An HIV and AIDS group work programme empowering adolescents for the possible death of their caregivers

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An HIV and AIDS group work programme empowering adolescents for the possible death of their caregivers

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ABSTRACT

TITLE: **An HIV and AIDS group work programme empowering adolescents for the possible death of their caregivers**

KEY WORDS: **HIV; AIDS; Adolescence; Caregiver; Empowering group work programme; Death, Household; Needs**

The overarching objective of this study was to develop and empirically evaluate an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers. This thesis comprised five sections:

Section A contains the problem statement, research objectives and the procedures that were followed. Furthermore the limitations of this study were discussed, the definitions of key words were given and an exposition was given of the composition of the research report. The problem statement can be condensed as follows:

> *The large and growing number of adolescents affected by HIV and AIDS makes knowledge concerning their needs essential so as to provide effective interventions. A better understanding of the emotional, social and health needs of adolescents of HIV-infected parents is essential. Responses to adolescents affected by HIV and AIDS should address their needs. Programme development must be done in response to adolescents' needs via their active participation in the entire process.*

The problem statement led to five research aims. The concurrent embedded strategy was used in this study and was implemented with a mixed method design model. Interviews and questionnaires were used to collect qualitative and quantitative data simultaneously. Literature studies were conducted on the themes *HIV and AIDS, adolescence, the needs of adolescents* and *group work*.

Section B consists of four articles that together formed the report on the research outcomes. Each article was a report on a particular sub-project of the research and had, as a self-contained unit, an own research aim, research method and report. Each article was linked to the central aim, the objectives and the content of the umbrella research project. The four articles were:

- **Article 1: A profile of adolescents' households infected with or affected by HIV and AIDS**

A comprehensive profile of adolescents' households infected with or affected by HIV and AIDS was drafted, based on the results gained from interviews with and the completion of questionnaires by 169 households. Data collected and discussed included various demographic data regarding the households, their health and well-being, school attendance as well as information on child-headed households.

- **Article 2: The needs of adolescents in households infected with or affected by HIV and AIDS**

The needs of adolescents whose caregivers are infected with or affected by HIV and AIDS were discussed. Various basic and developmental needs of adolescents were discussed as well as specific needs they may experience when their caregivers become infected with or affected by HIV and AIDS.

- **Article 3: An HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers**

An HIV and AIDS group work programme was developed, preparing adolescents for the death of their parents/caretakers and empowering them with skills to be able to deal with it. A needs assessment was done on a large number of adolescents from households infected with or affected by HIV and AIDS. The selection of members for this programme, as well as guidelines for group work with adolescents, were discussed. This article focused mainly on the themes and contents of the designed group work programme.

- **Article 4: The evaluation of an HIV and AIDS group work programme empowering adolescents for the possible death of their parents/caregivers**

The programme was implemented with 8 adolescents in an experimental group and 8 adolescents in the control group. The *Child Functioning Inventory High School (CFI-HIGH)* and the *Generalized Contentment Scale (GCS)* were used as quantitative measuring instruments at two occasions with both groups. The experimental group was also qualitatively and quantitatively evaluated by means of a self-developed questionnaire.

Section C provided a summary of the findings and conclusions of the research report in total and some recommendations are provided.

Section D consisted of various addenda, such as questionnaires and measuring instruments that were used.

Section E contained an integrated bibliography.

OPSOMMING

TITEL: **'n MIV en VIGS groepwerkprogram wat adolessente bemagtig om die moontlike dood van hul versorgers te kan hanteer**

SLEUTELWOORDE: MIV; VIGS; Adolessensie; Versorger; Bemagtigende groepwerkprogram; Dood, Huishoudings; Behoeftes

Die oorkoepelende doel van hierdie studie was om 'n MIV en VIGS groepwerkprogram te ontwikkel om adolessente te bemagtig om die moontlike dood van hul ouers/versorgers te kan hanteer en dit empiries te evalueer. Hierdie proefskrif is uit vyf afdelings saamgestel:

Afdeling A het die probleemstelling, navorsingsdoelwitte en die prosedures wat gevolg is, bevat. Voorts is die beperkinge van hierdie studie bespreek, die definisies van sleutelwoorde is gegee en 'n uiteensetting is gegee van die samestelling van die navorsingsverslag. Die probleemstelling kan soos volg saamgevat word:

> *Die groot en toenemende aantal adolessente wat deur MIV en VIGS geraak is, maak kennis aangaande hulle behoeftes noodsaaklik sodat doeltreffende intervensies ingestel kan word. Beter begrip van die emosionele, sosiale en gesondheidsbehoeftes van adolessente van MIV-geïnfekteerde ouers is noodsaaklik. Reaksies op adolessente wat deur MIV en VIGS geaffekteer is, behoort hulle behoeftes onder die loep te neem. Programontwikkeling moet in reaksie op adolessente se behoeftes gedoen word via hul daadwerklike deelname aan die hele proses.*

Die probleemstelling het aanleiding gegee tot vyf navorsingsdoelwitte. Die gelyktydig geintegreerde strategie is in hierdie studie toegepas en is met 'n gemengdemetode-ontwerp geïmplementeer. Onderhoude en vraelyste is gebruik om kwalitatiewe en kwantitatiewe data gelyktydig in te samel. Literatuurstudies is uitgevoer oor die temas *MIV en VIGS, adolessensie, die behoeftes van adolessente* en *groepwerk.*

Afdeling B het bestaan uit vier artikels wat saam die verslag oor die navorsingsuitkomste uitgemaak het. Elke artikel was 'n verslag oor 'n spesifieke subprojek van die navorsing en het, as 'n selfstandige eenheid, 'n eie navorsingsdoelwit, navorsingsmetode en navorsingsverslag. Elke artikel is gekoppel aan die sentrale doel, die doelwitte en die inhoud van die oorkoepelende navorsingsprojek. Die vier artikels was:

- **Artikel 1: 'n Profiel van adolessente se huishoudings wat deur MIV en VIGS geaffekteer en daarmee geïnfekteer is**

'n Omvattende profiel is geteken van adolessente se huishoudings wat met MIV en VIGS geïnfekteer en daardeur geaffekteer is, gebaseer op die resultate wat uit onderhoude met en die invul van vraelyste deur 169 huishoudings bekom is. Data wat ingesamel en

bespreek is, het verskeie demografiese data rakende die huishoudings, hul gesondheid en welsyn, skoolbywoning asook inligting oor huishoudings met 'n kind aan die stuur van sake ingesluit.

- **Artikel 2: Die behoeftes van adolessente in huishoudings wat met MIV en VIGS geïnfekteer en daardeur geaffekteer is**

Die behoeftes van adolessente wie se versorgers met MIV en VIGS geïnfekteer en daardeur geaffekteer is, is bespreek. Verskeie basiese en ontwikkelingsbehoeftes van adolessente is bespreek asook spesifieke behoeftes wat hulle dalk kan ondervind wanneer hulle versorgers met MIV en VIGS geïnfekteer en daardeur geaffekteer is.

- **Artikel 3: 'n MIV-en VIGS groepwerkprogram wat adolessente bemagtig om die moontlike dood van hul ouers/versorgers te kan hanteer**

'n MIV en VIGS groepwerkprogram is ontwerp wat adolessente voorberei op die dood van hul ouers/versorgers en hulle met vaardighede bemagtig om dit te kan hanteer. 'n Behoeftebepaling is gedoen onder 'n groot aantal adolessente uit huishoudings wat met MIV en VIGS geïnfekteer en daardeur geaffekteer is. Die seleksie van lede vir hierdie program is bespreek, asook riglyne vir groepwerk met adolessente. Hierdie artikel was hoofsaaklik op die temas en inhoud van die ontwerpte groepwerkprogram toegespits.

- **Artikel 4: Die evaluering van 'n MIV en VIGS groepwerkprogram wat adolessente bemagtig om die moontlike dood van hul ouers/versorgers te kan hanteer**

Die program is met 8 adolessente in 'n eksperimentele groep geïmplementeer en 8 adolessente in die kontrolegroep. Die *Child Functioning Inventory High School (CFI-HIGH)* en die *Generalized Contentment Scale (GCS)* is met twee geleenthede met albei groepe as kwantitatiewe meetinstrument gebruik. Die eksperimentele groep is ook kwalitatief en kwantitatief aan die hand van 'n self-saamgestelde vraelys geëvalueer.

Afdeling C het 'n opsomming van die bevindinge en gevolgtrekkings waartoe uit die algehele navorsingsverslag gekom is, voorsien, en enkele aanbevelings is aan die hand gedoen.

Afdeling D het bestaan uit 'n aantal addenda soos die vraelyste en meetinstrumente wat benut is.

Afdeling E het 'n geïntegreerde bibliografie bevat.

PREFACE

The article format was utilized in the presentation of the research results as stipulated in Rules A.11.5.3 and A.11.5.4 of the Yearbook of the Potchefstroom University for CHE (2008:17), currently the Potchefstroom Campus of the North-West University. The formulation of the articles is in accordance with stipulations of *Social Work/Maatskaplike Werk* (Annexure F), *International Social Work* (Annexure G) and *Practice Social Work in Action* (Annexure H).

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SECTION A:

GENERAL INTRODUCTION

1. PROBLEM STATEMENT

The AIDS epidemic in South Africa is among the worst in the world (Van Rooyen & Sewpaul, 1993:224) and has reached pandemic proportions (Visser, 2005:204). According to the UNAIDS Global summary of the AIDS epidemic (Dec. 2006) there was an estimated 39,5 (between 34,1 and 47,1) million adults and children infected with HIV worldwide at the end of 2006. Of this total an average of 24,7 (between 21,8 and 27,7) million were from Sub-Saharan Africa, of whom between 4,5 and 6,3 million were from South Africa. According to Abdool Karim, Abdool Karim and Baxter (2005:37), another 1 700 people are estimated to become infected with this virus daily. Whiteside and Sunter (2000:58) mention that, in South Africa, the highest rates of infection are among people between 20 and 44 years of age. Roalkvam (2005:218) states that AIDS illnesses primarily kill the mid-generations and isolate the children (including adolescents). It became clear that there is no segment of society that can claim to have escaped the effects of the HIV and AIDS pandemic.

Currently in South-Africa it increasingly happens that parents become terminally ill with AIDS before their children do. The HIV and AIDS pandemic affects all children by changing the nature of society we all live in. The quality and availability of health, welfare and education systems are deteriorating because of demands caused by this pandemic (Richter, Manegold & Pather, 2004:5). Saloner (2002:154) mentioned that it is estimated that by 2005, more than a million children under the age of 15 will already have lost their mothers to AIDS. The number of orphans in South Africa, due to AIDS, is forecast to reach close to

two million by 2010 (Whiteside & Sunter, 2000:70). Gow and Desmond (2002:63) estimated that by 2015, children (including adolescents) orphaned by AIDS will constitute between 9% and 12% of South Africa's total population. However, it is difficult to assess the contribution of HIV infection to the prevalence of orphans since it is not always possible to know whether the cause of death of the parent was related to HIV infection (Kamali, Seeley, Nunn, Kengeya-Kayondo, Ruberantwari & Mulder, 1998:221). Children orphaned by HIV and AIDS who live without parental support and protection are deprived of opportunities for nutrition, health care and shelter (Valdiserri, 2003:182).

Lyons (2001:4) notes that adolescents are forced into roles of adults when their parents become ill and die of AIDS. In the absence of adult caretakers, the adolescents take family responsibilities upon themselves for the survival of the family (Kaseke & Gumbo, 2001:54). These adolescents are left emotionally and psychologically vulnerable when they experience the illness and death of their parents due to AIDS (Mynhardt, 2002:10). Taylor-Brown and Garcia (1999:37) point out that the needs of adolescents in families who are infected with or affected by HIV and AIDS have received little attention despite the growing number of these youths nationwide. These adolescents stop attending school and Leming and Dickinson (2002:98) add that they can neglect their own health and developmental needs in order to take over the role of their parent, caregiver and provider.

According to UNAIDS's *Report on the global HIV/AIDS epidemic* (June 2000:93) there is more and more proof of the stress involved in caring for patients with AIDS. The impact of this becomes even worse when there is a close relationship between the patient and the caregiver, where the caregiver (adolescent) is the caretaker of the patient (parent). The adolescents are confronted with special circumstances regarding the act of caring for their parents who are ill with AIDS. The lack of material, emotional and developmental support from a parent can

lead to uncertainty, fear, loneliness and sorrow in the adolescent (Bauman, Draiman, Lavine & Hudis, 2000:157; Schultz, 2002:62). This result in restrictions regarding a successful youth which can influence the adolescent's future as an adult (Lyons, 2001:6). For this reason Corr, Nabe and Corr (2003:368) recommend that bereavement counselling with the adolescent should, where possible, commence before the death of the parents steps in.

The death of a parent is a traumatic experience for the adolescent (Vos, 1997:35). Leming and Dickinson (2002:503) remark that many factors influence the impact of the death of a parent on the adolescent. These factors include the dynamics of the family ties as well as the developmental stage of the adolescent (Bauman et al., 2000:167; Currer, 2001:108). Bester-Bredell (2002:3) mentions the fact that when a person experiences the loss of a loved one, especially through death, it is one of the most traumatic occurences in his or her life, and Strydom and Fourie (1998:389) add that the mourning experience is real and painful for the bereaved. The adolescent's personality and coping skills, as well as the gender of both the parent and adolescent are factors which determine the impact of the death of the parent on the adolescent (Vos, 1997:36).

Sanei (1998:2–5) holds that it is necessary for the family with an HIV and AIDS patient to receive sufficient and effective support from social work service delivery. Some of the Government's policy documents, which include the *White Paper for social Welfare* (1997) and the *Draft Social Welfare Action Plan (SWAP)* (1998) of the Department of Welfare include reference to the role social work should play in the act of empowering adolescents as a target group. The social worker has certain tasks regarding effective service delivery to families with HIV-infected persons (Mullan, 1998:27; Saloner, 2002:155, 156). Skidmore, Thackeray and Farley (1994:194–198) also mention that the social worker has an important task with regard to dealing with the adolescent's feelings when the parent passes away. One of the most important tasks of the social worker,

according to literature, is that the social worker should take the psycho-social needs of the adolescent into account (Raath, 2001:221). Adolescents have specific and unique physical, emotional, developmental and educational as well as spiritual needs. When their parents are infected with or affected by HIV and AIDS, adolescents have specific physical, emotional, educational and bereavement needs (Strydom & Mynhardt, 2005:190) which are also affected and become more complex. Other needs of adolescents affected by the death of their parents include economics, protection, to function as a family and household, love and support, security and life skills (Mynhardt, 2002:4-12).

The large and growing number of affected adolescents makes knowledge concerning their needs essential so that effective interventions can be provided (Siegel & Gorey, 1998:263). Niebuhr, Hughes and Pollard (1998:260) indicate that a better understanding of the emotional, social and health needs of adolescents of HIV-infected parents is needed. Responses to adolescents affected by HIV and AIDS should address their needs (Ungar, 2005:256). Programme development must be done in response to adolescents' needs via their active participation in the entire process (Kandasamy, 2002:5).

The following research questions can be formulated from the foregoing:

- What are the characteristics of adolescents' households whose parents/caregivers are infected with or affected by HIV and AIDS?
- What are the needs of adolescents in households infected with or affected by HIV and AIDS?
- Which programme activities indicated by literature and the empirical research should be included in a programme empowering adolescents to be able to deal with the possible death of their parents/caregiver?
- What influence can a programme have on preparation needs of the adolescents regarding the possible death of a parent/caregiver with AIDS?

- How can this programme be evaluated to test for it's effectiveness and be disseminated to possible users?

2. AIM AND OBJECTIVES OF THE STUDY

2.1 GENERAL AIM

To develop and empirically evaluate an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers.

2.2 OBJECTIVES

To reach the above-mentioned aim, the objectives are:

2.2.1 To explore and compile a profile of adolescents' households whose parents/caregivers are infected with or affected by HIV and AIDS.

2.2.2 To explore and identify the needs of adolescents in households infected with and affected by HIV and AIDS.

2.2.3 To develop an HIV and AIDS group work programme which empower adolescents to deal with the possible death of their parents/caretakers.

2.2.4 To empirically evaluate the effectiveness of the developed programme.

2.2.5 To disseminate the program.

3. CENTRAL THEORETICAL ARGUMENT

Adolescents in households affected by or infected with HIV and AIDS can be empowered to deal with the possible death of their parents or caregivers due to AIDS by participating in a group work programme being presented to them.

4. RESEARCH METHODOLOGY

4.1 STUDY OF LITERATURE

For this research it was necessary to analyse comprehensive literature and available research results (Fouche & Delport, 2005:84). This includes making use of sources (books, journals etc.) regarding the adolescent, HIV and AIDS, the death of persons due to AIDS as well as other related topics. The following databases were utilised to identify the available sources:

NRF-NEXUS	- SA ongoing and completed research
SSI	- Social Science Index
PSYC Info	- Psychosocial database
ISI	- Web of Science
AIDSearch	- HIV/AIDS

4.2 EMPIRICAL RESEARCH

4.2.1 Research model

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407).

These phases are: Phase 1 – Problem analysis and project planning
Phase 2 – Information gathering and synthesis
Phase 3 – Design

Phase 4 – Early development and pilot testing

Phase 5 – Evaluation and advanced development

Phase 6 – Dissemination

4.2.1.1 Phase 1: Problem analysis and project planning

A social problem is a condition affecting a significant number of people in ways considered undesirable, about which it is felt something could be done through collective action. This phase consists of several operations and was formulated as the following series of steps to be executed (De Vos, 2005c: 395 – 398):

- Identifying and involving of clients
- Gaining entry and cooperation from settings
- Identifying concerns of the population
- Analysing identified problems
- Setting goals and objectives

4.2.1.2 Phase 2: Information gathering and synthesis

In planning an intervention research project, it is essential to discover what others have done to understand and address the problem. The acquisition of knowledge involves identifying and selecting relevant types of knowledge, and using and integrating appropriate sources of information. The operations or steps of this phase are as follows (De Vos, 2005c: 398 – 400):

- Using existing information sources
- Studying natural examples
- Identifying functional elements of successful models

4.2.1.3 Phase 3: Design

Researchers must design a way of naturalistically observing events related to the phenomenon, as well as a method system for discovering the extent of the problem and detecting effects following the intervention. By observing the problem and studying naturally occurring innovations and other prototypes, researchers can identify procedural elements for use in the intervention. This phase consists of the following operations (De Vos, 2005c: 400 – 401):

- Designing an observational system
- Specifying procedural elements of the intervention

4.2.1.4 Phase 4: Early development and pilot testing

Development can be defined as the process by which an innovative intervention is implemented and used on a trial basis, developmentally tested for its adequacy, and refined and redesigned as necessary. This phase includes the following operations (De Vos, 2005c: 401 – 403):

- Developing a prototype or preliminary intervention
- Conducting a pilot test
- Applying design criteria to the preliminary intervention concept

4.2.1.5 Phase 5: Evaluation and advanced development

This phase of the D & D model comprises the following operations (De Vos, 2005c: 403 – 404):

- Selecting an experimental design
- Collecting and analysing data
- Replicating the intervention under field conditions
- Refining the intervention

4.2.1.6 Phase 6: Dissemination

Once the community intervention has been field tested and evaluated, it is ready to be disseminated to community organisations and other target audiences. The following operations help to make the process of dissemination more successful (De Vos, 2005c: 404 – 407):

- Preparing the product for dissemination
- Identifying potential markets for the intervention
- Creating a demand for the intervention
- Encouraging appropriate adaptation
- Providing technical support for adopters

4.2.2 Design

Research design can be defined as a blueprint of how the researcher intends to conduct research (Babbie & Mouton, 2001:55). Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms and involves the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Creswell, 2009:4). The concurrent embedded strategy was used in this study. Creswell (2009: 214) explains that the concurrent embedded strategy of mixed methods are identified by its use of one data collection phase during which both qualitative and quantitative data are collected simultaneously. This approach has a primary method that guides the project and a secondary database that provides a supporting role in the procedures. According to Creswell (2009:214) the secondary method (qualitative or quantitative) is embedded, or nested, within the predominant method (qualitative or quantitative). The questionnaire as survey data procedure was used to collect data and the main objective of the questionnaire was to obtain facts and opinions regarding a phenomenon from people who are informed about (or have knowledge of) the particular issue (Delport, 2005:166).

4.2.3 Participants

During this study a total of 169 households who are infected with or affected by HIV and AIDS (of which adolescents form part) were interviewed. In the Eastern Cape Province 119 households were selected and interviewed in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay. In October 2007 the researcher moved from Jeffreysbay to Potcheftstroom and the research resumed in Potchefstroom with another 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe) in the North West Province. These interviews were conducted as part of the needs assessment. Once the needs of adolescents in households infected with or affected by HIV and AIDS were established, a group work programme was developed. For inclusion in the programme a total of 24 adolescents from the Sonderwater and Extention 7 communities near Ikageng in Potchefstroom were selected according to certain criteria.

4.2.4 Sampling procedure

In this research non-probability sampling was used for the needs assessment because the odds of selecting a particular individual were not known, since the researcher did not know the population size (Strydom, 2005b:201-202). In this particular study accidental sampling was used for the needs assessment. Accidental sampling is done when any case happens to cross the researcher's path and has anything to do with the phenomenon and is therefore included in the sample until the desired number is reached (Strydom, 2005b:202). For the group work programme the comparison group pretest-posttest design was utilized (Grinnell, 2001:253). Twenty four (24) adolescents were recruited. Of these 24 adolescents, only 16 were able and willing to take part in the programme and were divided into two groups of eight members each. One group was exposed to the programme (experimental group) but not the other

group (comparison group). However, they (comparison group) were later given the opportunity to follow the programme after the testing had been completed. Both the experimental group and the comparison group were pre-tested as well as post-tested to measure the possible impact and effectiveness of the intervention programme (Rubin & Babbie, 2005:324). From all adolescents that were willing to participate in the programme, consent was obtained from their parent or caregiver (Bilides, 1992:134; Etemad, 1995:824).

4.2.5 Data collection

Data collection for the needs assessment took place by means of a survey which was drawn up by the researcher and completed by fieldworkers who interviewed the participants in accordance with the content thereof. This structured research questionnaire, *The needs of adolescents in households infected with or affected by HIV and AIDS* (Annexure B) as measuring instrument was used to obtain the demographic information of adolescents and their households which are infected with or affected by HIV and AIDS. The main objective of this questionnaire was to collect information on the circumstances of adolescents' households which may have an effect on their range of needs and information on their specific needs and their feelings regarding their circumstances. Demographic data were collected to investigate the living conditions, health and well-being, school attendance and needs of adolescents and their households to be able to compile a profile of these households. Data was also collected during the presentation of the programme through various measuring instruments at an experimental level comprising an experimental group and a comparison group (see 4.2.3).

4.2.6 Measuring instruments

For utilization in the first two phases of the D & D model (problem analysis and project planning and information gathering and synthesis), the researcher drew

up a structured questionnaire for the needs assessment which was completed by the 169 households, as mentioned in 4.2.2. Three different measuring instruments (Delport, 2005:160) were utilized in the phase of the evaluation and advanced development of the group work programme. These include the *Child Functioning Inventory High School (CFI-HIGH)* of Perspective Training College (Annexure C), the *Generalized Contentment Scale* of Hudson (Bloom, Fischer & Orme, 1999:220) (Annexure D) as well as two self-constructed questionnaires: *Qualitative and quantitative measuring instrument - before programme* (Annexure E) and *Qualitative and quantitative measuring instrument – after programme* (Annexure M).

4.2.7 Ethical aspects

Ethical guidelines should serve as standards and bases upon which researchers ought to evaluate their own conduct. To be accurate and honest when reporting their research, says Strydom (2005a:56), researchers have two categories of ethical responsibility; firstly, their responsibility towards those who participate in the research project and secondly, their responsibility towards the discipline of the science. Before conducting this research, permission was obtained from the Ethics Committee of the North-West University (No. 06.K21) (Annexure A). For this research study, the following aspects were adhered to:

- It was ensured that the researcher is competent and adequately skilled to undertake the research (Strydom, 2005a:63).
- Participation in research was strictly voluntary.
- Informed consent was obtained from the participants after all the aspects of this particular research had been explained to them (Etemad, 1995:824; Strydom, 2005a:59)
- Before completing the questionnaire, participants involved were assured of their anonymity.

- All participants were afforded the right to expect that the information they provided would be treated confidentially, especially with regard to AIDS-related matters (Etemad, 1995:824; Kartell & Chabilall, 2005:215; Motepe, 2005:45).
- The participants were informed that the information would be utilised for a research document (Strydom, 2005a:65; Tutty, Rothery & Grinnell, 1996:45) and that it could help in making a useful contribution to their community and society in general.
- It was ensured that the findings of this research would not have a negative impact on the participants.
- Participants were protected from unwarranted physical or mental discomfort, distress, harm, danger or deprivation (Strydom, 2005a:67).
- Participants were treated with respect and their rights to make their own decisions and choices were respected and promoted (Harrison & Wise, 2005:20).

4.2.8 Data analysis

Once the questionnaires were completed during this study, the **quantitative data** were analysed to gain information from it. De Vos (2005a:334–337) explains that data analysis is a process through which order and structure are brought to the mass of collected data. The purpose of data analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied and tested and conclusions be drawn (Kruger, De Vos, Fouche & Venter, 2005:218). The data in this study were statistically computed with SAS (SAS Institute Inc, 2003). The results were interpreted, inferences pertinent to the research relations studied were made and conclusions were drawn. In research, the practical significance of results is not only important when results of the population data are reported but also when the practical significance of statistically significant results are commented on (Ellis & Steyn,

2003:51-53). Ellis and Steyn (2003:51-53) further explain that statistical inference draws conclusions regarding the population from which a sample has been drawn by using descriptive measures that have been calculated. Instead of only reporting descriptive statistics, effect sizes can be determined. Practical significance should be understood as a large enough difference to have an effect in practice. Statistical significance tests have the tendency to yield small p-values (which indicate significance) as the size of the data sets increase. It is important to remember that the effect size is independent of the sample size used in the study and is a measure of practical significance. The effect size makes the difference independent of units and sample size and also relates it to the spread of data. The effect size that was utilized in this study was the effect size for the relationship in a contingency table.

For this study it was important to establish whether the relationship between two variables (response from the sample population in Eastern Cape and sample population of North West) are practically significant and whether the relationship is large enough to be important. The effect size is given by $w=\sqrt{\frac{X^2}{n}}$, where X^2 is the usual Chi-square statistic for the contingency table and n is the sample size. In the case of a 2×2 table, the effect size(w) is given by the phi(ϕ) coefficient. The following guidelines can be utilized for the interpretation of the effect size: (a) small effect: $w=0.1$, (b) medium effect: $w=0.3$, (c) large effect: $w=0.5$. A relationship with $w\geq0.5$ is considered practically significant (Ellis & Steyn, 2003:51-53).

The **qualitative data** that were collected during this research was analysed by following Tesch's approach to qualitative data processing (Poggenpoel, 1998:343 – 344). According to Poggenpoel (1998:343 – 344), there are eight steps to consider in data analysis:

1. The researcher ought to get a sense of the whole by reading through all of the transcriptions carefully and jot down some ideas as they come to mind.
2. The researcher selects one interview and goes through it asking "What is this about?", thinking about the underlying meaning in the information and writing thoughts that come up in the margin.
3. After this task has been completed for several respondents, a list is made of all the topics and similar topics are clustered together and formed into columns that might be arranged into major topics, unique topics and leftovers.
4. The researcher takes the list and returns to the data and the topics are then abbreviated as codes and the codes written next to the appropriate segments of the text. This preliminary organising scheme is tried out to see whether new categories and codes emerge.
5. The researcher finds the most descriptive wording for the topics and turns them into categories and endeavours to reduce the total list of categories by grouping together topics that relate to each other. Lines are drawn between the categories to show interrelationships.
6. A final decision is made by the researcher on the abbreviation for each category and alphabetises the codes.
7. The data material belonging to each category is assembled in one place and a preliminary analysis is performed.
8. Existing data can be recoded by the researcher if necessary.

5. LIMITATIONS OF THE STUDY

5.1 TIMEFRAME

The timeframe of this study extended over the period from 2002 until April 2009. It can be outlined as follows:

Figure 1: *Timeframe of study*

TIMEFRAME	WHAT WAS DONE?
2002 – 2003	**Collection of data:** Literature study already commenced in 2002 during the MA (SW) studies of the researcher.
2006	(Enrolled for PhD in 2006)
February - March	**Problem formulation, research proposal:** Wrote and submitted the research proposal, continuous in-depth review of literature.
March	**Start writing research report:** Started writing and compiling article 2.
June - September	**Develop research questionnaire:** Developed and compiled research questionnaire to be used for data collection in empirical reseach.
October - December	**Empirical research:** Interviewed households and completed research questionnaires in Tokyo Sexwale and Pellsrus communities in Jeffreys Bay, Eastern Cape Province.
2007	
February – April	**Statistical processing of empirical research: Processed** data from research questionnaires (Eastern Cape). Continuous writing of article 2.
May	**Writing of research report:** Continuous writing of article 2, incorporating statistical data from empirical research. Wrote article 1.
June – July	**Compiling of group work programme:** Commenced with the compilation of the programme based on information gathered from empirical research and literature.
October	***Move from Jeffreys Bay to Potchefstroom.***
October - November	**Empirical research:** Interviewed households and completed reseach questionnaires in Promosa and Ikageng communities in Potchefstroom, North West Province.
December	**Compilation of group work programme:** Continuous compilation of programme.
2008	
January	**Compilation of group programme:** Continuous compilation of programme.
February	**Statistical processing of empirical data:** Processed data from research questionnaires (North West).
March – April	**Continuous writing of articles 1, 2 and 3:** Finalised articles 1, 2 and 3.
May – October	***Time off:*** *Birth of child.*
November – December	**Preparations regarding group work programme:** Finalised all preparations for presentation of programme to adolescents of Ikageng in Potchefstroom, North West Province
2009	
January – March	**Presentation of group work programme**
March – April	
April	**Evaluation of group work programme:** Evaluated group work programme and wrote article 4.
	Finalisation of research report: Finalised the reseach report, compiled introduction and summary chapters and submit PhD.

5.2 PARTICIPANTS

The empirical research was planned and formulated according to and for the population of the communities in Jeffreys Bay in the Eastern Cape. The fact that the researcher moved from Jeffreys Bay to Potchefstroom was a limitation due to the fact that the group work programme was compiled and planned for adolescents who formed part of the communities in Jeffreys bay, Eastern Cape Province. Due to the sudden move, there was not enough time to present the programme to the above-mentioned population. Another phase of data collection through research questionnaires was then necessary for the population of the communities of Potchefstroom (Tlokwe) in North West Province. On the other hand, this limitation turned out to be in the best interest of the research process as the researcher was now exposed to different populations with different ethnic and cultural backgrounds which added to extended insight.

5.3 LITERATURE

The tremendous pace at which HIV and AIDS infection had taken place added to the difficulty of obtaining recent and up to date information, statistics and opinions. Once research had become available for viewing, it could in most cases be regarded as outdated and not a valid reflection of the real status of the disease. Stigmatization and lack of openness also added to this problem, since the real statistics regarding infections remain a matter of projection rather than facts. Litterature with adolescents as main focus in the field of HIV and AIDS was also limited and in most cases literature regarding AIDS orphans or children affected by HIV and AIDS or other literature regarding adolescence was utilized.

5.4 RESEARCH QUESTIONNAIRE

In the process of data collection through the research questionnaires, volunteers from hospice organizations were used to interview the households who formed

part of this study. On the one hand the researcher's time was limited, causing her to not be able to interview 169 households and on the other hand, the researcher depended on the volunteers' knowledge of the communities because accidental sampling was used to identify households (of which adolescents form part) who were infected with or affected by HIV and AIDS. The home language of the respondents also was a limitation, since a large percentage of these participants consisted of isiXhosa or Setswana-speaking households. The researcher therefore had to rely on the volunteers' translation and interpretation of questions.

6. DEFINITIONS OF KEY CONCEPTS

6.1 HIV

According to Becker (2005:103) and Gifford, Lorig, Laurent and Gonzalez (2000:5), **HIV** is the abbreviation for ***Human Immunodeficiency Virus***, which is the virus that causes AIDS by destroying important cells which control and support the immune system.

6.2 AIDS

AIDS refers to ***Acquired Immunodeficiency Syndrome***, which is the collective name for the complications that follow when a damaged immune system cannot fight infections (Barnett & Whiteside, 2002:28; Van Der Westhuizen, 2006:14). Herbst (2002:18) explaines that AIDS is not spoken of as a disease, but as a collection of various conditions damaging the immune system. According to Buthelezi (2003:19), people do not die of AIDS, but of opportunistic diseases and infections which attack the body when immunity is low.

6.3 ADOLESCENCE

Barker (2003:8), Scholtz (1998:16) and Strydom (2003:61) describe adolescence as being normally referred to as the life cycle period between childhood and adulthood, beginning at puberty and ending in adulthood. According to Van Der Westhuizen (2006:14), the life stage of adolescence is often accompanied by rapid growth and physical development, heightened sexual activities and a struggle to find self-identity.

Adolescence as a developmental phase is characterised by discovery, experimentation and exploration, which are brought about by a myriad of physical and emotional changes (Nefale, 2001:16) and is a time of numerous physical, cognitive, emotional, social and personal changes which impact on identity development (Richardson, 2001:41). Adolescence can also be described as a time filled with numerous changes (Roe-Sepowitz & Thyer, 2004:67) and goes hand in hand with radical development regarding attitudes, skills, knowledge and functions (Van Heerden, 2001:14).

6.4 CAREGIVER

Barker (2003:57) defines a caregiver as one who provides for the physical, emotional and social needs of another person who often is dependant and cannot provide for his or her own needs. The term most often applies to parents or parent surrogates. A caregiver can also be described as a person providing care or guarding children within the context of a household or family on a daily basis (Bauman et al., 2000:156, 167). This caregiver can be the biological parents of the child or someone else who has been appointed by the parent himself or authorities on behalf of the child or any other person (including relatives or neighbours) providing care to children during their parents illness or after their death.

6.5 EMPOWERING GROUP WORK PROGRAMME

Toseland and Rivas (2005:12) describe group work as a goal-directed activity with small treatment and task groups aimed at meeting socio-emotional needs and at accomplishing tasks. Social group work is an orientation and method of social work intervention in which small numbers of people who share similar interests or common problems convene regularly and engage in activities designed to achieve certain objectives (Barker, 2003:404). According to Herbst (2002:18, 19) group work is a process whereby individual and group objectives are realized within the group context by purposefully applying the group work process.

For purposes of this study a group work programme therefore is the process taking place between a facilitator (social worker) and group members (adolescents) in which a systematic pattern is followed to achieve certain goals. An empowering group work programme is a programme in which psychosocial principles and knowledge are converted into teachable skills which can empower people to respond effectively to the demands and problems of coping in certain situations or in a certain stage of life (Van der Westhuizen, 2006:7).

6.6 DEATH

Feltham and Dryden (2005:58) describe death as the cessation of all vital life processes. Barker (2003:110) defines death as the total and permanent cessation of vital functions.

6.7 HOUSEHOLD

A household refer to all people, whether or not related, who live in the same dwelling unit (Barker, 2003:201). This includes individuals as well as groups of people.

6.8 NEEDS

Barker (2003:291) says needs refer to the physical, psychological, economic, cultural and social requirements for survival, well-being and fulfilment.

7. PRESENTATION OF THE RESEARCH REPORT

The article format was utilized in the presentation of the research results as stipulated in Rules A.11.5.3 and A.11.5.4 of the Yearbook of the North West University. The formulation of the articles is in accordance with stipulations of *Social Work/Maatskaplike Werk* (Annexure F), *International Social Work* (Annexure G) and *Practice Social Work in Action* (Annexure H). The research report is presented in the following five sections:

7.1 SECTION A: GENERAL INTRODUCTION

The first section serves as a general introduction which includes aspects such as the problem statement, aims and objectives, the general theoretical argument, research methodology, limitations of the study as well as definitions and key concepts.

7.2 SECTION B: ARTICLES

The second section contains four articles which are successively outlined. Each article is presented as an entity on its own and therefore some information could have been repeated. This section is schematically outlined as follows:

FIGURE 2: ***Exposition of Section B***

ARTICLE 1
TITLE: ***A PROFILE OF ADOLESCENTS' HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS.*** **OBJECTIVE:** The objective of this article was to explore and compile a profile of adolescents' households infected with or affected by HIV and AIDS.
ARTICLE 2
TITLE: ***THE NEEDS OF ADOLESCENTS IN HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS.*** **OBJECTIVE:** The objective of this article was to explore and identify the needs of adolescents in households infected with or affected by HIV and AIDS.
ARTICLE 3
TITLE: ***AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/GAREGIVERS.*** **OBJECTIVE:** The objective of this article was to develop an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caretakers.
ARTICLE 4
TITLE: ***THE EVALUATION OF AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/CAREGIVERS.*** **OBJECTIVE:** The objective of this article was to empirically evaluate the effectiveness of the presented HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers, to make practical recommendations for the utilisation of the newly developed HIV and AIDS group work programme and to disseminate the program to potential users.

7.3 SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The third section consists of a comprehensive summary, conclusions and recommendations regarding this study.

7.4 SECTION D: ANNEXURES

The final section comprises various annexures included in the different articles.

7.5 SECTION E: INTEGRATED BIBLIOGRAPHY

The fourth section consists of an integrated list of the sources used during this study.

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SECTION B:

ARTICLES

ARTICLE 1

A PROFILE OF ADOLESCENTS' HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS

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ABSTRACT

This article focuses on a profile of adolescents' households who are infected with or affected by HIV and AIDS. The aim of this article was to collect information from adolescents and the households they form part of. This information is to serve as a starting point for developing and compiling a profile of these unique households. A questionnaire was developed in accordance with a prior literature study regarding adolescents from households whose parents are infected with or affected by HIV and AIDS. The data which was collected through this questionnaire was processed statistically and the results are discussed. This information includes various demographic data regarding the households, their health and well-being, school attendance as well as information on child-headed households.

1. INTRODUCTION

HIV and AIDS is by far the largest current health crisis in South Africa (Strydom, 2003:59) and, according to Visser (2005:204), has reached pandemic proportions. Podile (2004:1) expands on this by describing AIDS as the most dramatic, pervasive and tragic pandemic in recent history since this disease has cut the largest and deepest human swath across the countries of Sub-Saharan Africa where the majority of the world's 40 million persons infected with HIV can be found (Ungar, 2005:248). Households infected with or affected by HIV and AIDS are confronted with unique circumstances. When adolescents form part of these households, the profile becomes even more complex. In order to develop a programme by means of which these adolescents can be prepared for the possible death of their parents or caregivers due to AIDS, it is important to explore and understand their households' circumstances.

2. PROBLEM STATEMENT

The AIDS pandemic in South Africa is among the worst in the world (Van Rooyen & Sewpaul, 1993:224). According to the UNAIDS Global summary of the AIDS epidemic (Dec. 2006), there were an estimated 39,5 (34,1–47,1) million adults and children infected with HIV worldwide by the end of 2006. Of the total 24,7 (21,8–27,7) million are of Sub-Saharan Africa, of which 4,5–6,3 million are from South Africa. According to Abdool Karim, Abdool Karim and Baxter (2005:37), another 1 700 people are estimated to become infected with this virus daily. Whiteside and Sunter (2000:58) mentioned that in South Africa, the highest rates of infection are among people between 20 and 44 years of age. Currently in South Africa it increasingly happens that parents become terminally ill with AIDS.

Adolescents are confronted with special circumstances regarding the caretaking of their parents who are ill with AIDS. Lyons (2001:4) noted that adolescents are forced into roles of adults when their parents fall ill and die of AIDS. In the absence of adult caregivers, the adolescents take family responsibilities upon themselves for the survival of the family (Kaseke & Gumbo, 2001:54) and neglect their own health and developmental needs to take on the role of parent, caregiver and provider (Leming & Dickinson, 2002:98). These adolescents are left emotionally and psychologically vulnerable when they experience the illness and death of their parents due to AIDS (Mynhardt, 2002:10). According to Taylor-Brown and Garcia (1999:37), the needs of adolescents in families who are infected with or affected by HIV and AIDS have received little attention, despite the growing number of these youth nationwide.

Roalkvam (2005:218) states that AIDS illnesses primarily kill the mid-generations and isolate the children (including adolescents). Children orphaned by HIV and AIDS who live without parental support and protection are deprived of opportunities for nutrition, health care and shelter (Valdiserri, 2003:182). The number of orphans in South Africa due to AIDS is forecast to reach close to two million by 2010 (Whiteside & Sunter, 2000:70). Gow and Desmond (2002:63) estimated that by 2015, children (including adolescents) orphaned by AIDS will constitute between 9% and 12% of South Africa's total population. However, it is difficult to assess the contribution of HIV infection to the prevalence of orphans, since it is not always possible to know whether the cause of death of the parent was related to HIV infection (Kamali, Seeley, Nunn, Kengeya-Kayondo, Ruberantwari & Mulder, 1998:221).

The HIV and AIDS epidemic affects all children by changing the nature of the society in which we live. The quality and availability of health, welfare and education systems are deteriorating because of demands caused by this epidemic (Richter, Manegold & Pather, 2004:5). It became clear that there is no

segment of society that can claim to have escaped the effects of the HIV/AIDS pandemic. Responses to adolescents affected by HIV and AIDS should address their basic needs (Ungar, 2005:256). Niebuhr, Hughes and Pollard (1998:260) indicate that a better understanding of the emotional, social and health needs of adolescents of HIV-infected parents is needed. The large and growing number of affected adolescents makes it essential that we learn about their general needs so that effective interventions can be provided (Siegel & Gorey, 1998:263).

3. OBJECTIVE

The objective of this article is to explore the circumstances and compile a profile of adolescents' households where their parents/caregivers are infected with or affected by HIV and AIDS.

4. TERMINOLOGY

As Van der Westhuizen (2006:13) points out, in order to minimize different interpretations of the same term, it is essential to define key terms used in this article.

4.1 HIV AND AIDS

According to Becker (2005:103) and Gifford, Lorig, Laurent and Gonzalez (2000:5), **HIV** refers to ***Human Immunodeficiency Virus***, which is the virus that causes AIDS by destroying important cells which control and support the immune system.

AIDS is the acronym for ***Acquired Immunodeficiency Syndrome*** which is the collective name for the complications that follow when a damaged immune system cannot fight infections (Barnett & Whiteside, 2002:28; Herbst, 2002:18;

Van Der Westhuizen, 2006:14). Buthelezi (2003:19) stresses that people do not die of AIDS, but of opportunistic diseases and infections which attack the body when immunity is low.

4.2 ADOLESCENCE

Barker (2003:8), Scholtz (1998:16) and Strydom (2003:61) describe adolescence as normally being referred to as the life cycle period between childhood and adulthood, beginning at puberty and ending in adulthood. Harrison (2005:263) describes adolescence as a specific developmental stage that spans the period from puberty into young adulthood and which is characterized by transition, physical and emotional development, and change. Van Der Westhuizen (2006:14) adds that the life stage of adolescence is often accompanied by rapid growth and physical development, heightened sexual activities and a struggle to find self-identity. Adolescence as a developmental phase is characterised by discovery, experimentation and exploration, which all result from a myriad of physical and emotional changes (Nefale, 2001:16).

4.3 HOUSEHOLD

Household refers to all people, whether or not related, who live in the same dwelling unit (Barker, 2003:201). This includes individuals as well as groups of people.

5. RESEARCH METHODOLOGY

In this study the method of investigation is a literature study and empirical research.

5.1 LITERATURE STUDY

A literature study was conducted on various aspects of the study. Delport (2005:171) states that, in order to undertake meaningful research, the researcher should have made a thorough study on the subject under review. The focus of this study was on adolescents' households that are infected with or affected by HIV and AIDS, and related literature was studied.

5.2 EMPIRICAL RESEARCH

5.2.1 Research model

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407). The first two phases were conducted during this part of the study:

5.2.1.1 Phase 1: Problem analysis and project planning

A social problem is a condition affecting a significant number of people in ways considered undesirable, about which it is felt something could be done through collective action. This phase consists of several operations and was formulated as the following series of steps to be executed (De Vos, 2005c: 395 – 398):

- Identifying and involving of clients
- Gaining entry and cooperation from settings
- Identifying concerns of the population
- Analysing identified problems
- Setting goals and objectives

5.2.1.2 Phase 2: Information gathering and synthesis

In planning an intervention research project, it is essential to discover what others have done to understand and address the problem. The acquisition of knowledge involves identifying and selecting relevant types of knowledge, and using and integrating appropriate sources of information. The operations or steps of this phase are as follows (De Vos, 2005c: 398 – 400):

- Using existing information sources
- Studying natural examples
- Identifying functional elements of successful models

5.2.2 Design

Research design can be defined as a blueprint of how the researcher intends to conduct research (Babbie & Mouton, 2001:55). Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms and involves the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Creswell, 2009:4). The concurrent embedded strategy was used in this study. Creswell (2009:214) explains that the concurrent embedded strategy of mixed methods are identified by its use of one data collection phase during which qualitative and quantitative data are collected simultaneously. This approach has a primary method that guides the project and a secondary database that provides a supporting role in the procedures. According to Creswell (2009:214), the secondary method (qualitative or quantitative) is embedded, or nested, within the predominant method (qualitative or quantitative). The questionnaire as survey data procedure was used to collect data and the main objective of the questionnaire was to obtain facts and opinions concerning a phenomenon from people who are informed (or have knowledge) on the particular issue (Delport, 2005:166). In this research, a questionnaire, *The needs of adolescents in households infected*

with or affected by HIV and AIDS (Annexure B), was compiled and utilized to collect information from adolescents' households on the living standards, health and well-being, school attendance and the needs of the adolescents in these households. In this article the focus will be on drawing a profile of adolescents' households infected with or affected by HIV and AIDS.

5.2.3 Participants

Non-probability sampling was used in this research because the odds of selecting individuals affected by HIV and AIDS are not known to the researcher and she also does not know the population size (Strydom, 2005b:201-202). In this particular study accidental sampling was used. Accidental sampling takes place when any case that happens to cross the researcher's path and has anything to do with the phenomenon, is therefore included in the sample until the desired number of respondents is obtained. During this study 119 households in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province and 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, were interviewed, the total being 169 households.

5.2.4 Data collection

Data collection took place by means of a survey which was drawn up by the researcher and completed by fieldworkers (volunteers from hospices) who interviewed the participants in accordance with the contents of the questionnaire (Annexure B). This structured questionnaire (Annexure B), as measuring instrument, was used to obtain the demographic information of adolescents and their households which are infected with or affected by HIV and AIDS. The main objective of this questionnaire was to collect information on the circumstances of adolescents' households which may have an influence on their range of needs as

well as information on their specific needs and their feelings regarding their circumstances. Demographic data were collected to investigate the living conditions, health and well-being, school attendance and general needs of adolescents and their households.

5.2.5 Ethical aspects

Ethical guidelines should serve as standards and the basis upon which researchers ought to evaluate their own conduct. According to Strydom (2005a:56), researchers have two categories of ethical responsibility, namely their responsibility towards those who participate in the research project and their responsibility towards the discipline of the science, to be accurate and honest when reporting on their research. Before this research was conducted, permission was obtained from the Ethics Committee of the North-West University (No. 06K21) (Annexure A). For this research study, the following aspects were taken into consideration:

- It should be ensured that the researcher is competent as well as adequately skilled to undertake the research (Strydom, 2005a:63).
- Participation in research should be strictly voluntary.
- Informed consent should be obtained from the participants after all the aspects of this particular research have been explained to them (Etemad, 1995:824; Strydom, 2005a:59).
- The participants involved should be assured of their anonymity when they complete the questionnaires.
- All participants have the right to expect that the information they provide will be treated confidentially, especially in the case of AIDS-related research (Etemad, 1995:824; Kartell & Chabilall, 2005:215)
- It is important that the participants should know that the information will be utilised for a research document (Strydom, 2005a:65) and that it could

help in making a useful contribution to their community and the broader society.

- It should be ensured that the findings of this research should not have a negative impact on the participants.
- Participants should be protected from unwarranted physical or mental discomfort, distress, harm, danger or deprivation (Strydom, 2005a:67).
- Participants should be treated with respect and their rights to make their own decisions and choices should be respected and promoted (Harrison & Wise, 2005:20).

5.2.6 Data analysis

The purpose of data analysis is to reduce data to an intelligible and interpretable form so that research problems can be studied and tested and conclusions drawn (Kruger, De Vos, Fouché & Venter, 2005:218). The data in this study was statistically computed with SAS (SAS Institute Inc, 2003). The results were interpreted, inferences were made and conclusions were drawn. In research, the statistical significance of results is not only important when results are reported but also to comment on the practical significance of a statistically significant result (Ellis & Steyn, 2003:51-53). Ellis and Steyn (2003:51-53) further explain that statistical inference draws conclusions concerning the population from which a sample was drawn by using descriptive measures that have been calculated. Instead of only reporting descriptive statistics, effect sizes can be determined. Practical significance should be understood as a large enough difference to have an effect in practice. Statistical significance tests have the tendency to yield small p-values (which indicate significance) as the size of the data sets increase. However, it is important to remember that the effect size is independent of the sample size used in the study and is a measure of practical significance. The effect size makes the difference independent of units and sample size and also relates it with the spread of data. The effect size that was utilized in this study

was the effect size for the relationship in a contingency table. For this study it was important to know whether the relationship between two variables (response from the sample population in Eastern Cape and sample population of North West) is large enough to be important. The effect size is given by $w=\sqrt{\frac{X^2}{n}}$, where X^2 is the usual Chi-square statistic for the contingency table and n is the sample size. In the case of a 2×2 table, the effect size (w) is given by the phi (ϕ) coefficient. The following guidelines can be utilized for the interpretation of the effect size: (a) small effect: $w=0.1$, (b) medium effect: $w=0.3$, (c) large effect: $w=0.5$. A relationship with $w\geq0.5$ is considered practically significant (Ellis & Steyn, 2003:51-53).

6. RESULTS AND DISCUSSION

The results of the empirical research in this study will be discussed in accordance with the topics of the research questionnaire. In this article the results of the first part of the questionnaire will be discussed. These include demographic data, health and well-being, school attendance and child-headed households. The results of the second part of this study will be discussed in a follow-up article: *The needs of adolescents in households infected with or affected by HIV and AIDS.*

6.1 DETAILS OF RESPONDENTS

During this research 119 households in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province, and 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, were interviewed. A total of 169 households (N = 169) completed the questionnaire. The results of this study are discussed as a whole (N = 169) and differences between those of Eastern Cape and North West are highlighted.

6.2 DEMOGRAPHIC DATA

6.2.1 Race of family/household

A question was asked about the race of the family or household. They responded as follows:

Table 1: ***Number of people per race***

RACE	F	%
Black	135	79.88
Coloured	34	20.12
Total	N = 169	100

The questionnaires were completed randomly within the above mentioned communities and table one reflects that only these two races were included in the study. No practically significant differences were found between race and province.

6.2.2 Home language

A question was asked concerning the home language of the households. The results were as follows:

Table 2: ***Home language of households***

LANGUAGE	F	%
Afrikaans	35	20.71
isiXhosa	89	52.66
isiZulu	2	1.18
Setswana	35	20.71
Sesotho	8	4.73
Total	N=169	100

Table 2 reveals that the majority of respondents were isiXhosa (52,66%), Afrikaans (20,71%) and Setswana (20,71%)-speaking which is typical of the Eastern Cape and North West provinces. There were no respondents that

indicated that their home language is English or Tsonga. The effect size (w) for home language and province (given by the phi (ϕ) coefficient) is 0,77, which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to the 70,59% of respondents in Eastern Cape who indicated isiXhosa as their home language which is typical of the community that was involved in the research process and which is representative of this province with Xhosas as their main ethnic group. The 66,00% of respondents in North West who indicate Setswana as their home language is typical of the community that was involved in the research process and is representative of the ethnic population of the province.

6.2.3 Daily activities of members of household

A question was asked to determine the number of inhabitants within the household that formed part of the following categories:

6.2.3.1 Baby, pre-school/crèche

Table 3: *Baby, pre-school/crèche*

NUMBER OF PEOPLE	F	%
(0) None	112	66.27
(1) One person	45	26.63
(2) Two people	8	4.73
(3) Three people	3	1.78
(4) Four people	1	0.59
Total	N=169	100

Table 3 reveals that 66,27% of households do not have a baby or a pre-school/crèche-attending child as part of their household. A total of 33,73% of households (N) have at least one or more babies or pre-school/crèche-attending child. No practically significant differences were found between the number of babies/pre-school or crèche-attending children and province.

6.2.3.2 Scholar/student

Table 4: *Scholar/Student*

NUMBER OF PEOPLE	F	%
(0) None	23	13.61
(1) One Person	69	40.83
(2) Two people	53	31.36
(3) Three people	19	11.24
(4) Four people	4	2.37
(6) Six people	1	0.59
Total	N=169	100

The majority (72,19%) of households (N) have one or two scholars or students (school–attending children) in their household. No practically significant differences were found between the number of scholars or students and province.

6.2.3.3 School-going age, but not attending

Table 5: *School-going age, but not attending*

NUMBER OF PEOPLE	F	%
(0) None	129	76.33
(1) One person	27	15.98
(2) Two people	12	7.10
(3) Three people	1	0.59
Total	N=169	100

Table 5 reveals that 23,67% of the households (N) have children that are of school-going age, but who are not attending school. No practically significant differences were found between number of school-going age children who are not attending school and province.

6.2.3.4 Retired

Table 6: *Retired*

NUMBER OF PEOPLE	F	%
(0) None	133	78.70
(1) One person	32	18.93
(2) Two people	4	2.37
Total	N=169	100

In 21,30% of households (N), there are one or two retired household members. No practically significant differences were found between retired persons and province.

6.2.3.5 Disabled, with casual work

Table 7: *Disabled, with casual work*

NUMBER OF PEOPLE	F	%
(0) None	166	98.22
(1) One person	2	1.18
(2) Two people	1	0.59
Total	N169	100

Only 3 out of the 169 (N) households indicated having a disabled person(s) with casual work as part of their household. No practically significant differences were found between disabled persons with casual work and province.

6.2.3.6 Disabled, without casual work

Table 8: *Disabled, without casual work*

NUMBER OF PEOPLE	F	%
(0) None	163	96.45
(1) One person	6	3.55
Total	N=169	100

Out of 169 (N) households, 6 households indicated having a person that is disabled without casual work as part of their household. No practically

significant differences were found between disabled persons without casual work and province.

6.2.3.7 Own housework

Table 9: *Own housework*

NUMBER OF PEOPLE	F	%
(0) None	157	92.90
(1) One person	12	7.10
Total	N=169	100

Own housework implies that the person's main daily activity is housework in his/her own household or, in other words, a 'housewife'. Only 7,10% of households (N) have one person that was mainly a 'housewife'. No practically significant differences were found between persons doing their own housework and province.

6.2.3.8 Unemployed, seeking work

Table 10: *Unemployed, seeking work*

NUMBER OF PEOPLE	F	%
(0) None	118	69.82
(1) One person	38	22.49
(2) Two people	7	4.14
(3) Three people	4	2.37
(4) Four people	1	0.59
(5) Five people	1	0.59
Total	N=169	100

A total of 30,18% of the households (N) indicated that they have one or more persons in their household that are unemployed and seeking work. No practically significant differences were found between unemployed persons seeking work and province.

6.2.3.9 Unemployed, not seeking work

Table 11: *Unemployed, not seeking work*

NUMBER OF PEOPLE	F	%
(0) None	139	82.25
(1) One person	23	13.61
(2) Two people	5	2.96
(3) Three people	1	0.59
(5) Five people	1	0.59
Total	N=169	100

In 17,75% of the households (N) there were one or more persons that were unemployed and not seeking a job. No practically significant differences were found between unemployed persons not seeking work and province.

6.2.3.10 Employed full time

Table 12: *Employed full time*

NUMBER OF PEOPLE	F	%
(0) None	108	63.91
(1) One person	43	25.44
(2) Two people	15	8.88
(3) Three people	1	0.59
(4) Four people	2	1.18
Total	N=169	100

Only 36,09% of the households (N) indicated that they have one or more people employed full time. No practically significant differences were found between full time employed persons and province.

6.2.3.11 Employed part time

Table 13: *Employed part time*

NUMBER OF PEOPLE	F	%
(0) None	88	52.07
(1) One person	65	38.46
(2) Two people	15	8.88
(3) Three people	1	0.59
Total	N=169	100

In 47,93% of the households (N) one or more people indicated that they are employed part time. No practically significant differences were found between part time employed persons and province.

6.2.3.12 Self-employed

Table 14: *Self-employed*

NUMBER OF PEOPLE	F	%
(0) None	160	94.67
(1) One person	8	4.73
(2) Two people	1	0.59
Total	N=169	100

Only 9 out of 169 (N) households have one or two self-employed people as part of their household. No practically significant differences were found between self-employed persons and province.

6.2.4 Male and female

A question was asked to determine how many male and female members the household consists of.

Table 15: Male and female household members

	MALE		FEMALE	
NUMBER OF PEOPLE	F	%	F	%
(0) None	17	10.06	2	1.18
(1) One person	56	33.14	42	24.85
(2) Two people	53	31.36	60	35.50
(3) Three people	24	14.20	36	21.30
(4) Four people	11	6.51	10	5.92
(5) Five people	4	2.37	11	6.51
(6) Six people	1	0.59	4	2.37
(7) Seven people	2	1.18	2	1.18
(8) Eight people	-	-	1	0.59
(9) Nine people	1	0.59	-	-
(10) Ten People	-	-	1	0.59
Total	N=169	100	N=169	100

This table (Table 15) reveals the composition of the households with regard to the total male and female members (children and adults). An overall 11,24% of the respondents indicated that they have four or more male persons per household and 17,16% of respondents indicated that they have four or more female persons as part of their household. According to Van der Westhuizen (2006:19), crowded living conditions have the disadvantage of causing a negative lifestyle. The effect size (w) for the number of male members of the household and province (given by the phi (ϕ) coefficient) is 0,5060 which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to the 41,18% of respondents in Eastern Cape who indicated that their household consists of one male member as part of their household and only 6,72% who responded to have three male members in their household. In comparison, only 14% of respondents in the North West indicated having one male member as part of their household and 32,00% of the province's respondents indicated their households consist of at least three male members. In the Eastern Cape it is common for male household members to be at sea for long periods at a time working as fishermen or working in other parts of the country, since this province

is seen to be the poorest province in the country with the least job opportunities. It often happens that these men are then either not seen as part of the household and indicated as such or that they become alienated with their families/households. No practically significant differences were found between the number of female members of the household and province.

6.2.5 Family members and non-family members

Questions were asked to determine how many of the household members were family members and non-family members. The research reveals the following:

Table 16: ***Male and female family members***

	MALE		FEMALE	
NUMBER OF PEOPLE	**F**	**%**	**F**	**%**
(0) None	**17**	**10.06**	**2**	**1.18**
(1) One person	**56**	**33.14**	**42**	**24.85**
(2) Two people	**53**	**31.36**	**61**	**36.09**
(3) Three people	**25**	**14.79**	**35**	**20.71**
(4) Four people	**10**	**5.92**	**10**	**5.92**
(5) Five people	**4**	**2.37**	**11**	**6.51**
(6) Six people	**1**	**0.59**	**4**	**2.37**
(7) Seven people	**2**	**1.18**	**2**	**1.18**
(8) Eight people	**-**	**-**	**1**	**0.59**
(9) Nine people	**1**	**0.59**	**-**	**-**
(10) Ten people	**-**	**-**	**1**	**0.59**
Total	**N=169**	**100**	**N=169**	**100**

The effect sizes (w) for the number of male family members and province (given by the phi (ϕ) coefficient) is 0,5071 which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to a total of 41% of respondents in Eastern Cape indicating that they have one male family member as part of their household compared to only 14% of respondents in North West who have indicated to have only one male family member as part of their household. Only 6,72% of

respondents from Eastern Cape indicated having three male family members as part of their household compared to 34% of respondents from North West who indicated having three male family members in their household. Reasons for this significance should be the same as discussed in 6.2.4, since these figures are almost exactly the same as the figures indicating male household members. This resemblance is an indication that these households do not have many, if any, male members in their household that are not family. The effect sizes for the number of female family members and province is 0,4489, which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to 29,41% of respondents in the Eastern Cape who indicated having one female family member as part of their household and only 4,14% of respondents in North West who indicated having one female family member in their household. In the Eastern Cape, 38,66% of households indicated having two female family members in their household and only 8,88% of respondents in North West have two female family members as part of their household.

Table 17: ***Male and female non-family members***

	MALE		FEMALE	
NUMBER OF PEOPLE	**F**	**%**	**F**	**%**
(0) None	**168**	**99.41**	**167**	**98.82**
(1) One person	**1**	**0.59**	**1**	**0.59**
(2) Two people	**-**	**-**	**1**	**0.59**
Total	**N=169**	**100**	**N=169**	**100**

From the above two tables (Table 16 & Table 17) it became clear that the households (N=169) consist mostly of family members. Only two households indicated having non-family members as part of their households. No practically significant differences were found between the number of male and female non-family members and province.

6.2.6 Adults

A question was asked to indicate how many adults were in these households.

Table 18: ***Male and female adults***

	MALE		FEMALE	
NUMBER OF PEOPLE	F	%	F	%
(0) None	70	41.42	6	3.55
(1) One person	69	40.83	113	66.86
(2) Two people	22	13.02	40	23.67
(3) Three people	7	4.14	7	4.14
(4) Four people	-	-	1	0.59
(5) Five people	-	-	1	0.59
(6) Six people	1	0.59	1	0.59
Total	N=169	100	N=169	100

Of all the respondents, 41,42% of households indicated having no male adult as part of their household. Only 3,55% of households indicated having no female adult as part of their household. In 40,83% of households, it was indicated that they have only one male adult in their household. In 66,86% of households it was indicated that they have one female adult as part of their household. The effect size (w) for male adult household members and province (given by the phi (ϕ) coefficient) is 0,4433, which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This is due to only 49,58% of respondents in Eastern Cape who indicated they have one or more adult male as part of their household, compared to 80,00% of respondents in North West who indicated having one or more adult male as part of their household. Adult men working at sea or in other parts of the country could be possible reasons for this difference. No practically significant differences were found between female adult household members and province.

6.2.7 Children

A question was asked to determine the number, gender and age distribution of children in households.

Table 19: ***Male and female children***

	MALE		FEMALE	
NUMBER OF CHILDREN	F	%	F	%
(0) None	42	24.85	53	31.36
(1) One person	84	49.70	64	37.87
(2) Two people	30	17.75	31	18.34
(3) Three people	9	5.33	16	9.47
(4) Four people	3	1.78	4	2.37
(5) Five people	1	0.59	1	0.59
Total	N=169	100	N=169	100

The majority of households (N=169) have 1 or 2 male or female children as part of their household. In 24,85% of households they do not have any male children in their household and 31,36% of households do not have any female children as part of their household. In 7,7% of households they have 3 or more male children per household and 12,43% of households have 3 or more female children per household. No practically significant differences were found between male and female children and province.

Table 20: ***Age distribution of children***

	MALE		FEMALE	
NUMBER OF CHILDREN	F	%	F	%
Under 6 years of age	37	22.84	24	14.63
6 to 12 years of age	42	25.93	49	29.88
12 to 18 years of age	83	51.23	91	55.49
Total	N=162*	100	N=164**	100

*** Seven (7) respondents did not answer the question regarding male children**

**** Five (5) respondents did not answer the question regarding female children**

Table 20 reveals that 51,23% of male children and 55,49% of female children were between ages 12 and 18 years. Therefore the majority of children (male and female) in this study are in the adolescent stage and it became evident why the focus group for this research is adolescents. The effect size (w) for children under the age of 6 and province (given by the phi (ϕ) coefficient) is 0,4123, which indicates a medium to large effect (indicating a visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This is due to only 5,04% of respondents in Eastern Cape who indicated having one or more children under the age of 6 as part of their household, compared to 36% of respondents in North West who indicated having one or more child under the age of six as part of their household. Possible reasons for this difference could be that fieldworkers in the Eastern Cape focused more on households that definitely included adolescents (children 12 years and older) and that these households no longer have babies and toddlers (children up to the age of 6 years) as part of their household whereas fieldworkers in the North West province included households more in general. No practically significant differences of children were found between 6 and 12 years or 12 to 18 years of age and province.

6.2.8 Main caregiver

A question was asked to determine who the main caregiver of the household is. The response was as follows:

Table 21: ***Main caregiver***

CAREGIVER	F	%
Father and mother	18	10.71
Mother	62	36.90
Father	15	8.93
Brother/Sister	7	4.17
Maternal grandparent(s)	31	18.45
Paternal grandparent(s)	7	4.17
Relatives	26	15.48
Friends/neighbours	2	1.19
Total	N=168*	100

*** One (1) respondent did not answer this question**

In 56,54% of the households (N=168*) the mother or the father or both were the main caregivers although on average the head of the household is the mother (36,90%). In studies done by Kamali et al., (1998:225) it was indicated that loss of the father was more common than that of the mother. A total of 42,27% of the main caregivers in households were family members (other than parents) such as a brother or sister, grandparents or other relatives. In only 1,19% of households the main caregiver was not a relative (friends/neighbours). No practically significant differences were found between the main caregiver of the household and province.

6.2.9 Child-headed household

A question was asked to determine whether the household was child-headed. The respondents answered as follows:

Table 22: ***Child-headed household***

CHILD-HEADED HOUSEHOLDS	F	%
Yes	4	2.37
No	165	97.63
Total	N=169	100

For this research, a child-headed household implied that the person heading the household and caring for younger siblings is under 18 years of age when being orphaned, mostly by AIDS (Kartell & Chabilall, 2005:214). Table 22 indicates that only 2,37% of households (N=169) in this study were child-headed. Van der Westhuizen (2006:24) notes that children affected by the death of their parents are faced with the challenge of taking care of and supporting their younger siblings. Roalkvam (2005:211) states that the most obvious characteristic of the child-headed household is its isolation. These households appear to be invisible to the community surrounding them, which could be the reason why so few of these households were included in this research. No practically significant differences were found between child-headed households and province.

6.3 HEALTH AND WELL-BEING

6.3.1 Terminally ill

A question was asked to determine whether any members of the household were terminally ill. The respondents answered as follows:

Table 23: ***Terminally ill mother***

TERMINALLY ILL MOTHER	F	%
Yes	14	8.28
No	155	91.72
Total	N=169	100

Table 24: ***Terminally ill father***

TERMINALLY ILL FATHER	F	%
Yes	4	2.37
No	165	97.63
Total	N=169	100

Table 25: ***Terminally ill caretaker***

TERMINALLY ILL CARETAKER	F	%
Yes	1	0.59
No	168	99.41
Total	N=169	100

Table 26: ***Terminally ill children***

TERMINALLY ILL CHILDREN	F	%
Yes	3	1.78
No	166	98.22
Total	N=169	100

In all of the above tables (Table 23 to Table 26) it was indicated that only a few households (N=169) have a terminally ill person. As to the highest rate of terminally ill persons in households, the terminally ill mothers were the most, 8,28%. If taken into consideration that mothers were the main caregivers in more than a third of the households (Table 21), this can have a severe impact on the functioning of the household as well as on other members of the family (including adolescents). No practically significant differences were found between terminally ill household members and province.

6.3.2 Tested for HIV infection and infected with HIV

Questions were asked to determine whether household members were tested for HIV and whether any members were infected with HIV. They responded as follows:

Table 27: ***Tested for HIV infection***

TESTED FOR HIV-INFECTION	F	%
Yes	116	68.64
No	53	31.36
Total	N=169	100

Only 68,64% of households (N=169) indicated that they (or some members of the household) were tested for HIV infection. Almost a third (31,36%) of

households indicated they had never before been tested for HIV infection, which is alarming, the background of the HIV and AIDS pandemic taken into account. In the Eastern Cape, 73,96% of households indicated that a member(s) had been tested for HIV, compared to 56% of households from North West who indicated a member(s) had been tested for HIV infection. This difference may indicate that communities from the Eastern Cape are more open with regard to HIV and AIDS than the communities from North West. People from communities in South Africa who are most vulnerable to HIV infection are children (including adolescents), young adults, woman and the poor (Becker, 2005:105). Roux (2002:73) and Whiteside and Sunter (2000:32) point out that people between ages 15 and 45 years are most affected by HIV. Living in times such as these where effective antiretroviral therapies are available to enable people infected with HIV to live longer lives, it is of utmost importance to know your HIV status. No practically significant differences were found between persons tested for HIV-infection and province.

Table 28: ***Infected with HIV***

INFECTED WITH HIV	F	%
Yes	80	47.34
No	89	52.66
Total	N=169	100

Almost half of the households (N=169) that formed part of this research indicated that a member (or more than one) of their household was infected with HIV. No practically significant differences were found between household members infected with HIV and province.

Table 29: ***Gender of HIV-infected***

GENDER OF HIV-INFECTED	F	%
Male	40	40
Female	60	60
Total	N=100	100

In Table 28 the respondents indicated that a total of 80 individuals were HIV-infected. Table 29 reveals that respondents indicated a total of 100 individuals (40 male and 60 female) to be HIV infected. This difference is an indication that the respondents were not totally honest about their status or that they are still not open to share information regarding their status. No practically significant differences were found between the gender of HIV-infected household members and province.

6.3.3 Deaths in family during past year

Questions were asked regarding deaths in the families of the households during the past year. The response was as follows:

Table 30: ***Deaths in family during past year***

DEATH IN FAMILY OVER PAST YEAR	F	%
Yes	91	53.85
No	78	46.14
Total	N=169	100

In 53,85% of households included in this study (N=169) it was indicated that someone of the family (nuclear or extended) had passed away during the **past year**. No practically significant differences were found between deaths in the family of household members over the past year and province.

Table 31: ***Deaths in family due to AIDS over time***

DEATH IN FAMILY DUE TO AIDS	F	%
Yes	129	76.33
No	40	23.67
Total	N=169	100

In 76,33% of these cases the deaths were due to AIDS, which indicates that the respondents in this study (including adolescents) are severely affected by HIV

and AIDS. With regard to deaths in the family due to AIDS and province, the effect size (w) (given by the phi (ϕ) coefficient) is 0,5846, which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This visible difference is due to the 92,44% of respondents in Eastern Cape who indicated that a family member(s) had passed away **over time** due to AIDS, compared to only 38% of respondents in North West who indicated that a family member had passed away over time due to AIDS. This could be yet another indication of the difference in openness with regard to HIV and AIDS in the different communities from the Eastern Cape and North West.

Table 32: ***Male and Female deaths in the family due to AIDS***

	MALE		FEMALE	
DEATH IN FAMILY DUE TO AIDS	**F**	**%**	**F**	**%**
(0) None	**75**	**46.88**	**71**	**44.65**
(1) One person	**80**	**50**	**71**	**44.65**
(2) Two people	**5**	**3.12**	**15**	**9.44**
(3) Three people	**-**	**-**	**2**	**1.26**
Total	**N=160***	**100**	**N=159****	**100**

*** Nine (9) respondents did not answer the question regarding male deaths due to AIDS**

**** Ten (10) respondents did not answer the question regarding female deaths due to AIDS**

In table 31, a total of 129 deaths in the family due to AIDS over time were reported. Table 32 indicates that there were in total 173 deaths (85 male deaths and 88 female deaths) of family members due to AIDS over time. This could be yet another indication of the difference in openness with regard to HIV and AIDS. Table 32 only indicate statistics regarding male and female deaths due to AIDS but, as many other sources, Roalkvam (2005:218) concludes that it is the mid-generations that are primarily killed by AIDS illnesses. No practically significant differences were found between male and female deaths due to AIDS and province.

6.3.4 Head of household employed

A question was asked to determine whether the head of the household was employed (Full time as well as part time).

Table 33: *Head of household employed*

HEAD OF HOUSEHOLD	F	%
Employed	111	66.07
Not employed	57	33.93
Total	N=168*	100

*** One respondent did not answer the question regarding the employment of the head of the household**

In 65,68% of households (N=169) the head of the household was employed in some way or another. More or less a third of the households indicated having an unemployed head of the household, which could serve as an indication of the households' living standards (Van der Westhuizen, 2006:24). No practically significant differences were found between the employed head of the household and province.

6.3.5 Grants from Government

Questions were asked regarding households receiving grants from the Government.

Table 34: *Grants from Government*

RECEIVING GRANT FROM GOVERNMENT	F	%
Yes	105	62.13
No	64	37.87
Total	N=169	100

Table 35: ***Types of grants received from Government***

TYPE OF GRANT	F	%
'HIV' Grant	13	10.83
Disability Grant	16	13.33
Foster Care Grant	11	9.17
Child Support Grant	80	66.66
Total	N=120	100

A total of 62,13% of households (N=169) in this study indicated receiving a grant(s) from the Government. Of these households, 66,66% receive a Child Support Grant and 33,33% receive other grants, including 'HIV', Disability or Foster Care Grant. Table 34 reveals that 105 out of the 169 households receive a grant or grants from the Government. Table 35 indicates that the above-mentioned 105 households receive 120 grants in total, which means that a household can receive more than one grant, for example a Child Support Grant as well as a Disability Grant. In the Eastern Cape, 54,62% of households indicated that they receive a grant(s) from the Government, compared to 80% of households responding from North West that they receive a grant(s) from the Government.

As displayed in Table 28, respondents indicated that 47,34% of households have at least one HIV-infected member as part of their household. Table 35 reveals that only 10,83% of households indicated receiving an 'HIV' Grant. This could be an indication that people from different communities still lack knowledge of how to access financial support from the Government with regard to HIV and AIDS or it could still be an indication on people's openness regarding their (or a family member's) HIV status. No practically significant differences were found between the types of grants received by households from Government and province.

6.3.6 Household income

A question was asked to determine the average total monthly income of households. The response was as follows:

Table 36: *Average total monthly household income*

AMOUNT	F	%
Less than R200-00	12	7.32
R201-00 – R500-00	47	28.66
R501-00 – R1000-00	51	31.10
R1001-00 – R1500-00	26	15.85
R1501-00 – R2000-00	19	11.59
More than R2001-00	19	5.49
Total	N=164*	100

*** Five (5) respondents did not answer the question regarding the household's average monthly income**

In total, 31,10% of households have an average monthly income of R501,00–R1 000,00. Only 7,32% of households have a average monthly income of less than R200,00 and only 5,49% of households have an average monthly income of more than R2 001,00. In Table 15 it is indicated that 78,7% of households have an average of 1–3 male household members and 81,65% of households have an average of 1–3 female family members. Taken into account that the average household in this study consists of 4–6 persons and that the average monthly income is between R501,00 and R1 000,00, it could be an indication of the financial distress of these households. This definitely has an impact on family members' (including adolescents) functioning and well-being.

Two thirds of the respondents indicated receiving grants from the Government (Table 34). Taking this into consideration with regard to the total monthly income of a household, it can be concluded that a large number of households depend on grants as their lifeline. No practically significant differences were found between monthly household income and province.

6.4 SCHOOL ATTENDANCE

6.4.1 Children attending school

Questions were asked regarding the average school attendance of children that are of school-going age as well as reasons why children are not attending school regularly. They responded as follows:

Table 37: ***Children of school-going age***

	ATTENDING		NOT ATTENDING	
NUMBER OF CHILDREN	F	%	F	%
(0) None	21	12.43	124	75.61
(1) One child	70	41.42	27	16.46
(2) Two children	53	31.36	12	7.32
(3) Three children	20	11.83	1	0.61
(4) Four children	3	1.78	-	-
(5) Five children	1	0.59	-	-
(6) Six children	1	0.59	-	-
Total	N=169	100	N-164*	100

*** Five (5) respondents did not answer the question regarding children of school-going age not attending school**

A total of 75,61% of children in households involved in this study that are school going age, are attending school. In total, 12,43% of households have children that are of school-going age that are not attending school. In total, 16,46% of households in this study have one child of school-going age not attending school. 7,32% of these households have two children of school-going age not attending school and one household indicated having three children of school-going age not attending school. No practically significant differences were found between the number of school going-age children attending school and province.

Table 38: ***Average school attendance***

DAYS ATTENDING SCHOOL	F	%
Less than 5 days per month	4	2.70
6–15 days per month	10	6.76
16 days and more per month	134	90.54
Total	N=148*	100

*** 21 respondents did not answer the question regarding average school attendance**

Of the children attending school, 90,54% are attending 16 days or more per month. No practically significant difference was found between average school attendance and province.

Table 39: ***Reasons of children for not attending school***

REASON	F	%
Could not pay school fees	18	30
Too ill to attend	4	6.67
Looking after own child	4	6.67
Fell pregnant	3	5
Mother died, moved from area	2	3.33
Application refused, no birth certificate	1	1.67
Ran away from school	6	10
Dropped out	13	21.67
Poor performance at school	1	1.67
Disabled	1	1.67
Have to take care of ill family member	5	8.33
Have to take care of younger siblings	2	3.33
Total	N=60	100

According to most common reasons for children of school-going age not attending school, 30% responded that they could not afford school fees and 21,67% indicated that they had dropped out of school. A total of 11,66% of children not attending school indicated that they either have to take care of an ill family member or younger siblings, which are typical symptoms of the AIDS pandemic. Ghosh and Kalipeni (2004:311) confirms this by stating that adolescents are more likely to drop out of school due to financial difficulties, illness or the social stigma attached to parents dying of AIDS. No practically

significant difference was found between the reasons for children not attending school and province.

6.4.2 Progress of children in school

A question was asked to determine the progress of children attending school.

Table 40: ***Children's progress according to school report***

PROGRESS DESCRIBED AS	F	%
Poor	8	5.23
Average	33	21.57
Satisfying	36	23.53
Good	41	26.80
Excellent	35	22.88
Total	N=153*	100

*** 16 respondents did not answer the question regarding the children's progress according to school reports**

The average progress of children included in this study, according to school reports, can be described as average to excellent. The effect size (w) of progress of children in school and province (given by the phi (ϕ) coefficient) is 0,3825 which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to the majority of respondents in Eastern Cape (57,69%) who indicated that the children's progress, according to school reports, is average or satisfying, compared to the majority of respondents in North West (73,47%) who indicated that the children's progress, according to school reports, is good and excellent. Annually, the matric results in the Eastern Cape are of the poorest in South Africa according to news reports and papers. This practical significance could be an early indication of children's future academic performance.

6.5 CHILD-HEADED HOUSEHOLD

6.5.1 Children living alone

Only four (4) out of 169 households (N) indicated in this research that they were child-headed (see Table 22). These are households in which a child (person younger than 18 years of age) is the head of the household and taking care of younger household members, with no adults forming part of the household. These children (adolescents) experience a heavy responsibility by being faced with the challenge of taking care of and supporting younger siblings (Van der Westhuizen, 2006:24).

6.5.2 Parents of children

A question was asked to determine whether the parents of the children in households were still alive. They responded as follows:

Table 41: ***Parent(s) of children still alive***

BOTH PARENTS STILL ALIVE	F	%
Yes	28	18.92
No	120	81.08
Total	N=148*	100

*** 21 respondents did not answer the question regarding the parents of children**

Only 18,92% of households indicated that both the parents of the children in that household were still alive. In 81,08% of households children have only one parent still alive. The effect size (w) of parent(s) of children still alive and province (given by the phi (ϕ) coefficient) is 0,5668, which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to the 3,06% of respondents in Eastern Cape who indicated that both their parents were still alive, compared to

50% of respondents in North West who indicated that both their parents were still alive.

Table 42: ***Parent(s) that had passed away***

PARENT PASSED AWAY	F	%
Mother	45	37.19
Father	54	44.63
Both	22	18.18
Total	N=121*	100

*** 48 respondents did not answer the question regarding parents that had passed away**

In 18,18% of the households in this research both parents of the children had already passed away. A total of 37,19% of households indicated that the mother of the children in the household had passed away and 44,63% of households indicated that the father of the children in the household had passed away. This means that 81,82% of the households function with only one parent still alive. No practically significant differences were found between the gender of the parent(s) that passed away and province.

6.5.3 Death of parents

Questions were asked regarding the death of parents of children in households. The various responses were as follows:

Table 43: ***Children informed on anticipated death of parent(s)***

INFORMED	F	%
Yes	44	36.36
No	77	63.64
Total	N=121	100

*** 48 respondents did not answer the question regarding parents that had passed away**

Of the children of whom a parent(s) had passed away, only 36,36% were informed of the anticipated or possible death of their parent(s). No practically significant differences were found between children being informed on the anticipated death of their parent(s) and province.

Table 44: ***Person who informed children of death of parent(s)***

INFORMED BY	F	%
Parent him/herself	7	10
Other parent	14	20
Family member	49	70
Total	N=70	100

In 70% of cases where a parent(s) had passed away, children were informed by a family member that their parent was going to die. A total of 20% were informed by the other parent and only 10% of parents themselves informed their children that they were going to die. No practically significant differences were found between the person who informed the children of the death of their parent(s) and province.

Table 45: ***Children informed of cause of death of parent(s)***

INFORMED OF THE CAUSE OF DEATH	F	%
Yes	93	76.86
No	28	23.14
Total	N=121	100

Of all households included in this study (N=121) where children had lost a parent(s), 76,86% were informed of the cause of death of their parent(s). The effect size (w) of children informed of the cause of death of their parent(s) and province (given by the phi (ϕ) coefficient) is 0,4460 which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This is due to 86,46% of respondents (children) in Eastern Cape (mostly Xhosa respondents) who indicated that they were informed of the

cause of death of their parents, compared to only 40% of respondents (children) in North West (mostly Tswana respondents) who indicated that they were informed of the cause of death of their parents. This can be as a result of ethnic differences, as Niebuhr et al., (1998:258) indicate in their study on children's knowledge regarding their parents' diagnoses. The lack of openness of respondents in the North West Province can also be seen as a reason for this difference.

Table 46: *Cause of parent's death*

CAUSE OF DEATH	F	%
TB	13	12.26
Cancer	1	0.94
Pneumonia	15	14.15
Aids	74	69.81
Accident	3	2.83
Total	N=106	100

The causes of death of the parent(s) in the studied households were mainly Aids (69,81%). Van der Westhuizen (2006:36) reported that, in South Africa, it was estimated that 40% of all adult deaths now were due to AIDS. Two other causes that were also indicated were TB (12,26%) and Pneumonia (14,15%), which are both opportunistic diseases with regard to HIV. The effect size (w) of the cause of parent(s) death and province (given by the phi (ϕ) coefficient) is 0,5915, which indicates a large effect (a relationship with $w \geq 0.5$) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to the majority of respondents in Eastern Cape (78,16%) who indicated AIDS as the cause of death of their parent(s), compared to only 31,58% of respondents in North West who indicated AIDS as the cause of death of their parent(s). The majority of respondents in North West (57,89%) indicated pneumonia as the main cause of death of their parent(s), compared to only 4,6% of respondents in Eastern Cape. Pneumonia can be seen as an AIDS-related illness, but it cannot

be implied that AIDS was the cause of death in these cases (Foster, Shakespeare, Chinemana, Jackson, Gregson, Marange & Mashumba, 1998:212). This difference could also be yet another indication regarding the difference in openness regarding HIV and AIDS in households in Eastern Cape on the one hand and North West on the other, where the researcher experienced that the respondents from the Eastern Cape were far more open about their circumstances than respondents from the North West province.

6.5.4 Bereavement counselling and support

Questions were asked with regard to bereavement counselling of children of whom a parent(s) had passed away.

Table 47: ***Children received bereavement counselling***

RECEIVED COUNSELLING	F	%
Yes	22	18.64
No	96	81.36
Total	N=118	100

Only 18,64% of children in this study who had lost a parent indicated having received bereavement counselling after the death of their parent. The effect size (w) of children who received bereavement counselling and province (given by the phi (ϕ) coefficient) is 0,3230, which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to only 11,96% of children in Eastern Cape who indicated having received bereavement counselling after the death of their parent(s), compared to 42,31% of children in North West who indicated that they had received bereavement counselling after the death of their parent(s). The communities included in the research in the North West province, form part of Potchefstroom, a city with a network of resources and organisations rendering services in this field. The communities in the Eastern Cape included in this

research form part of Jeffreys Bay, which does not even have one local organisation rendering social work services. The availability and accessibility of support services could possibly be the reason for this difference.

Table 48: ***Source of bereavement counselling***

Source of counselling	F	%
Social Worker	2	5.88
Medical Worker	1	2.94
Teacher	6	17.65
Neighbour	10	29.41
Pastor/Minister	15	44.12
Total	N=34	100

Of the only 18,64% of children who have lost a parent(s) have received bereavement counselling after the death of their parent(s), 44,12% received bereavement counselling from a Pastor or Minister and 29,41% from a neighbour. Bereavement counselling from a social worker was only indicated in 5,88% of the cases. No practically significant differences were found between the source of bereavement counselling and province.

Table 49: ***Received support from***

SUPPORT FROM	F	%
Church	4	17.39
Clinic	2	8.70
Social Worker	2	8.70
Family member	8	34.78
Neighbours	7	30.43
Total	N=23	100

In 65,21% of cases where children had received support after the death of their parent(s), the support was given by family members or neighbours. In only 8,70% of cases did the children receive support from a Social Worker. No practically significant differences were found between whom the children received support from and province.

7. DISCUSSION

A comprehensive needs assessment (research questionnaire) of which the findings were discussed in this article, focused on the following: the demographic information on the adolescent's household, health and well-being of the household, school attendance of children (including adolescents) of the household, child-headed households and the needs of adolescents. A total of 169 households from Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province, and Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, participated in this study. The study indicated that most households consist mostly of family members, and adolescents formed part of all these households. It was expected that more child-headed households would have formed part of this research, but literature confirmed why such households are hidden by the community and difficult or almost impossible to reach in research. The households are characterized by terminal illnesses and deaths. At this stage of the AIDS pandemic, many of the respondents still indicated that no one in their family or household have ever been tested for HIV infection.

The results regarding infections and deaths due to AIDS differ considerably between those of the Eastern Cape and those of the North West Province. The possibility could exist that the population from the Eastern Cape were more open regarding these matter, since higher rates have been reported. Financial difficulty is a reality within most of the households, given their total monthly income. This relates to economic difficulties as being the strongest reason for children not attending school. In most of the families that responded in this research, only one of the two parents is still alive. Less than half of the children were informed of the anticipated death of their parent. In cases where the adolescent was informed of the cause of death, there was an unexpected openness regarding AIDS as cause of death of their parents. A serious lack of

bereavement counselling was revealed and support after the death of a parent was minimal. From the data collected in this research, it became clear that adolescents in households infected with or affected by HIV and AIDS encounter various related problems and needs as well as needs related to adolescence as a stage of life. Hence it can be seen that, on average, the following can be said regarding a profile of adolescents' households infected with or affected by HIV and AIDS:

- Most households consist of non family as well as family members.
- More than 40% of households do not have a male adult as part of their household.
- In more than a third of households the mother is the main caregiver.
- A terminally ill mother forms part of almost 10% of the households.
- A third of the households indicated that they have not yet been tested for HIV infection.
- Almost half of the households that were tested for HIV infection have one or more HIV positive household member, and more women than men were tested positive.
- More than 75% of the households have already had a death in the family due to AIDS.
- Two thirds of the households' heads are employed.
- Almost two thirds of the households do receive grants from the Government of which 66% are Child Support Grants.
- More than half of the households receives less than R1 000,00 income per month per household.
- Almost 25% of households have one or more children of school-going age not attending school.
- In 90% of households the school attendance is 16 or more days per month.

- The most indicated reasons for not attending school include: could not pay school fees (30%), dropped out (21,67%) and have to take care of ill family member (8,33%).
- More than 80% of children in these households indicated not having both parents still alive and almost 20% had already lost both parents.
- In most instances the children were informed of the death of their parent by a family member.
- More than 75% of these children were informed of the cause of death of their parent and in almost 70% the cause of death was AIDS.
- Not even 20% of these children had received bereavement counselling after the death of their parent and in two thirds of these cases the counselling was done by a pastor/minister or a neighbour.

8. RECOMMENDATIONS

It became clear that adolescents' households that are infected with or affected by HIV and AIDS have a unique profile. With a better picture of these adolescents' circumstances, any intervention with regard to adolescents in households infected with or affected by HIV and AIDS can be more specific, and directed towards their unique needs. Based on the discussion on the results from this study as well as the conclusion that was drawn, the following recommendations can be made:

- This research can be extended and can be used as platform for the development of various interventions with adolescents in households infected with or affected by HIV and AIDS.
- Before any intervention or programme is planned for adolescents in these circumstances, an assessment should be done within the given community in order to determine and verify that specific population's unique demographics.

- The circumstances in which adolescents have to grow into adulthood are difficult and as a group they should be a target population with respect to help and support.
- A programme should be developed in response to the unique profile of adolescents in households infected with or affected by HIV and AIDS.
- An empowerment group work programme should be developed to help and support adolescents in circumstances such as these, especially with regard to the possible death of a parent/caretaker.
- Life skills such as effective communication, assertiveness and conflict management can be used as elements for an empowerment programme to help adolescents to be in a better position for their needs to be met.

9. CONCLUSION

The purpose of this study was to explore the circumstances of and compile a profile of adolescents' households where their parents/caregivers are infected with or affected by HIV and AIDS. Collected data served as a starting point for developing and compiling a profile of these unique households. The data collected through this research was processed statistically and the results were discussed. These data include various demographic information regarding the households, their health and well-being, school attendance as well as information on child-headed households. From the preliminary study it seems that this objective has been reached. Through exploring the circumstances of adolescents' households that are infected with or affected by HIV and AIDS it became obvious that adolescents have complex and unique circumstances with regard to the households in which they function.

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ARTICLE 2

THE NEEDS OF ADOLESCENTS IN HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS

K OLIVIER & H STRYDOM

ABSTRACT

This article focuses on the needs of adolescents who's parents are infected with or affected by HIV and AIDS. Adolescents are in a unique phase of life and also have certain needs in life. When the parents of adolescents are either infected with or affected by HIV and AIDS, these children experience specific needs. In this article the various basic and developmental needs of adolescents are discussed as well as specific additional needs they may experience when their parents are infected with or affected by HIV and AIDS. The aim of the article, the research design and procedures followed are outlined. This is followed by a discussion on the various needs of adolescents according to the data from the empirical study as partly discussed in Article 1. The main emphasis of the article is on the needs of adolescents.

1. INTRODUCTION

The AIDS pandemic in South Africa is among the worst in the world (Van Rooyen & Sewpaul, 1993:224) and has reached pandemic proportions (Visser, 2005:204). According to the UNAIDS Global summary of the AIDS epidemic (Dec. 2006) an estimated 39,5 (34,1–47,1) million adults and children had been infected with HIV worldwide by end of 2006. Of this total, 24,7 (21,8–27,7) million are of Sub-Saharan Africa, of which 4,5–6,3 million are from South Africa. Currently in South-Africa it increasingly happens that parents or caregivers of

adolescents became terminally ill with AIDS first within the family structure. The sickness and death of a parent is a traumatic experience for the adolescent (Vos, 1997:35) and Lyons (2001:4) notes that adolescents are forced into roles of adults when their parents fall ill and die of AIDS. In the absence of adult caregivers, the adolescents take family responsibilities upon themselves for the survival of the family (Kaseke & Gumbo, 2001:54) and neglect their own health and developmental needs in order to take on the role of parent, caregiver and provider (Leming & Dickinson, 2002:98). Saloner (2002:154) mentioned that it was estimated that by 2005, more than a million children under the age of 15 had already lost their mothers to AIDS. When their parents are infected with or affected by HIV and AIDS, adolescents have specific physical, emotional, educational and bereavement needs (Strydom & Mynhardt, 2005:190) which are also affected and become more complex. The survey questionnaire addresses the overall needs of adolescents in households infected with and affected by HIV and AIDS. Programme development must be compiled in response to adolescents' needs via their active participation in the entire process (Kandasamy, 2002:5).

2. OBJECTIVE

The objective of this article was to identify, explore and discuss the needs of adolescents in households infected with and affected by HIV and AIDS.

3. TERMINOLOGY

As Van der Westhuizen (2006:13) points out, it is essential to define key terminology used in this research to minimize different interpretations.

3.1 HIV AND AIDS

According to Becker (2005:103) and Gifford, Lorig, Laurent and Gonzalez (2000:5), **HIV** refers to ***Human Immunodeficiency Virus***, which is the virus that causes AIDS. **AIDS** is the acronym for ***Acquired Immunodeficiency Syndrome*** which is the collective name for the complications that follow when a damaged immune system cannot fight infections (Barnett & Whiteside, 2002:28; Van Der Westhuizen, 2006:14). Buthelezi (2003:19) stresses that people do not die of AIDS, but of opportunistic diseases and infections which attack the body when immunity is low.

3.2 ADOLESCENCE

Barker (2003:8), Scholtz (1998:16) and Strydom (2003:61) describe adolescence as normally being referred to as the life cycle period between childhood and adulthood, beginning at puberty. Van Der Westhuizen (2006:14) describes the life stage of adolescence as often being accompanied by rapid growth and physical development, heightened sexual activities and a struggle to establish self-identity. Adolescence is a time of numerous physical, cognitive, emotional, social and personal changes which impact on identity development (Richardson, 2001:41).

3.3 HOUSEHOLD

A household refers to all people, whether or not related, who live in the same dwelling unit (Barker, 2003:201). This includes individuals as well as groups of people.

3.4 NEEDS

Barker (2003:291) defines needs as the physical, psychological, economic, cultural and social requirements for survival, well-being and fulfilment.

4. RESEARCH METHODOLOGY

In this study the method of investigation is a literature study and empirical research.

4.1 LITERATURE STUDY

A literature study was conducted on various aspects of the study. Delport (2005:171) states that, to undertake meaningful research, the researcher should have made a thorough study of the subject under review. The focus of this study was on the needs of adolescents from households that are infected with or affected by HIV and AIDS, and related literature was studied.

4.2 EMPIRICAL RESEARCH

4.2.1 Research model

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407). The first two phases were conducted during this part of the study:

4.2.1.1 Phase 1: Problem analysis and project planning

A social problem is a condition affecting a significant number of people in ways considered undesirable, about which it is felt something could be done through collective action. This phase consists of several operations and was formulated as the following series of steps to be executed (De Vos, 2005c: 395 – 398):

- Identifying and involving of clients
- Gaining entry and cooperation from settings
- Identifying concerns of the population
- Analysing identified problems
- Setting goals and objectives

4.2.1.2 Phase 2: Information gathering and synthesis

In planning an intervention research project, it is essential to discover what others have done to understand and address the problem. The acquisition of knowledge involves identifying and selecting relevant types of knowledge, and using and integrating appropriate sources of information. The operations or steps of this phase are as follows (De Vos, 2005c: 398 – 400):

- Using existing information sources
- Studying natural examples
- Identifying functional elements of successful models

4.2.2 Design

Research design can be defined as a blueprint of how the researcher intends to conduct research (Babbie & Mouton, 2001:55). Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms and involves the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Creswell, 2009:4). The concurrent embedded strategy was used in this study. Creswell (2009:214) explains that the concurrent embedded strategy of mixed methods are identified by its use of one data collection phase during which qualitative and quantitative data are collected simultaneously. This approach has a primary method that guides the project and a secondary database that provides a supporting role in the procedures. According to Creswell (2009:214), the secondary method

(qualitative or quantitative) is embedded, or nested, within the predominant method (qualitative or quantitative). The questionnaire as survey data procedure was used to collect data and the main objective of the questionnaire was to obtain facts and opinions concerning a phenomenon from people who are informed (or have knowledge) on the particular issue (Delport, 2005:166). In this research, a questionnaire, *The needs of adolescents in households infected with or affected by HIV and AIDS* (Annexure B), was utilized to collect information from adolescents' households on living standards, health and well-being, school attendance and needs of the adolescents in these households.

4.2.3 Participants

Non-probability sampling was used in this research because the odds of selecting individuals affected by HIV and AIDS are not known to the researcher and she also does not know the population size or the members of the population (Strydom, 2005b:201-202). In this particular study accidental sampling was used. Accidental sampling takes place when any case happens to cross the researcher's path and has anything to do with the phenomenon and is therefore included in the sample until the desired number of respondents is obtained. During this study 119 households in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province, and 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, were interviewed.

4.2.4 Data collection

Data collection for the needs assessment took place by means of a survey which was drawn up by the researcher and completed by fieldworkers who interviewed the participants in accordance with its content. This structured questionnaire (Annexure B), as measuring instrument, was used to obtain the demographic

information of adolescents and their households which are infected with or affected by HIV and AIDS. The main objective of this questionnaire was to collect information on the circumstances of the adolescents' households which may have an influence on their range of needs as well as information on their specific needs and their feelings regarding their circumstances. Demographic data were collected to investigate the living conditions, health and well-being, school attendance and needs of adolescents and their households.

4.2.5 Ethical aspects

Ethical guidelines should serve as standards and the basis upon which researchers ought to evaluate their own conduct. According to Strydom (2005a:56), researchers have two categories of ethical responsibility, namely their responsibility towards those who participate in the research project and their responsibility towards the discipline of the science, to be accurate and honest when reporting their research. Before this research was conducted, permission was obtained from the Ethics Committee of the North-West University (No. 06K21) (Annexure A). For this research study, the following aspects were taken into consideration:

- It should be ensured that the researcher is competent as well as adequately skilled to undertake the research (Strydom, 2005a:63).
- Participation in research should be strictly voluntary.
- Informed consent should be obtained from the participants after all the aspects of this particular research have been explained to them (Etemad, 1995:824; Strydom, 2005a:59).
- The participants involved should be assured of their anonymity when they complete the questionnaires.

- All participants have the right to expect that the information they provide will be treated confidentially, especially in the case of AIDS-related research (Etemad, 1995:824; Kartell & Chabilall, 2005:215).
- It is important that the participants should know that the information will be utilised for a research document (Strydom, 2005a:65) and that it could help in making a useful contribution to their community and the broader society.
- It should be ensured that the findings of this research should not have a negative impact on the participants.
- Participants should be protected from unwarranted physical or mental discomfort, distress, harm, danger or deprivation (Strydom, 2005a:67).
- Participants should be treated with respect and their rights to make their own decisions and choices should be respected and promoted (Harrison & Wise, 2005:20).

4.2.6 Data analysis

The purpose of data analysis is to reduce data to an intelligible and interpretable form so that research problems can be studied and tested, and conclusions drawn (Kruger, De Vos, Fouché & Venter, 2005:218). The data in this study was statistically computed with SAS (SAS Institute Inc, 2003). The results were interpreted, inferences were made and conclusions were drawn. The qualitative data that were collected during this study was analysed by hand according to themes and Tesch's approach to qualitative data processing was followed (Poggenpoel, 1998:343 – 344).

5. RESULTS AND DISCUSSION

The first part of the results of the research questionnaire, which includes demographic data, health and well-being, school attendance and child-headed

households, was discussed in a previous article: *A profile of adolescents' households infected with or affected by HIV and AIDS.* In this article the second half of the results from the research questionnaire will be discussed which will mainly focus on the needs of adolescents.

5.1 DETAILS OF RESPONDENTS

During this research 119 households in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province, and 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, were interviewed. A total of 169 households (N = 169) completed the questionnaire. The results of this study are discussed as a whole (N = 169) and differences between those of Eastern Cape Province and North West Province are highlighted.

5.2 THE NEEDS OF ADOLESCENTS

The needs of adolescents of HIV-infected parents can be diverse and can be marginalised when providing care to those who are infected (Green & McCreaner, 1996:141; Richter, Manegold & Pather, 2004:4). In the questionnaire the adolescents were requested to indicate their experiences regarding their different needs. They responded as follows:

Table 50: ***Adolescents' experiences regarding their needs***

NEED	SATISFIED		NEED HELP	
	YES	NO	YES	NO
Physical care (food, clothing etc.)	94	75	88	78
Financial needs	35	134	144	24
Protection	120	47	50	114
Alternative care (when parents died)	124	41	42	124
Functioning as part of household	135	33	28	139
Love and support	129	39	50	118
Professional help	123	45	60	107
Security	137	31	43	125
Stigmatisation	139	27	14	153
Emotional support	123	45	57	110
Social needs	116	51	53	113
Bereavement	132	35	28	139
Education, training	91	78	99	68
Life skills	102	66	86	82
School training	111	58	74	94
HIV and AIDS	114	54	53	115

In the research questionnaire the respondents were given the option to indicate whether they are satisfied regarding a need (yes/no) and whether they need help (yes/no) in that area. The differences between these indications are due to the adolescent respondents' own opinion regarding that specific need. They could have indicated that they are not satisfied regarding a specific need, but that they do not think that they need help or else they could have indicated that they are satisfied regarding a need, but that they think they still need help.

5.2.1 Physical needs

5.2.1.1 Physical care

A total of **55,62% (94)** of adolescents in these households said they were satisfied regarding their physical care and **44,38% (75)** indicated that they were not satisfied. On the other hand, **53,01% (88)** of adolescents indicated that they need help regarding their physical care and **46,99% (78)** said they

are not in need of any help. It became clear from the response that the need for basic physical care should be addressed in this study, since **more than 50%** indicated that they need help.

The need for physical care generally entails the fulfilment of basic material needs, including food, clothing and shelter. Most children, including adolescents, throughout the world are heavily reliant on the nurture and support of adults without which they will fail to thrive (Ungar, 2005:18). Adolescents need an adult to care for them and not an elderly person or someone who is only a couple of years older (Strydom & Raath, 2005:579). When a parent or both parents become infected with HIV or develop AIDS, the adolescents' physical and material needs are occasionally not met properly. According to Government, every child, which includes adolescents, has the right to the basic means of life including food, clothing and shelter (Richter et al., 2004:4). The death of a parent has an enormous influence on the quality of life of the adolescent (Ross, 2001:25). Access to basic physical care such as food and shelter is dramatically affected by the impact of HIV and AIDS on households (Richter et al., 2004:4).

5.2.1.2 Health and nutrition

Richter et al. (2004:9) highlight the following as direct impacts of HIV and AIDS on children: lower nutritional status, less attended to when sick, less likely to be immunised, increased vulnerability to disease, less access to health services and increased vulnerability to HIV infection and higher exposure to opportunistic infections. According to Taylor-Brown and Garcia (1999:39), youth who are living with a parent with AIDS often cope with stress in ways that put them at greater risk for HIV infection and other negative outcomes. Singh (1994:345) indicates that adolescence is the period during which people engage in and experiment with behaviours which increase the risk of exposure to HIV, including smoking, drinking, taking drugs and having sex.

5.2.1.3 Financial needs

A total of **20,71% (35)** of adolescents in these households indicated that they were satisfied regarding their financial needs and **79,29% (134)** said they were not satisfied in this respect. In total, **85,71% (144)** of adolescents said they need help regarding finances and **14,29% (24)** indicated that they are not in need of such help. With **over 80%** of adolescents responding that they need help, this should seriously be regarded as an area that needs to be addressed.

When the breadwinner of the household falls ill or dies, the household income reduces according to Barnett and Whiteside (2002:189) and Nefale (2001:8). AIDS often strains the financial resources of infected persons and many have needed to turn to their local communities for assistance (Corr, Nabe & Corr, 2003:550). At household level, HIV and AIDS has changed family composition, its earning potential, its consumption capabilities and its overall psychosocial well-being (Gow & Desmond, 2002:133; Valdiserri, 2003:182). Most children affected by HIV and AIDS are affected also by conditions of poverty and exclusion (Richter et al., 2004:4) and are often left vulnerable and financially desperate (Van Der Westhuizen, 2006:48) since the economic impact of an AIDS-related death is larger on poorer households (Gow & Desmond, 2002:114; Nefale, 2001:8).

Household production is greatly decreased and household savings are drained as a result of HIV and AIDS (Valdiserri, 2003:183). Increased poverty, loss of property and inheritance, loss of food security and shelter are some of the direct impacts of HIV and AIDS on children affected by HIV and AIDS. As a result of their marginalised conditions, they lack access to health, education and welfare services, and they lack legal protection of their rights (Richter et al., 2004:4). Gow and Desmond (2002:97) further explain that with competing priorities for limited resources, children living in AIDS-affected households are often unable to

afford school uniforms, school fees and textbooks and other materials or provide the financial resources required for transport and school feeding. These children who are unable to pay school fees report having cards withheld, being threatened by teachers, being excluded from the school feeding scheme and being embarrassed and teased.

5.2.1.4 Protection

A total of **71,86% (120)** of adolescents in these households said they were satisfied regarding their need for protection and **28,14% (47)** indicated that they were not. In total **30,49% (50)** of adolescents indicated that they need help regarding protection and **69,51% (114)** said they are not in need of any help in this respect. Only about **one third** of the respondents indicated that they need help in this regard, but it could be as a result of not being adequately informed.

According to Richter et al. (2004:9), HIV and AIDS directly impacts on children when there is decreased adult supervision, due to the parents being ill or deceased. Where parents are infected with HIV, have AIDS or have already died of it, adolescents are at a higher risk of abuse (physical and sexual), labour exploitation, early or frequent sex due to loss of income and parental care and attention, early (sometimes forced) marriage for girls and exposure to HIV infection, TB, pneumonia and other diseases. The constitutional and conventional rights of children affected by AIDS, their rights to an adequate standard of living, privacy, health, social security, education and leisure, protection from violence and the right to protection from economic and sexual exploitation and inhuman or degrading punishment are challenged by the impact of the HIV and AIDS epidemic (Sloth-Nielsen, 2004:7). As a result of this, the future potential of many children is being compromised says Richter et al. (2004:4).

5.2.1.5 Alternative care

A total of **75,15% (124)** of adolescents in these households indicated that they were satisfied regarding alternative care and **24,85% (41)** said they were not satisfied regarding it. A further **25,30% (42)** of adolescents said they need help regarding alternative care and **74,70% (124)** indicated that they are not in need of any help.

Richter et al. (2004:37) explain that family care is the first choice for all children, and even adolescents who are faced with the death of a parent often struggle with the question: 'Who will be there to care for me?' These adolescents have the need to be reassured that they have not been forgotten and that their wishes should, as far as possible, be taken into account (Green & McCreaner, 1996:144,145). Care for the adolescents affected by HIV infection can also take on various forms because both the illness itself and the financial burdens it generates may make it impossible for sometimes even the most basic needs to be met and it is then that alternative care could become the only option (Corr et al., 2003:552). Adolescents feel more secure when routines are in place and when they can stay in familiar surroundings (Green & McCreaner, 1996:145, Siegel & Gorey, 1998:266).

As most of the respondents' households consist of family members, it could not be assumed that family care is automatically able to fulfil in the basic needs of adolescents although it is their first choice, according to Richter et al., (2004:37). Richter et al. (2004:15) further explain that extended families, kin and communities remain the principal support for children (adolescents) affected by HIV and AIDS in Sub-Saharan Africa. Most commonly, grandparents (in particular grandmothers) seem to take over the parenting role and care (Gow & Desmond, 2002:117). The worst outcome for adolescents is that in which no

able-bodied adult is available to provide resources and keep households and families together.

5.2.1.6 Functioning as part of household

In total, **80,36% (135)** of adolescents in these households said they were satisfied regarding their functioning as part of a household and **19,64% (33)** indicated that they were not satisfied, but only **16,77% (28)** of adolescents indicated that they need help regarding their functioning as part of a household and **83,23% (139)** said they need no help. The high satisfactory percentage could be an indication that adolescents have become accustomed to their role and the roles of other family members as part of a household infected with or affected by HIV, although Abdool Karim, Abdool Karim & Baxter (2005:351) explains that the family as a traditional fundamental unit steadily becomes eroded as the pandemic progresses.

HIV infection and AIDS-related deaths have a huge impact on family structures and functioning (Nefale, 2001:12,13). In the absence of adult caretakers the adolescents take family responsibilities upon themselves for the survival of the family (Kaseke & Gumbo, 2001:54). Richter et al. (2004:12) mention that the emergence of adolescent-headed households, the increase in household dependency ratios, separation of siblings, family breakdown and remarriages are some of the possible direct impacts the epidemic can cause in the event where parents are infected with HIV or have AIDS. HIV and AIDS- affected adolescents who are forced into a change of role (from being child to caregiver) within the family may find the adjustment particularly difficult (Green & McCreaner, 1996:99,141; Strydom & Raath, 2005:576). Barnett and Whiteside (2002:206) add to this that adolescents who care for adults may experience a world gone all awry.

Establishing new roles within a relationship can be extremely difficult. In most cases the adolescent gets used to his or her role as a caregiver, and in most instances the parent (patient) dies first. In these cases the caregiver is then stripped of his or her role and would necessarily have to revert to the person he or she was before. Taylor-Brown and Garcia (1999:39) mention that the stigma associated with AIDS makes it difficult for adolescents and their families to call upon the extended family, friends and the larger community for support. When adolescents know there is a family secret they are not told (like HIV infection), it engenders feelings of isolation (Siegel & Gorey, 1998:267).

5.2.2 Emotional needs

5.2.2.1 Love and support

A total of **76,79% (129)** of adolescents in these households indicated that they were satisfied regarding love and support and **23,21% (39)** said they were not satisfied regarding this, but **29,76% (50)** of adolescents said they need help with regard to love and support and **70,24% (118)** indicated that they are not in need of any help in this respect. Support from family and their understanding are of utmost importance during the developmental stages of adolescence (Herbst, 2002:73). Social support and positive relationships are widely recognized as facilitating adjustment to stress and adversity (Ungar, 2005:235). According to Corr et al. (2003:245), one of the most important needs of a bereaved person is social support. Adolescents generally need a supportive environment in which to practise their decision-making and communication skills (Van Dyk, 2001:193). Kartell and Chabilall (2005:228) explain that the lack of an effective support system together with the lack of basic needs being met inhibit the development and the self-actualization of adolescents in households affected by HIV and AIDS.

In general, adolescents have emotional needs which can only be satisfied through interaction with friends (Van Dyk, 2001:183) and need support from their peers when they are coping with loss and grief (Corr et al., 2003:357). Strydom and Raath (2005:573) found in their study that adolescents indicated that support from their family, friends and social workers is high on adolescents' list of needs. In a study done by Herbst (2002:109), the most outstanding needs of adolescents that were identified were for family and social support. After a parental death, adolescents' needs for love, support and care are enormous (Siegel & Gorey, 1998:265). The emotional needs of affected significant others occasionally are similar to those experienced by the HIV-infected person. These needs include acceptance, respect, certainty, affiliation, support, love and caring (Van Dyk, 2001:261). The adolescent has the need to be seen and treated as an individual, especially where support and bereavement counselling is concerned. Green and McCreaner (1996:72) mentioned that good social support networks have been shown to be related to an increased quality of life in adolescents affected by AIDS.

In most cases the nearby family members and caregivers of the person dying of AIDS, for instance the adolescents, are the people who provide the most social support and therefore also need a firm base of support themselves (Green & McCreaner, 1996:72). Therefore the need for structured social support is increasing. Adolescents who are affected by HIV need society's support and not rejection (Van Dyk, 2001:273). Van Heerden (2001:56) also explains that adolescents need support, especially when they are learning new skills. Emotional support has a buffering effect on the impact of negative stressful life events (Siegel & Gorey, 1998:269).

5.2.2.2 Professional help

A total of **73,21% (123)** of adolescents in these households said they were satisfied regarding their need for professional help and **26,79% (45)** indicated that they were not satisfied. On the other hand, **35,93% (60)** of adolescents indicated that they do need professional help and **64,07% (107)** said they are not in need of such help. The effect size(w) (given by the phi(ϕ) coefficient) with respect to adolescents needing professional help is 0,3398, which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to only **25,42%** of respondents (adolescents) in Eastern Cape who indicated that they need professional help, compared to **61,22%** of respondents (adolescents) in North West who indicated that they need professional help.

The respondents from North West definitely expressed a need for professional help which is aimed at addressing issues such as uncertainty and confusion, confidentiality and sharing of information, multiple change and loss as well as plans for the future (Green & McCreaner, 1996:142). These issues need to be addressed within good time to enable the adolescent to lead an emotionally healthy life. Counsellors (such as Social Workers) are often chosen as suitable people with whom to discuss the topics of death and dying, since they are not professionally aligned to any particular belief system (Green & McCreaner, 1996:77; Leming & Dickinson, 2002:97). Adolescents also have the need for those who intend to help and support them to understand their cultural context (Green & McCreaner, 1996:265). Huba and Melchoir (1998:15) indicate that services offered (such as those by Social Workers) should be responsive to the needs of adolescents.

5.2.2.3 Security

In total, **81,55% (137)** of adolescents in these households indicated that they were satisfied regarding security and **18,45% (31)** said they were not satisfied in this respect, but **25,60% (43)** of adolescents said they need help regarding security and **74,40% (125)** indicated that they do not need any help. It seems that **75-80%** of the adolescents indicated that they are satisfied regarding the way their needs concerning security and stability are met.

All children, including adolescents, need stability and security (Richter et al., 2004:35). Adolescents can often feel they are excluded in situations where a parent (parents) falls ill and receives all the attention (Currer, 2001:52). Adolescents have the need to feel that the atmosphere is safe for them to show emotion and experience the emotions they have regarding their parents HIV-infection. On the other hand, adolescents who are affected by AIDS yearn for the prosperity, stability and prominence of thriving adulthood and they wish to become responsible adults who prosper in the working world (Kartell & Chabilall, 2005:227). Adolescents who experience multiple losses across generations lose the security of relationships and a familiar environment (Siegel & Gorey, 1998:268).

5.2.2.4 Discrimination and stigmatisation

A total of **83,73% (139)** of adolescents in these households said they were satisfied regarding their needs in respect of stigmatisation and **16,27% (27)** indicated that they were not satisfied. Only **8,38% (14)** of adolescents indicated that they need help concerning stigmatisation, and **91,62% (153)** said they are not in need of any help in this respect. The effect size (w) (given by the phi (ϕ) coefficient) with regard to adolescents needing help concerning stigmatisation is 0,3271, which indicates a medium to large effect (visible

difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to only **2,54%** of respondents (adolescents) in Eastern Cape indicating that they need help regarding stigmatisation, compared to **22,45%** of respondents (adolescents) in North West who indicated that they need help in this respect.

Stigma is an insidious and complicated phenomenon which goes hand in hand with discrimination which has tangible consequences. Discrimination against adolescents affected by HIV and AIDS, has spread rapidly, fuelling anxiety and prejudice against them as an affected group (Podile, 2004:2). Adolescents experience problems with respect to being accepted by their peers, families and communities and are generally discriminated against; this is basically due to the fact that HIV and AIDS is still highly stigmatized in South Africa (Etemad, 1995:829; Strydom & Raath, 2005:578). Where the adolescent acts as the caregiver, he or she can face a variety of problems such as stigma and discrimination (Green & McCreaner, 1996:66; Richter et al., 2004:9). Any form of discrimination can interfere with the ability of an affected person to receive needed support from others (Corr et al., 2003:546). Adolescents from AIDS-affected families who experience discrimination and victimization tend to withdraw from school and society (Kartell & Chabilall, 2005:226). Discrimination can increase the emotional impact on adolescents when their parents are infected with or affected by HIV and AIDS.

5.2.3 Psychosocial needs

5.2.3.1 Psychosocial support

A total of **73,21% (123)** of adolescents in these households indicated that they were satisfied regarding emotional support and **26,79% (45)** said they were not satisfied in this respect, but **34,13% (57)** of adolescents said they need

help regarding emotional support and **65,87% (110)** indicated that they do not need any help. Richter et al. (2004:31) explained that adolescents who's parents are infected with or affected by HIV and AIDS need psychosocial support helping them to recognise distress and depression, as adolescents are more likely than younger children to become depressed or to try to escape from their emotions through acting-out behaviour (Leming & Dickenson, 2002:504).

Increased psychosocial distress of adolescents affected by HIV and AIDS are caused by the grieving for illness and death of their parents, worsening economic circumstances, anxiety about the future, separation from siblings, being removed from school and required to work, which leads to deprivation of healthy social interaction, stigma and resulting isolation and discrimination within community and school as well as diminishing love, attention and affection (Taylor-Brown & Garcia, 1999:39, 40). Adolescents have certain emotional needs related to the parent's illness (Niebuhr, Hughes & Pollard, 1998:252), and seeing a relative being sick can have a significant emotional impact on the adolescent (Green & McCreaner, 1996:81). Where adolescents are the caregivers of their parents with AIDS, they often need to come to terms with their own fears and prejudices and the implications and consequences of their parents' sickness and ultimate death (Van Dyk, 2001:259,260).

Adolescents whose parents die of AIDS are forced to witness death (Van Dyk, 2001:292) and apart from just losing a parent or both parents, adolescents can also experience the loss of their future, their hopes, self-esteem, well-being and dignity. Richter et al. (2004:17) describe the long-term consequences for adolescents who experience profound loss, grief, hopelessness, fear and anxiety, without assistance. These consequences can include psychosomatic disorders, chronic depression, low self-esteem, low levels of life skills, learning disabilities, and disturbed social behaviour. Strydom and Raath (2005:573) found in their

study that adolescents indicated that to make peace with the illness (AIDS) can be seen as a psychosocial need.

5.2.3.2 Social needs

In total, **69,46% (116)** of adolescents in these households said they were satisfied regarding their social needs and **30,54% (51)** indicated that they were not satisfied. A total of **31,93% (53)** of adolescents indicated that they need help regarding their social needs and **68,07% (113)** said they are not in need of any help in this respect. Corr et al. (2003:245) state that one of the most important needs of a person is social support, and Van Dyk (2001:193) points out that adolescents generally need a supportive environment in which to practise their decision-making and communication skills.

5.2.4 Spiritual care

5.2.4.1 Bereavement counselling

A total of **79,04% (132)** of adolescents in these households indicated that they were satisfied regarding their needs towards bereavement counselling and **20,96% (35)** said they were not satisfied regarding it. Only **16,77% (28)** of adolescents said they need help regarding bereavement counselling and **83,23% (139)** indicated that they do not need any help. Seeing that **more than 50%** of the respondents still have their mother or father or both as main caregivers, they might not express the need for bereavement counselling since their caregivers are still alive. The need for bereavement counselling mostly only sets in once the adolescent experiences loss and grief from the death of a caregiver or someone else. The importance of counselling and support in helping adolescents cope with loss are highlighted by Evian (1993:175).

Children, including adolescents, who lose a parent to AIDS suffer loss and grief like any other orphan (Whiteside & Sunter, 2000:95). However, their loss is exacerbated by prejudice and social exclusion and Ghosh and Kaliperii (2004:314) explain that these adolescents face a more difficult future due to the social stigma a death from AIDS often entails in many African societies. The resolution of the tasks of mourning by the bereaved may be complicated, as AIDS is a stigmatized disease (Siegel & Gorey, 1998:262). Adolescent's understanding of death may be influenced by ambiguities or tensions arising from biological, cognitive, social and emotional factors (Corr et al., 2003:350). Where adolescents were the carers of their parents, their needs will continue to exist, and they will require support and help (Green & McCreaner, 1996:191). Bereavement in the context of HIV infection presents some unique features (Green & McCreaner, 1996:78).

The bereaved adolescent is additionally traumatized with each death and confronted repeatedly with social stigma, isolation, guilt, shame and fear (Corr et al., 2003:549), and support networks become damaged by multiple bereavements and available support decreases (Green & McCreaner, 1996:78). The adolescent has a unique understanding of death which can lead to unique needs regarding grief and bereavement. According to Seager and Spencer (1996:46), these can include that the adolescent may worry or think about his or her own death, avoid discussions on death, fear 'looking different', question religious beliefs, feel anger towards the deceased, fear for the future and act out behaviours which can include aggression, possessiveness, phobias, increased sexual activity or drug use, increased risk-taking, defiance or suicidal ideation.

5.2.4.2 Mourning process

After the death of a parent, adolescents need to pass through the mourning process (Van Dyk, 2001:293). Some of the stages of grief work or tasks of

bereavement can include denial, anger, negotiation, depression and acceptance. Van Dyk (2001:300) further explains that mourning entails the psychological task of detaching one's memories and hopes. Adolescent grief is manifested in many ways, such as confusion, crying, feelings of emptiness or loneliness, disturbances in patterns of sleep and eating and exhaustion. When adolescents' parent(s) die of AIDS, meeting their basic physical and emotional needs is a necessary precondition to permit mourning and if these needs are unmet, mourning may be inhibited because anxiety leads them to deny loss (Siegel & Gorey, 1998:265).

5.2.5 Developmental and educational needs

5.2.5.1 Development (Education and training)

Only **53,85% (91)** of adolescents in these households said they were satisfied regarding their educational and training needs and **46,15% (78)** indicated that they were not satisfied. On the other hand, **59,28% (99)** of adolescents indicated that they need help concerning education and training, and **40,72% (68)** said they are not in need of any help. The respondents indicated by **almost 60%** that they need help towards education and training, which could mean that they view it as an important component for their well-being. To develop a sense of control, self-efficacy and a positive sense of self and collective identity, adolescents have a need to interact with their world and have access to diverse opportunities to participate and to learn from adults in their community and culture (Ungar, 2005:248). Richardson (2001:44) states that adolescents have unique developmental needs. Adolescents need to complete a number of developmental tasks to successfully enter into adulthood. These tasks include a gradual move to independence from parents, an adjustment to sexual maturation, as well as establishing cooperative and workable relationships with peers (Tshiwula, 2005:107). The developmental characteristics of the adolescent

include cognitive, emotional, moral, social, sexual identity and self-concept (Van Dyk, 2001:158; Van Heerden, 2001:61). Kartell and Chabilall (2005:215) and Van Heerden (2001:61-650 identified the following developmental levels in adolescents affected by HIV and AIDS: cognitive development, physical development, emotional development, moral development, social development, cognitive development and religious development. Corr et al. (2003:341) accentuate the fact that the principle task of adolescence is the achievement of individuation and the establishment of a more or less stable sense of personal identity.

Adolescents' physical transformation and growth have a direct bearing on their social development (Kartell & Chabilall, 2005:222). Many experiences of death, especially the death of a parent, and other losses may have particular significance for an adolescent's developmental needs (Corr et al., 2003:348). Adolescents whose parents are infected with HIV/AIDS may stop going to school and Leming and Dickinson (2002:98) add that they can neglect their own health and developmental needs to take over the role of their parent, caregiver and provider. According to Kartell and Chabilall (2005:224), it is difficult for the adolescent to develop a personal value system and moral reasoning without the guidance of significant adults.

5.2.5.2 Life skills

Only **60,71% (102)** of adolescents in these households indicated that they were satisfied regarding life skills and **39,29% (66)** said they were not satisfied regarding it, but **51,19% (86)** of adolescents said they need help in respect of life skills and **48,81% (82)** indicated that they are not in need of any help. According to Van Der Westhuizen (2006:8), life skills are coping skills that can enhance the quality of life and prevent dysfunctional behaviour. **Almost 50%**

of the adolescent respondents indicated that they need help in this area which shows that there is still room for life skills and empowerment programmes.

Feltham and Dryden (2005:128) define life skills as being all those skills pertinent to everyday functioning and survival. According to Barker (2003:250), life skills are the relative abilities to carry out activities of daily living. Adolescents have the need to develop certain life skills which will enable them to implement knowledge, attitudes, values and decisions they make during the learning process (Van Dyk, 2001:158). These life skills include self-awareness, critical thinking, responsible decision making, problem solving, assertiveness, negotiation skills, communication skills, refusal skills, planning for the future/ goal setting, conflict resolution, handling emotions, handling failure and coping with related feelings, and positive self-concept. Van Dyk (2001:262) also mentions that most of the time adolescents have the need to be empowered to be able to make decisions for themselves. Nefale (2001:21) adds to the above that adolescents have the need to develop their self-efficacy and assertiveness which help them to cope with their circumstances when their parents are infected with or affected by HIV and AIDS.

5.2.5.3 School training

In total, **65,68% (111)** of adolescents in these households said they were satisfied regarding school training and **34,32% (58)** indicated that they were not satisfied. However, on the other hand, **44,05% (74)** of adolescents indicated that they need help concerning school training and **55,95% (94)** said they are not in need of such help. The above response does not provide a clear indication of whether the respondents need help regarding their school training as in school work or with respect to difficulties that may for instance prevent them from attending school.

Table 51: ***Reasons of children (as indicated by households) for not attending school***

REASON	F	%
Could not pay school fees	18	30
Too ill to attend	4	6,67
Looking after own child	4	6,67
Fell pregnant	3	5
Mother died, moved from area	2	3,33
Application refused, no birth certificate	1	1,67
Ran away from school	6	10
Dropped out	13	21,67
Poor performance at school	1	1,67
Disabled	1	1,67
Have to take care of ill family member	5	8,33
Have to take care of younger siblings	2	3,33
Total	N=60	100

A total of **75,61%** of children in households involved in this study that are of school-going age are attending school. Of these, **90,54%** attend school 16 days or more per month. According to most responses to the question as to why children of school-going age do not attend school, **30%** responded that they could not afford school fees and **21,67%** indicated that they had dropped out of school. In total **11,66%** of children not attending school indicated that they either have to take care of an ill family member or of younger siblings, which are typical symptoms of the AIDS pandemic. Education broadly needs to include formal schooling, informal education, vocational training, apprenticeships and the transfer of traditional knowledge and skills by community and kin (Richter et al., 2004:28).

Adolescents, especially girls, are most often taken out of school or they abandon school themselves to care for their sick parents or relatives or to bear other family burdens when parents are infected with or affected by HIV/AIDS (Corr et al., 2003:558; Guest, 2003:140). Adolescents are more likely to drop out of school due to financial difficulties, illness and the social stigma of parents dying of AIDS (Ghosh & Kalipeni, 2004:311) or are expected to take on more domestic

work in the household to replace a parent's labour contribution (Barnett & Whiteside, 2002:203). Richter et al. (2004:9) describe the direct impact of HIV and AIDS on children's education as follows: withdrawal from school to care for others and to save costs, increased skipping of school, lower educational performance, premature termination of education, fewer vocational opportunities and traditional knowledge not passed on.

Strydom and Raath (2005:578) add that adolescents' education is adversely affected because they cannot continue attending school owing to lack of funding and financial means. The educational needs of adolescents vary tremendously, depending on the children's ages, whether or not they are in school, whether their parents are infected with HIV or ill with AIDS, whether they have lost one or both parents and whether they have economic and care responsibilities (Richter et al., 2004:28). Nefale (2001:10) is of opinion that happier, healthier and better educated children are less likely to be at risk of HIV infection. The constitutional and conventional rights of children affected by AIDS, especially their right to adequate education, are challenged by the impact of the HIV and AIDS epidemic (Sloth-Nielsen, 2004:7). Hence the future potential of many children is being compromised according to Richter et al. (2004:61).

5.2.5.4 Knowledge of HIV and AIDS

In total, only **67,86% (114)** of adolescents in these households indicated that they were satisfied regarding HIV and AIDS and **32,14% (54)** said they were not satisfied in this respect. A total of **31,55% (53)** of adolescents said they need help concerning HIV and AIDS and **68,45% (115)** indicated that they are not in need of any help. The effect size (w) (given by the phi (ϕ) coefficient) with regard to adolescents' satisfaction concerning HIV and AIDS is 0,3604, which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to

78,81% of respondents (adolescents) in Eastern Cape indicating that they were satisfied with respect to their knowledge of HIV and AIDS, compared to **42,00%** of respondents (adolescents) in North West who indicated they were satisfied concerning their knowledge of HIV and AIDS. The effect size (w) (given by the phi (ϕ) coefficient) with respect to adolescents needing help concerning their knowledge of HIV and AIDS is 0,4917, which indicates a medium to large effect (visible difference) and is considered practically significant (Ellis & Steyn, 2003:51-53). This difference is due to only **17,09%** of respondents (adolescents) in Eastern Cape indicating that they need help regarding their knowledge of HIV and AIDS compared to **67,35%** of respondents (adolescents) in North West who indicated that they need help in respect of their knowledge of HIV and AIDS. There still is an increasing need for education campaigns that are sustainable and ongoing in the field of HIV and AIDS, and according to research done by Strydom (2003:69), adolescents indicated that they need more information on HIV and AIDS. Oxley (2001:221) states that where the needs of adolescents are addressed, there needs to be a focus on in-depth information on HIV and AIDS and that education in this respect should be constantly reinforced.

According to Van Dyk (2001:191), adolescents have a need for HIV and AIDS education when their parents are infected with or affected by HIV and AIDS. They also have a need to know their rights regarding this issue, although they do not always want to be reminded of their responsibilities. Adolescence is characterized by experimentation with and initiating into risky behavioural practices and is therefore at greater risk of contracting HIV than other age groups (Mbugua, 2004). Adolescents may occasionally have the need to know their own status regarding HIV infection (Van Dyk, 2001:249). Whether the results of an HIV test are negative or positive, the adolescent could experience various related needs accordingly. In research done by Strydom (2003:69), adolescents indicated that sex education is lacking and that they need more

information on HIV/AIDS. Evian (1993:235) adds to this that there is an increasing need for education campaigns that are sustainable and ongoing. According to Oppong and Kalipeni (2004:108), adolescents found it easier to understand and retain AIDS information they learned in a formal situation such as the school, than when they had learned about it from other sources beforehand, such as their peers, family or the media.

5.3 MAJOR PROBLEMS EXPERIENCED BY HOUSEHOLD

A question was asked as to what the adolescent experiences as being his or her household's major problems. Problems concerning finances were by far most mentioned. The majority of respondents indicated that their households lack sufficient money to function from day to day. Many adolescents also indicated that members of the household being jobless was also a major problem as it relates to the above. Having no problems at all was also indicated by a number of the respondents. Other problems that were mentioned as the households' biggest problems include a proper house to stay in, illness of household members, drinking problem of a household member, caregiver being single without support, problems experienced in respect of certificates, problem with the Government not supplying enough jobs for everyone and money for future education such as for university.

5.4 GENERAL

5.4.1 Stigmatisation experienced

Stigmatization leads to a feeling of withdrawal, guilt, shame, anger, depression and isolation (Podile, 2004:2). Gow and Desmond (2002:165) state that at the root of stigma and discrimination lies fear and ignorance of HIV and AIDS. A question was asked whether the adolescents experience stigmatization and why they feel that they do. The response to this question was very incomplete, since

the majority did not answer this question. Those who experienced stigmatization indicated that they feel stigmatized by their peers or the education system and in some cases the community at large. In households where a death due to AIDS has already occurred, it was more likely for the household members to experience stigmatization.

5.4.2 Interference in households from outside the family

A question was asked to determine whether the adolescent, as part of a child-headed household, feels that people from outside interfere in their household. Only 4 households were indicated being child-headed, but even these households did not respond to the question.

5.4.3 Discipline of younger siblings

In family, the parental subsystem assumes the role of teacher and model over the sibling subsystem since it is at family level that children get to learn what socially acceptable and socially unacceptable behaviour is (Nefale, 2001:13). A question was asked on how the adolescent, as oldest child of the child-headed household, disciplined the younger siblings. None of the respondents from the 4 child-headed households answered the question.

5.4.4 Feelings of adolescents regarding circumstances

A question was asked pertaining to how the adolescent feels about his or her circumstances. This was a question to all adolescents and not only those from child-headed households. Again the response was very incomplete, since the majority did not answer the question. From those who responded, the impression was given that either they do not think about their feelings or they do not know how to feel about their circumstances or they do not know exactly what they are feeling. From the answers were: "I feel sad", "I feel good", "I feel

not happy because... worries about money". Some of the responses were directly linked to problems of the household and not to the feelings of the adolescent as a person.

5.4.5 Biggest problem experienced by adolescent

A question was asked on what the adolescent experiences as his or her biggest current problem. Money, or the lack of sufficient finances, was again indicated by the majority as their biggest problem. Many adolescents once more indicated that they do not currently experience problems. Problems regarding foster care were mentioned by a few respondents as well as their staying with an aunt or other family member. Support for the future was mentioned as a problem, and fear of when their caregiver might pass away was also mentioned. Experiencing a problem with a certificate(s) was indicated once more and some adolescents indicated that they do not know what their biggest problem is.

5.4.6 Perspective of future

A question was asked regarding to what extent their biggest problem, as mentioned previously, influences their perspective of the future. This question was answered by most of the respondents and the responses were very diverse. The answers given by quite a number of the respondents were that they either do not know about the future or that they will wait and see what the future holds for them. Quite a number of adolescents also expressed fear of not having sufficient money or not being able to finish school or not receiving further education. A few indicated that they see the future as bright. Some of the other responses include:

" Need to act against AIDS, be more careful. "

" Future is stolen when being raped. "

" AIDS is taking my dreams away. "

" You go to school, when you finish you die. "

" I think I need to get tested. "

" Go to school and know what you want. Start to plan for life, it's too short. "

" Without money I have no future. "

" If Government don't help, the future is dark. "

" Fear of being alone in future. "

Some adolescents responded positively. Of these responses include:

" I'll be bold and be strong about the future. "

" I don't see a problem for the future, God will give anything. I have faith."

6. DISCUSSION

Adolescents from AIDS-affected households have various needs, according to various sources. These needs can be classified as physical needs, emotional needs, developmental and educational needs and spiritual care. The physical needs of adolescents include physical care, health and nutrition, economic implications and maintenance of the family, protection, alternative care and functioning as a family and a household. When the parent(s) or caregiver(s) of adolescents are affected by or infected with HIV and AIDS, it will also affect these adolescents. Should it happen that these parents or caregivers become infected with HIV or fall ill with AIDS, the needs of adolescents will be directly, and occasionally dramatically, affected. AIDS-affected households tend to be poorer and consuming less food and left with smaller disposable incomes; it is hardly surprising that adolescents in these households are usually less well-nourished. The emotional needs that were identified and discussed were love and support, professional help from social worker, security, help and support regarding discrimination and the psychological and emotional impact.

Developmental and educational needs were also discussed and include developmental needs, and learning and educational needs, needs concerning life skills and the need to have knowledge of AIDS. The adolescents' needs in respect of bereavement counselling and the mourning process were discussed under the section on general spiritual care. It became clear from this study that in any intervention with adolescents, the discussed needs should be kept in mind and should form the platform from which any helping or support programme should be developed. AIDS disrupts social roles, rights and obligations. For the orphaned adolescent there is often a premature entrance to burdens of adulthood, all without the rights and privileges, or the strengths, associated with adult status. Being in a sensitive and unique phase, adolescents should be supported and guided more than ever when they form part of an HIV and AIDS-affected household.

7. RECOMMENDATIONS

It is evident that adolescents in households or families that are infected with or affected by HIV and AIDS have unique circumstances and needs. With a better picture of their circumstances, a better idea is formed of their specific needs. Based on the discussion of the results from this study and on the conclusion that was drawn, the following recommendations can be made:

- This research can be extended and can be used as platform for the development of various interventions with adolescents in households infected with or affected by HIV and AIDS.
- The circumstances in which adolescents have to grow into adulthood are difficult and they as a group should be a target population with respect to help and support.
- Programme development must be compiled in response to adolescents' needs via their active participation in the entire process.

- An empowerment group work programme should be developed to help and support adolescents in circumstances such as these, especially with respect to the possible death of a parent/caretaker.
- Life skills can be used as elements for an empowerment programme to help adolescents to be in a better position for their needs to be met.

8. CONCLUSION

The purpose of this study was to identify, explore and discuss the needs of adolescents in HIV and AIDS households where their parents are infected with or affected by HIV and AIDS. From the preliminary study it seems that this objective has been reached. Various sources confirm that HIV and AIDS is infecting and affecting a large number of people in South Africa every second in several ways. By identifying and exploring the needs of adolescents it became obvious that creating awareness of adolescents' needs and engendering support for them is an important component of psychosocial interventions for children. It is, however, recommended that before any intervention or programme is planned for adolescents in these circumstances, a needs assessment be done within the given community to determine and verify that specific population's unique demographics and needs.

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ARTICLE 3

AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/CAREGIVERS

K OLIVIER & H STRYDOM

ABSTRACT

This article focuses on the development of an HIV and AIDS group work programme preparing adolescents for the death of their parents/caretakers and empowering them with skills to be able to deal with it. A needs assessment was done on a large number of adolescents from households that are infected with or affected by HIV and AIDS. During this study members were selected according to specific criteria for inclusion in the group work programme. The aim of this article is discussed as well as the definition of certain terms. The selection of members for this programme, as well as guidelines for group work with adolescents, are discussed. The main focus of this article is on the themes and contents of the designed group work programme.

1. INTRODUCTION

Adolescents have specific and unique physical, emotional, developmental and educational, as well as spiritual needs. The exploration of these needs should form the foundation of an effectively designed group work programme to act in the best interest of the adolescent (Kandasamy, 2002:5; Scholtz, 1998:123). Nefale (2001:25) indicates that, in designing a programme, it is important to take the adolescent's developmental phase into account and it should include addressing issues that are relevant to the context in which the adolescents find

themselves. For adolescents to reach their optimal potential as adults, it is important that they should be guided through a programme empowering them with skills within their specific circumstances (Van Heerden, 2001:1). This programme was designed to address various needs as well as different aspects adolescents have to deal with when their parents are infected with or affected by HIV and AIDS. Subsequently illness resulting in death due to HIV and AIDS becomes a reality. This article describes the aim of the study and terminology used is defined. Guidelines for doing group work with adolescents are provided and the criteria for selection and inclusion of adolescents as respondents for this programme are discussed as well as guidelines for group work with adolescents. The process planning and compilation of a group work programme are explained with regard to the process of programme compilation, phases of group work, group work as a process, elements of an empowering programme, and the selection of programme activities. The designed group work programme is then discussed thematically, providing the objectives and content of each session.

2. PROBLEM STATEMENT

Sanei (1998:2–5) holds that it is necessary for the family with an HIV and AIDS patient to receive sufficient and effective support from social work service delivery. Some of the Government's policy documents, which include the *White Paper for social Welfare* (1997) and the *Draft Social Welfare Action Plan (SWAP)* (1998) of the Department of Welfare include reference to the role social work should play in the act of empowering adolescents as a target group. The social worker has certain tasks regarding effective service delivery to families with HIV-infected persons (Mullan, 1998:27; Saloner, 2002:155, 156). When adolescents' parents or caregivers are infected with or affected by HIV and AIDS, adolescents have specific physical, emotional, educational and bereavement needs (Strydom & Mynhardt, 2005:190). Other needs of adolescents affected by the death of their parents or caregivers include economics, protection, to function as a family

and household, love and support, security and life skills (Mynhardt, 2002:4-12). The large and growing number of affected adolescents makes knowledge concerning their needs essential so that effective interventions can be provided (Siegel & Gorey, 1998:263) and responses to adolescents affected by HIV and AIDS should address their needs (Ungar, 2005:256). Programme development must be done in response to adolescents' needs via their active participation in the entire process (Kandasamy, 2002:5).

3. OBJECTIVE

The objective of this article was to develop an HIV and AIDS group work programme preparing adolescents for the death of their parents/caretakers and empowering them with skills to be able to deal with it.

4. TERMINOLOGY

It was essential to define key terms used in this article to minimize different interpretations of the same term as Van der Westhuizen (2006:13) indicates.

4.1 ADOLESCENCE

Adolescence is normally referred to as the life cycle period between childhood and adulthood (Barker, 2003:8; Scholtz, 1998:16; Strydom, 2003:61). It can also be described as the phase beginning at puberty and ending in adulthood. Adolescence is a time filled with numerous changes (Roe-Sepowitz & Thyer, 2004:67) and goes hand in hand with radical development regarding attitudes, skills, knowledge and functions (Van Heerden, 2001:14).

4.2 EMPOWERING GROUP WORK PROGRAMME

Toseland and Rivas (2005:12) describe group work as a goal-directed activity with small treatment and task groups aimed at meeting socio-emotional needs and at accomplishing tasks. Its purpose is also to bring some kind of change in its group members through the medium of group interaction (Phillips, 2001:87). Social group work is an orientation and method of social work intervention in which small numbers of people who share similar interests or common problems convene regularly and engage in activities designed to achieve certain objectives (Barker, 2003:404). Herbst (2002:18,19) defines group work as a process whereby individual and group objectives are realized within the group context by purposefully applying the group work process. For purposes of this study a group work programme is therefore the interaction between a facilitator (social worker) and group members (adolescents) in which a systematic pattern is followed to achieve certain goals. An empowering group work programme is one by means of which psychosocial principles and knowledge are converted into teachable skills which can empower people to respond effectively to the demands and problems of coping in certain situations or in a certain stage of life (Phillips, 2001:20, Van Der Westhuizen, 2006:7).

4.3 DEATH

Feltham and Dryden (2005:58) describe death as the cessation of all vital life processes. Barker (2003:110) defines death as the total and permanent cessation of vital functions.

4.4 CAREGIVER

Barker (2003:57) defines a caregiver as one who provides for the physical, emotional and social needs of another person who often is dependant and cannot provide for his or her own needs. The term most often applies to parents

or parent surrogates. A caregiver can also be described as a person providing care or guarding children within the context of a household or family on a daily basis (Bauman, Draiman, Lavine & Hudis, 2000:156, 167). This caregiver can be the biological parents of the child or someone else who has been appointed by the parent himself or authorities on behalf of the child or any other person (including relatives or neighbours) providing care to children during their parents illness or after their death.

5. RESEARCH MODEL

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407). The third and fourth phases were conducted during this part of the study:

5.1 PHASE 3: DESIGN

Researchers must design a way of naturalistically observing events related to the phenomenon, as well as a method system for discovering the extent of the problem and detecting effects following the intervention. By observing the problem and studying naturally occurring inovations and other prototypes, researchers can identify procedural elements for use in the intervention. This phase consists of the following operations (De Vos, 2005c: 400 – 401):

- Designing an observational system
- Specifying procedural elements of the intervention

5.2 PHASE 4: EARLY DEVELOPMENT AND PILOT TESTING

Development can be defined as the process by which an innovative intervention is implemented and used on a trial basis, developmentally tested for its

adequacy, and refined and redesigned as necessary. This phase includes the following operations (De Vos, 2005c: 401 – 403):

- Developing a prototype or preliminary intervention
- Conducting a pilot test
- Applying design criteria to the preliminary intervention concept

6. GUIDELINES FOR GROUP WORK WITH ADOLESCENTS

Group work is one of three primary methods of service delivery in social work (Geyer & Strydom, 2008:75) and is a dynamic and powerful intervention method with adolescents who find themselves in a unique phase of life. It was chosen as method for this programme as it affords adolescents the opportunity to relate to others and it is time and cost effective (Strydom & Herbst, 2007:248). When a group work programme is developed and planned, the following guidelines should be taken into account:

- Richardson (2001:83) states that a combination of biological, cognitive, social and familial factors determines each adolescent's perception of reality and view of the world. Adolescents should be met where they are, developmentally speaking (Richardson, 2001:43, 51-53).
- Group members should be prepared for the group work programme by determining their level of motivation, discussing the aim of the group work sessions and introducing methods and procedures that will be utilized during the programme for them be motivated for and involved in the process to ensure that they attend the sessions, are responsive and are able to contribute (Van der Westhuizen, 2006:58).
- Adolescent groups should have a well-defined structure with clear limits (Scholtz, 1998:168). Adolescents in a group need room to bounce around (both behaviourally and verbally), but they also want to make sure boundaries have been laid down (Bilides, 1992:141).

- For a group to reach its maximum potential it is important that the facilitator of the group work programme incorporates preparations of administrative aspects (such as venue, time and duration, number of sessions, type and size of group, functional resources) in the planning phase of the group (Van der Westhuizen, 2006:58).
- It is important to bear in mind that working with adolescents from households that are infected with or affected by HIV and AIDS is a sensitive and difficult assignment; therefore it is important to help the group develop dynamics (communication, cohesion, social control mechanisms and group culture) that promote the satisfaction of group members' needs while facilitating the accomplishment of group tasks (Modise, 2005:61; Van Heerden, 2001:169). An emphasis on normalcy is important for group work with adolescents since they desperately want to be normal and accepted, according to Bilides (1992:141).
- The facilitator of the group work programme needs to have knowledge regarding different problems which may occur in group work (Scholtz, 1998:166). These problems can include size and composition of group, formal structure of group, power structure, environment, aids, time and characteristics of members (Van Heerden, 2001:173). Adolescents should never be forced into an activity or conversation and the facilitator needs to be flexible (Seager & Spencer, 1996:57).
- Functional helping aids such as posters, pictures and music can be utilized during the group work programme (Scholtz, 1998:167) to assist, stimulate, explore, compliment or assess and can be used to stimulate discussion and are therefore only a means to an end (Van Heerden, 2001:161-165).
- The facilitator (social worker) needs certain skills in order to present a group work programme which includes assisting group members in achieving their goals, programme planning, dealing with values and conflict, helping group members help themselves as well as other group

members, building meaningful relationships, clarifying values, dealing with feelings, purposefully applying social work principles, identifying and purposefully handling the group work process, observing and devotedly concentrating, communicating effectively, purposefully applying group conversation, exploration, report writing, interpretation, exploitation and utilization of aids, and effective evaluation (Bilides, 1992:131; Du Preez, 1993:165-185; Scholtz, 1998:81-87).

- Bilides (1992:142) points out that, for adult facilitators to survive the adolescent group work programme, they must have a clear sense of their own identity, receive support from colleagues and have sufficient emergency backup, good supervision and a sense of humour.
- For the group work programme to be meaningful and purposeful, it is important to clarify during the development of the programme which specific objectives it will pursue (Scholtz, 1998:169). These objectives can include rehabilitation, habilitation, correction, socialization, prevention, social action, problem-solving or social values (Herbst, 2002:112-113; Scholtz, 1998:79-80).

7. SELECTION OF GROUP MEMBERS FOR THE PROGRAMME

The selection of group members needs expert knowledge seeing that it influences the quality of the planned group work programme (Scholtz, 1998:88, Zastrow, 2006:13). A total of 169 households infected with or affected by HIV and AIDS (of which the adolescent formed part) were interviewed. A programme was developed based on the needs assessment that was done on these households as well as on in-depth study of various literature sources in this regard. Criteria for members to be included in a group can be the following: the degree of acceptance of the situation, openness towards social interaction, willingness to share feelings and experiences and to empathise with other members (Strydom & Fourie, 1998:391).

For the group work programme the comparison group prestest-posttest design was utilized to select adolescents (Grinnell, 2001:253). Twenty four (24) adolescents were recruited. Of these 24 adolescents, only 16 were able and willing to take part in the programme and were divided into two groups of eight members each. One group was exposed to the programme (experimental group) but not the other group (comparison group). However, they (comparison group) were later given the opportunity to follow the programme after the testing had been completed. Both the experimental group and the comparison group were pre-tested as well as post-tested to measure the possible impact and effectiveness of the intervention programme (Rubin & Babbie, 2005:324). From all adolescents that were willing to participate in the programme, consent was obtained from their parent or caregiver (Bilides, 1992:134; Etemad, 1995:824).

8. PLANNING AND COMPILING OF THE PROGRAMME IN GROUP CONTEXT

The nature of the programme must be geared to the cultural, developmental and environmental needs and common problems that bring the participants (group members) together (Van der Westhuizen, 2006:59). Compiling and writing a group work programme is critical and will in the end determine whether the goal of the group and those of individuals will be reached. A specific process of programme planning and compilation needs to be followed keeping in mind the group work process consisting of various aspects and stages of the group work process. A specific process also needs to be taken in account when compiling an empowerment programme. The selection of programme activities is of vital importance as it will play a major role in the presentation of the programme. The planning of the group is then based on the compiled programme.

8.1 Process of programme compilation

A programme needs to address a need or problem and should be identified. This need or problem has to be clearly formulated regarding the extent of the problem as well as the community it forms part of. The purpose of the programme should be clearly formulated in order to compile the programme. The introduction and presentation of the programme should be directed at members concerned (Van Heerden, 2001:174-175).

8.2 Phases in the group work process

The social group work process consists of different phases (horizontal approach) and each phase involves certain objectives and actions. According to Geyer (2006:92) the empowering process consists of seven phases, namely the preparation phase, contact phase, assessment phase, contracting phase, action phase, evaluation phase and termination phase. The phases generally are as follows: the beginning/pre-group phase *(target group, goals, action plan)*, the initial phase *(orientation, relationships, commitment)*, the transition phase *(testing, playing, observing, taking responsibility)*, the working stage *(cohesion, intimacy, participation, interaction, commitment)*, the final stage *(less participation and commitment, need to function independently)* and the post group phase *(individual follow-up, assessment, measurement)* (Herbst, 2002:119-121).

8.3 Aspects of the group work process

The group work process encompasses the whole of dynamic interpersonal relationships, developments and changes in a group (Scholtz, 1998:102). Du Preez (1993:131-150) distinguishes between a vertical and horizontal approach. The vertical approach consists of group motivation, structuring of the group, norms and values, control, atmosphere, group cohesion, programme planning

and relationships. Strydom and Fourie (1998:391-394) suggest that the following aspects need to be taken into account when planning a group:

- Structure of the group (open-ended/closed-ended group, number of sessions, duration of sessions)
- Nature of the group (different needs of members, atmosphere)
- Aims of the group (based on mutual experiences/feelings)
- Preparation of group worker (sufficient knowledge, administrative arrangements in order, self-knowledge for emotional preparation)
- Needs addressed by the group (members' needs)
- Relationship between members and facilitator (role of facilitator toward group members, members' relationship with one another)
- Procedure of group (course of each session).

8.4 Empowering programme and process

Hepworth and Larson (1993:495) describe an empowering programme as the facilitator (helper) that enables the group members to gain capacity to interact with their environment in ways that enhance their needs gratification, well-being and satisfaction and is closely linked to competence, self-esteem, support systems and belief that individual actions or actions in consent with others can lead to improvement in one's life situation. Different groupings of helping processes and skills can be identified with special significance for empowering skills and functions:

- To bolster motivation, gain resources, attend to presenting problems and personal strengths and enlist energy in changing events,
- to maintain physical comfort and self-esteem, facilitate members to share and validate one another's experiences and reduce self-blame,

- to enhance problem solving and to promote self-direction, brain storming, sharing of possible solutions, challenging strengths and creativity,
- to promote social change, making clear mutual contact that bridges the personal, political and social change focus and reaching for maximum participation (Van der Westhuizen, 2006:60).

8.5 Selection of programme activities

Programme activities are the resources used within the group context to assist individual group members and the group as a whole to achieve their objectives (Modise, 2005:62) and provide a medium through which the functioning of members can be assessed in areas such as interpersonal skills, ability to perform daily living activities, motor coordination, attention span and ability to work supportively (Toseland & Rivas, 2005:259). The procedure for selecting programme activities follow next: 1) specify programme activities that are consistent with group purposes and goals, 2) specify the objectives of the programme activity, 3) specify programme activities that can be performed, given available facilities, resources and time, 4) list potentially relevant programme activities based on members' interests and motivation, age, skill level, physical and mental state and attention span, 5) classify programme activities according to characteristics, physical requirements of abilities, social requirements, psychological requirements and cognitive requirements and 6) select programme activities that are best suited to achieve the objectives specified (Toseland & Rivas, 2005:261). The group activities have to offer adolescents concrete benefits and Bilides (1992:141) adds that they will then buy into almost any kind of group work programme if they think they are going to get something out of it.

9. CONTENTS OF THE HIV AND AIDS GROUP WORK PROGRAMME FOR ADOLESCENTS

The general aim of the study is to design and develop a group work programme empowering adolescents from households infected with or affected by HIV and AIDS by teaching them life skills. This programme has been designed in accordance with results discussed in article two and guidelines of various books and articles. In planning the programme, the researcher has explored knowledge of different authors such as Herbst (2002), Modise (2005), Scholtz (1998), Van der Westhuizen (2006) and Van Heerden (2001). The programme to follow consists of objectives, aims and contents of an empowering group work programme of 12 sessions. The content of this programme will be given in a schematic manner first and will then be discussed more comprehensively according to subject, aim and content.

Figure 3: ***Schematic representation of the empowering programme for adolescents***

Number of session	Theme
Session 1	Introduction and orientation
Session 2	Healthy lifestyle
Session 3	Identity and self-esteem
Session 4	Roles and relationships
Session 5	Effective communication
Session 6	Assertiveness and conflict management
Session 7	Problem solving, decision making and time management
Session 8	Coping with stress and emotions
Session 9	Orientation and implications of HIV and AIDS
Session 10	Spirituality, death as reality and bereavement
Session 11	Financial security and planning for the future
Session 12	Conclusion and evaluation

This figure indicates that a broad spectrum of topics is covered which will enhance and empower the total being of an adolescent who's parents/caretakers are infected with or affected by HIV and AIDS. The

programme will subsequently be described in more detail with regard to the 12 sessions.

9.1 SESSION 1: INTRODUCTION AND ORIENTATION

OBJECTIVES

- ✓ To introduce group members to one another.
- ✓ To establish and build a relationship of trust.
- ✓ To develop insight with group members regarding the importance of confidentiality.
- ✓ To help members work together in a cooperative and productive manner.
- ✓ To outline and clarify the purpose, objectives and structure of the group work programme.
- ✓ To create an atmosphere of warmth, acceptance and enjoyment.
- ✓ To establish ground rules and set goals.
- ✓ To compile a work agreement (Annexure I) with group members.
- ✓ To complete the pre-group questionnaires: CFI-HIGH (Annexure C), GCS (Annexure D) as well as a self-constructed questionnaire, *Qualitative and quantitative measuring instrument - before programme* (Annexure E).

CONTENT

The group facilitator should welcome all present and introduce him/herself to the group members. The group members (adolescents) should have the opportunity to introduce themselves to the rest of the group, which will provide them with a starting point for interaction. This can be done through a game or icebreaker where a ball (or some other object) should be tossed to one another where the one that catches the object should introduce him-/herself to the rest of the group. Then the object is tossed at someone else. A relationship of trust can be established through a brief discussion of ethics in group work. The importance of confidentiality can be highlighted by means of an example of something these

adolescents do not wish anybody else to know. The adolescents should be encouraged to be cooperative and productive to gain the maximum from this programme.

The facilitator should outline the purpose and objectives of the group and can also briefly discuss the content and structure of the programme. The facilitator initially has the responsibility to create an atmosphere in which the adolescents feel comfortable (Van der Westhuizen, 2006:65). The adolescents should be given the opportunity to establish the rules for themselves, the facilitator as well as the group as a whole and could be written out and should be visible for the duration of the programme (Geyer, 2006:97). A *Work agreement* (Annexure I) should be discussed and members should sign a declaration of participation (Herbst, 2002:288). Pre-group questionnaires (standardized assessment instruments) such as the *Child Functioning Inventory High School (CFI-HIGH)* from Perspective College (Annexure C), the *Generalized Contentment Scale* of Hudson (Bloom, Fischer & Orme, 1999:220) (Annexure D) as well as a self-constructed questionnaire, *Qualitative and quantitative measuring instrument - before programme* (Annexure E) should be completed by the adolescents. This is utilized at the end of the programme (when they complete the same questionnaire once more) to indicate whether they have benefited from the programme.

AIDS

- Ball or teddy bear
- Standing board with a flip chart to write on, markers
- Copies of *Work agreement* (Annexure I)
- Copies of *CFI-HIGH* (Annexure C), *GCS* (Annexure D) as well as a self-constructed questionnaire, *Qualitative and quantitative measuring instrument - before programme* (Annexure E).
- Pencils and pens

9.2 SESSION 2: HEALTHY LIFESTYLE

OBJECTIVES

- ✓ To help adolescents define a healthy lifestyle within the context of their needs regarding physical care.
- ✓ To enhance awareness regarding HIV and AIDS, alcohol and drug abuse and sexuality.
- ✓ To emphasize the role of prevention in HIV infection.
- ✓ To empower the adolescent to be able to follow a healthy lifestyle.
- ✓ To discuss the benefits of a healthy lifestyle within the adolescent's context as being part of a household infected with or affected by HIV and AIDS.
- ✓ Guidelines for a healthy lifestyle for households living with HIV and AIDS.
- ✓ To establish the benefits of a healthy lifestyle for an adolescent as part of a household infected with or affected by HIV and AIDS.

CONTENT

The facilitator can utilize a group discussion to determine the adolescents' attitude, knowledge, beliefs and background regarding a healthy lifestyle. This can be done in smaller group discussions providing feedback to the larger group. The discussions should include aspects such as eating habits, physical activity, use of alcohol, sexual activity and stress (Raath, 2001:179). As the adolescents already have knowledge of HIV and AIDS, alcohol and drug abuse and sexuality, it is important to elaborate on it (Van Heerden, 2001:228). The importance of guidance regarding the prevention of HIV infection can be discussed in general but should also be in the context of these adolescents being part of households that are infected with or affected by HIV and AIDS (Sito, 2004:13-17). The facilitator can guide the discussion regarding manageable outcomes of following a healthy lifestyle. It is important to utilize the adolescents' knowledge and experiences regarding the above-mentioned as a basis for discussion so that they

do not feel bombarded with yet another session of information. The adolescents' needs regarding physical care could be utilised as basis to encourage them to take ownership regarding their health in realising that they can be the most important role-player with regard to their health.

AIDS

- Standing board with flip chart to write on, markers
- Paper and pens

9.3 SESSION 3: IDENTITY AND SELF ESTEEM

OBJECTIVES

- ✓ To provide an opportunity to adolescents to evaluate their self-esteem.
- ✓ To assist adolescents in discovering their positive qualities and unique individuality.
- ✓ To help adolescents discover and identify their talents and potential to help them improve their quality of life and empower them with skills to deal with stigmatization.
- ✓ To help adolescents identify with positive affirmation.
- ✓ To assist adolescents in working towards an increasingly positive self-concept.

CONTENT

Stigmatization leads to feelings of withdrawal, guilt, shame, anger, depression and isolation (Podile, 2004:2). A positive self-esteem is important for each individual to continuously improve their quality of life and social functioning in the battle against stigmatization. The psychological and physiological changes that occur during adolescent development have a significant impact on adolescents' perceptions of and feelings about themselves (Oxley, 2001:215). Kartell and Chabilall (2005:221) explain that adolescence is a traumatic and confusing period of adaptation and it is important for the adolescent to accept

physical changes for them to have a positive self-concept and sufficient self-esteem. Each adolescent should be given the opportunity to evaluate his own self-esteem by means of a questionnaire (Annexure J). An exercise can follow in which members discover their positive qualities and unique individuality. An example of such an exercise could be the making of a collage.

Making a collage from magazine photos is a well-known multicultural assessment and treatment technique through which individuals create an image or representation of an aspect of their lives (Herbst, 2002:129). The adolescent has the opportunity to choose from various pictures which he/she mostly associates with. The pictures are then pasted as a collage and can be shared with the group. This exercise can then be repeated, but this round the members of small groups choose pictures for one another. For adolescents to discover their unique individuality, a shoebox with a mirror pasted on the bottom can be circulated in the group. Each member should be afforded the opportunity to look at him/herself in the mirror and to share with the group what they had seen.

AIDS

- Copies of *Index of self-esteem* (Annexure J)
- Pens
- Old magazines, glue, scissors, A3 papers

9.4 SESSION 4: ROLES AND RELATIONSHIPS

OBJECTIVES

- ✓ To assist adolescents in developing insight into the value of friendship and other relationships with regard to their needs pertaining to love and support.

- ✓ To assist adolescents in distinguishing between friendship and peer pressure.
- ✓ To help adolescents determine and clarify their role within the family and then function as part of a household.
- ✓ To identify strengths within relationships and how it can be utilized in the process of empowering.
- ✓ To provide guidelines on maintaining healthy relationships with regard to possible alternative care.

CONTENT

When the adolescent maintains healthy relationships, it helps him/her to experiment. This could give them a sense of self-worth which can boost their self-image and help them to be in touch with their own needs (Van Heerden, 2001:56). Every member in the group should be afforded the opportunity to briefly share with the group which existing relationship they consider closest and why they think so. This can form a platform for a group discussion on the difference between friendship and peer pressure. An activity can then follow through which the adolescents 'act out' their role in their households by making use of different 'props' that should be available (apron, hat, overall, broom etc.).

The strengths of the adolescents' relationships with family members, extended family and friends are important and valuable in the empowering process of this adolescent who forms part of a household infected with or affected by HIV and AIDS. To identify strengths within different relationships, an individual exercise can be done by which they identify five different existing relationships and write what they consider 'the best thing' about those relationships. Adolescents can then share in the group and the different strengths can be discussed. The adolescents can then take turns in providing guidelines with regard to maintaining healthy relationships. It could happen in the adolescent's near future that his/her caregivers could fall away and leave them needing alternative

care. Whatever this alternative care may be, building and maintaining a healthy relationship will play a central role.

AIDS

- Standing board and flip chart to write on, markers
- 'Props' such as hats, clothes, apron, overall, broom etc.
- Paper and pens

9.5 SESSION 5: EFFECTIVE COMMUNICATION

OBJECTIVES

- ✓ To define communication and the different elements of communication.
- ✓ To demonstrate communication as platform for all interaction and with regard to their social needs.
- ✓ To raise awareness of the importance of communication skills in relationships with significant people in their lives.
- ✓ To define the process that takes place whenever people share ideas, thoughts and feelings.
- ✓ To emphasize the importance of eye contact in the process of communication.
- ✓ To identify and discuss the most common obstacles in communication.

CONTENT

This session will focus on what communication skills are, the different ways of communicating (verbal and non-verbal communication), the process of communication and levels of communication (Van Heerden, 2001:68-72). Being effective communicators, the adolescents can handle the demands more easily within their circumstances (Van Heerden, 2001:3). A group exercise can be done where the group is split into two. The facilitator tells one member of each group a short descriptive story in private which they then have to repeat by whispering to the next person and so forth. The last person has to tell the rest of the group

what he/she heard. A discussion could then follow on the importance of good communication and the value thereof in social interaction and maintaining relationships. The facilitator should guide the discussion to distinguish between verbal and non-verbal communication.

Non-verbal behaviour can offend other people but can also be positive in that it can enhance the verbal message (Scholtz, 1998:148). The group members can be asked to 'communicate' different examples in a verbal and non-verbal way through role-play. The importance of eye contact in communication can be demonstrated by two adolescents sitting back-to-back trying to have a conversation. The facilitator can explain the process of communication: transfer of information, the receiver should understand it, the receiver should accept it and it must have the desired outcome (Van Heerden, 2001:197-198). This could empower the adolescents with the skills necessary for possible occasions when they might need the help of a professional person such as a social worker to work through different aspects within their circumstances.

AIDS

- Standing board with a flip chart to write on, markers

9.6 SESSION 6: ASSERTIVENESS AND CONFLICT MANAGEMENT

OBJECTIVES

- ✓ To explain and discuss the process of assertiveness.
- ✓ To give the adolescent the opportunity to participate in the process of assertiveness.
- ✓ To assist adolescents in developing strategies to manage assertiveness.
- ✓ To define conflict and the dimensions of conflict.
- ✓ To provide the adolescents with sufficient space to analyse their own conflict resolution styles.

- ✓ To provide guidelines for constructive conflict management.
- ✓ To help them practice different ways of solving and managing conflict.

CONTENT

For most adolescents it is difficult to be assertive when they lack self-confidence. Because of that they behave in a non-assertive manner (Van der Westhuizen, 2006:67). Assertiveness as skill plays an essential role when it comes to the educational and training needs of the adolescent. Adolescents need to learn and practise skills of negotiation and limit-setting which will enable them to be more assertive (Etemad, 1995:833). Problems with assertiveness range from extreme shyness, introversion and withdrawal to inappropriate rages that can alienate others (Zastrow, 2001:330). Assertiveness training should be designed to lead one to realize and feel that one has the right to be oneself and express one's feelings freely and to act on the assumption (Van der Westhuizen, 2006:67; Van Heerden, 2001:3, 82) and that assertiveness means standing up for yourself and in what you believe is right.

The facilitator can divide the group into smaller groups to let them discuss what they think assertiveness is. The adolescents can then share in the larger group what they come up with and the facilitator can direct the discussion at the need for assertiveness and the benefits of being assertive. The adolescents can then again be divided into smaller groups (3-4 adolescents per group). Each individual should think of a situation in which he wants to act assertively. The adolescents can then take turns in practising their assertive behaviour on one another. The one can practise his/her assertiveness, one can play the role of the person on whom the first person wishes to act out his assertiveness and the other(s) can evaluate (Annexure K) the process and provide the adolescent with feedback.

According to Van Heerden (2005:46), conflict arises when two or more values, perspectives and opinions are contradictory by nature and have not yet been aligned or agreed on. Conflict itself is not necessarily a bad thing and is a reality of life, but when it is not dealt with correctly it can become counter-productive. When it is handled effectively, it has a number of pay-offs such as producing lively discussions, defining issues more sharply, leading to potential growth and encouraging creativity (Zastrow, 2001:175). A group exercise can be done where the adolescents display their own conflict managing 'styles', for example: do they attack like a lion, shrink away like a tortoise or try to please like a teddy bear? The facilitator should then guide a group discussion on guidelines and life skills that can be useful in managing conflict. The stages of conflict should also be discussed to enable the adolescent to identify potential conflict (Van der Westhuizen, 2006:73). The adolescents should be given the opportunity to review the major conflicts in their lives, their usual reactions to conflict and their habitual conflict solving strategies as well as new methods for resolving these conflicts. This can be enhanced through role-play by means of which the adolescents have to indicate how they manage conflict against the background of all the newly acquired information.

AIDS

- Standing board with flip chart to write on, markers
- Copies of *Assertiveness evaluation* (Annexure K)

9.7 SESSION 7: PROBLEM SOLVING, DECISION MAKING AND TIME MANAGEMENT

OBJECTIVES

- ✓ To help the adolescent gain insight into what should be considered a problem.
- ✓ To guide the adolescent in the process of decision making.

- ✓ To define the concept of time management.
- ✓ To explore methods of managing time.
- ✓ To give adolescents the opportunity to apply these skills to normal-life situations.

CONTENT

Skills regarding problem solving and decision making are necessary for adolescents to support their developmental needs, since humans are dynamic and find themselves in the process of development which requires constant decision making and problem solving (Van Heerden, 2001:73, 83-88). The process of problem solving and decision making goes hand in hand and will be facilitated accordingly. Kartell and Chabilall (2005:219) point out that adolescents are capable of considering possibilities and assumptions that allow them to deliberate on the merits of present actions in relation to future consequences, risks or benefits of such behaviour. The facilitator can divide the group into smaller discussion groups that have to explore and give definitions to what they consider a problem. They should be given the opportunity to share it with the rest of the group. The group should be given the opportunity to identify and share examples of problems from their own lives. The facilitator can then explain the process of problem solving and decision making.

Van Heerden (2001:214-215) describes the process as follows:

Step 1: STOP – realise that something demands your attention, stay calm.

Step 2: IDENTIFY THE PROBLEM – what is the problem, who's problem is it, how do I feel about it?

Step 3: THINK OF SOLUTIONS – as many as you can, do not make any final decisions yet.

Step 4: EVALUATE ALL SOLUTIONS – think about possible consequences.

Step 5: MAKE A DECISION & CHOOSE THE SOLUTION – choose the solution you think is best and try it, remember to take responsibility for your choice, accept the consequences of your decision.

The adolescents can define time management through discussions in smaller groups, which can then be shared with the larger group. The facilitator can lead a general discussion on the importance of time management and its benefits as a life skill. A group exercise can then be conducted in which the adolescents should think of as many ways as possible of effective time management within their circumstances (Geyer, 2006:100). The results can then be shared with the larger group and the facilitator can share more information regarding time management. The adolescents can then be afforded the opportunity to practice this by means of the following exercise: the group is divided into smaller groups of two persons each. These two adolescents can then take turns in sharing the course of a normal day. The other one can then give advice on how time can be managed more profitably to benefit the adolescent.

AIDS

- Standing board with a flip chart to write on, markers
- Paper and pens

9.8 SESSION 8: COPING WITH STRESS AND EMOTIONS

OBJECTIVES

- ✓ To assist the adolescent in identifying different emotions.
- ✓ To help the adolescent define stress.
- ✓ To identify the causes of stress in the adolescent.
- ✓ To help the adolescents develop insight into the effect of stress on the quality of life.
- ✓ To introduce techniques of coping with stress.

- ✓ To learn and practice relaxation techniques.

CONTENT

Emotions such as anxiousness, fear, sadness, hopelessness, rejection and rage are most common with adolescents that are affected by HIV and AIDS (Strydom & Raath, 2005:572). Adolescents have different emotional needs and it is important that they should be able to distinguish between different emotions in order to clarify how these needs should be met. At the beginning of this session the facilitator can divide the group into smaller groups. These groups can each compile a collage of faces expressing different emotions. The facilitator can then collect these collages and exchange them among the groups. Each group can then try to identify the different emotions and a group discussion can follow. A handout (Annexure L) can be given concerning the extreme variety of emotions (Brittz, 2007: 177 – 181). Kandasamy (2002:5) explains that stress describes many different situations that pose threats to the wellness of the adolescent.

The session can then continue by asking the adolescents to formulate a definition of stress in their small groups and to share it with the larger group. The adolescents can then be asked to make collages from various pictures of what they think the causes of stress are (Van Heerden, 2001:240). These collages can be shared with the larger group and the facilitator can lead a group discussion based on the collages. The facilitator should then encourage the adolescents to identify a cause of stress in their own lives and guide them to identify the impact it has on their daily functioning (Scholtz, 1998:146). The larger group can be split into two groups. Each group should then simultaneously brain-storm for two minutes on ways to reduce and cope with stress. Following the two minutes, those members in the group with the most ideas get to share theirs first.

The facilitator can facilitate a practical relaxation exercise in which all adolescents should participate. An example of such an exercise is to let everyone lie down on the floor, if possible, or alternatively sit at ease with their eyes closed. The facilitator then guides them by instructing them to contract and relax different parts of their bodies beginning with the toes, working towards the head and ending by contracting and relaxing the entire body (Van Heerden, 2001:241-244). Calming music can accompany this exercise.

AIDS

- Old magazines, glue, scissors, A3 papers
- Copies of *Emotions* (Annexure L)
- Standing board with a flip chart to write on, markers .
- Calming music

9.9 SESSION 9: ORIENTATION AND IMPLICATIONS OF HIV AND AIDS

OBJECTIVES

- ✓ To present facts concerning HIV and AIDS to the adolescent in a straightforward manner.
- ✓ To discuss the causes and effects of HIV and AIDS.
- ✓ To educate them on the stages and symptoms of AIDS.
- ✓ To discuss the orientation to and issues concerning AIDS.
- ✓ To convey values concerning responsibility for oneself and the well-being of others.
- ✓ To discuss the caretaking of a person with AIDS.

CONTENT

According to Raath (2001:185) it is important to extend the adolescents' knowledge regarding HIV and AIDS regardless of whether they or their parents/caretakers are infected with the virus. AIDS education must be

comprehensive and must include increased emphasis on environmental, social and psychological factors that affect the transmission of HIV and AIDS (Oxley, 2001:221). The possibility could exist that the adolescents already know a great deal about HIV and AIDS (Podile, 2004:17) and would be negative or less motivated to once again receive information regarding this subject (Singh, 1994:345). Hence it is important to involve the adolescent in the presentation of the session's information. At the beginning of the session the facilitator should outline the impact of HIV and AIDS in South Africa and give some necessary statistics and information. To intensify the message, the facilitator can make use of various materials such as posters. The group can then be divided into two groups. Each group will then receive a topic: causes of HIV and AIDS infection or effects of HIV and AIDS infection. The groups must then discuss their topic in their group and prepare a brief presentation on that topic. They should be encouraged to be as creative as possible in order to present 'old' information in a 'new' jacket. The adolescents should be provided with information on the different stages and symptoms of the infection and disease.

The following psychological and social issues regarding HIV and AIDS should be discussed randomly: family structure, misunderstandings, financial burden, stigma, discrimination, emotional responses and the stages of death (Van der Westhuizen, 2006:69). The facilitator should be made aware of the possibility that this discussion can evoke negative emotions, frustrations, powerlessness, anger or feelings of depression which serve to further drain the personal resources of those who live with people with HIV and AIDS. This can be used as a platform for a brief discussion on values about taking responsibility for oneself and for the well-being of others. Taking care of a person with AIDS needs special insight into the disease and regarding the practical implications thereof. (Etemad, 1995:829). With all of the above as background a person with experience in the field (such as a hospice worker or home-based carer) can use

the final part of the session to teach adolescents how to take care of a person with AIDS.

AIDS

- Posters with statistics and information regarding HIV and AIDS
- Standing board with a flip chart to write on, markers

9.10 SESSION 10: SPIRITUALITY, DEATH AS A REALITY AND BEREAVEMENT

OBJECTIVES

- ✓ To define spirituality.
- ✓ To discuss the empowering benefits of spirituality.
- ✓ To share thoughts on death as a reality.
- ✓ To discuss the role of bereavement.
- ✓ To provide the adolescents with practical guidelines on bereavement.

CONTENT

It is important that the facilitator should remember to be objective regarding different religions, beliefs and viewpoints when discussing spirituality. The different principles of social work should be taken into consideration, such as the human dignity of each individual, acceptance of each person, the principle of individuality, the right of self-determination of each person, faith in the ability of each person, non-judgemental attitude that should be maintained as well as the principle of confidentiality (Raath, 2001:186). The adolescents need to be encouraged to share their own thoughts on spirituality. For a group exercise, the adolescents can be divided into smaller groups. Each group can discuss and share ideas on the benefits of spirituality with regard to their circumstances. It can then be shared with the larger group. The facilitator can guide the adolescents in an individual exercise regarding their thoughts on death. Seager and Spencer (1996:58) explain that by allowing adolescents to express their

feelings concerning the death of a significant person in a safe and non-judgemental atmosphere can prevent unresolved grief later in adult life. Every adolescent should be given the opportunity to write down ten words he/she associates with death. A group discussion can then be facilitated on the reality of death. At an occasion such as this adolescents should be given the space and opportunity to share thoughts or feelings on their experience of the death of a loved one.

Bereavement as a process should be discussed as a reality that goes hand in hand with the death of a loved one. The adolescents may have an attitude that as long as you do not anticipate it, death will not step in and it will not be necessary to receive bereavement counselling. Only adolescents who have already faced the death of a loved one or who have a significant other who is terminally ill, may directly express the need for bereavement counselling. It is important that the facilitator should handle this topic with care and the individuals with respect (Raath, 2001:187-188). The facilitator should incorporate literature on this topic from authors such as Corr, Nabe and Corr (2003), Currer (2001), Kübler- Ross (1989), Leming and Dickenson (2002), Seager and Spencer (1995) or Vos (1997).

AIDS

- Standing board with flip chart to write on, markers
- Paper and pens

9.11 SESSION 11: FINANCIAL SECURITY AND PLANNING FOR THE FUTURE

OBJECTIVES

- ✓ To increase the adolescents' knowledge of the value of money and the role it plays in households.

- ✓ To increase the adolescents' awareness regarding financial management and the responsibilities related to it.
- ✓ To help the adolescent understand the need for budgeting and financial planning.
- ✓ To provide the adolescent with knowledge regarding alternative resources.

CONTENT

The facilitator can start the session with an exercise every adolescent should do individually. The adolescents should be asked to list all the things they need on a daily basis, for example food, clothes, shelter and education. Subsequently the facilitator should ask them to indicate where everything comes from. For example, education at school – parents pays school fees. This can be used to form the background for a group discussion on money, its value and the role it plays in our day to day lives. The adolescents should be made aware that basically everything we need costs money. The group can then play a game such as shop-shop. The larger group can be split into two groups. The first group will receive some 'play' money as well as shopping lists that differ from one another. The second group can be the shop keepers of a groceries store, chemist, butchery, municipality, games shop, hair dresser etc. and are provided with articles related to the shops. The members of the first group then have a set time span in which to spend their money, while those in the second group (shop keepers) are encouraged to convince the shoppers to spend a large amount of or all their money at the different shops.

After some time has elapsed the two groups should exchange places and play the game once more. The adolescents can then share their experiences with the group. This should be used as background for a group discussion on managing finances and the responsibilities related to it. The adolescents should then be divided into smaller groups for an activity on budgeting. Every group will receive an amount they can budget for as well as details regarding the household for

which they have to draw up a monthly budget, for example R1 000-00, household 3 members, one in school, one generating income, one ill at home. Each group should have a different scenario, and after some given time they can share with the larger group their experiences regarding budgeting. It is a reality that the breadwinners of the household can fall ill and that the adolescent will have to start carrying the financial burden of the household (Barnett & Whiteside, 2002:189).

It is important to empower the adolescents by explaining the resources available within their community that can be utilized so that the adolescent and the household can become more able to survive in circumstances in which security is lacking. Information on the different grants available for households with young children, people infected with HIV and AIDS, people with disabilities etc. should be shared as well as practical and helpful information regarding housing schemes and health care within their communities.

AIDS

- Paper and pens
- Standing board with flip chart to write on, markers
- 'Play money', 'Groceries' from different shops such as chemist.

9.12 SESSION 12: CONCLUSION AND EVALUATION

OBJECTIVES

- ✓ To prepare adolescents for the termination of the group.
- ✓ To consolidate with adolescents what they have learnt during the sessions.
- ✓ To evaluate the programme and sessions through an evaluation form provided – *Qualitative and quantitative measuring instrument - after programme* (Annexure M).

- ✓ To complete the post-group questionnaires: CFI-HIGH (Annexure C), and GCS (Annexure D).

CONTENT

This session should be used to terminate the programme or group sessions. Termination can be difficult and emotional because the adolescents have worked closely together over an extended period of time in a safe environment and may have developed strong bonds (Van der Westhuizen, 2006:74). It may also mean ending and affirming the beneficial experience from the sessions, but also having to return to the realities of problematic or challenging environments. The facilitator should provide the adolescents with space to creatively express what they have learned during the course of the programme. For example, the adolescents could be provided with blank posters and they should individually or in small groups design and make posters on what they have learnt or gained from the programme. Zastrow (2001:296) mentions that the ending phase of a group frequently offers the greatest potential for powerful and important work. It is therefore important that the facilitator should be very sensitive to attitudes and feelings and individuals should be afforded the opportunity to communicate their feelings regarding the termination of the group (Geyer, 2006:108).

A discussion on 'the way forward' should be facilitated in order to help the adolescents incorporate the empowering skills they gained during the sessions into their day to day life and future. The evaluation as phase in group work is vital, since adolescents are given the opportunity to clarify the meaning of their experiences in the programme and to consolidate the gains they have made. Adolescents should complete a self-constructed questionnaire, *Qualitative and quantitative measuring instrument – after programme* (Annexure M) as well as a post-group questionnaire (standardized assessment instruments) such as the *Child Functioning Inventory High School (CFI-HIGH)* of Perspective College (Annexure C) and the *Generalized Contentment Scale* of Hudson (Bloom et al.,

1999:220) (Annexure D). This should be the same instrument as that was used as the pre-group questionnaire to measure whether they have benefited from the programme.

AIDS

- Blank posters (A2)
- Pens, markers, crayons, magazines, glue, scissors
- Standing board with a flip chart to write on
- Copies of *Qualitative and quantitative measuring instrument – after programme* (Annexure M), *CFI-HIGH* (Annexure C) and the *GCS* (Annexure D).

10. DISCUSSION

The specific needs of adolescents, including their physical, emotional, developmental, educational and spiritual needs, as obtained through a needs assessment, formed the foundation when this group work programme was planned and compiled. Various existing guidelines regarding group work with adolescents were studied and taken into consideration in the planning process. The process through which adolescents should be selected to form part of the programme was discussed as well as how the programme would be presented in different groups. The planning and compilation of a group work programme is an intense process and consists of different aspects.

The different phases of group work, including the pre-group, initial, transition, working, final and post-group phases were taken into consideration in the planning process. The process of an empowering programme comprises the following phases: preparation, contact, assessment, contracting, action, evaluation and termination. Programme activities should be considered carefully as it plays an important role in the presentation of the programme. Different

aspects were considered in the actual planning of the group work programme. These aspects include the structure, nature and aims of the group, the preparation of the social worker, the needs to be addressed by the group, relationships between the group members and the facilitator, as well as the procedure of the group. The programme was planned and compiled, taking into account the needs of adolescents as discussed in article 1 and the empirical data of article 2.

An empowering programme is recommended for adolescents who form part of households infected with or affected by HIV and AIDS. Various literatures and research taken into account, it is possible that these adolescents can in future experience the illness and death of their parents or caregivers due to AIDS. A comprehensive empowerment programme based on the needs of adolescents can help these adolescents and enable them to use different life skills to empower them so that their different needs can be met more comprehensively so as to lead a quality life within their given circumstances. With their basic needs being addressed or met, these adolescents should be more empowered to be able to cope with the reality of sickness and death caused by AIDS in their families and households.

11. CONCLUSION

Individuals such as adolescents can gain certain skills through group work programmes (Toseland & Rivas, 2005:23-24). This empowering programme was designed in correlation with the needs of adolescents anticipating that their parents or caretakers can fall ill with AIDS and eventually die from it. With regard to the unique stage of adolescence and functioning as part of households that are infected with or affected by HIV and AIDS, an empowerment programme can be utilized as part of service delivery in the battle against the pandemic. The presentation of an empowering programme can be seen as a

constructive and 'non-threatening' way of providing support and help to vulnerable adolescents. In this article the objective of the study was outlined and related terminology discussed. Guidelines for group work with adolescents were provided and the selection of members for the group was discussed. The process of planning and compiling a group work programme was explained. The main focus of this article was on the content of the designed group work programme. The discussion was structured thematically and comprehensively providing the objectives and content of each session. During the last session of the programme questionnaires (quantitative and qualitative) should be completed to evaluate the programme. It is recommended that these evaluations form the basis for recommendations that could improve the programme or being build into prospective programmes.

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ARTICLE 4

THE EVALUATION OF AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/CAREGIVERS

K OLIVIER & H STRYDOM

ABSTRACT

In this article an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers will be evaluated both qualitatively and quantitatively. The data were obtained by means of the Child Functioning Inventory High School (CFI-HIGH) developed by Perspective Training College (Annexure C) and the Generalized Contentment Scale (GCS) of Hudson (Bloom, Fischer & Orme, 1999:220) (Annexure D). Qualitative and quantitative evaluation was also done by means of self-developed questionnaires (Annexure E and Annexure M). The guidelines for selection and inclusion of respondents in the comparison and experimental groups will be discussed, followed by information on the measuring instruments. The results coming forth from the quantitative as well as qualitative evaluations will then be discussed. An evaluation of the programme's contents will follow and the article will conclude with conclusions and recommendations.

1. INTRODUCTION

The aim of this article is to evaluate and determine the effect of a compiled group work programme on adolescents from households infected with and affected by HIV and AIDS. Mixed methods research, which was utilized, is an approach to inquiry that combines the use of qualitative and quantitative

approaches and the mixing of both approaches in a study (Creswell, 2009:4). A combination of quantitative and qualitative measuring instruments was used in evaluating the programme (Fouche & De Vos, 2005:103) and is referred to as triangulation. Two structured measuring instruments were utilised for quantitative data collection and the programme presenter used two self-developed questionnaires for a combination of the qualitative and quantitative evaluation of the programme. The triangulation of measures enables the researcher to be more likely to see all aspects and provide greater confidence that that which is being targeted, is being captured accurately (De Vos, 2005b:361–362). This programme is based on the following theoretical assumption: Adolescents can be empowered to deal with the possible death of their parents/caregivers by means of an HIV and AIDS group work programme. This empowerment of adolescents through this programme includes aspects such as a healthy lifestyle, identity and self-esteem, roles and relationships, effective communication, assertiveness, and conflict management. Other aspects included are problem solving, decision making and time management, coping with stress and emotions, orientation to and implications of AIDS, spirituality and death as a reality, bereavement, financial security and planning for the future.

2. PROBLEM STATEMENT

Responses to adolescents affected by HIV and AIDS should address their needs (Ungar, 2005:256) and programme development must be done in response to adolescents' needs via their active participation in the entire process (Kandasamy, 2002:5). The exploration of these needs should form the foundation of an effectively designed group work programme to act in the best interest of the adolescent (Kandasamy, 2002:5; Scholtz, 1998:123). For adolescents to reach their optimal potential as adults, it is important that they should be guided through a programme empowering them with skills within their specific circumstances (Van Heerden, 2001:1). To determine whether the

designed empowering group work programme as a social intervention has produced the intended results, it is necessary to evaluate it (Fouche & De Vos, 2005:108). Programme evaluation includes the systematic collection of information on programme activities, characteristics and outcomes of the programme to make judgements concerning the programme, improvement of programme effectiveness and making suggestions regarding the future use of the programme. In the evaluation of a programme as a potential method, it should be borne in mind that it should produce the quantitative and qualitative information required to assess the programme's progress towards achieving its desired outcomes (Rankin, Weyers & Williams, 2008:244-245).

3. OBJECTIVE

The objective of this article was to empirically evaluate the effectiveness of the developed empowering group work programme and to disseminate it.

4. EMPIRICAL RESEARCH

4.1 RESEARCH MODEL

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407). The fifth and sixth phases were conducted during this part of the study:

4.1.1 Phase 5: Evaluation and advanced development

This phase of the D & D model comprises the following operations (De Vos, 2005c: 403 – 404):

- Selecting an experimental design
- Collecting and analysing data

- Replicating the intervention under field conditions
- Refining the intervention

4.1.2 Phase 6: Dissemination

Once the community intervention has been field tested and evaluated, it is ready to be disseminated to community organisations and other target audiences. The following operations help to make the process of dissemination more successful (De Vos, 2005c: 404 – 407):

- Preparing the product for dissemination
- Identifying potential markets for the intervention
- Creating a demand for the intervention
- Encouraging appropriate adaptation
- Providing technical support for adopters

4.2 DESIGN

Mixed methods research is an approach to inquiry that combines the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Creswell, 2009:4). The concurrent embedded strategy was used in this study. Creswell (2009:214) explains that the concurrent embedded strategy of mixed methods is identified by its use of one data collection phase during which qualitative and quantitative data are collected simultaneously. For the experiment the comparison group prestest-posttest design was utilized (Grinnell, 2001:253). This design includes two groups: experimental group and comparison group. Although the assignment to the groups was done randomly as with the classic experimental design (Grinnell & Williams, 1990:167), the groups can never be exactly the same and therefore will be regarded as an experimental and comparative group (Rubin & Babbie, 2005:345).

The comparison group pretest-posttest design according to Grinnell (2001:253-254):

Experimental group:	**01**	**X**	**02**
Comparison group:	**01**		**02**

With:

01	=	First measurement of the dependent variable (CFI-HIGH & GCS)
X	=	Independent variable (Group work programme)
02	=	Second measurement of dependent variable (CFI-HIGH & GCS)

The aim of this experiment was to determine whether the application of a group work programme, focussing on certain life skills to empower, had an influence on the adolescent's functioning as part of a household infected with or affected by HIV and AIDS. Both groups were exposed to pre-testing one week before the onset of the programme and were tested once again within two weeks after the experimental group had completed the group work programme.

4.3 PARTICIPANTS

A total of 24 adolescents were selected by means of accidental sampling. Only 16 of these adolescents were available after the initial sampling to conduct this research. All of these 16 adolescents met the criteria previously discussed. These 16 adolescents were then divided into 2 groups with age and gender as main criteria to have two as identical as possible groups. One group was then selected randomly as the comparison group and the other as the experimental group.

FIGURE 4: *Experimental and comparison groups*

EXPERIMENTAL GROUP	COMPARISON GROUP
BOY – 12 YEARS OLD	BOY – 12 YEARS OLD
BOY – 18 YEARS OLD	BOY – 16 YEARS OLD
BOY – 14 YEARS OLD	GIRL – 14 YEARS OLD
GIRL – 12 YEARS OLD	GIRL – 12 YEARS OLD
GIRL – 14 YEARS OLD	GIRL – 14 YEARS OLD
GIRL – 15 YEARS OLD	GIRL – 15 YEARS OLD
GIRL – 16 YEARS OLD	GIRL – 16 YEARS OLD
GIRL – 17 YEARS OLD	GIRL – 18 YEARS OLD

Both groups were exposed to pre-testing and post-testing which included the Child Functioning Inventory High School (CFI-HIGH) developed by Perspective Training College (Annexure C) and the Generalized Contentment Scale (GCS) of Hudson (Bloom et al., 1999:220) (Annexure D). The experimental group was also exposed to self-developed questionnaires: Qualitative and Quantitative Measuring Instrument – Before Programme (Annexure E) and Qualitative and Quantitative Measuring Instrument – After Programme (Annexure M), before and after intervention respectively. After the pre-testing, the experimental group was exposed to the group work intervention programme. As ethical consideration, the comparison group was informed that they would be afforded the opportunity to undergo the same group work programme as the experimental group once the last-mentioned group had completed it. This is to give all participants equal access to an empowering opportunity, as Strydom (2005a:66) indicates, namely that participation in a research project should be a learning experience for all concerned.

4.4 SAMPLING PROCEDURE

The study population included in this programme consisted of 16 adolescents from households infected with or affected by HIV and AIDS. All these adolescents presently have a parent or caretaker who is infected with HIV or is

already ill due to AIDS or those adolescents who have already lost a parent(s) to AIDS. They were selected by means of accidental sampling (Strydom, 2005b:201-202) to participate as comparison and experimental groups. Strydom (2005b:202) defines accidental sampling as "any case which happens to cross the researcher's path and has anything to do with the phenomenon (who) is (then) included in the sample until the desired number is obtained." For this study, the following criteria were set to identify respondents to be included in this experiment:

- Respondents should be adolescent (for purposes of this study, 12 – 18 years of age).
- Respondents should be from a household that is infected with or affected by HIV and AIDS.
- Respondents should indicate willingness and be available to participate in the programme.
- There should be an equal as possible distribution of respondents for the comparison and experimental groups according to age and gender.

4.5 DATA COLLECTION

Data were collected quantitatively as well as qualitatively by making use of two self-developed questionnaires as survey data procedure: Qualitative and Quantitative Measuring Instrument – Before Programme (Annexure E) and Qualitative and Quantitative Measuring Instrument – After Programme (Annexure M) as well as two standardized scales: Child Functioning Inventory High School (CFI-HIGH) developed by Perspective Training College (Annexure C) and the Generalized Contentment Scale (GCS) of Hudson (Bloom, Fischer & Orme, 1999:220) (Annexure D).

4.6 MEASURING INSTRUMENTS

Different measuring instruments (Delport, 2005:160) were utilized in the process of the evaluation of the group work programme. These include the *Child Functioning Inventory High School (CFI-HIGH)* of Perspective Training College (Annexure C), the *Generalized Contentment Scale* of Hudson (Bloom et al., 1999:220) (Annexure D) as well as two self-constructed questionnaires: *Qualitative and quantitative measuring instrument - before programme* (Annexure E) and *Qualitative and quantitative measuring instrument – after programme* (Annexure M).

4.7 DATA ANALYSIS

The **quantitative** data in this study was statistically computed with SAS (SAS Institute Inc, 2003). The results were interpreted, inferences pertinent to the research relations studied made and conclusions drawn. In research, the practical significance of results is not only important when results of the population data are reported but also for commenting on the practical significance of a statistically significant result (Ellis & Steyn, 2003:51-53).

The **qualitative** data that were collected during this study was analysed by hand according to themes and Tesch's approach to qualitative data processing was followed (Poggenpoel, 1998:343 – 344).

5. QUANTITATIVE EVALUATION BY MEANS OF CHILD FUNCTIONING INVENTORY HIGH SCHOOL (CFI-HIGH)

The Child Functioning Inventory High School (CFI-HIGH) (Annexure C) of Perspective Training College was administered in pre- and post-testing as part of the quantitative evaluation. The CFI-HIGH is a standardized pen-and-paper self-reporting measuring instrument that can be utilized to evaluate the general

functioning of children of high school age (adolescents) regarding various aspects. This measuring instrument can only be obtained from Perspective Training College (www.perspektief.com). In this experiment, the aim of administering the CFI-HIGH was to determine the respondents' general functioning in life. The following areas of personal functioning are included: *Positive functioning areas* (including perseverance, satisfaction, future perspective), *Self-perception* (including anxiety, guilt feelings, lack of self-worth, isolation, responsibility for others, lack of assertiveness), *Trauma dynamics* (including memory loss, frustration, helplessness, attitude towards adults, mistrust, stigma, body image, personal boundaries, school problems), *Relationships* (including relationship with friends, relationship with mother, relationship with father, relationship with family), *Decision making skills* (including independency, responsibility). Both the pre- and post-test data were utilized to determine a link between the respondents' functioning and the impact of an empowering group work programme.

5.1 RELIABILITY OF THE CFI-HIGH

The Cronbach Alpha coefficient is a criterion to determine the internal consistency of a measuring instrument (Huysamen, 1996:28). The reliability of the CFI-HIGH of Perspective was calculated with Cronbach Alfa coefficient. Huysamen (1996:30) points out that a reliability coefficient as low as 0.6 can be considered acceptable for making decisions regarding groups. Four of the constructs were found to be not reliable with reliability coefficients that were below 0.5. The constructs of the CFI-HIGH measuring **anxiety, responsibility, relationships with friends and independency**, can thus not be accepted as reliable. The constructs of the CFI-HIGH measuring **perseverance, satisfaction, future perspective, guilt feelings, lack of self-worth, isolation, lack of assertiveness, memory loss, frustration, helplessness, attitude towards adults, mistrust, stigma, body image, personal**

boundaries, school problems, relationship with mother, relationship with father, relationship with family and **responsibility** were found to be reliable with reliability coefficients that varied between 0.57 and 0.90.

5.2 PRE- AND POST-TESTING

Both the comparison and experimental groups were requested to complete the CFI-HIGH one week before the onset of the group work programme. After the pre-testing, only the experimental group was exposed to the group work programme. This programme was presented over a period of six weeks and included 12 sessions. The post-test was conducted by requesting both the experimental and the comparison group to complete the CFI-HIGH once again. This post-testing took place one week after the experimental group had completed the group work programme. Because of the small sample size, the tests might not have had enough power to indicate statistical significance on a 5% level of significance, and effect sizes will be used as an indication of the practical significance of differences. The results are expounded in Table 52:

Table 52: *Results of pre- and post-testing of CFI-HIGH*

	EXPERIMENTAL GROUP						COMPARISON GROUP						ANCOVA	
	Pre-test		Post-test		Test with-in group		Pre-test		Post-test		Test with-in group		TEST BETWEEN GROUPS	
	Average	Standard deviation	Average	Standard deviation	P	D	Average	Standard deviation	Average	Standard deviation	P	D	P-values	Effect size
Perseverance	85.1	20.0	92.5	13.2	0.1705	0.37	60.1	24.3	63.5	22.1	0.2849	0.14	0.0616	-1.19
Satisfaction	74.3	17.9	87.4	12.3	0.0093	0.73	57.9	20.6	55.0	19.6	0.2742	-0.14	0.0004	2.58
Future perspective	70.6	19.9	74.3	11.0	0.5557	0.19	50.1	18.5	46.9	15.5	0.3566	-0.17	0.0094	1.74
Guilt feelings	28.8	25.7	18.0	17.9	0.0176	-0.42	42.0	22.3	42.8	17.3	0.7416	0.04	<0.0001	3.28
Lack of self-worth	19.1	15.9	9.9	9.6	0.0460	-0.58	36.3	22.1	34.5	24.4	0.5062	-0.08	0.0642	1.12
Isolation	43.6	20.5	40.1	15.5	0.3001	-0.17	41.3	20.1	41.4	22.2	0.9581	0.00	0.3983	0.45
Lack of assertiveness	29.4	22.9	19.8	20.6	0.0705	-0.42	40.4	23.3	41.1	22.6	0.7043	0.03	0.0271	1.27
Memory loss	23.9	28.5	13.9	18.5	0.1460	-0.35	35.9	22.8	39.9	24.9	0.2524	0.18	0.0160	1.39
Frustration	28.1	26.7	14.9	11.1	0.2003	-0.49	38.8	29.8	39.3	33.1	0.8679	0.02	0.0697	0.97
Helplessness	33.9	26.5	21.0	13.8	0.1038	-0.49	46.4	19.9	46.8	23.9	0.8904	0.02	0.0190	1.34
Attitude towards adults	23.5	26.6	15.3	12.6	0.2619	-0.31	33.6	21.8	35.4	19.2	0.4496	0.08	0.0105	1.48
Mistrust	45.4	12.7	32.5	7.1	0.0362	-1.02	53.4	7.4	51.0	9.5	0.1572	-0.32	0.0027	2.00
Stigma	44.5	26.6	31.6	18.5	0.0685	-0.48	57.8	17.1	60.5	15.7	0.2846	0.16	0.0021	1.95
Body image	26.3	29.2	14.4	18.9	0.0540	-0.41	32.4	25.6	33.1	25.9	0.1970	0.03	0.0058	1.66
Personal boundaries	32.3	25.1	12.5	6.2	0.0495	-0.79	34.4	16.0	41.8	18.2	0.1464	0.46	0.0005	2.33
School problems	27.9	27.9	11.4	13.5	0.0486	-0.59	28.9	24.5	33.2	27.1	0.1163	0.18	0.0046	1.61
Relationship with mother	74.6	26.4	80.5	16.6	0.4645	0.22	66.0	29.0	59.3	26.5	0.0412	-0.23	0.0379	1.17
Relationship with father	58.5	25.4	63.1	28.2	0.2713	0.18	40.9	23.6	41.0	23.0	0.9751	0.00	0.3930	0.48
Relationship with family	77.4	17.0	85.0	18.5	0.1017	0.45	50.8	27.6	48.8	27.2	0.3699	-0.07	0.0604	1.18
Responsibility	71.3	19.6	83.5	18.7	0.0249	0.62	59.8	24.2	59.8	23.1	1.0000	0.00	0.0131	1.50

5.3 DISCUSSION OF PRE- AND POST-TEST RESULTS

5.3.1 Results after pre-testing

After pre-testing, the p-value (P) of the *grouping of the experimental and comparison group* regarding all the constructs measured >0.05. P-values > 0.05 indicate that the two groups did not differ statistically significantly on a 5% significance level at this point (before the experimental group was exposed to the programme) with regard to these constructs. The effect-size (D) of the *test between groups* (after pre-testing) regarding **future perspective, guilt feelings, lack of self-worth, lack of assertiveness, memory loss, helplessness, mistrust, stigma, relationship with father, relationship with family** and **responsibility** were found to be >0.4, which indicates a medium visible and significant difference and an effect size > 0.8 indicates that there is a large visibly to practically significant difference between the two groups regarding these constructs before the experimental group was exposed to the programme, with the experimental group being better. The effect-size (D) of the *test between groups* (after pre-testing) regarding **isolation, frustration, attitude towards adults, body image, personal boundaries, school problems** and **relationship with mother** was found to be <0.4, which indicates an insignificant difference between the two groups regarding these constructs before the experimental group was exposed to the programme.

5.3.2 Results after post-testing

- **Within experimental group**

After post-testing, the p-value (P) of the *experimental group* regarding the constructs of **satisfaction, guilt feelings, mistrust and responsibility** measured <0.05, which indicates a statistically significant difference. The p-value (P) after post-testing of the *experimental group* regarding **perseverance, future perspective, lack of self-worth, isolation, lack of assertiveness,**

memory loss, frustration, helplessness, attitude towards adults, stigma, body image, personal boundaries, school problems, relationship with mother, relationship with father and relationship with family measured >0.05, which indicates that there is no statistically significant difference on a 5% significance level regarding these constructs in this group after their exposure to the programme with regard to these constructs. The effect-size (D) of the *experimental group* regarding **guilt feelings, lack of self-worth, lack of assertiveness, frustration, helplessness, stigma, body image, school problems, relationship with family** and **responsibility** was found to be >0.5, which indicates a medium visible improvement. The effect-size (D) of the experimental group regarding **satisfaction, mistrust** and **personal boundaries** measured >0.7, which indicates that there is a large practically significant improvement in the *experimental group* after being exposed to the programme. The effect-size (D) of *experimental group* regarding **perseverance, future perspective, isolation, memory loss, frustration, attitude towards adults, relationship with mother** and **relationship with father** is <0.4, which indicates that there is no visibly significant difference in the *experimental group* after their exposure to the programme regarding these constructs.

❖ **Within comparison group**

After post-testing, the only p-value (P) <0.05 of the *comparison group* is regarding **relationship with mother** with the p-value = 0.04. It indicates a statistically significant difference regarding this construct. All the other constructs measured >0.05. P-values that are > 0.05 indicate that there is no statistically significant difference on a 5% significance level in the *comparison group* after post-testing. The effect-size (D) of the *comparison group* regarding all constructs measured <0.5, which indicates that there is no practical or significant improvement in the comparison group after post-testing.

❖ **Test between groups**

After post-testing, the p-value (P) of the *test between groups* (experimental and comparison groups) regarding **satisfaction, future perspective, guilt feelings, lack of assertiveness, memory loss, helplessness, attitude towards adults, mistrust, stigma, body image, personal boundaries, school problems, relationship with mother** and **responsibility** measured <0.05, which indicates a statistically significant difference regarding the ANCOVA means (adjusted for pre-test counts) of these constructs between the two groups. All the other constructs, including **perseverance, lack of self-worth, isolation, frustration, relationship with father** and **relationship with family**, measured p>0.05. P-values that are >0.05 indicate that there is no statistically significant difference between these groups on a 5% significance level. The effect-size (D) of the ANCOVA *test between groups* (experimental and control groups) regarding **perseverance, satisfaction, future perspective, guilt feelings, lack of self-worth, lack of assertiveness, memory loss, frustration, helplessness, attitude towards adults, stigma, body image, personal boundaries, school problems, relationship with mother, relationship with family** and **responsibility** are all >0.8. An effect size >0.8 indicates that there is a large practically significant difference between the groups. The effect-size (D) of ANCOVA *test between groups* regarding **isolation** and **relationship with father** is 0.45 and 0.48. An effect-size of 0.5 indicates that there is a medium visibly significant difference on the test between the groups regarding these constructs. In all these differences the experimental group was better than the comparison group in the post-test

5.3.3 Results of constructs

The following aspects were observed regarding the results within the constructs of the CFI-HIGH:

- **Perseverance**

In both the *experimental group and the comparison group* there was no statistically significant improvement with regard to pre- and post-testing. In the *test between groups* there was no statistically significant difference between the groups with regard to perseverance. In the post-testing there was a large practically significant improvement regarding perseverance.

- **Satisfaction**

With regard to satisfaction, the *experimental group* showed a statistically significant improvement in the group and the *comparison group* showed no statistically significant improvement in the group. In the *test between groups* there was a large practically significant difference regarding satisfaction, where adjusted means of the experimental group were better than those of the comparison group.

- **Future perspective**

After pre-testing (before the experimental group was exposed to the programme), the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was a large practically significant difference between the groups. In both the *experimental group and* the *comparison group* there was no statistically significant improvement with regard

to pre- and post-testing. There was a large practically significant improvement in the *test between groups* regarding future perspective, where adjusted means of the experimental group were better than those of the comparison group.

❖ Guilt feelings

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was a medium visibly significant improvement between the groups after pre-testing. The *experimental group* showed a statistically significant improvement with regard to guilt feelings and the *comparison* group showed no statistically significant improvement in the group. In the *test between groups* there was a large practically significant improvement regarding guilt feelings, where adjusted means of the experimental group were better than those of the comparison group.

❖ Lack of self-worth

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups regarding lack of self-worth. In the *grouping of the experimental and comparison groups* there was a large practically significant difference between the groups after pre-testing. The *experimental group* showed a statistically significant improvement in the group and the *comparison group* showed no statistically significant improvement in the group. In the *test between groups* there was a large practically significant improvement regarding lack of self-worth, where adjusted means of the experimental group were better than those of the comparison group.

❖ Isolation

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there was no practically significant improvement regarding isolation.

❖ Lack of assertiveness

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visible and significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there is a large practically significant improvement regarding lack of assertiveness, where adjusted means of the experimental group were better than those of the comparison group.

❖ Memory loss

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visible and significant difference between the groups after pre-testing. Neither the

experimental group nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding memory loss, where adjusted means of the experimental group were better than those of the comparison group.

❖ Frustration

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. The *grouping of the experimental and comparison groups* showed no visible and significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding frustration, where adjusted means of the experimental group were better than those of the comparison group.

❖ Helplessness

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant differences between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. There was a large practically significant improvement regarding helplessness in the *test between groups*, where adjusted means of the experimental group were better than those of the comparison group.

❖ Attitude towards adults

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visible and significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. There was a large practically significant improvement regarding attitude towards adults in the *test between groups*, where adjusted means of the experimental group were better than those of the comparison group.

❖ Mistrust

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was a medium visibly significant difference between the groups after pre-testing. The *experimental group showed* a statistically significant improvement with regard to pre- and post-testing and the *comparison group* showed no statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding mistrust, where adjusted means of the experimental group were better than those of the comparison group.

❖ Stigma

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the

grouping of the experimental and comparison groups there was a medium visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement in the groups with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding stigma, where adjusted means of the experimental group were better than those of the comparison group.

- **Body image**

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement with regard to pre- and post-testing. In the *test between groups* there was a large practically significant difference regarding body image, where adjusted means of the experimental group were better than those of the comparison group.

- **Personal boundaries**

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. The *experimental group* showed a statistically significant improvement and the *comparison group* showed no statistically significant improvement with regard to personal boundaries. In the *test between groups* there was a large practically significant

improvement regarding personal boundaries, where adjusted means of the experimental group were better than those of the comparison group.

❖ School problems

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visible and significant difference between the groups after pre-testing. The *experimental group* showed a statistically significant improvement in the group with regard to school problems. The *comparison group* showed no statistically significant improvement in the group with regard to school problems. In the *test between groups* there was a large practically significant improvement regarding school problems, where adjusted means of the experimental group were better than those of the comparison group.

❖ Relationship with mother

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. The *experimental and comparison groups* both showed statistically significant improvement with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding relationship with mother, where adjusted means of the experimental group were better than those of the comparison group.

❖ Relationship with father

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was a medium visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement with regard to pre- and post-testing. In the *test between groups* there was no visibly significant difference regarding relationship with father.

❖ Relationship with family

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was a medium visibly significant difference between the groups after pre-testing. Neither the *experimental group* nor the *comparison group* showed any statistically significant improvement with regard to pre- and post-testing. In the *test between groups* there was a large practically significant improvement regarding relationship with family, where adjusted means of the experimental group were better than those of the comparison group.

❖ Responsibility

After pre-testing, the *grouping of the experimental and comparison groups* showed no statistically significant difference between the groups. In the *grouping of the experimental and comparison groups* there was no visibly significant difference between the groups after pre-testing. The *experimental group* showed a statistically significant improvement in the group with regard to

responsibility. The *comparison group* showed no statistically significant improvement in the group with regard to responsibility. In the *test between groups* there was a large practically significant improvement regarding responsibility, where adjusted means of the experimental group were better than those of the comparison group.

6. QUANTITATIVE EVALUATION BY MEANS OF GENERALIZED CONTENTMENT SCALE (GCS)

The Generalized Contentment Scale (GCS) (Annexure D) of Hudson (Bloom et al., 1999:220) was administered during pre- and post-testing. The GCS is a standardized pen-and-paper self-reporting measuring instrument designed to measure the way respondents feel about their life and surroundings. This measuring instrument can be obtained from Perspective Training College (www.perspektief.com). In this experiment, the aim of administering the GCS was to determine the respondents' general contentment with life. Both the pre- and post-test data were utilized to determine a link between the respondents' contentment with life and the impact of an empowering group work programme. The GCS scores range from 0–100 and the following values were used to interpret the GCS scores:

- A score higher than 35 shows need for improvement
- A score between 25 and 35 indicates warning area that needs attention
- A score below 25 is in the recommended range

6.1 RELIABILITY OF THE GCS

The Cronbach Alpha coefficient is a criterion to determine the internal consistency of a measuring instrument (Huysamen, 1996:28). The reliability of the GCS of Hudson was calculated with Cronbach Alpha coefficient and was 0.79.

Huysamen (1996:30) point out that a reliability coefficient as low as 0.6 is acceptable to make decisions regarding groups. All the tests (constructs) of the GCS can be accepted as reliable.

6.2 PRE- AND POST-TESTING

Both the comparison group and the experimental group were requested to complete the GCS one week before the onset of the group work programme. After the pre-testing, only the experimental group were exposed to the group work programme which was presented over a period of six weeks and included 12 sessions. The post-test was conducted by requesting both the experimental group and the comparison group to complete the GCS once again. This post-testing took place one week after the experimental group had completed the group work programme. Because of the small sample size, the tests might not have had enough power to indicate statistical significance on a 5% level of significance, and effect sizes were used as an indication of the practical significance of differences. The results are expounded in Table 53:

Table 53: *Results of pre- and post-testing of GCS*

	EXPERIMENTAL GROUP						COMPARISON GROUP						ANCOVA	
	Pre-test		Post-test		Test within group		Pre-test		Post-test		Test within group		TEST BETWEEN GROUPS	
	Average	Stan-dard devia-tion	Average	Stan-dard devia-tion	P	D	Average	Stan-dard devia-tion	Average	Standard deviation	P	D	P-value	Effect -size
General contentment	39.1	15.1	17.3	8.4	0.004	1.45	48.9	13.8	52.9	11.8	0.0322	0.29	<0.0001	4.0

6.3 DISCUSSION OF PRE- AND POST-TEST RESULTS

6.3.1 Results after pre-testing

After pre-testing, the p-value (P) of the *grouping of the experimental and comparison groups* measured 0.20. This p-value is > 0.05 and indicates that the two groups did not significantly differ statistically on a 5% significance level at this point (before the experimental group was exposed to the programme). After pre-testing, the effect-size (D) of the *grouping of the experimental and comparison groups* was 0.84. The *experimental group* was better than the *comparison group*.

6.3.2 Results after post-testing

- **Within experimental group**

After the *experimental group* had been exposed to the programme, a p-value of 0.004 was measured. A p-value of <0.05 indicated that there is a statistically significant difference in this group after their exposure to the programme. The effect-size (D) of the *experimental group* after their exposure to the programme was 1.45. An effect-size > 0.8 indicates that there is a visibly and practically significant improvement in the group after their exposure to the programme. The *experimental group* improved regarding their generalized contentment after their exposure to the programme.

- **Within comparison group**

After the post-testing of the *comparison group*, a p-value of 0.0322 was measured. A p-value of <0.05 indicates that there is a statistically significant difference in this group after the exposure of the experimental group to the programme. The effect-size (D) of the *comparison group* after post-testing is 0.27. An effect-size < 0.5 indicates that there was a no visibly significant improvement in this group after the post-testing.

❖ **Test between groups**

After the *experimental group* had been exposed to the programme, the ANCOVA *test between the groups* (experimental and comparison groups) registered a p-value of <0.0001. A p-value of <0.05 indicates that there is a statistically significant difference regarding the ANCOVA means (adjusted for pre-test counts) of this construct between the two groups. The effect-size (D) of the ANCOVA *test between groups* (experimental and comparison groups) after the experimental group had been exposed to the programme, is 4.00. An effect-size > 0.8 indicates that there is a visible and significant improvement between the groups after post-testing. The *experimental group* improved regarding their generalized contentment, but the *comparison group* did not show any visibly significant improvement.

7. QUALITATIVE AND QUANTITATIVE EVALUATION BY MEANS OF SELF-DEVELOPED QUESTIONNAIRES

Two questionnaires (Annexure E & Annexure M) were developed by the researcher for this experiment with a view to utilize them as qualitative and quantitative measuring instruments with regard to the group work programme. The *Qualitative and quantitative measuring instrument – before programme* (Annexure E) was developed for pre-testing the experimental group before exposing them to the programme. The second questionnaire, *Qualitative and quantitative measuring instrument – after programme* (Annexure M) was developed for post-testing the experimental group after they had been exposed to the programme with a view to evaluate the possible impact of the programme. These questionnaires were developed with the aim of evaluating the presentation and outcome of the empowering group work programme. Open-ended questions (Greeff, 2005:309) were utilized as well as questions where the respondent had to rate an aspect according to a scale (1= very bad, 5 = average, 10 excellent).

The results of these questionnaires were processed by the researcher by means of targeted analysis.

7.1 RELIABILITY OF THE SELF-DEVELOPED QUESTIONNAIRES

The self-developed questionnaires are regarded as reliable since it was completed consistently and once by the respondents of the experimental group. Consistency is regarded as one of the methods to undertake qualitative research (Neuman & Kreuger, 2003:183-184). The experimental group received the *Qualitative and quantitative measuring instrument – before programme* before they started with the contents of the empowering programme and the *Qualitative and quantitative measuring instrument – after programme* after completion of the sessions of the programme.

7.2 QUALITATIVE AND QUANTITATIVE EVALUATION BEFORE AND AFTER THE PROGRAMME

As part of the *Qualitative and quantitative measuring instrument – before programme,* the respondents had to answer 7 questions regarding their **expectations of the programme**:

FIGURE 5: ***Questions and responses of the Qualitative and quantitative measuring instrument – before programme***

Question	Responses
What do you expect to gain from the programme?	• *" to become happy again "* • *" to gain knowledge "* • *" to gain self-respect "* • *" to learn about health and spiritual life "*

What do you want to learn from the programme?	• *" information "* • *" life "* • *" health "* • *" to help others "* • *" to challenge life "* • *" HIV-spreading "*
What topics would you like to be included in an empowering HIV and AIDS programme for adolescents?	• *" HIV "* • *" School "* • *" Future "* • *" Adolescence "* • *" Giving help to others "* • *" Sex/sexuality "* • *" Conflict resolution "* • *" Emotions "*
What are you looking forward to regarding the programme?	• *" to gain strength from what I learn "* • *" to grow in myself"* • *" to be respected "* • *" learning new things "*
How do you feel about your future?	• *" happy "* • *" good "* • *" excellent "* • *" bright "*
How do you feel about your household?	• *" happy "* • *" good "* • *" good, but not everyday "* • *" happy, sometimes "*
What do you think is the biggest problem regarding HIV and AIDS?	• *" it is dangerous "* • *" people don't like it "* • *" sleeping with other people "* • *" people that don't believe that it kills "* • *" laughing at someone that is HIV positive "* • *" stigma and discrimination "*

As part of the *Qualitative and quantitative measuring instrument – after programme,* the respondents had to answer 11 questions regarding their **evaluation of the programme**:

FIGURE 6: ***Questions and responses of the Qualitative and quantitative measuring instrument – after programme***

Question	Responses
What did you gain from the programme?	• *"a lot of teachings"* • *"food"* • *"help"* • *"feeling happy"* • *"experience"* • *"respect"*
What did you learn from the programme?	• *"I learned how to accept myself-and my circumstances where I live"* • *"many-many things"* • *"having unprotected sex will give you many diseases"* • *"I learned that you can learn through many games"* • *"I learned a lot about HIV/AIDS"*
Which topics had the most value for you that were included in the empowering HIV and AIDS programme for adolescents?	• *"HIV infection"* • *"Healthy lifestyle and to be safe"* • *"HIV and how to protect yourself"* • *"Many things"*
Which topics had the least value for you?	• *"Communication and stress"* • *"HIV and AIDS"*
Which other topics would you have liked to be included in the programme?	• *"How to move on with life"* • *"How to help other persons to be safe"* • *"Teenage pregnancy"* • *"How to tell you have HIV"* • *"Teenage abusing drugs"*

What did you enjoy most with regard to the programme?	• *"Sharing with others and learning things"* • *"To get nice food"* • *"To learn on HIV/AIDS"* • *"to enjoy with others that are the same"* • *"playing games and decorating things together"*
If you can change anything about this programme, what would it be?	• *"Nothing"* • *"tell them to have safe sex"* • *"I don't want to change the programme"* • *"time of the programme"*
How do you feel about your future?	• *"I feel that I will be successful in future"* • *"I feel okay about my future"* • *"My future is bright"* • *"I feel so happy"* • *"I am so excited"*
How do you feel about your household?	• *"Happy"* • *"A little good"* • *"Okay"* • *"I feel that they are fine"*
What do you think is the biggest problem regarding HIV and AIDS?	• *"people who believe that AIDS can't kill them"* • *"people get sick from it and they die"* • *"HIV and AIDS anybody, young and old"* • *"It kills"*
Since you have completed the programme, what is different in your life?	• *"I am now so happy"* • *"I know now many ways of a healthy lifestyle"* • *"There is no difference"* • *"The way I view things in life"*

As part of the *Qualitative and quantitative measuring instrument – before programme* and the *Qualitative and quantitative measuring instrument – after programme,* the respondents had to rate their attitude and knowledge with regard to the outcomes of the programme.

The values of the ratings for interpretation are the following:

1 = very bad

5 = average

10 = excellent

The average of respondents' ratings is expressed percentage-wise (before and after programme) and their qualitative responses after they had completed the *Qualitative and quantitative measuring instrument – after programme* will be discussed in Figure 7.

FIGURE 7: ***Results of qualitative and quantitative evaluation (group members' attitude and knowledge)***

QUALITATIVE AND QUANTITATIVE EVALUATION			
SUBJECT	**AVERAGE SCORE (%) BEFORE PRO-GRAMME**	**AVERAGE SCORE (%) AFTER PRO-GRAMME**	**QUALITATIVE RESPONSE AFTER PROGRAMME**
Healthy lifestyle	72.8%	72.9%	• *"I feel lucky not to have any serious diseases."* • *"I am motivated to eat healthy and to keep myself-clean."* • *"It is benefit to have a healthy lifestyle in many ways."*
Identity and self-esteem	67.1%	71.4%	• *"I feel confident and good about myself."* • *"It is more important how you feel about yourself-than what others think."* • *You are happy if you have a good self-esteem."*

Role and relationships	75.7%	88.6%	• *"I am happy with other people because I am happy with the person I am."* • *"My best relationship is with my mother, because we share a lot of love."* • *"I feel lucky to have positive relationships with many people."*
Effective communication	82.9%	77.1%	• *"I learned that there are better ways to communicate."* • *"I am motivated to speak to others in a matured way."* • *"To communicate effective you have to adapt."*
Assertiveness and conflict management	74.3%	70%	• *"To be assertive is not to be a softy."* • *"I am now able to solve many problems without fighting."* • *"To be assertive is to stand up for yourself."*
Problem solving, decision making and time management	64.3%	85.7%	• *"I am now able to solve problems in a better way."* • *"I can take positive decisions on my own and I am able to manage my time better."* • *"I feel happy to be learn to solve many problems."*
Coping with stress and emotions	55.7%	77.1%	• *"I feel so happy to learn to cope better with stress."* • *"I have a lot of emotions and are allowed to have them."* • *"There are many ways to cope with stress and emotions, you have to handle them."*

Orientation and implications of AIDS	51.4%	84.3%	• *"When someone gets AIDS you have to take special care of that person and be nice to her."* • *"I got all the information I need."* • *"We must help each other not to get AIDS."*
Spirituality, death as reality, and bereavement	45.7%	85.7%	• *"I know now better to cope with the loss of friends and family."* • *"Death will happen sometime to all of us, I am not afraid."* • *"I learn it is important to get bereavement after you lost someone you love for your life goes on."*
Financial security and planning for the future	41.4%	62.9%	• *"When I grow up I have to take care of myself, there will not be anyone to protect me."* • *"I am now able to plan and budget with money."*
GROUP'S AVERAGE (ALL SUBJECTS)	**63.13%**	**77.57%**	

Only 7 of the 8 respondents from the experimental group completed the *Qualitative and quantitative measuring instrument – before programme* and *Qualitative and quantitative measuring instrument – after programme.* These scores are each respondent's total of their ratings with regard to the 10 subjects. These ratings are expressed in percentages. Individuals' ratings before and after the programme are displayed in Figure 8.

FIGURE 8: *Individual scores – before and after the programme*

INDIVIDUAL SCORES OF EXPERIMENTAL GROUP		
Respondent	**Score – before programme**	**Score -after programme**
1	66%	72%
2	-	-
3	47%	75%
4	82%	85%
5	95%	85%
6	35%	82%
7	71%	73%
8	46%	71%
AVERAGE	**57.4%**	**77.8%**

7.3 DISCUSSION

The average scoring regarding the group members' attitude and knowledge according to their scorings improved with 14.44% from 63.13% to 77.57%. In 8 of the 10 sections of the programme there was improvement regarding the group members' attitude and knowledge according to their scorings summarised in FIGURE 7. The sections on **healthy lifestyle** and **identity and self-esteem** show small improvements ranging from 0.1-4.3%. The sections on **roles and relationships, problem solving, decision making and time management, coping with stress and emotions, orientation and implications of AIDS, spirituality, death as reality and bereavement** and **financial security and planning for the future** show larger improvements ranging from 12.9% to 40.0%. The section on **effective communication** and **assertiveness and conflict management** shows no improvement, with scores declining respectively with 4.3% and 5.8%. The average individual scoring improved with 20.4% from 57.4% to 77.8%. Six of the seven group members' individual scorings improved between 2% and 47%. Only one group member showed no improvement regarding her/his scoring with a decline of 10%.

According to the respondents' qualitative responses (as displayed in Figure 7), the respondent's attitude and knowledge regarding the following topics did improve: Healthy lifestyle, Identity and self esteem, Roles and relationships, Effective communication, Assertiveness and conflict management, Problem solving, decision making and time management, Coping with stress and emotions, Orientation and implications of AIDS, Spirituality, death as reality and bereavement and Financial security and planning for the future.

8. EVALUATION BY THE PROGRAMME PRESENTER AND CO-PRESENTER

This evaluation was conducted by the researcher as programme presenter and a co-presenter during and after presentation of the programme and represents the viewpoints of the researcher on various aspects of the programme. The purpose of this evaluation is to determine the practical applicability of the programme and to make recommendations for future utilization. Once respondents were recruited for this research project, it was decided that the pre-testing (CFI-HIGH & GCS) would be done simultaneously with both the comparison (control) group and the experimental group in the same venue, one week before the programme would be presented to the experimental group.

Reasons for this include that the co-presenter needed to translate the statements from the questionnaire from English to Tswana to make sure that every respondent had clarity on its meaning. The presenter and co-presenter of the programme decided to let all respondents complete the CFI-HIGH and GCS as a group, one statement at a time and not individually, each with his own questionnaire, as is normally done. See Annexure N for pictures taken during the presentation of the programme. These pictures are published with the permission of the co-presenter and group members.

8.1 SESSION 1: INTRODUCTION AND ORIENTATION

The name of the group was established as *Hope Again* and group members created a poster of it demonstrating their cooperation (Annexure N). The CFI-HIGH and GCS measuring instruments were completed one week before this session for practical reasons, although it was planned to be included in this session. Although translation was needed at times to clarify certain aspects to the group, members communicated openly and freely. The atmosphere during this session was relaxed and the games helped in establishing the wanted outcomes without unnecessary discussion or explanation. The group members took ownership of the programme and seemed excited about the forthcoming sessions. The completion of the work agreement (Annexure G) took place as a 'ceremony' to emphasise the importance of their participation and cooperation and was a highlight, as members wore a crown and robe, and pictures were taken while they signed the 'contract' (Annexure N).

8.2 SESSION 2: HEALTHY LIFESTYLE

Group members were asked to find and cut out pictures in magazines presenting any aspect of a healthy lifestyle. The topic of a healthy lifestyle is a mutual and safe point of discussion since it involves everybody's everyday life and all members were able to make inputs. The pictures were utilized well as tool to start the discussion and everyone was able to make inputs. Members took turns in sharing and their confidence grew as their inputs were valued and added on to the whole.

8.3 SESSION 3: IDENTITY AND SELF-ESTEEM

It was decided not to use the Index of self-esteem (ISE) (Annexure H) in evaluating the self-esteem, since limited time was available in the venue used for this session. The completion of scales like these is very time consuming since

the co-presenter (Annexure N) needs to translate each statement and everybody needs to understand its meaning before a score can be given. Members were asked to evaluate their self-esteem by rating it according to a scale from 1–10, 1 being very bad and 10 being excellent. Simply rating their self-esteem did not establish grounding for the rest of the session as intended, since all members except one rated their self-esteem as a 10 (excellent). Group members then made individual collages (Annexure N) using magazines and different arts and crafts materials incorporating different aspects regarding the topic. Members were given the opportunity to share their collages. They enjoyed making the collages, and sharing with the group was a highlight and established better knowledge and understanding regarding fellow group members.

8.4 SESSION 4: ROLES AND RELATIONSHIPS

Members were asked to identify their closest relationship and had the opportunity to share this with the group. This formed a platform for a group discussion on the difference between friendship and peer pressure in which the members actively joined. A game was then played in which members identified their role in their household and acted it out with the help of 'props' which they found slightly difficult but with guidance, were able to participate well and benefit from it.

An individual exercise was done where they were asked to identify the strengths of their closest relationship and group members willingly shared these with the rest of the group, which led to a discussion on maintaining healthy relationships. The cohesion of the group increased since the previous week and group members were very relaxed during this session. They cooperated very well during discussions and encouraged one another to share. It was sensed that they were very honest about what they shared, since they freely shared feelings regarding relationships in their households that were not that positive. They

expressed that this session made them think differently about relationships and the importance of it and that relationships stretch far further than only with the one's you love.

8.5 SESSION 5: EFFECTIVE COMMUNICATION

The session started with playing a game, 'three-legged race', where every two group members had to tie their ankles together with a sock. The members then had to communicate without saying anything on how they intend to run with their ankles tied up and then run a race. Another game was played called 'musical chairs', where they had to walk in a circle and find a chair to sit on the moment the music stopped. These games formed the platform for a discussion on communication, covering various aspects. Another game was played, 'telephone-telephone', where one member was shown a picture with some detail and he/she then had to tell another group member what he/she had seen. That group member then had to pass the information on until the last member had to tell the group what he/she had heard.

The value of effective communication as well as the aspects and process of communication were highlighted through this game. A game named 'back-to-back' was utilised to illustrate the importance of eye contact in communication. The various games helped to keep the atmosphere light and informal during this session. Each game presented much opportunity for the explanation and discussion of the different aspects of communication. The games also helped the participants to understand different concepts better by experiencing it first hand. The participants enjoyed this session in particular by playing all through it.

8.6 SESSION 6: ASSERTIVENESS AND CONFLICT MANAGEMENT

A brief introduction to the topic was given and the concept of assertiveness was discussed. Group members then had the opportunity to 'act out' real life situations in which they need to be assertive. An exercise was also done where group members evaluated each other on assertiveness, and the need and value of assertiveness was discussed. The concept *assertiveness* seemed very abstract to the participants and a great deal of time went into explaining rather than discussion. The practical exercise helped them to gain a better understanding and to bring the concept 'home'. Since they identified real-life situations in which they needed to be assertive, this exercise was empowering. The concept *conflict* was defined by the group and an exercise followed by which group members had to identify with an animal with regard to their conflict handling style. The different conflict resolution styles were discussed. A group discussion followed by means of which the group members identified practical ways of dealing with conflict. In general the group members had a better understanding of the concept *conflict* and they participated well in the group discussion.

8.7 SESSION 7: PROBLEM SOLVING, DECISION MAKING AND TIME MANAGEMENT

Regarding problem and problem solving, group members were instructed to form a circle holding hands, facing each other. They had to figure out how to end up facing the outside of the circle, still holding hands. With regard to problem solving and decision making, another exercise followed in which they had to write down as many uses for a paperclip they could think of. Group members were then asked to plot down their daily schedule and after sharing it, had to come up with ideas on how they could manage their time better. The three aspects covered in this session were easy for the group members to identify with and to participate in. Every aspect was applicable to their day-to-day lives. The

exercises helped a lot to form a background for discussion, since they experienced it and, out of that, were able to share and participate. Since time was limited, every aspect was only briefly covered, although it could have been elaborated on much more.

8.8 SESSION 8: COPING WITH STRESS AND EMOTIONS

The session started with a game in which each group member received a sticker with a face on it showing a certain emotion. The group members then had to make that same face, showing the emotion to the rest of the group. Other group members had to tell what emotion was shown. The group members were surprised by the extreme variety of emotions that can be identified, other than happy, sad or angry. It seems that the reality of emotions is something most of the group members are not in contact with. Others expressed that they were pleased to finally be able to label what they were feeling. At first the group members struggled to come up with a definition of stress. It seems that it is a concept that they use very often but understand little of. Their collages (Annexure N) on the causes of stress and ways to reduce stress empowered them by enabling them as a group to come up with the possibilities. The group members enjoyed the relaxation exercise and were keen to try it the next time they felt stressed.

8.9 SESSION 9: ORIENTATION AND IMPLICATIONS OF HIV AND AIDS

The group members have a broad knowledge on HIV and AIDS, but it seems that most of it was learned knowledge, since they easily rumbled down facts about HIV and AIDS. It was necessary to bring this knowledge home to their everyday life. The session mainly elaborated on their existing knowledge base and they had to share information they had. Games, such as the sharing of a

can of Coke, and other exercises helped them to bring their knowledge and their everyday world together. Although these adolescents are bombarded with information on this issue, they still have misconceptions which could sprout from their own fears. Generally the session was very interactive and the group members shared easily. The exercise regarding the most important aspects with regard to taking care of a person with HIV and AIDS was empowering since the group members that were or currently are in that situation shared practical knowledge and advise.

8.10 SESSION 10: SPIRITUALITY, DEATH AS REALITY AND BEREAVEMENT

The session was facilitated by the co-presenter of the group work programme. He started the session by giving the group members the opportunity to share what they think spirituality is. The group joined in a discussion on spirituality and on the benefits of it as part of an empowerment programme. A discussion on death followed as well as the correlation of death and the role of bereavement. The group then discussed some practical guidelines with regard to the death of a loved one. This was an emotional session for the group members as all of them had already lost someone in their family. The group members took some time sharing and were generally uncomfortable throughout the session. The concept of bereavement seemed foreign to them as if it was a concept that did not form part of their world. With the discussion on practical guidelines, the group members shared more openly.

8.11 SESSION 11: FINANCIAL SECURITY AND PLANNING FOR THE FUTURE

The session was built mainly around a game in which the group members were divided into two 'households'. Each household received a description of their

composition as well as their circumstances. The head of each household received the 'income' for the month as well as some mail which included bills or other letters with financial implications. As a household, each group then had to draw up a budget and plan for the month ahead (Annexure N). Each group had the opportunity to present its budget, and a group discussion followed on the value of money, the need for budgeting and financial management and planning. This game took up a great deal of time since the households found it difficult to decide and plan and to take all aspects into account. The game fulfilled its purpose as eye-opener since the group members experienced the difficulties regarding financial planning and a tight income first hand. They found the exercise difficult since they had to think of aspects of the household they normally do not know much of.

The group members expressed that they find it impossible to budget realistically although they received a realistic income (R1 500-00 for a household of 4 for a month). They expressed that they did not know how their caregivers make ends meet, since there are so many expenditures to take into account. They found the information on grants and alternative financial resources helpful, as they did not know the details of the wide variety of grants that can be applied for or how to access it.

8.12 SESSION 12: CONCLUSION AND EVALUATION

The session started with each group member sharing his/her highlight of the programme. A group discussion followed on what they would have changed in the programme should they be given the opportunity to do so. They completed the questionnaire (Annexure M). The post-group questionnaires: CFI-HIGH (Annexure B) and GCS (Annexure C) were completed. It was previously decided that the conclusion of the programme, in the form of a celebration, should be held the following week seeing that the questionnaires took up a lot of time.

Final arrangements regarding the following week's celebration were discussed. The evaluation questionnaire: *Qualitative and quantitative measuring instrument – after programme* was also to be completed the following week. The different games and activities were highlighted as the group members found it more appealing than the group discussions. The outcomes of the questionnaires were discussed earlier in this article. The group members seemed excited about the following week's celebration. During this celebration they would each receive a certificate for their participation in the group work programme (Annexure N) and would join in a party with sweets and treats accompanied by their choice of music.

9. FUTURE OF THE PROGRAMME

One of the aims of this research is to disseminate the programme to possible users. The research report (in the form of different articles) was sent to different professional journals for publication. These journals include *Social Work/Maatskaplike Werk* as well as the international journals, namely *International Social Work* and *Practice Social Work in Action*. The *Hope Again Foundation* in Potchefstroom, who supported and assisted the researcher and the group work programme during this research, are planning to utilise the programme as part of their service delivery in the communities of Extension 7 and Sonderwater in Ikageng, Potchefstroom, and have already applied for funding for the project for the next three years. If 10 adolescents are included in every programme, a total of 120 adolescents could be reached and 120 households could be empowered by 2011.

The co-presenter was trained during this programme and will be trained and supported for the future presentation of this programme. The estimated costs to present the programme are:

FIGURE 9: Costs of the programme

	Costs per session	Total
Venue	R300-00 per session (3 hours) x 12 sessions	R3600-00
Transport	R170-00 per session (private taxi to and from venue) x 12 sessions	R2040-00
Food, snack and drinks	R20-00 per adolescent per session (10 adolescents x 12 sessions)	R2400-00
Programme materials and extras		R500-00
TOTAL		R8540-00

The estimated cost per adolescent for inclusion in the programme is R854-00, which makes external funding essential for future presentation of the programme.

10. CONCLUSION

The purpose of this study was to evaluate and determine the effect of a compiled group work programme on adolescents from households infected with and affected by HIV and AIDS. A mixed methods research approach was followed with both quantitative and qualitative measuring instruments. Adolescents for inclusion in the experimental and comparison groups were selected by means of accidental sampling from a limited population. After sampling, the adolescents were divided into two groups randomly according to gender and age. For this experiment the comparison group prestest-posttest design was utilized and included two groups: experimental group and comparison group. For the aim of evaluation the two groups were quantitatively evaluated by means of the CFI-HIGH of Perspective Training College (Annexure C) and the GCS of Hudson

(Annexure D). Further qualitative and quantitative evaluation of the experimental group was done by means of self-developed questionnaires.

The reliability of the CFI-HIGH was calculated and 20 of the 24 constructs were regarded as reliable. After the pre-testing the grouping of the experimental and comparison groups showed no statistical differences. There were visibly significant differences in more than half of the constructs in the test between the groups before the experimental group was exposed to the programme. After the programme intervention, the experimental group showed visibly to practically significant difference regarding **guilt feelings, lack of self-worth, lack of assertiveness, frustration, helplessness, stigma, body image, school problems, relationship with family, responsibility, satisfaction, mistrust** and **personal boundaries**. Within the comparison group, in all the constructs but one, **relationship with mother,** there was no statistically significant difference. There are no visibly significant differences in any of the constructs in the comparison group after post-testing. In 14 of the 20 reliable constructs, a statistically significant difference in the test between groups was measured. In all of the constructs, excluding **isolation** and **relationship with father**, in the test between groups, there was a practically significant difference after the experimental group had been exposed to the programme.

The experimental group improved in all but two of the constructs, but with no visibly significant difference the comparison (control) group did not improve in any of the constructs. All the tests of the GCS were accepted as reliable. After pre-testing the two groups showed no statistically significant differences. There was a large practically significant difference between the two groups after pre-testing, with the experimental group being the better of the two. After the experimental group had been exposed to the programme, there was a statistically significant difference in the group. There was a large practically significant difference in this group after the programme intervention. In the

comparison group there was a statistically significant difference in the group after post-testing. There was no visibly significant difference in the comparison group after post-testing. There was a statistically significant difference between the experimental and comparison groups after the programme intervention in the test between groups.

A large practically significant difference was reported in the test between groups after programme intervention. The *experimental group* improved regarding their generalized contentment, but the *comparison group* showed no visibly significant difference, which indicates no improvement. The self-developed questionnaires were regarded as reliable. The average scoring regarding the group members' attitude and knowledge according to their scorings improved with 14.44% from 63.13% to 77.57%. In 8 of the 10 sections of the programme there was improvement regarding the group members' attitude and knowledge according to their scorings summarised in Figure 7. The average individual scoring improved with 20.4% from 57.4% to 77.8%. Six of the seven group members' individual scorings improved between 2% and 47%. According to the self-developed questionnaires, the programme did indeed make an impact and improved the group members' attitude and knowledge regarding the included aspects according to the above-mentioned improvements.

The researcher evaluated the sessions of the programme qualitatively, which should serve as basis for adjustments to the programme for future utilisation. The aims of the group work sessions of the programme were met in general, but the nature of some of the activities was adjusted according to the levels of understanding and knowledge of the group members as well as to time available, since some programme activities took up more time than planned. As this programme was developed and tested to become a tool in service delivery to adolescents, the dissemination of the programme forms an important part of the research project. Further possibilities of utilisation of the programme by the

Hope Again Foundation indicate that it is considered a useful and complete empowering instrument.

11. RECOMMENDATIONS

Based on the discussion of the results from this study and the conclusion drawn, the following recommendations can be made:

- This empowerment programme should be evaluated with larger and more groups, like the Solomon-four group design, so that the quantitative results of this research can be confirmed or refuted.
- Respondents find it difficult to answer the CFI-HIGH in English (for most respondents their second or third language) and it was completed as a group with a translator translating every statement from English to Tswana. The CFI-HIGH can be more user-friendly and accessible if the questionnaire and answering sheets are translated in more languages such as Tswana, isiXhosa and isiZulu.
- The understanding, perception and knowledge base of an adolescent of 12 years and those of one of 18 years differ considerably, based on their levels of development and life experience. Much time was spent explaining concepts to the younger members of the group and the older adolescents felt obliged to take care and help them with various activities during the programme. It is recommended for future presentation of the programme that the age distribution of the adolescents should be closer, say 15 – 19 years.
- This programme was presented doing two sessions on one day, due to time limitations in the research process. It is definitely recommended that only one session be presented per day (preferably once a week) due to the extent of the sessions and the intensity of some of the activities. Time available for the session should not be less than two hours per

session and adequate time should be included for a meal or snack and breaks.

- The empowerment programme can be extended to include a session or part of a session on the troubling or coping behaviour of adolescents from mentioned households, which can include alcohol and drug abuse and teenage sexual activity and pregnancies.
- In the session on the orientation to and implications of HIV and AIDS, a discussion on sharing your or your household's status as well as how to move on with life with regard to your or your household's status could be included.
- This empowerment programme can be adjusted for young adults based on their unique needs as many of them form part of households with circumstances similar to those of the respondents in this research.
- Household circumstances of the respondents included in this programme vary from having an HIV-infected parent/caregiver or having an ill parent/caregiver to dealing with the death of a parent/caregiver due to AIDS. This programme can be adjusted and extended for adolescents who have already lost a parent/caregiver to AIDS, since their needs can be more complex because they already are in the situation.

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SECTION C:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

❖ INTRODUCTION

This research project was executed in two phases. The first phase focused on the needs assessment as discussed in articles 1 and 2. The second phase centred on the development and evaluation of the group work programme as discussed in articles 3 and 4. The research report includes the following:

SECTION A: **GENERAL INTRODUCTION**

SECTION B: **ARTICLE 1 – A profile of adolescents' households infected with or affected by HIV and AIDS**

ARTICLE 2 – The needs of adolescents in households infected with or affected by HIV and AIDS

ARTICLE 3 – An HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers

ARTICLE 4 - The evaluation of an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/ caregivers

SECTION C: **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

2. SUMMARY AND CONCLUSIONS

The most important findings and conclusions of this research are summarized based on the research methodology and the articles of Section B of this research report.

2.1 RESEARCH METHODOLOGY

The main purpose of this study was to design and evaluate an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregiver. These goals were reached by studying literature and by means of an empirical study.

2.1.1 Literature study

For this research it was necessary to analyse comprehensive literature and available research results (Fouche & Delport, 2005:84). These included sources (books, journals, research reports etc.) regarding the adolescent, HIV and AIDS, the death of persons due to AIDS as well as other related topics. This literature study led to the demarcation of this research, the development of an assessment schedule, the comparison of empirical data with literature and the development of an empowering HIV and AIDS group work programme for adolescents.

2.1.2 Empirical research

- **Research model**

  The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos, 2005c: 394 – 407). These phases are: Phase 1 – Problem analysis and project planning, Phase 2 – Information gathering and synthesis, Phase 3 –

Design, Phase 4 – Early development and pilot testing, Phase 5 – Evaluation and advanced development, Phase 6 – Dissemination.

❖ **Design**

Mixed methods research is an approach to inquiry that combines or associates and involves the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Creswell, 2009:4). The concurrent embedded strategy was used in this study. Creswell (2009: 214) explains that the concurrent embedded strategy of mixed methods is identified by its use of one data collection phase during which qualitative and quantitative data are collected simultaneously. This approach has a primary method that guides the project and a secondary database that provides a supporting role in the procedures. According to Creswell (2009:214), the secondary method (qualitative or quantitative) is embedded, or nested, within the predominant method (qualitative or quantitative). In this research it cannot really be said that one method was more important than the other. However, the fact remains that the two methods were integratedly embedded throughout the study.

❖ **Participants**

During this study a total of 169 households who are infected with or affected by HIV and AIDS (which adolescents form part of) were interviewed. In the Eastern Cape Province 119 households were selected and interviewed in the Tokyo Sexwale and Pellsrus communities in Jeffreysbay and 50 households from Ikageng and Promosa communities in Potchefstroom (Tlokwe) in the North-West Province were interviewed. Twenty four (24) adolescents were recruited for participation in the group work programme, but only 16 adolescents were included in the experiment as comparison and experimental group.

❖ **Sampling procedure**

In this study accidental sampling was used which takes place when any case happens to cross the researcher's path and has anything to do with the phenomenon and is therefore included in the sample until the desired number is obtained (Strydom, 2005**b**: 202). For the group work programme the comparison group pretest-posttest design was utilized (Grinnell, 2001:253). Twenty four (24) adolescents were recruited. Of these 24 adolescents, only 16 were able and willing to take part in the programme and were divided into two groups of eight members each. One group was exposed to the programme (experimental group) but not the other group (comparison group). However, they (comparison group) were later given the opportunity to follow the programme after the post-testing had been completed. Both the experimental group and the comparison group were pre-tested as well as post-tested to measure the possible impact and effectiveness of the intervention programme (Rubin & Babbie, 2005:324).

❖ **Data collection**

The questionnaire as survey data procedure was used to collect data and the main objective of the questionnaire was to obtain facts and opinions regarding a phenomenon from people who are informed about (or have knowledge of) the particular issue (Delport, 2005:166). Data collection took place by means of a structured research questionnaire, *The needs of adolescents in households infected with or affected by HIV/AIDS* (Annexure B) which was drawn up by the researcher and completed by fieldworkers who interviewed the participants according to the content of it. For the evaluation of the programme both qualitative and quantitative data were collected by means of two self-developed questionnaires as survey data procedure: Qualitative and Quantitative Measuring Instrument – Before Programme (Annexure E) and Qualitative and Quantitative

Measuring Instrument – After Programme (Annexure M) as well as two standardized scales: Child Functioning Inventory High School (CFI-HIGH) developed by Perspective Training College (Annexure C) and the Generalized Contentment Scale (GCS) of Hudson (Bloom, Fischer & Orme, 1999:220) (Annexure D). .

❖ **Measuring instruments**

Different measuring instruments (Delport, 2005:160) were utilized in the process of the evaluation of the group work programme. These include the *Child Functioning Inventory High School (CFI-HIGH)* of Perspective Training College (Annexure C), the *General Contentment Scale* of Hudson (Bloom et al., 1999:220) (Annexure D) as well as two self-constructed questionnaires: *Qualitative and quantitative measuring instrument - before programme* (Annexure E) and *Qualitative and quantitative measuring instrument – after programme* (Annexure M).

❖ **Data analysis**

Data in this study was statistically computed with SAS (SAS Institute Inc, 2003). The results were interpreted, inferences pertinent to the research relations studied were made and conclusions drawn. In research, the practical significance of results is not only important when results of the population data are reported but also for commenting on the practical significance of a statistically significant result (Ellis & Steyn, 2003:51-53). The qualitative data that were collected during this study was analysed by hand according to themes and Tesch's approach to qualitative data processing was followed (Poggenpoel, 1998:343 – 344).

2.2 A PROFILE OF ADOLESCENTS' HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS

The objective for this part of the study was to explore the circumstances and compile a profile of adolescents' households where their parents/caregivers are infected with or affected by HIV and AIDS. A comprehensive needs assessment (research questionnaire) of which the findings were discussed, focused on the following: the demographic information on the adolescent's household, health and well-being of the household, school attendance of children (including adolescents) of the household, child-headed households and the needs of adolescents. A total of 169 households from Tokyo Sexwale and Pellsrus communities in Jeffreysbay, Eastern Cape Province, and Ikageng and Promosa communities in Potchefstroom (Tlokwe), North-West Province, participated in this study.

The study indicated that most households mostly consist of family members, and adolescents formed part of all these households. It was expected that more child-headed households would have formed part of this research, but literature confirmed why these households are hidden by the community and difficult or almost impossible to reach in research. The households are characterized by terminal illnesses and deaths. In this date and time of the AIDS pandemic, many respondents still indicated that no one in their family or household had ever been tested for HIV infection.

The results regarding infections and deaths due to AIDS differ largely between those of the Eastern Cape and those of the North West Province. The possibility could exist that the population from the Eastern Cape were more open regarding these matters since higher rates have been reported. Financial difficulty is a reality within most of the households, given their total monthly income. This relates to economic difficulties as being the strongest reason for children not

attending school. In most of the families that responded in this research, only one of the two parents is still alive. Less than half of the children were informed regarding the anticipated death of their parent. In cases where the adolescent was informed about the cause of death, there was an unexpected openness regarding AIDS as cause of death of their parents. A serious lack of bereavement counselling was discovered and support after the death of a parent was minimal. From the data collected in this research it became clear that adolescents in households infected with or affected by HIV and AIDS encounter various related problems and needs as well as needs related to adolescence as a life stage. It can thus be seen that, on average, the following can be said regarding a profile of adolescents' households infected with or affected by HIV and AIDS:

- Most households consist of non-family as well as family members.
- Over 40% of households do not have a male adult as part of their household.
- In more than a third of households the mother is the main caregiver.
- A terminally ill mother forms part of almost 10% of the households.
- A third of the households indicated that they had not yet been tested for HIV infection.
- Almost half of the households that were tested for HIV infection have one or more HIV positive household members, and more women than men tested positive.
- More than 75% of the households already had a death in the family due to AIDS.
- Two thirds of the households' heads are employed.
- Almost two thirds of the households do receive grants from the Government of which 66% are Child Support Grants.
- More than half of the households receive less than R1 000-00 income per month per household.

- Almost 25% of households have one child or more of school-going age not attending school.
- In 90% of households the school attendance is 16 or more days per month.
- The most indicated reasons for not attending school include: could not pay school fees (30%), dropped out (21,67%) and have to take care of ill family member (8,33%).
- More than 80% of children in these households indicated not having both parents still alive and almost 20% had already lost both parents.
- In most instances the children were informed about the death of their parent by a family member.
- More than 75% of these children were informed on the cause of death of their parent and in almost 70% the cause of death was AIDS.
- Not even 20% of these children had received bereavement counselling after the death of their parent and in two thirds of these cases the counselling was done by a pastor/minister of a neighbour.

2.3 THE NEEDS OF ADOLESCENTS IN HOUSEHOLDS INFECTED WITH OR AFFECTED BY HIV AND AIDS

The objective of this part of the study was to identify, explore and discuss the needs of adolescents in households infected with and affected by HIV and AIDS. Adolescents from AIDS-affected households have various needs, according to various sources. These needs can be divided into physical needs, emotional needs, developmental and educational needs and spiritual care. The physical needs of adolescents include physical care, health and nutrition, economic implications and maintenance of the family, protection, alternative care and functioning as a family and a household. When the parent(s) or caregiver(s) of adolescents are infected with or affected by HIV and AIDS, it will also affect these adolescents. Should it happen that these parents or caregivers become

infected with HIV or fall ill with AIDS the needs of adolescents will be directly, and occasionally dramatically, affected. AIDS-affected households tend to be poorer, consuming less food and receiving smaller disposable incomes; it is hardly surprising that adolescents in these households are usually less well-nourished.

The emotional needs that were identified and discussed were love and support, professional help from social worker, security, help and support regarding discrimination and the psychological and emotional impact. Developmental and educational needs were also discussed and include developmental needs, learning and educational needs, needs regarding life skills and the need to have knowledge of AIDS. The adolescents' needs regarding bereavement counselling and the mourning process are discussed under the section on general spiritual care. From this study it became clear that in any intervention with adolescents, the discussed needs should be kept in mind and should form the platform from which any helping or support programme should be developed. AIDS disrupts social roles, rights and obligations. For the orphaned adolescent there is often a premature entrance to burdens of adulthood, all without the rights and privileges, or the strengths, associated with adult status. Being in a sensitive and unique phase, adolescents should be supported and guided more than ever when they form part of an HIV and AIDS-affected household.

2.4 AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/CAREGIVERS

The objective of this part of the study was to develop an HIV and AIDS group work programme empowering and preparing adolescents to deal with the death of their parents/caretakers. The specific needs of adolescents, including their physical, emotional, developmental, educational and spiritual needs, as obtained

through a needs assessment, formed the foundation when this group work programme was planned and compiled. Various existing guidelines regarding group work with adolescents were studied and taken into consideration in the planning process. The process through which adolescents should be selected to form part of the programme was discussed as well as how the programme would be presented in different groups. The planning and compilation of a group work programme is an intense process and consists of different aspects. A process was followed through which this programme was planned. The different phases of group work, including the pre-group, initial, transition, working, final and post-group phase were taken into account in the planning process.

The process of an empowering programme consists of the following phases: preparation, contact, assessment, contracting, action, evaluation and termination. Programme activities should be carefully considered, since it plays an important role in the presentation of the programme. Different aspects were considered in the actual planning of the group work programme. These aspects include the structure, nature and aims of the group, the preparation of the social worker, the needs to be addressed by the group, relationships between the group members and the facilitator as well as the procedure of the group. The programme was planned and compiled with the needs of adolescents as discussed in article 1 and the empirical data of article 2 in mind. An empowering programme is recommended for adolescents who form part of households that are infected with and affected by HIV and AIDS.

Given a variety of literature and research being taken into account, it is possible that these adolescents can be empowered to deal with the illness and death of their parents or caregivers due to AIDS more effectively in the future. A comprehensive empowerment programme based on the needs of adolescents can help these adolescents and enable them to use different life skills to empower them so that their different needs can be met more comprehensively

and that they can therefore lead a quality life within their given circumstances. With their basic needs being addressed or met, these adolescents should be more empowered to be able to cope with the reality of sickness and death caused by AIDS in their families and households.

2.5 THE EVALUATION OF AN HIV AND AIDS GROUP WORK PROGRAMME EMPOWERING ADOLESCENTS TO DEAL WITH THE POSSIBLE DEATH OF THEIR PARENTS/CAREGIVERS

The aim of this article was to determine the effect of a compiled group work programme on adolescents from households infected with or affected by HIV and AIDS. A mixed methods research approach was followed using both quantitative and qualitative measuring instruments. Adolescents for inclusion in the experimental and comparison groups were selected by means of accidental sampling from a limited population. After sampling, the adolescents were divided randomly into two groups according to gender and age. For this experiment the comparison group prestest-posttest design was utilized and included two groups: experimental group and comparison group. With evaluation in mind, the two groups were quantitatively evaluated by means of the CFI-HIGH of Perspective Training College (Annexure C) and the GCS of Hudson (Annexure D). Further qualitative and quantitative evaluation of the experimental group was done by means of self-developed questionnaires.

The reliability of the CFI-HIGH was calculated and 20 of the 24 constructs were regarded as reliable. After the pre-testing the grouping of the experimental and comparison groups showed no statistical differences. There were visibly significant differences in more than half of the constructs in the test between the groups before the experimental group was exposed to the programme. After programme intervention, the experimental group showed visibly to practically significant difference regarding **guilt feelings, lack of self-worth, lack of**

assertiveness, frustration, helplessness, stigma, body image, school problems, relationship with family, responsibility, satisfaction, mistrust and **personal boundaries**. Within the comparison group, in all the constructs but one, **relationship with mother,** there was no statistically significant difference. There were no visibly significant differences in any of the constructs in the comparison group after post-testing. In 14 of the 20 reliable constructs, a statistically significant difference in the test between groups was measured. In all the constructs, excluding **isolation** and **relationship with father**, in the test between groups there was a practically significant difference after the experimental group had been exposed to the programme. The experimental group improved in all but two of the constructs, but with no visibly significant difference. The comparison group did not improve in any of the constructs.

All the tests of the GCS were accepted as reliable. After pre-testing, the two groups showed no statistically significant differences. There was a large practically significant difference between the two groups after pre-testing, with the experimental group being the better one of the two. After the experimental group had been exposed to the programme, there was a statistically significant difference in the group. There was a large practically significant difference in this group after the intervention of the programme. In the experimental group, there was a statistically significant difference in the group after post-testing. There was no visibly significant difference in the comparison group after post-testing. There was a statistically significant difference between the experimental and comparison groups after the intervention of the programme in the test between groups. A large practically significant difference was reported in the test between groups after programme intervention. The *experimental group* improved regarding their generalized contentment, but the *comparison group* showed no visibly significant difference, which indicates no improvement.

The self-developed questionnaires were regarded as reliable. The average score regarding the group members' attitude and knowledge, according to their scorings, improved with 14.44%, namely from 63.13% to 77.57%. In 8 of the 10 sections of the programme there was improvement regarding the group members' attitude and knowledge according to their scorings summarised in Figure 7. The average individual scoring improved with 20.4% from 57.4% to 77.8%. Six of the seven group members' individual scorings improved between 2% and 47%. According to the self-developed questionnaires, the programme did indeed make an impact on and improved the group members' attitude and knowledge regarding the included aspects in accordance with the above-mentioned improvements.

The researcher evaluated the sessions of the programme qualitatively, and this should serve as basis for adjustments to the programme for future utilisation. In general the aims of the group work sessions of the programme were met but the nature of some of the activities was adjusted according to the levels of understanding and knowledge of the group members and to time available since some programme activities took up more time than planned. As this programme was developed and tested to become a tool in service delivery to adolescents, the dissemination of the programme is an important part in the research project. Further possibilities of utilisation of the programme by the Hope Again Foundation indicate that it is considered a useful and complete empowering instrument.

3. TESTING THE CENTRAL THEORETICAL ARGUMENT

This research was based on the following theoretical argument:

Adolescents in households infected with or affected by HIV and AIDS can be empowered to deal with the possible death of their parents or

caregivers due to AIDS by participating in a programme being presented to them.

Based on the findings and conclusions of this research, as discussed previously, the central theoretical argument was proven based on a qualitative and quantitative research study.

4. AIM AND OBJECTIVES OF THE STUDY

4.1 GENERAL AIM

The general aim of this study was to develop and empirically evaluate an HIV and AIDS group work programme empowering adolescents to deal with the possible death of their parents/caregivers.

4.2 OBJECTIVES

The above-mentioned aim was reached by achieving the following objectives:

4.2.1 To explore and compile a profile of adolescents' households whose parents/caregivers are infected with or affected by HIV and AIDS.

- **This objective was reached in Article 1 by doing a needs assessment on adolescents' households and compiling a profile of them.**

4.2.2 To explore and identify the needs of adolescents in households infected with and affected by HIV and AIDS.

- **This objective was reached in Article 2 through a needs assessment and a literature study.**

4.2.3 To develop an HIV and AIDS group work programme which empowers adolescents to deal with the possible death of their parents/caretakers.

- **This objective was reached in Article 3 through the development and compilation of an empowering group work programme.**

4.2.4 To empirically evaluate the effectiveness of the developed programme.

- **This objective was reached in Article 4 by implementing and evaluating the designed group work programme.**

4.2.5 To disseminate the program.

- **This objective was reached in Article 4 by submitting the articles for publication and by networking with the Hope Again Foundation for future utilization of the programme.**

5. RECOMMENDATIONS

Based on the findings and conclusions, the following recommendations are made:

- This research can be extended and can be used as platform for the development of various interventions with adolescents in households infected with or affected by HIV and AIDS.
- Before any intervention or programme is planned for adolescents in these circumstances, an assessment should be done within the given community so as to determine and verify that population's unique demographics.
- The circumstances in which adolescents have to grow into adulthood are difficult and they as a group should be a target population regarding help and support.

- The results with regard to the needs of adolescents should be utilised in further research regarding programme development in the field of HIV and AIDS.
- A programme should be developed in response to the unique profile of adolescents in households infected with or affected by HIV and AIDS.
- Life skills such as effective communication, assertiveness and conflict management can be used as elements for an empowerment programme to help adolescents to be in a better position where their needs can be met.
- Programme development must be compiled in response to adolescents' needs via their active participation in the entire process.
- This empowerment programme should be evaluated with larger and more groups, like the Solomon-four group design, so that the quantitative results of this research can be confirmed or refuted with more participants in the programme.
- Respondents find it difficult to answer the CFI-HIGH in English (for most respondents their second or third language) and it was completed as a group with a translator translating every statement from English to Tswana. The CFI-HIGH can be more user friendly and accessible if the questionnaire and answering sheets are translated in more languages such as Tswana, isiXhosa and isiZulu.
- The understanding, perception and knowledge base of an adolescent of 12 years and those of one of 18 years differ considerably, based on their levels of development and life experience. Much time was spent explaining concepts to the younger members of the group and the older adolescents felt obliged to take care of and help them with various activities during the programme. It is recommended for future presentation of the programme that the age distribution of the adolescents be closer, say 15–19 years.

- This programme was presented doing two sessions per occasion due to time limitations in the research process. It is definitely recommended that only one session be presented per occasion (preferably once a week) due to the extent of the sessions and the intensity of some of the activities. Time available for the session should not be less than two hours per session and adequate time should be included for a meal or snack and breaks.
- The empowerment programme can be extended to include a session or part of a session on the troubling or coping behaviour of adolescents from mentioned households which can include alcohol and drug abuse, and teenage sexual activity and pregnancies.
- In the session on the orientation to and implications of HIV and AIDS, a discussion on sharing your or your household's status as well as how to move on with life with regard to your or your household's status could be included.
- This empowerment programme can be adjusted for young adults based on their unique needs as many of them form part of households of whom the circumstances are similar to those of respondents in this research.
- Household circumstances of the respondents included in this programme vary from having an HIV-infected parent/caregiver or having an ill parent/caregiver to dealing with the death of a parent/caregiver due to AIDS. This programme can be adjusted and extended for adolescents who have already lost a parent/caregiver to AIDS, since their needs can be more complex because they already are in the situation.

6. CONCLUSION

Through exploring the circumstances of adolescents' households that are infected with or affected by HIV and AIDS it became obvious that adolescents have complex and unique circumstances regarding the households they function

in. Through identifying and exploring the needs of adolescents it became evident that creating awareness of adolescents' needs and engendering support for them is an important component of psychosocial interventions for children. With regard to the unique life stage *adolescence* and functioning as part of households infected with or affected by HIV and AIDS, an empowerment programme can be utilized as part of service delivery in the battle against the pandemic. The presentation of an empowering programme can be seen as a constructive and 'non-threatening' way of providing support and help to vulnerable adolescents. This study was successful by empowering adolescents by means of a group work programme. After compiling a profile of the adolescents' households and defining the needs of adolescents in these households, new technology was developed and implemented and qualitatively and quantitatively evaluated as successful in empowering adolescents to deal with the possible death of their parents/caregivers.

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SECTION D:

ANNEXURES

ANNEXURE A

YUNIBESITI YA BOKONE-BOPHIRIMA
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Prof H Strydom
Bussie 184
Noordwes-Universiteit

21 Julie 2006

Geagte prof Strydom

GOEDKEURING VIR EKSPERIMENTERING MET MENSE (KWALITATIEWE NAVORSING)

Hiermee wens ek u in kennis te stel dat u projek "*An HIV/AIDS group work programme preparing adolescents for the death of their parents*" goedgekeur is met nommer 06K21.

Gebruik asseblief die nommer in paragraaf 1 genoem in alle korrespondensie rakende bogenoemde projek en let daarop dat daar van projekleiers verwag word om jaarliks in Junie aan die Etiekkomitee verslag te doen insake etiese aspekte van hulle projekte asook van publikasies wat daaruit voortgespruit het. U sal in Mei 2007 die dokumentasie hieroor ontvang.

Goedkeuring van die Etiekkomitee is vir 'n termyn van hoogstens 5 jaar geldig (volgens Senaatsbesluit van 4 November 1992, art 9.13.2). Vir die voortsetting van projekte na verstryking van hierdie tydperk moet opnuut goedkeuring verkry word.

Die Etiekkomitee wens u alle voorspoed met u werk toe.

Vriendelike groete

A.T. Malan

Prof NT Malan
VOORSITTER

POTCHEFSTROOMKAMPUS
Privaatsak X6001, Potchefstroom, Suid-Afrika, 2520
Tel: (018) 299-1111 • Faks: (018) 299-2799

ANNEXURE B

The needs of adolescents in households infected with or affected by HIV and AIDS.

SECTION 1: DEMOGRAFIC INFORMATION

1.1 Race of family/household

Black	1
Coloured	2
Indian	3
White	4

1.2 Home language

Afrikaans	1
Xhosa	2
English	3
Zulu	4
Tswana	5
Sesotho	6
Tsonga	7

1.3 How many members of the household are...

1.3.1	Baby, pre-school/crèche		
1.3.2	Scholar/student		
1.3.3	School going age, not attending		
1.3.4	Retired		
1.3.5	Disabled, with casual work		
1.3.6	Disabled, without casual work		
1.3.7	Own housework		
1.3.8	Unemployed, seeking work		
1.3.9	Unemployed, not seeking work		
1.3.10	Employed full time		
1.3.11	Employed part time		
1.3.12	Self employed		

1.4 How many members do the household consist of?

1.4.1	Male		
1.4.2	Female		

1.5 How many of the above are family members?

1.5.1	Male		
1.5.2	Female		

1.6 How many members of the household are not family members?

1.6.1	Male		
1.6.2	Female		

1.7 How many members of the household are adults (18 years and older)?

1.7.1	Male		
1.7.2	Female		

1.8 How many members of the household are children (younger than 18)?

1.8.1	Male		
1.8.2	Female		

1.9 How many children in your household belong to the following age groups?

		Male		***Female***	
1.9.1	Under 6 years of age				
1.9.2	6 to 12 years of age				
1.9.3	12 to 18 years of age				

1.10 Who is the main caregiver of this family? (mark only one)

Father & Mother	1
Mother	2
Father	3
Brother/sister	4
Maternal grandparent(s)	5
Paternal grandparent(s)	6
Relatives	7
Friends/neighbours	8
Living alone	9

1.11 Is this a child-headed household?

Yes	1
No	2

1.12 If it is a child-headed household, how old is this person (as mentioned in 1.10)?

SECTION 2: HEALTH & WELLBEING

2.1 Are any members of the household terminally ill?

		Yes	*No*
2.1.1	Mother	1	2
2.1.2	Father	1	2
2.1.3	Caretaker	1	2
2.1.4	Children	1	2

2.2 If answered YES in 2.1.4, how many children?

2.3 Have any household members been tested for HIV infection?

Yes	1
No	2

2.4 Are anyone in your household infected with HIV?

Yes	1
No	2

2.5 How many members of the household are infected with HIV?

2.5.1	Male		
2.5.2	Female		

2.6 Did any of your family pass away during the last year?

Yes	1
No	2

2.7 Did any of your family pass away due to AIDS?

Yes	1
No	2

2.8 If answered YES in 2.7, how many?

2.8.1	Male		
2.8.2	Female		

2.9 Are the head of the household employed?

Yes	1
No	2

2.10 Do the household receive a grant(s) from Government?

Yes	1
No	2

2.11 If answered YES in 2.10, which grant(s)?

		YES	NO
2.11.1	'HIV' Grant	1	2
2.11.2	Disability Grant	1	2
2.11.3	Foster Care Grant	1	2
2.11.4	Child Support Grant	1	2

2.12 What is the average total monthly income of the household?

Less than R200-00	1
R201-00 – R500-00	2
R501-00 – R1000-00	3
R1001-00 – R1500-00	4
R1501-00 – R2000-00	5
More than R2001	6

SECTION 3: SCHOOL ATTENDANCE

3.1 How many children are...

3.1.1	Attending school		
3.1.2	Not attending school		

3.2 How often do the children attend school on average?

Less than 5 days per month	1
6 – 15 days per month	2
16 days per month and more	3

3.3 What are the reasons for not attending school of the children who don't attend school?

		Yes	*No*
3.3.1	Could not pay school fees	1	2
3.3.2	Too ill to attend	1	2
3.3.3	Looking after own child	1	2
3.3.4	Fell pregnant	1	2
3.3.5	Mother died, moved from area	1	2
3.3.6	Application refused, no birth certificate	1	2
3.3.7	Ran away from school	1	2
3.3.8	Dropped out	1	2
3.3.9	Poor performance at school	1	2
3.3.10	Disabled	1	2
3.3.11	Have to take care of ill family member	1	2
3.3.12	Have to take care of younger siblings	1	2

3.4 According to school reports, the children's progress can be described as:

Poor	1
Average	2
Satisfying	3
Good	4
Excellent	5

SECTION 4: CHILD-HEADED HOUSEHOLD

4.1 If you as children are living alone, how many siblings are under your care?

4.2 Are both parents still alive?

Yes	1
No	2

4.3 If not, who has passed away?

Mother	1
Father	2
Both	3

4.4 Were you as children informed that your parent(s) were going to die?

Yes	1
No	2

4.5 Who informed you firstly of the above? (mark only one)

Parent him/herself	1
Other parent	2
Family member	3
Sibling	4

4.6 Were the children informed on the cause of death of their parent(s)?

Yes	1
No	2

4.7 What were the children told was the main cause of death of their parent(s)? (mark only one)

TB	1
Cancer	2
Pneumonia	3
Aids	4
Accident	5

4.8 Did you as children received bereavement counselling after the death of your parent(s)?

Yes	1
No	2

4.9 If answered YES in 4.8, by whom?

		Yes	***No***
4.9.1	Social Worker	1	2
4.9.2	Medical Worker (Doctor, nurse)	1	2
4.9.3	Teacher	1	2
4.9.4	Neighbour	1	2
4.9.5	Pastor/Minister	1	2

4.10 As a child-headed household, from whom do you receive support? :

		Yes	***No***
4.10.1	Church	1	2
4.10.2	Clinic	1	2
4.10.3	Social Worker	1	2
4.10.4	Family members	1	2
4.10.5	Neighbours	1	2

SECTION 5: NEEDS OF ADOLESCENTS

5.1 As adolescent, you experience the following regarding your needs:

		SATISFIED		***NEED HELP***	
		Yes	***No***	***Yes***	***No***
5.1.1	Physical care (food, clothing, housing)	1	2	3	4
5.1.2	Financial needs	1	2	3	4
5.1.3	Protection	1	2	3	4
5.1.4	Alternative care (when parents died)	1	2	3	4
5.1.5	Functioning as part of household	1	2	3	4
5.1.6	Love and support	1	2	3	4
5.1.7	Professional help	1	2	3	4
5.1.8	Security	1	2	3	4
5.1.9	Stigmatisation	1	2	3	4
5.1.10	Emotional support	1	2	3	4
5.1.11	Social needs	1	2	3	4
5.1.12	Bereavement	1	2	3	4
5.1.13	Education, training	1	2	3	4
5.1.14	Life skills	1	2	3	4
5.1.15	School training	1	2	3	4
5.1.16	HIV/AIDS	1	2	3	4

5.2 What do you regard as your 2 major problems experienced by your household?

SECTION 6: **GENERAL**

6.1 If stigmatisation is experienced, explain why you feel that way.

6.2 Do you as a child headed household feel that people from outside the family interfere in your household?

Yes	1
No	2

6.3 Explain your answer in 6.2:

6.4 As the oldest child of the child-headed household, how do you discipline the younger siblings?

6.5 As adolescent, describe your feelings regarding your circumstances:

6.6 As adolescent, describe your biggest problem at present:

6.7 To what extent does the problem you mentioned in 6.6 influence your perspective of the future?

Mrs. K. Olivier
Researcher

ANNEXURE C

Comprehensive Children Assessment
Omvattende Kinderassessering

Child Functioning Inventory - High School (CFI-HIGH)
Kinderfunksioneringsinventaris - Hoërskool (CFI-HOëR)

About your Personal Functioning Profile
Oor u Persoonlike Funksioneringsprofiel

Confidentiality / Vertroulikheid

We want you to know that the personal information you share will remain just that, personal. Your confidentially will be respected.

Ons wil hê jy moet weet dat die persoonlike inligting wat jy met ons deel persoonlik bly. Jou vertroulikheid sal beskerm word.

Purpose / Doel

The CFI is designed to improve the quality of your life by evaluating your present functioning and making recommendations for the future. For the report to be accurate, all questions need to be answered to the best of your ability.

Die CFI is ontwerp om kwaliteit van jou lewe te verhoog deur jou huidige funksionering te evalueer en aanbevelings vir die toekoms te maak. Vir die verslae om akkuraat te wees moet al die vrae na die beste van jou vermoë beantwoord word.

A few Suggestions / 'n Paar Voorstelle

Grade yourself as quickly and as honestly possible. Do not speculate too long before you answer. This is not a test and there are no right or wrong answers. The first answer that comes to mind is usually the correct one.

Gradeer jouself so vinnig en eerlik moontlik. Moenie te lank oor 'n antwoord dink nie. Dit is nie 'n toets nie en daar is geen regte of verkeerde antwoorde nie. Die eerste antwoord wat in jou gedagtes opkom, is normaalweg die korrekte een.

Procedure / Prosedure

A ***Mark the relevant number on the answer sheet, by filling in the oval.***
A Merk die relevante nommer op die antwoordblad, deur die ovaal in te kleur.

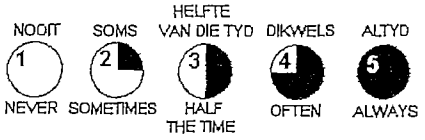
B ***Check to be sure you have answered every question.***
B Maak seker jy het elke vraag geantwoord.

Perspektief Training College, PO Box 20842, Noordbrug 2522
Tel +27 18 297 3716 Fax +27 18 297 4775
E-mail perspektief@lantic.net

Child Functioning Inventory - High School
Kinderfunksioneringsinventaris - Hoërskool

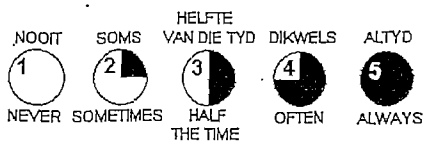
Questionnaire / Vraelys

Met hierdie vrae wil ons jou graag beter leer ken. Beantwoord die vrae so vinnig as wat jy kan. Moenie te lank dink oor 'n vraag nie. Die eerste antwoord wat by jou opkom, is gewoonlik die beste een. Onthou daar is nie regte of verkeerde antwoorde nie. Antwoord elke item deur net die regte sirkel met 'n pen / potlood op die antwoordblad in te kleur.

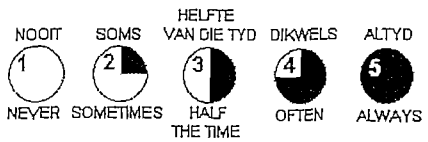


With this questionnaire we would like to get acquainted with you. Grade yourself as quickly and as honestly as possible. Do not speculate too long before you answer. The first answer that comes to mind is usually the correct one. There are no wrong or correct answers. Mark the relevant number on the answer sheet, by using a pencil. Print clearly in the boxes and fill in the corresponding ovals.

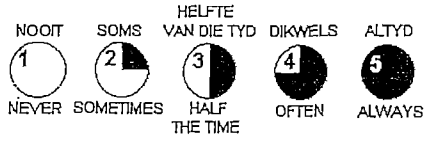
Ek hou aan probeer totdat ek iets regkry.	1.	I keep on trying until I succeed.
Ek doen my huiswerk tot ek klaar is.	2.	I keep on doing my homework until it is done.
Dit is vir my belangrik om my skoolwerk te verstaan.	3.	It is important to me to understand my school work.
Ek maak my skoolwerk klaar al is dit moeilik.	4.	I complete my school work, even if it is difficult.
Dit is vir my belangrik om beter en beter te doen.	5.	It is important to me to do better and better.
Ek werk hard by die skool.	6.	I work hard at school.
Dit is belangrik vir my om my skoolwerk reg te doen	7.	It is important to me to do my school work correctly.
Dit is belangrik vir my om goed te doen.	8.	It is important to me to do well.
Dit is vir my lekker om hard te werk.	9.	I enjoy working hard.
Ek is tevrede.	10.	I am satisfied.
Ek voel vrolik.	11.	I feel cheerful.
Ek voel gelukkig.	12.	I feel happy.
Dit is vir my lekker om te lewe.	13.	I enjoy living.
Ek doen dinge wat vir my lekker is.	14.	I do the things that I enjoy.
Ek hou van my lewe soos dit is.	15.	I like my life the way it is.
Ek wens dat my lewe anders was.	16.	I wish my life was different.
Ek wens dat ek na 'n ander plek kon gaan.	17.	I wish that I could go somewhere else.
Ek dink ek sal gelukkig wees as ek groot is.	18.	I think I will be happy when I am a grown-up.
Ek dink aan wanneer ek groot sal wees.	19.	I think of the time when I will be a grown-up.



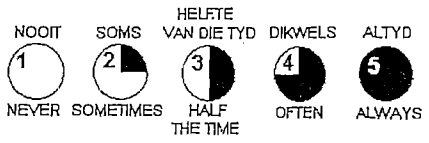
Ek dink dit sal goed gaan met my as ek groot is.	20.	Things will go well for me when I am a grown-up.
Ek dink dit sal lekker wees as ek groot is.	21.	I think it will be fun when I am a grown-up.
Ek wens ek was al groot.	22.	I wish I was a grown-up already.
Ek dink my planne sal uitwerk as ek groot is.	23.	I think my plans will work out when I am a grown-up.
Ek dink dit sal vir my sleg wees wanneer ek groot is.	24.	I think things will be bad when I am a grown-up.
Ek dink dit is beter om eerder 'n grootmens as 'n kind te wees.	25.	I think it is better to be a grown-up, rather than being a child.
Ek is bang ek maak foute.	26.	I am afraid to make mistakes.
Ek voel lus om weg te hardloop van die dinge wat my bang maak.	27.	I feel like running away from the things that scare me.
Goed wat ek nie ken nie laat my bang voel.	28.	Things I don't know, scare me.
Ek kry maagpyn van spanning.	29.	I get stomach pains from stress.
Ek is bang iets gaan verkeerd.	30.	I am afraid that things may go wrong.
Daar is plekke waar ek bang voel.	31.	There are places where I feel scared.
Daar is mense wat my bang maak.	32.	There are people who scare me.
Ek voel bang.	33.	I feel afraid.
Ek voel ek moet raas kry.	34.	I feel I deserve getting shouted at.
Dit is my skuld as dinge verkeerd gaan.	35.	I am to blame when things go wrong.
As daar fout is, is dit my skuld.	36.	When something is wrong, I am to blame.
Ek voel ek doen te veel goed verkeerd.	37.	I feel I do too many things wrongly.
Ek veroorsaak probleme.	38.	I cause problems.
Ek voel ek moet gestraf word.	39.	I feel I should be punished.
Dis vir my moeilik om myself te gedra.	40.	I find it difficult to behave myself.
Ek kom maklik in die moeilikheid.	41.	I easily get into trouble.
Baie goed is my skuld	42.	I am to blame for many things.
Mense hou van my.	43.	People like me.
Ek hou van myself.	44.	I like myself.
Ek is belangrik.	45.	I am important.
Ek is skaam.	46.	I feel shy.
Mense is lief vir my.	47.	People love me.
Ek voel goed oor myself.	48.	I feel good about myself.



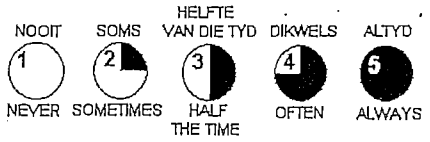
Mense luister na my.	49.	People listen to me.
Ek voel nikswerd.	50.	I feel worthless.
Ek voel minder bang wanneer ek op my eie is.	51.	When I am on my own, I feel less afraid.
Ek hou van mense om my.	52.	I enjoy having people around me.
Ek is bang om vriende te maak.	53.	I am scared to make new friends.
Ek hou daarvan om dinge op my eie te doen.	54.	I like to do things on my own.
Ek is bang vir ander kinders.	55.	I am afraid of other children.
Ek hou daarvan om alleen te wees.	56.	I like to be alone.
Ek vertel maklik vir ander mense hoe ek voel.	57.	I easily tell other people how I feel.
Ek doen dinge alleen.	58.	I do things alone.
Ek moet keer dat ander hartseer word.	59.	I must prevent others from becoming sad.
Ek moet keer dat slegte goed met ander mense gebeur.	60.	I must prevent bad things from happening to other people.
Ek is bekommerd oor ander mense.	61.	I am worried about other people.
Ek moet sorg dat ander mense gelukkig is.	62.	I must make sure that other people are happy.
Ek moet ander mense uit die moeilikheid uit hou.	63.	I must keep other people out of trouble.
Ander se probleme is belangriker as my eie.	64.	Other people's problems are more important than mine.
Ek mag jok om ander mense uit die moeilikheid te hou.	65.	I may tell a lie to keep other people out of trouble.
Ek beskerm ander deur die skuld te vat as iets verkeerd gaan.	66.	I protect others by taking the blame when things go wrong.
Ek sê nee vir goed wat vir my sleg is.	67.	I say no to things that are bad for me.
Ek wys as iets vir my sleg is.	68.	I show it when I dislike something.
Ek sê ja, wanneer ek eintlik nee bedoel.	69.	I say yes when I actually mean to say no.
Ek sal vir iemand sê as ek dink hy/sy is verkeerd.	70.	I will tell someone when I think he/she is wrong.
Ek is bang om te sê wat ek dink.	71.	I am scared to say what I think.
Ek maak asof ek tevrede is.	72.	I pretend to be satisfied.
Ek bly stil, al dink ek ander is verkeerd.	73.	I keep quiet even when I think others are wrong.
Ek doen dinge wat ander wil doen.	74.	I do things that others want to do.
Ek vergeet waar ek goed bêre.	75.	I forget where I put things.
Wanneer ek boodskappe moet oordra, onthou ek presies wat om te sê.	76.	When I have to give a message, I remember exactly what to say.



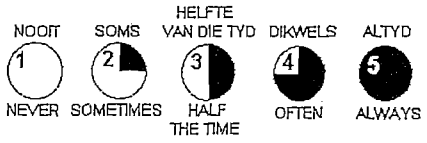
Ek vergeet watter dag dit is.	77.	I forget which day it is.
Ek sukkel om belangrike goed te onthou.	78.	I find it hard to remember important things.
Ek vergeet die dinge wat ek elke dag moet doen.	79.	I forget to do my daily tasks.
Ek vergeet om briewe van die skool af vir my ouers te gee.	80.	I forget to give my parents letters from school.
Ek vergeet belangrike dinge.	81.	I forget important things.
Ek vergeet watter huiswerk ek het.	82.	I forget which homework I have to do.
Ek voel gou kwaad.	83.	I easily feel angry.
Ek is afknouerig teenoor my vriende as hulle my kwaad maak.	84.	I bully my friends when they make me angry.
Ek kry wat ek wil hê deur my vriende bang te maak.	85.	I get what I want by scaring my friends.
Ek sê lelike goed vir my vriende as hulle my kwaad maak.	86.	I say nasty things to my friends when they make me angry.
Ek voel lus om te vloek as my vriende my kwaad maak.	87.	I feel like swearing when my friends make me angry.
Ek voel lus om iets te breek wanneer ek kwaad is.	88.	When I'm angry, I feel like breaking something.
Ek voel lus om te skree wanneer ek kwaad is.	89.	I feel like shouting when I'm angry.
Ek sukkel om dinge reg te doen.	90.	I find it hard to do things right.
Ek het opgehou om te lag.	91.	I have stopped laughing.
Ek huil maklik.	92.	I cry easily.
Ek voel moeg.	93.	I feel tired.
Ek is hartseer.	94.	I feel sad.
Daar is min dinge wat vir my lekker is om te doen.	95.	There are only a few things I enjoy doing.
Ek voel soos 'n mislukking.	96.	I feel like a failure.
Ek voel alleen.	97.	I feel alone.
Grootmense is simpel.	98.	Grown-ups are stupid.
Grootmense maak my kwaad.	99.	Grown-ups make me angry.
Ek haat dit om saam met grootmense te wees.	100.	I hate being with grown-ups.
Ek is bang vir grootmense.	101.	I am afraid of grown-ups.
Grootmense moet my uitlos.	102.	Grown-ups must leave me alone.
Ek hou van grootmense.	103.	I like grown-ups.
Grootmense hou van my.	104.	Grown-ups like me.
Ek hou daarvan om saam met grootmense te wees.	105.	I enjoy being with grown-ups.



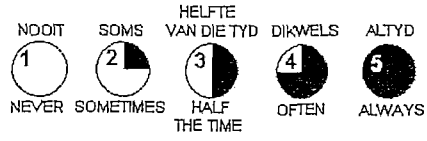
Grootmense irriteer my.	106.	Grown-ups irritate me.
Mense jok vir my.	107.	People lie to me.
Ek is bang ander mense maak my seer.	108.	I am afraid other people will hurt me.
Ek weet ander mense sal my help.	109.	I know other people will help me.
Mense maak asof hulle van my hou.	110.	People pretend to like me.
Ek kan ander mense glo.	111.	I can believe other people.
Mense bedoel wat hulle sê.	112.	People mean what they say.
Ek is versigtig om alleen saam met ander te wees.	113.	I am cautious being alone with others.
Ander mense steek goed vir my weg.	114.	People hide things from me.
Ek hou my geheime vir myself.	115.	I keep my secrets to myself.
Ander mense wil my net seermaak.	116.	Other people only want to hurt me
Ek is anders as ander kinders.	117.	I am different from other children.
Ek wens ek was soos ander kinders.	118.	I wish I was more like other children.
Ander kinders het minder probleme as ek.	119.	Other children have less problems than I do.
Slegte goed gebeur net met my.	120.	Bad things only happen to me.
Dit gaan beter met ander kinders as met my.	121.	Other children are getting on better than I do.
Ander kinders is gelukkiger as ek.	122.	Other children are happier than I am.
My vriende dink dat ek anders is.	123.	My friends think I am different.
My vriende sê lelike goed vir my.	124.	My friends say rude things to me.
Ek hou van my liggaam.	125.	I like my body.
Ek wens ek het anders gelyk.	126.	I wish I looked different.
Ek voel goed oor myself as ek in die spieël kyk.	127.	I feel good about myself when I look in the mirror.
Ek voel lus om my liggaam weg te steek.	128.	I feel like hiding my body.
Ek is skaam vir my liggaam.	129.	I feel ashamed of my body.
My liggaam voel vuil.	130.	My body feels dirty.
Ek dink mense lag vir my liggaam.	131.	I think people laugh at my body.
Ek wens ek kan my liggaam verander.	132.	I wish I could change my body.
Ek gril vir my eie liggaam.	133.	*My body gives me the horrors.*
Ek kyk in ander kinders se tasse.	134.	I look into other children's bags.
Ek kyk in die onderwysers se laaie.	135.	I look into my teachers' drawers.
Ek klop voor ek in 'n kamer ingaan.	136.	I knock before I enter a room.



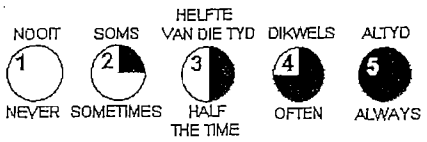
Ek hou daarvan om teenaan mense te staan.	137.	I like standing close to people.
Ek soek na goed wat ander mense wegsteek.	138.	I search for things other people hide.
Ek loer in ander mense se goed.	139.	I peep at other people's belongings.
Ek soek maklik in ander mense se goed rond.	140.	I easily snoop around other people's stuff.
Voltooi 141 - 147 met betrekking tot alkoholgebruik. Indien jy geen alkohol gebruik nie, los dit uit en begin weer by nommer 148 invul. ***Complete 141 - 147 with regard to the use of alcohol. If you do not use any alcohol at all, leave this blank and start at number 148.***		
Ek drink wanneer ek saam met my vriende is.	141.	I drink when I am with my friends.
Ek en my vriende drink in die geheim.	142.	My friends and I drink in secrecy.
Dit is OK om te drink.	143.	It's OK to drink.
Ek drink so baie dat ek opgooi.	144.	I drink so much that I vomit.
Ek drink om gewild te wees by my vriende.	145.	I drink to be popular.
Ek kom in die moeilikheid omdat ek drink.	146.	I get into trouble because of my drinking.
Dit is lekker om te drink.	147.	It is fun to drink.
Voltooi 148 - 154 met betrekking tot dwelmgebruik (dagga, gom, hoesstroop, ens.). Indien jy geen dwelms gebruik nie, los dit uit en begin weer by nommer 155 invul. ***Complete 148 - 154 with regard to the use of drugs (dagga, glue, cough medicine, etc). If you do not use any drugs at all, leave this blank and start at number 155.***		
Ek gebruik dwelms wanneer ek saam met my vriende is.	148.	I use drugs when I am with my friends.
Ek en my friende gebruik dwelms in die geheim.	149.	My friends and I use drugs in secrecy.
Dit is OK om dwelms te gebruik.	150.	It is OK to use drugs.
Ek moet dwelms gebruik.	151.	I must use drugs.
Ek gebruik dwelms om gewild te wees by my vriende.	152.	I use drugs to be popular.
Ek kom in die moeilikheid omdat ek dwelms gebruik.	153.	I get into trouble because I use drugs.
Dit is lekker om dwelms te gebruik.	154.	It is fun to use drugs.
Ek hou van skool.	155.	I like school.
Dit is vir my lekker by die skool.	156.	I enjoy being at school.
Ek haat skool.	157.	I hate school.
Ek is verveeld by die skool.	158.	I am bored at school.
Skool is vir my sleg.	159.	School is unpleasant to me.
Ek hou van my onderwysers.	160.	I like my teachers.



Ek kom maklik in die moeilikheid by die skool.	161.	I easily get into trouble at school.
Ek hou van my vriende.	162.	I like my friends.
Ek en my vriende doen dinge saam.	163.	My friends and I do things together.
Ek wens ek het ander vriende gehad.	164.	I wish I had other friends.
Ek kan eerlik wees met my vriende.	165.	I can be honest with my friends.
Ek haat my vriende.	166.	I hate my friends.
My vriende deel hul geheime met my.	167.	My friends share their secrets with me.
Ek en my vriende het 'n lekker tyd saam.	168.	My friends and I have fun together.
Ek deel my geheime met my vriende.	169.	I share my secrets with my friends.
Ek deel my geheime met my ma.	170.	I share my secrets with my mother.
Ek en my ma doen dinge saam.	171.	My mother and I do things together.
Ek bring tyd saam met my ma deur.	172.	I spend time with my mother.
Ek en my ma het 'n lekker tyd saam.	173.	My mother and I have fun together.
Ek deel my gevoelens met my ma.	174.	I share my feelings with my mother.
Ek voel kwaad as ek aan my ma dink.	175.	I feel angry when I think of my mother.
My ma verstaan my.	176.	My mother understands me.
My ma is kwaad vir my.	177.	My mother is angry with me.
Ek en my pa doen dinge saam.	178.	My father and I do things together.
Ek bring tyd saam met my pa deur.	179.	I spend time with my father.
Ek deel my geheime met my pa.	180.	I share my secrets with my father.
Ek deel my gevoelens met my pa.	181.	I share my feelings with my father.
Ek en my pa het 'n lekker tyd saam.	182.	My father and I have fun together.
Ek voel kwaad as ek aan my pa dink.	183.	I feel angry when I think of my father.
My pa verstaan my.	184.	My father understands me.
My pa is kwaad vir my.	185.	My father is angry with me.
As jy 'n stiefma het, voltooi 186 - 193 soos dit op haar van toepassing is. *Complete 186 - 193 if you have a stepmother.*		
Ek deel my geheime met my stiefma.	186.	I share my secrets with my stepmother.
Ek en my stiefma doen dinge saam.	187.	My stepmother and I do things together.
Ek bring tyd saam met my stiefma deur.	188.	I spend time with my stepmother.
Ek en my stiefma het 'n lekker tyd saam.	189.	My stepmother and I have fun together.



Ek deel my gevoelens met my stiefma.	190.	I share my feelings with my stepmother.
Ek voel kwaad as ek aan my stiefma dink.	191.	I feel angry when I think of my stepmother.
My stiefma verstaan my.	192.	My stepmother understands me.
My stiefma is kwaad vir my.	193.	My stepmother is angry with me.
As jy 'n stiefpa het, voltooi 194 - 201 soos dit op hom van toepassing is. ***Complete 194 - 201 if you have a stepfather.***		
Ek en my stiefpa doen dinge saam.	194.	My stepfather and I do things together.
Ek bring tyd saam met my stiefpa deur.	195.	I spend time with my stepfather.
Ek deel my geheime met my stiefpa.	196.	I share my secrets with my stepfather.
Ek deel my gevoelens met my stiefpa.	197.	I share my feelings with my stepfather.
Ek en my stiefpa het 'n lekker tyd saam.	198.	My stepfather and I have fun together.
Ek voel kwaad as ek aan my stiefpa dink.	199.	I feel angry when I think of my stepfather.
My stiefpa verstaan my.	200.	My stepfather understands me.
My stiefpa is kwaad vir my.	201.	My stepfather is angry with me.
Voltooi 202 - 216 soos dit op die gesin waar jy die meeste bly, van toepassing is. ***Complete 202 - 216 with regard to the family where you stay most of the time.***		
Ek deel my gevoelens met my gesinslede.	202.	I share my feelings with my family members.
My gesin help my wanneer ek in die moeilikheid is.	203.	My family bails me out of trouble.
Ons gesin bring saam tyd deur.	204.	Our family spends time together.
Ek voel alleen by die huis.	205.	I feel alone at home.
Ek kan eerlik wees met my gesinslede.	206.	I can by honest with my family members.
Ek deel my geheime met my gesinslede.	207.	I share my secrets with my family members.
Ek kan vir my gesin vertel wat met my gebeur.	208.	I can share what happens to me with my family.
Ek voel ongelukkig as ek by my gesin is.	209.	I feel sad when I am with my family.
In my gesin word ek toegelaat om vir myself te besluit.	210.	In my family I am allowed to decide for myself.
In my gesin word ek toegelaat om die dinge te doen waarvan ek hou.	211.	In my family I am allowed to do the things I like doing.
My ouers probeer beheer uitoefen oor met wie ek meng.	212.	My parents try to control whom I mix with.
My ouers hou daarvan dat ek my eie besluite neem.	213.	My parents like me to make my own decisions.
My ouers respekteer my privaatheid.	214.	My parent/s respect my privacy.
My gesin gun my soveel vryheid as wat ek wil hê.	215.	I am given as much freedom as I want in my family.

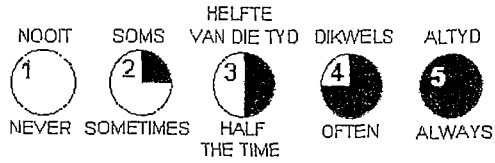


My ouers oorbeskerm my.	216.	My parents are overprotective of me.
Ek neem goeie besluite.	217.	I make good decisions.
Ek is seker van my opinies.	218.	I am sure of my opinions.
Mislukkings veroorsaak dat ek harder probeer.	219.	Failure makes me try harder.
Ek verkies situasies waar ek op iemand anders se vermoëns kan staatmaak.	220.	I prefer situations where I can depend on someone else's ability.
Ek voel my vermoë om moeilike situasies te hanteer is swak.	221.	I feel that my ability to handle difficult situations is poor.
Ek is daartoe in staat om probleme in my lewe te hanteer.	222.	I am capable of dealing with problems that come up in my life.
Ek vermy die aanleer van nuwe dinge wanneer dit vir my te moeilik lyk.	223.	I avoid trying to learn new things when they seem too hard for me.
Ek glo ek kan 'n sukses van my lewe maak.	224.	I believe I can make a success of my life.
Ek voel in beheer van my lewe.	225.	I feel in control of my life.
Wat ek werklik in die lewe wil hê, is buite my bereik.	226.	What I really want in life is beyond my reach.

Child Functioning Inventory - High School (CFI-HIGH)
Kinderfunksioneringsinventaris - Hoërskool (CFI-HOëR)

Naam / Name: ..... Datum / Date: .....

Ouderdom / Age: ..... Geslag / Gender: .....



1.	① ② ③ ④ ⑤	47.	① ② ③ ④ ⑤	92.	① ② ③ ④ ⑤	137.	① ② ③ ④ ⑤	182.	① ② ③ ④ ⑤
2.	① ② ③ ④ ⑤	48.	① ② ③ ④ ⑤	93.	① ② ③ ④ ⑤	138.	① ② ③ ④ ⑤	183.	① ② ③ ④ ⑤
3.	① ② ③ ④ ⑤	49.	① ② ③ ④ ⑤	94.	① ② ③ ④ ⑤	139.	① ② ③ ④ ⑤	184.	① ② ③ ④ ⑤
4.	① ② ③ ④ ⑤	50.	① ② ③ ④ ⑤	95.	① ② ③ ④ ⑤	140.	① ② ③ ④ ⑤	185.	① ② ③ ④ ⑤
5.	① ② ③ ④ ⑤	51.	① ② ③ ④ ⑤	96.	① ② ③ ④ ⑤	~~141.~~	~~① ② ③ ④ ⑤~~	~~186.~~	~~① ② ③ ④ ⑤~~
6.	① ② ③ ④ ⑤	52.	① ② ③ ④ ⑤	97.	① ② ③ ④ ⑤	~~142.~~	~~① ② ③ ④ ⑤~~	~~187.~~	~~① ② ③ ④ ⑤~~
7.	① ② ③ ④ ⑤	53.	① ② ③ ④ ⑤	98.	① ② ③ ④ ⑤	~~143.~~	~~① ② ③ ④ ⑤~~	~~188.~~	~~① ② ③ ④ ⑤~~
8.	① ② ③ ④ ⑤	54.	① ② ③ ④ ⑤	99.	① ② ③ ④ ⑤	~~144.~~	~~① ② ③ ④ ⑤~~	~~189.~~	~~① ② ③ ④ ⑤~~
9.	① ② ③ ④ ⑤	55.	① ② ③ ④ ⑤	100.	① ② ③ ④ ⑤	~~145.~~	~~① ② ③ ④ ⑤~~	~~190.~~	~~① ② ③ ④ ⑤~~
10.	① ② ③ ④ ⑤	56.	① ② ③ ④ ⑤	101.	① ② ③ ④ ⑤	~~146.~~	~~① ② ③ ④ ⑤~~	~~191.~~	~~① ② ③ ④ ⑤~~
11.	① ② ③ ④ ⑤	57.	① ② ③ ④ ⑤	102.	① ② ③ ④ ⑤	~~147.~~	~~① ② ③ ④ ⑤~~	~~192.~~	~~① ② ③ ④ ⑤~~
12.	① ② ③ ④ ⑤	58.	① ② ③ ④ ⑤	103.	① ② ③ ④ ⑤	~~148.~~	~~① ② ③ ④ ⑤~~	~~193.~~	~~① ② ③ ④ ⑤~~
13.	① ② ③ ④ ⑤	59.	① ② ③ ④ ⑤	104.	① ② ③ ④ ⑤	~~149.~~	~~① ② ③ ④ ⑤~~	~~194.~~	~~① ② ③ ④ ⑤~~
14.	① ② ③ ④ ⑤	60.	① ② ③ ④ ⑤	105.	① ② ③ ④ ⑤	~~150.~~	~~① ② ③ ④ ⑤~~	~~195.~~	~~① ② ③ ④ ⑤~~
15.	① ② ③ ④ ⑤	61.	① ② ③ ④ ⑤	106.	① ② ③ ④ ⑤	~~151.~~	~~① ② ③ ④ ⑤~~	~~196.~~	~~① ② ③ ④ ⑤~~
16.	① ② ③ ④ ⑤	62.	① ② ③ ④ ⑤	107.	① ② ③ ④ ⑤	~~152.~~	~~① ② ③ ④ ⑤~~	~~197.~~	~~① ② ③ ④ ⑤~~
17.	① ② ③ ④ ⑤	63.	① ② ③ ④ ⑤	108.	① ② ③ ④ ⑤	~~153.~~	~~① ② ③ ④ ⑤~~	~~198.~~	~~① ② ③ ④ ⑤~~
18.	① ② ③ ④ ⑤	64.	① ② ③ ④ ⑤	109.	① ② ③ ④ ⑤	~~154.~~	~~① ② ③ ④ ⑤~~	~~199.~~	~~① ② ③ ④ ⑤~~
19.	① ② ③ ④ ⑤	65.	① ② ③ ④ ⑤	110.	① ② ③ ④ ⑤	155.	① ② ③ ④ ⑤	~~200.~~	~~① ② ③ ④ ⑤~~
20.	① ② ③ ④ ⑤	66.	① ② ③ ④ ⑤	111.	① ② ③ ④ ⑤	156.	① ② ③ ④ ⑤	~~201.~~	~~① ② ③ ④ ⑤~~
21.	① ② ③ ④ ⑤	67.	① ② ③ ④ ⑤	112.	① ② ③ ④ ⑤	157.	① ② ③ ④ ⑤	202.	① ② ③ ④ ⑤
22.	① ② ③ ④ ⑤	68.	① ② ③ ④ ⑤	113.	① ② ③ ④ ⑤	158.	① ② ③ ④ ⑤	203.	① ② ③ ④ ⑤
23.	① ② ③ ④ ⑤	69.	① ② ③ ④ ⑤	114.	① ② ③ ④ ⑤	159.	① ② ③ ④ ⑤	204.	① ② ③ ④ ⑤
24.	① ② ③ ④ ⑤	70.	① ② ③ ④ ⑤	115.	① ② ③ ④ ⑤	160.	① ② ③ ④ ⑤	205.	① ② ③ ④ ⑤
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26.	① ② ③ ④ ⑤	72.	① ② ③ ④ ⑤	117.	① ② ③ ④ ⑤	162.	① ② ③ ④ ⑤	207.	① ② ③ ④ ⑤
27.	① ② ③ ④ ⑤	73.	① ② ③ ④ ⑤	118.	① ② ③ ④ ⑤	163.	① ② ③ ④ ⑤	208.	① ② ③ ④ ⑤
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30.	① ② ③ ④ ⑤	76.	① ② ③ ④ ⑤	121.	① ② ③ ④ ⑤	166.	① ② ③ ④ ⑤	211.	① ② ③ ④ ⑤
31.	① ② ③ ④ ⑤	77.	① ② ③ ④ ⑤	122.	① ② ③ ④ ⑤	167.	① ② ③ ④ ⑤	212.	① ② ③ ④ ⑤
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33.	① ② ③ ④ ⑤	79.	① ② ③ ④ ⑤	124.	① ② ③ ④ ⑤	169.	① ② ③ ④ ⑤	214.	① ② ③ ④ ⑤
34.	① ② ③ ④ ⑤	80.	① ② ③ ④ ⑤	125.	① ② ③ ④ ⑤	170.	① ② ③ ④ ⑤	215.	① ② ③ ④ ⑤
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36.	① ② ③ ④ ⑤	82.	① ② ③ ④ ⑤	127.	① ② ③ ④ ⑤	172.	① ② ③ ④ ⑤	217.	① ② ③ ④ ⑤
37.	① ② ③ ④ ⑤	83.	① ② ③ ④ ⑤	128.	① ② ③ ④ ⑤	173.	① ② ③ ④ ⑤	218.	① ② ③ ④ ⑤
38.	① ② ③ ④ ⑤	84.	① ② ③ ④ ⑤	129.	① ② ③ ④ ⑤	174.	① ② ③ ④ ⑤	219.	① ② ③ ④ ⑤
39.	① ② ③ ④ ⑤	85.	① ② ③ ④ ⑤	130.	① ② ③ ④ ⑤	175.	① ② ③ ④ ⑤	220.	① ② ③ ④ ⑤
40.	① ② ③ ④ ⑤	86.	① ② ③ ④ ⑤	131.	① ② ③ ④ ⑤	176.	① ② ③ ④ ⑤	221.	① ② ③ ④ ⑤
41.	① ② ③ ④ ⑤	87.	① ② ③ ④ ⑤	132.	① ② ③ ④ ⑤	177.	① ② ③ ④ ⑤	222.	① ② ③ ④ ⑤
42.	① ② ③ ④ ⑤	88.	① ② ③ ④ ⑤	133.	① ② ③ ④ ⑤	178.	① ② ③ ④ ⑤	223.	① ② ③ ④ ⑤
43.	① ② ③ ④ ⑤	89.	① ② ③ ④ ⑤	134.	① ② ③ ④ ⑤	179.	① ② ③ ④ ⑤	224.	① ② ③ ④ ⑤
44.	① ② ③ ④ ⑤	90.	① ② ③ ④ ⑤	135.	① ② ③ ④ ⑤	180.	① ② ③ ④ ⑤	225.	① ② ③ ④ ⑤
45.	① ② ③ ④ ⑤	91.	① ② ③ ④ ⑤	136.	① ② ③ ④ ⑤	181.	① ② ③ ④ ⑤	226.	① ② ③ ④ ⑤
46.	① ② ③ ④ ⑤								

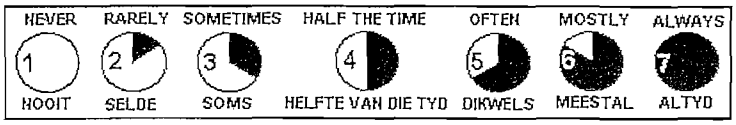
PO Box 20842, Noordbrug, 2522, tel (018) 297 3716, fax (018) 297 4775, e-mail perspektief@lantic.net

ANNEXURE D

Generalized Contentment Scale (GCS)

Naam / Name: ..... Datum / Date: .....

This questionnaire is designed to measure the way you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by using the following scale:



Hierdie vraelys is ontwerp om jou gevoel oor jou lewe en omstandighede te meet. Dit is nie 'n toets nie, dus is daar nie regte of verkeerde antwoorde nie. Beantwoord asseblief elke item so noukeurig en akkuraat moontlik deur die bostaande skaal te gebruik:

I feel powerless to do anything about my life.	1.____	Ek voel magteloos om iets aan my omstandighede te doen.
I feel blue.	2.____	Ek voel bedruk.
I think about ending my life.	3.____	Ek dink daaraan om 'n einde aan my lewe te maak.
I have crying spells.	4.____	Ek kry huilbuie.
It is easy for me to enjoy myself.	5.____	Dit is vir my maklik om myself te geniet.
I have a hard time getting started on things that I need to do.	6.____	Dit is vir my moeilik om 'n begin te maak met die dinge wat ek moet doen.
I get very depressed.	7.____	Ek raak baie depressief.
I feel there is always someone I can depend on when things get tough.	8.____	Ek voel daar is altyd iemand op wie ek kan staatmaak.
I feel that the future looks bright for me.	9.____	Ek voel my toekoms lyk rooskleurig.
I feel downhearted.	10.____	Ek voel terneergedruk.
I feel that I am needed.	11.____	Ek voel ander het my nodig.
I feel that I am appreciated by others.	12.____	Ek voel ander waardeer my.
I enjoy being active and busy.	13.____	Ek geniet dit om aktief en besig te wees.
I feel that others would be better off without me.	14.____	Ek voel andere sal beter af wees sonder my.
I enjoy being with other people.	15.____	Ek geniet dit om by andere te wees.
I feel that it is easy for me to make decisions.	16.____	Ek voel dis vir my maklik om besluite te neem.
I feel downtrodden.	17.____	Ek voel vertrap.
I feel terribly lonely.	18.____	Ek voel vreeslik eensaam.
I get upset easily.	19.____	Ek voel maklik ontsteld.
I feel that nobody really cares about me.	20.____	Ek voel niemand gee meer om vir my nie.
I have a full life.	21.____	Ek het 'n vol lewe.
I feel that people really care about me.	22.____	Ek voel ander gee om vir my.
I have a great deal of fun.	23.____	Ek het baie pret.
I feel great in the morning.	24.____	Ek voel soggens wonderlik.
I feel that my situation is hopeless.	25.____	Ek voel my situasie is hopeloos.

5, 8, 9, 11, 12, 13, 15, 16, 21, 22, 23, 24

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ANNEXURE E

NORTH WEST UNIVERSITY

POTCHEFSTROOM CAMPUS

SCHOOL FOR PSYCHOSOCIAL BEHAVIOURAL SCIENCES

SOCIAL WORK DICVISION

QUALITATIVE AND QUANTITATIVE MEASURING INSTRUMENT – BEFORE PROGRAMME

This questionnaire's main focus is on <u>your expectations</u> regarding the empowering HIV and AIDS group work programme for adolescents. Please try to answer them as honestly as possible.

1. What do you expect to gain from the programme?

_____

_____

2. What do you want to learn from the programme?

_____

_____

3. What topics would you like to be included in an empowering HIV and AIDS programme for adolescents?

_____

_____

4. What are you looking forward to regarding the programme?

_____

_____

5. How do you feel about your future?

_____

_____

6. How do you feel about your household?

_____

_____

7. What do you think is the biggest problem regarding HIV and AIDS?

_____

_____

8. On a scale from **one to ten,** how do you regard your **attitude and knowledge** regarding the following matters?
(1 = very bad, 5 = average, 10 excellent)

8.1. Healthy lifestyle

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.2. Identity and self-esteem

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.3. Roles and relationships

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.4. Effective communication

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.5. Assertiveness and conflict management

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.6. Problem solving, decision making and time management

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.7. Coping with stress and emotions

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.8. Orientation and implications of AIDS

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.9. Spirituality, death as reality and bereavement

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

8.10. Financial security and planning for the future

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

Thank you for your co-operation.

K OLIVIER , PhD STUDENT

ANNEXURE F

SOCIAL WORK. A PROFESSIONAL JOURNAL FOR THE SOCIAL WORKER!
MAA TSKAPLIKE WERK. 'n V AKTYDSKRIF VIR DIE MAATSKAPLIKE WERKER

EDITORIAL POLICY/REDAKSIONELE BELEID

The Journal publishes articles, book reviews and commentary on articles already published from any field of social work. Contributions may be written in English or Afrikaans. All articles should include an abstract in English of not more than 100 words. All contributions will

- be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Articles of fewer than 2,000 words or more than 10,000 words are normally not considered for publication. Two copies of the manuscript as well as a diskette with the text, preferably in MS Windows should be submitted. Manuscripts should be typed in 12 point Times Roman double-spaced on one side of A4 paper only. If possible the manuscript should be sent electronically to hsu@sun.ac.za. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "..." Berger, 1967: 12). More details about sources referred to in the text should appear the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors. Note the use of capitals and punctuation marks in the following examples.

Die Tydskrif publiseer artikels, boekbesprekings en kommentaar op reeds gepubliseerde artikels uit enige gebied van die maatskaplike werk. Bydraes mag in Afrikaans of Engels geskryf word. Alle artikels moet vergesel wees van 'n Engelse opsomming van nie meer as 100 woorde nie. Alle bydraes moet krities deur ten minste twee keurders beoordeel word. Beoordeling is streng vertroulik. Manuskripte sal na outeurs teruggestuur word indien ingrypende hersiening vereis word, of indien die styl nie ooreenstem met die tydskrif se standaard nie. Artikels van minder as 2,000 woorde of meer as 10,000 woorde sal normaalweg nie oorweeg word vir publikasie. 'n Disket met die teks, verkieslik in MS Windows, moet twee kopieë van die manuskrip vergesel. Manuskripte moet in 12 pt "Times Roman" dubbelspasiëring slegs op een kant van 'n A4 bladsy getik word. Indien enigsins moontlik moet die manuskrip ook per e-pos versend word aan hsu@sun.ac.za. Verwysings moet volgens die Harvard-stelsel geskied. Verwysings in die teks: Wanneer woordelikse sitate, feite of argumente uit ander bronne gesiteer word, moet die van(ne) van die outeur(s), jaar van publikasie, en bladsynommers tussen hakies in die teks verskyn, bv. "..." (Berger, 1967:12). Meer besonderhede omtrent bronne moet alfabeties volgens die vanne van die outeurs aan die einde van die manuskrip onder die opskrif "Bibliografie" verskyn. Let op die gebruik van hoofletters en leestekens by die volgende voorbeelde

TWO AUTHORS/TWEE OUTEURS: SHEAFOR, B.W. & JENKINS, L.E. 1982. **Quality field instruction in social work.** Program development and Maintenance. New York: Longman.

COLLECTION/BUN DEL ARTIKELS: MIDDLEMAN, R.R. & RHODES, G.B. (eds) 1985. **Competent supervision, making imaginative judgements**. New Jersey: Prentice-Hall.

ARTICLE IN COLLECTION/ARTIKEL IN BUNDEL: DURKHEIM, E. 1977. On education and society. In: KARARABEL, J. & KALSEY, A.H. (eds) **Power and ideology in education**. New York: Oxford
University Press.

JOURNAL ARTICLE/ARTIKEL IN TYDSKRIF: BERN STEIN, A. 1991. Social work and a new South Africa: Can social workers meet the challenge? **Social Work/Maatskaplike werk**,27(3/4):222-231.

THESISITESIS: EHLERS, D.M.M. 1987. **Die gebruik van statistiese tegnieke vir die ontleding van gegewens in maatskaplikewerk-navorsing**. Pretoria: Universiteit van Pretoria. (M tesis).

MINISTRY FOR WELFARE AND POPULATION DEVELOPMENT 1995. Draft White paper for Social Welfare. **Government Gazette**, Vol. 368. No. 16943 (2 February). Pretoria: Government Printer.

NEWSPAPER REPORT/KOERANTBERIG: MBEKI, T. 1998. Fiddling while the AIDS crisis gets out of control. **Sunday Times**, 8 March, 18.

INTERNET REFERENCESNERWYSINGS: MCKIERNAN, G. 1998. **Beyond bookmarks: schemes for organizing the Web**. Available: http://public.iastate.edu/CYBER-STACKS/CTW.htm. [Accessed: *18/06/1998].*

ANNEXURE G

International Social Work

An official journal of the International Association of Schools of Social Work, International Council on Social Welfare, International Federation of Social Workers

Information for Contributors

International Social Work is a scholarly journal for the extension of knowledge and the promotion of communication in social work, social welfare, social development and human services, through its focus on international themes in service delivery, and the education and functions of social workers, in the context of social policy and social service provision. Emphasis is on cross-national research and comparative analysis, as well as trends and issues in social welfare policy and practice beyond single nations. New developments in the roles and training of social service personnel are reported and the notion of 'international social work' is explored. Occasional thematic issues focus '. on specific international developments.

Manuscript preparation

Submissions must be in English and about 4000 words, typewritten and double spaced throughout including notes and references. An abstract of no more than 50 words describing the article's main findings and conclusions and 5 or 6 key words must be included on a separate page; this will be translated into French, Spanish, Chinese, Arabic and Russian if the article is published. Please send your submission as an electronic file, preferably in Word.

In addition to full articles the journal is interested in brief notes of up to 2000 words on topics such as reports of research in progress, examples of unresolved problems, descriptions of policy, and current programmes that would be of interest to the international community.

Titles and subtitles should be clear and brief. Quotations over 40 words should be displayed. Notes are indicated by numbers in the text and printed at the end of the article. Tables and figures should have short titles; please give sources and indicate their placement in the text. Please supply figures as camera ready artwork.

Omit points in abbreviations such as USA; use the fewest numerals possible in dates and page numbers (e.g. 42-5, 1991-2). Write dates as 22 November 1998; spell out numbers from one to nine, but use numerals for 10 and over, for percentages and for all tables.

Give citations in the text as Schmidt (2004: 33-4), LeBlanc and Virdee (1999, 2005). Use' et al.' for works with more than two authors, but give ,all surnames in the references list. Use 'a', 'b', 'c', etc. for different works by the same author in a single year: Dominelli (2002a). All the cited references should appear in full at the end of the article, using this style:

Articles in journals: Chan, K.L. and CL. Chan (2005) 'Chinese Culture, Social Work Education and Research', *International Social Work* 48(4): 381-9.

Books: Ife, J. *(2002) Human Rights and Social Work: Towards Rights-based Practice.* Cambridge: Cambridge University Press.

Contributions to books: Sewpaul, V. (2004) 'Globalization, African Governance and New Partnerships for Africa's Development', in N-T. Tan and A. Rowlands (eds) *Social Work Around the World,* pp. 62-89. Bern: IFSW Press.

Unpublished works: Comely, S. (1998) 'En la busqueda de caminos para el mafiana', Younghusband Lecture, 36th IASSW Congress, Washington, DC, 20 July.

Author affiliation and address should be submitted with the article, but on a separate page for blind refereeing. Articles will be considered on the understanding that they are not simultaneously submitted for publication elsewhere. Manuscripts and editorial correspondence should be sent to the Editor: Karen Lyons, Honorary Professor of International Social Work, London Metropolitan University, Department of Applied Social Sciences, Ladbroke House, 62-66 Highbury Grove, London N5 2AD, UK. Email: isw@londonmet.ac.uk

Book reviews should be sent to Annie Huntington, Book Review Editor, *International Social Work,* University of Central Lancashire, Preston PR 1 2H E.
Email: AEHuntington@uclan.ac.uk

ANNEXURE H

Instructions to authors

All submissions should be made online at *Practice's* Manuscript Central site at http:// mc.manuscriptcentral.com/cpra. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to referees. When uploading files authors will then be able to define the non-anonymous version as "File not for review" .

Practice is intended, as the name suggests, as a forum for research and ideas related to the practice of social work. We particularly welcome contributions from practitioners. If we feel that an article can be improved, most of our assessors will provide detailed suggestions as to how this might be done.

Material submitted to *Practice* should not knowingly give offence and should demonstrate sensitivity to anti-discriminatory practice. The confidentiality of identifiable individuals should be maintained unless informed consent has been obtained, and a statement confirming this must be included. We encourage the model of emancipatory research which respects the rights and dignity of those participating in it.

Major articles should be 3000-5000 words in length but shorter notes on research in progress, new innovations in practice, or comments on papers previously published in the journal are also welcomed. Although the bulk of the journal's readership is within the UK it also has a substantial international readership and papers from overseas are welcomed. In considering papers for publication the journal's assessors take into account not only the intrinsic merit, but readability and interest to the range of journal readers. Assessors are asked to look for relevance to practice, wider applicability of the material, the appropriateness of language and the ability of the writer to keep the reader's attention. The paper must include a section which explicitly draws out the messages for practitioners and for social work/social care practice.

All submissions will be sent to two assessors for their comments. Manuscripts should be double spaced, with ample margins of at least one inch and the approximate number of words should be stated. The first page should include the title of the paper, name(s) of author(s) and the academic and/or professional qualifications as commonly used by the author, main appointment and address. Please state whether or not you are a previously published author as the journal seeks to encourage and supports new writers. The second page should repeat the title, and contain an abstract of not more than 200 words and three key words. Where English is not the language in which the article is first written, a further summary should be provided in the author's first language. The third page should repeat the title as the heading to the start of the main text of the paper. All pages should be numbered. Proofs for checking will normally be sent to the first author named, to whom any correspondence and reprints will also be addressed. Footnotes to the text should be avoided wherever this is reasonably possible.

Authors should also provide a brief biographical note (not more than 50 words) together with an email address.

Papers will be considered providing that they are not submitted simultaneously elsewhere for publication.

References should follow the Chicago author-date system, i.e. they should be indicated in the typescript by giving the author's name, with the year of publication in parentheses, e.g. Smith (1997), Smith and Jones (1998), Smith, Jones, and Baker (1999); if there are more than three authors, Smith *et at.* (2000). A page number must be given where a direct quotation is made, e.g. (Smith 2001, 277). References to more than one publication from the same year by the same author should be distinguished by a, b, c, etc. All references cited in the text should be listed in full at the end of the paper in the following form:

Carnaby, S. 1997. What do you think? A qualitative approach to evaluating individual planning services. *Journal of Intellectual Disability Research* 41 (3): 225-31.

Community Care Archive. 2001. Carers act must be funded to succeed [accessed 15 February 2001]. Available at www.community-care.co.uk.

Department of Health. 2002. *Planning with people: Towards person centred approaches.* London: The Stationery Office.

Milner, J., and P. O'Byrne. 1998. *Assessment in social work.* Basingstoke: Macmillan.

Reed, J., and D. Stanley. 2001. Discharge from hospital to care home. In *Care services for later life,* edited by A. M. Warnes, L. Warren and M. Nolan. London: Jessica Kingsley.

Titles of journals should. not be abbreviated.

Illustrations should not be inserted in the text but each provided separately and numbered on the back with Figure numbers, title of paper and name. Three copies of all figures must be submitted. All photographs, graphs and diagrams should be referred to as Figures and should be numbered consecutively in the text in Arabic numerals (e. g. Figure 1). A list of captions for the figures should be submitted on a separate sheet and should make interpretation possible without reference to the text.. Captions should include keys to symbols.

Tables should be typed on separate sheets and should be given Arabic numbers (e.g. Table 1). Their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words or numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Proofs will be sent to the author by email if there is sufficient time to do so. Proofs including proofs of illustrations are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within 3 working days of receipt.

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of the issue containing their article. Complimentary reprints are available through Rightslink and additional reprints can be ordered through Rightslink when proofs are received or alternatively on our journals website. If you have any queries, please contact our reprints department at reprints@tandf.co.uk

ANNEXURE I

WORK AGREEMENT

DECLARATION OF PARTICIPATION

I, _____ declare that I voluntary joined the HOPE AGAIN Group Work Programme and I want to participate in it for the duration of the programme.

I understand that this programme is part of a research project and that personal information of me could be published anonymously for research purposes only.

I understand that all information regarding me and other group members will be treated confidentially.

I declare that I will be honest in sharing my experiences and respect other group members in sharing theirs.

I will treat information of other group members with sensitivity and confidentiality.

Signed at _____ on this _____ day of 2009.

_____

Signature

ANNEXURE J

INDEX OF SELF-ESTEEM (ISE)

NAME: _____ **TODAY'S DATE:** _____

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each as accurately as you can by placing a number by each one as follows:

1	Rarely or none of the time
2	A little of the time
3	Some of the time
4	A good part of the time
5	Most of the time

1.	I feel that people would not like me if they really knew me well.	____
2.	I feel that others get along much better than I do.	____
3.	I feel that I am a beautiful person.	____
4.	When I am with other people I feel that they are glad I am with them.	____
5.	I feel that people really like to talk to me.	____
6.	I feel that I am a very competent person.	____
7.	I think I make a good impression on others.	____
8.	I feel that I need more self-confidence.	____
9.	When I am with strangers I am very nervous.	____
10.	I think that I am a dull person.	____
11.	I feel ugly.	____
12.	I feel that others have more fun than I do.	____
13.	I feel I bore people.	____
14.	I think my friends find me interesting.	____
15.	I think I have a good sense of humour.	____
16.	I feel very self-conscious when I am with strangers.	____
17.	I feel that if I could be more like other people I would have made it.	____
18.	I feel that people have a good time when they are with me.	____
19.	I feel like a wallflower when I go out.	____
20.	I feel I get pushed around more than others.	____
21.	I think I am a rather nice person.	____
22.	I feel that people really like me very much.	____
23.	I feel that I am a likeable person.	____
24.	I am afraid I will appear foolish to others.	____
25.	My friends think very highly of me.	____

ANNEXURE K

ASSERTIVENESS EVALUATION

	YES	NO
EYE CONTACT Does the person make eye contact with the person he is talking to?		
USE HANDS Does the person use his hands while talking emphasising certain aspects?		
FACIAL EXPRESSION Is the person's facial expression supporting his verbal communication?		
BODY LANGUAGE Is the person's body language supporting his verbal communication? Is his body language showing that he is really listening?		
VOICE Are you clearly hearing the person speaking?		
FLUENCY OF SPEECH Is the person speaking fluently and clearly?		

ANNEXURE L

EMOTIONS

GLAD

ACCEPT	ABLE	IMPORTANT	ENCOURAGED
THANKFULL	ECSTATIC	ENTHUSIASTIC	INSPIRED
COMFOTABLE	CLEAR	HIGH	HOPEFULL
JOLLY	CALM	COOL	CAREFREE
LIVELY	SPIRITED	LOVED	LIGHT
RELAXED	OVERWELMED	ENLIGHTENED	CARED FOR
CHEERFULL	EXCITED	OPTIMISTIC	SELFASSURED
SUNNY	PLAYFULL	SPECIAL	STRONG
SATISFIED	RESTED	SAFE	DELIGHTED
UNDERSTOOD	PAMPERED	CHEERFULL	FREE
VALUABLE	WARM	WELCOME	

SAD

HORRIBLE	CARELESS	APATHETIC	BURDENED
MOODY	DEPRESSED	DESPERATE	DULL
DARK	TORTURED	STRANGLED	GRIEVED
HELPLESS	PARALYZED	EMPTY	LAZY
RESTLESS	ABUSED	IGNORED	DISCOURAGED
TIRED	AWFULL	DESPONDENT	USELESS
UNIMPORTANT	OPPRESSED	UNLOVED	UPSET
UNWELCOME	DESPERATE	HURT	SENSITIVE
VICTIMIZED	DISAPPOINTED	CLOSED	REJECTED
EXCLUDED	TIRED	FORGOTTEN	LONELY
DEFEATED	BORRED	CONFUSED	DISENTEGRATED

ANGRY

OFFENSIVE	BITTER	RAGE	CROSS
OUT OF CONTROL	USED	FRUSTRATED	IRRITETED
CHEATED	BOTTHERED	VENGEFULL	HYSTERICAL
IRRATIONAL	JEALOUS	SEETHING	MISUSED
SULKY	IMPATIENT	RUDE	REBELLIOUS
STEAMING	CHALLENGED	EVOKED	PUGNACIOUS
BETRAYED	ANNOYED	BLAMEFULL	FURIOUS

AFRAID

HORRORED	DEPENDENT	ALONE	PANICKY
TERRIFIED	OPPRESSED	SHAKY	TENSED
TARGETED	FAINT-HEARTED	UNCOMFORABLE	RESTELESS
UNSURE	SPINELESS	FIDGETY	NERVOUS
SCEPTIC	SUSPISCIOUS	DELIVERED	TRAPPED
BEWILDERED	PARALYZED	CAREFUL	FRIGHTENED
DESPAIRED	PROSECUTED	ENTANGLED	SUSPECTED
HESITATING			

ASHAMED

RIDICULOUS	REMORSEFUL	ACCUSED	LUDICROUS
STUPID	ABSURD	PECULIAR	TEASED
MISTRUSTED	SORRY	CHILDISH	SMALL
CLUMSY	OLD	PATHETIC	CONSCIOUS
SILLY	REGRETFUL	SLOW	OUT OF PLACE
WRONG	BELITTLED	DEGRADED	UNFAMILIAR
WORTHLESS	UNVISIBLE	LIKE A BLACKSHEEP	

ANNEXURE M

NORTH WEST UNIVERSITY

POTCHEFSTROOM CAMPUS

SCHOOL FOR PSYCHOSOCIAL BEHAVIOURAL SCIENCES

SOCIAL WORK DICVISION

QUALITATIVE AND QUANTITATIVE MEASURING INSTRUMENT – AFTER PROGRAMME

This questionnaire's main focus is <u>your evaluation</u> of the empowering HIV and AIDS group work programme for adolescents after you completed the programme. Please try to answer them as honestly as possible.

1. What did you gain from the programme?

   _____

   _____

2. What did you learn from the programme?

   _____

   _____

3. Which topics had the most value for you that were included in the empowering HIV and AIDS programme for adolescents?

   _____

   _____

4. Which topics had the least value for you?

   _____

   _____

5. Which other topics would you have liked to be included in the programme?

_____

_____

6. What did you enjoy most with regards to the programme?

_____

_____

7. If you can change anything about this programme, what would it be?

_____

_____

8. How do you feel about your future?

_____

_____

9. How do you feel about your household?

_____

_____

10. What do you think is the biggest problem regarding HIV and AIDS?

_____

_____

11. Since you have completed the programme, what is different in your life?

_____

_____

12. On a scale from **one to ten**, how do you regard your **attitude and knowledge** regarding the following matters after you have completed the programme?

(1 = very bad, 5 = average, 10 excellent)

12.1. Healthy lifestyle

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.2. Identity and self-esteem

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.3. Roles and relationships

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.4. Effective communication

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.5. Assertiveness and conflict management

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.6. Problem solving, decision making and time management

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.7. Coping with stress and emotions

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.8. Orientation and implications of AIDS

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.9. Spirituality, death as reality and bereavement

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

12.10. Financial security and planning for the future

1	2	3	4	5	6	7	8	9	10

Motivate:

_____

_____

13. Since you completed the programme, what is different in terms of .....

13.1. your attitude /knowledge regarding a healthy lifestyle?

_____

_____

13.2. your attitude /knowledge regarding your identity and self-esteem?

_____

_____

13.3. your attitude /knowledge regarding roles and relationships?

_____

_____

13.4. your attitude /knowledge regarding effective communication?

_____

_____

13.5. your attitude /knowledge regarding assertiveness and conflict management?

_____

_____

13.6. your attitude /knowledge regarding problem solving, decision making and time management?

_____

_____

13.7. your attitude /knowledge regarding coping with stress and emotions?

_____

_____

13.8. your attitude /knowledge regarding orientation and implications of AIDS?

_____

_____

13.9. your attitude /knowledge regarding spirituality, death as reality and bereavement?

_____

_____

13.10. your attitude /knowledge financial security and planning for the future?

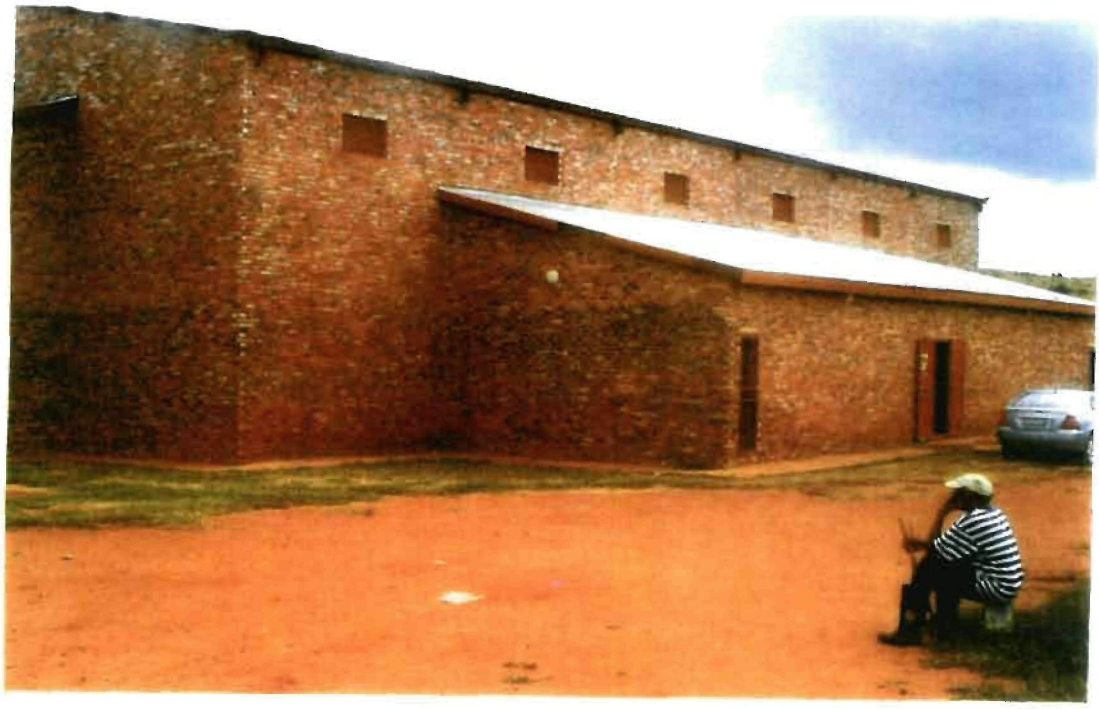
_____

_____

Thank you for your co-operation.

K OLIVIER , PhD STUDENT

ANNEXURE N



Picture 1: Venue – OR Tambo Hall, Extension 7, Ikageng, Potchefstroom

Picture 2: Programme Presenter – Korita Olivier & Co-presenter – George Themba

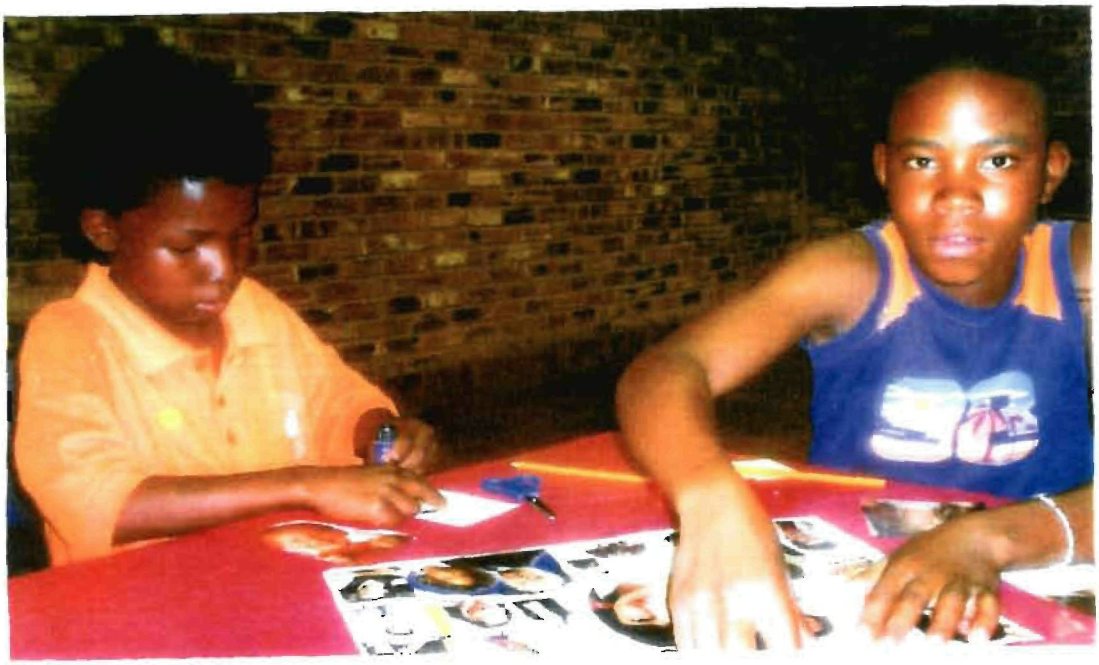
Picture 3: Co-presenter – George Themba

Picture 4: Presenters of the programme with some of the children involved in the research project

Picture 5: The name of the group work programme: HOPE AGAIN

Picture 6: Group members working together as a group

Picture 7: Group members signing the work agreement

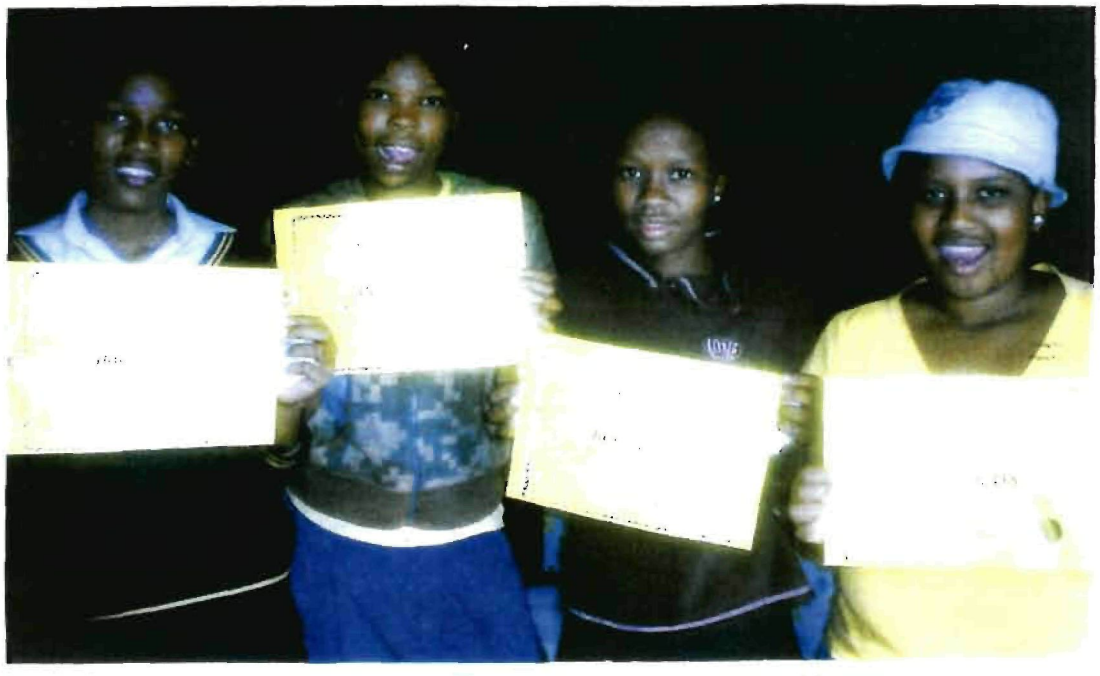


Picture 8: Group members working together on a collage

Picture 9: Group members busy with a budgeting exercise

Picture 10: Collage of one of the group members

Picture 11: Collage of one of the group members



Picture 12: Group members with their certificates, after completion of the programme

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