6 Data analysis

The programme, The SAS System for Windows Release 9.2 TS Level 1MO, was used to process and analyse the quantitative data (SAS Institute, 2005). The assistance of the Statistical Consultation Services of the North-West University was harnessed to process and

analyse the data by making use of the programme. The few open questions were analysed by hand.

6. RESULTS

The empirical data were organized in accordance with the schedule and the data will be discussed as follows:

6.1. IDENTIFYING PATRICULARS OF RESPONDENTS

6.1.1. Age of respondents

TABLE 1: AGE

AGE	NUMBER	PERCENTAGE
21 – 30	44	19.21
31 – 40	50	21.83
41 – 50	63	27.51
51 – 60	43	18.78
Above 60	29	12.66
TOTAL	229	100.00

Frequency missing = 1

The table above reflects that most of the respondents are people aged between 31 and 50.

6.1.2. Gender of respondents

TABLE 2: GENDER

GENDER	NUMBER	PERCENTAGE
Male	49	21.40
Female	180	78.60
TOTAL	229	100.00

Frequency missing = 1

The female respondents were significantly more than the males. This could be as a result of more women staying at home, and men searching for work or working. It can also be due to the increase in female headed households.

6.1.3. Marital status of respondents

TABLE 3: MARITAL STATUS

MARITAL STATUS	NUMBER	PERCENTAGE
Married	54	23.68
Single	111	48.68
Divorced	8	3.51
Widowed	30	13.16
Separated	5	2.19
Live together	20	8.77
TOTAL	228	100.00

Frequency missing = 2

According to the table, the majority of respondents are single, with only 23.68% indicating that they are married.

The way a family and its functions is understood in the 21st century has changed, since the world around families has changed. Saleebey (2001:264) notes that '... the nuclear, modern family clearly has lost the statistical and moral dominance it once had. But if it is in decline, there has arisen no other singular structure to support it." Today the current debate is whether there should be a dominant family structure or whether people should come together and form relationships to perform the economic, socialization, sexual and civil functions families often fulfil. Single mothers, gay and lesbian couples, extended families, remarried or blended families are all family structures seeking to extend the blessings of social legitimacy in their efforts. Although the structure of families changes, the family is still that intimate place where fragile, tiny human beings have the best opportunity of sprouting into hardy blooms, where adults can find surcease, appreciation and comfort, and where they can exercise and have their sexuality affirmed, and where elders can gather together the remnants of their lives and put them together into a comprehensive advice and comforting activity. The family is the base from which the members can venture out into and make a contribution to a wider world of people and the community they belong to (Saleebey, 2001:264). Much has been said and many debates will take place in future regarding definitions of a family. When one looks at the term 'family" in a broad sense, Thomlison (2002:4) writes the following: 'Families are made up of people who have a common history, experience a degree of emotional bonding, and engage in shared goals and activities." Today, family members may or may not be biologically related, and bonds that

unite them may or may not be legal ties. Hartman and Laird (1983:30) explains that '... a family consists of two or more people who have made a commitment to share living space, have developed close emotional ties, and share a variety of family roles and functions." It is for these reasons clear that the family today is not always biologically related and in most cases there are no legal ties. Therefore they are not committed

6.1.4. Highest level of education of head of household

TABLE 4: HIGHEST EDUCATION LEVEL

GRADE	NUMBER	PERCENTAGE
None	59	26.22
1-7	98	43.56
8-10	36	16.00
11-12	32	14.22
TOTAL	225	100.00

Frequency missing = 5

The majority of the respondents indicated that they either had no formal education or only primary education. It is estimated that 7,5 million people over the age of 15 were illiterate or severely undereducated in South Africa in 1994 (Booysens, 1997:114). The Green Paper on Population Policy (1995) reports that an estimated 50% of the rural population were then illiterate, compared to 38% in urban areas (South African Communication Services, 1996:317). Bernstein and Gray (1997:114) confirm that illiteracy is much higher in rural areas of South Africa and it plays an important role in poverty and low level of entrepreneurship. In responding to a question on the causes of poverty, 75% of the respondents said that a low level of education was one of the causes of poverty. It is evident that the level of education plays an important role in obtaining employment. In a community such as Heuningvlei it is important for people to acquire the necessary training and skills to generate their own income.

6.1.5. Language of respondents

All respondents were Setswana-speaking.

6.2. LIVING CONDITIONS

In this section, the living conditions of the community were examined to demonstrate how HIV/AIDS impact negatively on the lives of the community and their living conditions deteriorate due to the pandemic.

6.2.1. Housing

TABLE 5: TYPE OF HOUSE

TYPE	NUMBER	PERCENTAGE
Traditional hut	124	54.30
Mokuku	5	2.26
Brick house	95	42.99
Other	1	0.45
TOTAL	221	100.00

Frequent missing = 9

From the table it is obvious that most respondents live in traditional huts which are built of mud and bricks. These houses are not strong and are easily destroyed by strong winds or heavy rains. However, they give a neat appearance, unlike shacks in urban areas.

6.2.2. Water

TABLE 6: MAIN SOURCE OF WATER

SOURCE	NUMBER	PERCENTAGE
Piped water in yard	4	1.75
Public tap (share water)	220	96.07
Water carrier / tanker	3	1.31
Borehole / well	1	0.44
Dam / river / stream / spring	1	0.44
Rain water tank	-	-
TOTAL	229	100.00

Frequent missing = 1

The table shows that respondents have access to clean water from public taps, even though some have to travel far to fetch it. The basic need of this community is met by the government's promise that there will be access to clean water. The only problem is that

there are no water taps inside their yards they share water taps. Approximately 3.5 million people in South Africa have no access to clean running water (Tempelhoff, 2006:5).

6.2.3. Toilet facility

TABLE 7: TYPE OF TOILET FACILITY

TOILET FACILITY	NUMBER	PERCENTAGE
Flush toilet (own)	0	0
Flush toilet (share)	2	0.90
Bucket latrine	0	0
Pit latrine	216	97.74
No facility / bush	2	0.90
Other	1	0.45

The table indicates that the majority of respondents have pit latrines which they dig themselves. 15 Million people in South Africa have no access to sanitation (Tempelhoff, 2006:5).

6.2.4. Number of people living in the house

TABLE 8: NUMBER OF INHABITANTS

NUMBER OF INHABITANTS	NUMBER	PERCENTAGE
1	9	3.95
2	13	5.70
3	21	9.21
4	24	10.53
5	39	17.11
6	19	8.33
7	18	7.89
8	28	12.28
9	18	7.89
10 – 20	27	17.11

It can be concluded from the table that the average number of people in the household was five (5). There were some households that accommodated up to twenty (20) people. The difference in age between children are in months and the respondents indicated that they are grandchildren. It is evident that most houses are overcrowded in as a result of taking in

other family members. This is supported by Lyons (1998:4) who points out that when children lose both parents to HIV/AIDS, other caring adults frequently assume responsibility and take them into their own families and households.

6.2.5. Number of rooms

TABLE 9: NUMBER OF ROOMS

NUMBER OF ROOMS	NUMBER	PERCENTAGE
1	45	19.74
2	51	22.37
3	41	17.98
4	28	12.28
5	16	7.02
6	16	7.02
7	20	8.77
8 – 12	11	5.71

The table displays that the majority of households has two (2) rooms, with an average of five inhabitants. This indicates overcrowding, which could mean a lack of privacy and not having enough living space. Most of these children are grand children whose mothers have passed away and the grandparents took over the caring.

6.2.6. People go hungry

TABLE 10: PEOPLE WHO GO TO BED HUNGRY

TIME FRAME	NUMBER	PERCENTAGE
Never	9	3.93
Seldom	15	6.55
Occasionally	65	28.38
Often	140	61.14
TOTAL	229	100.00

Frequency missing = 1

The table indicates that 61.14% of the people in the community often go hungry. This could be a result of lack of employment, or not having food gardens. Respondents indicated that their daily diet consists of porridge, bread, tea, rice, cabbage and coffee. Very few

respondents indicated that they include meat, poultry, vegetables or fruit in their diet. It is thus clear from their comments that malnutrition is a problem in the community.

6.2.7. Appliances

TABLE 11: APPLIANCES

APPLIANCES	NUMBER	PERCENTAGE
Radio	88	38.26
Television	62	26.96
Telephone (land line)	4	1.74
Cell phone	109	47.39
Refrigerator	89	38.70
Washing machine	5	2.17
Personal computer	2	0.87

From the table it is evident that even people in the rural areas have been reached and provided with electricity. This figure compares favourably to the rest of situation in South Africa, since Statistics South Africa found that seven out of ten households have electricity (Van Eeden, 2003:15). Only a small number of households have appliances and this is an indication of poverty.

6.2.8. Grant

TABLE 12: TYPE OF GRANT

GRANT	NUMBER	PERCENTAGE
Child support	144	70.94
Disability grant	24	11.82
Foster care grant	3	1.48
Old age grant	51	25.12

The table shows that the majority of households are dependent on grants. As a result of HIV/AIDS, an increasing number of infected young adults are unable to contribute to their communities through their work as parents, teachers, labourers, drivers and farmers (Lyons, 1998:3). The entire economic and social structures of communities suffer and demands for services increase with fewer able people to provide them. Statistics South Africa indicates

that approximately 10 million people in South Africa receive social grants (De Lange, 2006:2). The amounts of social grants are as follows:

Old age	R890 00
Disability grant	R890.00
Foster care grant	R590.00
Child support grant	R200.00

The grant should serve as temporary measure, people be empowered through training and skill development.

It should be noted that the amounts of these grants increase annually. Research commissioned by the Nelson Mandela Children's Fund found that South African AIDS orphans are being ostracized by their communities and exploited financially by relatives who have taken them in primarily to receive a state grant (Chirambo & Ceasar, 2002:105). Foster parents should be screened and trained not be chosen because they are related to the children in order to reduce this exploitation.

6.3. IMPACT ON CHILDREN WHOSE PARENTS HAVE HIV/AIDS

In this section the views of the community on the impact of the parents' HIV/AIDS status on the children were examined.

6.3.1. Effects on children when their parents have HIV/AIDS

TABLE 13: EFFECTS ON CHILDREN

EFFECT	YES	PERCENTAGE
Trauma	143	64.71
Depression	144	65.16
Caring for younger siblings	171	77.38
Additional domestic chores	156	70.59
Generating income	130	58.82
Receiving less care from parents	162	73.30
Nursing ill parents	162	73.30

The respondents felt that the strongest effect on the children could be seen in the caring for younger siblings. The illness or death of a parent or other family member has differing

effects on children, depending in part on a child's age and stage of development. Responses that take these differences into account will be more effective, that is it should not be taken for granted that the effects will affect the children in the same way (USAID, 2004:13). As parents and other family members become ill, children take on more responsibilities for income generation, food production and care of family members (Kallmann, 2003:34). The response is also supported by Pharoah and Weiss (2002:2) who indicate that many children feel the effects of parents' illness long before their death when they shoulder new responsibilities of caring for younger siblings, taking on additional chores and also generating income for the family. Children who are deprived of the guidance and protection of their primary caregiver are more vulnerable to health risks, violence, exploitation and discrimination (USAID, 2004:4).

Geballe, et al (1995:84) stress that many adolescents living in families with HIV/AIDS are called upon to assume care-taking responsibilities for younger siblings and ill parents. Some may miss days of school while others drop out, thereby increasing their isolation from social support. Placement of these adolescents after the parents' death can be extremely difficult, especially if they have been functional heads of households where they wish to establish a new household as guardian for their siblings.

This is further supported by Kallmann (2003:34) who mentions that the social and economic impact of HIV/AIDS threatens the well-being and security of millions of children world-wide. They face decreased access to adequate nutrition, basic health care, housing and clothing. Fewer families can afford to send their children to school, with young girls at particular risk of being denied education. In both urban and rural areas, many orphans are struggling to survive on their own in child headed households. Many more are forced to live on the streets and girls as they tend to take over the caregiving when the parent become sick or after death of the parent will drop out of school to generate income for the family through becoming prostitutes.

6.3.2. Feelings of these children when they realize their parents have HIV/AIDS

TABLE 14: FEELINGS

FEELINGS	YES	PERCENTAGE
Sad	194	87.39
Shocked	155	70.14

Ashamed	145	65.32
Afraid	122	54.95
Rejection	96	43.24
Anger	95	42.79
Despondent	79	35.59

It is clear from the table that respondents thought that the children mostly felt sad, shocked and ashamed. The feelings experienced by children when parents are ill are that they are tormented with the uncertainty about the recovery of their parents, and if he or she does not survive; they worry about who will take care of them. These children experience feelings of sadness and loneliness and they feel isolated (USAID, 2004:21). The illness or death of a mother or guardian during a child's first year has life threatening consequences. During the first one or two years of life, young children need to feel emotionally close to at least one consistent and loving caregiver for their healthy development, and in fact for their survival. In addition to the fulfilment of basic physical needs, the child needs touching, holding, emotional support and love from this consistent caregiver. When a child loses such a caregiver, he or she is at risk of losing the ability to make close emotional bonds, and they are sensitive to feelings of loss and stress in others and need reassurance (USAID, 2004:14).

The adolescents understand the nature of loss but might not directly express their worries and anxieties. They may feel resentment and anger at the death of a parent or close family member. They may seem to be coping, but at the same time they can experience depression, hopelessness and increased vulnerability (USAID, 2004:17).

6.3.3. Needs of these children

TABLE 15: NEEDS

NEED	YES	PERCENTAGE
Financial care	212	95.07
Physical care	161	72.20
Support from family	202	90.58
Support from friends	143	64.13
Support from community	171	76.68
Support from church	153	68.61
Support from school	168	75.34

It is evident from the table that the majority of respondents viewed financial care and the support from the family, community and school as the most important needs. They are of opinion that with financial assistance the children will be able to obtain basic needs.

Children will be able to obtain basic needs. The community believes that these children do indeed have financial problems such as a lack of food, clothing, proper housing, basic furniture and transport.

Support from the family, community and school will help them to cope and survive. Children between 3 and 6 years need assurance and support from caregivers as they may fear that they have caused a loved one's death. Caregivers need to help children feel safe and loved. Children should be encouraged to talk about loss and about the person who has died. There is a pressing need to ensure that family-based care is available for these children (USAID, 2004:15).

Children in primary school need a sense of security and belonging in a family or family-like environment. In addition to this family identity, a growing child needs to develop a positive self-identity and self-esteem. The adolescents need help with life skills training (USAID, 2004:17). Financial care can be in the form of social grants. Barrette-Grant, Fine, Heywood and Strode (2001:274) point out that the South African Government accepts that it has a responsibility to care for people who cannot take care of themselves. When people are too young, ill, old or injured to take care of themselves, the government should provide social support where possible. This kind of support is called social assistance.

6.3.4. Problems of these children

TABLE 16: PROBLEMS

PROBLEMS	NUMBER	PERCENTAGE
Behaviour problems	155	69.82
Alcohol / drug abuse	143	64.41
Discipline problems	171	77.30
Learning problems	179	80.63
Emotional problems	184	82.88
Developmental problems	127	57.21

Health problems	157	70.72

From the table above it is clear that the respondents thought that emotional, learning and discipline problems were the greatest problems the children experienced. Kallmann (2003:34) maintains that children impacted by HIV/AIDS are also at serious risk of exploitation, physical and sexual abuse and emotional isolation from family. Some turn to risky sexual and anti-social behaviour. Those forced to live on the streets may turn to prostitution and crime as a means to survive. While most of these children were born free of HIV, they are highly vulnerable to infection. Studies on AIDS orphans show that they have a low self-esteem and tend to display more aggression, anxiety and depression than other children (Kallmann, 2003:34).

USAID (2004:17) is of opinion that if the children's needs are not met it could lead to a sense of alienation, desperation, risk-taking behaviour and withdrawal. Feelings of depression and hopelessness could be common reactions to these circumstances and this needs special attention and strong protection measures.

6.3.5. Discrimination against these children

Of the respondents, 89 (45.41%) answered that they thought these children were discriminated against while 107 (54.59%) answered no. The highest number of respondents did not think that these children are discriminated against. This is contrary to the literature. Bor and Elford (1998:211) found in their study that orphans were discriminated against in their community. The children were known by the other community members as children whose parents had died of HIV/AIDS and were consequently isolated. USAID (2004:17) argues that discrimination prevents parents from appointing guardians while they are still alive and preparing their children for a future without them. The results do not correlate with the literature because in the area of this research the people feel sorry for the children.

6.3.6. People who discriminate against these children

TABLE 17: PEOPLE WHO DISCRIMINATE

GROUP OF PEOPLE	NUMBER	PERCENTAGE
Family	38	22.49
Friends	49	28.99
The church	23	13.61

The school	37	21.89
The community	84	49.70
The hospital	11	6.51

Table 17 indicates that the highest number of respondents felt that family, friends, the church, the school and the hospital did not discriminate against these children. A significant number 89 (45,41%) of the respondents, however, felt that these children are discriminated against by the community.

Bor and Elfort (1998:211) found that orphans have a generally unhappy existence and were reported to be neglected and to suffer from a lack of care, lack of food and health problems. Even young children would be put to work and carers were said not to provide school fees. Some community members in other research gave examples of orphans who had been exploited or beaten physically, and who had subsequently run away from their homes (Bor & Elford, 1998:211). Orphans are often stigmatized and discriminated against, both within foster households and in the larger community. Stigmatization may prompt affected children to stay away from school, rather than endure exclusion or ridicule by teachers and peers. These children are abused either sexually or physically and mistreated by caregivers or their children (USAID, 2004:24).

6.3.7. Attitudes towards people living with HIV/AIDS

TABLE 18: ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS

ATTITUDES	NUMBER	PERCENTAGE
I feel sorry for them	190	86.36
I treat them the same as others	177	80.45
I do not want to mix with them	64	29.09
They must leave our community	84	8.68

The majority of respondents (190 - 86.36%)indicated that they feel sorry for people with HIV/AIDS and will treat them the same as they do others (177 - 80.45%). This is contrary to the literature which indicates that there is no ownership when it comes to HIV/AIDS.

There is much denial and stigma concerning the disease from both the infected and affected. Families and the infected do not disclose because they fear discrimination by society and communities. Mostly people attribute their illnesses and deaths to witchcraft, jealousy, poisoning and some acceptable illnesses such as sugar diabetes, tuberculosis, pneumonia and cancer (Mahlangu. 2005:6). The results differ because of the mode of transmission of HIV/AIDS especially sexually. People do not want to disclose information about their status as they will be regarded as sleeping around. The results are also different from other studies due to the fact that they did not consider the views of the community.

6.4. STRATEGIES FOR CARING FOR THESE CHILDREN

In this section the respondents' views regarding services to address the HIV/AIDS issues were asked.

6.4.1. The best way to care for these children after the death of their parents

TABLE 19: BEST WAY OF CARING

PLACEMENT	YES	PERCENTAGE
Foster care with grandmother/-father	144	64.86
Foster care with family	142	63.96
Foster care with non-family	38	17.12
Children's home	122	54.95
Care for themselves	43	19.37

Most respondents indicated that the best care for these children would be if they were placed in foster care with grandparents or within their own family system. Bor and Elford (1998:21) accentuate the fact that the extended family continues to remain a predominant orphan-caring unit in Zimbabwe. Throughout Africa the extended family has maintained its place as the central human social unit where a grandmother was caring for orphaned children. This was more likely to be a maternal rather than paternal grandmother. A maternal grandmother may be in a better position to provide for the children than the paternal grandmother and thus more capable of providing financial support to orphaned children. The maternal grandmother may also be more knowledgeable about appropriate child care (Bor & Elford, 1998:21).

These extended family members should be able to apply for foster care grants to provide the children with the basic needs. At first they only receive child support grant, which is much less than foster care grant.. Home-based care givers assist the families with the caring for the sick parent and assist the family to access birth certificates and identity documents.

6.4.2. Means of social work support

TABLE 20: SOCIAL WORK SUPPORT

MEANS	NUMBER	PERCENTAGE
Regular visits	171	78.08
HIV/AIDS counselling	159	72.60
Help to secure social grants	201	91.78
Providing information on resources	170	77.63

The table explicates that the respondents feel that assistance in securing grants, regular visits, provision of information on resources and HIV/AIDS counselling should be provided to these children by the social worker. The community need to be educated about the importance of counselling because they did not take it as a priority. The community views counselling as the lowest priority because they feel that they can benefit more from the other services.

Barrette-Grant, et al (2001:274) site the following types of Social Assistance for children offered by the Department of Social Development in South Africa:

- Child Support Grant (CSG)

It is given to a person who takes care of the child. The caregiver does not have to be the natural mother to the child. It caters for children up to the age of 14 years, and is transferred with the child if he/she changes guardians.

- Foster Care Grant (FCG)

A foster care grant is paid to someone who takes care of the child who has been placed in his/her care under the Child Care Act 74 of 1983. The Social Worker compiles a report and the Children's Court officially appoints a foster parent. A court order is issued, which the

foster parent uses to apply for the grant. The grant has to be for the provision of basic needs for the children.

- Care Dependency Grant

This grant enables the caregiver to care for a child who is ill or needs special medical attention. The care-dependent child must be in an applicant's full-time care. This child can be either disabled or very ill and in need of full-time care so that the caregiver is unable to seek employment.

7. DISCUSSION

7.1. LIVING CONDITIONS OF THE COMMUNITY

From the results it is evident that 48.68% of respondents are single, while only 23.68% are married. The small percentage of married people could be attributed to couples having children outside wedlock or children being the head of households. This gives rise to the implication of the increase in infection rate and the rising number of orphans.

It is clear that 43.56% of the respondents have a primary education and 26.22% have no formal education. Potgieter (1998:68) explains that illiteracy is a difficult concept to define, and people use different criteria for its measurement. Whiteford, Poseland and Kelatwang (1995:8) point out that households with poorly educated heads have a far higher incidence of poverty than those with better educated household heads. The results from Heuningvlei village are confirmed by the literature in that most people are unemployed and are unable to generate income due to lack of skills and training.

Half of the respondents live in traditional huts built of mud and bricks. These huts are not strong enough to withstand weather changes such as heavy rains. As a minimum standard all housing should provide protection from weather conditions, have a durable structure and reasonable living space and privacy. A house should provide sanitary facilities, storm water drainage and access to clean water (Reconstruction and development programme, 1994:28). It is evident from the results that 96.07% of the respondents access water at communal taps, and this means travelling long distances to fetch water.

The average number of people in the household was five, while some accommodated up to twenty inhabitants. The majority of households had two-roomed houses. It is obvious that there is overcrowding in most households. This leads to lack of privacy and lack of sufficient living space. Fox (2001:23) holds that people need enough living space, and there should be separate rooms for adults and children to allow for privacy.

From the research findings it is clear that most people (61.14%) often go hungry. According to King and Heaton (2002:16), children in AIDS affected households are often inadequately nourished. As an affected family's financial situation worsens, their ability to fulfil nutritional needs will be impaired on an ongoing basis with the impact being most acutely felt by its most vulnerable members, the children.

7.2. VIEWS OF THE COMMUNITY ON THE IMPACT OF PARENTS' HIV/AIDS STATUS ON CHILDREN

From the research findings it is clear that the community is of the opinion that children are negatively affected when their parents have HIV/AIDS. The findings are supported by Lyons (1998:2). He argues that the effects of HIV/AIDS on children who are orphaned, or who live in families where parents are living with the virus, can be seen not only in calculated losses, but also in altered roles and relationships within families.

In the absence of capable adult caretakers, children themselves take on responsibilities for survival of the family and home. Children assume adult roles as heads of households because there are no alternatives. They take charge of the care and running of the home for themselves and their siblings. In numerous HIV/AIDS-affected households, children have not simply increased the amount of work they do but have assumed decision-making and responsibilities that transform roles within families and households. The care older siblings can provide for younger children is likely to be inadequate because of poverty and lack of maturity and experience (Lyons, 1998:5). Mahlangu (2005:5) writes that many communities in South Africa experience an increase in the number of households headed by children, women and grandparents and that these households are often not able to provide adequately for the children. In this study it was evident that many of the households were headed by women.

From the results it is evident that the community thinks that these children feel sad, shocked, ashamed and afraid. Fear and frustration lead children to run away in search of a better life, often only to join the growing number of homeless and exploited children (Lyons. 1998:12). Fox (2001:20) brings to the attention the fact that children with ill parents worry about the future, where they will go and who will take care of them. Children might not understand the situation and therefore cannot express their feelings and they can be assisted through therapy. Even if they do want to express their feelings, there is often no one to listen. Children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer emotional neglect long before they are orphaned. Eventually they suffer the death of their parent(s) and this could result in emotional trauma. The children experience psychological distress, anxiety, depression and anger. These psychological problems can become more severe if a child is forced to separate from the siblings upon becoming orphaned (Fredrikson & Kanabus, 2006:chapter 4). The children need to deal with their loss and be prepared through therapy for a possible separation from siblings if there is no other alternative.

The community feels that financial care, physical care, support from family, support from friends, support from the community, support from church and support from the school are very important for these children. This is supported by literature, namely that the loss of a parent to AIDS can have serious consequences for a child's access to basic needs such as shelter, food, clothing, health, emotional needs and education. Orphans are more likely than non-orphans to live in large, female-headed households where more people are dependent on fewer-income earners. This lack of income exerts extra pressure on AIDS orphans to contribute to the households financially, in some cases driving them to the street to work, beg or seek food (Fredrikson & Kanabus, 2006:40-50).

The majority of children who have lost a parent continue to live in the care of a surviving parent or family member, but often have to take on the responsibility of doing housework, looking after siblings and caring for ill or dying parents (Fredrikson & Kanabus, 2006:40-50). Children orphaned by AIDS may miss out on school due to expenses such as school fees and school uniform. Outside school these children may also miss out on valuable life skills and practical knowledge that would have been passed on to them by their parents. Traditional systems of taking care of children who lose their parents, for whatever reason, have been in place throughout Sub-Saharan Africa for generations. But HIV/AIDS is

eroding such practices by creating larger numbers of orphans. The demand for care and support is simply overwhelming in many areas. The pandemic reduces the caring capacity of families and communities by deepening poverty through medical and funeral costs as well as loss of labour. That is the reason there are a number of child-headed households which also are struggling to make ends meet.

From the findings it is clear that the community views emotional, learning and discipline problems as being major for these children. Lyons (1998:6) points out that millions of children suffer neglect and physical and sexual abuse. Boys and girls trade abusive situations for the streets where life and survival are even more difficult. The risk of HIV-infection rapidly increases.

These children become vulnerable in many ways after parents die of AIDS. Normally their extended families reject them, and they end up fending for themselves to survive. The majority drop out from schools, some go to the cities and become street kids. They become desperate since there is no one to take care of them and provide them with the parental guidance children need for survival (Mahlangu, 2005:7).

Almost half of the community felt that the children are discriminated against while the other half did not agree. The contradictory statements made by the community could be due to denial that HIV/AIDS exists in their community. Mahlangu (2005:8) maintains there is much denial and stigma from the infected and the affected. Families of the infected and the infected themselves do not disclose because they fear stigma and discrimination by society and communities. Children may be stigmatized either because their parents are living with HIV/AIDS or because they themselves are infected. Such stigmatization can come from all sections of the community, such as other children, school and teachers which can impact on access to education, for example the case of Nkosi Johnson who was discriminated against and denied education (King & Heaton, 2002:15). Often children who have lost their parents to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face discrimination and damaging their future prospects (Fredriksson & Kanabus, 2006: 40-50).

7.3. VIEWS OF THE COMMUNITY ON SERVICES TO ADDRESS THE HIV/AIDS ISSUE

The community views foster care with grandparents (64,86%), foster care with family (63,96%) and children's home (54.95%) as the best way of caring for these children.

Mahlangu (2005:5) says extended families have assumed responsibility for most of the orphaned children, but they also break down because they struggle to carry the burden of caring for the children. Most people and government now believe that orphans should be cared for in family units through extended family networks, foster families and adoption, and that siblings should not be separated. Studies in Sub-Saharan Africa have repeatedly demonstrated that growing up in a family environment is more beneficial to a child than institutional care, which should be considered a temporary option or last resort. The extended family can only serve as part of the solution to mass orphanhood through the support of the state, other sectors and the community. The community should be encouraged to foster and adopt orphans where the extended family does not exist (Fredriksson & Kanabus, 2006: 40-50).

The community views support of social workers as being important, and regular visiting, , helping to secure social grants and providing information on resources are considered invaluable. The community sees the services as coping mechanisms that will assist the families in dealing with the impact these children and their caregivers are facing. This is supported by Mahlangu, (2005:7) in that the government, as part of the social security plan, has made grants available to support poor people of the country.

INTERVENTION GUIDELINES

Programmes and work plans to address the HIV/AIDS pandemic have been established in various government departments and civil society organisations. However, these strategies have not been successful in addressing the impact of the HIV/AIDS of parents on their children. Experience shows that communities have particular or occasionally strong views on HIV/AIDS-related problems. Families suffering from HIV/AIDS will thus be affected by the attitudes of the community. It thus follows that any intervention programme for HIV/AIDS must consider the views of the community. The following intervention guidelines are proposed:

- Building family and community capacities is not enough, but it must be the foundation for addressing the impacts of HIV/AIDS on children. The coping capacity of families and communities need to be reinforced in order to prevent children from slipping through the basic social safety nets.

- Peer education programmes should be presented to children and adolescents, during which children work with facilitators in learning about the disease, projects are designed, educational material is created and the confidence and self-esteem of children are improved.
- HIV-prevention programmes should be presented in the community.
- There should be community support groups for children and family members who will provide emotional support, share information on available resources and function as a platform for discussions on prevention, care and treatment. Home-based care services can also be marketed at these meetings for people to volunteer their services and for those who need the service to be referred. This will also reduce fear and discrimination which result from people not accessing relevant resources.

- Proper future planning such as preparing a will, should be encouraged and needs to be part of HIV/AIDS-counselling in order to prevent property grabbing and non-involvement of children in decision making. These children need to be prepared for the parental death and know who will be their guardian. This will also ease the grieving process, and children will be informed by the parent regarding the nature of his or her illness so as to prevent the children from being infected in future. The emotional needs of these children should not be forgotten. Having seen their parent become ill and eventually die is a major trauma for any child, and it may affect them for the rest of their lives. These children should be provided with counselling.

- The extended family can serve as part of the solution to this problem of the large number of orphans. By fostering, these children are kept in the family.

- The school plays a vital role in improving the prospects of children orphaned by HIV/AIDS and in securing their future. A good education can boost their self-esteem, provide better job opportunities and economic independence. These children can be lifted out of poverty to break the cycle and give them a better understanding of HIV/AIDS, decreasing the risk of themselves becoming infected. Schools can provide support and care to orphans by visiting then at home, by providing children with food, by providing flexible school programmes (attending afternoon classes) for those who are household heads, and by assisting with day-care services to siblings

while the heads are at school. They should be exempted from paying school fees and provided with uniforms so that they can at all times feel part of the system.

- If they are treated as active members of the community, the lives of AIDS orphans can be given purpose and dignity. Many children function as heads of households and caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of AIDS in their families and communities. They prevent siblings from being moved from one family to another or of being exploited and abused. Those who are 21 and older can apply to foster their siblings and receive financial support through grants. In the meantime a grant should be provided which does not require long and complicated procedures in order to be provided with basic needs. Their child-care skills should be improved, especially in the area of early childhood development and adolescence.

- The community needs to be supportive of orphaned children by making sure that they are accepted, not discriminated against, and have access to essential services such as health care and education.

- Awareness should be continuous in order to prevent further infections. Community members should be encouraged to go for voluntary counselling and testing so that those who test positive can be reached in time and live a healthy life, and those who test negative make sure that they remain negative through abstinence or condom usage.

- Antiretroviral treatment should be scaled up and continual awareness raised to reach all communities, including those in the deep rural areas, so that adults can be kept alive for a long time so as to delay orphanhood

8. CONCLUSION

In this study the first objective was to study the living conditions of a deep rural village. It was clear that the inhabitants were very poor, taking into account their low level of education, small income, overcrowded houses and unhealthy life-style.

The second objective was to investigate the views of the community on the impact of the parents' HIV/AIDS status on the children. From the research findings it was obvious that the community thought that the children were negatively affected. The community felt that the children needed financial care, physical care as well as support from the family, friends, community, church and school in order to cope with their parents' infection. The community was also of opinion that the children experienced major emotional, learning and discipline problems, and that they also experienced discrimination.

The third objective was to examine the views of the community on services to address the HIV/AIDS issue. They thought that orphans should rather be placed with grandparents or other family members. They were also of opinion that social workers could play an important role, in seeing to it that orphans were well looked after.

The fourth objective was to provide guidelines, and this was compiled from the literature and research findings.

The aim of the research study was reached by reaching the four objectives.

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ADDENDUMS

ADDENDUM A: QUESTIONNAIRE

Reference number

DEMOGRAPHIC DETAILS: TSHWARAGANO PROJECT.

1. Age in years

21 – 30	
31 – 40	
41 – 50	
51 – 60	
Above 60	

2. Gender

Male	
Female	

3. Marital Status

Married	
Never married	
Divorce	
Widowed	
Separated	
Live together	

4. Highest level of education

None	
Primary, Gr 1 -7	
Secondary, Gr 8,9,10	
Secondary, Gr 11,12	

LANGUAGE

5. Home language

Setswana	
English	
Afrikaans	
Other	

HOUSING

6. What type of house do you live in?

Traditional hut	
Mokuku	
Brick house	
Other	

7. What is the main source of drinking water for members of your household? (Choose only one)

Own piped water	
Piped water in yard	
Public tap (share water)	
Water carrier/tanker	
Borehole/well	
Dam/river/stream/spring	
Rain-water tank	
Other/Remarks	

8. What kind of toilet facility does your household have?

Flush toilet (own)	
Flush toilet (share)	
Bucket latrine	
Pit latrine	
No facility/bush/field	
Other/Remarks	

9 What does your household use for cooking and heating? Record all mentioned.

		Yes		No	
9.1	Electricity		1		2
9.2	Gas		1		2
9.3	Paraffin		1		2
9.4	Wood		1		2
9.5	Coal		1		2
9.6	Animal Dung		1		2
9.7	Other/Remarks:				

10 How many people are in your household? _____people

11 How many rooms are in your household? _____rooms

12 How many rooms are used for sleeping? _____rooms

13 Would you say that people here often, sometimes, seldom or never go hungry? Mark the answer.

Never	
Seldom	
Sometimes	
Often	

14. What did you and the others in the household eat yesterday? Probe for answer. Write down what the person tells you.

Morning: _____

Afternoon: _____

Night: _____

Other: _____

15. Does your household have the one or more of the following:

		Yes		No	
15.1	Electricity		1		2
15.2	Radio		1		2
15.3	Television		1		2
15.4	Telephone (land line)		1		2
15.5	Cell-phone		1		2
15,6	Refrigerator		1		2
15.7	Washing machine		1		2
15.8	Personal computer		1		2

POVERTY

16. Does anyone in the household receive any grant from social services?

Yes	
No	

17. If you answered yes, what kind of grant? Yes/No

		Yes		No	
17.1	Child grant		1		2
17.2	Disability grant		1		2
17.3	Foster care grant		1		2
17.4	Old age pension		1		2

IMPACT ON CHILDREN WHOSE PARENTS HAVE HIV/AIDS

EFFECT ON CHILDREN

18. What is he effect on children when their parents have HIV/AIDS?

	Effect	Yes		No	
18.1	Trauma		1		2
18.2	Depression		1		2
18.3	Caring for younger siblings		1		2
18.4	Additional chores		1		2
18.5	Generating income		1		2
18.6	Receiving less care from parents		1		2
18.7	Nursing ill parents		1		2

FEELINGS OF CHILDREN

19. What do you think were the feelings/ emotions of these children when they heard their parents had HIV/AIDS.

	Feelings/emotion	Yes		No	
19.1	Afraid		1		2
19.2	Anger		1		2
19.3	Sadness		1		2
19.4	Rejection		1		2
19.5	Despondent/neutral		1		2
19.6	Ashamed		1		2

19.7	Shocked		1		2
19.8	Other emotions, specify:		1		2

NEEDS OF THESE CHILDREN

20. Which of the following needs do these children experience?

	Need	Yes		No	
20.1	Financial care		1		2
20.2	Physical care		1		2
20.3	Support form family		1		2
20.4	Support from friends		1		2
20.5	Support from community		1		2
20.6	Support form church		1		2
20.7	Support from school		1		2

21. What financial problems could these children have?

_____

_____

_____

_____

PROBLEMS OF CHILDREN

22. Do you think they experience any of the following problems?

	Problem	Yes		No	
22.1	Behavioural problems		1		2
22.2	Alcohol or drug abuse		1		2
22.3	Discipline problem		1		2
22.4	Learning problems		1		2
22.5	Emotional problem		1		2
22.6	Developmental problem		1		2
22,7	Health problem		1		2

DISCRIMINATION

23. Do you think that these children experience discrimination against them?

Yes	
No	

24. Who discriminate against them?

	Institution	Yes		No	
24.1	Family		1		2
24.2	Friends		1		2
24.3	The church		1		2
24.4	The school		1		2
24.5	The community		1		2
24.6	The hospital/clinic		1		2
24.7	Other, specify:		1		2

25 In what way do they discriminate against them?

DEATH OF PARENTS

25. If both parents die, what is the best way to care for these children?

	Placement	Yes		No	
25.1	Foster care with grandmother/-father		1		2
25.2	Foster care with family		1		2
25.3	Foster care with non-family		1		2
25.4	Children's Home		1		2
25.5	Care for themselves		1		2

STRATEGIES TO CARE FOR CHILDREN

26. What do you think could be done to help these children?

27. What means of social work support do they need?

	Means	Yes		No	
27.1	Regular visits		1		2
27.2	HIV/AIDS counselling		1		2
27.3	Helping to receive grants		1		2
27.4	Providing information on resources		1		2

The Researchers

ADDENDUM B: INFORMED CONSENT FORM

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

POTCHEFSTROOMCAMPUS

TSHWARAGANO PROJECT
INFORMED CONSENT FORM

I, the undersigned ..... (full names)
Read/listened to the information on the project and I declare that I understand the information. I had the opportunity to discuss aspects of the project with the project leader and I declare that I participate in the project as a volunteer. I hereby give my consent to be a subject in this project.

I indemnify the University, also any employee or student of the University, of any liability against myself, which may arise during the course of the project.

I will not submit any claims against the University regarding personal detrimental effects due to the project, due to negligence by the University, its employees or students, or any other subjects.

.....
(Signature of the subject)

Signed at..... .on.....,.....

Witnesses
1. .....

2. .....

Signed at..... ...on.....

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