

**The collaborative construction
of an intergenerational relationship
education model to address the needs
of grandparents caring for
grandchildren orphaned by AIDS**

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University.

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DECLARATION

I Phumuzani Mpofu declare herewith that the thesis entitled: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by aids, which I herewith submit to North-West University is in compliance with the requirements set for the degree Philosophiae Doctor in Educational Psychology. It is my own work, has been text edited in accordance with the requirements and has not already been submitted to any other university.

Signature 

Date 2021/02/01

DEDICATION

This study is dedicated to my late parents, Elijah Mguti Mpofu and Elizabeth Tshabangu, and my two children, Ntokozo Mguti Mpofu and Buhlebenkosi Darlene Mpofu.

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ABSTRACT

This study addressed the problem posed by the HIV and AIDS epidemic with regards to its impact on elderly grandparents caring for grandchildren orphaned by AIDS. As a result of having to care for their AIDS-orphaned grandchildren, elderly grandparents face challenges, such as financial constraints, health problems, social isolation, and mired intergenerational relationships. This study therefore aimed at engaging stakeholders to collaborate towards coming up with intergenerational education based strategies to address the needs of grandparents caring for AIDS-orphaned grandchildren in the Kingdom of Eswatini. To achieve the aims of the study, I employed a qualitative design situated within a transformative philosophical paradigm utilising a participatory action research approach to inquiry. The intergenerational relationship theory, activity theory and the continuity theory were the theoretical frameworks that informed this study. Ten grandparents formed the action learning set and eight stakeholders participated in focus group discussions. Data generation was done over three cycles employing several action learning set meetings, drawing activities, narratives and storytelling as well as focus group discussions. The participatory action research process was inductively analysed and thematically interpreted. Findings suggest that grandparents taking care of AIDS-orphaned grandchildren have needs that compromise their well-being. Nonetheless, if stakeholders effectively collaborate to come up with intergenerational programmes that address these needs, grandparents in the Kingdom of Eswatini could keep active and continue to play a parental role even at late life. Basing on the findings of the study, I then developed an intergenerational education model that could be employed for sustainable grandparenting in intergenerational households. The model could also be adapted to other contexts to improve support for elderly grandparents who are the primary caregivers of their grandchildren.

Key words

Activity, continuity, grandparenting, intergenerational relationships, needs, stakeholders, well-being

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GLOSSARY OF ABBREVIATIONS

ALS:	Action Learning Set
AIDS:	Acquired Immune Deficiency Syndrome
ART:	Antiretroviral Therapy
AT:	Activity Theory
CDC:	The Centre for Disease Control and Prevention
CT:	Continuity Theory
DPM:	Deputy Prime Minister's Office
FDA:	Food and Drug Administration
HIV:	Human Immunodeficiency Virus
IRT:	Intergenerational Relationship Theory
NGO:	Non-governmental Organisation
OAG:	Old Age Grants
PALAR:	Participatory Action Learning and Action Research
PAR:	Participative Action Research
PEPFAR:	President's Emergency Plan AIDS Relief
USA:	United States of America
UNICEF:	United Nations International Children's Fund
WFP:	World Food Programme
WHO:	World Health Organization

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CHAPTER ONE

STUDY OVERVIEW

1.1 BACKGROUND AND RATIONALE FOR THE STUDY

The focus of this study was to examine the problems faced by elderly grandparents who have to care for their AIDS-orphaned grandchildren, and how an intergenerational relationships education model may be used to mitigate them. The study aimed to investigate how these grandparents can be supported within the contexts of education theory to cope with an intergenerational relationship with grandchildren, despite their advanced age, that make the task burdensome (McLeod, 2018).

According to Erik Erikson's theory of psychosocial development, individuals at 65 years and above slowdown in productivity and might even prefer to explore life as retired senior citizens, rather than be involved in caring for grandchildren. However, Erik Erikson also contends that if these elderly people consider themselves to be unproductive, they might feel guilty about their past, and guilt leads to despair and depression (McLeod, 2018). This implies that the task faced by grandparents of looking after their AIDS-orphaned grandchildren might, in fact, be beneficial despite the former's advanced age. Thus, by being involved in an intergenerational relationship with their AIDS-orphaned grandchildren, elderly grandparents might find a new meaning for life and enjoy active engagement in the task.

Globally, the number of people living with HIV is estimated to be around 36.9 million, and 940,000 people die because of AIDS-related illnesses (UNAIDS, 2018). In Eastern and Southern Africa there are 19.6 million adults and children living with HIV. In the same regions, there are 800,000 new HIV infections in both children and adults. There are 380,000 AIDS-related deaths per annum (UNAIDS, 2018). In the Kingdom of Eswatini, there are 210,000 people living with HIV and 3,500 AIDS-related deaths per year (Avert, 2018).

Since the first HIV case was reported in the Kingdom of Eswatini in 1986, the disease has had a devastating impact on the Eswatini population, as it had on other sub-Saharan African countries. A study conducted by UNICEF (2018) reveals that grandparents in sub-Saharan Africa were the most affected group in the population, as they were left to look after grandchildren who had lost both parents to AIDS. In this context, Huber et al. (2015) define grandparents as those aged 60 and above who experience challenges such as poverty, little education, health problems, unstable families, mental-related illnesses and an absence of social support. Yet, despite these challenges, grandparents are expected to look after AIDS-

orphaned grandchildren who are estimated, globally, to be 17 million in number. About 90% of these children live in sub-Saharan Africa (UNAIDS, 2018). In the Kingdom of Eswatini alone, 56,000 children aged between 0 and 17 were orphaned because of AIDS, according to a 2015 report (Wanjiku, 2015). In addition, a survey undertaken by UNAIDS (2018) reported that there was an increase in the number of AIDS-orphaned grandchildren aged between 0 and 17. UNAIDS (2018) reported that there was an exponential increase in this figure between 1990 and 2009, and thereafter a slight decrease until 2016. According to UNAIDS (2018), AIDS related deaths dropped owing to access to antiretroviral medication. However, despite this decrease in the number of deaths, there is still a large number of AIDS-orphaned grandchildren who need to be looked after by their grandparents.

The prevalence of HIV and AIDS in African societies has also changed the status quo in family settings. The mortality rate has increased in the economically productive age group of those between the ages of 15 and 64, leaving the economically unproductive age group, including grandparents, to take care of grandchildren (Ministry of Sports, Culture, and Youth Affairs, 2015). Grandparents raising grandchildren encounter the challenges of limited financial support, coping with their own chronic illnesses and accessing educational resources (Baker & Silverstein, 2008; Carr et al., 2012; Yancura, 2013; Lee et al., 2015). The grandparents may also lack emotional, social and peer support (Hayslip & Goldberg-Glen, 2000; Lee et al., 2015; Segalo et al., 2016), experience disintegrated extended families (Sithole, 2009; Eagle, 2009), and face difficulties in relating to their grandchildren because of the large generation gap (Shakya et al., 2012; Lee et al., 2015; Ngwenyenyi, 2016). Grandchildren today belong to Generation Z, also known as post-millennials, whereas their grandparents belong to either the Baby Boomer generation, born between 1945 and 1964, or Generation X, born between 1965 and 1980 (Beall, 2017).

In this study, I focus on grandparents above 60 years. There is a large age difference between grandchildren and their grandparents. This problem can seriously affect the successful mitigation of the challenges already faced by grandparents, who, in old age, experience the physiological changes associated with growing old such as menopause, physical deterioration and reduced income (Mokone, 2006). Mokone (2006) argues that the generation gap is more profound between grandparents and grandchildren than between parents and children.

There is a vast difference in experiences and expectations regarding life by grandparents who are at a stage where they need to slow down from a physical and psychosocial perspective. Thus, grandparents cannot rely on past parenting experiences to enable them to raise their

grandchildren. When they were parents, they were younger and possibly physically fit; there was less of a generation gap.

Despite all the above problems, elderly grandparents are still expected to care for their AIDS-orphaned grandchildren when they might expect to have been taken care of by their own children. This view is supported by Smith and Segal (2018) who contend that it is natural for elderly grandparents to feel uncertain about bringing up grandchildren. They may feel burdened by having this responsibility that ought to be handled by their children. Thus, they need significant support if they are to cope with the intergenerational relationship challenges that they face as elderly grandparents caring for AIDS-orphaned grandchildren. This support might even contribute to the well-being of these elderly grandparents if it leads to them perceiving the task as meaningful intergenerational engagement and activity that, according to the activity theory, leads to a sense of purpose in the final years of their lives.

1.2 CHALLENGES ENCOUNTERED BY ELDERLY GRANDPARENTS IN AN INTERGENERATIONAL RELATIONSHIP

Elderly grandparents of AIDS orphans face stress, worry, and grief owing to additional responsibilities and fear of the unknown (Smith & Segal, 2018; Bennell, 2005). In addition, as their grandchildren are likely to suffer grief and stress owing to the loss of their parents who used to take care of them, these grandparents have to attend to the particular emotional needs of their AIDS-orphaned grandchildren. This is a challenging task, and elderly grandparents of AIDS-orphaned grandchildren may even feel guilty because they perceive themselves as bad parents. In particular, anger and resentment may result from the fact that the elderly grandparents' peers, who are probably not looking after grandchildren, are enjoying life. Smith and Segal (2018) posit that taking full-time care of orphaned grandchildren leads to loss of independence, thus confining grandparents to the home instead of being free of responsibility in their retirement.

The former Deputy Prime Minister of the Kingdom of Eswatini, Mr Albert Shabangu, as cited by Sithole (2009, p. 11), concurs with Smith and Segal. He highlighted in his speech that:

Elders in our societies are revered in our culture. We must see to their needs because our older citizens are facing a situation they never expected. At this time in their lives they had believed they could relax after a life of hard work. Instead, many grandparents have to raise young children all over again. This is after their own children have died of AIDS (Sithole, 2009, p. 11).

Besides social and emotional support, grandparents probably need to provide financial security to their orphaned grandchildren, particularly with regard to health-care and education in line with emerging trends. Thus, grandparents might find themselves in a quandary as they are expected to provide these grandchildren with essentials, such as food, shelter, clothing, school fees and medical care (Baker & Silverstein, 2008; Carr et al., 2012; Yancura, 2013, Lee et al., 2015). In the Kingdom of Eswatini, the major challenge that the elderly face is food security. Grandparents have land, but they lack farming inputs (ULARN, 2003). Thus, ULARN (2003) recommends that any help given to the elderly should include services, such as farming input, health-care and school fees.

The financial needs discussed above caused the government of the Kingdom of Eswatini and some non-governmental organisations (NGOs) to come up with intervention strategies. First, in 2005, the government of the Kingdom of Eswatini introduced old age grants (OAG) to the elderly known as *imbasha yabogogo*, which is currently at E500 per month, to meet some of their minor financial needs (Annex Deputy Prime Minister's Office, 2016). This grant is not specifically for elderly grandparents caring for orphans who lost their parents owing to AIDS, but also for other elderly people. However, the money that they receive from the government is not enough for both their basic needs and those of their grandchildren. However, the government also pays school fees for orphaned and vulnerable children (OVC) and grants free access to medical check-ups and treatment. Second, the NGO, Philani Maswati Charity Organisation, was launched in 2000 with the primary aim of providing food commodities, blankets for elderly people and school uniforms for OVC (FANRPAN, 2011).

Apart from Philani Maswati, there are other local NGOs, for example, Young Heroes, which was established in 2006. This organisation aims to provide financial support for the provision of necessities for orphans in Eswatini, in addition to providing HIV testing and care programmes. These NGOs mostly rely on donations from organisations, such as the President's Emergency Plan for HIV and AIDS Relief (PEPFAR), The Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Food Programme (WFP). Despite the aforementioned financial aid schemes, the government, NGOs and communities have not introduced policies and programmes that offer psychosocial support to elderly grandparents caring for their AIDS-orphaned grandchildren (ULARN, 2003). ULARN (2003) further notes that even the financial support that exists is sporadic and inadequate. Thus, there is a need for all stakeholders to collaboratively develop programmes that support elderly grandparents in meeting both their psychosocial and material needs.

1.3 THE EDUCATION COLLABORATION POSSIBILITY

The discussion above reveals that there may be collaborative assistance given by the government and NGOs of Eswatini, but the elderly grandparents of AIDS orphans are excluded from the process. There is no collaborative model that includes these grandparents so that they may also contribute solutions that address their needs. An effective collaboration approach should include the whole stakeholder community. This is supported by Rowland (2018) who argues that:

Collaboration is the ability to multiply each other's strengths to produce a result that no party could have achieved alone. Never, before seen capability, opportunity, is the hallmark of true collaboration. Each member will contribute to the mutually agreed upon objectives and goals. The outcome is "we did it together." (p. 1)

Rowland (2018) further contends that an effective collaborative model should have the following key elements: a shared vision, a strong relationship between partners and meaningful results. However, the Kingdom of Eswatini lacks these elements because the elderly grandparents tasked with caring for their AIDS-orphaned grandchildren are not part of the process of vision formulation by the institutions helping them. Yet, these grandparents could help identify strategies and come up with solutions to the problems they face daily. Despite the current strategies in place, there is still a lack of educational programmes involving grandparents, which could help mitigate the challenges they face.

Rowland (2018) argues that success cannot be achieved alone as it is a joint approach. Hence, I endeavoured to bring everyone on board to take part in the development of a collaborative model that can address the needs of elderly grandparents of grandchildren orphaned by AIDS.

According to Henkins (2018), if grandparents and grandchildren are called upon to support each other and work together in addressing their concerns, stronger bonds and healthy relationships are built. However, in this study, the focus was on the grandparents who are involved in an intergenerational relationship with their AIDS-orphaned grandchildren, whose needs they have to cater for. The study required the grandparents to be the participants in a participatory action research (PAR) that endeavoured to help them find their own solutions to the problems facing them in this relationship. Stakeholders who were *Tinkundla*, Department of Social Welfare, the Inner Council of Chiefdom, World Vision, Bantwana, Philani Maswati, Young Heroes and the Primary Health Care system took part in this study. Their roles were to highlight what they are currently offering the grandparents and their grandchildren orphaned

by AIDS. The roles also show how stakeholders can collaborate in order to help grandparents and their grandchildren orphaned by AIDS. This is partly reflective of the life-changing outcomes for children and youth, older adults, families and communities that Kuehne (2013) had implied in her experiences with community-based intergenerational programmes.

The strength of this study lies in the fact that this is the first education oriented study that explores the teaching and learning transactions that frequently go on between grandparents and AIDS-orphaned grandchildren, but which had been largely underestimated and ignored to date. There are so many traditions of innovative teaching and learning initiatives (Young, 2014) that have been going on in Africa, and almost all of these have laid unresearched for so long.

Most researchers in the field of intergenerational relationships in Africa tended to have laid more emphasis on the socio-economic and anthropological aspects of these transactions rather than the value of education in making better the mitigations that have been proposed towards helping Africans to better cope with the identified challenge (Oduaran, 2010). Perhaps, this study is one of the responses that Oduaran (2014) had invited in his call for the intergenerational pathways for strengthening communities in sub-Saharan Africa. And, this study is possibly adding value to the call earlier made in 2006 by Nyesigomwe (2006) in which she demanded for the need to strengthen the capacity of grandparents involved in providing care to young children affected by HIV and AIDS.

1.4 RATIONALE

This research study followed the participatory action research design which reflects on the needs of elderly grandparents caring for AIDS-orphaned grandchildren, and the teaching and learning transactions implied by using an intergenerational relationship lens. These teaching and learning transactions embedded in the exchange are encapsulated in a kind of cultural transmission that Adjaye and Aborampah (2014) had studied among the Akan of Ghana (2014).

This study elicited the collaboration of the grandparents themselves in exploring how they can cope with the problems they face, when they might need to be supported and disengaged from demanding social responsibilities. Stakeholders came in to see how they can collaborate to help meet the needs raised by the grandparents.

My intent was to find a coping mechanism for the ageing grandparents caring for AIDS-orphaned grandchildren. My primary aim was to develop, in collaboration with the

grandparents, a model that could support them in the intergenerational relationship in which they find themselves.

Hampton and Wadud (2018) assert that the people who are affected by a problem should be directly involved in developing strategies to solve it, as they are the ones with a better understanding of their own needs. Thus, this study specifically targeted the application of a strategy that mitigated the problems encountered by elderly grandparents caring for AIDS-orphaned grandchildren in the Eswatini Kingdom.

The study was geared towards the collaborative development of an intergenerational relationship education model that supports ageing grandparents caring for AIDS-orphaned grandchildren. Intergenerational programmes are activities that foster cooperation, interaction and exchange between two or more generations (Kaplan and Sanchez, 2014). These are suitable accomplishments for lifelong learning among older adults and for the development of a change in attitudes that young people exhibit toward the elderly (Borrero, 2015; Park, 2015; Thompson & Weaver, 2016). According to Celtran et al., (2009), Galbraith et al. (2015), Fujiwara (2016), and Sakurai et al. (2016), taking part in intergenerational activities leads to improved health and well-being of adults by facilitating continued intellectual or physical activity in the elderly, and it concurrently contributes to the encouragement of values and behaviours in grandchildren and to the construction of identity among adolescents. The ideas highlighted above are in line with the activity and continuity theory, which guided this study. I considered the grandparents when designing a model to meet their needs. My study could contribute to the body of knowledge on intergenerational relationship programmes in the Kingdom of Eswatini, as there is no well-documented literature on this. Although there have been some indications of the use of intervention models, as observed by Mohammed (2009). These have not been too effective. Mohammed (2009) writes about *lisango*, which is a place next to the kraal where boys sit with their fathers and grandfathers and where much of the helpful cultural exchange takes place for both parties. Mohammed (2009) also mentions *liguma*, a place for females only, where girls convene with their mothers and grandmothers and are taught how to be better women in relation to the Eswatini culture. This resembles intergenerational relationships and programming, but scholarly documentation of this is inadequate. These two models aim to educate young girls and boys about the norms and values of society. Socially assigned life skills and gender roles of these two groups are discussed in such gatherings (Pato, 2018). It should, however, be noted the use of *lisango* and *liguma* have not been clearly outlined and procedures of the models have not been properly documented.

1.5 RESEARCH QUESTIONS

Based on the background statement and the rationale provided above, the following research questions were planned:

- What are the education needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?
- How can relevant stakeholders in Eswatini collaborate in order to come up with strategies embedded in education to address the needs of elderly grandparents caring for grandchildren orphaned by AIDS?
- How can the findings of the empirical study be translated into an education model and guidelines for improving the intergenerational support or care given by grandparents to their AIDS-orphaned grandchildren?

1.6 RESEARCH AIM AND OBJECTIVES

1.6.1 RESEARCH AIM

The main aim of this study was to collaboratively design an intergenerational relationships education model that can meet the needs of grandparents taking care of grandchildren orphaned by AIDS in the Kingdom of Eswatini.

1.7 RESEARCH OBJECTIVES

To achieve the research aim, the study did the following:

- Engage grandparents in identifying the challenges they face in caring for grandchildren orphaned by AIDS.
- Engage grandparents and stakeholders in developing education-based strategies to help minimise the challenges.
- To translate the findings of the empirical study into an education model and guideline for improving intergenerational support or care given by grandparents to their AIDS-orphaned grandchildren.

1.8 THEORETICAL FRAMEWORK

A theoretical framework provides a structure for the philosophical, epistemological, methodological and analytical approaches of the study (Grant & Osanloo, 2014). The intergenerational relationship theory (IRT), activity theory (AT) and continuity theory (CT) form the theoretical framework for this study.

1.8.1 INTERGENERATIONAL RELATIONSHIP THEORY

Since the study sought to better understand and appreciate the intricacies of intergenerational relationships education which affect grandparents caring for grandchildren orphaned by AIDS, I adopted an intergenerational relationship theory based on a behaviour change model. The above combination was chosen due to the fact that the elderly grandparents caring for grandchildren orphaned by AIDS at Eswatini face stress, worry and grief owing to additional responsibilities and fear of the unknown (Smith & Segal, 2018). A behaviour change model based on education was deemed as essential to provide the framework for the approach in the development of health promotion programmes. The behaviour change model that was seen as ideal was the Whole Person Wellness Model that targets the six-wellness dimensions (physical, emotional, spiritual, intellectual, occupational and social). The implication is that improved wellness enhances the overall functional fitness of grandparents caring for grandchildren orphaned by AIDS. Next, I discuss the AT theory as one of the psychosocial theories underpinning this study.

1.8.2 ACTIVITY THEORY

Activity theory proposes that successful ageing occurs when older adults stay active and maintain social interactions (Havighurst, 1961). This theory provides an outline of the significance and overall effect of participating in activities in older age (Havighurst, 1961; Winstead et al., 2014). Gitlin et al. (2013) contend that elderly individuals need ongoing stimulation, socialisation, connectivity and a sense of belonging. The activity theory claims that participation in activities is healthy and ensures the overall well-being and quality of life of older adults (Winstead et al., 2014). Activity engages older adults both physically and mentally and allows them to socialise with others. This increases feelings of self-worth and pleasure, which are important for happiness and longevity (Wurtele, 2009). In the study, I established if the participants perceived care for the AIDS-orphaned grandchildren as a worthwhile activity that helps them to maintain their general well-being. I aimed to explore how the elderly participants perceived their needs in successfully continuing this activity.

According to Nilsson et al. (2015), the intention of the activity theory is to find the best way for handling the challenges of ageing and bringing ease and enrichment to the lives of grandparents. In contrast to the activity theory, the disengagement theory of ageing proposes that it is natural for the elderly to disengage from society as they realise that they are approaching death. However, I did not base my study on the disengagement theory because

the elderly participants were involved in an intergenerational relationship with their orphaned grandchildren.

1.8.3 CONTINUITY THEORY

The continuity theory proposes that older adults maintain the same activities, behaviours, personalities and relationships of the past. The continuity theory is a psychosocial theory of ageing, which posits that, as middle-aged and elderly adults adapt to changes associated with the normal ageing process, their experiences, decisions, and behaviours to form the foundation for their present and future decisions and behaviours (Minhat et al., 2013, p. 1). An individual's internal structures remain relatively constant throughout a person's lifetime and include elements, such as personality traits, ideas and beliefs. An individual's external structures, which comprise relationships and social roles, support the maintenance of a stable self-concept and lifestyle. These structures help people make future decisions by providing them with a stable foundation in the past (Atchley, 2003). In the study, this implied that, having been parents themselves, these old adults continued with the same responsibility. As a result, I aimed to establish whether the participants were drawing on their experience in caring for their grandchildren.

1.9 METHODOLOGY

A *research methodology* is a map of how a study is conducted and outlines a way in which detailed information may be attained. In qualitative research, a research methodology is an extensive approach to social experiences (Creswell & Creswell, 2018). The following paragraphs provide an explanation regarding the aspects of the research methodology of this study.

1.9.1 RESEARCH PARADIGM

A *paradigm* is a system of thinking that includes accepted theories, traditions, approaches and methodologies (Creswell & Creswell, 2018).

To help change the lives of grandparents taking care of their grandchildren orphaned by AIDS, I applied the transformative paradigm. The transformative paradigm was a reaction to post-positivism (Creswell & Creswell, 2018). According to Creswell and Creswell (2018), "Post-positivist assumptions imposed structural laws and theories that did not fit marginalised individuals in our society or issues of power or social justice." The transformative paradigm is based on the assumption that there is a need to link research inquiry with politics and political change agenda to confront social oppressions at whatever level it occurs (Mertens, 2010).

The transformative paradigm is best suited for my study as it is based on an action agenda aimed at changing the lives of the participants, their communities, and the researcher's view of life (Creswell & Creswell, 2018). I believed that, by carrying out this study, the lives of the grandparents and grandchildren would change for the better as they were actively involved. Creswell and Creswell (2018) further posit that the transformative paradigm becomes the voice for reforming and improving the lives of the participants as it is collaborative and change-oriented. In this study, the collaboration of all stakeholders helped in translating the information gathered into education guidelines and a model that can improve the intergenerational support given by grandparents to their AIDS-orphaned grandchildren.

1.9.2 RESEARCH APPROACH

Creswell and Creswell (2018) define *approaches* as, "Plans and the procedures for research that span the steps from broad assumptions to a detailed method of data collection, analysis and interpretation." In this study, I adopted a qualitative approach since my intentions were to give a voice to grandparents taking care of AIDS-orphaned grandchildren and helping them express their perceptions and experiences regarding intergenerational households. According to Miller (2018), cited by Creswell and Creswell (2018, p. 204), qualitative research, "Occurs in natural settings where human behaviour and events occur and focuses on participants' perceptions and experiences, and the way they make sense of their lives."

1.9.3 RESEARCH DESIGN

A research design depends on the inquiry that is used in qualitative, quantitative and mixed research approaches and provides a guide for conducting research (Creswell & Creswell, 2018). In this study I opted for a participatory action research design, because this kind of an approach aims at action to bring about a desired change (Kemmis & McTaggart, 1988). Participatory action research as described by Nelson (2017) is:

A qualitative approach to inquiry that builds capacity, focuses on community development, empowerment, access, social justice and participation, is democratic, equitable, liberating and life-enhancing, providing agency and giving voice to those in society who are marginalised from power and resources. (p. 4)

Reason and Bradbury (2008) concur with Nelson's definition as they describe PAR as an active research inquiry that links practices and ideas in a quest to give humans a sense of meaning about their lives. Kemmis and McTaggart (2005), Lykes et al. (2011), and MacDonald (2012) posit that PAR aims to contribute knowledge and bring about social transformation.

Of importance is that participatory action research focuses on producing practical knowledge useful to people and their lives. In this study instead of grandparents taking care of AIDS-orphaned grandchildren being told what action to take to reduce their plight, they are given the chance to take part in the research as core researchers to understand their phenomenon better. Todd (2016) postulates that PAR is deeply rooted in expanding aspirations through sound emancipatory intentions, typically equated with empowerment. This is a design that requires: encouraging contribution, allowing and sharing power, building interactions, and negotiating change. PAR involves iterative cycles of action and learning as depicted below:

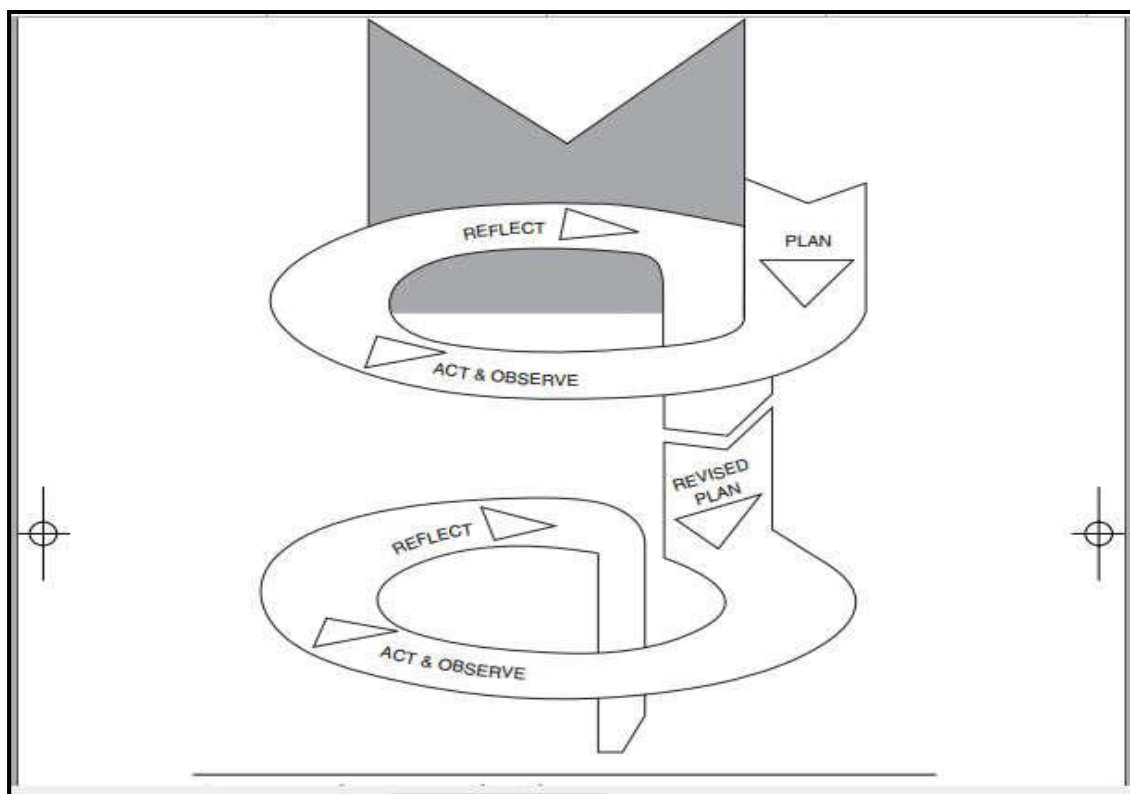


Figure1.1: *The Action Research Spiral (Kemmis & McTaggart, 2005)*

I have used PAR to inform my study which focused on working with Emaswati grandparents caring for AIDS-orphaned grandchildren to explore their experiences and to help them collaboratively meet their identified needs.

1.10 RESEARCH METHODS

Research methods involve procedures of participant selection, data generation/analysis and the interpretation that researchers propose for their studies (Creswell & Creswell, 2018).

1.10.1 PARTICIPANT RECRUITMENT

According to a document compiled by the Health Information Technology Archive (2017), recruitment entails: finding eligible participants, fully explaining the aim of the study to them, recruiting the sample that suited the study aims and design, gaining informed consent from relevant stakeholders, upholding ethical standards and maintaining the same participants throughout the study. I involved chiefs from two chiefdoms in the Manzini region, the community councillor (*bucopho*) and community health workers (*bagcugcuteli*) in recruiting eligible participants for the research. The first step in the recruitment of the participants was to come up with a list of the characteristics of the participants I desired to study. Here, I considered eight stakeholders and ten grandparents who were looking after AIDS-orphaned grandchildren and who also came from the two chiefdoms that I chose as my research sites. I limited the number of participants to ten as the recommended number in an action learning set. Pedler and Burgoyne (2008) argue that limiting this number to ten allows maximum participation by participants.

In qualitative research it is ideal to select participants that offer information which is rich (Hennink et al., 2011). Thus participants were not recruited based on friendship or haphazardly. I used purposive sampling to recruit my action learning sets. The recruitment process took four to six months. This was due to the processes I needed to follow before I was granted full permission to recruit. I got information from the community leadership or from local schools and, where possible, I asked some prospective participants to suggest other participants that they thought qualified to be part of my study. I therefore further employed snowballing sampling to get my participants (Creswell & Creswell, 2018) until I reached the number ten.

1.10.2 DATA GENERATION METHODS

In qualitative research, data generation depends on the theory and methods used to create data from a sampled data source (Given, 2008). The researcher carefully chose and implemented the selected data generation methods (Merriam, 2009). Merriam (2009) further contends that, in research, the role of qualitative methods is to explore individuals' feelings, perceptions and relationships with their communities.

In this research study, I focused on the lived experiences of the grandparents taking care of AIDS-orphaned grandchildren and their feelings, thoughts and opinions on how they can meet their needs and therefore used the following data generation methods:

1.10.2.1 Action learning set meetings [ALS]

I used action learning sets to provide grandparents taking care of AIDS-orphaned grandchildren a chance to discuss their needs and also suggest potential solutions. Pedler and Burgoyne (2008) describe an action learning set as a group of people who gather to learn alternative ways of thinking, work on problems they encounter daily, share experiences and assist one another with problem-solving through questioning. Action learning sets gave grandparents a chance to discuss their needs and also suggest potential solutions. This was achieved by allowing the set to ask supportive and challenging questions that led to a clear and deep understanding of the grandparents' needs.

The researcher and the participants agreed on the issues to be discussed before meeting. The values stated by Zuber-Skerrit (2002, p. 114) guided the success of our action learning set and these are:

- Collaboration trust and openness.
- Team spirit and mutual respect for individual differences, talents and needs.
- Tolerance of mistakes, from which we learn.

The discussions were audio and video recorded and then transcribed for data analysis.

1.10.2.2 FOCUS group discussions

A focus group discussion is a data collection method usually used when generating data from people from similar backgrounds or experiences. The people are brought together to discuss a specific topic of interest within their experience (Creswell & Creswell, 2018; Hennink, 2014). In a focus group discussion, questions asked seek to elicit perceptions, attitudes, beliefs or opinion of participants. I used two-way focus group discussion (Hennink, 2014) which I moderated. In this study, the stakeholders were an active focus group and the grandparents were an observer group. After presenting the challenges the grandparents taking care of AIDS-orphaned grandchildren were facing to the stakeholders, they actively discussed the challenges and how they were attempting to address them while grandparents representatives observed.

1.10.2.3 Reflective journal

I used a reflective journal to encapsulate perceptions gathered during the PAR process. A reflective journal or research diary is a tool that a social science researcher uses for immersed research (Bourgoin & Harvey, 2018). In a journal, I recorded my thoughts, reflections, the

participants' actions, and provided a continuous description of events. This data generation strategy is discussed in detail in Chapter Four (see Section 4.7.2.1)

1.10.2.4 Drawings and narratives

Drawing is a critical way of getting participants' inner world because it captures feelings and emotions, especially when participants lack equally expressive written language (Knowles & Cole, 2008). I asked the grandparents taking care of AIDS-orphaned grandchildren to make drawings, which were accompanied by narrations. I used drawings to allow the ALS members to convey first, their negative lived experiences and secondly hope for an improved intergenerational relationship. In addition, the grandparents narrated their illustrations, and the audio recordings were transcribed for analysis. I chose to use drawings because they are valuable for bringing forth emotions for data generation (Theron et al., 2011).

1.10.3 DATA ANALYSIS

Merriam (2009) maintains that data analysis is finding answers to research questions. In my study, I gathered and analysed data simultaneously (Denscombe, 2007; Merriam, 2009). This simultaneous task assisted me in deciding on the next step in data gathering and changes to be made. This also helped me to avoid repetitions and being overwhelmed by the data gathered (Merriam, 2009). Data analysed this way is not only prudent and illuminating but leads to a thorough analysis (Merriam, 2009).

Using a thematic approach in my data analysis allowed me to contrast themes by following Merriam's (2009) suggested criteria. First, I made sure the themes answer my research questions. Second, I ensured that my themes accommodate all the data I considered important. Third, I verified that those themes do not overlap but fit into only one theme. Fourthly, my themes were enlightening so that their meaning was clear to those who read the explanations. Lastly, the themes were conceptually compatible (Merriam, 2009). The grandparents taking part in the study were involved in determining the main issues/themes to be analysed. I summarised their narratives and let them discuss the themes to see if they agreed. Most of the themes were agreed upon by me and the grandparents.

1.10.4 VALIDATION

In my study, validity refers to the suitability of the data generation methods, processes and the actual data collected (Leung, 2015). I used the validation criteria suggested by Anderson and Herr (1999): outcome, process, democratic, dialogic and catalytic validity. For my study, outcome validity refers to the extent to which the actions taken lead to guidelines and a model

for improving intergenerational support/care given by grandparents to their AIDS-orphaned grandchildren.

Process validity refers to the extent to which the problems faced by these grandparents are framed and resolved in a manner that allows for their continuous learning. It also refers to the degree to which I used a sound research method. Democratic validity refers to the degree that I did the research in collaboration with all parties who are involved in meeting the needs of grandparents so that the results are pragmatic. Dialogic validity refers to the extent to which I sought dialogue during the research process with peers who critiqued my study. This also involved communicating the research findings to the stakeholders responsible for meeting the needs of grandparents. Catalytic validity refers to the extent to which the research process reoriented, focused and invigorated me and the grandparents towards understanding the roles they need to play to meet their needs, which changed the way they view the problems. I validated the research findings by comparing themes from the transcribed meetings with the results of the process analysis.

1.10.5 ETHICAL CONSIDERATIONS

I addressed ethical considerations by, first, seeking permission from the university's ethics committee where an ethics approval certificate was granted. I followed the university's ethical guidelines. Second, by obtaining permission from the Eswatini Ministry of Tinkhundla (constituencies) that issued letters for me to submit to the two chiefs of the selected chiefdoms. I got the participants' written consent to participate. I strictly adhered to ethical and legal considerations, and to meet these requirements, and took into account and avoided what Creswell and Creswell (2018) describe as the common pitfalls often made by researchers. These pitfalls are exploitation, collecting harmful information, siding with participants, deception, plagiarism, discriminating participants, falsifying authorship, and disclosing only positive results. All participants voluntarily participated and I ensured their confidentiality. All participants in my action learning set were given documentation explaining all the processes that were followed.

Besides the above, participation was voluntary and participants were informed that they may withdraw from the study anytime they wished. Documentation from the action learning sets were signed, filed and securely locked in a safe place. In order to ensure confidentiality code names were allocated to each member of the action learning set. This was done to avoid easy identification of participants. I made use of grandparents who volunteered to represent the grandparents during focus group discussions with the other stakeholders. I have received their

consent that their identities may be revealed to other stakeholders during focus group discussions. Where participants needed to be videotaped or voice recorded, written consent forms were signed by the participants. I respected and cared for my participants. I encouraged them when they found the going was getting tough.

1.11 DIVISION OF CHAPTERS

The proposed outline of the study is shown below:

Chapter One:

This chapter comprised: the introduction, the background of the study, the statement of the problem, the purpose of the study, research questions and objectives, assumptions of the study, justifications of the study, limitations and delimitations of the study, and definitions of terms.

Chapter Two:

In this chapter, I critically discussed HIV, the OVC issues, and what these imply for grandparents. I looked at these topics from socio-psychological health and economic angles. I also looked at what had already been done to help grandparents.

Chapter Three:

In this chapter, I looked at the theoretical framework that was an analytical lens to guide my study.

Chapter Four:

This chapter describes the research design and methodology used in this study.

Chapter Five:

This chapter presents the data in cycles to answer each question. Cycle One answers the question: What are the needs of grandparents?

Chapter Six:

Examines the research findings of Cycle Two that identifies strategies and the implementation/evaluation of the current strategies being used.

Chapter Seven:

This chapter dealt with the design of the model and the guidelines based on the findings of the study. These were discussed in relation to the literature reviewed and the data gathered. A model, developed by the grandparents and the researcher, in line with the objectives of the

study, designed to justify the use of an intergenerational relationship model in meeting the needs of grandparents caring for AIDS-orphaned grandchildren.

Chapter Eight:

This chapter presents the summary, conclusions and recommendations.

1.12 SUMMARY

The purpose of this chapter was to discuss the overview of the study and its context. I prepared the research questions, discussed in detail the research methodology followed, and the data generation methods including data analysis. I also discussed how validation will be carried out and how ethical considerations will be observed. In the next chapter I will provide a review of related literature on issues of HIV and AIDS and grandparenting of grandchildren orphaned by AIDS.

CHAPTER TWO

REVIEW OF RELATED LITERATURE ON ISSUES OF HIV AND AIDS AND GRANDPARENTING OF GRANDCHILDREN ORPHANED BY AIDS

2.1 INTRODUCTION

HIV and AIDS remain a global concern in the 21st century regardless of efforts done by governments to reduce their effects. One of the challenges faced by many communities is the issue of grandparenting. My study focuses on soliciting the views of grandparents who are caregivers to grandchildren orphaned by the AIDS pandemic. The main thrust of my study is to focus on the huge challenge of grandparenting and mitigating its socio-psychological and economic impact on the grandparents and the nation's orphans. Some of the orphans under the guardianship of their grandparents are subjected to live in conditions of extreme poverty while being HIV-positive and on the antiretroviral programme (Arrehag et al., 2006). The grandparents, by virtue of being advanced in age, often experience ill health, lack adequate knowledge, skills and resources to cope with this huge responsibility (Littrell, et al, 2012).

The current study focuses on the real life experiences of the grandparents caring for their grandchildren orphaned by AIDS, some of whom are living with HIV. The study investigates the challenges that the grandparents face in providing such a crucial mandate, as well as the strategies they employ to deal with the situation and the support systems available to them. This chapter provides a brief introduction to the HIV and AIDS pandemic. A description of the salient characteristics of the disease, its spread and prevalence globally, sub-Saharan Africa at large and in the Kingdom of Eswatini in particular, then the chapter explores the challenges HIV and AIDS imposed on orphaned grandchildren. Finally, an exploration of how the Kingdom of Eswatini is mitigating the socio-psychological and economic challenges of grandparenting. The knowledge, geographical and sampling gaps of previous studies will be highlighted with emphasis on clarity of how the current study seeks to bridge the gaps.

2.2 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Acquired Immune Deficiency Syndrome (AIDS) was first detected in 1981 (Arrehag et al., 2006). Since then, it has become a worldwide epidemic. AIDS is caused by infection with the HIV (Human Immunodeficiency Virus), which attacks cells of the body's immune system and gradually destroys the body's ability to fight infections. The severity of the pandemic as a unique threat to mankind is undeniable, largely because it is incurable and surrounded by silence and stigma (Makadzange, 2011). In Africa, AIDS emerged against a backdrop of

extreme poverty, hunger, conflict and inadequate infrastructure (Littrell et al., 2012). These factors combined have exacerbated the spread of the disease in this impoverished region of the world and it is the one hardest hit by the epidemic.

2.3 HISTORICAL BACKGROUND OF HIV AND AIDS

Avert (2018) and Gallagher (2014) claim that it is believed that HIV originated in Kinshasa, in the Democratic Republic of Congo around 1920 when HIV crossed species from chimpanzees to humans. Avert (2018) further asserts that up until the 1980s, there are no known people who were infected with HIV or developed AIDS. Avert (2018) postulates that HIV was unknown and transmission was not accompanied by noticeable signs or symptoms. Avert (2018) further alludes that while erratic cases of AIDS were recognised before 1970, obtainable data suggests the current epidemic started in the mid to late 1970s. It is believed that by 1980 HIV may have already spread to five continents (Africa, Europe, Australia, South America and North America). It is estimated that between 100,000 and 300,000 people could have already been infected (Avert, 2018).

The Centers for Disease Control and Prevention (CDC) (1983), Osmond (2003), Smith and Whiteside (2010), Venter (2005) and Jansen (2005) assert that Acquired Immunodeficiency Syndrome (AIDS) was first identified in 1981 in San Francisco, New York and Los Angeles, USA, among five gay men with pneumocystis carinii pneumonia (PCP) and twenty-six cases of a skin disease called Kaposi's sarcoma (KS). These unusual diseases had weakened the body's defence mechanism to fight diseases. Osmond (2003) further asserts that in 1982 HIV was then identified among drug injecting users, people with haemophilia and transfusion recipients. In Uganda, a fatal wasting disease known as slim disease was discovered by doctors. AIDS-specific organisations like San Francisco AIDS Foundation (SFAF) in the USA and Terrence Higgins Trust in the UK were formed (Avert, 2018).

In 1983 AIDS cases were reported among female partners of men who had the disease signifying that it can be passed on via heterosexual sex (Avert, 2018). In May 1983 doctors at the Pasteur Institute in France reported the discovery of a new retrovirus called lymphadenopathy-associated virus (or LAV) that could be the cause of AIDS (Avert, 2018). AIDS among children was reported on June 1983. At first, it was thought it could be passed via casual contact but later ruled out and it was established that they had probably acquired it directly from their mothers before, during or shortly after birth. The Centers for Disease Control and Prevention (1983) reported that the main methods of HIV transmission include

unprotected sexual intercourse or blood transfusions and rejected the hypothesis that it can be transmitted by casual contact or could be waterborne, airborne and foodborne.

The cause of AIDS was announced by the National Cancer Institute in 1984. In a joint conference with the Pasteur Institute, they announced that LAV and HTLV-III are identical and the likely cause of AIDS. According to Avert (2018), a blood test was created to screen for the virus with the hope that a vaccine would be developed in two years. Sharing of needles for injecting drugs was stopped to prevent transmission of the virus. At the end of 1984 cases of AIDS stood at 7,699 and AIDS-related deaths were at 3,665 in the USA while Europe reported 762 cases.

When HIV was first discovered it was referred to as gay-related immunodeficiency syndrome (GRID) but then in 1984 it was designated as Acquired Immunodeficiency Syndrome (AIDS) and was rapidly adopted by researchers. According to the U.S. Food and Drug Administration (FDA) (2018), the first commercial blood test known as ELISA used to detect antibodies against HIV was licensed in 1985. In 1985 at least one AIDS case was reported from every region of the world (History.com Editors, 2019). Avert (2018) and Watson (2016) claim that in 1987, the World Health Organization (WHO) launched The Global Program on AIDS whose aim was to raise awareness, formulate evidence-based policies, offer countries both financial and technical support, encourage active engagement of NGOs, carry out research and campaign for the rights of people living with HIV. Avert (2018) and the U.S. Food and Drug Administration (FDA) (2018) assert that in 1987 the first antiretroviral therapy (ART), which is a drug active against HIV called zidovudine or AZT and a more precise HIV antibody test called Western blot blood test kit was approved.

Avert (2018) further asserts that in 1987 the WHO agreed that HIV can be transmitted from mother to child through breastfeeding and that it has received 7,1751 reports of short paragraph cases of AIDS. The U.S. Food and Drug Administration (FDA) (2018) also published some regulations requiring the screening of blood and plasma collected in the U.S. for HIV antibodies, and they also reviewed its policy for the regulation of condoms. The drug extended the lives of many people but as years went by it became less effective for many people as the virus mutated to become resistant to the single drug (National Center for Biotechnology Information, 2010).

According to Myhre and Sifris (2018) and Avert (2018), the WHO in 1988 declared the first of December as World AIDS Day. Since 1988 this day is commemorated annually with short paragraph different themes ranging from “grandchildren and youth” in 1988 and “know your

status” in 2018. The purpose of this day is to create public awareness on the impact of the AIDS epidemic on families and the society at large (Myhre & Sifris, 2018). In March 1989, 145 countries reported 142,000 AIDS cases. In the same year the WHO estimated that there were up to 400,000 cases of AIDS worldwide. This is a clear indication that AIDS cases were increasing every year at an alarming rate. Zidovudine (AZT) was approved in October to treat grandchildren with AIDS (US Food and Drug Administration, 2018). In 1990, 8 to 10 million people were believed to be living with HIV globally (Avert, 2018).

In 1995 the highly active antiretroviral treatment (HAART) was approved by the FDA and included into clinical practice. This led to an instant decrease in AIDS-related deaths and significant decline of hospitalisation by about 60-80%. Despite the introduction of HAART as an intervention strategy HIV incidences increased from 2.5 million in 1993 to 4.7 million in 1995. Of these new infections, 2.5 million were from South East Asia and 1.9 million in sub-Saharan Africa. These deaths have been a direct consequence of poverty, cultural practices and lack of information about HIV and AIDS in these parts of the world. This is an indication that prevention strategies were not working to prevent the spread of HIV. HAART was only reducing AIDS-related deaths and hospitalisation due to AIDS.

In 2000, the United Nations devised and adopted the Millennium Development Goal (MDG) number 6 which was aimed at halting and reversing the spread of HIV by 2015 and achieving universal access to treatment for all those who are HIV positive by 2010 (The Guardian, 2017). Myhre and Sifris (2018) further assert that the MDGs were developed to reduce the global prevalence and incidence of HIV, HIV stigma, gender violence and the criminalisation of HIV. There are four MDGs on HIV and AIDS. These were to:

- Reduce sexual transmissions of HIV by 50%,
- Place 15 million HIV-Positive people on antiretroviral therapy (ART),
- Eliminate mother-to-child transmission of HIV and reduce AIDS-related maternal deaths by 50%, and
- Halve the number of tuberculosis deaths in people living with HIV.

According to Myhre and Sifris (2018) from 2001 to 2011 HIV infections dropped by approximately 21% worldwide. In sub-Saharan Africa, it dropped by 25%. It is important to note that the target reduction of 50% was not achieved. Another disturbing scenario was the increase of new infections due to men who had sex with other men (MSM) in Eastern Europe

and Central Asia. Impressive gains were achieved in the Caribbean where new cases dropped by 43%.

On the second point, namely, placing 15 million HIV-positive people on antiretroviral therapy (ART) the target was missed by about 55% of 14.4 million people in need of ART received it (Myhre & Sifris, 2018). On the part of grandchildren with HIV, only 28% were able to access ART. It is however encouraging that in the Caribbean and Latin America (68%) was achieved. Eastern Europe and Central Asia had far from impressive coverage of (19%). According to the UNAIDS 2013 report, seven African countries achieved a 50% reduction in mother-to-child transmission of HIV (MTCT) by 2009 (Myhre & Sifris, 2018). On halving the number of tuberculosis deaths in people living with HIV, seventeen of forty-four priority countries recorded (50%) reductions by 2013. By the year 2015, UNAIDS announced that the MDG-6 goal was reached as 15 million people were on ART (Avert, 2018). This indicates that to a larger extent the MDG-6 was partially achieved. Later in the year 2015, the WHO launched new treatment guidelines which recommended that all people living with HIV and even the newly diagnosed should receive antiretroviral treatment irrespective of their CD4 count (Avert, 2018).

According to the Southern Africa HIV and AIDS Regional Exchange (SHARE) (2016) report, 18.2 million people were on ART, having 910,000 grandchildren which doubled 2010 statistics. However, achieving increased access to ART harmed the lives of people on ART as it could lead to a higher risk of drug resistance (SHARE, 2016). In 2017 an estimated 19.5 million people living with HIV were receiving ART and new infections had decreased by a third in East and Southern Africa (Avert, 2018).

2.4 HISTORICAL DEVELOPMENT OF HIV AND AIDS IN SUB-SAHARAN AFRICA

HIV and AIDS in sub-Saharan Africa is a major global public health issue in the present day and perhaps in the history of mankind (MEDWISER, 2013). According to Avert (2018), and Thomas (2019) it is believed that the first epidemic occurred in Kinshasa, the DRC capital, in the 1970s. HIV quickly reached an epidemic level in Eastern Africa in the early 1980s. This was as a result of extensive labour migration, low status of women, lack of circumcision, high ratio of men in urban areas and the ubiquitousness of sexually transmitted infections (Thomas, 2019). The epidemic continued to progress during the 1980s spreading to the Southern African countries with devastating results in the entire population (Thomas, 2019). These results led to a shift in the focus of the global HIV epidemic from East Africa to the Southern African

countries. This indicates that HIV became known in the Southern African countries including the Kingdom of Eswatini during the same decade.

Worldwide trends in HIV infection show a general increase in HIV prevalence and a considerable decrease in AIDS-related deaths, mainly as a result of the health benefits of antiretroviral treatment (Karim and Kharsany, 2016). Karim and Kharsany (2016), MEDWISER (2013), History.com Editors (2019) further assert that sub-Saharan Africa is mostly affected by HIV accounting for more than 70% of the infection worldwide. The unprecedented levels of HIV infections were reached in the Southern African countries in the 1990s. This happened at a time when these countries had no probable solutions of dealing with the epidemic. According to Cichocki (2018) in South Africa, politics and a long history of government denial, the HIV and AIDS epidemic reached calamitous levels by the late 1990s and early 2000s.

Thomas (2019) contends that despite the increase of HIV and AIDS in Southern Africa in the late 1990s, glimmers of hope for the future to deal with the epidemic began to emerge. In Eastern African countries that were seriously hit by the epidemic in the 1980s began to experience a rapid decline in new infections. In Uganda, the prevalence rate dropped from 30% to 12% by 1998. In sub-Saharan Africa in 1993, 9 million people were estimated to be infected with HIV out of 14 million globally. Although prevalence is stable in most sub-Saharan countries, it is still escalating in the Kingdom of Eswatini.

2.5 HISTORICAL DEVELOPMENT OF HIV AND AIDS IN THE KINGDOM OF Eswatini

The Kingdom of Eswatini is a sovereign state in Southern Africa with an estimated population of about 1.4 million (World Population Review, 2019). By 2017, 27.4% of adults in Eswatini were living with HIV, while 7,000 adults were newly infected with HIV and 3,500 people died of an AIDS-related illness (UNAIDS, 2018). This made Eswatini the country with the second-highest prevalence rate, after South Africa, as a home to the largest population of people living with HIV in the whole world (Avert, 2018; Simelela & Venter, 2014). According to AVERT (2020) and Mabuza and Dlamini (2017) the first HIV and AIDS case was reported in 1986 but has now reached epidemic levels partly due to the country's cultural beliefs which do not support safe sex practices such as condom use and monogamous relationships. Swati culture encourages men to practice polygamy. Besides, sexual aggression is common with approximately 18% of sexually active high school students declaring that their first sexual encounter was through coercion (AVERT, 2020).

According to Crush et al. (2010) and Revolv.com (2019), in the 1990s the spread of HIV throughout The Kingdom of Eswatini corresponded with the increase of internal mobility and cross-border migration to South Africa. Crush et al. (2010) further postulates that mobility led to a major increase in vulnerability to HIV especially the Swati miners. These miners were subject to anonymity and loneliness which led them to engage in unprotected casual and commercial sex which put them at considerable risk of contracting sexually transmitted infections including HIV and AIDS (Crush et al., 2010). In addition, the proximity of Eswatini to South Africa made it easier for about 50% of the Emaswati miners to return home at least once a month as most of them are either married or cohabiting. The high-risk behaviour of the migrant partners increases the risk of them contracting the virus and infecting their rural women when they return home (Crush et al., 2010). Most of the discordant couples engage in unprotected sexual intercourse hence spreading the transmission of HIV.

In the early 1990s, the epidemic harmed the Eswatini nation which included the loss of many lives (NERCHA, 2017). NERCHA (2017) also pointed out that in the early 1990s there was still a lack of treatment for HIV. Crush et al. (2010) also argues that during the same period most of Swati miners were retrenched from the gold mining industry and others with full-blown AIDS, who could no longer work, returned home to die. As a result of the retrenchments and deaths, the female spouses of the former male mine migrants joined the workforce and engaged in cross-border trading to supplement the now insufficient household income. The conditions in which these females lived and worked in the cities and farms increased their vulnerability to HIV (Crush et al., 2010). This indicates that eventually, both parents would die leaving behind orphaned grandchildren.

According to the National Emergency Response Council on HIV/AIDS (NERCHA) (2017), in 1987 the Ministry of Health under Swaziland National AIDS Programme (SNAP) anchored the first HIV and AIDS response by classifying the situation as an emergency. This was mainly due to the high number of deaths per year which was approximately 7,000 people whilst several Emaswati were being infected. In 1999 King Mswati III of Eswatini declared the HIV epidemic as a national disaster (USAIDS, 2012). The Government of Eswatini then launched a Cabinet Committee on HIV and AIDS and a Crisis Management and Technical Committee (CMTC) and this showed the country's political commitment and strengthened collaboration.

According to UNAIDS (2014) and Revolv.com (2019) in 2003, the National Emergency Response Committee on HIV and AIDS (NERCHA) was established through the Act of the Parliament as a result of the global recognition of the multi-sectoral nature of HIV and AIDS.

NERCHA was mandated by the Eswatini government to coordinate and facilitate the national multi-sectoral response to HIV and AIDS by coordinating the biomedical and non-biomedical sectors of the HIV response (Mabuza & Dlamini, 2017). According to the Swaziland HIV Incidence Measurement Survey (SHIMS) report (2012), the national efforts included HIV testing and counselling, social and behaviour change communications, HIV care and ART services, and prevention of mother-to-child transmission (PMTCT).

UNAIDS (2014) posits that as part of the national response, NERCHA identified six key areas of the 2006 to 2008 strategic plan to use. These included prevention, care and support, impact mitigation, communications, management, and monitoring and evaluation. NERCHA further led to the development of a new extended National Strategic Framework (NSF) covering the period of 2014 to 2018 (UNAIDS, 2014). ETFs focused mainly on high impact interventions targeting populations and geographic areas where most of the infections come from and also continued the reduction of HIV costs. On the other hand, the Ministry of Health and Social Welfare (MOHSW) was directed to implement these activities (UNAIDS, 2014).

According to the U.S. Embassy Eswatini (2017), in 2009 the Government of Eswatini, the United States government and its partners signed a partnership through the President's Emergency Plan for AIDS Relief (PEPFAR). The PEPFAR Partnership Framework aimed to help Eswatini, among other countries, to implement the NSF on HIV and AIDS (Revolvy.com, 2019). In Eswatini, PEPFAR leveraged the national response by strengthening capacity and quality through collaborative activities with the government and the country's community-based, faith-based and non-governmental organisations (U.S. Embassy Eswatini, 2017). PEPFAR has achieved this through providing resources, technical assistance and capacity building to ensure that interventions complement and develop on existing programmes, providing high-quality HIV and AIDS-related services, coordinating and collaborating with other donors and other developmental programmes (U.S. Embassy Eswatini, 2017). This indicates that the Eswatini government is making an effort to reduce the impacts of HIV and AIDS.

According to the SHIMS report (2012), a number of clinical trials carried out randomly by the WHO and UNAIDS in 2007 revealed that there was a 60% reduction in HIV heterosexual acquisition in circumcised men compared to those who are uncircumcised. Also, data obtained from the Central Statistics Office (CSO) (2008), showed that only 8% of Emaswati men were circumcised. These results led to the launching of a male circumcision campaign known as *Soka Uncobe* in 2011 by the Ministry of Health (MOH). The key aim of the campaign was to

scale-up the uptake of voluntary medical male circumcision (VMMC) to 80% coverage among HIV-uninfected men aged between 15 and 49.

In the year 2014, The Joint United Nations Programme on HIV and AIDS (UNAIDS, 2014) launched the 90-90-90 goals for testing and treatment targets. The 90-90-90 strategy required the country to make an effort towards meeting the three goals by 2020. These goals include: 90% of people living with HIV will be aware of their HIV-positive status, 90% of those who have been diagnosed with HIV will continuously and consistently receive antiretroviral therapy (ART), and 90% of all people who are receiving ART will have viral suppression (Mabuza & Dlamini, 2017; UNAIDS, 2018). To meet these targets PEPFAR identified three priority demographics in Eswatini which were adolescent girls and young women (aged 9 to 29), men aged 15 to 39, and orphaned and vulnerable grandchildren. To add to these three, PEPFAR further identified three key demographics which were men who have sexual relations with other men (MSM), female sex workers (FSW) and transgender people (Mabuza & Dlamini, 2017).

The Ministry of Health (2016), the U.S. Embassy Eswatini (2017) and Goliber (2002) assert that the country has the largest HIV prevalence globally at 27% of the population aged between 15 and 49 years. The U.S. Embassy Eswatini (2017) further asserts that 32.5% prevalence is among females and 20.4% among males. The HIV epidemic made its impact on the socio-economic status of the country, resulting in reversing life expectancy in the last two decades and high mortality rates mainly in the economically productive age groups (Goliber, 2002; Mabuza & Dlamini, 2017; NERCHA, 2017). NERCHA (2017) further posits that in 2010 HIV and AIDS resulted in a decline in life expectancy from 60 years in 1997 to 47.9 years for females and 48.8 years for males. These figures later increased in 2015 to 48.1 years for females and 49.6 years for males (NERCHA, 2017). These results indicate that the country is unwavering in implementing strategies intended to decrease the impacts of the HIV epidemic through multiple sectors.

The prominent increase in life expectancy of the Emaswati population is attributed to the country's substantial progress toward achieving all three of the 90-90-90 targets set by UNAIDS to help curb the HIV pandemic in 2016 (U.S. Embassy Eswatini, 2017). According to the U.S. Embassy Eswatini (2017), 84.7% of people living with HIV (PLHIV) aged 15 and above knew their HIV status, 87.4% of these were already on ART and 91.9% of those on ART treatment had viral load suppression (VLS). Achieving the 90-90-90 goals in Eswatini was a conspicuous indication that the national HIV response was successful in reducing the

impacts of HIV pandemic. Even though the country has made progress, when comparing the life expectancy of Eswatini people and those in other countries in Southern Africa, Eswatini is ranked last.

According to Medwiser (2013), approximately 2% of the Eswatini total population die yearly as a result of HIV and AIDS. These impacts have forced the country to invest more of its natural resources to fund intervention strategies aimed at curbing the epidemic (NERCHA, 2017). However, this has crippled the country's economy leaving other sectors such as education and farming adversely affected.

According to the SHIMS 2 report (2017), a household-based national survey was conducted from 2016 to 2017 as a follow up after achieving the 90-90-90 goals. The purpose of the survey was to measure the impact of Eswatini's national HIV response on HIV incidence and viral load suppression. The SHIMS 2 report (2017) further postulates that to sustain and improve the 90-90-90 progress, continued expansion in HIV prevention and treatment programmes would be required. Also, closing the gap in knowledge of HIV status and uptake of medical male circumcision, among other proven interventions, would be essential in continuing the advances in the national response (SHIMS 2 report, 2017). Even to date, the same strategies are still being implemented by the Eswatini government to reduce the incidence of HIV. The intervention strategies used in the country target strategies aimed at reducing the incidence of HIV but does not address the impacts of HIV and AIDS in the society especially the grandparents caring for grandchildren orphaned by AIDS.

2.6 STATISTICS OF AIDS-RELATED DEATHS GLOBALLY AND THE STATISTICS OF GRANDCHILDREN ORPHANED BY AIDS

2.6.1 STATISTICS OF AIDS-RELATED DEATHS GLOBALLY

HIV continues to be a global public health concern. According to UNAIDS (2018), the number of people who died of AIDS-related deaths in 2017 was 940,000 and this number shows a vast reduction by more than 51% (1.9 million) since the peak in 2004 and 1.4 million in 2010. Of the 940,000 deaths, the number of adults who died due to AIDS-related illnesses was estimated to be 830,000 people. This drastic change is attributed to the scale-up of antiretroviral treatment in most countries. UNAIDS (2018) further asserts that progress towards 90-90-90 targets for prevention and treatment seem to be stalling, and, at current rates, most countries will not achieve the targets by 2020. This is supported by data reported by UNAIDS (2018) which indicated that in 2017, worldwide, 75% of people living with HIV

knew their status of which 79% (59% of all people living with HIV) had access to antiretroviral therapy and 81% (47% of all people living with HIV) had the viral load suppressed.

In general, there is a decline in the number of AIDS-related deaths in many countries and this is mainly due to the scale-up of antiretroviral therapy (UNAIDS, 2018). Data collected in 2017 indicates that the number of global deaths from AIDS-related illnesses among people living with HIV has reduced from a peak of 1.9 million in 2004 to 940,000 in 2017 and has declined by 34% since 2010. These figures still have not reached the 2020 target which aims to reduce global deaths to nearly 150,000 per year (UNAIDS, 2018).

Avert (2018) asserts that since 2010 the number of AIDS-related deaths has declined by 34%. The reduction in AIDS-related mortality is largely driven by progress in sub-Saharan Africa, particularly Eastern and Southern Africa which has 53% of the world's people living with HIV. In Eastern and Southern Africa alone AIDS-related mortality reduced by 42% (380,000 deaths) from 2010 to 2017 and this is largely due to the rapid scale-up of antiretroviral therapy in the region (Avert, 2018).

However, during the same period, a 24% decline (280,000 deaths) was observed in Western and Central Africa, a 39% decline (170,000 deaths) in Asia and the Pacific, a 23% reduction (10,000 deaths) in the Caribbean, a 36% decline in Western and Central Europe and North America, and a 12% decline (37,000 deaths) in Latin America (Avert, 2018). In Eastern Europe and Central Asia, there has been no reduction in AIDS-related deaths, it remained at 34,000 deaths and in the Middle East and North Africa deaths increased by 11% (9,800 deaths).

Globally the HIV burden is higher on men than on women. This is partly due to the social behaviour of men, such as injecting drugs and homosexual carnal relations (Avert, 2018). Despite women being the most vulnerable population to HIV, there is higher mortality in HIV infected men than women (Avert, 2018). Statistically, data collected in 2017 revealed that an estimated 300,000 men in sub-Saharan Africa died of AIDS-related illnesses as compared to an estimated 270,000 women even though the percentage of women (56%) living with HIV is higher (Avert, 2018). This is largely due to the higher treatment coverage among women than men.

This could increase the burden on families since men are usually the sole breadwinners. It is worth noting that the high number of deaths due to AIDS-related illnesses increases the number of grandchildren orphaned by AIDS. However, it may safely be concluded that the scale-up of treatment has greatly reduced the mortality as a result of AIDS-related illnesses in

people living with HIV but there still remains the fact that the 2020 target is not achieved in many countries. This calls for a need to consider scaling-up other intervention methods such as VCT and VMMC.

2.6.2 STATISTICS OF GRANDCHILDREN ORPHANED BY AIDS IN ESWATINI

The impacts of the HIV and AIDS pandemic have devastated many families and communities in Eswatini. HIV and AIDS left a trail of orphans, most of whom are taken care of by their grandparents. Globally, it is estimated that 17.8 million grandchildren under the age of 18 have been orphaned by HIV and AIDS (Nkomo et al., 2018; UNICEF, 2015; Lia et al., 2015), and it is estimated that 15.1 million (85%) of the grandchildren orphaned by AIDS live in sub-Saharan Africa. Lia et al. (2015) and UNICEF (2015) further postulate that millions of children are yet to face the potential threat of being orphaned due to AIDS. This is not surprising as preceding studies have shown that there is lower antiretroviral treatment coverage in men resulting in large numbers of them dying as a result of AIDS-related illnesses thus rendering their children as orphans.

An orphan is defined as a child who has lost one or both parents (Cluver et al., 2012). According to the African Charter on the Rights and Welfare of the Child (United Nations, 1990), Article 2, every human being aged below 18 years is a child. Article 14 of the same document states that:

Every child shall enjoy the best attainable state of physical, mental and spiritual health. This includes the provision of nutritious food and safe drinking water, as well as adequate health care.

The percentages of grandchildren orphaned by AIDS vary from country to country and largely depend on the prevalence of the disease in that country (Nkomo et al., 2018). In the Kingdom of Eswatini, there is a high HIV adult prevalence of 27.4% between persons aged 15 and 49 years which is mainly the most productive working age group and about 3,500 AIDS-related deaths per year (Avert, 2018). However, in Zimbabwe, there were 74% orphans at a prevalence of 13.3% (Zimbabwe National and Sub-National HIV Estimates Report, 2017) and in South Africa there were 63% orphaned grandchildren at a prevalence of 18.8% (Nkomo et al., 2018; UNICEF, 2015; Avert, 2018). Nkomo et al. (2018) further postulates that the number of orphans is also dependent on the period from when the parents are infected and when they lose their lives. This implies that as adults continue to lose their lives from AIDS-related illnesses over the next decade, the number of orphans is also expected to increase.

In the Kingdom of Eswatini, some of the grandchildren live with HIV; some are on antiretroviral therapy and others are orphans as a result of AIDS-related illnesses. Avert (2018) postulated that in Eswatini an estimated 13,000 grandchildren aged between 0 and 14 years were living with HIV in 2017. Avert (2018) further postulates that 75% (9,750) of the grandchildren living with HIV were on antiretroviral treatment. Besides, an estimated 44,000 (37%) grandchildren aged between 0 and 17 years were orphaned because they have lost both parents as a result of AIDS (Avert, 2018).

Currently, 38% of the Eswatini population is aged below 15 years and only an estimate of 5% is aged ≥ 60 years (Avert, 2018). According to law, grandchildren below the age of 18 are supposed to be catered for by their parents for the basic needs, however, the grandchildren should be protected from any form of abuse. As a result of the HIV and AIDS pandemic, a large number of Emaswati grandchildren are orphaned, thus, leaving them with no one to take care of their needs properly. In an ideal family setting, it is the parents who would cater to the needs of their children and the grandparents but now that the parents have died as a result of AIDS-related illnesses it means that the grandchildren would require an alternative caregiver.

The extended family setup of care-giving has positioned sub-Saharan African grandparents to protect and provide for the millions of grandchildren orphaned by HIV/AIDS by ensuring family-based care in the face of large-scale loss of young parents (Littrell et al., 2012). This, therefore, means that the responsibility for the care of grandchildren orphaned by AIDS has shifted to the older generation such as grandparents. This aggravates the condition of already poverty stricken families as a result of the loss of the productive member of the family. According to Lia et al. (2015) orphans experience an increased risk of poverty, homelessness, curtailed education, discrimination and loss of life-changing opportunities. Nkomo et al. (2018) further assert that these grandchildren orphaned by AIDS face a future filled with uncertainty and many more grandchildren are vulnerable to being in the same position. The challenges faced by the orphans have a domino-effect as they also affect the grandparents of these grandchildren.

2.7 CHALLENGES FACED BY GRANDPARENTS IN RAISING GRANDCHILDREN ORPHANED AS A RESULT OF AIDS-RELATED DEATHS

The impact of HIV and AIDS has placed an insurmountable burden on the extended family systems, hence, disrupting family patterns. As parents die due to AIDS-related illnesses, a majority of orphans (90%) are cared for by their extended family, especially grandparents (Kidman & Thurman, 2014; Monasch & Boerma, 2004). According to a study conducted by

UNICEF (2018), grandparents in sub-Saharan Africa were the most hard-hit group in the population, as they were left to be the primary caregivers at their advanced age, to their grandchildren who had lost both parents to AIDS. Grandparents, in many sub-Saharan African countries, are defined as those aged ≥ 60 and are characterised by the prevalence of poverty, little or no education, health problems, unstable families, mental-related illnesses and absence of social support (Huber et al., 2015). In the following paragraphs, I elaborate on the challenges.

2.7.1 GRANDPARENTS BEING PARENTS AGAIN

The escalating numbers of HIV/AIDS orphans place a burden on grandparents who would traditionally be cared for at this time in their life, rather than take responsibility for the care of others. In many sub-Saharan African settings, grandparents have traditionally been the first-choice foster parents (Littrell et al., 2012). In the context of the burden of loss of income, grandparenting, for these elderly caregivers, may be incapacitated, to provide fully for orphaned grandchildren's basic needs, and that caretaker's responsibilities can thus be detrimental to the grandparents' health and well-being (Nyambedha et al., 2007; Ssengonzi, 2007; WHO, 2002). According to the Guardian (2010) grandparents in Eswatini have assumed the role of parents to their grandchildren in spite of the frail state and physical challenges they face as a result of age and not having an income.

According to a study conducted by Kidman and Thurman (2014), caring for these grandchildren is not one-dimensional; it involves a lot of facets which include paying attention to their medical, financial and emotional needs. This concurs with a survey by REPSSI (2011) which revealed that grandparents caring for grandchildren orphaned by AIDS faced constraints such as:

- Lack of regular and consistent income to help them with the costs of care,
- Being neglected by social support programmes,
- Inadequate time to engage in income-generating activities,
- Poor and limited housing leading to poor hygiene,
- Difficulties in meeting the educational expenses and needs of their grandchildren,
- Lack of information and difficulty in accessing their rights and entitlements,
- The intergenerational gap which makes it a challenge in parenting and imparting life skills to the grandchildren,
- Difficulty in meeting the emotional and psychosocial needs of their grandchildren because of their own experiences of loss and grief,

- Difficulty in accessing health services,
- Inadequate knowledge about HIV and AIDS,
- Challenge of coping with questions of sexuality and reproductive health of the growing grandchildren,
- Danger of exposure to neglect and violence, and
- Social exclusion and discrimination.

A study conducted by Parker and Short (2009) also showed that the grandparents encounter the financial difficulty of paying for treatment of their ill children, funerals and also the loss of income support once their children succumb to the disease. However, the financial and emotional stress culminating from the loss of a child, as if that is not enough, is further exacerbated by the emotional impact their grandchildren face from losing their parents.

In this study, I discuss the challenges the grandparents face caring for grandchildren orphaned by AIDS. I will also get them to share their lived experiences. Neglecting the needs of the grandparents adversely affects their abilities as caregivers, and they contemplate, and are uneasy about, the future of their grandchildren should they themselves pass on as well (Guardian, 2010). The Guardian (2010) further asserts that national responses in Eswatini mainly target the grandchildren and little is done to meet the needs of the grandparents. This is especially true regarding grief counselling, safe and adequate housing, economic security, and support in raising grief-stricken grandchildren, breaking stigmatisation, and safety from gender-based violence.

In this study, I had discussions focusing on how best to mitigate the challenges such as parenting and difficulties they encounter as caregivers daily. Previous studies explored the challenges faced by grandparents as caregivers of their grandchildren orphaned by AIDS and also on intervention strategies to help meet the needs of the grandparents without making them active participants in the research. The strength of my research lies in the fact that it focuses on including the grandparents in this study.

2.7.2 SOCIO-ECONOMIC FACTORS

According to Mohale (2013), HIV and AIDS have shown the ability to distort the social and economic structure of society due to its potential to affect adults at their prime working age. This poses a burden to the grandparents of the grandchildren orphaned by AIDS as they have to provide financial support for their ill children when they lose income, as well as the orphaned grandchildren when their parents succumb to the disease. Kidman and Thurman (2014)

concur with the findings by Mohale (2014) in that grandparents caring for grandchildren who have lost parents as a result of AIDS-related illnesses also experience economic impacts, including heightened poverty and greater food insecurity.

Similar studies carried out by Lia et al. (2015) and Sithole (2009) on psychological resilience among children affected by parental HIV and AIDS revealed that HIV and AIDS brought severe and long-term financial strains. These strains include loss of income, increased health care expenses and disruption of savings. Lia et al. (2015) further posits that these may indirectly affect children's living conditions and quality care, especially for the grandchildren and this could aggravate physical and emotional stress on the grandparents, as they have to scrape the bottom of the barrel in order to meet the grandchildren's needs. Many grandchildren are subject to food insecurity, lack of necessary medical care, child-headed households, child labour, school drop-outs, sexual exploitation and inadequate care were often reported in sub-Saharan Africa (Cluver et al., 2012). Grandchildren orphaned by AIDS in Eswatini are also hard hit by these factors which increase stress on the grandparents caring for them. This leads to the grandparents selling their acquisitions to provide financial support to their grandchildren.

It is also worth noting that these grandchildren have special needs that increase the burden on the grandparents (Cluver & Gardener, 2007; Cluver & Orkin, 2009; Govender et al., 2011; Kidman & Thurman, 2014). These special needs include a high probability of them being HIV positive, experiencing grief, experiencing AIDS-related stigma, having emotional stress and behavioural problems. However, the grandparents have no formal training on how to handle these additional challenges in taking care of their grandchildren orphaned by AIDS and they receive limited external support (Kidman & Thurman, 2014; Van Durme et al., 2012). In this study the grandparents and I will discuss ways to best handle or overcome these social, psychosocial and economic factors.

A study conducted by Safman (2004) in Thailand concurs with the above findings as it showed that grandparents caring for AIDS-orphaned grandchildren encountered economic burdens. These burdens exacerbate the issue of poverty if their grandchildren do not receive a formal education, coupled with emotional stress because there is a scarcity of solutions.

According to Mohale (2013), stigmatisation is another factor that may exacerbate the challenges faced by grandparents caring for their grandchildren orphaned by AIDS. Mohale (2013) believes that some grandparents cope with the effects of stigma by not disclosing the cause of death of their children and keep it discreet. This is likely to disadvantage them from getting financial support. Lesar et al. (1995) posit that stigmatisation and secrecy are not the

only factors; grandparents may also encounter problems of their orphaned grandchildren being HIV infected, resulting in special health and mental needs which further compounds the situation.

The socio-economic factors faced by grandparents caring for grandchildren orphaned by AIDS place them in a potentially vulnerable situation because HIV and AIDS rob them of their main source of economic support. Mohale (2013) adds that grandparents who had anticipated getting financial assistance from their children find themselves now struggling to provide care and support for their grandchildren orphaned by AIDS. This compels the grandparents to practice small-scale farming and trading to sell their produce for income as well as selling fruits and vegetables at market places.

The socio-economic factors as discussed are based on research carried out on the grandparents caring for grandchildren orphaned by AIDS. This study will differ from the preceding studies in that I will not only conduct research on the grandparents, but they will also have a resounding voice in the study. The contributions made by the grandparents will be used to design an intergenerational relationship education model to address the socio-economic needs of grandparents caring for grandchildren orphaned by AIDS.

2.7.3 LACK OF SOCIAL SUPPORT

In an African context, social support refers to support groups, respite care, access to services such as health care, education and spirituality, that grandparents caring for grandchildren orphaned by AIDS could access. According to Hayslip and Shore (2000), grandparents, especially grandmothers, caring for grandchildren who sought out formal aid from professionals showed lower psychosocial adjustment problems compared to those who did not. As social support, extended families help grandparents by providing instrumental forms of care such as emotional support, behavioural management of grandchildren and the entire role satisfaction (Mohale, 2013). Mohale (2013) further alluded that formal social support programmes include pensions, unemployment benefits, housing benefits, self-help groups, home-based care groups, and social security benefits.

However, grandparents do not only need formal social support, but informal social support is necessary too. A study carried out by Philips et al. (2008) in Hong Kong revealed that informal social support such, as the size of social effects, residential place of the grandparent (urban or rural), and type of housing (public or private) were found to be more important predictors of psychological well-being. The results showed that grandparents who are contacted more by

other extended family members, living in rural or old urban areas and dwelling in public houses, received more social support. Low social support to the grandparents caring for their grandchildren orphaned by AIDS can affect their psychological well-being as well as their health (Mohale, 2013; Philips et al., 2008). However, this study seeks to find out from the grandparents caring for their grandchildren orphaned by AIDS the kind of social support they need during parenting. The recommendations from the grandparents will be used to design an intergenerational relationship education model to address the psychological needs of grandparents caring for grandchildren orphaned by AIDS.

2.7.4 DISCIPLINARY PROBLEMS

A study conducted by Mohale (2013) showed that grandparents especially grandmothers faced disciplinary problems with their grandchildren. As a result of the intergenerational gap between grandparents and grandchildren, conflicts were common (Nyasani et al., 2009). The study by Nyasani et al. (2009) also revealed that the common disciplinary problems for the grandchildren included peer pressure, lack of interest in school, the wastefulness of the available meagre financial resources, early initiation into sexual activity, poor academic performance, reluctance to receive any psychological intervention, and teenage pregnancy. The main worry of most grandparents, including those in Eswatini, is that the grandchildren do not understand their situation and its causes, which exasperates them making the vicious cycle of poverty perennial and new HIV infections prevalent (Nyasani et al., 2009; Schatz & Gilbert, 2012).

On another note, the grandparents have raised their children using corporal punishment as a way of instilling discipline and this is no longer the status quo as they are now expected to use positive discipline to instil discipline in their grandchildren. The African Charter on the Rights and Welfare of the Child (United Nations, 1990) is strongly against the use of corporal punishment. It states clearly in its document, article 16 that: "Children should be protected from torture, inhuman, or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse."

In the same vein, the Kingdom of Eswatini enacted a Sexual Offences and Domestic Violence Act in 2018 which aimed to protect people from domestic violence or sexual assault (Eswatini Government Gazette Extraordinary, 2018). This advocates for the use of positive discipline by all stakeholders, especially those taking care of children. This imposes a challenge on the grandparents as they lack information and essential experience on what positive discipline is and how best they can administer it as they raise their grandchildren.

In addition, the grandparents find it difficult and inappropriate to discuss issues of sexual and reproductive health issues such as sex and sexuality which leads their grandchildren soliciting conflicting information about sex and sexuality (Mohale, 2013). This further results in grandchildren making unwise and impulsive decisions and choices about sex and access to support services. However, most of the grandparents in Eswatini are not educated and this makes them place their focus more on providing for their grandchildren, rather than investing in quality education for their grandchildren which will ensure that their future is secured. This study explored various strategies which facilitated the grandparents with an opportunity to come up with viable methods in dealing with disciplinary problems and how they might be encouraged to promote the education of their grandchildren.

2.8 CURRENT STRATEGIES USED BY ESWATINI GOVERNMENT TO MEET THE NEEDS OF GRANDPARENTS RAISING GRANDCHILDREN ORPHANED AS A RESULT OF AIDS-RELATED ILLNESSES

The challenges faced by grandparents who are caregivers to their grandchildren orphaned by AIDS necessitated the government of the Kingdom of Eswatini and some non-governmental organisations (NGOs) to come up with intervention strategies. Firstly, in 2005 the government of the Kingdom of Eswatini introduced the old age grants (OAG) to the elderly known as *imbasha yabogogo*, which is currently at E200 per month to meet some of their minor financial needs (Annex Deputy Prime Minister's Office, 2016). This grant is not specifically for grandparents caring for orphans who lost their parents due to AIDS, but also for other elderly people. However, the money that they receive from the government does not suffice for both their basic needs and those of their grandchildren. The government also pays school fees for orphaned and vulnerable grandchildren (OVC) and grants free access to medical check-ups and treatment. With such aids in place there is still a challenge for the grandparents who live in remote areas to access services like medical check-ups and treatment.

Secondly, an NGO called Philani Maswati was launched in 2000 with the main aim of providing food commodities, blankets for the elderly people, and school uniforms for OVC (FANRPAN, 2011). Apart from Philani Maswati, there are other local NGOs, for example, Young Heroes which was established in 2006. The organisation's mandate is to provide financial support for the provision of necessities for orphans in Eswatini in addition to providing HIV testing and care programmes. The provisions made by these organisations are not as comprehensive, as only a few grandparents and grandchildren benefit leaving many without assistance. However,

it is important to note that the benefits are not solely to help those affected by the AIDS scourge.

The Eswatini nation has one of the highest incidences of HIV and AIDS globally, as illustrated by the staggering number of 70,000 orphans and 15,000 households led by grandchildren as reported by Aid for Africa (Bailey, 2017). These NGOs mostly rely on donations from organisations like the President's Emergency Plan for AIDS (PEPFAR), UNAIDS, and World Food Programme (WFP) to mention a few. Despite the mentioned strategies, there are no policies and programmes in place that have been instituted by the government, NGOs and communities that offer psychosocial support to grandparents caring for their AIDS-orphaned grandchildren (ULARN, 2003). ULARN (2003) further allude to the fact that the support tends to be sporadic and inadequate.

In South Africa, Zimbabwe, Uganda, Kenya and Mozambique there are policy guidelines used which were suggested by the Regional Psychosocial Support Initiative (REPSSI, 2011). These guidelines help to determine how practitioners could best integrate psychosocial support for the grandparents caring for their grandchildren orphaned by AIDS into their programmes. REPSSI (2011) suggests the use of a participatory approach as one of the policies for intervention where the grandparents caring for their grandchildren orphaned by AIDS are involved in identifying their needs, planning, facilitating and evaluating interventions.

Research done in Eswatini by Sithole (2009), showed a lack of the use of the participatory approach in identifying the needs of grandparents caring for their grandchildren orphaned by AIDS. My study will be ground-breaking as it will delve in depth into the nitty-gritties, and clearly reinforce the strategies to the grandparents that we are working hand-in-hand towards a common goal, in what Wenger, McDermott and Synder (2002) termed "community of practice." Wenger et al. (2002) described the community of practice as: "A group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an on-going basis."

This will help to create insights on challenges faced by grandparents taking care of the grandchildren orphaned by AIDS, as they will be engaged in honest talk. In this study, I will use the participatory approach involving the grandparents caring for grandchildren orphaned by AIDS and I will collaboratively develop strategies to inform programmes that will support the grandparents in meeting their needs. The above social scenario necessitated by the HIV and AIDS scourge introduces remarkable shifts in traditional family networks and care of children as an intergenerational relationship or childcare system emerges. Richter and Sherr

(2009) note that there is another emerging paradigm shift in childcare due to attrition levels of the active population. There emerges a reliance on grandparents as caregivers and child foster-parents. Foster et al. (2000), in their overview, reiterate that contemporary Southern African research findings reveal a paradigm shift from uncles and aunts caring for children who are victims of the pandemic to grandparents despite their frailty. Safman's (2004) study in Thailand further corroborates the trends. That implies that the issue of childcare as a result of the pandemic is a global phenomenon and an intergenerational model of care emerges as an alternative family unit in mitigating the effects of the pandemic on the family care system.

2.9 SUMMARY

This chapter has presented, described and discussed the characteristics of HIV and AIDS and its spread and prevalence globally, in sub-Saharan Africa at large, and in the Kingdom of Eswatini. It has also revealed that grandparents taking care of grandchildren orphaned by AIDS faced challenges as they assumed the parenting roles. The chapter also showed that previous studies were carried out in Eswatini on grandparents but the challenges and solutions were not explored with them. Furthermore, the chapter revealed that the government of Eswatini has still to institute policies and programmes, NGOs, and communities that offer psychosocial support to grandparents caring for their grandchildren orphaned by AIDS. In South Africa, Zimbabwe, Uganda, Kenya and Mozambique policy guidelines are in place and in use and these were suggested by the Regional Psychosocial Support Initiative (REPSSI, 2011). This shows that there is a need for the Eswatini government to have policy guidelines for psychosocial support to assist grandparents caring for their grandchildren orphaned by AIDS. The chapter also illustrated how the Kingdom of Eswatini is mitigating the socio-psychological and economic challenges of grandparenting. The next chapter will focus on a critical discussion of theories underpinning the study.

CHAPTER THREE

A CRITICAL DISCUSSION OF THEORIES UNDERPINNING MY STUDY

3.1 INTRODUCTION

The purpose of this chapter is to discuss the frameworks through which I approached my study, giving an account of some important contributors to theory. The study aims at finding a strategy through which grandparents can be supported so as to cope with an intergenerational relationship with grandchildren who have been orphaned by AIDS. Their advanced age may make the task burdensome as observed by McLeod (2018). I, therefore, identified three theories namely: intergenerational relationship, activity theory (AT), and continuity theory (CT) as key frameworks that underpin my study.

In my discussion of the intergenerational relationship theory, I will begin with an overview of intergenerational relationships and programmes. Furthermore, I will delve in the Whole Person Wellness Model. In my discussion of the activity theory, I will begin with an overview of the activity theory, which outlines the significance, and overall effect of participating in activities at an elderly age (Winstead et al., 2014). Lastly, I will discuss the continuity theory, which proposes that older adults maintain the same activities, relationships of the past, behavioural and personality traits.

3.2 INTERGENERATIONAL RELATIONSHIP THEORY

According to Wofford (1998), intergenerational relationship theory encourages young and old participants to serve side-by-side to address unmet needs in their communities. Because people are raised in different times, their values and perceptions of the world can be quite different. This can lead to conflicts in understanding one another, as there is a generational gap. This gap in understanding one another, calls for an establishment of links between younger and older generations. My framework for understanding intergenerational relations is based on the construct of generation and is set within a life-course perspective that recognises the dynamic nature of generations across time. Generation in this study refers to, "A historical explanation; a way to catalogue time; a source of community; a way to identify injustice; and an axis of conflict and impending crisis" (White, 2013, p. 217). I am clarifying the use of the term because it is a foundation for understanding intergenerational relations. Based on these definitions - I then interpret intergenerational relationships to be social and family relationships between members of different generations. The "Baby Boomers" generation, which is the focus of this study, grew up within a social setting of welfare where the elderly were considered wise and their instructions were followed to the letter. The "Millennial" generation; "Generation

Z”, who they are care-providing, is growing up in a different societal context that increasingly value social media as medium for instruction. This then brings dissonance in the family. In the face of the AIDS scourge, it then becomes pertinent to consider intergenerational programmes that will remove a dose of dissonance within such families.

Intergenerational programmes are, “Social vehicles that create a purposeful and on-going exchange of resources and learning among older and younger generations” (Kaplan et al., 2003). Intergenerational programmes bring about cohesion between people from different generations to help enhance understanding and appreciation between the accomplices. Furthermore, they allow people of all ages to share their talents and to support each other in relationships that benefit both the young and the old. Through the interaction in intergenerational programmes, each generation gives and receives; there is a symbiotic benefit as the wisdom of the older generation is combined with the energy of the younger generation (Butts & Chana, 2007), hence, the need to develop an intergenerational relationship education model in this study.

Education in intergenerational relationships education context comes out very clearly in the social transfer negotiations that occur. Knowledge and skills, attitudes, values and interests are transferred from the grandparents to their grandchildren in teaching and learning exchanges that exist. I realise that the education content of the exchanges in the context referred to in this study has not been adequately researched and reported upon until now. Thus, so much information that should inform the development of intergeneration programs has been lost to the many years of undervaluing and understudying the education aspects of what has been happening in Africa. This is one reason why I view my study as exceptional and worthy.

Eswatini is an important context in which to examine intergenerational relationships. As a country in Eastern and Southern Africa, with 19.6 million adults and children living with HIV and 380,000 AIDS related deaths per annum (UNAIDS, 2018), it is estimated that families with children orphaned by AIDS are likely to increase, hence the need to develop an intergenerational relationship education model that can be applied to the Eswatini population. Grandparents caring for grandchildren constitute an important social role in later life (Lou et al., 2013; Yoo & Zippay, 2012) and has consequences on grandparents’ health and well-being (Hayslip et al., 2015; Hughes et al., 2007). My study examines three primary questions related to these aspects of intergenerational relationships:

- What are the intergenerational relationships educational needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?
- How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education-based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?
- How can the findings of the empirical study be translated into an education model and guidelines for improving the intergenerational support or care given by grandparents to their grandchildren orphaned by AIDS?

To answer these three questions I collaborated with grandparents at Eswatini and created an intergenerational relationship education model for the elderly grandparents to use in providing support for their grandchildren orphaned by AIDS with a behavioural change theoretical model. Behavioural change theories essentially provide the framework for the approach in the development of health promotion programmes. There are several different theories and models available to the health field, depending on the health concerns, needs, and situation (Fertman & Allensworth, 2010). Elderly grandparents of grandchildren orphaned by AIDS face stress, worry and grief owing to additional responsibilities and fear of the unknown (Smith & Segal, 2018). In addition, grandparents need to provide financial security to their grandchildren orphaned by AIDS, particularly with regard to health care and education in line with emerging trends. Thus, grandparents might find themselves in a quandary as they are expected to provide these grandchildren with essentials, such as food, shelter, clothing, school fees and health/medical care (Baker & Silverstein, 2008; Carr et al., 2012; Lee et al., 2015; Yancura, 2013).

Despite the financial aid schemes that have been provided by the government, NGOs and communities, there is no psychosocial support offered to elderly grandparents caring for their grandchildren orphaned by AIDS (ULARN, 2003). With this as a background, the crucial question arises as to what models of well-being and wellness can I use as a theoretical framework to inform my inquiry and answer my major research question? The aspect of interest that I have identified is based on the Whole Person Wellness Model, which I articulate next.

3.2.1 WHOLE PERSON WELLNESS MODEL

The purpose of developing an intergenerational relationship education model was to facilitate change and to improve grandparents' wellness as well as that of their grandchildren. The expression "wellness" was first introduced by Dr Halbert Dunn in the year 1961. Though this

expression is frequently largely linked to physical health, when used in the Whole Person Wellness Model, it speaks to several aspects besides physical health (Kang & Russ, 2009) to include environmental, social, spiritual and mental dimensions (Dunn, 1991). In the context of my study, when I talk about *wellness* - I am alluding to a position of life form, where grandparents taking care of AIDS-orphaned grandchildren experience most favourable health in all dimensions and this enables them to function well. The founder of Whole Person Wellness theory, Dunn (1961, p. 6) explains that optimal wellness is, "An integrated method of functioning which is orientated toward maximising the potential of which the individual is capable, within the environment which one is functioning." From this definition, I deduce that the environment plays a critical role in wellness. However, in my study, I was not so much engrossed in the physical environment per se, i.e., where grandparents taking care of AIDS-orphaned grandchildren in Eswatini live. Rather, I intended to focus on the external environmental factors, such as political, economic and social influences that are brought in by the burden of caring for grandchildren orphaned by AIDS and how they affect the wellness of the grandparents. These socio-economic factors thwart the potential of grandparents to experience wellness fully.

The model, I adopted and adapted in this study was introduced by Hettler (1979). It is a model with a holistic perspective on wellness that incorporates six wellness facets that include social, emotional, physical, intellectual, spiritual and occupational (see Figure 3.1).



Figure 3.1: ***Whole Person Wellness Model adapted from Hettler (1979)***

Below I explain how these dimensions could contribute to the wellness of the elderly taking care of AIDS-orphaned grandchildren at Eswatini:

- *Social wellness* persuades one to take part in community programmes and relate well with others in the community. Interacting with peers of similar experiences in support groups could enable grandparents taking care of AIDS-orphaned grandchildren take care of themselves better as well as the children they are care-giving.
- *Emotional wellness* centres on establishing good relations that anchor on respect and trustworthiness. I foresaw relations in intergenerational households improving as grandparents taking care of AIDS-orphaned grandchildren get to understand their grandchildren's behaviour better and cement their relationship. *Physical wellness* allows one to appreciate good health, keeps active, and adheres to a good diet. I

envisioned grandparents taking care of AIDS-orphaned grandchildren engaging in physical activities that would improve their health and keep them active.

- *Intellectual wellness* functions to inspire an individual to think more deeply and gain skills and knowledge. The intellectual wellness of the elderly in intergenerational relationships could be enhanced as they share their lived experiences with peers and acquire skills and knowledge on how to handle their AIDS-orphaned grandchildren being raised in a generational environment that is different from theirs.
- *Spiritual wellness* takes into account values, ethical principles and beliefs for a purposeful and meaningful life. After having gained spiritual wellness, grandparents taking care of AIDS-orphans at Eswatini would be guided by these ethical principles to manage intergenerational households they find their selves living in with ease.
- *Occupational wellness* focuses on individual fulfilment one gets in the course of working and getting involved in tasks that lead to self-actualisation. I saw that as grandparents come together and share their experiences, they might understand the importance of complementing work-related issues with relaxation so as to promote a healthy lifestyle.

My intention was to develop a model that would centre on all six wellness dimensions and enable the elderly taking care of AIDS-orphaned grandchildren to lead a healthy lifestyle. Kang and Russ (2009) explain that the most significant way to advance the well-being of older adults is to encourage participation in wellness activities. I realised that the Whole Person Wellness Model if incorporated in designing educational programmes for the elderly taking care of AIDS-orphaned grandchildren would enhance their livelihood in all dimensions. Next, I discuss the activity theory.

3.3 ACTIVITY THEORY

In this section, I begin by offering a critical analysis of the concept *activity* in order to establish how it is defined within the boundaries of this framework. In the works of Kaptelinin and Nardi (2012, p. 24) activity is conceptualised as an association that exists “between the subject (that is, an actor)” in this context the grandparents, and “the object (that is, an entity objectively existing in the world)” that is the grandchildren. Kaptelinin and Nardi (2012, p. 24) further postulate two idiosyncratic features that distinguish a special type of relationship:

- *Subjects having needs, which should be met with interaction with the world in order to survive.* Subjects normally experience needs and, to address these needs require teaming up with objects. In this study, I take this to imply that both grandparents and

their grandchildren have needs. As explained in preceding chapters, the grandchildren taken care of belong to Generation Z, while their grandparents belong to the Baby Boomer generation. The generation gap is deep and presents huge disparities in understanding and expectations concerning life on either party. The question is, how then do grandparents cope at a stage in life where they need to slow down from a physical and psychosocial perspective? I take this is not a repertoire question but a question that would be answered in this study.

- *Activities and subjects jointly determining one another.* In this study, I consider this to mean that quality of care of children orphaned by AIDS is influenced by attributes of grandparents. Whether or not grandparents can shoulder the burden of caring for the AIDS-orphaned grandchildren depends on the nature of the problem and the individual grandparent's abilities and skills. As time lapses, both the subject (grandparents) and object (grandchildren) are changed by the activity. How the grandparents taking care of AIDS-orphaned grandchildren would cope largely depends on previous experiences they have developed through solving such kind of problems. Apparently, a grandparent's skill of care-giving is influenced by experience, hence the need to link this with the continuity theory. While it is true that a person's ability to tackle a problem (taking care of an orphan) is determined by how the person solves the task, it is also true that tackling or solving problems determines the person's abilities.

I now turn to the theory itself. To conceptualise fully the AT, required me to understand its origins. My literature review revealed that this is an old theory (as evidenced by old sources of information that I acknowledge in this chapter). However, I consider this as still very current and ideal in the syntax of ageing, hence its application in my study. The proponents of this theory are old psychologists such as Cavan et al. (1949); Havighurst and Albrecht, (1953) and Havighurst (1961). The theory suggests that graceful aging results when the elderly remain active and keep socially active. Such a scenario defers the ageing process and enhances a good lifestyle among the elderly in their late life. I realise that as people age, they strive to keep improving and renewing their self-concepts in the way they carry along and perfect their actions to ascertain that they are socially acceptable in the communities they live in. However, naturally at elderly stage the scope of interaction and what the elderly could perform becomes limited, consequently reducing their self-esteem. This affects them psychologically. To negate these diminutions and maintain self-respect, the AT of aging assumes that restoration, in the form of keeping active and social interaction must be encouraged. The theory postulates that

remaining active at that age will enable the older people to stay collectively and expressively fit. Sidiako and Anevinch (2010) further postulate that AT focuses on practice, which obviates the need to distinguish applied from pure science, understanding everyday practice in the real world is the very objective of scientific practice. In light of AIDS having had a devastating impact on the Emaswati population, there is need to understand everyday living and practice of these grandparents who are active players in this scenario, hence the choice of the AT.

The AT in the work of old psychologists (Cavan et al., 1949; Havighurst & Albrecht, 1953) applauds life satisfaction. Increased activity at an old people age tends to satisfy the elderly and boost their morale. It would seem the theory revolves around the terms; activity, adjustment and satisfaction. I therefore considered these concepts in the application of the AT in my study, which deviates from the disengagement theory. The disengagement theory advocates that old age is a period where one should be enjoying the benefits of life and disengage from roles, activities and relationships (Cumming & Henry, 1961). The theory assumes that there should be inherent diminution in community participation and liabilities, with a subsequent demur in activity. I perceive this theory, in my study, as very negative and opposing in the Kingdom of Eswatini that recorded 56,000 children aged between 0 and 17 orphaned as a result of AIDS (Wanjiku, 2015). In addition, a survey undertaken by UNAIDS (2018) reported that there was an increase in the number of grandchildren orphaned by AIDS who fell into the age range of 0 to 17. With this huge number, perceiving grandparents as inactive members of society and encouraging an expulsion would be very inconsiderate. I therefore abandon it in favour of a more expressly developmental perspective: activity theory. As syntax of the old age problem, AT is analysed around the questions of agency, timing and responsibility which I consider to be the main components of AT. In the next section, I shed more light on these.

3.3.1 THE MAIN COMPONENTS OF THE ACTIVITY THEORY

In this section, I detail the key concepts of AT: agency, timing and responsibility. I will also relate them to my study. I begin by focusing on agency, which is mainly concerned with the driving force (agent) of individual well-being.

3.3.1.1 AGENCY

Due to HIV and AIDS pandemic, life in the 21st century is changing drastically and individuals of all ages find themselves having to deal with new kinds of interpersonal and psychological issues. This calls for agency on the part of the elderly taking care of AIDS-orphaned grandchildren, as they no longer have to deal with the usual circumstances of retirement,

widowhood and social isolation but have new undertakings in family set-ups that have changed due to a number of AIDS-orphaned grandchildren left in their custody. This added “unique challenge” of caring for grandchildren orphaned by AIDS at an older age implies that grandparents providing care to these children at Eswatini have to streamline their behavioural patterns in reaction to the added responsibility and remain exceptionally energetic in an attempt to meet the needs of these AIDS-orphaned grandchildren. Carrying on with myriad activities at a time that one would expect them to reduce the workload might present adjustment challenges. Lynott (1986) suggests that the only route to effective adjustment in such scenarios is self-assessment. Thus, the elderly should understand the added role and what action to take in line with their experiences, as the process is merely personal (Cavan, et al., 1949; Havighurst & Albrecht, 1953).

Cavan et al. (1949) are of the opinion that effective adjustment occurs in social settings. In any society, there are approved values and roles that individuals should play. Concerning the AIDS scourge, the societal demand is that the elderly simply conform to the added responsibility of taking care of AIDS-orphaned grandchildren. In effectively doing so, they will be evaluated as having adjusted and to be coping well with the situation. However, on the other hand Cavan et al., (1949) contend that although societal standards are influential to a certain extent, they do not bind individual adjustment but people simply adjust after reaching a certain level of aspiration. In this study, I interpret this to mean that continuity within the lifetime of grandparents taking care of AIDS-orphaned grandchildren is their initiative as they assess the situation and find it mandatory to act. The question to ponder on is: how long can it take grandparents taking care of AIDS-orphaned grandchildren at Eswatini to adjust? This question leads me to the discussion of the concept, timing.

3.3.1.2 TIMING

Activity theorists hold that there is no definite time when an individual sincerely experiences the dilemma of ageing and successfully adjusts. Crisis associated with caring for grandchildren orphaned by AIDS who might have also contracted the disease may even make some grandparents seriously maladjusted for a longer period. For some elderly the burden of care-giving might be so extreme practically eliminating the desire to adjust at any given period. It would seem that adjustment is an issue of individual incentive (Lynott, 1986) taking various dimensions depending on the grandparents’ response to their particular situations. Suffice it to say adjustment is cyclical as one could possibly become maladjusted at one instance and

feel having adjusted at some later stage, consequently experience maladjustment and the cycle goes on.

I realise that timing and adjustment also have to do with personal attributes. The AT theory assumes that an individual's potential to adjust to responsibility changes and predicaments in late life is replicated in one's ability to perform so at preceding occasions in life (Cavan et al., 1949). This means that the kind of activities an individual engages in, in earlier life should have continuity in later life. Cavan et al., (1949) presume that work-like activity in old age surrogate activities typically done in middle age. This therefore implies that how grandparents at Eswatini cope is determined by how they used to carry on in earlier life. The AT advocates "proper and unidimensional" facets of continuity (Lynott, 1986, p. 40). This suggests that the elderly taking care of AIDS-orphaned grandchildren may just have to take up responsibilities they used to do in earlier life without deviation yet the status quo has changed. This is in direct contrast with the continuity theory (see Section 3.5) which assumes that continuity is not merely focused on a particular kind and quality of activity but could take any dimension (Lynott, 1986). An individual who has acclimatised himself/herself to making rational decisions would continue doing so even in later life; an individual who has managed to cope at an earlier age would be able to do so at old age. Issues of responsibility, which I focus on next, also come into play.

3.3.1.3 RESPONSIBILITY

From what I have discussed in the preceding paragraphs, it is moderately evident that as individuals we are solely responsible for our destiny in old age. With HIV and AIDS wreaking havoc the world over resulting in mushrooming of intergenerational households, it becomes prudent for all individuals to accept reality earlier on and prepare for easy adjustment when time comes to keep away from the crises that might arise in care-giving.

I presume the crises that might arise among the elderly taking care of AIDS-orphaned grandchildren might not necessarily have to do with failing to come up with coping mechanisms as such but denial or individual resistance (Cavan et al., 1949). Grandparents caring for AIDS-orphaned grandchildren have a responsibility to accept the situation as it has unfolded and adjust accordingly. Resisting facts of the status quo could result in maladjustment, which has devastating consequences such as deteriorating health.

Further, Lynott (1986) is of the view that, responsibility is not confined solely to acceptance and readiness for role changes, but becoming confident in what one has to do. As such, the implication in this study is that the elderly taking care of AIDS-orphaned grandchildren have a

responsibility to opt for and strive towards accepting their fate of playing an active position at an older age in intergenerational households they find themselves managing to prevent maladjustment. These elderly are agents for preventing maladjustment. If they choose not to adjust, it becomes their yoke. Furthermore, AT underpins my study in the sense that grandparents involved in Eswatini may seek to be engaged as this makes them remain active. Moreover, for these grandparents, the greater the experience with which they get to old age, the more they will be able to endure the disheartening effects of losing their children and taking care of the orphaned grandchildren with depleted resources. Moreover, the grandparents who take care of the grandchildren orphaned by AIDS in Eswatini may show what Havighurst et al. (1968) call successful ageing. This simply means active ageing whereby the elderly remain full of life and defy the reduction of their social world by continuing with activities of the middle age as far as is feasible. In the next section, I explore another psychosocial theory on ageing: the continuity theory.

3.4 CONTINUITY THEORY

This theory assumes that in the course of ageing, a person grows certain behaviours, commitments, inclinations, and other additional dispositions that constitute his/her individuality and when they become old, they are liable towards sustaining continuity in these dispositions (Atchley, 2003). To elaborate further on the theory Atchley (2003) highlights that the theory speaks to how we can engage in similar activities throughout our lives but in diverse ways. For instance, grandparents taking care of AIDS-orphaned grandchildren could have been into commercial farming earlier in life but could still earn an income through small scale gardening in later life to sustain the livelihoods of their grandchildren. Thus, they would have engaged in the same activity but in different ways. The continuity theory is concerned with continued patterns of behaviour based on lifelong experiences that one repeats as they age. In this study, I take this to imply that grandparents have experiences of care-giving their own children and as such, they have ideas on how to go about given this responsibility of taking care of their AIDS-orphaned grandchildren.

The theory assumes that what is fundamental at old age is the application of previous experiences and perceptions to adjust to the changes brought about by normal ageing (Ebersole, 2011; Onega & Tripp-Reimer, 1997). The theory underpins my aspiration to see grandparents taking care of AIDS-orphaned grandchildren at Eswatini, continuing to make decisions and flexible alternatives in the extra responsibility of caring for grandchildren of a different generation. Given the new role of taking care of orphaned grandchildren as their own

children, CT is at hand to explain and espouse on how grandparents can adjust to this responsibility and plan on how they would use sparingly the resources accessible to them. This theory is very relevant in a scenario where the elderly are moving from being care recipients to care providers (Furstenberg, 2011; Perrig-Chiello & Höpflinger, 2005).

The continuity theory holds that, people do not truly adjust as they age, but turn out to be what they have always been (Agahi et al., 2006). I adopted this theory with the understanding that preserving patterns of thinking, actions, and lifestyle will be an ideal approach for adjusting amongst the elderly taking care of AIDS-orphaned grandchildren. The theory holds that, in making adaptive choices, middle-aged and older adults try to preserve and uphold existing internal and external structures (Atchley, 2003) The internal structure of an individual facilitates future decision-making while the external structure supports the maintenance of a stable self-concept and lifestyle (Eberson, 2011). With the advent of orphans due to AIDS pandemic it remains to be established how these internal structures (beliefs, ideas and personalities) would change.

The internal structure allows individuals to make future decisions by providing them with a secure foundation in the past while the external structure that entails relationships and social roles offers support for maintaining a stable self-concept and life style (American Society of Ageing, 2007). The CT asserts that the behaviour and thinking of the elderly is inclined to follow a person's patterns and thoughts established in the course of life, whilst flexibly adjusting to changes in life. The theory links adjustable change with experience to a successful ageing process, focusing on continuity and discontinuity and the need for flexibility resulting in positive outcomes. For these reasons, CT makes a vital contribution to my study, hence, its adoption.

I opted for applying the CT in my study because it explains how individuals develop and cope with responsibility in later life. Development in this context is not only aligned to ageing but also to assuming and adjusting to social change. Adjusting implies coping with new demands and responsibilities. If the needs of grandparents taking care of AIDS-orphaned grandchildren at Eswatini are to be examined and how they are coping with this added responsibility, then the application of CT is essential in this study. I also chose CT as a theory underpinning my study because its focus is on an individual. To be precise, I scrutinise the theory from the lenses of the functionalists who are of the opinion that an individual and social formation take responsibility to strike a balance. An individual's practice and priorities will have to come to terms with societal norms, expectations and values. Whilst an individual's past experiences,

values and practices may remain constant, the social formation expectations vary depending on the existing conditions. The existing conditions in this study are loss of autonomy by grandparents taking care of AIDS-orphaned grandchildren and confinement to the home instead of being free of responsibility at retirement (Smith & Segal, 2018). Where such variance exists, CT becomes salient.

The significant variable in this study is continuity in lifestyle. The source of adjustment, then, is continuity in one's lifelong style of life, what one has become accustomed to as personally normal. Kali and Cavanaugh (2016) recognise that individuals tend to cope with daily life when growing older by applying familiar strategies learnt from their past. With the advent of new expectations for the 21st century to the aged, maintaining the same activities, habits and patterns of thought is the most common strategy for adjustment (Minhat et al., 2013).

3.5 SUMMARY

This chapter discussed the main theories underpinning this study. Through a discussion of the intergeneration relationship model, this chapter illustrated that intergenerational relationship programmes are critical in the era we are living in where it has become mandatory for grandparents to provide support for their grandchildren orphaned by AIDS. Through a discussion of activity theory, the chapter illustrated that life satisfaction of old people is related to the amount of activity in their daily lives. The more active the grandparents are, presumably, the more satisfied they are with life, the higher their morale. A discussion of the continuity theory in the chapter illustrated that in the process of becoming old, a person establishes practices that form his or her character and are inclined to maintain this in their later life. The next chapter discusses the research design and methodology used in this study.

CHAPTER FOUR

RESEARCH APPROACH, DESIGN AND METHODOLOGY

4.1 INTRODUCTION

My interest in seeing grandparents and of grandchildren orphaned by AIDS living fruitful lives encouraged me to embark on this study. I have observed many grandparents in Eswatini struggling to raise grandchildren orphaned by AIDS due to the fact that when their children died they were left with nothing to help them raise the grandchildren. Looking at the challenges that they face I decided to carry out a study that involves grandparents of grandchildren orphaned by AIDS using participatory action research (PAR). PAR calls for my relationship with participants to be authentic, collaborative, self-critical and involving people in theorising about their practices (Kemmis et al., 2014). This would give the grandparents an opportunity to come up with their own sustainable solutions to their problems. This is the reason for my choice of participatory action research (PAR) design. PAR advocates for 'nothing for us without us'. Similar studies on grandparents caring for grandchildren orphaned by AIDS were carried out in Uganda (Rutakumwa et al., 2015; Matovu, 2017; Stella & Annet, 2019) Zimbabwe (Mhaka-Mutepfa et al., 2014) and Botswana (Shaibu, 2013). However, these studies did not use PAR design. In the Kingdom of Eswatini a study conducted by Sithole (2009) did not use PAR. It is my wish, therefore, in this study to collaboratively develop an education model for enhancing an understanding of the social exchanges and interactions between the grandparents and their grandchildren.

In this chapter I discuss my preferred research paradigm, approach, design and methods of data generation and analysis. I also discuss validation criteria, ethical considerations and limitations of the study. I begin by highlighting the purpose of research followed by discussing my research paradigm and research approach. I then proceed to discuss PAR as my research design, the research methods I use, validation criteria and ethical considerations.

4.2 PURPOSE OF RESEARCH

The study's purpose is premised on the research problem which is summarised below:

- Create a collaborative education model that resonates with intergenerational relationships that are formed between grandparents that assume guardianship roles to grandchildren orphaned by AIDS.

- Develop informed intergenerational education-based strategies that could be employed to address the challenges faced by grandparents in caring for grandchildren orphaned by AIDS.

4.2.1 MAIN RESEARCH QUESTION

How can grandparents collaborate with other stakeholders to design an intergenerational relationships education model that can be used to meet the needs of grandparents taking care of grandchildren orphaned by AIDS in the Kingdom of Eswatini?

4.2.2 RESEARCH SUB-QUESTIONS

Cycle One

What are the intergenerational relationships education needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?

Cycle Two

How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?

Cycle Three

How can the findings of the empirical study be translated into an education model and guidelines for improving the intergenerational support or care given by grandparents to their grandchildren orphaned by AIDS?

4.3 RESEARCH PARADIGM

Leavy, (2017, p. 10) defines a research paradigm as, “A worldview or framework through which knowledge is filtered; it is a foundational perspective carrying a set of assumptions that guides the research process.” A paradigm is viewed as a cluster of beliefs and dictates that influence what should be studied and how it is to be studied.

In this study I adopt the transformative paradigm, which is a radical humanist paradigm (Leavy, 2017). Mertens (2015) posits that transformative theory encompasses paradigmatic perspectives that are viewed as emancipatory, participatory and inclusive. Therefore, transformative paradigm embodies a political agenda for the emancipation of individuals in a social organisation. The transformative paradigm thus places central importance on the transformation of the lives of marginalised groups (Mertens 2015). This makes it a suitable

paradigm for my study in which I seek to work with the participants to transform their livelihoods. Like all philosophical paradigms the transformative paradigm has its ontological, epistemological and methodological assumptions.

4.3.1 ONTOLOGICAL ASSUMPTIONS

Ontology is concerned with the nature of being (Brodsky et al., 2016). The transformative paradigm's ontological assumption is that there is no single reality but multiple realities that are socially constructed (Mertens, 2015). The multiple realities are socially constructed in a context where certain individuals are in positions of greater power (Mertens, 2015). Such privileged individuals have a higher likelihood of excluding other people in constructing reality (Mertens, 2015). The ontological concern of the transformative paradigm is that the researchers should serve to curtail undue privileging of some views. In this study I need to be aware of the societal values and privileges which determine the construction of reality by grandparents. I adopt Afrocentric ontology by viewing grandparents of Eswatini as ordinary African people living and working in their communities and the ways they understand the context of their challenges (Metz & Gaie, 2010). This would assist me in determining the reality that has the potential for social transformation.

4.3.2 EPISTEMOLOGICAL ASSUMPTIONS

Simply put, epistemology is a term which refers to how we know (Neuman, 2014). The transformative epistemological assumption holds that the question of knowing is answered through the manner in which the researcher relates to participants (Mertens 2015). In order to know realities; there should be an interactive link between the researcher and the participants (Mertens 2015). Understanding the culture of the participants and the building of collaboration and trust is paramount. Knowledge would thus be socially constructed within a complex interactive cultural context which promotes a fair understanding of key issues. In this study I adopt an Afrocentric epistemology of the transformative paradigm. An Afrocentric epistemology seeks to understand how African grandparents experience the reality of solving problems in their own communities (Metz & Gaie, 2010). I need to ask myself such questions as, "If I am to know the reality of the grandparents' lived experiences, how should I relate to them in generating data?" Such questions help me address not only my epistemological assumption but also my methodological assumptions.

4.3.4 METHODOLOGICAL ASSUMPTIONS

Mertens (2015) points out that the methodological assumptions of the transformative paradigm are underpinned by the conviction that when conducting research, researchers should confer with participants on methods to be used and how they should be used. This makes the transformative paradigm suitable for an Afrocentric approach in methodology. Africans have a strong collective consciousness rooted in their cultural philosophy of Ubuntu (Wane, 2019). This makes partnership with the people being researched an essential component for the success of any research project (Wane, 2019). Therefore, in this study I use participatory action research which allows me to research with the participants, rather than research on them.

4.4 RESEARCH APPROACH

Research approach refers to the general orientation to the conduct of research. Research approach can be quantitative, qualitative or mixed methods. In this study I used the qualitative approach. Quantitative research concerns itself with quantification of data generation and analysis (Cohen et al., 2011; Creswell & Creswell, 2018). On the other hand qualitative research seeks the understanding of social reality in a manner that provides thick descriptions of participants and their interaction within their natural context (Cohen et al., 2011). The researcher seeks to make sense of phenomena in the manner they are understood by the participants and present data in a descriptive and non-statistical manner (Cohen et al., 2011; Creswell & Creswell, 2018). The researcher uses interaction as means of gaining access to inside experience so that he/she views events in the social world through the eyes of the participants who experience the events.

In this study I seek to understand the phenomenon of grandparenting through the eyes of grandparents of grandchildren orphaned by AIDS. I will thus present qualitative features of the grandparents' individual feelings, and views without interfering with or manipulating the participants. There will be sharing between me and the grandparents, thus affording both of us an opportunity to share and learn. In so doing I will use participatory action research (PAR) design.

4.5 RESEARCH DESIGN

The study employs participatory action research (PAR) whose locus is to provide solutions that address the contextual challenges affecting society through involving the participants in crafting solutions that are responsive to the context (Kemmis et al., 2014). Participatory action

research (PAR) is a genre of action research. Action research is generally considered to be a systematic way of generating and analysing data in order to bring in interventions for changing the status quo and generating practical knowledge (Kemmis et al., 2014).

I have particularly opted for this genre of action research because it ties in with the transformative paradigm, which is my chosen philosophical paradigm. My research has an agenda for social change which embodies the view of pooling knowledge in defining a problem as a way of mitigating the problem. It is underpinned by the ontological assumption that encompass action being value laden and a moral commitment. The researcher is viewed in relation to participants in their social contexts (Leavy, 2017). In PAR the researcher assumes the role of facilitator, guide, formulator and summariser of knowledge (Cohen et al., 2011) so that he/she collects data in non-threatening methods.

The philosophical underpinnings of participatory action research, as a qualitative design, are that objectivity is impossible. Instead multiple or shared realities exist. Participatory action research is of the view that people have a right to determine solutions to their own challenges (Kemmis et al., 2014). Therefore, in this study I provide the grandparents with the opportunity to participate meaningfully in the process of analysing their challenges and coming up with their own solutions. The PAR process gives them power and control leading to the development of sustainable grandparenting. The process also gives the participants and me spaces to reshape our knowledge of the socio-economic and political contexts that impact the daily life of the participants. In this case PAR is a dynamic educative process. The ultimate goal of PAR is to empower individuals to partner in social change by encouraging capacity development and capacity building of the participants (Kemmis et al., 2014). The PAR cycle revolves around four steps namely: plan, act, observe and reflect (Department of Health and Human Services, 2012; Kindon et al., 2007). A typical action research in a continuous quality improvement process is shown in Figure 4.1.

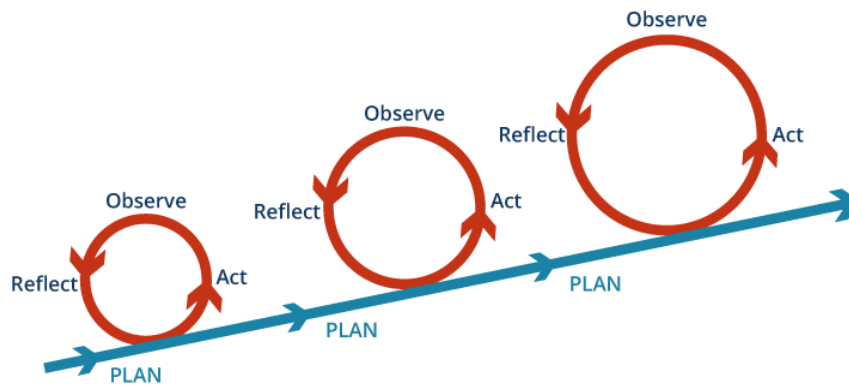


Figure 4.1: *The participatory action research cycles (Crane & Richardson, 2012, p. 10)*

The PAR cyclic process involves action and reflection, which leads to further inquiry and action for change. In my study the cycles are iterative but allow for incremental changes in the grandparents' learning with each step. Each subsequent cycle is bigger (Department of Health and Human Services, 2012) to reflect an increase in focus on issues that affect the grandparents' everyday life and the increase in stakeholders' participation and suggestions.

Hendricks (2017) posits that in PAR participants ought to discuss issues using dialogical, dialectical and hermeneutic approaches, which align with critical theory. This means participants in PAR are not only primary sources of data but they generate data, solutions are crafted through providing an interactive platform where they air their perceptions and proffer solutions to the challenges presented. Participants' different perspectives consequently become subjects of interaction and negotiation as people explore ways to resolve their problems (Leavy, 2017).

Yin (2012) explains that PAR combines research and action with the participants being central to the process. Hendricks (2017) further reiterates that PAR reveals participants' immediate and honest responses to my research questions. Additionally, the use of participant-researchers would bring various benefits to the research, such as access to knowledge that is relevant to their lives, and developed from their experiences, and the potential to present their learning to the wider community in ways that are understandable, current and contextualised. Thus the study will tap from the participants' experiences and perceptions of the challenges as they affect them and how they think the solutions to the challenges could

be. Ultimately, the participant – researcher role authenticates the findings and makes results applicable and relevant to the context of the research setting.

However, the use of PAR came with challenges, one of which emanated from me working with grandparents. The grandparents could have struggled to maintain their commitment to the project over time. I was able to keep their morale high by treating them well. Refreshments were of high standard such that they were always looking forward to our ALS meetings. Instead of pushing them, they were pushing me. The other challenge I faced was that the participants were illiterate. This made me to use data generation methods which did not involve reading and to take the lead in data analysis. In that case I allowed the grandparents to lead in implementing strategies for improving their identified social issue.

PAR has some draw backs some academics like Cornwall and Jewkes (1995) noted that when engaged in participatory action research, working with local people is not easy. This is as a result of not everyone within the community willing to partake in participatory research. Some local people may be sceptical about the perceived benefits of the research and may not want to invest their time on it (Bennett, 2004). In my study I also encountered challenges when I was recruiting the stakeholders. Some did not see why I wished them to participate in the study. Some chief's council members were also sceptical in participating in this study as they thought grandparents will expose them. I assured them that my study was about getting the truth about the plight of grandparents so that better ways of solving their challenges is arrived at. I assured them about me maintaining high ethical standards. After that they agreed. They ended up enjoying being part of the study. Grandparents were also afraid initial in participating in this study fearing their traditional leaders. I allayed their fears by showing them letters of good will from the two chiefs and telling them that their names will be kept confidential. When we started our ALS meetings they were first afraid of each other but using my psychological knowledge I made them to loosen up. They ended being free to discuss issues openly.

4.6 RESEARCH PROCESS

In conducting this participatory action research I purposively recruited ten grandparents caring for children orphaned by AIDS in the Manzini Region of Eswatini. For data generation I used narratives, drawings and storytelling, action learning set meetings, focus group and reflective journal as my data generation instruments methods. The participants and I used thematic analysis to analyse the data. The research process followed the format indicated in Table 4.1.

Table 4.1: Research process (adapted from Luthuli, 2019)

Cycle One			
Research question: What are the education needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?			
Step	Method	Participants	Data generation/ recording tools
Plan	Storytelling and drawings	Grandparents and researcher	Video recording and drawings
Act	Presenting the stories in action learning set	Grandparents and researcher	Video recording
Observe	Listening to others' stories and making suggestions	Grandparents and researcher	Video recording
Reflect	Action learning set on teasing out what works and what does not work	Grandparents and researcher	Drawings and labelling

Cycle Two			
Research question: How can relevant stakeholders in Eswatini collaborate in order to come up with strategies to address the education needs of grandparents caring for grandchildren orphaned by AIDS?			
Step	Method	Participants	Data generation/ recording tools
Plan	Action learning set on deciding grandparents' challenges to be presented to stakeholders	Grandparents and researcher	Annotated Posters
Act	Focus group discussion on challenges faced by grandparents	Grandparents, researcher and stakeholders	Video recording
Observe	Action learning set on suggestions made by stakeholders	Grandparents and researcher	Video recording
Reflect	Action learning set on sifting suggestions from stakeholders. What works and what does not work?	Grandparents	Annotated drawings

Cycle Three			
Research question: How can the findings of the empirical study be translated into a model and guidelines for improving the intergenerational support or care given by grandparents to their grandchildren orphaned by AIDS?			
Step	Method	Participants	Data generation/ recording tools
Plan	Action learning set on prioritising suggestions for successful and sustainable grandparenting	Grandparents	Annotated drawings
Act	Action learning set on producing guidelines for successful parenting	Grandparents	Annotated drawings
Observe	Examining the grandparents' guidelines and recording observations in reflective journal	Researcher	Entries in reflective journal
Reflect	Producing a model on successful and sustainable grandparenting	Researcher	Model in reflective journal

4.7 RESEARCH METHODS

Research methods are the technical side of the research investigation, such as sampling and data generation techniques, data analysis tools, and measures to ensure trustworthiness. Babbie (2010) and Creswell and Creswell (2018) concur that it is a science of finding out the procedures for scientific investigation. In this study I employed a qualitative and participatory research method that resonates with the transformative paradigm of the study. I adopted an Afrocentric approach in selecting my methods because my participants are mainly old traditional African people. Since my research topic is on intergenerational education process on grandparenting my methods were dominated by action learning sets (Zuber-Skerrit, 2015). I also used narratives (Brodsky et al., 2016) wherein drawing of their life experiences was one of the methods and I used a two-way focus group discussion (Hennink, 2014). All the while, I

kept a reflective journal (Kemmis et al., 2014) where I recorded my reflexive experiences. Besides drawings, video recording was my major data recording tool. The recordings were transcribed verbatim.

4.7.1 PARTICIPANT RECRUITMENT

I recruited participants for two samples. Firstly I recruited grandparents caring for grandchildren orphaned by AIDS. Secondly, I recruited stakeholders in the caring for children orphaned by AIDS.

4.7.1.1 Recruitment of grandparents

In this study I chose a small sample size, which allowed for the development of contextually rich narratives (Creswell & Creswell, 2018) that would deepen my understanding of the study's inquiry. I selected ten participants using snowball sampling (Johnson & Christen, 2016). Snowball sampling is based on a referral approach in situations where a small number of individuals with specific characteristics recruit others with similar characteristics from their community (Creswell & Creswell, 2018). The major advantage of this sampling method is that it gives the assurance that a cross-section of the population would be represented (Johnson & Christen, 2016) in a small sample. Nevertheless, I acknowledge that I may not have been able to identify all contributing variables and characteristics found in the population. I worked on the assumption that grandparents caring for grandchildren orphaned by AIDS knew each other since they were from the same rural community.

I selected participants who provided instrumental and expressive care to a grandchild or grandchildren orphaned by AIDS with whom they live in the same household on a daily basis for an indefinite period of time. For households where both grandfather and grandmother were caring for the same orphans in the same household I preferred the grandmother. My preference for grandmothers was based on research findings which established that in Africa it is elderly women who have to attend to their ailing children, and also provide support for orphaned grandchildren (Mudavanhu et al., 2018; Shaibu, 2013; Mhaka-Mutepfa et al., 2014).

The first participant was a member of the Chiefs' Council of the two chiefdoms of Kutsimuleni and Mbelebeleni in the Manzini Region, who volunteered to participate when I went to seek permission to carry out the study. After identifying the first grandparent caring for orphans I asked him if he knew any more grandparents caring for grandchildren orphaned by AIDS and he gave me three referrals who in turn provided additional contacts until I got 10 participants

whose general characteristics are as indicated in Table 4.2. I coded my participants as P1, P2, P3 and so forth because it would have been unethical to use their real names.

Table 4.2: Characteristics of participants

Participants	Age	Sex	Special attribute	Number of orphans cared for
P1	66	F	Illiterate	6
P2	60	F	Grade 3	1
P3	68	F	Grade 6	2
P4	81	M	He brings a wealth of experience as he is taking care of many orphans. He is the only male participant.	8
P5	80	F	One of the oldest female grandparents from the ALS. One of the grandchildren she is taking care is on ART. She brings a lot of experience in terms of taking care of grandchildren on ART.	3
P6	65	F	The husband is still alive.	2
P7	79	F	Illiterate whose husband deserted her. She is taking care of the grandchildren alone. She is also taking care of grandchildren whose ages vary.	8
P8	72	F	Grade 3	9
P9	70	F	Illiterate	2
P10	63	F	Form 3	2

Although this sampling method may not be effective in recruiting diverse individuals, it assists in identifying participants meeting the required characteristics especially where the required sample is limited to a small group of the population.

4.7.1.2 Recruitment of stakeholders

I used purposive sampling to select stakeholders' representatives who participated in this study. However, I needed to observe Swati traditional customs in that I did not have much freedom to select individual office bearers. Instead I selected offices and requested for representatives from those offices. Offices relevant to my study were *Tinkundla*, Department of Social Welfare, the Inner Council of Chiefdom, World Vision, Bantwana, Philani Maswati, Young Heroes and the Primary Health Care system.

According to the Constitution of the Kingdom of Eswatini, the system of government emphasises the devolution of state power from central government to *Tinkhundla* (Singular: *Inkundla*) (Constitution of the Kingdom of Swaziland, Act 2005 [Eswatini], 2005). An *Inkhundla*, is an administrative subdivision smaller than a district but larger than an *umphakatsi* (chiefdom) (Simelane, 2017). One of the roles of *Inkhundla* which relates to my study is that it is the foundation for the bottom-up development planning process and the delivery of local services in partnership with central government (Constitution of the Kingdom of Swaziland, Act 2005 [Eswatini], 2005). The delimitation of my study fell under one *Inkundla*. Therefore I required one representative from the *Inkundla* administration to be in my sample of stakeholders.

The Department of Social Welfare in Eswatini is mandated with implementation of policies and strategies on integrated social welfare services that meet the needs of all vulnerable groups such as the elderly, persons with disabilities, persons/children affected by HIV and AIDS, ex-servicemen and substance abusers (Constitution of the Kingdom of Swaziland Act 2005 [Eswatini], 2005). There are social welfare officers for each of the two chiefdoms in which I carried out my study. I, therefore, requested for one social welfare officer from each of the two chiefdoms to be in my stakeholder sample.

In Eswatini, communities are organised through the traditional set-up with the Inner Council as an important decision-making body (Constitution of the Kingdom of Swaziland, Act 2005 [Eswatini], 2005). The Inner Council at chiefdom level is the main decision-making body. It is made up of traditional leaders and community members. The chiefs are princes and can report directly to His Majesty, the King (Constitution of the Kingdom of Swaziland, Act 2005 [Eswatini], 2005). I, therefore, requested one representative from the Inner Council of each of the two chiefdoms to be part of the stakeholders.

The NGOs Philani Maswati, Bantwana, World Vision and Young Heroes were selected to be part of the stakeholders because they are either helping grandparents or grandchildren orphaned by AIDS. The form of assistances varies from physical items like clothes, blankets and money to pay fees or their other items like soap and nourishment. Some of these NGOs help in arranging mobile health facilities for grandparents and their grandchildren.

In the provision of Primary Health Care in rural areas, Eswatini makes use of *bagcugcuteli* (rural health motivators) at the grassroots level of the health system (Jenniskens, 2018). My assumption was that these rural health motivators were acquainted with grandparents caring for grandchildren orphaned by AIDS and the challenges they face. I, therefore, requested for one rural health motivator from each of the two chiefdoms to be part of my sample.

4.7.2 DATA GENERATION METHODS

I employed transcription of a reflective journal, narratives and drawings, action learning sets and focus group discussion as data generation techniques of the study.

4.7.2.1 Reflective journal

A reflective journal or research diary is a tool that social science researchers use for immersed research (Bourgoin & Harvey, 2018). In the journal the researcher records his/her thoughts, reflections, his/her and the participants' actions and to provide a continuous description of events. In this study I kept a reflective journal (Creswell & Creswell, 2018) in which I recorded my thoughts and actions as I explored the values, attitudes, thoughts, and experiences of participants. Reflective journals are a means of data generation in qualitative research that is effective in recording information about a person's feelings (Cohen et al., 2011). Reflective journaling is a way of describing a recent experience as well as unpacking salient aspects concerning learning in an on-going manner (Lutz, 2019).

In this study I used the journal to describe not only my thoughts and feelings but also the exceptional moments that I experienced. In my reflective journaling I sought to answer questions shown in Figure 4.2 below:

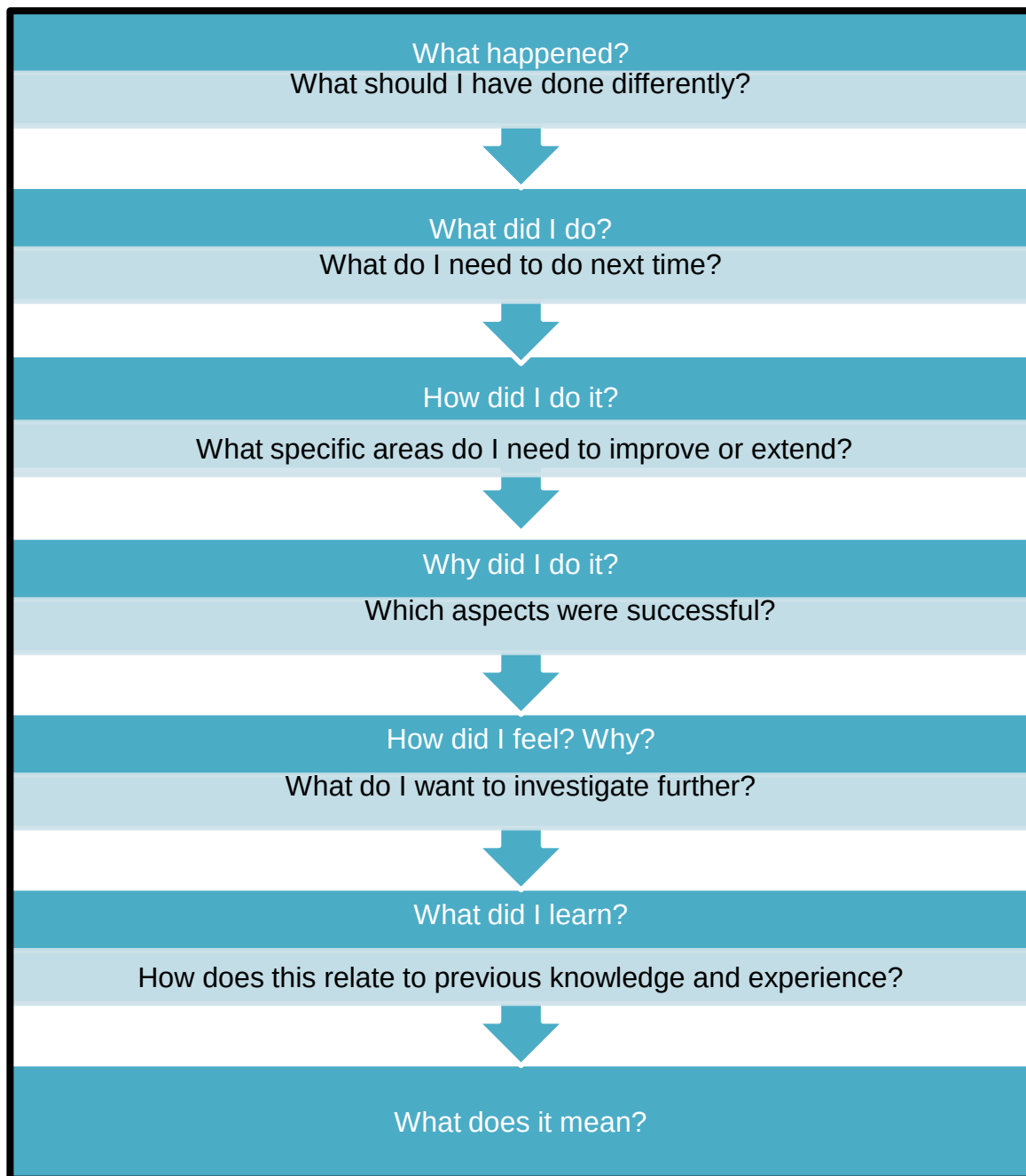


Figure 4.2: *My reflective questions*

The reflective journal assisted me in capturing some underlying issues in grandparenting and critical incidents in my interaction with participants, which might lead me to developing new realisations and appreciations.

4.7.2.2 Narratives

Some of the grandparents in this study did not have formal education. They were, thus, given an opportunity to present oral rather than written responses. To generate data from these old people I used oral narratives or storytelling (Morgan & Hoffman, 2018) accompanied by drawings whereby they narrated and illustrated their lived experiences. Narratives have become a well-established and well-theorised methodological approach in research (Moore, 2012). Although some scholars want to distinguish between stories and narratives, such categorisation gives stories a special status, but actually includes them as a type of narrative (Webster & Mertova, 2007).

In this study I viewed stories as narratives, told by participating grandparents about their life experiences. I asked the participating grandparents to tell me their life experiences in caring for grandchildren orphaned by AIDS. Of interest to me were the emotions produced by the story: the fantasies, desires, wishes embedded in the story, and an understanding of the meaning and value of the story to the participant. I took it that the stories were not creations of the grandparents but real life experiences based on an understanding of the historical, contextual and temporal world around them (Creswell & Creswell, 2018). The stories were audio recorded and later transcribed verbatim. I was aware that storytelling often includes embellishment or exaggeration. I left these to be dealt with during data analysis when such questions as, "Would you say this experience is common or rare?" would be asked.

4.7.2.3 Drawing

Together with storytelling I asked the grandparents to make drawings, which accompanied and illustrated their narrations. The use of drawings as a data generation method in social research is located within arts-based or arts informed research (Knowles & Cole, 2008), participatory visual methodologies (Mitchell et al., 2011), and textual approaches in visual studies in the social sciences (Mitchell et al., 2011).

I used drawing because it is a more expressive, engaging, and fun activity, which has the potential of turning the research study into an enjoyable experience for those involved (Knowles & Cole, 2008). Drawing also helps in maintaining the participants' attention in situations where their enthusiasm or concentration levels are of concern (Knowles & Cole, 2008). As a method of data generation it entails participants' drawing and talking or drawing and writing about the meaning embedded in their drawing (Mair & Kierans, 2007). In this study I used drawing and talking. It is a critical way of getting the grandparents' inner world because it captured feelings and emotions especially when participants lacked equally expressive

written language (Knowles & Cole, 2008). Unlike interviews and focus group sessions where participants are expected to give an instantaneous response, use of drawing allows participants to reflect on their responses, thus encouraging active conceptualisation and contemplation (Mitchell et al., 2011). The additional time for reflection provides the participants with an opportunity to come up with clearer depiction of what they want to communicate.

In this study I asked the grandparents to make a series of drawings which sought to answer the following questions:

- What are your responsibilities in the family?
- What challenges do you encounter in carrying out your responsibilities?
- What are your wishes?

I worked with the grandparents in analysing the messages depicted by the drawings and narratives.

4.7.2.4 Action learning sets

An action learning set (ALS) is an educational learning process comprising of a group of people working together to solve difficulties with no clear resolution (Zuber-Skerritt, 2015). It consists of six to twelve people who meet regularly to help or learn from each other. It is underpinned by the cycle of practical learning (Revans, 2017). Each individual participant studies his or her own actions and experience in order to improve performance. In the process participants try to solve their own problems. Cohen et al., (2011) posits that in ALS the process is non-directive, non-judgmental, supportive and confidential. This involves active listening and analysing skills, participants are given an opportunity to reach their own solutions to their challenges. In this study, ALS provided grandparents taking care of grandchildren an opportunity to discuss challenges they faced in looking after grandchildren and come up with better solutions to the problems.

My ten participants met as one action learning set over two sessions. In the first session each grandparent presented challenges he/she faced in his/her caring for grandchildren. Other participants assisted the presenter by asking questions that made him/her reflect on his/her perceptions, understanding and assumptions. Questioning by peers encouraged a deeper understanding of the challenges and a reflective reassessment of their problems so as to come up with a way forward. The idea was to develop in the presenter new insights. After the first session the grandparents went home and put in practice their new understanding.

In the following sessions the grandparents individually presented to others results of their new practices and were assisted by others in drawing conclusions on what worked and what did not work. At the end of the second session the action learning set compiled challenges that required the intervention of other stakeholders. The entire process was recorded and transcribed verbatim.

After we had compiled challenges that require the intervention of other stakeholders we took these challenges to a focus group discussion that I conducted with the stakeholders.

4.7.2.5 Focus group

In a focus group discussion, questions seek to elicit perceptions attitudes, beliefs or opinion of participants. There are five types of focus group discussion, namely: dual-moderator focus group, two-way focus group, mini focus group, client-involvement focus group and participant-moderated focus group (Nyumba et al., 2018). The growth of online platforms has allowed for the emergence of more types. In the two-way focus group that I opted for, there were two groups; one group actively discussed a topic while the other observed (Hennink, 2014). The usual practice in this type of focus group is to have two groups separated by a one-way glass so that the observer group can observe the active group without being seen (Nyumba et al., 2018). There was no one-way glass between the two groups (stakeholders & grandparents) because I wanted to avoid a situation where one group spied on the other. Openness was also likely to elicit candid responses to real-life challenges faced by the grandparents. This method of data generation allowed grandparents to reflect on their suggestions for successful grandparenting in the light of the views of stakeholders. The two-way focus group discussion was video recorded and transcribed verbatim.

During data generation I encountered a few challenges. The major one was due to COVID-19. There was a week we postponed our ALS due to COVID-19 cases that were experienced in the community where I conducted the study. I did not want to risk my participants as they were a vulnerable group. Since I was sponsoring myself sometimes I was facing some financial challenges to get money to buy refreshments for the participants. My relatives assisted me with money that I used for catering my participants. I did not want to lose them as I knew the success of the study lied with them. Giving them best food motivated them to continue up to the end. Being a full time teacher was also a challenge as I had limited time to collect me data, but I was lucky that my head teacher was generous with time, he was giving me off days when I needed days to collect data.

4.8 DATA ANALYSIS

Data analysis is a critical stage of the research process and as such it has to be accurately and meticulously done to enable the researcher to answer the research question(s). In qualitative research, data analysis is not separate from data generation (Brodsky et al., 2016). Informal analysis begins during data generation because initial thoughts may impact on subsequent data (Brodsky et al., 2016). Brodsky et al. (2016) further explain that the goal of qualitative analysis is to condense a large volume of data to enable researchers to interact with it in a meaningful way. Thus data analysis is a means of giving meaning to the collected data and affords the researcher tools to answer the research question(s).

The study employed a qualitative, thematic data analysis approach where the data collected was coded, organised into emerging themes and analysed. Creswell and Creswell (2018), explain that thematic analysis has three steps namely: organisation of total data sets from various data collection instruments, identification of themes through coding of data into similar patterns of ideas, and lastly interpretation of collected data and writing of the research report. Braun and Clarke (2013, pp. 80-85) further outline that there are six phases of Thematic Analysis (TA) and these are: familiarisation, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and producing the report.

Familiarisation refers to the process of becoming familiar with the data through reading and rereading interview transcripts. The purpose of this step is to get the qualitative researcher engaged with the data and begin thinking about prevalent topics discussed by participants. This is followed by *generating initial codes*, which begins with the systematic analysis of the data through coding. Codes will be the building blocks of analysis. Codes will identify and provide a label for a feature of the data that is potentially relevant to the research question. The process of coding was done for every transcript until each transcription was coded. This left the researchers with a list of generated codes. In this analysis I played a key role because some of the participants were illiterate. However, I worked with the participants and sought their approval of generated meanings and patterns.

Coded data was collated into a list of the different codes that were identified across the data set. We started *searching for themes*. In this phase we refocused the analysis at the broader level of themes by clustering codes together that have similar meanings or have a relationship to one another. After the codes had been clustered together, I labelled the clusters based on the meaning or relationship shared among the codes. The labels formed the themes. We reviewed the themes against the data to make sure the themes captured the meaningful

aspects of the data without missing any important details. This is the process of *reviewing potential themes*.

Once we were satisfied that the themes represented the data, we then moved on to *defining and naming themes*. This process involved utilising the labels created for the theme and providing a comprehensive name that described the relationship or meaning conveyed in the theme. The final phase in our thematic data analysis was *producing the report*. I produced the report. The purpose of the report was to provide a compelling story about the data based on the analysis. The story should be convincing and clear yet complex and embedded in a scholarly field.

4.9 TRUSTWORTHINESS/ENSURING QUALITY OF THE RESEARCH PROCESS

Measurement of quality in action research has evolved over time. Prior to this evolution all scientific research was measured in terms of internal and external validity. Although the concept of validity is central to both quantitative and qualitative research, some researchers proposed alternative measures such as trustworthiness, for qualitative research (Cohen et al., 2011). Trustworthiness is the ability of a research study to establish credibility, transferability, confirmability and dependability (Cohen et al., 2011). The identified four variables imply that a credible study ought to be truthful and accurate, its findings must be applicable in new contexts, and the study must not be biased and could be repeatable in different contexts.

Herr and Anderson (2005), whose conceptualisation of validity subsumes trustworthiness (Marchand & Van der Steen, 2014), argue that action research requires different validity criteria that address the purposes and conditions of the research. Herr and Anderson (2005) argue that validity criteria for action research are tentative and in flux. They, therefore, suggested five different validity criteria that they considered suitable for consideration to make action research valid. These are outcome validity, process validity, democratic validity, dialogic validity and catalytic validity (Herr & Anderson, 2005).

4.9.1 OUTCOME VALIDITY

Outcome validity refers to the extent to which actions occur that lead to the resolution of the problem that led to the study (Herr & Anderson, 2005). In my study this refers to whether the participants and I took appropriate action resulting in the mitigation of challenges faced by grandparents caring for grandchildren orphaned by AIDS.

4.9.2 PROCESS VALIDITY

Process validity refers to the extent to which problems are framed and solved in a manner that permits on-going learning of the individual or system, including the extent to which methods are used (Herr & Anderson, 2005). The implication for my study is that I check on how well the study opens up new avenues for learning for the grandparents and community leaders. My use of action learning sets research would help ensure that continuous learning is promoted in the research process.

4.9.2.1 Democratic validity

Democratic validity refers to the extent to which research is done in collaboration with all parties who have a stake in the problem under investigation to guarantee results are relevant to local settings (Herr & Anderson, 2005). In my study I need to involve the grandparents caring for grandchildren orphaned by AIDS and community leaders. I also involved government departments that have a stake in the welfare of the orphans and the grandparents. For ethical reasons I did not involve the orphans because they could have been traumatised by discussions, which might have kept on reminding them of their parents and that they are orphans.

4.9.2.2 Dialogic validity

Dialogic validity refers to the extent to which dialogue with peers was sought in the process, for instance in the form of a critical friend or collaborative inquiry (Herr & Anderson, 2005). In this study the participants were involved in data generation and analysis. I play the role of facilitator except where reading and writing needed to be done. Moreover, an experienced academic promoted and guided the researcher from the outset of the study to its conclusion. I also welcomed opportunities for scrutiny of the project by colleagues, peers and academics so that I could get feedback during any presentations (e.g. at conferences) that are made throughout the project.

4.9.2.3 Catalytic validity

Catalytic validity refers to the degree to which the research process reoriented, refocused and energised both researchers and participants toward knowing reality in order to change their view and their own role (Herr & Anderson, 2005). My chosen philosophical paradigm, which I discussed earlier in this chapter recognised multiple realities and that reality is a social construct. The methodological assumptions of my philosophical paradigm and my choice of research methods address the essence of catalytic validity.

4.10 ETHICAL CONSIDERATIONS

Conducting research studies using human beings requires the researcher to adhere to ethical issues that guide scientific research studies. McMillan and Schumacher (2001, p. 196) define ethics as a set of principles that people use to decide what is right and what is wrong or what is good or bad. In carrying out this study, I first of all sought permission to research this study from the Deputy Prime Minister's office of the Kingdom of Eswatini. A letter of approval is attached in the annexure. I also got ethical clearance from North-West University Ethics Committee.

I also worked with volunteers who signed informed consent forms after the whole purpose and process of the research was explained to them. I assured the participants that the information obtained during the research process would be solely used for scholarly purposes and no harm would befall them. I also informed them that if they felt uncomfortable at any given time they were free to withdraw and were not obliged to give any reason for withdrawing. To protect participants I made sure that their names, occupation and life in general would not be disclosed. I assured them that their trust would not be exploited for personal gain or benefit, by deceiving or betraying them in research route or its published outcomes, (Lubbe, 2003, p. 41).

4.11 LIMITATIONS OF THE STUDY

Conventional research studies are affected by numerous technical, professional, logistical and social constraints which may have negatively affected the validity and authenticity of the research findings of the study. In this study, financial constraints hindered me from studying a much bigger and more representative sample. I was aware that a small sample gives less generalisable findings. However, though my study was small it was subjected to intensive, in-depth study confined to the Manzini region in the Kingdom of Eswatini.

I may not have provided the participants with sufficient information about the research problem due to its complexity and elusiveness. Therefore some may have responded without adequate interest hence providing unreliable or predictable data for the study. However, I gave adequate background information to stakeholders and participants before the collection of data and assured them of their anonymity and confidentiality of the data they provided, which made them fully co-operate.

4.12 SUMMARY

The chapter discussed my preferred research paradigm, approach, design and methods of data generation, and analysis. It also discussed validation criteria, ethical considerations and limitations of the study. I began by highlighting the purpose of research followed by discussing my research paradigm and research approach. I then proceeded to discuss PAR as my research design, the research methods I used, validation criteria and ethical considerations. In the next chapter the first cycle of participatory action research will be presented and discussed. The research outcomes will be discussed in detail, supported by the explanations, extracts from journals and views from the literature.

CHAPTER FIVE

A DISCUSSION OF FINDINGS ON LIVED EXPERIENCES AND NEEDS OF GRANDPARENTS TAKING CARE OF AIDS-ORPHANED GRANDCHILDREN

5.1 INTRODUCTION

In the preceding chapter, I discussed the research design and methodology as it pertains to the participatory action research (PAR), which the study employed. In this chapter, I present my research findings of the first cycle that addresses the question: *What are the intergenerational relationship needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?* I support my interpretation of the data by verbatim quotations from oral responses of the participants as well as their drawings and control these findings against relevant literature sources. I then discuss my learning and reflections from the first cycle of the research study. I discuss the educational needs of grandparents along the ideas of intergenerational relationship theory (IRT) that is the Whole Person Wellness model, activity theory (AT) and continuity theory (CT) as key frameworks that underpin my study.

5.2 DATA ANALYSIS

As indicated in Chapter Four, I employed different methods in each cycle to encourage mutual understanding between grandparents from diverse backgrounds (see Table 4.2). In Cycle One, data was generated through storytelling, action learning set meetings, drawings and narratives. These are summarised in Table 5.1.

Table 5.1: Data generation and analysis strategies used in Cycle One

Data generation strategy	Purpose	Data documentation	Data generated by:	Data analysed by:
Storytelling, drawings and narratives	To get views from grandparents	Drawings and narratives	Grandparents and researcher	Grandparents and researcher
Action learning set meetings	Reflecting on action taken and planning of next move	Audio recordings and transcribed verbatim	Grandparents and researcher	Researcher then feedback at next ALS meeting

Qualitative data was coded, organised into emerging themes, and analysed (see Chapter 4.7). In the following discussion, I deconstruct and interpret the voices of the grandparents caring for grandchildren orphaned by AIDS to answer the first research question.

5.3 PRESENTATION AND DISCUSSION OF THEMES

I identified four main themes with several interwoven sub-themes from grandparents' lived experiences. I discuss each theme and sub-theme, giving evidence in the form of verbatim quotations and support with literature where necessary. To ensure participant anonymity I assigned identification codes. "P" stands for participant and "D" stands for drawing. The following themes emerged from our data analysis:

Theme 1: Financial Needs

- Insufficient money to buy food provisions
- Infrastructural development
- Educational requirements

Theme 2: Need of Knowledge on Current Parental Practices

- Early sexual maturity by grandchildren

Theme 3: Social Support Needs

- Lack of emotional support with the family system
- Lack of recreational facilities
- Lack of platforms to be heard

Theme 4: Health Needs

- Need to monitor chronic illnesses
- Need to engage community care givers
- Need for community burial schemes and funeral policies

5.3.1 THEME 1: FINANCIAL NEEDS

The dominant narrative that emerged from the grandparents was that of financial challenges. Limited finance is a key challenge facing elderly caregivers in Africa at large (Mhaka-Mutepfa et al., 2014) and Eswatini included. Data revealed that grandparents' financial challenges exist because of unemployment, no history of employment, and lack of financial support from remaining family members. At their age, the elderly are not able to engage in paid work and income generating activities and their only source of income are the meagre social grants they receive from the government which rarely meet their needs. Participants expressed disappointment at the amount they receive as social grants popularly known as, *imbasha yabogogo* from the government meant for their upkeep. *Imbasha yabogogo* literally means something so small that can fit into one hand. One of the participants remarked:

My son, we are starving. The grant we are getting is too little to meet most of our needs. It gets finished the first day we are paid. Our needs are just too many because of the large number of grandchildren I am raising. I wish the government can increase our social grants.
[P3]

This demonstrates the fact that by design the social grant cannot sustain the livelihood of a family in its entirety. The government avails the grant with an understanding that it is a supplementary kind of assistance. For these vulnerable grandparents, the grant unfortunately adds no recognisable relief since they solely rely upon it for all their needs. This translates into a situation where intergenerational households regularly face shortage of basic needs such as food, secure shelter, medication, infrastructural development and educational needs for the grandchildren. The foregoing are physiological needs that require satisfactory gratification before higher order needs may be satisfied (Maslow, 1987; McLeod, 2020). In the following sections, I shed more light on the needs that the grandparents raised during the action learning set (ALS) meetings.

5.3.1.1 FOOD PROVISIONS

Grandparents caring for grandchildren who have lost parents because of AIDS-related illnesses experience heightened poverty and greater food insecurity (Mohale, 2013). Looking

at the high cost of food, the social grant given to the elderly at Eswatini is too little to buy enough food for a month even for a small family. According to the World Bank Report (2020), the poverty datum line in Eswatini stands at US \$1.90 and the support structure provided for by the Eswatini Government is far below this line and food insecurity is negatively impacting intergenerational households. Some participants remarked:

Ladies and gentlemen, life is tough sometimes we survive on one meal per day because the situation will be calling for that. My grandchildren go to school on an empty stomach and with no money for break. My grandchildren are always sad because of this situation. [P9]

We are surviving because of my kind neighbours who always assist us with food parcels. If it wasn't [for] them we could have [been] long gone. Sometimes I feel like committing suicide but because of my grandchildren, I soldier on. [P3]

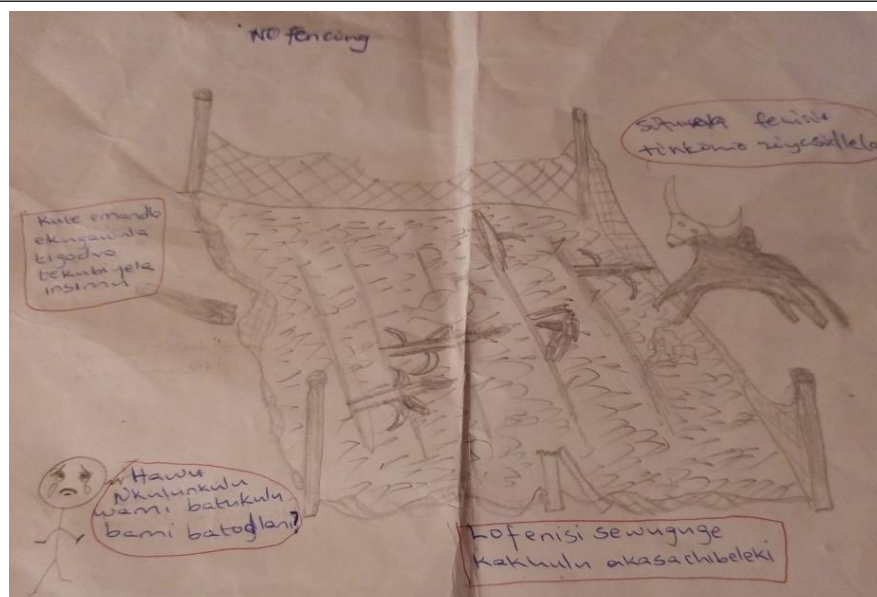
Site imali yekutsenga kudla kanjalo nemandla ekulima asisenawo ngobe sesikhulile
We don't have enough money to buy food and the energy to grow crops is no longer there. [P6]

Such a set-up results in grandparents getting frustrated and you would hear them use such words as *uneasy*, *harassed*, *stressful*, *hurt*, and *frustrated* when narrating their scenarios. Through the ALS members' participation in drawing, I observed that emotions that grandparents had earlier concealed surfaced. The drawing exercise provided an open space for the elderly to thwart their feelings on how lack of food was affecting them and how they were handling it. Figures 5.1.1 and 5.1.2 contain some visual content and accompanying narratives indicative of how grandparents feel about their predicament.



- This drawing indicates the poor harvest as a result of lack of farming inputs like fertilizers and seeds.
- I did not get enough food.
- What will I feed my grandchildren with?
- My grandchildren are lazy to work in the fields.
- I am tired of asking for maize from my neighbours.
- I no longer have enough energy to cultivate large fields
- The diagram shows an empty maize crib

Figure 5.1.1: “Poor harvest” (D8)



- The cattle are eating my crops because my fence is old and now needs to be replaced.
- I am feeling sad what will my grandchildren eat?
- I don't have energy to cut logs to replace my old fence.

Figure 5.1.2 “No fencing” (D3)

Figures 5.1.1 and 5.1.2 draw attention to the plight of grandmothers who are victims of a poor harvest, consequently facing hunger. At the apex of the left corner of the first drawing, the participant expresses a traumatic experience where her grandchildren made her feel hopeless having them around as part of her family because they cannot assist with fieldwork as they wake up too late. In our African setup, young children are the ones who are expected to work in the fields. Elders play the role of managers. But from the drawings grandchildren are doing the opposite. Another drawing on the extreme right illustrates a plate full of food with an X, and this signifies that such food is in short supply in this household.

In another ALS meeting, after having explained to the grandparents the three theories that underpinned the study, they appeared to have appreciated their stressful situation in that, as they participated in the generation of data through drawing one member commented:

I can see that we have same problems, but my situation is different as I have nine orphans to look after. [P3]

From the above data, it could be seen that coping mechanisms are subject to one's personality, similar prior experiences and events, culture, and mental health (Folkman, 2010). However, not all individuals react the same way to similar experiences. The same participant while reflecting on the drawings and storytelling presented by others, she appeared to now understand herself better:

I learnt that I kept so many things in my heart and battled with high blood pressure. Some of these challenges I had forgotten. I only remembered when my neighbour here explained what she has in her drawing. [P3]

Further, the same participant reflected as follows on her emotional response to stress:

Seeing these drawings, all the depressing feelings resurfaced. I felt so bitter about this disease that took away my children but I am happy that I have actually moved on from some of the negative feelings [I] had. But I do not want to keep on looking at these drawings because they have reminded me of where I am coming from. [Laughs]. [P3]

For me, the achievement of this drawing exercise as a method of data generation is apparent in that although this member of the ALS felt defenceless, she was able to triumph over her personal qualms and express her emotional setbacks. I concur with Wilkins (2014) who says that:

Laughter itself is incompatible with anger and negative affective states. The physical act of laughter results in physiological changes that stimulate feelings of mirth and cognitive release from anxiety and tension. (p. 287)

My understanding of laughter as a psychologist with some background of science is that it beneficial. Apart from enhancing one's emotional and psychological state, laughter also improves ones' physiological health, in that it boosts up muscle tone and cardiovascular functioning (Lebowitz, et al., 2011). When I reflect on laughter, I relate it back to the theoretical stance that I took on wellness and health in Figure 3.1, where I adapted Hettler's (1979) model of Whole Person Wellness. The model illustrates a holistic perspective on wellness that integrates six wellness dimensions: social, emotional, physical, intellectual, occupational and spiritual. I saw that laughter takes all these dimensions and thus I give good reason for my choice of using this model. My reflections were that ALS meetings utilise an all-encompassing holistic approach as the meeting empowers an individual to feel as having a potential of enjoying well-being despite the stressful situations they will be going through. Laughter elicits a coping reaction to negative feelings about care-giving practices.

I observed that drawing and storytelling of different experiences as methods of collecting data in PAR enable individuals to grow out of their challenges. In an ALS meeting which was held three weeks after this one, participants appeared to have weaned themselves from what they had expressed in the previous ALS meetings. They now showed zeal to continue working in the fields to put food on the table.

Sicela mane hulumende asifakele fenisiwetingadze. Siyetamakulima mane tinkomotiyasidlela.

We [would] appreciate [it] if the government and other stakeholders can provide us with fence. We are trying to grow crops but cattle always destroy them. [P9]

Ngifise kuthola manyolo kuzengitokhona kulimakahle, njengoba ubona inganyo ayinalutfo.

I wish I could get some fertilizer so that I [would] be able to grow crops well. As you can see my maize crib is almost empty [P8].

The above data advocates for the AT theory. One of the theoretical frameworks underpinning this study refers to is successful ageing, which simply means active ageing. This implies that grandparents at Eswatini used to engage in farming in their middle ages, hence the need to continue with this earlier role and not be redundant by overwhelming care-giving practices. Thus, the AT helped me to understand and interpret the findings in this study to mean that

grandparents involved in caring for grandchildren orphaned by AIDS may aspire to keep active as this has holistic benefits. On the other hand, while grandparents still felt that they should continue with their roles, they wanted to do it in a much easier way.

As an old person it is now hard to till the land using my hands. If I had money I [would] hire a tractor to till the land for me ... I love farming ... If I can get these I wouldn't be starving. [P4]

As we analysed data it confirmed that in the process of ageing, an individual develops certain preferences that become part of their personality and this is in contrast with the CT perspective that is concerned with continued patterns of behaviour based on life experiences that are repeated as one ages (Atchley, 2003). The more active the elderly, presumably the more satisfied they are with life, the higher their morale. At old age, the elderly are deprived of several roles that could have been so pivotal in their earlier life. Morgan and Claypool (2012) perceive such a scenario as leading to loss of sense in which one is. To offset this change of lifestyle and maintain positive emotional and mental state, the AT presumes that restitution, in the form of compensatory activities, must take place. By keeping active, it is assumed that people will remain socially and psychologically fit, and this is relevant in the context of grandparents taking care of grandchildren orphaned by AIDS at Eswatini.

The second drawing, as it relates to this theme, was done two months later, as I did not want grandparents to have any links between negative emotions expressed in the initial drawings and the second activity, which required participants to draw images of how they intend living in the near future. In other words, I wanted the second drawing to focus on determination to live a better grandparenting life. Lopez (2014) rightly puts it that determination matters and is a choice that one can learn and share. This is exactly what happened after a series of ALS meetings. The grandparents chose to have a better orientation to their scenarios after learning and sharing their lived experiences with others. The first drawing allowed grandparents to voice openly their lived experiences. My intention was that they do away with negative experiences in their care-giving practices, and move towards visualising an encouraging future. The emphasis was on hope. Hope, biblically explained, is to believe in things that someone has not yet seen and have a better orientation towards the future. I saw that providing this open space for ALS members was an endeavour to uplift them spiritually in line with the spiritual dimension in the Whole Person Wellness model and this further justifies the choice of this model in this study. To hope for a better future enabled the grandparents caring for the grandchildren orphaned by AIDS at Eswatini to bring about a change in their lives. In this ALS meeting, the elderly were given a chance to express their feelings and determination

for a better future and changed care-giving practices, which are less stressful. Figure 5.1.3 considers grandparents' future hopes.



Figure 5.1.3: *Image expressing hope for a bumper harvest (D5)*

In this drawing, grandparents' hopes are plainly visible, and when I compare the two drawings (Figures 5.1.1 & 5.1.3), I notice conspicuous differences. In Figure 5.1.3, the images are more positive, notably containing green maize plants which suggest a bumper harvest and the sad expressions have been replaced by jovial faces full of energy, which suggests that the grandparents taking care of AIDS-orphaned grandchildren have moved from previous unenthusiastic practices to optimistic aspirations. This indicates that grandparents taking care of AIDS-orphaned grandchildren are predestined for better livelihoods. When I chose drawing as a method for collecting data, it was simply for the reason that the elderly lack expressive written language (Knowles & Cole, 2008). However, when we analysed data we saw that it went beyond transformation, and enabled the elderly to gain confidence in managing intergenerational households. The drawing exercise proved to be healing and inspirational as seen in the following words of the two ALS members quoted below:

Um, I'm a bit relieved. I just think this gathering was very important, and I think we must continue having such meetings in our neighbourhood. [P1]

I have just got out of it ... being aware that I am not alone in this journey. [P5]

Participants agreed that the only way to realise financial independence was knowledge on new farming practices. In the second ALS meeting, I asked participants how they have coped differently with stress related issues having participated in the preceding meeting. Some of the members responded:

I think we have learnt. I now do not take things personally because previously I thought I was alone. [P3]

I have started a vegetable garden at the backyard and these ones [grandchildren] are now assisting. I am now a happy person. [P7]

From the above excerpts, it could be seen that besides the motivation to deal with financial stress related issues, the ALS members also turned out to be decisive of the habits they could engage in to relieve stress at the same time alleviating their financial issues. In addition to personal development, the elderly also learnt from within the ALS members the importance of interaction and sharing experiences. The ALS members understood that sharing experiences could support them against the negative impact of care-giving practices. The grandparents' learning about how to cope with financial issues and stress feeds into and supports my choice of using a Whole Person Wellness model, and it also indicates that I have been working within my theoretical framework. Whilst bringing about change in the lives of grandparents, I observed that financial issues are perennial as they reported that money was not enough for other things to include infrastructural development.

5.3.2 INFRASTRUCTURAL DEVELOPMENT NEEDS

The ALS members raised a number of concerns related to infrastructural development that were a hindrance to sustainable grandparenting which included the following.

5.3.2.1 AVAILABILITY OF CLEAN AND SAFE WATER

The participants agreed that for them to successfully look after their grandchildren they needed water for many of their activities. One participant said:

We need water to start our small gardens we agreed on in our ALS meetings. It is hard to walk long distances to fetch water. Lack of clean water will compromise our health and end up not being effective in looking after our grandchildren. [P3]

They alluded to the fact that water will also help them start income generating projects like piggery and rearing chickens. In Chapter Five, grandparents complained about lacking financial support. They argued that if they can be provided with water, they can be able to start

projects to generate enough food for their families. They will also be able to sell some of their products and supplement the money they get from the government in the form of grants. Participants were against relying on hand-outs as it made them redundant. They argued that inactivity causes boredom and sickness. These assertions by participants are confirmed by Kathleen et al., (2016) and Knight (2012) who posit that inactivity causes diseases like high blood pressure, diabetes mellitus, osteoarthritis, cancer, obesity and neurodegenerative diseases. Kathleen et al. (2016) further assert that old people who remain physically active gain some health benefits. Knight (2012) posits that the diseases will eventually cause mortality if unabated. This conforms to AT, which is one of the theories underpinning my study. When we started our ALS, I stated to the grandparents that I wanted them to remain active now that they are parents again. I highlighted to them the benefits of remaining active. Throughout our ALS meetings grandparents kept on emphasising the importance of remaining active. Knight (2012) recommends that moderate intensity activity for 30 minutes every day will result in significant health benefits. This is the reason why grandparents wanted to remain active. This made me reflect on Figure 3.1, where I adapted Dr Bill Hettler's 1979 Whole Person Wellness theory underpinning my study.

5.3.2.2 NEED TO IMPROVE LIVING STRUCTURES

The living structures for the majority of families that care for orphans at Eswatini are seriously worrying. The ALS members raised concern over the type of shelter that they are living in with their orphaned grandchildren. The families live in an extreme form of impoverishment with structures that are too old, made of clay and, therefore, not habitable (see Figure 5.2).



Figure 5.2: *Photos of sticky and muddy huts at Eswatini*

As participants related their stories on how they survive in such conditions, all of them had appalling and disturbing experiences and in their stories, they used words such as *devastating*, *not valued*, and *frustrating*. Framing my discussion in the wellness theory required me to view such dilapidated structures as an environment that is not safe and conducive. Grandparent's health and social life cannot be complete if they are living in substandard accommodation.

5.3.2.3 NEED FOR ELECTRICITY CONNECTION

Linked to proper shelter was the need for electricity connectivity. Electricity was required for charging phones, powering radios, television sets and other electrical appliances. For most, electricity was required for the new normal in the education system that has been necessitated by the Covid-19 pandemic where lessons are done online. For grandparents without electricity it means their grandchildren are excluded. Their grandchildren complain about being left behind in their studies. The wellness of the grandparents and grandchildren will be affected.

5.3.2.4 NEED TO CONSTRUCT A PROPER BRIDGE LINKING COMMUNITIES

Construction of a proper bridge linking communities was another factor suggested by grandparents for successful grandparenting in their communities. The grandparents felt that lack of a proper bridge is affecting their daily lives with their grandchildren. This is particularly so during the rainy season. When the river is overflowing the grandparents can't cross to go to the local Roman Catholic clinic. Grandchildren are deprived opportunity to learn as they can't go to school during the rainy season. Public transport also becomes a challenge they indicated. They wondered why the bridge is not a priority. Participant 6 had this to say:

All aspiring Members of Parliament [MPs] always campaign using the bridge but once they are elected they forget about it. There was a time His Majesty came to open the school; he couldn't cross the bridge and we were promised the bridge will be fixed, but up to today there is nothing. At one time, community members were asked to contribute E10 towards the construction of the bridge. We paid that amount but nothing happened. I am disappointed and frustrated; something needs to be done so that the children do not attempt to cross the flooded river and risk being swept away by the flood waters. [P6]

The above submission makes it clear how important the bridge is in the lives of grandparents and their grandchildren. They argued they cannot be successful grandparents when their grandchildren cannot go to school.

5.3.3 NEED FOR EXTRA EDUCATIONAL PROVISIONS

Provision of educational needs remains one of the most pressing priorities for Eswatini intergenerational households. Grandparents voiced a number of challenges charged with emotions as far as the educational needs of their grandchildren are concerned:

You would hear them today saying my Maths book is finished. The following day the English book is required. No matter how wealthy one is, they can't survive in today's schools. Maybe if their parents were here they [could] afford it. As for me my hands are tied. [P4]

Since this disease [COVID-19] started, teachers are giving them work to do on phones. I told them to relax as I cannot afford money for data bundles; they will have to wait for schools opening. When I don't know, but God knows. [It is] so stressful. [P5]

The issue of their schooling does not give me peace at all. Although the government pays fees for these little ones, but ... hmmm ... meeting other needs now like books

required is so stressful and uniforms are a problem. It's painful to see my grandchildren going to school [almost] naked. [P1]

The above submissions illustrate that grandparents caring for grandchildren orphaned by AIDS have serious challenges when it comes to meeting the additional school needs of their grandchildren. A survey carried out in Uganda established that, out of twenty-two orphans and vulnerable children in households affected by HIV and AIDS and headed by older people, only eight were attending school (International HIV and AIDS Alliance, 2003; Sengonzi, 2007). Failure to meet grandchildren's educational needs results in strained intergenerational relationships:

I cannot be fending for people who cannot assist in fieldwork or household chores yet when they come back from school you will hear them say tomorrow I want to take this and that to school without fail. They demand what they want but cannot help in anything. When you reprimand them, they threaten to leave the home. We are living under stressful conditions, my son. [P5]

From the above submission, it could be seen that the grandchildren become emotionally unstable and often having emotional outbursts when one communicates with them (Louw & Louw, 2007). Participants reported that the intense mood swings by grandchildren compromises their well-being and were finding it difficult to cope. To conclude this theme it would suffice to mention that unmet needs result in emotional illnesses, which affect an individual's capability to function well. Framing my discussion of findings on the Whole Person Wellness model required me to view financial challenges faced by grandparents as affecting their well-being. Due to limited finances, grandparents fail to meet their physiological needs as well as that of their grandchildren consequently affecting their relationship.

5.3.4 THEME 2: NEED OF KNOWLEDGE ON CURRENT PARENTAL PRACTICES

There are unique characteristics around parenting of children in intergenerational relationship households. One participant remarked:

Mntfwana mitsinesite tidlela letinsha tekukhulisa bantfwana. Basitjela ngepozetivu asiya tsine leyopozetivu yakhona. Sitokele ngephandle.

We lack current present parenting skills. These days they tell us about positive discipline; we don't know anything about positive discipline. We can be arrested any time. [P9]

Grandparents expressed desire to learn about new parenting skills applicable to the millennium generation. Grandparents need to understand the developmental changes that

now take place amongst the millennium generation as they mature faster with different expectations. The grandparents reported that this generation has intense mood swings and this compromises their well-being and were finding it difficult to cope. For grandparents without psychological knowledge it is difficult to understand the behaviour of their grandchildren leading them to have many questions resulting in them employing power-assertive discipline strategies at the same time experiencing elevated levels of stress. Therefore, grandparents needed to understand that such behaviour is common as children mature into adolescence and should let them be while performing their work as nurturers and disciplinarians (Kangendo, 2017). The major disciplinary issue emerging was that of early sexual debut resulting in orphans playing truancy, dropping out of school, abusing drugs and getting pregnant during their teenage years.

5.3.4.1 EARLY SEXUAL ENCOUNTERS BY GRANDCHILDREN

Grandparents reported that their grandchildren have developed devastating ways of coping with the challenges they face in intergenerational households by engaging in sex at a tender age. When they compare themselves with this new generation, it becomes difficult for them to understand their behaviour:

I don't understand these grandchildren. I remained a virgin until I got married. But these grandchildren start having sexual intercourse as early as eleven years. What is wrong with them? Is it food they are eating? Is it the television which is teaching them all these things? [P10]

Posing more questions than answers is indicative of the fact that grandparents have no information on how to deal with deviant behaviour and the literature confirms that most grandparents are illiterate, have no information or adequate information dissemination, and this makes these grandparents' situation difficult (Winston, 2006). The anxious grandmothers then resort to punitive and coercive disciplinary methods (Oburu & Palmerus, 2003). It would seem that because of the fact that grandchildren's need for autonomy are often at variance with the challenges they face in caring for their grandchildren, they resort to stricter controls, and when they do, the grandchildren rebel against the stricter control. One participant narrated:

She was disappearing every weekend and coming back on Sundays very late, and I used to beat her now and then and chase her out of my home; but it didn't work. She ended up contracting HIV and dying and leaving an HIV-positive great-grandchild that I am taking care of as we are speaking. [P7]

It is evident from the above data that grandparents in intergenerational households have no ability and skills to deal with their circumstances. An educational intervention programme that deals with insights regarding HIV and AIDS, and in particular how to handle the problems grandparents are encountering in their roles as caregivers is pertinent. In light of this, Mudavanhu et al. (2008) are of the view that skills training, knowledge, and orientation in raising grandchildren, some of whom are infected, is required. The more knowledgeable the elderly, presumably the more satisfied they will be with life and the higher their morale. Life satisfaction and adjustment are terms that are frequently used in the AT which is one of the lenses through which I view this study, hence, its relevance.

From 30 June until the second week in August 2020, I was not able to engage with the action learning set due to strict lockdown measures in the context of this study. I thought this was a period of inactivity but for the ALS members it was indeed a period of adjustment in their role changes after the first meeting to deal satisfactorily with their experiences. I found that working with ALS members was amazing as I saw it empowering grandparents caring for grandchildren orphaned by AIDS at Eswatini. Negative emotions changed to positive ones and grandparents now viewed their roles differently. This was after they implemented some of the ideas that we generated during our ALS. They appeared to have learnt to embrace their grandchildren:

Ah, even though at times we might think that they are wild. They keep us company; I can no longer cope without them. [P5]

This is evident in the observation that grandparents have adjusted in their life courses, have understood proxy parenting. They also find it mandatory to develop positive attitudes towards their new roles. Sharing ideas in the ALS meetings enabled grandparents to learn to become tolerable and flexible in raising grandchildren orphaned by AIDS. From the data above, it could be seen that the grandparents are now somewhat satisfied and they identified themselves with their own children and have generated positive dispositions in care-giving. The concerned grandmothers in Eswatini are now more likely to provide emotional care for their orphaned grandchildren. Moreover, literature reveals that grandmothers have been reported to be relatively, “more caring, compassionate and less discriminative towards orphans than were other categories of care providers due to their child-rearing experiences and unsurpassed determination to provide the best for their grandchildren” (Oleke et al., 2006). What these elderly caregivers required was necessary support and an open space to let out their views to enable them to cope with their frustrating roles they encounter in intergenerational

relationships. It would seem mutual support and reciprocity constitutes important aspects of intergenerational relationships.

5.3.5 THEME 3: SOCIAL SUPPORT NEEDS

Another recurring impact suggested by grandparents was lack of social support to deal with their experiences. Social support plays a critical role in mental health (Winston, 2006) and provides important benefits to an individual's physical and emotional health (Alpaslan & Mabutho, 2005). Grandparents caring for grandchildren orphaned by AIDS at Eswatini reported lower levels of social support from within the family structures and find themselves with no one to confide to and this makes them to be more vulnerable. Lack of social support put the grandparents at risk of maladjustments and missing love, care and attention at a time when they are ageing and they require it most to help protect them from the harmful effects of stress. Social support can come in many forms. In this study, the recurring theme was lack of emotional support within the family system.

5.3.5.1 LACK OF EMOTIONAL SUPPORT WITHIN THE FAMILY SYSTEM

The majority of participants reported that they no longer had emotional support from within the family system especially the surviving children whom they looked to for support. There is no one to show sympathy or care in the dilemma.

It is disheartening to note that my elderly children are not even showing up to see how I am living with these children. They think I need their money; it won't be the case I just need someone to talk to. [P8]

Nonetheless, the ALS meetings were a useful way of introducing the grandparents to each other. I observed that they were now showing greater interest in their well-being and that of their grandchildren having learnt from the experiences of the other members. They began to think and talk positively about grandparenting as compared to when the meetings began. The ALS meetings became their source of comfort and strength. I concur with Dutton et al. (2014) who assert that showing care alleviates the suffering of another person. I witnessed grandparents developing stronger relationships by sharing personal problems related to caring for their grandchildren. I observed grandmothers expressing joy, reflecting, and feeling the warmth of being in supportive relationships within the group, where they felt solidarity and experienced trust in a non-stressful environment. The direct consequence of the meetings motivated participants to decide on what they could do about lack of support as members of the ALS, and how they could move to a better livelihood.

As alluded to, the Whole Person Wellness model applied in this study focuses on six dimensions (physical, emotional, spiritual, intellectual, occupational and social). Participants reported that they feel the social dimension is met as they receive grants, but what was often ignored was the physical dimension, and they needed to focus on it for improved quality of life and healthier living. Many people will think old people do not deserve recreational facilities or activities especially Africans, but the participants in this study expressed the desire for recreational activities that would keep them engaged and offer social and physical benefits such as crafts and gardening clubs:

We are enjoying meeting each other in these meetings. We would appreciate a situation where we might meet once or twice a week and work on something productive such as sewing mats or a community club. [P2]

These interventions could meet the needs to socialise and maintain work life balance for the elderly and address feelings of negative emotions of caring for grandchildren orphaned by AIDS. When working with the ALS members, as I have, by improving their whole person well-being, changing the language of hurt and hopelessness I have come to realise that the livelihoods of grandparents taking care of grandchildren orphaned by AIDS can change, and that the grandparents can take responsibility for change within their own initiative.

5.3.5.2 LACK OF RECREATIONAL FACILITIES

The ALS members argued that for them to successfully carry out grandparenting duties they needed recreation facilities.

We always spend days in our homes with no one to talk to. Coming here for these ALS meetings is therapeutic. We thank you for selecting us for this study. After the meetings we always feel relieved. This is the reason why we are advocating for the creation of recreational facilities. [ALS]

The grandparents felt that going to recreational facilities would afford them the opportunity to meet other grandparents, grandchildren and even other community members to share ideas. They will also gain physical fitness. This is supported by the AT that contends that life satisfaction of old people is related to the amount of activity in their daily lives (Cavan et al., 1949; Havighurst & Albrecht, 1953). Kiran (2014) posits that recreation is important for the well-being of older adults and enhances their quality of life. The benefits of recreation for grandparents include opportunities for socialising, health and fitness, using old skills and talents and learning new skills (Kiran, 2014). The above submission by Kiran (2014) satisfies the Whole Person Wellness model guiding my study.

5.3.5.3 LACK OF PLATFORMS TO BE HEARD

Another concern by grandparents for successful and sustainable grandparenting is platforms where they can air their grievances. They complained that they do not have platforms where grandparents could discuss openly without fear their daily challenges and needs. I could feel they had a lot that they wanted to voice out but fear gripped them. As a result of this fear it is difficult for them to say what is troubling them. They applauded the ALS as it gave them an opportunity to pour out their troubles. They felt that if such platforms can be afforded to them even at community level they would appreciate it. I observed that as people who lived when there were still serious gender inequalities that fear of men is still there. Most institutions in the communities are still headed by men; this makes it difficult for grandparents who are mainly females to freely speak their concerns.

5.3.6 THEME 4: HEALTH NEEDS

Studies have established that health and functionality are factors that affect grandparents caring for grandchildren orphaned by AIDS (Olungando, 2017). The fourth theme that emerged was that of health challenges faced by both grandparents and their grandchildren.

5.3.6.1 NEED TO MONITOR CHRONIC ILLNESSES

When people advance in age, many health challenges come in, such as diabetes, high blood pressure, arthritis, kidney failure and other old age related diseases. Care-giving then becomes a challenge, as the elderly would need constant health monitoring. One grandparent remarked:

I am hypertensive and getting my BP tablets is now a challenge; no transport to get to the hospital and if it is there it is too expensive. The only bus that passes here pass early in the morning and if you miss it you will be in trouble. The nearby clinic is a Roman Catholic one and is very expensive. At the end of the day I just have to endure with my BP. Without even doing anything for these grandchildren I was left with, [I] can't even work hard because most of the times I will be down; [I] am pained. [P6]

From the above data, I reflected that care-giving requires good health and physical ability to do all the chores. Grandparents at Eswatini find it difficult to respond to these challenges and think they would be more productive if they have energy, vitality and great interest in the activities they do. The grandparents added that their health issues are further compromised by the fact that, their grandchildren contract sexually transmitted infections and when they

become infected, they fall back on them. Grandparents also expressed fears that they might be living with the disease unknowingly:

My fears are that I might have also contracted this thing. These orphans cannot resist [the] difficult times we are facing. They engage in sexual intercourse with older people without protection for monetary gains and when they are now infected it becomes my burden and we will end up [contracting] this disease also, because no one tells us what to do with what we face. [P8]

From the above, grandparents at Eswatini are at the risk of exposure to communicable opportunistic infections, and fear of contracting the disease can cause considerable anxiety on their part as caregivers. Especially if they are not well informed about the actual risks. Grandparents also find themselves caring for grandchildren on antiretroviral therapy and without adequate training and information on how to administer the medication it becomes a challenge. This situation becomes grave when some of the grandchildren fail to conceptualise their fate, and grandparents have to provide counselling:

This other time I was in a dilemma not knowing what to say to [P6's grandchild's name]. You know these children tend to analyse many things. One of my grandchildren was failing to understand why she was on ART, yet her younger sister was not explaining to her that her sister was saved by PMTCT, was a challenge. [P6]

From the above it could be seen that grandparents acting as caregivers should be equipped with counselling skills. Enabling the grandchild to understand his/her situation is a critical psychological issue that requires training on the part of the grandparents. Grandparents expressed the need for education on how to help the grandchildren to accept their situation. This should be a gradual process that involves communication, love and openness depending on the age of the grandchild and the prevailing situation. Grandparents also require to be educated on how to create a good interactive environment to facilitate discussion with their grandchildren. The stakeholders involved should consider strengthening their programs to this effect for the elderly caregivers.

5.3.6.2 NEED TO ENGAGE COMMUNITY CAREGIVERS

Grandparents reported that they wished to be in a community that identified with them and to receive extra help within the existing support networks put in place in the community. Members of the ALS meeting reported that support from home-based caregivers from the local clinic was going to be an important buffer for them:

Labanye babo labakhona bakhulile njengatsi. Sekulukhuni kutsi bawente kahle lomsebenti wabo webugcugcuteli. Hulumende akafake bagcugcuteli labasha labashabutelako kutewuhamba kahle lomsebenti.

Village health workers are few. We [would] appreciate it if they can increase the number of village health workers. Some who are there are old and are finding it difficult to cope with their work. It will be ideal for the government to appoint able-bodied village health workers. [P3]

The main thrust of home-based care programs is to empower the community and the family to cope effectively with the physical, psychological and spiritual needs of those living with HIV infection and AIDS and educate the community about the prevention of HIV transmissions (Van Dyk, 2008).

5.3.6.3 NEED FOR COMMUNITY BURIAL SCHEMES AND FUNERAL POLICIES

The other important point raised by participants was the issue of a funeral policy. Most the grandparents cannot afford most of the current policies offered by local funeral brokers. Their paying terms are not friendly for grandparents who depend mainly on their social grants they get once in three months. One participant had this to say:

I opened a policy and paid it faithfully for twenty years without experiencing any death in my family. However after twenty years one of my sons fell sick while in South Africa. I left Eswatini to SA to look after him. After three months he died and when I came back to Eswatini to bury him I approached the funeral broker and I was told my policy has been closed and I can't be assisted. It really pained me because all my twenty years [that] I was paying went to waste. As I speak I no longer have a funeral policy for my family. If I die or my family members die I don't know how I will bury them. I'm worried. [P10]

The implication of the excerpt implies that the grandparents need a user-friendly funeral policy. Death is something that comes unexpectedly. The grandparents cannot live happily with their grandchildren when they don't have a funeral policy. They asked if it wasn't possible to organise a funeral broker that would understand their situation, like allowing them to pay once in three months when they are paid their grants or when they sell their handcraft and agriculture products. Another suggestion was forming a community burial society. Still linked to this challenge was the issue of grandchildren born by their daughters and their fathers not belonging to the chiefdom. With these types of grandchildren, grandparents faced challenges when it comes to burying them. They are expected to pay a cow for them to be buried in the community. They felt it was rather too harsh for them especially at their advanced age. They

said they appreciated this traditional practice as it worked well in the past and fostered stable marriages but under current conditions with increased divorce cases and deaths due to HIV and AIDS it's now problematic and thus needs to be revised. The practice now also goes against the traditional belief that a child has two homes, the mother's and the father's home.

5.4 REFLECTIONS ON MY PERSONAL LEARNING AND THE PAR PROCESS

The impact of my learning on this study and practice as a psychologist centres on compassion. I have always shown compassion for other people as part of my ontological values, but I became more aware of the hurt the elderly in intergenerational relationships are going through, and my compassion grew to the point that I engaged with the literature in order to gain a better understanding of how being compassionate impacts others. It was very easy to deepen negative emotions when dealing with grandparents caring for grandchildren orphaned by AIDS in a non-caring environment. First, I developed compassion towards the ALS members and later extended it to all the people with whom I keep company. I found myself showing greater interest in the welfare of the grandparents caring for their grandchildren orphaned by AIDS. I became mindful of their traumatic experiences to the extent that they most probably noticed and could not afford missing any of the ALS meetings scheduled. I would hear them seeking advice on other personal issues that had nothing to do with the PAR process. My learning with regard to compassion is consistent with my use of the Whole Person Wellness model that underpins my study. Compassion is a spiritual dimension found in virtually all forms of Christianity. Therefore, my choice of using an adapted version of the Whole Person Wellness model is justified, as this view incorporates the spiritual dimension.

Taking part in PAR by simply either attending meetings or engaging fully in the proceedings resulted in behavioural and attitudinal changes. I observed grandparents living with grandchildren orphaned by AIDS adjusting and creating relationships that they built on trust and mutual understanding that are the key characteristics of the PAR process (Kindon et al., 2007). The members of the ALS learnt to embrace each other, work with each other, solve problems together, and accept their situation and in so doing contributed to their wellness. The fact that the ALS members opened themselves up to believe that they can learn from others, and that the challenges they are facing are not personal, indicates a change in their epistemology in how to deal with their dilemmas.

The grandparents became more self-confident during the PAR process and changed the language they used beginning of the study. My reflections were that they have learnt to care for their grandchildren's well-being and had moved from a dependency attitude syndrome

towards emancipatory behaviour. Furthermore, the PAR process allowed the grandparents to experience personal growth and express their feelings and opinions in an open and free way. The grandparents began to trust their grandchildren and their motives and valued the opportunity to express their personal feelings freely during the process. They felt that it was the first opportunity ever since they took up these roles to talk about their lives and circumstances.

5.5 SUMMARY

I conclude this chapter by suggesting that I have allowed the grandparents living with grandchildren orphaned by AIDS's voices to be heard, through their participation in ALS meetings, storytelling and drawings and their reflections on the process. What the ALS members engaged in during this cycle brought about adjustment and satisfaction, as they reflected on and became reflexive in their own care-giving practices. The open space I provided found grandparents' own voice, and they could not only confidently articulate their pain of being victims of the HIV and AIDS pandemic but could see themselves adjusting and gaining life-satisfaction consequently realising their wellness. Within the ALS, they have found grandparents with similar situations, who were also in need of adjustment and together offered a support structure, to which they could turn to for help and advice. Over and above that, they are now aware of what intergenerational relationships are all about, and they have understood how they dealt with their anxieties in the past, and what negative effects this had on their whole person well-being. The process was to them therapeutic. They have learnt to depersonalise issues, adjust to the new roles and appear satisfied to some extent. They are taking personal responsibility for the welfare of their grandchildren and are now in a stronger position to challenge their status quo. They are already experiencing hope; the kind of hope they expressed in their second drawing in Figure 5.1.3. In the next chapter, I address the question, "How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education-based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?"

CHAPTER SIX

FINDINGS AND DISCUSSION OF CYCLE TWO: A DISCUSSION OF THE FINDINGS ON HOW DIFFERENT STAKEHOLDERS COULD COLLABORATE TO MEET THE NEEDS OF GRANDPARENTS TAKING CARE OF AIDS-ORPHANED GRANDCHILDREN

6.1 INTRODUCTION

In Chapter Five, I discussed and presented findings on the intergenerational needs of the grandparents. The findings revealed that the grandparents taking care of AIDS-orphaned grandchildren were experiencing challenges regarding their financial, health and social support needs and current parental practices. Nonetheless, the aim of this study was not only to present an account of the grandparents' needs, but also to enable grandparents taking care of AIDS-orphaned grandchildren at Eswatini to improve their livelihoods through engaging different stakeholders to collaborate and come up with educational intergenerational programmes that would alleviate the plight of the grandparents. This chapter therefore attempts to address the research question, "How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education-based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?" To answer the research question and to come to an understanding of the initiatives, different stakeholders have taken to support grandparents who are caregivers of grandchildren orphaned by AIDS. I engaged seven different stakeholders to establish what they are currently offering and how they could collaborate to mitigate the needs of the elderly caregivers at Eswatini. The research methods used in this cycle are summarised in Table 6.1.

Table 6.1: Data generation and analysis used in Cycle Two

	Data generation strategy	Purpose	Data documentation	Data generated by:	Data analysed by:
Cycle Two	Action learning set on deciding grandparents' challenges to be presented to stakeholders	Making the stakeholders aware of the needs of grandparents	Annotated posters	Grandparents and researcher	Researcher and grandparents as co-researchers
	Focus group discussion on challenges faced by grandparents	Establishing what is being done by stakeholders to help meet the needs of grandparents and how they can collaborate to meet these needs	Video and audio recordings transcribed verbatim	Independent person	Researcher and independent recorder
	Action learning set on suggestions made by stakeholders	To deliberate on the suggestions made by stakeholders	Video recordings	Grandparents and researcher	Researcher and grandparents as co-researchers
	Action learning set	Sifting suggestions from stakeholders. What works and what does not work?	Annotated drawings	Grandparents	Researcher and grandparents

6.2 PRESENTATION ON GRANDPARENTS' NEEDS TO STAKEHOLDERS

Firstly, we used the FGDs to make the stakeholders conscious of the plight of grandparents taking care of the grandchildren orphaned by AIDS at Eswatini. The group decided to focus on all the four identified categories of needs (financial, current parental practices, social support needs and health needs) in the preceding chapter (cf. 5.3) as ALS members felt that they were all challenging and required intervention. Initially, I had strategized that all grandparents in the ALS be part of the observer group since this was a two-way focus group discussion (Hennink, 2014). In light of the Covid-19 regulations, we deliberated on that two members of the ALS represent the group as observers in the FGD with stakeholders.

I presented the needs of the grandparents to the stakeholders using a projector. Included in this presentation were grandparents' drawings on charts for clarity on the extent the needs affected them. On each drawing, there were narratives that explained challenges grandparents taking care of AIDS-orphaned grandchildren were facing at Eswatini and the consequences.

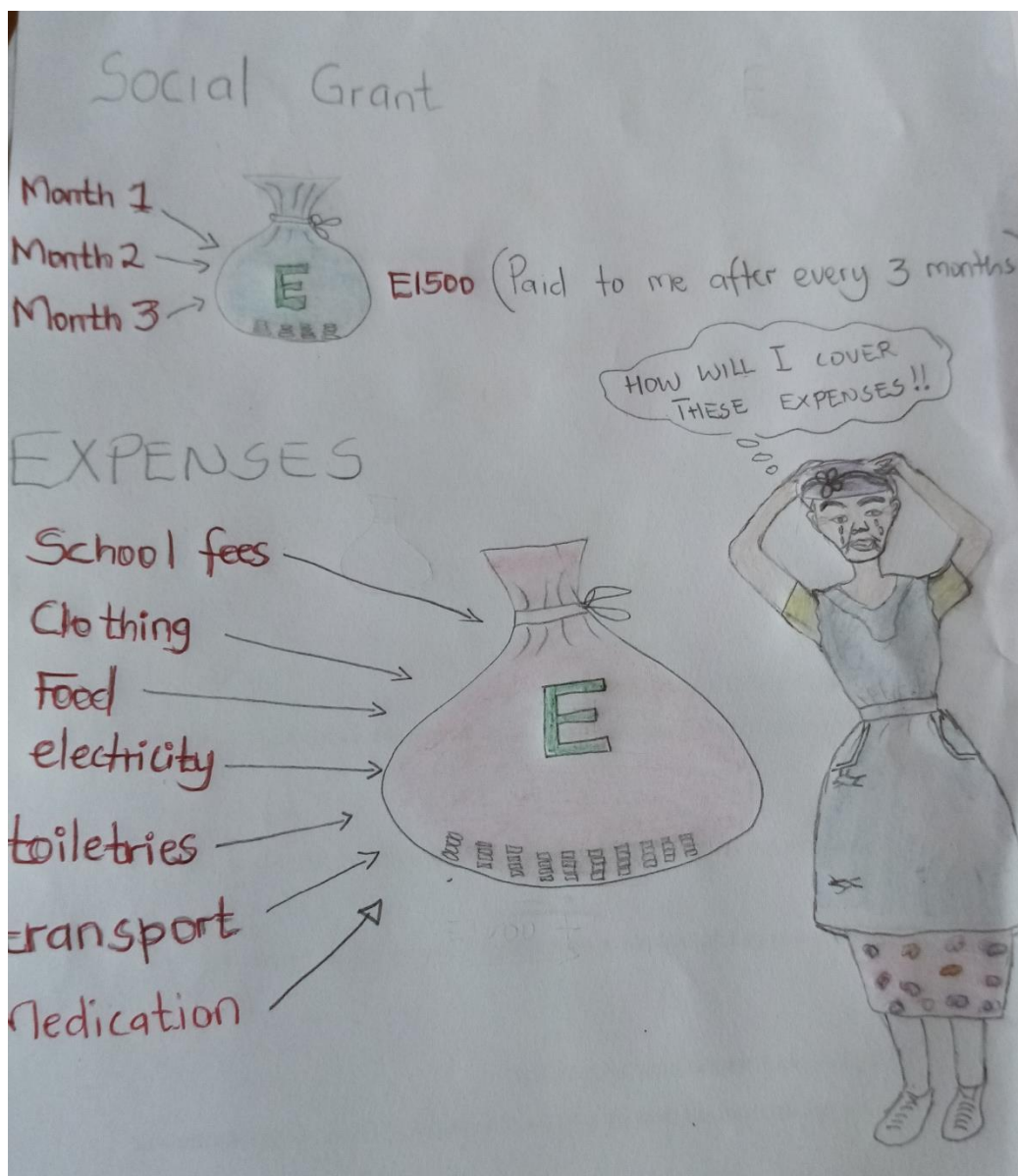


Figure 6.1: Shows some of the charts that I displayed

After the presentation, we sought feedback from the stakeholders. However, while some stakeholders warmed to the presentation immediately, other stakeholders perceived the presentation as a direct challenge to their organisational mission and goals. The following aspects came to the fore:

- Meagre social grants Inadequate psychosocial support
- Need for a functional health system, and
- Need for education on new parental practices.

6.2.1 MEAGRE SOCIAL GRANTS

The social grant provided by different stakeholders is a potential financial supply for grandparent caregivers. Nevertheless, of the seven stakeholders who participated in the FGD, only three stakeholders (1, 2 & 5) were offering financial support in form of a monthly social grant of E500 payable as E1500 every three months, E200 monthly grant to caregivers of double orphaned and vulnerable children below nineteen years. The intent of this funding is to cater for the personal needs of grandparents. Conversely, due to the new burden of grandparenting, grandparents find themselves using this money to raise grandchildren in an ever-rising cost of living (Kidman & Thurman 2014; REPSSI, 2011). What came out of the FGDs is that the financial assistance offered to the elderly taking care of AIDS orphans was inadequate.

With the prevalence of HIV and AIDS here at Eswatini, organisations must do what they can to ease the predicament of the elderly taking care of children orphaned by HIV and AIDS by making sure that they are supported financially. If these elderly are overwhelmed by the demands of the grandchildren and stressed it could lead to burnout and poor parenthood. [S5]

Grandparents need support and training if they are to meet the challenges of care-giving to children orphaned by HIV and AIDS. If their children orphaned by HIV and AIDS are to properly benefit from the new education reforms that require that no one should be left behind, increased financial support is not an obligatory extra, but indispensable for improved livelihoods of the elderly. [S2]

It is quite evident that the stakeholders are aware that what they offer grandparents taking care of AIDS-orphaned grandchildren is not enough to sustain their livelihoods. Identifying support services to address grandparents' needs for financial support would be essential to any program design to rescue the elderly suffering from chronic conditions such as high blood pressure, gastrointestinal ulcers, depression and other stress related illnesses (Griffin, 2020) consequently, reducing their motivation towards living longer (Nomura et al., 2007).

In the FGDs, it came out that stakeholders have also considered other solutions to alleviate the financial crisis of the grandparents with regard to education of their grandchildren. The stakeholders have availed a support fund to ensure that all school age OVC attend school and were not deterred from full participation through lack of financial means. The government through the office of the Deputy Prime Minister (Department of Social Welfare) pays school fees for all primary school children to fulfil the UN Convention that all children have a basic right to education (UNICEF, 2002). At secondary level, from Form 1 to 3, the government pays E1980 per year for each OVC. The government extends this form of aid to upper levels, Form

4 to 5, where they receive E2500 per year. Nonetheless, the incongruence is that benefits are due when grandparents produce proper documentation which requires clearance by *Imiphakatsi*. Stakeholders had this to share:

To avoid the duplication of sponsorship we work with S1. Before we can assist a child financially, we first establish if the government is not paying school fees for the same child and the child has proper documentation to be qualified [as] vulnerable. [S4]

According to UNAIDS and UNICEF's (2004) definition, a vulnerable child is a child who is under the age of eighteen and has either lost one or both parents or has a chronically ill parent. It could also refer to a child staying in a household where in the past year at least one adult died after having being sick for three months before dying. Another category for vulnerable children could be when a child is in a household where an adult has been seriously ill for at least three months in the past year. Children living outside their family care or on the streets are also vulnerable. Grandparents taking care of grandchildren orphaned by AIDS have to go through this verification process before they receive any form of assistance. This is evident that the reality of the situation is complex as the support payments are available according to certain eligibility criteria requiring both grandchildren and stakeholders to negotiate several bureaucratic muddles and this impact negatively on the grandparents who sometimes may not have proper documentation for the funding to be processed. The grandparents who were part of the FGD reiterated that the element of the wait-period is stressful, as they have to wait impatiently not knowing the outcome of their grandchildren's schooling.

Kube kuya ngami ngabe ngiyatikhunga, ngoba vele ngite lemali leyenele kutsi ngingabentela konke labakundzingako labatukulu

I wish I could commit suicide because I cannot afford to provide my grandchildren with everything they need. [P10]

While stakeholders have responded with such inclusive policies and action plans, it is evident from the above excerpt that grandparents remain susceptible to unhealthy conditions and this is against the wellness theory that remains a guiding principle in this study. The wellness theory stresses and embraces the definition of health as provided by the World Health Organization. The World Health Organization (1946, p. 100) defines health as, "The positive state of well-being apart from any disease and a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The relevance of this definition in this study is that it defines the health of an individual more holistically just as the Whole Person Wellness theory does when applied in this study. When we speak about the wellness of the grandparents caring for AIDS-orphaned grandchildren, we are referring to it in a holistic way. Thus, assuming social, emotional, physical, mental, spiritual and psychological aspects that allow grandparents to, "Maximize the potential' of which

they are 'capable' to do within the environment they are functioning in," as expounded by the father of wellness, Dunn (1961, p. 6). I reflected that to realise such benefits it is essential that support systems ensure there is universal education for all OVCs regardless of their social situation while grandparents are assisted to process proper documentation.

6.2.2 INADEQUATE PSYCHOSOCIAL SUPPORT

The psychosocial well-being of grandparents living with grandchildren orphaned by AIDS was another important area that stakeholders needed to explore. My understanding of psychosocial support for the elderly caregivers is drawn from the works of HelpAge International (2011, p. 2) who define it as, "Showing love and respect, for the elderly, and connecting them to social support systems, so that they regularly receive care and appreciation from their families and communities." In communities affected by HIV and AIDS, the forms of care that seem to be most realistic, and therefore most widespread, are those where the care of children is shared among various actors (UNICEF, 2016). Grandparents taking care of AIDS-orphaned grandchildren become isolated from their peers (Backhouse & Graham, 2012) due to care-giving responsibilities consequently, making their physical and emotional issues more difficult (Samson & Hertlein, 2015). With little peer interaction, one would then expect that grandparents taking care of AIDS-orphaned grandchildren receive companionship and support from within the family system, which we found was not the case at Eswatini (cf., 5.4.3.1). What came forward in the FGD was that the national responses in Eswatini mainly target the welfare of the grandchildren. Little is done to meet the needs of the grandparents, especially grief counselling (Guardian, 2010). The stakeholders saw the need for increasing social support to improve the wellness of the grandparents:

Generally, our programmes have been focused on providing social support to OVCs. We provide life-skills education to the children by collaborating with Eswatini Ministry of Education. We also mentor young girls to prevent them from early pregnancy and contracting HIV and AIDS as well as COVID-19 preparedness. I can see that supporting grandparents could also reap longer-term benefits. [S2 and S5]

As an organisation we have worked hard to contribute to a supportive environment for AIDS-orphaned children. We work with social workers and police to help grandchildren cope psychologically in cases of physical, sexual abuse, paternity disputes and deaths of parents - we offer DNA tests. And I admit that we have not been responsive to the psychosocial well-being of the elderly. [S2]

This is evident that the psychosocial needs of the grandparents taking care of AIDS-orphaned grandchildren are largely unmet by the stakeholders. Stakeholder activities generally target and are most appropriate for the grandchildren themselves excluding their carers who are in

the same predicament or even in a worse situation than they are. Lack of psychosocial support can affect the psychological well-being and health of grandparents (Mohale, 2013). Therefore, the best psychosocial care and support for the elderly could be provided through everyday interpersonal interactions that occur in caring relationships within the family environment. Such interventions enable the elderly to form a sense of self-worth and become particularly critical of their well-being (HelpAge, 2011). Just like the grandchildren, the elderly caregivers must also have all of their needs met. The grandparents are not only taking care of the needs of their grandchildren but they also have their own needs. All needs are equally important and they depend on one another for fulfilment (Peace Corps, 2013). Thus if grandparents' needs are not met, their psychological well-being is compromised, consequently affecting the grandchildren whom they are taking care of. Hence, the stakeholders' view that all needs should be taken care.

As organisations, we seem to override that care-giving responsibilities come at a time when older people will be looking forward to receiving support from their children and families. But because of the HIV and AIDS pandemic, grandparents find themselves confronted with the responsibility of caring for their grandchildren and this is overwhelming psychologically and socially, not mentioning the physical and economic dimensions. [S5]

Evidence has indicated that for elderly caregivers to maintain an adequate level of functionality they require a warm and supportive relationship with another adult or within the family system to promote resilience in times of continuity.

6.2.3 NEED FOR A FUNCTIONAL HEALTH SYSTEM

According to the WHO (2010), a functional health system responds in an even-handed way to the needs and expectations of the people in any given society. A functional health system should: improve the health status of individuals, families and communities, protect the population against what threatens its health, provide equitable access to people-centred care, and provides opportunities for people to participate in decisions affecting their health and health system (WHO, 2010). In response to health challenges faced by grandparents caring for AIDS orphans, the active focus group members (stakeholders) felt that they were keeping health systems on track and responsive to the health needs of the communities.

We offer health-user fee support, basic personal hygiene and menstrual dignity toiletry packs. Also we sensitise and educate grandchildren on HIV prevention, refer and link the grandparents/grandchildren to health-care facilities for male circumcision, ART initiation and enrolment into support groups. Sometimes we provide them with transport fares to get to the health-care facilities. [S2]

During home visits, we help grandparents understand and interpret the grandchildren's child-health cards for their grandchildren orphaned by AIDS, and also remind them to observe clinic days. We encourage grandparents to boil water from unsafe water sources. We also sensitise/educate grandparents on symptoms of other diseases e.g. bilharzia, coughs, that may manifest in the grandchildren orphaned by AIDS and encourage grandparents to immediately seek health care when they suspect infections. [S3]

We have close ties with health facilities in the communities we work. Through the clinic registers, health-care workers refer grandchildren orphaned by AIDS to our project for non-clinical care like psychosocial support and food assistance. [S2]

Since this was a two-way focus group discussion, the sentiments shared by the active group opened up more discussions as the observer group delved into health issues and offered greater perspective (Massey, 2011) about their predicament. The observer group felt that stakeholders tend to prioritise the needs of children orphaned by AIDS and this could result in a dysfunctional intergenerational household.

While we appreciate what you are doing, my children [stakeholders], [for] our grandchildren, you are neglecting the drivers of the journey. If we collapse and die, who will remain [to] care of the little ones since their parents have departed in this world? I want you to realise that something planned for them [grandchildren] can only be successful if we the caregivers are in good health. [P6]

From the above excerpt, it could be seen that the observer group was of the opinion that the stakeholders barely addressed their issues (cf. 5.4.4.1 & 5.4.4.2). An intervention that focuses on health-care systems that promote lifelong good health for the elderly caregivers could result in a significant increase not only in the life of the elderly, but also in the life of AIDS-orphaned grandchildren whom they are taking care of. In terms of the rights-based approach to meeting needs, all needs are of equal importance and are non-negotiable (Loening-Voysey & Wilson, 2001). Therefore, the grandparents taking care of grandchildren orphaned by AIDS needed not to engage in a lengthy debate with the stakeholders to bring home to them that health promotion and well-being throughout life is "the cornerstone of healthy ageing" (Lloyd-Sherlock, 2010, p. 91). On reflection after the lengthy debate that ensued, stakeholders came to a realisation that there is a dire need to harmonise the approaches to health systems to cater for the needs of the grandparents.

Part of our duty is to monitor and evaluate programs that we put in place in communities to improve [their] livelihoods. It would appear generally our policies and programs for OVC do not explicitly target older persons and this is something maybe to consider in the next intervention. [S2]

Therefore, the intervention plans set forth should call upon stakeholders first, to reduce “the cumulative effects of factors that increase the risk of disease” among grandparents taking care of AIDS-orphaned grandchildren and develop programmes and “policies to prevent ill health among older persons” (UNPDMIPAA, 2003, p. 29). On the other hand, the activity theory (AT) that informs this study holds the view that adjusting in later life has nothing to do with societal factors but is solely dependent on how an individual adjusts. The implication in the context of this study is that continuity within the grandparents’ lifespan may take precedence over societal standards. Whatever adjustment the elderly need to do, they have to do it on their own, even though the intervention programmes are not tailor-made to suit them. Precisely, in the work of one of the oldest proponents of the AT, Cottrell (1942, p. 618), the elderly caring for AIDS-orphaned grandchildren at Eswatini are “called on to act” in relation to the roles they now occupy in their late life.

6.2.4 A NEED FOR EDUCATION ON NEW PARENTAL PRACTICES

Children orphaned by AIDS like all the other children require basic needs (parental love, care and protection in the early stages of development) to develop and grow to healthy and responsible adults (UNICEF, 2016). The immediate intergenerational family environment of AIDS-orphaned children is critical in determining how these children will develop because it is in this environment that they get nurtured, thereby experiencing love and acceptance, a sense of belonging, safety and security as well as developing trust, respect and confidence (Nkironke & Mugambi, 2019). As discussed in the preceding chapter (cf. 5.4.2) grandparents taking care of grandchildren orphaned by AIDS were finding it difficult to cope with the intense moods their grandchildren sometimes display and reported that this compromised their well-being. Grandparents find themselves in a dilemma without any psychological knowledge to handle such scenarios. Stakeholders had this to say concerning this need:

The age difference between grandparents and their grandchildren orphaned by AIDS is a challenge in itself. Grandparents have been conditioned to use parenting styles that they used with their children of which most are now obsolete and new practices have emerged in this generation. Our parenting practice intervention aims to assist grandparents adopt modern knowledge and skills to better communicate and provide care and support to their grandchildren orphaned by AIDS. [S2]

We impart skills and knowledge on grandparents on how to better care for their grandchildren. The emphasis is on [the following] fronts: sensitisations on basic health and hygiene through use of locally available resources, reminders to grandparents to honour their grandchildren’s clinic days, discussions with grandparents on child-grandparent communication skills and practices (components

within parenting skills), counselling and mental-health support to grandparents to cope with the energetic grandchildren and COVID-19 pandemic, etc. [S2]

From the above submissions, education and training could be important since there is need to improve the intergenerational relationships between the grandparents and their grandchildren orphaned by AIDS. This is also imperative for the grandparents not to be caught violating the rights of the grandchildren and end up in conflict with the law and dragged to the courts of justice. Concepts of Sexual Offences Domestic Violence Act (SODVA) is the law which was enacted by the Eswatini government in 2018 to try and reduce domestic and gender-based violence. Grandparents need to be well informed on the rights and the welfare of the child and sensitised on positive discipline to avoid increased vulnerability and high-risk behaviour (Baron et al., 2009). Both the active and observer groups were of the opinion that workshops on current parental practices were ideal. This is in line with African Charter on the Rights and Welfare of Children (2020) article 4 paragraph 1, which states that all actions concerning the child undertaken by any person or authority, the best interests of the child shall be the primary consideration. Due to lack of knowledge on this, the law can find grandparents on the wrong side. It is important to note that not all these activities were a once off process. I conducted the two-way focus group discussions over three sessions to guard against participants suffering from fatigue from lengthy discussions (Nyumba et al., 2017). The intent was to bring together different stakeholders to share their varied opinions (Manion et al., 2011) on how they could work in collaborative ways to recognise the needs of the elderly taking care of AIDS-orphaned grandchildren. In the following section, I present the guiding principles towards the collaborative approach.

6.2.5 COLLABORATIVE STRATEGIES IN ADDRESSING THE NEEDS OF GRANDPARENTS

My aim of engaging stakeholders was to come up with collaborative strategies to address intergenerational educational needs of grandparents taking care of AIDS-orphaned grandchildren at Eswatini. Below are submissions made by some of the stakeholders:

There is a need for each community to keep data on the grandparents and the children which could be used for mobilising resources that can be used in meeting their needs. Community structures should work with service providers especially those working in their communities to refer grandparents who are in need for support. [S1]

Programmes need to engage community leaders for better acceptability at the community levels. [S2]

Programmes particularly those on parenting skills and those [targeted] at sensitisations need to leverage peer-to-peer support and networks at the community level for better outcomes. [S2]

Provide adequate social grants and food allowances. Besides direct support, government and stakeholders can also initiate light community wage/food for work programs for able bodied grandparents. [P2]

As stakeholders, we need to engage the grandparents and grandchildren to better understand their specific and diverse needs/challenges. [P2]

We encourage the caregivers of OVCs to join Young Heroes WORTH groups which aim to alleviate poverty by teaching rural Swati women to be financially literate and by creating the opportunity for them to become micro-entrepreneurs so that they may support themselves and their families. [S5]

The above suggestions were made by the stakeholders aimed at solving each challenge faced by the grandparents. Most of them felt that keeping a register will help the stakeholders the number of grandparents and grandchildren who need help.

6.3 AREAS OF STAKEHOLDER COLLABORATION

Stakeholders were asked to state areas where they can collaborate in helping the grandparents meet their needs. Stakeholders indicated that they can collaborate in a number of areas to help meet the needs of grandparents taking care of grandchildren orphaned by AIDS.

6.3.1 Providing health care facilities

Stakeholders S1, S2, S3 and S6 agreed that they could collaborate in helping the grandparents get health-care facilities in their communities by organising mobile clinics with specialised staff members like nurses and doctors. They check all the chronic diseases from the grandparents and immunise grandchildren.

6.3.2 OFFERING TRAINING AND EDUCATION ON CURRENT PARENTING PRACTICES

Another area of collaboration was teaching them current parental practices by organising workshops for them. Stakeholders S1 and S2 agreed to work together to teach grandparents on the use of positive discipline. They will also educate them about the negative effects of using corporal punishment.

Stakeholders observed that they needed to work together towards meeting the needs of grandparents taking care of grandchildren orphaned by AIDS. It is in this respect that they felt

that collaboration amongst themselves and grandparents will be ideal. They said the best way to collaborate was to meet grandparents and gather their needs, share with them their plans as stakeholders, agree on the modalities and priorities, implement the activities and jointly review the progress. Grandparents can also bring local contributions in the activities for example providing the venue for meetings, labour, volunteers or programme facilitators at the community.

Another suggested approach to collaboration was adopting a Multi-sectorial approach to provide care and support to the grandparents. In the multi-sectorial all stakeholders offering different services to the grandparents and their grandchildren will gather together at specific venues to offer different services. These services may include counselling, health services and educational programmes of specific items. With this approach stakeholders felt it will save the grandparents' time. This will also help the stakeholders meet the majority of the challenges of grandparents. It will also save them travelling costs they talked about in our first cycle.

We organise mobile outreaches where we have: Police, Department of Social Welfare (DSW), SWAGAA, Births, Marriages and Death Department/Home Affairs, nurses, School Health Program, etc. [S2].

Stakeholders proposed establishing a directory of support/reference directory. A reference directory is a list of stakeholders which details the services and support that they provide within the community. They believed it will help in understanding the gaps and unmet needs among grandparents. Administration for Children and Families, Region IV (2020) posits that developing resource directories will help grandparents find services close by, such as legal guidance, childcare, financial assistance and specialised services for their grandchildren. They also felt it will help engage and link grandparents with the relevant stakeholders.

Robertson (2019) proposed an Advisory Council that will identify, promote, and disseminate to the public information, resources, and the best practices available to help grandparents and other older relatives both meet the needs of the children in their care. Robertson (2019) further contended that this will help keep the grandparents' physical and mental health and emotional well-being. This is in line with the wellness theory guiding my study (Dunn, 1961).

This will also help stakeholders who want to collaborate in activities. It was proposed that for the challenges/needs of grandparents to be well addressed village health workers (*bagcugcuteli*) should visit homesteads of these grandparents and record all their needs. Bagcugcuteli will then forward these challenges to *Bandlancane* (chief's council). *Bandlancane* will then register all the needs. *Bandlancane* representatives would then forward the needs to the Department of Social Welfare. Any stakeholder wishing to assist the

grandparents or their grandchildren should consult the Department of Social Welfare or at community level *Bandlancane*. This approach will promote collaboration and avoid a situation whereby stakeholders find themselves offering the same assistance.

Similarly collaboration will promote stakeholders' feedback meetings at a cluster level. In these meetings we will share data sets/needs assessment data highlighting what each organisation is doing. This will help the other organisations identify and bring support to unmet needs/support gaps. We will use these platforms to report out, identify unmet needs/gaps and then better coordinate to address the gaps.

Stakeholders' collaboration is also challenged by different stakeholder interests and the sector's scramble for resources or funding. More often stakeholders compete than collaborate. [S2]

To encourage and reap rewards of a better coordinated stakeholder community, the government should take greater responsibility to call stakeholders to order. [S2]

Police are attending to abuse cases, sensitising on child protection, sensitise to SODVA, the Department of Social Welfare desk will be concentrating on psychosocial issues. Here the stakeholders agreed that it is important for them to collaborate and train grandparents and grandchildren on how to manage their finances and how they can start income generating projects. Stakeholders agreed that they will organise workshops to address a particular need area. Resource people will be used to educate and train them on a specific area. They all agreed that spoon-feeding them might not go a long way thus stakeholder 6 had this to say:

The best way of helping a neighbour is not to give him/her fish but to teach a neighbour how to fish. [S6]

Educating and training them on financial management will help the grandparents save the little grants they get from the government and other stakeholders. Starting income-generating projects like backyard gardens, weaving mats and sewing will help to supplement their incomes. A study conducted by Toperesu (2010) in Zimbabwe at Nyanga Chitsanza ward proved that income-generating activities helped volunteer caregivers improve financial positions and enhance their technical and planning skills. Engaging the grandchildren in these income-generating activities will help to keep these grandchildren busy and prevent them from engaging in crime. Working together with their grandparents will help to develop positive relationships with their grandparents. This will make them appreciate each other.

6.4 UNMET NEEDS

From our discussion in our focus group, the major need that remained unaddressed by the stakeholders was the problem of water. All grandparents indicated that they are still getting water from unsafe water sources. Some of these water sources are very far from their homesteads. Considering their ages it is difficult for them to walk long distances. Water problem also posed a challenge to the gardens that they started as a result of our previous meetings.

Most grandparents are unable to assist their grandchildren with school work due to illiteracy. This has become a serious concern during Covid-19 period where their grandchildren are expected to learn via home schooling. This requires one to have a radio and television. As alluded in 6.2.1 most grandparents have financial challenges. Buying these gadgets is a tall order for grandparents.

6.5 MY REFLECTIONS ON THE STAKEHOLDER ASSISTANCE AND COLLABORATION

I engaged the stakeholders with the aim of getting what they were offering grandparents and their grandchildren orphaned by AIDS. I also wanted to know how these stakeholders can collaborate in order to meet the needs of grandparents taking care of grandchildren orphaned by AIDS. Initially I had thought they may not be willing to participate in my focus group discussions, but surprisingly they enjoyed being part of the discussions. The enthusiasm they showed was humbling. In my view, they felt honoured to be given the opportunity as stakeholders to be part of the discussions. Some of them personally approached me to enquire if it was possible to facilitate similar gatherings to other members of the community. In my observation they were experiencing PAR approach for the first time. I also realised that participating in this study gave them an opportunity to meet, discuss and see areas where they can collaborate in order to meet the needs of the grandparents taking care of grandchildren orphaned by AIDS. I also realised that stakeholders' assistance is not well coordinated. This resulted in them offering the same services.

In my analysis most of the assistance is directed to the grandchildren and little is done to cater for the basic needs of the grandparents. I also observed that stakeholders are not open to each other, instead they work as competitors. This makes collaboration difficult. I personally learnt that the stakeholders do not find out from the grandparents what they need (needs assessment) instead they provide services they think they need. This is against the PAR approach that emphasises "something for us, without us, is not for us" (Luthuli & Wood, 2020). Stakeholders end up providing services that are not relevant to the grandparents. For example the main challenge grandparents are facing is the provision of safe clean water which was

never tackled by stakeholders. This behaviour of stakeholders is what Franz (2015) termed inside-out thinking. Ideally to meet the needs of grandparents an outside-in thinking should be employed (Franz, 2015). This involves needs assessments before trying to solve their problems and this will reduce complaints as well as increase satisfaction on the assistance provided to them.

I also saw that from what the stakeholders were unable to provide, they were defensive and shifting the blame to others, such as surviving children instead of acknowledging the concerns to improve their service delivery. From what the grandparents said their surviving children are not supportive. Even the Deputy Prime Minister, Honourable Themba Masuku, on Friday, 2 October 2020, urged children to support their elderly parents.

Personally as I was working with stakeholders I learnt that grandparents have many needs. Some can be met by stakeholders while others cannot be met by stakeholders. This is partly because some of the needs are outside their organisational objectives. What matters most is meeting the objectives of the organisation rather than what the grandparents need. I also learnt the importance of engaging all stakeholders in decision making especially vulnerable groups like grandparents.

6.6 SUMMARY

In this chapter, I discussed the findings of my Cycle Two where I wanted to find out what the stakeholders were doing to help the grandparents meet their needs. I also wanted to find out how the stakeholders can collaborate in order to meet the needs of grandparents taking care of grandchildren orphaned by AIDS. I started by discussing the themes that emerged with the assistance of current stakeholders. This was followed by looking at how stakeholders can collaborate in order to help meet the needs of grandparents. The next chapter will look at the research question: How can the findings of the empirical study be translated into an education model and guidelines for improving the intergenerational support or care given by grandparents to their grandchildren orphaned by AIDS?

CHAPTER SEVEN

DEVELOPMENT OF GUIDELINES AND AN EDUCATION MODEL FOR IMPROVING INTERGENERATIONAL RELATIONSHIPS AND CARE GIVEN BY GRANDPARENTS TAKING CARE OF AIDS-ORPHANED GRANDCHILDREN

7.1 INTRODUCTION

In this chapter, I develop an education model and guidelines for improving the intergenerational support and care given by grandparents to their grandchildren orphaned by AIDS. This chapter is based on data generated in Cycles One and Two. Grandparents in Cycle One explained their needs and challenges that they faced as they raised their grandchildren. In Cycle Two, I engaged the stakeholders to find out their contributions for grandparents and grandchildren. In the third Cycle I engaged grandparents on prioritising suggestions for successful and sustainable grandparenting. In addition, a model was suggested for successful grandparenting. Working with the grandparents, I used the information generated in Cycles One and Two, to develop the model that can be used for successful grandparenting. The model I built is informed by the literature and theories guiding my study. I also used data generated by my Cycles One and Two and guidelines raised by grandparents in our Cycle Three.

7.2 ACTION LEARNING SET GUIDELINES FOR DEVELOPING AN INTERGENERATIONAL RELATIONSHIP EDUCATION MODEL THAT WOULD MEET THE NEEDS OF GRANDPARENTS TAKING CARE OF AIDS-ORPHANED GRANDCHILDREN

Participating grandparents (see Figure 7.1) came up with suggestions for guidelines for developing an intergenerational education model by first prioritising their needs.

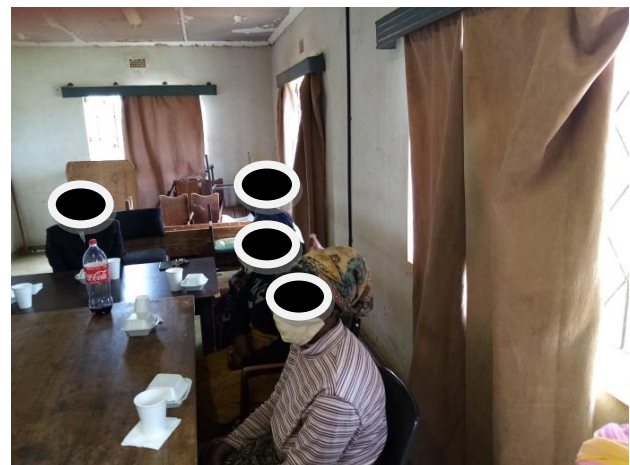


Figure 7.1: ***Action learning set members in a meeting to prioritise their needs and develop guidelines to inform the development of an intergenerational educational model***

Since some of my participants were illiterate, I first explained the purpose of our meeting in SiSwati. I explained to them that they first needed to prioritise their needs and then suggest guidelines that would inform the development of an intergenerational educational model to enable successful and sustainable grandparenting. In order not to influence the flow of the discussion and avoid researcher bias, one grandparent was selected to be the moderator of the discussions. The moderator first asked the participants to raise all things they felt are important for successful and sustainable grandparenting. We then arranged them according to their weight. The ALS members prioritised the needs as follows:

- Access to clean and safe water,
- Availability of farm inputs,
- Availability of proper shelter and clothing,
- Access to health services,
- Electricity connection,
- Need for recreational facilities,
- Having platforms to be heard,
- Education and training needs,
- Need for community burial schemes and funeral policies, and
- Need to construct a proper bridge across the river linking communities.

From the participants' explanation clean and safe water was the most important factor for successful and sustainable grandparenting. The grandparents felt that having clean and safe water was vital in their lives as most of their needs revolved around water. The ALS meeting reported that access to water would give them a purposeful and meaningful life consequently realising spiritual wellness. Next on the list was the need for farm inputs. These included tractors for tilling the land, fertilisers, seeds, and fencing. Obtaining these would keep the elderly actively engaged, with enough food provisions that are nutritional to cater for their physical wellness. In addition, ALS members felt that their finances would also be improved through engaging in farming activities. The participants believed that farming would keep their grandchildren occupied and make them forget about illicit things. And this would lead to occupational wellness which results when individuals get engaged in activities that lead to self-actualisation. Working together in the fields would also enable the two generations to bond

resulting in improved relationships, social and emotional wellness, which focus on interacting with others well and establishing good relations built on respect and trustworthiness.

What emerged as third on the list was proper shelter and clothing. Shelter and clothing in Maslow's hierarchy of needs are basic and this is supported by McLeod (2020). If basic needs are unmet, both grandparents and grandchildren live in anxiety and this affects them psychologically resulting in lack of mental stability. Therefore, provision of such basic needs would result in social, emotional and spiritual wellness realised. The need for access to health facilities came up fourth. Erratic public transport was a cause for concern in these intergenerational households. Grandparents with chronic illnesses and grandchildren on antiretroviral therapy need to access health services now and then. Facilitating easy access would go a long way in improving the wellness of the elderly and their grandchildren in all dimensions as illustrated in the Whole Person Wellness model. Prioritised as number five was need for electricity connection as the ALS meeting felt that electricity is now a basic need due to the advent of online learning and teaching methodologies necessitated by the Covid-19 pandemic. Accessing these facilities would bring about healthy intergenerational relationships that are mired due to lack of access to educational provisions by grandchildren. Sixth on the list was the need for recreational facilities. Participants felt that they needed to loosen up their tension of care-giving with depleted resources by going to recreational facilities and interact with others for physical, social and emotional wellness. The same sentiments are shared by Kiran (2014) who is of the view that that recreation is important for the well-being of older adults and enhances their quality of life. Having platforms to be heard featured as number seven on the list. The ALS meeting applauded this study as it gave them an opportunity for their voices to be heard. They felt that if such platforms could be afforded to them at community level they would appreciate as it would enable them to acquire skills and knowledge on how to handle their AIDS-orphaned grandchildren being raised in a millennium generation environment that is different from theirs, consequently realising intellectual wellness.

The desire to realise intellectual wellness also participants subscribing to the need for education and training as priority number eight. They felt that training on current parenting practices, budgeting, emotional intelligence, entrepreneurial skills, modern farming methods, counselling skills, and team work was mandatory as it would improve grandparenting styles. The transfer of knowledge, skills, attitudes, values and interests from the grandparents to their grandchildren would definitely require a heavy dose of programme development and methods and techniques for the transfer of the same. The other critical need raised as priority number nine by ALS members was the need for an affordable funeral policy or community burial societies. Most the grandparents reported that most of the funeral policy services available

now were not affordable taking into consideration the meagre social grants that were being offered. Provisions of such affordable policy services would remove all their anxieties and give them spiritual wellness. At the end on the list but obviously not suggesting that it is the least, is the need to construct a proper bridge that would link communities to better health facilities or whatever need would have been arisen. This prioritisation informed the development of an intergenerational educational model that could be used to improve support or care given by grandparents to their AIDS-orphaned grandchildren.

7.3 THE MODEL

I designed this model based on what the grandparents said they needed to be successful in grandparenting. While designing this model I considered many factors. Firstly, I considered the priorities that the grandparents suggested for successful grandparenting. Secondly, I considered The Whole Person Wellness model, AT and CT underpinning my study. When I embarked on this study my main objective was to come up with a model that will be used for successful grandparenting. In my model I considered the role played by the stakeholders for successful grandparenting.

The model is presented in the form of a fruit tree. The rationale for my choice is that a tree resembles life. The tree has roots, a stem, branches and leaves. In order for the tree to bear fruits it should be well-nurtured. Similarly, in order for the grandparents to bear fruit in grandparenting, their priorities need to be taken care of by relevant stakeholders. In the communities where I carried out the study the stakeholders were the government, *Imiphakatsi* and NGOs. For their contributions to grandparents refer to Chapter 6. Below, I present and explain my model for improving the intergenerational support and care given by grandparents to their grandchildren orphaned by AIDS.

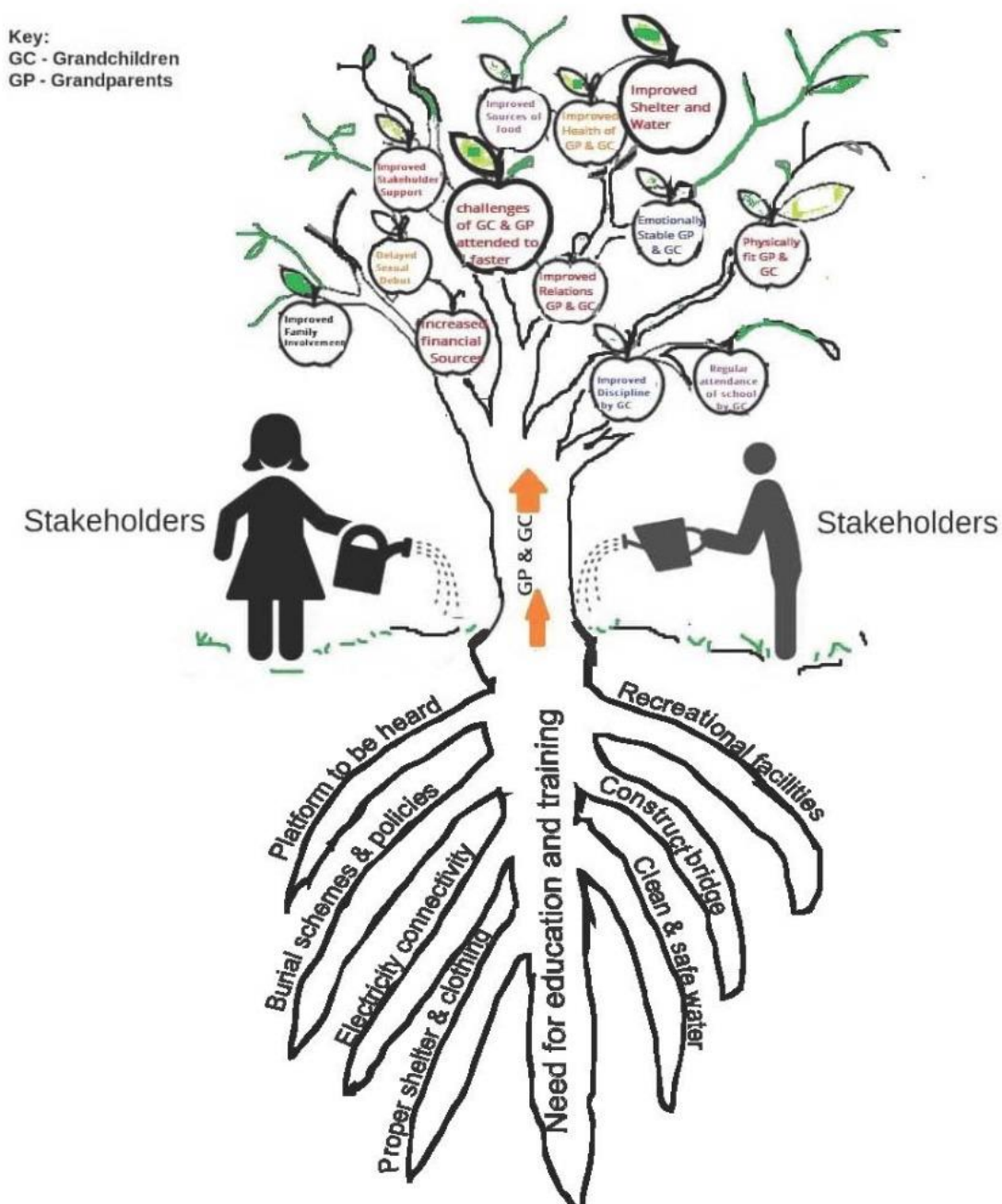


Figure 7.2: *A model for improving the intergenerational support and care given by grandparents to their grandchildren orphaned by AIDS*

As seen in the model, the roots symbolise the priorities of grandparents. The functions of roots in a tree are to anchor it and supply it with water and nutrients, so that it bears fruit. In order for the roots to perform this function they need to be watered and supplied with manure. Similarly, for grandparents to be able to get their priorities (roots), stakeholders need to supply

them. When I was in the field, it was observed that stakeholders need to be coordinated by the government in order to meet diverse priorities of grandparents. In the model bigger roots carry basic priorities that Maslow (1987) refers to as physiological needs. The smaller roots represent supplementary needs. However it should be noted that all these priorities are important for successful grandparenting.

The stem in the model represents grandparents and their grandchildren. Scientifically the stem is there to give support to the tree and convey water and nutrients to branches and leaves so that tree can bear fruit. One may question as to why the grandchildren are part of the stem. This is because grandchildren live with grandparents and sometimes receive assistance from stakeholders directly, for example school fees and sanitary pads. I deliberately put them above the grandparents because in most cases assistance is received by grandparents and passed on to grandchildren.

A tree can only bear fruit if it is well nurtured. A tree which is not well taken care of either fails to bear fruit or bears fruit of poor quality. In the same way grandparents cannot be successful in grandparenting if their priorities are not met by stakeholders. The model explains clearly that in order for them to successfully look after grandchildren their priorities must first be met by stakeholders. When the priorities are met, it results in improved sources of income, food supplies, proper shelter and good health for both grandparents and grandchildren. For the model to be effective, stakeholders will employ participatory project management approaches under the leadership of community leaders who are the gatekeepers in all community interventions.

Involving grandparents and *Imiphakatsi* local leaders in prioritising the needs, outlined as the roots, and the implementation, progress review and monitoring of the projects will enhance project outcomes. Through community meetings, grandparents and grandchildren orphaned by AIDS will actively participate in the projects implemented by the stakeholders. Able grandparents will take up volunteering positions to support their peers or colleagues. Promoting peer-to-peer support will improve results in the model. Community leaders will keep a register of all stakeholders in the communities and hold regular meetings to get updates and review progress of the projects. When the fruit/outcomes are realised there will be improved intergenerational relationships and the six dimensions of the Whole Person Wellness theory will be realised (see Chapter 3.1). In the same note the AT applies as grandparents will remain active (refer to Chapter 3.2). The CT will also be evident as grandparents will also be able to continue with their past activities. Of importance is also offering grandparents opportunity to engage in education and training programmes. These will be offered by different stakeholders

as per arising need. This is also in line with my whole person theory on intellectual wellness (see 3.2.1)

The model has two people watering the tree. This symbolises the different assistance provided by the stakeholders to grandparents and their grandchildren in order to meet their priorities. The model advocates for needs assessments by stakeholders before offering assistance to grandchildren and grandparents. Stakeholders should offer what the grandparents are prioritising. When I was conducting the study it emerged that grandparents are not consulted about the assistance that they want. As a result of this, grandparents may be given assistance which is not a priority for them. It should also be noted that priorities are not static but change with time, therefore, there is need for continuous needs assessment by stakeholders.

Like a tree, it needs different nutrients at different stages of its growth. I also observed that sometimes there is a duplication of assistance by stakeholders. Therefore, by doing needs assessments stakeholders will help establish who is doing what for the grandparents. Overwatering of a tree will lead to leaching. In the same vein, stakeholders attending to the same priority will lead to waste in over-supplying that priority. My model empowers the grandparents to be heard as it seeks that stakeholders should first ask the grandparents what they want before they assist them.

7.4 SUMMARY

In this chapter I discussed the priorities for successful grandparenting. I also discussed the guidelines for successful grandparenting. Using the priorities and guidelines suggested by the participants I developed a model for successful grandparenting. I then explained how the model will be used for successful grandparenting. The next chapter presents a summary of conclusions from this study; it will also look at questions for further research, and the study's contribution to knowledge. The next chapter will further contain my personal reflection on this study as well as the limitations of the study

CHAPTER EIGHT

SUMMARY OF FINDINGS, QUESTIONS FOR FURTHER RESEARCH, CONTRIBUTION TO KNOWLEDGE AND CONCLUSION

8.1 INTRODUCTION

My previous three chapters answered my main research question, which was on collaboratively designing a model that can be effectively used to meet the needs of grandparents taking care of grandchildren orphaned by AIDS in the Kingdom of Eswatini. In Chapter Five I looked at the needs of grandparents. In Chapter Six I looked at how relevant stakeholders in Eswatini can collaborate in order to come up with strategies to address the needs of elderly grandparents caring for grandchildren orphaned by AIDS. In Chapter Seven I developed a model based on the data generated throughout the study, with explanations on how the model can be used. I generated the knowledge through participatory action research (PAR) process, done with ten grandparents from two chiefdoms.

8.2 SUMMARY OF THE STUDY

My **Chapter One** presented the overview of the study, setting the context of the study. I reviewed literature on challenges faced by grandparents taking care of grandchildren orphaned by AIDS. I presented a case on the need for grandparents who are caregivers to their grandchildren orphaned by AIDS to be directly involved in developing strategies to solve the problems they are faced with, as they have a better understanding of their own needs. I also justified my choice of participatory action research methodology, which allowed the grandparents to contribute in developing strategies and guidelines for successful grandparenting. I also presented the rationale for conducting the study. The chapter also looked at the theoretical framework, paradigm and methodology adopted in the study.

In **Chapter Two** I reviewed literature on HIV and AIDS. My main thrust of this study was on focusing on the huge challenges of grandparenting and mitigating its socio-psychological and economic impact on the grandparents and their grandchildren. The literature reviewed was on global trends on HIV and AIDS zeroing down to the Kingdom of Eswatini. The chapter proceeded to explore the challenges of HIV and AIDS on orphaned grandchildren followed by an exploration of how the Kingdom of Eswatini is mitigating the socio-psychological, physiological and economic challenges of grandparenting. The knowledge, geography, and sampling gaps of previous studies were highlighted and emphasis was placed on clarity of how the current study seeks to bridge the gaps. The chapter concluded by looking at guidelines for successful grandparenting.

In **Chapter Three** I discussed the framework through which I approached my study, giving an account of some important contributors to theory. The study aimed at getting strategies through which grandparents can be supported so as to cope with an intergenerational relationship with grandchildren who have been orphaned by AIDS. The theories guiding this study were discussed and validated. The theories discussed include intergenerational relationship theory, which encourages young and old people to serve side-by-side to address unmet needs in their communities successfully. I also used the activity theory which allows grandparents to remain active in their old age. Lastly I discussed the continuity theory that maintains that as the individual grows older, he/she is predisposed toward maintaining continuity in their habits, associations and preferences.

In **Chapter Four** I discussed the transformative paradigm, its ontological, epistemological and methodological assumptions, research approach and PAR design. I first explained how I recruited the grandparents and the stakeholders. This was followed by the methods that I used to generate data. The methods I used were reflective journals, narratives, drawings, ALS and focus group discussions. I then discussed how I will analysis my data. I also discussed validation criteria, ethical considerations and limitations of the study.

In **Chapter Five**, I presented my research findings of the first cycle that addresses the question: *What are the intergenerational relationship needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?* The following were the themes that emerged; Financial Needs, need of knowledge on current parental practices, social Support Needs and Health Needs. I supported my interpretation of the data by using verbatim quotations from oral responses of the participants as well as their drawings, and control these findings against relevant literature sources. I then discussed my learning and reflections from Cycle One of the research study. I discussed the educational needs of grandparents along the ideas of intergenerational relationship theory (IRT) that is the Whole Person Wellness theory, activity theory (AT) and continuity theory (CT) as key frameworks that underpin my study.

In **Chapter Six**, the focus was to answer the second research question: *How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?* In this chapter I established what the stakeholders were doing to help the grandparents. I also described how they can collaborate in order to come up with intergenerational education-based strategies to address the educational needs of grandparents taking care of grandchildren orphaned by AIDS.

In **Chapter Seven** I discussed the priorities for successful grandparenting. I also discussed the guidelines for successful grandparenting. Using the priorities and guidelines suggested by the participants I developed a model for successful grandparenting. I then explained how the model will be used for successful grandparenting.

8.3 SYNTHESIS OF MY RESEARCH FINDINGS

In this section, I synthesise the findings of the study in relation to my research questions. The findings provided comprehensive answers to the three questions, thereby addressing the main focus of this research study. The main research question of the study is: *How can grandparents collaborate with other stakeholders to collaboratively design a model that can be used to meet the needs of grandparents taking care of grandchildren orphaned by AIDS in the Kingdom of Eswatini?*

- My first research question was: What are the intergenerational relationships education needs of elderly Emaswati grandparents caring for grandchildren orphaned by AIDS?

The findings of this question included financial needs. Grandparents said they needed money to buy food, infrastructure development and educational requirements for their grandchildren. The grandparents complained about the few social grants that they received from the government. Considering the expenses listed above, they felt it was insufficient to sustain them and their grandchildren. Another need that emerged was the need of knowledge on current parental practices. The participants acknowledged that parenting styles have changed. They cited issues like positive discipline which they said they have little knowledge about. They also complained about the wayward behaviour of their grandchildren especially early engagement in sexual activity. Engaging in sex early exposed them to sexually transmitted infections including HIV and AIDS.

The grandparents also complained about lack of emotional support within the family system. They alluded to the fact that their surviving children do not support them, especially the male children once they get married. They felt neglected and had no reasons to live. They also felt that there is no proper support system from the community. They wished for platforms where they could be heard. Another challenge was health needs. They said since they have chronic illnesses there was need to monitor their illnesses regularly for them to survive longer. They complained that health facilities had negative attitudes towards them. They are always given

painkillers and told that their illnesses are normal at their ages and therefore not emergencies.

- The second research question was: How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS? The stakeholders indicated that they can collaborate in a number of ways in order to meet the needs of grandparents taking care of grandchildren orphaned by AIDS. The collaboration areas included providing all the services required by the grandparents on one day at a central place. They proposed organising a fair day where all stakeholders will converge in one place. They however pointed out the challenges that have been brought in by Covid-19 that discourages large crowds.

They also said they can collaborate in doing needs assessments. After identifying the needs of grandparents they can then distribute those needs among themselves. This will also help to avoid duplication of help rendered to grandparents. Stakeholders also agreed on collaborating in training the grandparents and grandchildren in different areas like modern farming methods, financial management and emotional intelligence. They also agreed to collaborate on offering psychosocial support to the grandchildren and grandparents. They also promised to collaborate to revive the chief's fields and offer financial and labour support in order to produce crops in these fields.

- The third research question was: How can the findings of the empirical study be translated into an education model and guidelines for improving the intergenerational support or care given by grandparents to their grandchildren orphaned by AIDS? The participating grandparents prioritised the suggestions for successful grandparenting and also came up with guidelines for successful grandparenting. Using these priorities and guidelines and theories underpinning my study I was able to develop a model for successful grandparenting.

8.4 REFLECTIONS ON MY PERSONAL LEARNING

In this section I focus on my personal learning in this study. Action learning research taught me a lot of things that I did not know when carrying out research. Naturally I am a shy person who does not like to be with strangers for a long time. Therefore, before the study I had to work on this weakness. I was not sure whether I will be able to cope to be with people who are as old as my parents. I felt uncomfortable. But as I was recruiting my participants I developed courage. I actually grew to love all my participants. I adopted a strategy of calling

them my sweethearts and they loved it. During our first ALS meeting the situation was a bit tense but using my psychological skills I was able to make them to relax. I ensured that I served my participants with the best food throughout the day. I also showed them respect. Like they say: respect is earned not demanded. Grandparents began to love and trust me. We became a solid team. Not even for a single day would a participant skip our ALS. They encouraged each other to attend our ALS meetings religiously.

The trust that had developed among us made it easier for participants to voice their challenges. The participants were now free to discuss even those things that were not part of the study. This shows how relaxed they were. At the beginning and end of the meetings they prayed that our study becomes a success. Some would even call me to find out how I am progressing in terms of the write up. Some would engage me in public and private to ask if the same approach cannot be employed to address societal issues. I could tell that they wanted the PAR approach in addressing issues.

I also realised that PAR helped me to develop negotiation skills, patience and improved my social skills. I always looked forward to our next ALS meetings. We had developed love for each other. The participants had many commitments at home and there was the threat of Covid-19 but because of my organisational skills and the love and care I gave them, they sacrificed.

From the findings of the study I learnt that grandparents are deprived of entertainment. Many people think old people do not need recreational facilities but in our ALS meetings they emphasised that they needed these facilities. They also needed platforms to be heard at community level. I also learnt to have concern for others. Thus PAR made me into a philanthropist. I wish one day I can start my own organisation that will offer assistance to needy people.

8.5 LIMITATIONS

The major limitation is that the grandchildren's voices were not heard. The study only concentrated in rural areas, a comparative study could have been ideal. Time was a constraint as I was a full time teacher. The other limitation was that I conducted this study during Covid-19. Everyone was scared to be in a group. My participants belonged to the most vulnerable group. I had thought they would chicken out of the study but fortunately for me they all cooperated. At one time I had to suspend ALS meetings because of increasing cases in the two chiefdoms where the study was conducted. I also adhered to the World Health Organization and Eswatini national Covid-19 guidelines religiously and none of my participants caught Covid-19.

8.6 RECOMMENDATIONS TO STAKEHOLDERS

The reason why I conducted this study is because I wanted to see the welfare of the grandparents and their grandchildren improve. With this in mind I make the following recommendations to the stakeholders in line with the model that I developed. The stakeholders are the government represented by different ministries, the NGOs and community leadership.

8.6.1 THE GOVERNMENT

For the payment of social grants, I recommend that it is increased to meet the poverty datum line (see Chapter Five) and be paid monthly instead of after every three months.

The grandparents also complained about the ill-treatment they receive from health workers. They also appealed to the government to provide them with a local clinic. For the first challenge I urge the Ministry of Health to enhance the capacity of the health-care workers on customer care services. The government should make an effort to build a clinic nearby or provide mobile clinics.

The grandparents also complained about unavailability of a proper bridge that impedes movement during the rainy season. I, therefore, recommend that a proper bridge be constructed so that this challenge is solved. Another challenge that is linked to the government is the provision of clean and safe water. Since there is a perennial river passing through the community there is a need to establish a water plant that will purify the water and make it available to the community.

Government is also recommended to better coordinate the work of stakeholders implementing projects within the communities for improved grandparenting. Regular surveillance and needs reports are crucial and the government should direct resources including budgets and personnel so that the specific grandparenting needs are well documented for stakeholders to attend to.

8.6.2 NON-GOVERNMENTAL ORGANISATIONS

NGOs work with the government to assist the grandparents and grandchildren to meet their different needs. In our focus group meetings it emerged that there is no synchronisation by NGOs in terms of offering assistance to the grandparents and grandchildren. This leads to same type of assistance being offered by the NGOs. I therefore recommend that instead of them competing to offer assistance they must do needs assessments together and share the responsibilities afterwards. They should also avoid assuming what the grandparents want but they should go to them and ask what the grandparents want. This is the reason my model

suggests a list of priorities before the assistance is offered. It is no use giving someone something that is not a priority to him/her. NGOs have a tendency of planning what they want to assist in without involving the recipients. NGOs also need to work with local leadership closely in order to get to know what the grandparents need.

Another problem is that most stakeholders are assisting the grandchildren. They are not offering direct assistance to the grandparents. I recommend that they should be directing assistance to grandparents more to sustain the assistance. Grandparents and grandchildren should be involved throughout the project life cycle from design, implementation, monitoring and evaluation. This will help shape the projects to better respond to the needs of the grandparents and grandchildren.

8.6.3 LOCAL TRADITIONAL LEADERSHIP

Eswatini is a traditional society. Most important decisions are taken at community level. Chiefs have power to run their communities. The chief has a council that helps him or her to run the community. All challenges faced by the community members are handled by this council. The assistance from all the stakeholders normally goes via this council. The grandparents appealed for special platforms where their challenges can be heard. In our focus group meeting it was recommended that chiefs' councils must have a member who will specifically look at the affairs of grandparents and their grandchildren orphaned by AIDS. As recommended by other stakeholders the chief's fields need to be revived.

8.6.4 RECOMMENDATIONS FOR GRANDPARENTS

My main focus was on grandparents therefore it is imperative that I also make recommendations to them. In as much as they are lobbying for social grant increments it is important that they also have income-generating projects like growing vegetables, fruit trees, weaving sleeping mats, and raising chickens and avoid dependency syndrome. The gardens that we started as a result of our ALS meetings must be continued. This will help them to remain active. Some of the illnesses that they are suffering from are as a result of living sedentary forms of life. They should also make deliberate efforts to learn new things as life is changing fast these days.

8.6.5 RECOMMENDATIONS FOR INTERGENERATIONAL RELATIONSHIPS EDUCATION

It is a fact that there is a wide gap between the grandparents and their grandchildren. It is therefore important that an intergenerational relationship education programme be put in place to help bridge the gap between grandparents and their grandchildren. The two groups of

people should be able to learn from each other. Workshops must be conducted to help these two generations to bridge their differences.

8.7 SUGGESTIONS FOR FURTHER RESEARCH

- This study targeted grandparents taking care of grandchildren orphaned by AIDS. My wish was to recruit equal representation between female and male grandparents, however only one male participant volunteered to take part in the study. In his submissions during our ALS meetings he highlighted that grandparenting is an uphill task. I therefore recommend that future studies must focus on having a sample that is male dominated so that we can get more views from male participants on grandparenting. Their priorities might be different from those raised by female grandparents.
- This study was also conducted in a rural setup: I suggest a similar study using PAR could be conducted in an urban setup. One would find that the priorities and challenges of urban grandparents may be different from those of rural grandparents.
- This study excluded the grandchildren as participants: therefore, their views on intergenerational relationships were not captured yet they are part of the study. I, therefore, recommend that a study involving both grandparents and grandchildren must be conducted.
- The study covered chiefdoms in one region of Eswatini maybe a similar study involving PAR can be conducted in other regions of the country that may have different priorities.
- Further studies should also include mixed methods. Quantitative aspect will enable such study to deduce the relationship between variables which further supports the qualitative findings.

8.8 CONTRIBUTION TO KNOWLEDGE

The reason for conducting research is to bring new knowledge. In this section I discuss the study's theoretical and methodological contribution to knowledge.

8.8.1 THEORETICAL CONTRIBUTION

The reason for conducting this study was to contribute something new in the body of knowledge. The participatory action research has revealed to the communities where this study was conducted that grandparents collaborating with stakeholders can solve their challenges. Before solutions were generated by stakeholders without the involvement of grandparents. This is against the PAR approach which believes in "something for us, without

us, is not for us” (Luthuli & Wood, 2020). Grandparents are the ones doing grandparenting practically, therefore solutions to their problems must be jointly generated by them and stakeholders. Grandparents must take a leading role in the prioritisation of their needs. The study also revealed that development should be community-based, solutions should also be community generated as advocated by PAR. Government, NGOs and other stakeholders should know that the beginning of development and solutions to the problems lie in the communities, therefore before offering any assistance it is essential to conduct needs assessments and intensive community engagement.

In the field of academia there is no evidence of a similar study involving intergenerational relationships in education. From the literature and practical evidence no one in Eswatini has conducted such a study especially using PAR. Communities can use the same approach in solving community problems. Participants indicated that participating in this study was an eye-opener to them. This reveals the effectiveness of the PAR approach in solving practical problems. I have also presented a model for improving the intergenerational support and care given by grandparents to their grandchildren orphaned by AIDS. This model can be used for successful grandparenting.

8.8.2 METHODOLOGICAL CONTRIBUTION

The use of PAR in this study shows how grandparents can actively work together in an ALS in order to solve their challenges in collaboration with relevant stakeholders. Giving the grandparents a voice in solving their challenges motivates them and gives them a sense of hope. The PAR approach gives voice to this marginalised group of people. Using PAR grandparents were able to voice their concerns to the stakeholders. Using PAR will help the grandparents to be heard by the stakeholders and they will be able to tell the stakeholders their specific priorities.

8.9 CONCLUSION

In this chapter I gave a summary of my research highlighting the silent-salient points in each chapter. I went on and looked at synthesis of my research findings. I also reflected on my personal learning, limitations of the study, made suggestions for successful grandparenting to NGOs, government, grandparents and local community leaders. I also made suggestions for further research and contribution to knowledge. From the findings of my study I feel my goals for this research were achieved. I gained knowledge on conducting a PAR study, working with grandparents and stakeholders. I learnt how to be an effective facilitator. The grandparents learnt how they can effectively deal with their challenges by engaging stakeholders. Like a new-born philanthropist I wish to continue engaging myself in such projects.

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APPENDICES

APPENDIX A - BANTWANA



August 13, 2020

Phumuzani Mpofu,
P. O. Box 73
Luve, Manzini,
ESWATINI

**Re: PERMISSION TO ENGAGE BHEKITHEMBA MAVUSO, BANTWANA
PROGRAM MANAGER FOR THE SOLE PURPOSES OF YOUR ACADEMIC
STUDY**

Dear Sir,

Reference is made to your request to engage Bantwana Initiative in your academic study on *"A collaborative construction of an intergeneration relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS"*.

Bantwana Initiative (Bantwana) for Orphans and Vulnerable Children (OVC) thus approves Mr. Bhekithemba Mavuso, a senior program manager to represent us and partake in your study. It is our hope that Phumuzani Mpofu will share with us his study findings so that we better inform the various interventions we conduct targeting HIV infected and affected OVC and young people within Manzini region.

Bantwana is a locally registered not-for-profit NGO under the Company's Act (No. 397 of 2008) supporting the Government of the Kingdom of Eswatini reduce the impact of HIV/AIDS and improve the overall wellbeing of OVC, young people and their families.

Bantwana is humbled to respond to this request and it is our hope that Bhekithemba's work experience at the community and household levels will contribute immensely in the research.

Wish you good health in these trying times.

Yours in care and support for Orphans and Vulnerable Children and their families,

Collen Masibhera

Head of Programs



Office# 604, Sivuno Parkade Building, Nkoseluhlaza Street Box 6006 Manzini, M200 (office) +268 2505 2848
or 2505 2852, Fax +268 2505 2992,
www.bantwana.org/eswatini

APPENDIX B - MINISTRY OF TINKHUNDLA ADMINISTRATION AND DEVELOPMENT MANZINI



GOVERNMENT OF THE KINGDOM OF SWAZILAND

MINISTRY OF TINKHUNDLA ADMINISTRATION AND DEVELOPMENT
MANZINI

P.O. Box 13
Manzini M200
Swaziland

Tel: 25052291
Fax 25052294

12th August 2020

TO WHOM IT MAY CONCERN

RE: REQUEST FOR PERMISSION TO COLLECT DATA FOR NORTH WEST UNIVERSITY
STUDENT – PHUMUZNI MPOFU

This serves to confirm that the Mkhweni Inkhundla Secretary Ms Futhi Dlamini has been given authority to partake in a study conducted by Phumuzani Mpofu, a student at North West University.

The study or research topic is: **A COLLABORATIVE CONSTRUCTION OF AN INTERGENERATIONAL RELATIONSHIP EDUCATION MODEL TO ADDRESS THE NEEDS OF GRANDPARENTS CARING FOR GRANDCHILDREN ORPHANED BY AIDS.**

your Assistance in this regard will be greatly appreciated.

Yours Faithfully

MINISTRY OF TINKHUNDLA
ADMINISTRATION & DEVELOPMENT
P.O. BOX 441, MANZINI M200
13 AUG 2020
GCINA DLAMINI
SNR REGIONAL OFFICER - MANZINI
REGIONAL OFFICER
ESWATINI

APPENDIX C - PHILANI MASWATI CHARITY ORGANIZATION



P. O. Box 302 Lobamba
Kingdom of Eswatini

Philani Maswati Charity Organization

registered as a non-profit making organisation to aid the elderly and destitute

Cell: +268 76062909 or
+268 76028500
Email: dlamined@gmail.com

19 August 2020

TO WHOM IT MAY CONCERN|

Title: The Collaborative construction of an of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

This serves to confirm that PHILANI MASWATI CHARITY ORGANIZATION represented by **HON. LUTFO DLAMINI – EXECUTIVE CHAIRMAN** gave authority to Phumuzani Mpofu to do a study research on the above captioned topic.

Yours sincerely

Patron: Her Majesty, The Indlovukazi

APPENDIX D - PROPOSAL APPROVAL MINUTES



Faculty Education: Research & Innovation - M&D Administration

MINUTES

Meeting: COMBER Scientific Committee
Date of meeting: 20 March 2019
Time of meeting: 08:30
Meeting room: Potchefstroom Campus: Building C6 - Room 299E

1.1 Attendance

Prof L Wood: Chairperson.....Research Director: COMBER
Prof J Hay.....Research Professor
Dr D Kirsten.....Research Professor
Ms R van Staden: Minute Keeper.....Administrative Support – MEd & PhD

2 PhD matters

2.1 Approval of research proposals that have previously been referred back

2.1.1 Student	Mr P Mpofu (30623200)
Degree	PhD Educational Psychology
Proposed Title	A collaborative construction of an intergenerational relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS
Promoter	Prof A Oduaran
Work Distribution	• Prof L Wood • Dr C Botha
Comments	• Prof L Wood has accepted the proposal unconditionally. • Dr C Botha has accepted the proposal unconditionally.
Risk Level	Low, direct benefit – EduREC
Approved Title	A collaborative construction of an intergenerational relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS
Decision	Unconditionally approved; minor changes

Minute keeper: Ms R van Staden

APPENDIX E - ETHICS APPROVAL LETTER OF STUDY



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 086 016 9698
Web: <http://www.nwu.ac.za/>

North-West University Education, Management
and Economic Sciences, Law, Theology,
Engineering and Natural Sciences Research
Ethics Office (NWU-EMELTEN-REC)

Tel: +2718 299 4707
Email: lukas.meyer@nwu.ac.za

15 June 2020

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-NWU-EMELTEN-REC) on 15 June 2020, the NWU-EMELTEN-REC hereby approves your study as indicated below. This implies that the NWU-EMELTEN-REC grants its permission that, provided the general and specific conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

Principal Investigator/Study Supervisor/Researcher: Prof A. Oduaran

Student: Mr. P Mpofu

Ethics number:

N	W	U	-	0	1	1	0	7	-	2	0	-	A	2
Institution			Study Number				Year			Status				

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation;
A = Authorisation

Application Type: Single study

Commencement date: 1/06/2020

Expiry date: 31/05/2021

Risk:

Medium

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly monitoring report and the concomitant issuing of a letter of continuation.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-EMELTEN-REC:
 - six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and
 - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-EMELTEN-REC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.

- Annually a number of studies may be randomly selected for active monitoring.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility, the NWU-EMELTEN-REC reserves the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the NWU-EMELTEN-REC or that information has been false or misrepresented;
 - submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or
 - new institutional rules, national legislation or international conventions deem it necessary.
- NWU-EMELTEN-REC can be contacted for further information via Ethics-EMELTEN-apply@nwu.ac.za or 018 299 4707

The NWU-EMELTEN-REC would like to remain at your service and wishes you well with your study.

Please do not hesitate to contact the NWU-EMELTEN-REC for any further enquiries or requests for assistance.

Yours sincerely,



Prof Lukas Meyer
Chairperson NWU-EMELTEN-REC

APPENDIX F - MKHIWENI INKHUNDLA

MKHIWENI INKHUNDLA

P. O. BOX 13

MANZINI

20th February 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

**RE: APPROVAL OF VENUE FOR PHUMUZANI MPOFU TO USE ON HIS
UNIVERSITY STUDIES**

The Inkhundla kindly accepts the request for Mr. Phumuzani Mpofu to use Inkhundla as a meeting point to do his survey on **'collaborative construction of an intergenerational relationship model to address the needs of grandparents caring for grand children orphaned by AIDS'**.

This has been done following the attachments submitted by the North West University student – a teacher at Florence Mission High School approved by the two chiefdoms (Kutsimuleni and Mbelebeleni) who agreed to use their subjects for his studies.

Yours faithfully



Ntombifuthi P. Dlamini
Inkhundla Secretary



APPENDIX G - MBELEBELENI ROYAL KRAAL

Mbelebeleni Royal Kraal

P.O Box 107

Luve

13 July 2019

RE: REQUEST FOR PERMISSION TO COLLECT DATA FOR NORTH WEST UNIVERSITY STUDENT- PHUMUZANI MPOFU

Bandlancane under Prince Gcokoma , Ndvuna George Khumalo received a request from MrPhumuzani Mpofu, a student at North West University that in order for him to fulfill his academic requirements at North West University, he has to collect data (conduct research) and his study or research topic is: **"A collaborative construction of an intergenerational relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS"**. The population for the study includes grandparents taking care of grandchildren orphaned by AIDS.

Having heard his request Bandlancane has given him permission to continue with his study in the chiefdom.

Yours Faithfully

Signed:



APPENDIX H - DEPUTY PRIME MINISTER'S OFFICE (1)

TELEPHONE: (+268) 2404 5980/1
(+268) 2404 2723/4
FAX: (+268) 2404 6854



DEPUTY PRIME MINISTER'S OFFICE
GWAMILE STREET
P.O. BOX A33
SWAZI PLAZA H101
MBABANE
SWAZILAND

OUR REF

OUR REF: SW/1/4/1

28th June, 2019

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

CLEARANCE LETTER TO CONDUCT A STUDY ON GRANDPARENTS IN THE MANZINI REGION

Permission has been granted to Fnumuzani Mpofu, Student No. 30623200 to conduct a study on grandparents in the Manzini Region. His research topic is "A collaborative construction of an intergeneration relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS".

Please assist him in his research with the necessary information and cooperation.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Moses Dlamini', written over a horizontal line.

MOSES DLAMINI
FOR: PRINCIPAL SECRETARY



APPENDIX I - EKUTSIMULENI ROYAL KRAAL

Ekutsimuleni Royal Kraal

P.O Box 72

Luve

13 July 2019

RE: REQUEST FOR PERMISSION TO COLLECT DATA FOR NORTH WEST UNIVERSITY STUDENT- PHUMUZANI MPOFU

Bandlancane under Prince Maloyi , NdvunaNkonyane received a request from MrPhumuzaniMpofu, a student at North West University that in order for him to fulfill his academic requirements at North West University, he has to collect data (conduct research) and his study or research topic is: **"A collaborative construction of an intergenerational relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS"**. The population for the study includes grandparents taking care of grandchildren orphaned by AIDS.

I will highly appreciate your assistance you will give him when conducting his study.

Yours Faithfully

S Nhlengetfwa

Sandile Nhlengetfwa(secretary for umphakatsi)



APPENDIX J - DEPUTY PRIME MINISTER'S OFFICE (2)

TELEPHONE: (+268) 2404 5980 /
2404 2723 /4
2404 6854

Fax: 24044073



DEPUTY PRIME MINISTER'S OFFICE
OWAMILE STREET
P.O. BOX A33

MBABANE
SWAZILAND

13th August 2020

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: AUTHORIZATION OF AN OFFICER TO PARTICIPATE IN A FOCUS GROUP DISCUSSION

This letter serves to confirm that Sandile Ndzimandze – Senior Social Welfare Officer has been authorized by the Department of Social Welfare under the Deputy Prime Minister's Office to participate in a focus group discussion as part of a research by Phumuzani Mpofu on Collaborative construction of an Intergeneration relationship model to address the needs of grandparents caring for grandchildren orphaned by AIDS.

Thank you for your cooperation.



SIMANGA MASEKO
PRINCIPAL SOCIAL WELFARE OFFICER



APPENDIX K - FOCUS GROUP QUESTIONS

Questions for focus group discussions with social worker (DPM), health workers, World vision representative, Bantwana representative, Chief's council representative, secretary to induna yenkundla, Philani Maswati representative and Young Heroes representative stakeholders and grandparents

Title: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS.

Introduction

My name is Phumuzani Mpofu; I am a PhD student at NWU. I am conducting a study on the above topic. My study leader is Professor Oduaran. I have identified you to participate in my focus group. I have the permission to conduct this study from the Deputy Prime Minister's office, Ekutsimuleni and Mbelebeleni Imiphakatsi and the Approval letter from NWU-ELMELTEN-REC.

My research question: How can relevant stakeholders in Eswatini collaborate in order to come up with intergenerational education based strategies to address the educational needs of grandparents caring for grandchildren orphaned by AIDS?

I have met several times with grandparents caring for grandchildren orphaned by AIDS. In our meetings we discussed about their needs and also challenges they encounter as they take care of these grandchildren. I will show you their challenges/needs first using a PowerPoint presentation and drawings from participants. We are now here, to hear from you how you can provide assistance to the grandparents. The discussion will be guided by the following questions:

My focus group questions:

- What assistance do you currently provide for the grandparents and their grandchildren orphaned by AIDS?
- How do you identify the grandparents caring for grandchildren orphaned by AIDS?
- When do you offer assistance to the grandparents caring for grandchildren orphaned by AIDS?
- To what extent does your assistance address the challenges/needs of the grandparents or their grandchildren?
- What techniques can be used to address their challenges/needs of grandparents?

- What other stakeholders can you work with to address the needs of the grandparents?
- As stakeholders, to what extent do you work together providing assistance to the grandparents?
- As stakeholders, how can you collaborate to address the challenges/needs of grandparents caring for grandchildren orphaned by AIDS?

APPENDIX L - CONSENT FORM FOR PARTICIPATING STAKEHOLDERS



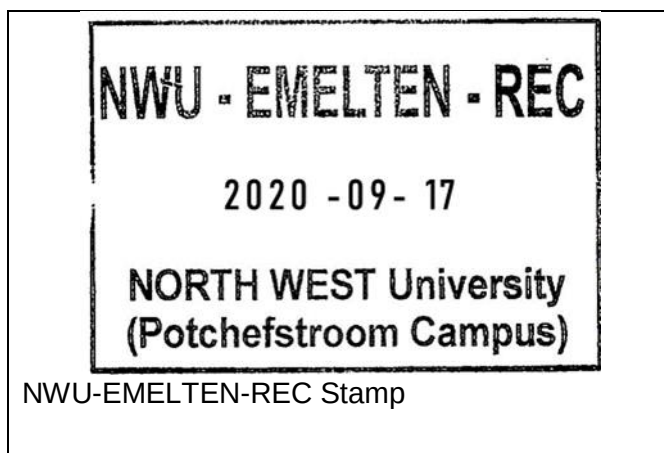
Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +27 (18) 299-1111/2222

Fax: +27 (18) 299-4910

Web: <http://www.nwu.ac.za>

The Faculty of Health Sciences Ethics Office of the North-West University is acknowledged for the use of their document with minor adjustments made by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-EMELTEN-REC).



INFORMED CONSENT DOCUMENTATION FOR PARTICIPATING STAKEHOLDERS.

TITLE OF THE RESEARCH STUDY: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

ETHICS REFERENCE NUMBER: NWU-01107-20-S2

PRINCIPAL INVESTIGATOR: Professor A. B. Oduaran

POST GRADUATE STUDENT: PHUMUZANI MPOFU

ADDRESS: BOX 73 LUVE MANZINI Eswatini

CONTACT NUMBER: 0026876652791

You are being invited to take part in a **research study** that forms part of a Doctoral study. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-01107-20-S2) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- We plan to identify the challenges faced by the grandparents in caring for their grandchildren orphaned by AIDS and to find solutions to the challenges raised above.
- This study will be conducted at Mkhiweni Inkundla in the Manzini region of Eswatini. 15 participants will be included in this study.

Why have you been invited to participate?

- You have been invited to be part of this research because you are assisting the grandparents and/or grandchildren one way or the other, to address their needs/challenges.
- You will unfortunately not be able to take part in this research if you are not assisting grandparents or their grandchildren orphaned by AIDS to meet their needs.

What will be expected of you? You will be expected to respond to the following questions:

- What assistance do you currently provide for the grandparents and their grandchildren orphaned by AIDS?
- How do you identify the grandparents caring for grandchildren orphaned by AIDS?
- When do you offer assistance to the grandparents caring for grandchildren orphaned by AIDS?
- To what extent does your assistance address the challenges/needs of the grandparents or their grandchildren?
- What techniques can be used to address their challenges/needs of grandparents?
- What other stakeholders can you work with to address the needs of the grandparents?

Will you gain anything from taking part in this research?

- The gains for you if you take part in this study will be to gain an understanding and knowledge about the exact challenges faced by grandparents taking care of grandchildren orphaned by AIDS.

Are there risks involved in you taking part in this research and what will be done to prevent them?

The possible risks to you in this study could be victimisation by your employers or managers at work. To minimize the risk of you taking part in this study I will first seek the permission from the authorities so that they are aware of your participation in the study. The above questions will be made available to your authorities. Another possible risk could be contracting COVID-19 during your participation. I will strictly adhere to the prescribed COVID-19 regulations, protocols and procedures during the execution of the research. . I will provide you with brand new surgical face masks, sanitizers and social distancing will be maintained at all times. Windows will remain open for free circulation of air. The venue will be sanitized before we use

it. Our meeting will not last more than two hours. Screening of participants will be done before one enters the discussion room. Should you feel uncomfortable taking part in the study you may withdraw at any stage without fear of negative consequence.

How will we protect your confidentiality?

By participating in this study you will not be identified in any way. Your names will not be mentioned in any research reports. It is only the researcher and the supervisor who will have access to the data and the hard copy data will be stored in a locked cupboard in the supervisor's office for seven years. All electronic data will be saved on the supervisor's password protected computer for a period of seven years. After seven years all data will be destroyed.

What will happen with the data?

- The data of this study will only be used for the purposes of this study

How will you know about the results of this research?

The findings will be shared with you in writing and verbally at a meeting after the study has been completed.

Will you be paid to take part in this study and are there any costs for you?

For those of you who will travel to the venue using your own transport, travel costs will be compensated.

Refreshments will be served at the meetings

There will thus be no costs for you, if you do take part in this study.

Is there anything else that you should know or do?

- You can contact .PHUMUZANI MPOFU at mpofup89@gmail.com or 0026876652791 if you have any further questions or have any problems.
- You can also contact the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee via Mrs Villera le Roux at 018 299 4707 or villera.leroux@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I PHUMUZANI MPOFU declare that:

- I clearly and in detail explained the information in this document to
.....
- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at Manzini, Eswatini on (*date*) 20....

.....

Signature of person obtaining consent

Declaration by researcher

I PHUMUZANI MPOFU declare that:

- I explained the information in this document to
.....
- I did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

PMPOFU

Signature of researcher

APPENDIX M - CONSENT FORM FOR VOLUNTEERED GRANDPARENTS WHO PARTICIPATED IN FOCUS GROUP DISCUSSION WITH STAKEHOLDERS



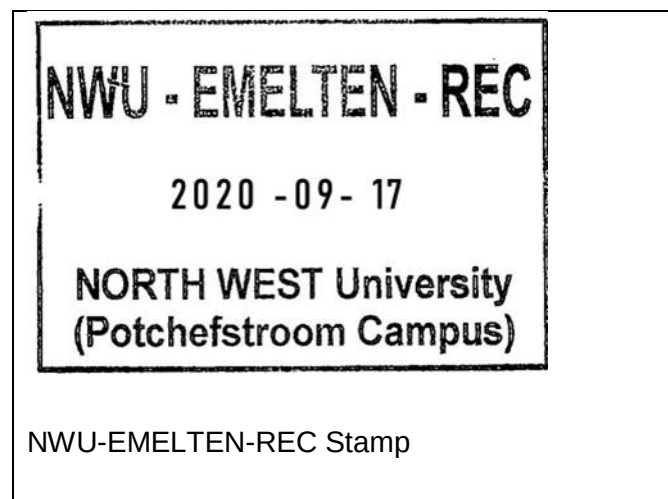
Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +27 18 299-1111/2222

Fax: +27 18 299-4910

Web: <http://www.nwu.ac.za>

The Faculty of Health Sciences Ethics Office of the North-West University is acknowledged for the use of their document with minor adjustments made by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-EMELTEN-REC).



INFORMED CONSENT DOCUMENTATION FOR GRANDPARENTS WHO VOLUNTEERED TO PARTICIPATE IN FOCUS GROUP DISCUSSIONS WITH OTHER STAKEHOLDERS

TITLE OF THE RESEARCH STUDY: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

ETHICS REFERENCE NUMBER: NWU-01107-20-S2

PRINCIPAL INVESTIGATOR: Professor Oduaran A

POST GRADUATE STUDENT: PHUMUZANI MPOFU

ADDRESS: BOX 73 LUVE MANZINI Eswatini

CONTACT NUMBER: 0026876652791

You are being invited to take part in a **research study** that forms part of a Doctoral study. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-01107-20-S2) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- We plan to identify the challenges faced by the grandparents in caring for their grandchildren orphaned by AIDS and to find solutions to the challenges raised above.
- This study will be conducted at Mkhweni Inkundla in the Manzini region of Eswatini. 15 participants will be included in this study.

Why have you been invited to participate?

You have been invited to participate because you volunteered to represent the grandparent group at the focus group discussions with the other stakeholders and you have given your consent that your identities may be revealed to the other participants during the focus group discussions.

- You will unfortunately not be able to take part in our focus group discussions if you do not feel comfortable for your identities being revealed to the other stakeholders.
- You will be expected to facilitate in our focus group discussions together with the researcher. You may ask the stakeholders specific questions during our focus group discussions.

Will you gain anything from taking part in this research?

- The gains for you if you take part in this study will be finding solutions to the challenges you face as a grandparent looking after your grandchildren orphaned by AIDS. You will also get an opportunity to interact directly with stakeholders and ask them anything affecting you as a grandparent.

Are there risks involved in you taking part in this research and what will be done to prevent them?

The possible risk is being identified and associated with the needs presented to the stakeholders. To minimise the possible risk I will explain to the participating stakeholders the need for confidentiality and adhering to research ethics.

How will we protect your confidentiality?

By participating in this study you will not be identified in any way. Your names will not be mentioned in any research reports. It is only the researcher and the supervisor who will have access to the data and the hard copy data will be stored in a locked cupboard in the supervisor's office for seven years. All electronic data will be saved on the supervisor's password protected computer for a period of seven years. After seven years all data will be destroyed.

What will happen with the data?

- The data of this study will only be used for the purposes of this study

How will you know about the results of this research?

The findings will be shared with you in writing and verbally at a meeting after the study has been completed.

Will you be paid to take part in this study and are there any costs for you?

Refreshments will be served at the meetings. There will thus be no costs for you, if you do take part in this study, so therefore you will not be paid for participating in the study.

Is there anything else that you should know or do?

- You can contact .PHUMUZANI MPOFU at mpofup89@gmail.com or 0026876652791 if you have any further questions or have any problems.
- You can also contact the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee via Mrs Villera le Roux at 018 299 4707 or villera.leroux@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to participate in focus group discussions with other stakeholders in the research study titled: **The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS.**

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I PHUMUZANI MPOFU declare that:

- I clearly and in detail explained the information in this document to
-
- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at Manzini, Eswatini on (*date*) 20....

.....

Signature of person obtaining consent

Declaration by researcher

I PHUMUZANI MPOFU declare that:

- I explained the information in this document to
.....
- I did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

PMPOFU

Signature of researcher

APPENDIX N - CONSENT FORM FOR PARTICIPATING GRANDPARENTS



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +27 18 299-1111/2222

Fax: +27 18 299-4910

Web: <http://www.nwu.ac.za>

The Faculty of Health Sciences Ethics Office of the North-West University is acknowledged for the use of their document with minor adjustments made by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-EMELTEN-REC).

NWU-EMELTEN-REC Stamp

INFORMED CONSENT DOCUMENTATION FOR PARTICIPATING GRANDPARENTS.

TITLE OF THE RESEARCH STUDY: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

ETHICS REFERENCE NUMBER: NWU-01107-20-S2

PRINCIPAL INVESTIGATOR: Professor Oduaran A

POST GRADUATE STUDENT: PHUMUZANI MPOFU

ADDRESS: BOX 73 LUVE MANZINI Eswatini

CONTACT NUMBER: 0026876652791

You are being invited to take part in a **research study** that forms part of a Doctoral study. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee (NWU-01107-20-S2) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- We plan to identify the challenges faced by the grandparents in caring for their grandchildren orphaned by AIDS and to find solutions to the challenges raised above.
- This study will be conducted at Mkhiweni Inkundla in the Manzini region of Eswatini. 15 participants will be included in this study.
- **Why have you been invited to participate?**
- You have been invited to be part of this research because you are the grandparent/s taking care of your own grandchildren orphaned by AIDS and you are between 60 and 75 years old.

- You will unfortunately not be able to take part in this research if you are not taking care of your own grandchildren orphaned by AIDS but you are younger than 60 years old, or you are taking care of children orphaned by AIDS who are not your own grandchildren.
- **What will be expected of you?**
- You will be expected to write/tell the stories of your lived experiences as a grandparent. I also expect you to participate in focus group discussion with stakeholders. I expect you to make drawings and share them with other participants about your lived experiences. You will also be expected to participate in group activities. You will also express your experiences using photographs that you have taken. You will attend meetings at least once per fortnight for a period of 3 months. Meetings may last between one and half hours to two hours per day. With your permission, video-recordings will be taken during these meetings.

Will you gain anything from taking part in this research?

- The gains for you if you take part in this study will be finding solutions to the challenges you face as a grandparent looking after your grandchildren orphaned by AIDS.
- **Are there risks involved in you taking part in this research and what will be done to prevent them?**
- The possible risks to you in this study could be that you may experience feelings of sadness when you think of your late children. Should you feel uncomfortable taking part in the study you may withdraw at any stage without fear of negative consequences. If you are triggered emotionally during any discussion, a local psychologist will be on standby to help you with negative emotions.
- Another possible risk could be contracting COVID-19 during your participation. I will strictly adhere to the prescribed COVID-19 regulations, protocols and procedures during the execution of the research. I will provide you with brand new surgical face masks, sanitizers and social distancing will be maintained at all times. Windows will remain open for free circulation of air. The venue will be sanitized before we use it. Our meeting will not last more than two hours. Screening of participants will be done before one enters the discussion room.
- There are more gains for you in joining this study than there are risks.

How will we protect your confidentiality?

By participating in this study you will not be identified in any way. Your names and those of your grandchildren will not be mentioned in any research reports. Information to be presented to other stakeholders will be presented to them as coming from the group of grandparents and not from individual grandparents in order to protect your individual identifies. It is only the researcher and the supervisor who will have access to the data and the hard copy data will be stored in a locked cupboard in the supervisor's office for seven years. All electronic data will be saved on the supervisor's password protected computer for a period of seven years. After seven years all data will be destroyed.

What will happen with the data?

- The data of this study will only be used for the purposes of this study

How will you know about the results of this research?

The findings will be shared with you in writing and verbally at a meeting after the study has been completed.

Will you be paid to take part in this study and are there any costs for you?

There are no travel expenses as all the participants live within a walking distance from the Inkundla centre where the meetings will be held.

Refreshments will be served at the meetings

There will thus be no costs for you, if you do take part in this study.

Is there anything else that you should know or do?

You can contact .PHUMUZANI MPOFU at mpofup89@gmail.com or 0026876652791 if you have any further questions or have any problems.

You can also contact the North-West University Education, Management and Economic Sciences, Law, Theology, Engineering and Natural Sciences Research Ethics Committee via Mrs Villera le Roux at 018 299 4707 or villera.leroux@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.

You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I PHUMUZANI MPOFU declare that:

- I clearly and in detail explained the information in this document to
.....
- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at Manzini, Eswatini on (*date*) 20....

.....

Signature of person obtaining consent

Declaration by researcher

I PHUMUZANI MPOFU declare that:

- I explained the information in this document to
.....
- I did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them
- .
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

MPOFU

Signature of researcher

APPENDIX O – DECLARATION OF LANGUAGE EDITING



Declaration by the language editor

To whom it may concern,

This declaration certifies that the dissertation below has been edited within reasonable, ethical, and professional limits, for syntax, grammar, spelling, punctuation, references, and specific stylistic requirements of the English language by one or more qualified language practitioner(s) at Word Order. The editor's revisions and comments serve as recommendations; the overall quality of the final product's contents remains the responsibility of the client/author. The language editor does not accept responsibility for any changes made to the mini-dissertation after issuing this declaration.

Manuscript title: The collaborative construction of an intergenerational relationship education model to address the needs of grandparents caring for grandchildren orphaned by AIDS

Author: P. Mpofu (30623200)

Date Issued: January 2021

Issued by: Wynand Steyn

BA (Hons) English, (SATI number 1000331)

on behalf of Word Order

A handwritten signature in black ink, appearing to read 'Steyn', enclosed within a dashed rectangular box.

Wynand Steyn

APPENDIX P – TURNITIN ORIGINALITY REPORT

Henry

ORIGINALITY REPORT

20%

SIMILARITY INDEX

16%

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7%

PUBLICATIONS

12%

STUDENT PAPERS

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Internet Source

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APPENDIX Q – MAP OF ESWATINI

