An ecosystemic programme for dealing with

difficulties experienced by AIDS orphans at schools

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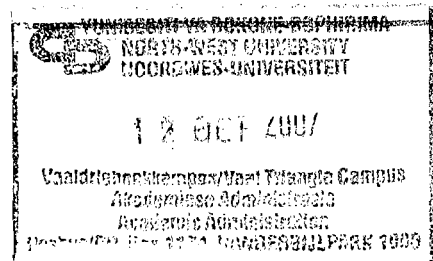
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2007

Declaration

I, Mahlatsi Jeremiah Mokoena, declare that the research dissertation submitted for Masters Degree in Educational Management is my own work. I further declare that all sources used have been acknowledged by means of complete references and that I have not submitted the same work at any other university in the past.

MJ MOKOENA

SIGNED AT VANDERBIJLPARK

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ACKNOWLEDGEMENTS

(families staying with the orphans) for allowing me time to interview them. Thank you very much.

- Finally, I want to sincerely thank God for giving me life and courage to work for what I am meant to be.

SUMMARY

The aims of this research about an ecosystemic programme for dealing with difficulties experienced by AIDS orphans at schools was to determine, by means of a qualitative research, the psychological well being condition of learners affected or orphaned by HIV/AIDS; their general performance at school; the nature and extent of social support they get from their schools, family, community and society; their physical well-being; and to make suggestions for an ecosystemic psycho-social support for them in order to enhance and strengthen their psycho-social well-being.

The literature review highlighted that, as a result of HIV/AIDS, new family forms are emerging, such as "skip-generation" families, where the parent generation has succumbed to HIV/AIDS and HIV/AIDS-related illnesses and the families are made up of grand-parents and orphaned grand-children, and child-headed families. The empirical research revealed that some learner AIDS orphans come to school hungry, steal money for food, are exploited and abused through child labour and sex by adults, and drop out of school

On the basis of both the literature review and empirical research findings, recommendations which emphasize a psycho-social counselling programme for AIDS orphans and strategic management for their schools, were made.

OPSOMING

Die doelwitte van hierdie navorsing gaan om 'n ekosisteemprogram wat te make het met die probleme wat ondervind word deur VIGS-weeskinders in skole en dan vas te stel, deur middel van kwalitatiewenavorsing, die welsynstoestand van leerders wat deur hierdie sindroom geraak word; daarbenewens ook, die algemene skoolprestasies van hierdie leerders; die aard en omvang van die sosiale ondersteuning van hulle skole, ouers, gemeenskappe en die samelewing; hulle fisieke welsyn, en om dan voorstelle te formuleer vir die ekosistemiese psigo-sosiale ondersteuning van hierdie leerders ten einde hulle algemene psigo-sosiale welsyn te verbeter en te vertrek.

Aan die een kant het die literatuurgedeelte van die navorsing die volgende uitgewys: as gevolg van MIV/VIGS het nuwe gesins-tipes na vore getree, soos onder andere generasie-oorslaangesinne, waarin die ouerlike generasie as gevolg van MIV/VIGS afgesterf het, waar hierdie gesinne dan oorslaan na 'n gesin wat bestaan uit grootouers en weeskinders - wat soms insluit kind-hoof gesinne - laasgenoemde waar daar nie grootouers of 'n grootouer beskikbaar is die weesgelate kind (ers) nie.

Andersyds, het die empiriese studie aan die lig gebring, dat weesgelate kinders honger skool toe kom, geld vir voedsel steel, mishandel of ge-eksploiteer word deur kinderardbeid en seks deur volwassenes, en dan die skool verlaat.

Op die basis van beide die literatuuroorsig en die empiriese bevindinge, word aanbevelings gemaak wat 'n psigo-sosiale beradingsprogram benadruk vir VIGS weeskinders, asook die strategiese bestuur van hulle skole.

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ADDENDUMS

1. Permission letter from the Free State Department of Education to conduct research in schools.

2. A proofreading certificate by Dr. J.C. Huebsch.

3. Declaration of originality of the research document by the student, Mr. MJ Mokoena.

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND STATEMENT OF THE PROBLEM

More than twenty years after HIV/AIDS was discovered in 1981, it has become clear that it is more than just a medical issue. It pervades all areas of people's social, economic, political and cultural lives. UNAIDS (2004:2) reveals that in 2003 alone, almost five million people in the world became newly infected with HIV, the greatest number in any one-year since the epidemic was discovered. The number of people living with HIV has now grown from 35 million in 2001 to 44 million in 2004 and more than 20 million people have died since the first cases of AIDS were identified (WHO, 2004a:25).

HIV/AIDS has not only been an individual problem but also a social epidemic within other social epidemics such as poverty, gender injustice, social discrimination of certain groups, war, violation of children's rights and cultures of inequality. One of its most visible social impacts is seen on families. The impact of HIV/AIDS on families is seen most dramatically in the wave of AIDS orphan numbers that had by December 2004 grown to an estimated 15 million worldwide (UNICEF, 2004:4). UNICEF's (2004a:5) Children on the Brink predicts that by the year 2010, this number is expected to increase to over 25 million worldwide. Nyblade, Kidanu and Mbambo (2003:16) reveal that the vast majority of children affected by HIV/AIDS today are concentrated in Africa, with 70% of them living in Sub-Saharan Africa while an additional 10% in other areas on the continent. It seems that similar crises are building in Asia, Eastern Europe, Latin America, and the Caribbean Islands. WHO (2003a:1) reports that in Asia, HIV sero-prevalence rates are lower than in Sub-Saharan Africa but the combination of large populations and rising incidence of HIV infections suggest that it will be affected severely as well.

For years the world has been besieged by wars, famines, natural disasters, mass migration, and diseases, which threatened the health and well-being of children, but the social impact of HIV/AIDS on children, families, and communities is unique (Harries, 2002:268). For children, living with infected parents is associated with elevated psychological distress and diminished emotional support prior to and following parental death. Relative to unaffected youths, children whose parents become infected, face higher rates of psycho-social problems such as having to drop-out of school to become wage-earners and care-providers; loss of access to economic resources and inheritance assets; diminished access to basic needs, including nutrition, shelter, health care, clothing; and increased vulnerability to exploitation, violence, abandonment, and abuse – particularly for girls in societies with inadequate social, legal, and cultural protection (Tawfik & Kinoti, 2002:21). In addition, affected children from communities unwilling or unable to provide adequate psycho-social support face additional problems such as inadequate housing or homelessness, financial hardship, substance abuse, HIV risk-taking, and initiation or exacerbation of psychological well-being and behavioural disorders (Barnett & Whiteside, 2000b:16; Whiteside, 2000:685; Fox, Fawcett, Kelly & Ntlabati, 2002:2).

In many parts of the world, it is no longer the issue of divorce that creates single-parent and step-families, but parental death and orphanhood due to the HIV/AIDS pandemic. New family forms are emerging, such as "skipgeneration" families, where the parent generation has succumbed to HIV/AIDS and HIV/AIDS-related illnesses and the families are made up of grand-parents and orphaned grand-children, and child-headed families, where grandparents are not available to care for orphaned grandchildren (Govender, McIntyre, Grimwood & Maartens, 2000:16; Barraclough, Chapman & Richens, 2001:15).

In light of the foregoing paragraphs, it is apparent that children and adolescents whose parent(s) died of HIV/AIDS are daily subjected to psychological and social distress which can impact on the healthy psychological development. This research therefore endeavours to

investigate the psychological experiences of school-going children and adolescents who have been affected or orphaned by the HIV/AIDS epidemic. The psychological and social experiences of learners affected or orphaned by HIV/AIDS need special research attention if the world is to succeed in developing psycho-social resilience of all its children and adolescents.

The lack of sufficient research on psychological experiences of learners affected or orphaned by HIV/AIDS epidemic creates a void in understanding the new ecosystemic and constructivist roles that schools, communities, and the society as a whole should play in facilitating and advocating for improved conditions for AIDS victims or orphans' families (Kinoti & Tawfik, 2002c:18). South Africa and the world need a theoretically-based research which is able to answer the following questions, about learners affected or orphaned by HIV/AIDS, which are:

- In what condition is the psychological well being of these learners?

- How is the general academic, physical and mental performance of these learners in schools?

- What is the nature and extent of social support do these learners receive from their families, communities and societies?

- How is the physical well being of these learners affected?

- How can the psycho-social support for these learners be enhanced to strengthen their psycho-social well-being?

All these questions translated to the aims of this research and were answered through both the literature review (see chapter 2) and empirical research.

1.2 OBJECTIVES OF THE RESEARCH

On the basis of the research questions presented in 1.1, the aims of this research about learners affected or orphaned by HIV/AIDS were to:

- determine the psychological well being condition of learners affected or orphaned by HIV/AIDS;

- determine the general academic, physical and mental performance of these learners at school;

- determine the nature and extent of social support these learners get from their families, communities and societies;

- determine the physical well- being of these learners; and

- make suggestions for an ecosystemic psycho-social support of these learners in order to enhance and strengthen their psycho-social well-being.

1.3 ECOLOGICAL AND SYSTEMS THEORIES AS THE FRAMEWORK OF THIS RESEARCH

This research is conducted from an ecosystemic, that is, ecological and systems theoretical framework. Ecological and systems theories provide a framework for this research because of their ability to create a broadened understanding of social and cultural processes of children and adolescents affected by HIV/AIDS. The premise of ecological and systems theories is that knowledge, understanding and reality constructions of all kinds are created by communications, especially conversations (Castle, 2001a:547; Taylor, 1999:197; Costanza, 1998a:2; Grove & Burch, 1997:259) among all social systems such as families, community social agencies and societal structures. Thus, creating knowledge by research in the area of social sciences is actually conversations about conversations, or conversations about social conversations, which create new social constructions and in turn influence those that follow to be open for new dialogues.

For ecological and systems theories, the social context and the use of effective communication through language is significant in terms of the expressions of 'lived' experiences and alternative stories (McDonnell, Pickett, Groffman, Bohlen, Pouyat, Zipperer, Carreiro & Medley, 1997a:21). This research deems such a theoretical framework and paradigm to be significant in dealing with children and adolescents affected by the scourge of HIV/AIDS or AIDS orphans' experienced psycho-social problems because of its holistic

approach to the role of families, schools, communities and societal agencies in dealing with HIV/AIDS epidemic.

To enquire into above aspects, a certain method of research is required and is discussed in the next section.

1.4 RESEARCH DESIGN AND METHODS

The research design and methods are briefly outlined below, with a detailed discussion to follow in chapter three.

1.4.1 Research Methods

The data that was derived from AIDS orphan's "lived" experiences and alternative stories were regarded as meanings they have constructed of their personal experiences and were understood from their frames of reference. In this regard, reporting should contain extensive descriptions such as quotations, narrations, and detail. As the aim of this study is to determine the way accessible psycho-social support prevails at schools for learners orphaned by HIV/AIDS, this research is qualitative and descriptive in nature. The case study method was used in this study. Welman and Kruger (1999:21) formally define a case study as 'an empirical enquiry that investigates a contemporary phenomenon within its real life context, especially if the boundaries between phenomenon and context are not clearly evident. The participants comprised a sample (N=55) of orphaned learners (n=16), School Based Support Teams (n=12), School Management and Governance Developers (n=6), District Based Support Team (n=3), school principals (n=7) and three families of orphaned learners (n=12). The aim of qualitative research is to gain insight into the meanings participants give to their reality (Merriam, 1998:17). This insight was gained by obtaining detailed descriptions of the 'lived' experiences of children and adolescents affected or orphaned by HIV/AIDS within certain social contexts. The researcher acted as an observer and interviewer.

1.4.2 Sample selection

The sample of this research comprises one case of sixteen AIDS orphans from two different schools, twelve school based support teams from two different schools (educators), six school management and governance developers, three district based support team, seven school principals and three families of AIDS orphaned learners. The sensitive nature of investigating a topic such as the one in this research compelled the researcher to use the snowball technique as propounded by Fink (2002a:163) where he postulates that snowball sampling is suitable for sensitive research topics such as HIV/ADS. Fink (2002:163) defines snowball sampling is a special non-probability method used when the desired sample characteristic is rare. It may be extremely difficult or cost prohibitive to locate participants in these situations. Snowball sampling relies on referrals from initial subjects to generate additional subjects. While this technique can dramatically lower search costs, it comes at the expense of introducing bias because the technique itself reduces the likelihood that the sample will represent a good cross section from the population. With the use of this type of sampling, the researcher managed to interview chosen sixteen affected learners, two school based support (n=12) teams, six school management and governance developers, one district support team (n=3) seven school principals and three families of AIDS orphaned learners (n=12) in Thabo Mofutsanyana Education District in the Free State Province.

1.4.3 Data Collection

A literature review on children and adolescents affected by HIV/AIDS, AIDS orphans and ecological and systems theories was undertaken in order to develop the theoretical framework and basis for the achievement of the aims of this study. The following key words were used to conduct the electronic search for relevant national and international literature data:

- child-headed families due to HIV/AIDS;

- HIV/AIDS affected families;

- children and adolescents affected by HIV/AIDS;

- Bronfenbrenner's ecological theories;

- ecosystemic theory;

- psychological experiences of children and adolescents affected by HIV/AIDS; and

- psychological well being of learners affected by HIV/AIDS

As mentioned above, a case study method of data collection was selected for the qualitative empirical research. Such a method was necessary, in the context of this research, because finding cases of children affected by HIV/AIDS is difficult because of the stigma that is still associated with families and individuals which are affected by the HIV/AIDS disease.

1.4.4 Data Analysis

Before the collected data were analysed they were first transcribed. Audio-taped interviews were listened to and typed in order to produce written text. The next step was to code the transcribed data into relevant categories and to consider the frequency of occurrence with the purpose of producing themes (Potter & Wetherell, 1987:98). Thereafter proper analysis, which is the process of searching for patterns and forming connections about what the AIDS orphans were saying and the effects thereof, began.

1.5 ETHICAL ISSUES

In order to facilitate the participants giving their fully informed consent, all the necessary information pertaining to the research including the nature, purpose and usefulness, procedures, confidentiality and the protection of anonymity as well as the voluntary nature of participation in the research were given. This exercise was carried out with the participants rather than only effecting what Terre Blanche and Durrheim (1999:103) refer to as "gatekeepers".

1.6 SIGNIFICANCE OF THE RESEARCH

This research should contribute to the theory and practice of socially and cognitively contextualized individual and family counselling of victims of HIV/AIDS or AIDS orphans, and has the potential to reveal the unique social realities of AIDS orphans' families.

The new role of the school in the ecology and psychology of families is highlighted. The ecology and psychology of AIDS orphans fall within the scope of practice of schools, families, community agencies that are oriented towards HIV/AIDS issues and societal agencies such as the Departments of Social Development and Health because of their being the social systems within which the children and adolescents develop.

1.7 CHAPTER DIVISION

Chapter 1:   Orientation to the research

Chapter 2:   Literature review

Chapter 3:   Qualitative research design

Chapter 4:   Data analysis and interpretation

Chapter 5:   Recommendations, summaries and conclusions

1.8 CONCLUSION

In Chapter 1, the orientation of the research, in the form of the statement of the problem, the aims of the research, the methods of research and the programme of research were discussed.

Chapter 2 presents literature review on ecological and systems theories and the psychological experiences of children and adolescents affected or orphaned by HIV/AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Children who are affected or orphaned by AIDS are found in almost every country of the world. In some countries, there could be only a few hundred or it could be a few thousand. In Africa, millions of HIV orphans are found who have all suffered the tragedy of losing one or both parents to AIDS, and many are growing up in deprived and traumatic circumstances without the support and care of their immediate family. Hargreaves and Glynn (2002a:489) and Lamptey, Wigley and Carr (2002b:16) reveal that by the year 2003, 15 million children under the age of 18 had been orphaned by HIV/AIDS, of whom eight out of ten lived in Sub-Saharan Africa. WHO (2002a:23) further reveals that two million more children live in households with ill and dying family members. The latest 2005 statistics on the world epidemic of HIVAIDS were published by UNAIDS/WHO in November 2005 (UNAIDS/WHO, 2005:3) and revealed that Africa has 12 million AIDS orphans and that by 2010, this number is expected to escalate to more than 18 million. As staggering as these numbers are, the crisis could worsen if parents affected by HIV do not get access to life-prolonging treatment and effective prevention services. In South Africa, the number of orphans is expected to increase from 2.2 million (12% of all children) in 2005 to 3.1 million (18% of all children) by 2010. (Department of Health, 2000)

The effects of the HIV/AIDS epidemic on children pervade every aspect of their lives, that is, their emotional well-being, physical security, mental development, and overall health (Blower & Farmer, 2003:22). This could be the reason that compels most of them to often drop out of school to go to work, care for their parents, look after their siblings, and put food on the table. These children are often much more at risk of facing malnutrition, becoming victims of violence, exploitative child labour, as well as discrimination or other abuses (Barnett, Whiteside & Desmond, 2000c:17).

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This chapter provides a clarification of concepts which are used throughout this research, the theoretical framework of this research, the impact of HIV/AIDS on children and resilience models for helping children affected by HIV/AIDS.

2.2 CLARIFICATION OF CONCEPTS

The concepts, which are used throughout this research such HIV/AIDS are clarified in this section.

2.2.1 HIV/AIDS

HIV (human immunodeficiency virus) is the causative virus of AIDS (acquired immune deficiency syndrome) (Last, 2001:2). AIDS has no precedent in medical history. It was first widely recognised in 1981, although evidence of the virus was found in stored blood collected in 1959, and so it seems that it has been in existence for longer than was first thought. The virus primarily attacks the white blood cells (the T-lymphocytes or CD-4 cells) and macrophages of the body (Minuye, 2003:25). These cells play a key role in maintaining a person's immunity to disease. As a result, HIV infected people become susceptible to illnesses caused by the collapse of the body's immune system. Individuals infected with the virus can infect others for the rest of their lives, and can transmit HIV *via* blood or sexual fluids (Carr-Hill, Kataboro & Katahoire, 2000:9).

The common conditions and diseases related to AIDS include kaposi's sarcoma (cancer of the lining of the blood vessels), pneumonia, tuberculosis, toxoplasmosis (viral infection affecting the central nervous system), cytomegalovirus (CMV) infection (a common viral infection that can cause retinitis and blindness), candidiasis, and severe herpes (Gregson, Waddell & Chandiwana, 2001:467).

As the depressed immune system makes the individual vulnerable to many illnesses, almost any symptom may occur in a person suffering from HIV infection (Hanson, 2002:268).

HIV infection occurs in various stages, which presents itself in the following ways:

2.2.1.1 First 12 weeks

Some people develop an illness resembling an acute glandular fever-like illness within six weeks of infection. Symptoms include fever, headache, swollen glands, tiredness, aching joints and muscles, and a sore throat although, most people do not feel unwell or develop any abnormality for years (Barnett, Bhawalkar, Nandakumar & Schneider, 2001a:7). Antibodies to HIV usually develop within two to eight weeks, and almost always by twelve weeks. The twelve weeks after initial infection is called the "window period", where a negative test does not necessarily indicate that a person is free of the virus and a follow-up test could be necessary (Bennett & Fairbank, 2003c:12). However, by the end of the window period virtually all infected people will test positively in a subsequent blood test (i.e. they will test "seropositive" or "HIV-positive") which is known as "seroconversion" (Chapman, Barraclough & Richens, 2001a:24).

2.2.1.2 After seroconversion

HIV-infected individuals can remain physically well for many years after initial infection. However, in general, the virus slowly attacks the immune system and, at a critical point, the condition AIDS develops (Wilkinson, Floyd & Gilks, 2000:94).

Within five years of infection, up to 30% of those individuals infected with HIV are likely to develop AIDS (i.e. severe conditions such as cancer and pneumonia). A proportion of people will develop less severe symptoms, such as persistent generalised lymphadenopathy (swollen glands), diarrhoea, fever, and weight loss. Studies indicate that about 50% of adults infected with the virus develop AIDS within ten years after initial infection (WHO, 2002b:11).

Of individuals diagnosed as having AIDS, 90% are likely to die within two years if not treated. Antiretroviral therapy with zidovudine (also known as AZT or Retrovir), which can reduce mortality, illness, and the number of

opportunistic infections, is available to people with diagnosed AIDS. However, the avoidance of infections, the prompt treatment of infections, and a generally healthy lifestyle with exercise and good nutrition, may substantially reduce the likelihood that an HIV-infected individual will develop AIDS (Brugha, 2003:1382).

2.2.1.3 Transmission

HIV is transmitted only through the exchange of infected body fluids, whereby a substantial quantity of virus gains access to the T4 cells in a susceptible individual. Although the virus occurs in saliva, tears, cerebrospinal fluid, and urine, these fluids do not pose a significant risk because of the low concentration of the virus and the absence of a common mechanism for them to enter the blood of another person (Beck, Miners & Tolley, 2001:13; Benatar, 2002b:163).

Hanson (2002b:71) states that HIV occurs in relatively high concentrations in the blood, semen, and vaginal and cervical secretions of infected individuals. Therefore, there is a significant risk of infection when these body fluids are passed directly into another person's blood or anal or genital tract. HIV is also present in breast milk, which is a possible vehicle of transmission to infants.

- According to Lewis & Arndt, 2000:856; Morrison, 2002:180 there are only three significant routes of transmission for HIV, which is from infected:

- blood or blood products;

- sexual fluids; and

- mother to baby during pregnancy and delivery (if a pregnant woman is HIV-positive, the baby has a one in three chance of being infected)

2.2.2 Children affected by HIV/AIDS

Affected children are described as those who may be abandoned or orphaned as a result of HIV/ AIDS, who may be from an HIV infected family, or who may be vulnerable to becoming HIV infected and be from an uninfected family in

an affected community (Musinguzi, Okware & Opio, 2001:14). Being affected by HIV/AIDS triggers multiple anxieties and affects children's lives at multiple levels. Stressors may be environmental demands such as exclusion from school, or having to find money for basic needs such as food, housing, clothes, and medical care, as well as for funerals. Internal challenges may be bewilderment at drastic changes in family circumstances, profound grief after the loss of a mother or having to adjust to placement in institutional care (Kibret, 2003:39). Considering issues above it is highlighted that the effects of the HIV/AIDS epidemic on children occur in a number of overlapping and interdependent domains, including children's psycho-social development. Some of these effects are:

- **economic impact -** In several countries, income in orphaned households has been found to be 20–30% lower than in non-orphaned households. Studies of urban households in Ivory Coast, for example, show that where a family member has AIDS, the average income falls by as much as 60%, expenditure on health care quadruples, savings are depleted and families often go into debt to care for sick individuals. Other studies have suggested that food consumption may drop by as much as 41% in orphan households. Asset selling to pay for health care, loss of income by breadwinners and funeral costs may deplete all household reserves, as well as savings (Lemma, 2003b:733);

- **migration -** has been identified as an important family and community coping mechanism in the face of the HIV/AIDS epidemic. This is especially so in Southern Africa and, to a lesser extent, in Southeast Asia. Migration occurs for several reasons and people move both within and between rural and urban areas. Some identified forms of migration include 'going-home-to-die', rural widows moving to town to seek work or the help of relatives, and potential caregivers and dependants moving between households of relatives to obtain the most optimum care arrangements for all concerned. Children are frequently relocated. Adolescents are particularly affected by migration, as girls are sent to render assistance in other households, or as

children are encouraged to try and fend for themselves by working - including street work (Hepburn, 2001b:9; WORLD BANK, 2002a:11);

- **changes in caregiver and family composition** - As a result of death and migration, family members, including dependent children, often move in and out of households. Caregivers change and siblings may be divided between families. Separation of siblings has not only been found to be a predictor of emotional distress in children and adolescents, but children become more vulnerable when they are cared for by very aged relatives due to the conditions of mutual dependency that often exist between adult and child. Death and migration may also result in the creation of child-headed households. These are most likely to form when there is a teenage girl who can provide care for younger children, when there are relatives nearby to provide supervision, and siblings either wish to stay together or are requested to do so by a dying parent (Okware, Opio & Musinguzi, 2001:19);

- **new responsibilities and work for children** - Several studies have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents or caregivers become ill or die. In such circumstances, instances of work and responsibility being given to children as young as five years old have been observed. Responsibilities and work in the household include domestic chores, subsistence agriculture and provision of care giving to very young, old and sick members of the household. Work outside of the home may involve a variety of formal and informal labour, including farm work and begging for food and supplies in both the community and beyond (Wallace, Tasker & Shinohara, 2001b:86);

- **education** - In households affected by HIV/AIDS, the school attendance of children ceases because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities, medication and health services. Even where children are not withdrawn from school, education often begins to compete with the many other duties that affected

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children have to assume. In addition, stigmatisation may prompt affected children to stay away from school, rather than endure exclusion or ridicule by educators and peers. A study in Zambia, for example, showed that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children. At a national level, a World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children by as much as 22% and secondary school children by 14% as a result of increased child mortality, and decreased attendance and dropping out (Adeyi, Hecht, Njobvu & Soucat, 2001:13);

- **loss of home and assets** - As effects on households deepen and parents die, children may suffer the loss of their home and livelihood through the sale of livestock and land for survival, as well as through asset stripping by relatives. Losses of skills also occur because fewer healthy adults are present in the household and/or are involved in livelihood activities (Desmond, Barnett & Whiteside, 2000:13);

- **health and nutrition** - Children affected by HIV/AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet indicated increased morbidity and mortality among extensively affected children, compared to unaffected control groups. In this regard, it has been suggested that the "safety nets" of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic - or alternatively, that orphans may not be worse off than peers living in extreme poverty. Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV/AIDS (Floyd, Creese & Alban, 2002:43);

- **psycho-social impact** - Affected and orphaned children are often traumatised and suffer a variety of psychological reactions to parental illness and death. In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatisation as it is either assumed that they too are infected with HIV or that their family has been

disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of children's reactions suggest that they tend to show internalising rather than externalising symptoms in response to such impacts - depression, anxiety and withdrawal as opposed to aggression and other forms of antisocial behaviour (Mekonnen, 2003:39);

- **vulnerability to infection** - Apart from other impacts, children affected by HIV/AIDS are themselves often highly vulnerable to HIV infection. Their risk for infection arises from the early onset of sexual activity, commercial sex and sexual abuse, all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape. Some studies of street children, for example, show that vulnerable children do little to protect themselves from HIV infection because the pressures for basic survival such as finding food, far outweigh the future orientation required to avoid infection (Coombe & Kelly, 2001c:40); and

- **long-term psychological effects of emotional deprivation** - Children who grow up without the love and care of adults devoted to their wellbeing are at higher risk of developing psychological problems. A lack of positive emotional care is associated with a subsequent lack of empathy in others and such children may develop antisocial behaviour. Not all children are, however, affected or affected to the same degree. Protective factors in the form of compensating care from other people, including educators, as well as personality predisposition may lessen the impact on children of reduced care in the home environment (Petersen & Swartz, 2002:8).

More often than not, the stressors co-exist in the tension-fraught lives of children poorly equipped to deal with demands and tasks far exceeding their developmental level (Haacker, 2001:15).

In this research children affected by HIV/AIDS are those who are eighteen years of age and have been orphaned or have lost one or both parents to AIDS.

2.3 ECOLOGICAL AND SYSTEMS THEORIES AND RESILIENCE MODELS AS FRAMEWORKS OF THIS RESEARCH

This section provides both ecological and systems theories and resilience models which are applicable to the effective human development of children and adolescents affected and orphaned by HIV/AIDS.

2.3.1 Ecological and systems theories

The HIV/AIDS epidemic affects societies at multiple social levels and in multiple ways. For example, families experience the death and incapacity of loved ones and providers and must cope, in addition to the burden of caring for the ill and dying (Barnett, Whiteside & Desmond, 2000d:14). School enrolments decline and the payoffs to investment in education are undercut by high death rates among young adults (Benell, Hyde & Swainson, 2002b:5). The demographic structure of the population is affected, challenging systems for supporting dependent populations such as children and the elderly. In many cases, the impact of the HIV/AIDS epidemic on families, communities, and countries has multiple effects that influence the course of the epidemic, for example, poverty and the breakdown of social and economic systems impair community systems that could assist to stem the spread of infection (Gupta, 2001b:8).

Many factors are likely to have important influences on these effects as well as the ability of populations to respond to them. Resources initially available to combat the epidemic are likely affected by characteristics of the age structure, economic systems, cultural and political systems, and institutions present in a country before the epidemic gathers momentum (Cooper, 2004:31). The geographic, demographic, and social characteristics of the epidemic such as the way infection and death rates are distributed over geographic and social areas and the dynamics of change due to the fact that distribution have important implications for the way societies experience and respond to the impact of HIV/AIDS (Castle, 2000a:153).

The increasing numbers of infants, children and youths, whose lives are forever changed by loss of parents due to HIV/AIDS, call for a multi sectoral

and socio-cultural response from government agencies. It is for this reason that this research has adopted both the ecological and systems theories and social constructivism in conducting this research. The ecological model, the major proponent of which is Bronfenbrenner (1979a:20), seeks to explain individual knowledge, development, and competencies in terms of the social guidance, support, and structure provided by families, communities and societies and to explain social change over time in terms of the cumulative effect of individual choices.

Bronfenbrenner (1979b:21) postulates that each person is significantly affected by interactions among a number of overlapping ecosystems. At the centre of the model is the individual. According to him, the ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. In addition, Bronfenbrenner (1979c:22), Vailant (2000:28) and Shrader-Frechette, Earl and McCoy (2000:63) outline the following four components of the ecological model, one situated within the next:

- The *micro-system* refers to the interaction between an individual and a setting, which is "a place where people can readily engage in face-to-face interactions" such as a family, peer group, classroom, neighbourhood, church, temple, mosque, school, a home, or a workplace. *Microsystems* are, therefore, the systems that intimately and immediately shape human development.

- The *mesosystem*, the next level of the ecological model, refers to the interaction between two settings, such as the interaction between parents and schools, the interaction between communities and families, or the interaction between churches and communities. Interactions among the *microsystems*, for example, when parents and educators co-ordinate their efforts to educate the child, take place through the *mesosystem*.

- Surrounding the *microsystems* is the *exosystem*, which includes all the external networks, such as community structures and local educational, medical, employment, and communications systems that influence the *microsystems*. The *exosystem* signifies the relationship of an individual and a setting once removed from an individual, such as the relationship between a child and her/his parent's social group, or between a husband and his wife's workplace.

- Finally, the *macrosystem* is described as the cultural thread that binds the institutions in lower systems (Sterelny, 2001:437; Castle, 2001b:547). The effect of the *macrosystem* is to cause these institutions to resemble each other in broad terms, when compared to the same institutions in other *macrosystems* (Meyer, 1997a:136). The *macrosystem* influences all other systems, which includes:

  o cultural values;

  o political philosophies;

  o economic patterns; and

  o social conditions (Grove & Burch, 1997:259).

Together, these systems are termed the social context of human development. McDonnell *et al.* (1997b:33) posit that human ecology theory provides a rationale for the exploration of ecological variables related to the family. It suggests taking into account individual and family characteristics and attributes, as well as various activities and processes related to family functioning. These systems are diagrammatically depicted below:

Figure 2.1: The social context of human development
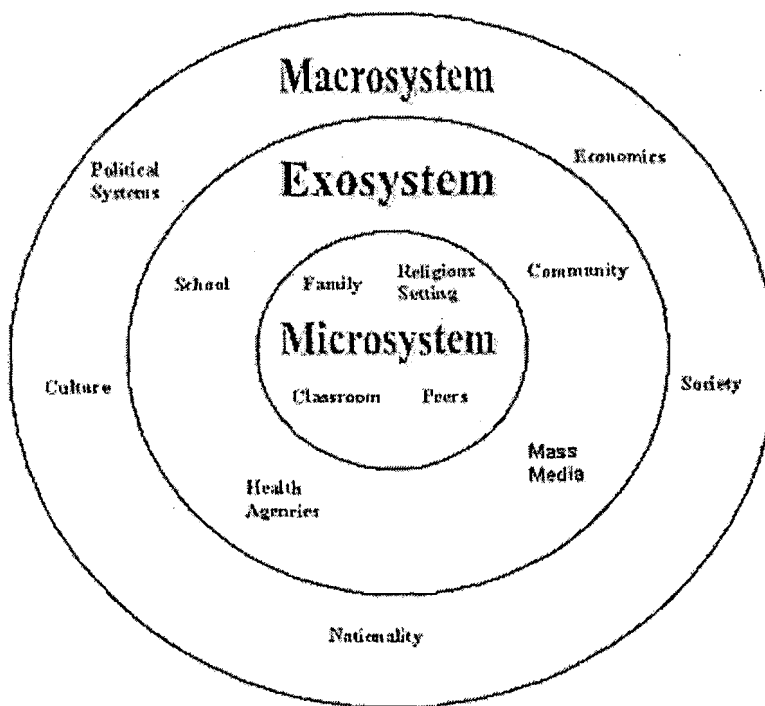
(Bronfenbrenner, 1979d:24)

In this research, the social context of human development of learners affected or orphaned by HIV/AIDS is regarded as crucial. A myriad of issues arise from the effects of the HIV/AIDS epidemic, which impact the sustainability of family units and family networks in communities (Barnett & Whiteside, 2000c:30). Whiteside (2000b:86), Dixon, McDonald and Roberts (2002a:34) and Hepburn, (2001a:44) have found that food deprivation is a major issue for affected families, as are expressed material and financial needs for clothes and bedding, schooling expenses for grandchildren and funeral expenses. A major problem is the education of vulnerable children - either through a lack of money to pay for schooling, or because children fall out of the education system because of a lack of money, and end up ill equipped to earn a living in future (Dixon, McDonald & Roberts, 2002b:23). Emotional consequences of HIV/AIDS, which have different generational effects, also constitute key issues for the following:

- grandparents - the strain of caregiving, financial difficulties, the pain of coping with the death of children, personal health problems, uncertainty and fears about the future;

- adult children - anger, distress, shame, sadness, illness, pain and fear; and

- grandchildren - anguish and hurt, a lack of understanding, confusion, deprivation, fear, neglect and perhaps abandonment (Kebede, 2004b:43).

HIV/AIDS also remains a forbidden subject in many communities, and persons infected and affected by AIDS and their families may conceal the status of infected family members and thus forego opportunities of community support (Hailom, Kidanu & Nyblade, 2003:18). Stigmatisation of infected persons and affected families further aggravates the isolation and loneliness of these persons and families (Kidane, Banteyena & Nyblade, 2003:56). These contribute to being key social and economic issues which impact the functioning and well-being of AIDS affected families – at a *meso*-level and a micro-level (UNAIDS & WHO, 2005:9).

From the foregoing paragraphs it can be deduced that the ecosystemic framework has its roots in the general systems theory and human ecology. The former postulates that any entity structurally comprises subsystems that are functionally interactive and interdependent. Malfunctioning in one sub-part disturbs the effectiveness of the entire system (Crabtree, 2000:289). However, should the malfunctioning subsystem be replaced, the effectiveness of the complete system is restored. The human ecosystem on the other hand, involves two exposed systems namely:

- the individual; and

- the environment (Odenbaugh, 2001:51).

Mikkelson (2001:35) describes the latter as comprising physical, psychological and physiological subsystems. Representing the environmental system are the physical environment, cultural, community and social subsystems.

Boundaries between and within sub-systems are permeable, thus fostering interaction at various levels of individual and environmental subsystems.

The ecosystemic approach construes the human system as the central unit of analysis while the environment forms the context in which behaviour occurs. As such, the behaviour of the individual cannot be examined without addressing the context in which it occurs (Castle, 2001c:57). Shrader-Frechette (1997:65) explains that in combination, individual and environmental systems function synergistically – meaning that the impact of the whole ecosystem is greater than the sum of its individual components. The ecosystemic perspective additionally conceptualises pathology or health as patterns of activity that may be caused, maintained or perpetuated by multiple and interacting environmental and social factors. Meyer (1997b:137) and Costanza (1998b:2) refer to ecologically based factors as having the potential to either lessen or aggravate the impact of negative experiences. These researchers argue that unravelling ecological factors provides an understanding of how people cope with and respond to experiences that threaten their lives.

In the light of the foregoing paragraphs, it is possible to regard the ecosystemic framework as an integrated approach for conceptualising and assessing complicated psychological experiences of children and adolescents affected by HIV/AIDS in terms of families, communities and societies as social contexts of human development.

The ecosystemic approach, in the context of this research:

- regards communities as capable of responding effectively to the plight of orphans and children whose parents are dying of AIDS. Internationally, a wide variety of relatively formal projects have sprung up from the concern of families, neighbours and religious groups (WHO, 2002c:22). A case in point is Cambodia. The monks at Wat Kien Kes Temple provide some of the country's orphans and vulnerable children with vocational training and income-generating skills to improve their standard of living. They also mobilize local communities to donate food, land and material goods to

affected families. The monks have also stimulated HIV-oriented dialogue within the community, which raises AIDS awareness, engenders compassion and reduces discrimination (USAID, 2004:13). If properly recognized and supported, these initiatives can provide the backbone of national strategies;

- necessitates national action plans from societies which should include societies' commitments to:

  o conducting participatory situation analyses;

  o implementing a national policy and legislation review to provide improved protection to children;

  o establishing national coordination mechanisms for responding to the orphan challenge;

  o developing and implementing national action plans addressing both orphan prevention and the needs of orphans; and

  o implementing monitoring and evaluation activities based on indicators that specifically measure effects on the well-being of orphans and children made vulnerable by HIV and AIDS (UNICEF, 2004b:12).

- necessitates that the orphan challenge be met through resolute political decree before it reaches crises proportions. In countries, a wide range of government and civil society stakeholders need to provide financial help to children, families and communities, along with HIV prevention, care and support (Ainsworth & Teokul, 2000c:56);

- necessitates national policies, such as those developed by Honduras, Jamaica, Malawi, Rwanda, Swaziland, Thailand and Uganda as a good starting point. Policies are meaningless if no commitment to translate them into practical action exists. Certain families and communities often demonstrate strong commitments and resiliency, and are leading the responses to protect children affected by AIDS. Policy frameworks and national plans need to provide environments that foster these efforts in

order for orphans to be able to survive and thrive in future (Barnett & Whiteside, 2002:17) ; and

- highlights that social support at the level of the family, school and the wider community reduces the impact of stress on children living in adverse conditions. Lack of social support - through poor coping by available adults, the depletion of social networks and isolation from regular social institutions - increases children's vulnerability to stress by reducing their resources for dealing with stress (Halperin, 2001a:13).

The 2005 report on progress in the meeting of the 2001 United Nations' Declaration of Commitment on HIV/AIDS goals notes that 39% of countries with 'generalized epidemics' have no national policies to provide orphaned and vulnerable children with essential support. Some 14% of these countries are developing policies, but 25% have no plans to do so (UNAIDS, 2005c17).

Various studies have indicated that grandmothers play a significant role in bringing up and supporting bereaved grandchildren, due to HIV/AIDS. For example, studies in Thailand show that almost half of the country's orphaned children live with their grandparents (Beeharry, Schwab & Akhavan, 2002:19). Projects to support these elderly caregivers have been developed in response. In Chiang Mai, the Mother Child Concern Foundation helps to strengthen older people's associations, develops volunteer schemes to assist older caregivers, and provides low-interest loans to set up small businesses (Carr et al., 2002:7).

Formal institutions, such as orphanages, may provide a last resort for a limited number of orphaned or ill children. In the early days of the orphan crisis, countries such as Zimbabwe built a number of orphanages (Desmond et al., 2000a:17). Unfortunately, it quickly became apparent that the orphanage solution was unsustainable and conflicted with a child's fundamental right to grow up in a family environment.

If preserving the family is the best option for orphaned children, then the family's capacity to care for, and protect these children, must be urgently strengthened. This means adopting programmes that keep parents living with

AIDS alive and healthy as long as possible, improve a household's money-earning capacity, and provide children and their caregivers with psycho-social and other social support (Fox et al, 2002b:28).

Thailand is one country in which family capacity has been strengthened. There, the MTCT-Plus Programme (mother-to-child transmission plus antiretroviral treatment) provides antiretroviral treatment for HIV-positive mothers, their infected partners, and children (Brugha, 2003:1383; WHO, 2002d:11; Bertozzi, Opuni & Bollinger, 2002:58). The programme was launched by UNICEF and Columbia University's Mailman School of Public Health, and links preventing mother-to-child transmission with treatment and care options in antenatal-care clinics. The programme also operates in the Ivory Coast, Kenya, Mozambique, Rwanda, South Africa, Uganda and Zambia (UNICEF, 2004:5). In Haiti, the international Non-Governmental Organization, which stands for Hunger Grow Away, is promoting a new micro-intensive gardening system that uses limited viable soil, water resources, tools and labour to offer orphaned children and their caregivers' food security and income. Improved nutrition and a food supply should improve a family's overall health (Petersen & Swartz, 2002:10).

The implications of the ecosystemic theoretical framework are, principally, the following:

- the strength and quality of social institutions, such as the family, school, church and community associations are critical for children's capacity to cope with the effects of the epidemic, and to avert personal distress, maladjustment and social disorder. It is also true that these institutions are likely to be depleted as a result of the epidemic, as key individuals become ill and die, and as those people, who remain, become demoralised and overwhelmed by loss and the demands placed on them by difficult conditions. Therefore, every effort has to be made to support and strengthen these social institutions in the face of the epidemic, as they provide the cornerstone for the protection of children (Meyer, 1997c:138);

- schools need to be adapted to provide a range of supports for children. Schooling must be available to all children and every effort must be made to ensure that all children remain in school. Educators and older children can be sensitised and trained to provide support for children. Food and clothing, especially uniforms, can be provided through schools; and shorter- or longer-term accommodation can be provided to children in especially difficult circumstances (Coombe & Kelly, 2001a:38; Gregson, Waddell & Chandiwana, 2001c:468);

- maintaining children's schooling is an important intervention in several ways. It retains children's connectedness to peers, familiar adults and to an institutional identity. Schooling provides children and society with future knowledge and skills. Keeping older children in school could also help to prevent vulnerability to HIV infection, by protecting children and reducing the child's need to seek shelter, food and clothing through risky encounters with unscrupulous adults (Hagreaves & Glynn, 2002:490);

- every effort also needs to be made to avert conditions that result in impersonal and cruel child care. Orphanages and unstable foster care have been identified as high-risk environments for neglect and abuse (Department of Health, 2003:1); and

- finally, it is critical to address the background poverty effects experienced by children affected by HIV/AIDS. Mechanisms exist to identify and target assistance to needy children and families. Children not attending school, working children, children not living with either a biological parent and adult illness and death are all indicators of potential vulnerability. Such indicators need to form the foundation of an early warning system in which economic and other assistance should be provided to families and children (Benell, Hyde & Swainson, 2002a:16; Halperin, 2001b:13).

2.3.2 Resilience models for helping children affected by HIV/AIDS

Various conceptual models have been advocated as tools for better understanding the concept of resilience, namely:

2.3.2.1 A first model

The first model conceives resilience as simply being the opposite of risk. The early resiliency studies assumed that risk and resilience represented opposite ends of a single spectrum. At times, these assumptions held true. For example, having a poor parent–child relationship is a risk factor, and having a good parent–child relationship contributes to resilience. There are, however, sufficient exceptions to this simple model to require further conceptual refinement (Pulley & Wakefield, 2001:13).

2.3.2.2 The second model

The universal strengths model was developed during the work of the International Resilience Project. This model maintains that resilience is a universal human capacity that enables a person, group or community to deal with adversity by preventing, facing, minimising, overcoming and even being strengthened or transformed by adversity. This model also maintains that human beings are naturally endowed (probably through evolution) with the ability to cope with adversity, but that this capacity needs nurturing and support within a facilitative environment to enable resilience to win over vulnerability and risk. In many respects, the universal strengths model is consistent with theories on the social ecology of childhood (see 2.3), since it encourages a focus on those contextual variables and systems that can either support or detract from optimal functioning (Pretorius, 1997:24; Jang, Poon & Martin, 2004:138). Above model has the clear advantage of having shifted the focus away from individual deficits to individual strengths, competencies and capacities and, as such, is a critical step in understanding resilience within the context of the individual, family and larger social environment. Previous work had focused on deficits and problems that required diagnoses and treatment. The paradigm shift to a strengths model focused on building individual, family and community strengths. Jacoby (2003:44) also challenged the notion that people could be "vulnerable but invincible", arguing that people do not remain unscathed by adversity. Kogan (2001:70) contends that resilient people are not protected against, but are better prepared for, difficulties and hardship.

Resilient people address adversity more successfully than non-resilient people in the following ways:

- a person grieves the death of a loved one;

- a rape survivor chooses the long, slow road to recovery; and

- someone who is terminally ill addresses his/her fears and worries (Peterson, 2000:44; Mischel & Shoda, 1998:29).

This model has decided appeal and has made important contributions towards theory building. It does not, however, always hold up in practice. It seems that only 50% to 66% of children have the capacity to bounce back despite adversity. There are also individual variations in the degree of resilience exhibited by different children, at different points in time, and in different contexts (Block & Kremen, 1996a:51).

2.3.2.3 A third model of resilience

A third model of resilience states that certain children, families and communities have protective capacities or processes that enable them to cope in a better way with the trials and tribulations of life. Protective processes encompass a wealth of experiences and mechanisms that enable positive adaptation despite adversity. Protective processes, like risk factors, include personality and genetic characteristics, as well as external dynamics within the family, school or community environment which are often interrelated and interdependent (Cilliers, Viviers & Marais, 1998:32), and are:

2.3.2.3.1 Internal personal strengths

Some children begin life with certain advantages. They are either born with, or develop through the interaction of genetic and environmental factors, internal strengths or qualities that enable them to cope in a better way with life. Children who are observant, good at solving problems and believe in their own ability to cope with difficulties, often achieve more in the face of adversity (Norem, 2001:28). These children are also more likely to understand and attribute a deeper meaning to adverse events. Resilient children are socially

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competent, have a positive self-esteem and a sense of their own efficacy and ability. Intellectually, there may be a 'window of ability' that is associated with greater resilience, for example, children with above average intelligence do better (Reivich & Shatte, 2002a:78) than those who are below average or are intellectually gifted. Resilient children are more creative, innovative and naturally curious. Parenting and schooling systems that encourage questions and curiosity enhance resilience more than schooling and parenting styles that uphold obedience and respect as the ultimate qualities of a well brought-up child (Walsh, 2001:70).

Children who are able to understand and express a wide range of emotions in a socially appropriate manner are also more resilient. Indeed, a goal of most intervention programmes is to enable children to identify a wider range of emotions and to express these emotions in socially acceptable ways. This is due to externalising distressing experiences, people are able to psychologically process such events and so gain a sense of mastery and control over them. Children express their feelings in words, actions, play or drawing. Being able to talk about or play out difficult experiences, while not dwelling on painful memories, is a basic principle underlying all psychotherapy (Ryan & Deci, 2001:109). Gender is also considered important in moderating risk and resilience. In first world countries, pre-adolescent boys report less stress, and exhibit more distress than girls. Boys are thus more likely to develop childhood problems. This pattern is reversed during adolescence, when girls experience more distress. In many developing countries, high rates of child sexual abuse and gender-based discrimination place girls at a particular psycho-social risk. In these countries girls are more likely to have to sacrifice their education, take on household responsibilities and chores and be accorded lower status than boys - all of which seem to make them less resilient than their male counterparts (Schmutte & Ryff, 1997:549).

2.3.2.3.2 Interpersonal resources or skills

Another source of strength stems from children's interactions with others. The ability to access social support is significant in predicting resilience. Resilient children trust and enjoy secure attachments to others and are confident that

people will be 'there' for them. They thus seek and find emotional support and are confident of their right to such support. They relate to others in a positive manner and have the ability to see humour in difficult situations (Siebert & Paul, 2003a:88). They also discuss difficulties with people whom they trust and respect. Such traits help children to develop relationships and a network of supportive others which they can draw on when difficulties arise. Such relationships serve as a buffer during adversity and create opportunities for positive interaction, messages and experiences. The ability to find and make use of social support outside of the family also improves communication skills and problem-solving ability. Interestingly, such social support systems are especially protective for children from low socio-economic groups.

Resilient children also tend to have a sense of purpose and future orientation, combined with a sense of usefulness. Gupta (2001c:26) identified 'required helpfulness' - wherein children have set responsibilities and tasks at home, community and/or at school, such as taking care of siblings or relatives, or being responsible for animals or pets - as a resilience factor. Boys do better when given tasks and clear routines, whereas girls benefit from being given appropriate responsibilities, especially in caring for others (WHO, 2002e:13). Careful consideration of what constitutes appropriate tasks and responsibilities for children is, however, needed. Children need time to be children, to go to school, play with peers and enjoy themselves.

Faith in a higher power, or a religious philosophy of life, has also been identified as an interpersonal resource. A resilient person, adult or child, is likely to have a strong spiritual or ideological belief that there is a God, or one or more Higher Beings, which transcend life on earth. Such belief systems are usually instrumental in creating a vision of moral order and a sense of justice, in which there is a clear distinction between right and wrong and acceptable and unacceptable behaviour. The form that this belief system takes is unimportant - a child may believe in one God, or in many gods or in the power of ancestors (Strumpfer, 2001:15).

2.3.2.3.3 External support

The extent and nature of the support, resources and structures available to children may either build resilience or increase vulnerability. A positive emotional climate and the availability of supports and resources within the family and broader community context can serve a protective function. A supportive environment can also help to develop personal qualities that enable children to cope with adversity (Abdool-Karim, 2001:193). These resources often take the form of social relationships, as opposed to facilities that need to be made available. They make children feel important and give them a sense that others are concerned about them.

As already mentioned, feeling secure, loved and accepted by more than one person is an important resilience factor. Beyond infancy, security of attachment is demonstrated by the time spent with children listening, showing an interest, being actively involved in what they do, think and feel and recognition of their achievements (Case, 2003a:44). When a parent is terminally ill it is imperative that children begin to develop a secure attachment with those who will be responsible for their care once the parent has died. In many African families care of the child will be vested in several family and community members. The presence of multiple caregivers who offer consistency, care and secure attachments bodes well for children's emotional development. The disadvantage may be that children lack consistency in care, which may contribute to a lack of security in interpersonal relationships (CPSA, 2004:5).

The availability of adequate and competent adults who serve as consistent role models is also important in moulding a positive attitude and adaptive coping. Resilient children seem to be especially adept at actively recruiting surrogate parents and it is imperative that adults exist who make themselves emotionally and socially available to such children (Department of Health, 2000:23). Positive role models are instrumental in helping children develop strong moral values and principles to guide them through life and provide structure and form to their dreams and aspirations. Realistic goal setting,

combined with the motivation and support necessary to achieve such goals, is associated with resilience (Teokul & Ainsworth, 2000:57).

A sense of belonging and feeling integral to a family, community and culture is another key feature of resilient children. Being able to trust their primary caregivers provides children with the security that enables them to venture out, explore and engage with the world.

Castle (2000b:156) supports this view but also highlights the importance of cultural connections and a sense of history. Since resilient children feel that they belong within their family, home, school and community, they are more likely to participate actively in decision-making processes - an often-neglected clause of the Convention on the Rights of the Child. A further consequence of having a sense of belonging is that the network of people from whom social support can be sought is significantly broadened, making it easier for children in distress to access support. Feeling part of a community and believing that a person belongs, generates both security and pride, which in turn precipitates helpfulness, open-hearted and social behaviour (Fox et al, 2002a:53).

External supports and resources operate within the three primary systems of the child's world, that is, at *microsystemic*, *mesosystemic* and *exosystemic* levels (see 2.3). It is clear that certain families, schools, communities and cultures have protective processes that promote resilience. Resilient families who live in poor and disrupted communities, and cope successfully through disadvantage, serve as important positive role models for their children. Resilient families tend to have certain characteristics in common (Masten, 2001:229). Such families have or are able to:

- establish a strong, durable belief in their ability to control life;

- maintain a sense of order through the implementation of routines for activities such as meals, bedtimes, as well as household tasks;

- establish systems for celebrating and acknowledging key events in the life of the family and its members;

- clearly delineate parent-child roles and relationships with firm boundaries - the child is not expected to be the parent's friend, confidante, or to provide emotional support;

- exhibit a manageable maternal workload, both in terms of the number of children cared for and daily tasks; and

- enjoy financial stability so that families are able to continue with the business of living and bringing up children without the constant worry about where the next meal will come from. Closely aligned with this variable is having sufficient food, clothing, shelter and medical services available to meet the basic survival needs of children and families. The problem of food security is a major contributor to the social disarray that exists in many high-prevalence communities (Whiteside & Sunter, 2000:53; Cillier *et al.*, 1998:33; Norem, 2001a:30; Reivich & Shatte, 2002b:88).

2.3.2.4 Cultural variants in child rearing

Cultural variations in child-rearing patterns are also important. Beneficial practices, such as praising children for finding their own solutions and demonstrating independence or providing them with the support to help overcome adversity, can build resilience (Siebert & Paul, 2000b:109). Some cultural practices contain an element of risk pertaining to child rearing. They are:

- severe punishment;

- excluding children from various activities in an endeavour to protect them from the harsh realities of life and death;

- a focus on obedience to the exclusion of the development of inner strengths and independence;

- not discussing sexuality with children; and

- leaving children to solve their own problems, without providing them with opportunities to ask for assistance (Fleischman, 2003a:5).

Resilience-promoting schools can ameliorate the impact of stress associated with disadvantaged homes of children and adolescents affected by HIV/AIDS. Most children spend at least five hours a day at school during term times. Schools therefore have the potential to be a major resource for at-risk children. The characteristics associated with effective schools are almost identical to the qualities of those that build resilience in their learners. Effective schools provide children with positive experiences that are associated with success and pleasure in a variety of arenas - academic, sport, cultural, good peer and educator relationships and shared responsibilities (Vailant, 2000:89; Walsh, 2001a:83).

Cairns (2002:66) has identified five major strategies to enhance resilience within schools. These involve:

- offering opportunities for learners to develop significant relationships with caring adults;

- building on social competencies and academic skills to provide children with experiences of mastery and success;

- offering opportunities for learners to be meaningfully involved and take on responsibility;

- working to identify, collaborate with and co-ordinate support services for children; and

- striving to 'do no harm' by ensuring that the structures, expectations, policies and procedures do not aggravate the risks already experienced by children.

2.3.2.5 External protective processes

The external protective processes at community level are remarkably similar to the resilience-enhancing processes that pertain to traditional African societies. Implicit and critically important in many traditional lifestyles is the belief that "our children are gifts from Our Creator and it is the family, community, school and tribe's responsibility to nurture, protect and guide them". A culture's worldview is grounded in fundamental beliefs that guide and shape daily life, and the valid and positive role that culture plays in supporting the youth, connecting them with a common heritage and tapping their resilience, has long been recognised by traditional peoples (Maddi, 1999b:46). Through their work amongst Native American youth who are American Indians, for example, Fontana and Rosenheck (1998a:190) identified ten innate and natural aspects of resilience-promoting traditional cultural beliefs, namely:

- spirituality;

- child-rearing/extended family;

- respect for nature;

- generation of age/wisdom/tradition;

- generosity and sharing;

- co-operation/group harmony;

- autonomy/respect for others;

- composure/patience;

- relativity of time; and

- non-verbal communication.

This is a finding that the interconnectedness embodied in cultural spirituality was especially important in promoting resilience. Although these findings

cannot necessarily be extrapolated to all children and youths, they suggest that traditional rituals - such as those associated with a child's birth and naming or puberty rites - which explicitly acknowledge the interconnectedness of all life are associated with resilience (Shrader- Frechette, Earl & McCoy, 2000a:39). Most of these protective processes appear to transcend ethnic, social class, geographical and historical boundaries. For example, having good relationships within a person's family enhances resilience, no matter what their life circumstances are or where they live. In fact, there is a growing world literature which reflects much consistency in those features that make children resilient, especially if their lives are threatened by adversity (Norem & Chang, 2001b:347).

2.3.2.6 Mechanisms through which resilience can be developed

From the foregoing paragraphs it is apparent that resilience is a dynamic and unfolding process in which individuals and their environment interact to produce beneficial outcomes. Resilience is "not something some children simply have a lot of". It is an acquired capacity influenced by on-going changes in context. Children inherently possess the capacity to stay organised, to cope and to maintain positive expectations in the face of challenges and across successive periods of adaptation. Acknowledging that resilience is a learned phenomenon enables the development of intervention programmes that have clear aims and objectives. An individual can explicitly focus on building resilience and protective processes, thereby enhancing individual, family or community abilities to face adversity (Ryan & Deci, 2001:141).

Both resilience and protective processes can be nurtured through:

- **reduction of exposure to risk** - Protection is afforded to some children simply by reducing their exposure to risk. Family and community variables are significant in building this form of resilience. For example, some children experience minimal exposure to risk by virtue of their family or community circumstances. They live in close, secure families in which hostility is handled effectively and their basic physical, emotional and

social needs are met. Activities aimed at the *exo-* and *macrosystemic* levels are particularly important in reducing exposure to risk. If the principles of the Convention on the Rights of the Child are embraced, children are protected from many risks, and to this end will always form an integral aspect of an effective intervention (Costanza, 1998:2);

- **minimising negative chain reactions** - A stressful event or experience often sets in motion a sequence of negative chain reactions, which results in accumulation of risk from both external and internal sources. For example, having a parent with HIV sets off a sequence of diagnosis, illness, recovery, further illness and, finally, death. This often adversely affects children's school performance, which in turn leads to loss of self-esteem. Programmes that provide psycho-social support to children who have suffered, or soon will suffer, the death of their primary caregiver aim to reduce such negative chain reactions. Poverty alleviation programmes aim to reduce negative chain reactions associated with poverty by providing food security, adequate sanitation, health resources and mental stimulation (Coombe & Kelly, 2001d:12);

- **promotion of self-esteem and self-efficacy** - Positive self-esteem is recognised as being critically important in boosting resilience. One method of promoting self-esteem is through enhancing opportunities for accomplishment and a sense of achievement by developing competency and success in the various spheres of life. Experiential programmes that offer new opportunities can create cognitive and emotional shifts in self-concept and can enhance self-esteem through the provision of challenges within a supportive and facilitative environment (Walsh, 2001b:83); and

- **provision of opportunities for positive relationships and experiences** Where people develop their social networks through participation in positive and supportive processes, they develop greater resilience. Positive relationships and experiences thus offer children access to much needed resources and new directions in life. The goals of most community development programmes are consistent with this form of resilience building. Their major goal is to empower individuals through participation in

programmes that enable supportive, caring and focused interpersonal interactions, as well as opportunities to experience new ways of being (Ryan & Frederick, 1997:29).

All of these resilience-building mechanisms are relevant to the current epidemic. Children and communities in the Sub Saharan African region, according to Walsh (2001c:83) face numerous profound risks and hardships. Individuals, families and communities pass in and out of difficult and challenging circumstances on a more or less continuous basis. Thus, although limited knowledge exists about either resilience or coping in such dire circumstances, experience suggests that facilitative intervention programmes and policies need to encourage as many protective processes as possible (Saleebey, 1997:33). This can in large part be achieved by adopting an empowerment-oriented approach. Somewhat simplistically, one can think of empowerment as being based on two generally accepted principles:

- given a nurturing environment that taps into universal strengths, all people have an innate capacity for change and transformation; and.

- human potential is always there, waiting to be discovered and invited forth, even in situations of dire adversity (Seligman & Csikszentmihalyi, 2002:14).

Empowerment is usually achieved through community organisation, democratic decision-making processes and active participation of community members in a sustained and responsible manner. These are the age-old principles of ubuntu. Such an approach values respect, participation and care as critical aspects of all interactions with community members, be they children or adults (Siebert & Scheele, 2003:56).

These values provide important mechanisms through which change, development and transformation become possible. Caring relationships provide love, consistent support, compassion and trust. High expectations convey respect, provide guidance and build on the strengths of each person, family and the community. Opportunities for participation and contribution provide meaningful responsibilities, real decision-making power, a sense of

ownership and belonging, and ultimately a sense of spiritual connectedness and meaning. Programmes, however, also need to ensure that basic needs are fulfilled. If people are starving and are worried about their basic survival, they may rightly be too preoccupied with where their next meal is coming from to embrace activities that aim to empower (Adeyi & Chakraborty, 2003:14).

A significant conclusion from the International Resilience Research Project was that resilient individuals are helped to become resilient. Although Welman & Kruger (2001:12) defined resilience as a universal capacity that allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity, it is important that partnerships be formed to facilitate this process. People can be helped to draw on their inner resources and strengths within a structure of guidance, direction and support. Intervention programmes need to target several aspects of *microsystemic* and *macrosystemic* interactions in order to build resilience and minimise the impact of the risks brought about by the epidemic (Symister & Friend, 2003:125).

It seems that there are a few critical factors that would enhance resilience in the general population of vulnerable children. First, adherence to the Convention on the Rights of the Child would certainly assist in making policies that are child friendly. Of paramount concern in this regard is that all those children who are entitled to receive government assistance, be helped to access such support (Strassle, Mckee & Plant, 1999:191). This would constitute one important step in alleviating the dire poverty experienced by most children in the Sub-Saharan Africa which are beyond this, educators, leaders of faith-based organisations and all community members can facilitate the development of resilience by:

- genuinely attempting to build trust between adults and children in their community;

- focusing on the individual and not on the problem;

- remaining positive; establishing high expectations and providing the support that children and the youth need to fulfil these expectations;

- providing opportunities for community involvement in supporting vulnerable children;

- involving parents and other family members in activities that include the entire family; and

- creating a sense of community that encourages people to strive towards the ideal of *ubuntu* (Whiteside & Sunter, 2000:67).

There has been a tendency in the past to focus on children and adolescents' obvious physical and educational needs at the expense of their psychological, social and spiritual needs. The study of risk and resilience has brought into sharp focus the need to address these psycho-social needs. Resilience could thus also be developed in large numbers of children by strengthening the capacity of individuals, families and communities to offer psycho-social support. Introducing psycho-social support can effectively enhance the impact of community-based initiatives (Shrader-Frechette, Earl & McCoy, 2000b:44). The term psycho-social support is much in use in social sciences as identifying the type of social support needed, but the uncertainties over what it entails has led it to become overly connected with ideas of psychological approaches and interventions. The term counselling has become so much associated with psycho-social support that the two terms are often conflated. But psycho-social support can be a useful term, if the range of interventions encompassed are acknowledged and taken up. In particular, an emphasis on the social dimensions, which, in the context of children and adolescents affected by HIV/AIDS, include groupwork with an emphasis on their participation and broad approaches to their protection. Children and adolescents' Activity Centres designed and working to a set of psycho-social principles for psycho-educational practice, and with competent adults, have the potential of providing practical means of initiating and providing psycho-social support, based on children and adolescents' participation. These centres and other resources in a community based approach that includes working against stigma and discrimination and a commitment to child-focused methods, are first stages in providing psycho-social support for children. Essentially, according to Shrader-Frechette, Earl & McCoy (2000c:44),

psychological interventions such as counselling should never be a starting point, and not practised by non-professionals. Social support, children's participation and child protection comes first and can achieve a great deal.

2.3.2.7 Strategies to promote resilience and coping among children and adolescents affected or orphaned by HIV/AIDS

The scale of the HIV/AIDS epidemic and the socio-cultural and economic context in communities demand new and bold ecosystemic strategies, different from Western clinical models. New strategies, which can be presented to vast numbers of people through existing systems (schools, clinics, religious institutions, non-governmental agencies oriented towards HIV/AIDS issues) and by 'trained' peer lay persons, are needed (Diener, Suh, Lucas & Smith, 1999:85). Community and voluntary supplementary support can provide basic contact comfort and stimulation for children when ill or depressed in the case of their mothers being unable to do so. In addition, the research underscores other important strategies, such as - pre-planning for the child's care while the parent is still alive, involving the orphans themselves in moves toward a solution, and, whenever possible, having the child remain with the surviving family or extended family in the community. Other strategies address ways to handle migration that can reduce stress and maximize the effectiveness of relocation, if necessary (Fournier, Ridder & Bensing, 2002:409).

Given the critical care-giving role of parents and grandparents, who may also be grieving the loss of their adult child(ren), more strategies are needed to address these adult family members' grief and depression. The clinic or community setting, where parents seek HIV testing and care, as well as workplaces or village gathering sites provide potential locales for addressing caregivers' own mental health to relieve the impact on the child (Lightsey, 1997:699). Strengthening the counselling component for loss and depression to equip parents with the comfort and skills to speak to their children about their illness or impending death, could onset a supportive grieving process for the child. Parents need skills and support to disclose their status and prepare

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their children for their impending death (Maruta, Colligan, Malinchoc & Offord, 2000:140).

There are not enough trained professionals to provide the emotional support needed by children orphaned by AIDS. Much more use must be made of peer, lay groups for group counselling and support. A randomized control trial with adults in Uganda, for example, showed that group interpersonal therapy was highly effective in reducing and dysfunction in adult men and women. A new mindset is needed, which moves beyond the narrow sphere of using professionals to one that respects the abilities of lay people to provide counselling and support (Masten, 2001:227; McMillen, 1999:455).

A few studies suggest that the condition of living in poverty is the major factor causing depression, more so than illness. Attending to the economic and basic survival needs, along with emotional and mental health, may be beneficial. Harries (2002a:13) study of orphan support models in Zambia and Uganda has concluded that economically empowering guardians is a more effective strategy than just reaching out to the orphaned children. If caregivers are to be trained in income-generating activities, participant guardians with potential economic abilities can be selected for training, while those who lack these skills can be assigned specific duties within their capacity in an integrated orphan management programme (James, 2001:61).

Knowing how children conceptualize their experience should help guide strategies to communicate with them. Research indicates that children have at least a dim conception of death by age three. Representations of grief in children under three include:

- crying;

- regressive behaviours;

- excessive fear; and

- clinging (Aspinwall & Staudinger, 2003b:246).

From ages three to five, children realize death occurs, but they may imagine it as reversible and partial. Indeed, they fear separation from others more than they fear death. Sometime between ages six and ten, children realize that death is both final and universal (Brissette, Scheier & Carver, 2002a:102).

The majority of parents dying of AIDS choose not to discuss their illness and impending death because they fear harming their children. Some parents report that trying to decide whether or not to disclose their HIV diagnosis to their children is as emotionally charged as learning of the diagnosis itself (Kelly, 2002:27). In Shona culture in Zimbabwe, children are kept from participating in funerals. Nevertheless, they are aware of what is happening, but lack the skills to understand it (Fleischman, 2003b:33). "Children are fantastic observers but poor interpreters," according to Garcia-Mareno and Watts (2000:71). In the absence of clear communication about the losses they are experiencing, children construct their own meaning of the excruciating things happening in their lives. They often blame themselves, especially if they tend to lose one parent, or one caregiver, one educator after another.

Discussing AIDS and death can help both children and their parents. Painet (2001:99) investigated the reactions of parents who chose to disclose their HIV status to their children and those who did not; because of fear their children would be psychologically harmed. The study indicated that those parents who chose not to reveal their illness were more depressed than those who did. None of the parents who spoke honestly to their children about their disease and inevitable death regretted having done so. Talking about the disease can also encourage parents to plan for their children's future care. Research conducted by (2004a:21) in Kenya showed that only 3.7% of parents infected with HIV currently planned to do this. Children seem to prosper, even considering the wide variation in cultural behaviours around death, when the truth is presented honestly to them. Heyzer (2003:20) reported that when caregivers told children their parents had died instead of that they "went to church," the children's night terrors diminished.

Low-cost strategies can be implemented to help children deal with their depression and grief. For instance, journal writing, creating storyboards, art

therapy and expressive drama have been shown to help children cope with depression, stress and trauma in circumstances where resources are scarce and long-term psychological counseling is unavailable. Volunteers, using locally available materials, can put such programs in place and sustain them (WHO, 2003:22).

UNICEF (2004:26) states that the Memory Book Project, developed in the United Kingdom and first used in Uganda, has been used in several areas of Sub-Saharan Africa to assist parents and children to deal with AIDS and death. Parents are encouraged to compile books that include pictures and descriptions of family history, thoughts, feelings, and messages for the future. Compiling and passing on Memory Books helps parents prepare for their death and reassures children that their parents and families love them.

Educators and health workers can be trained to provide support and counseling for children of parents who are ill or dying from AIDS. Educators can learn to recognize children who need special support, to encourage interactions between orphans and other learners, and to use activities like art and storytelling, encouraging children to express their emotions. For example, a new regional campaign launched by UNESCO encourages leaders in the education sector to help counter the impact of HIV and AIDS (UNICEF, 2003:10). The approach encompasses policies to reduce stigma and discrimination, educator training, steps toward a healthy physical and psycho-social school environment, and counselling services. This initiative calls on the education sector to move beyond its traditional focus on academics and to plan such strategies for the growing number of children and families affected by AIDS in that region (Badcock-Walters, 2001b:12).

Other strategies are known to strengthen the psycho-social response of children orphaned by AIDS. Some of these concern children's placement after the death of their parent(s). The research of Gonzalea, Penedo, Antoni, Duran, Fernandez, McPherson-Baker, Ironson, Klimas, Fletcher and Schneiderman (2004:413) research has shown that orphans experience less trauma if they are cared for by members of their extended family. Informal, non-institutional care by a member of the extended family is overwhelmingly

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preferable to institutional care. This finding appears to be true across cultures. In most African countries, families do not cease to exist when parents die, as most people live in communities of extended families in rural areas. A study of children orphaned by AIDS in Thailand posits that the extended family may be even more important in South-East Asia than in Sub-Saharan Africa and suggests that the grandmother is an especially critical family member to serve as her orphaned grandchild's caregiver (UNICEF, 2003:10).

Brissette *et al.* (2002b:103) conducted a study of resiliency factors among eight to ten year old children from Zimbabwe and concluded that the following six traits seem to be linked to resiliency in children orphaned by AIDS:

- a willingness to accept surrogate caregivers;

- an open definition of family;

- a developmental age consistent with or greater than chronological age;

- interpersonal relationships based on reality;

- positive perception of home life and family life relations; and

- a perception of warmth and nurturance and the stability from the overall environment.

Considering these six factors is important for designing programmes that help children cope with losses due to AIDS.

Attending to the mental health needs of children and all caregivers such as parents, grandparents, extended family and surrogates should start at the earliest possible intervention stage, which is at diagnosis of the disease in the child's parent. Joining the scientific mindsets of clinical medicine even more intensively with psychiatry, psychology, counselling, and faith-based spiritual support can enable programmes to assess and minimize the impact on caregivers and children early in the process (Pretzer & Walsh, 2001:321).

In light of the literature findings in this section of this chapter, societies need to consider advocacy and policies; research and practice in their concerted

efforts to assist children and adolescents who are affected by HIV/AIDS in the following ways:

- physical and mental health are inextricably linked. AIDS advocacy must address the important role of mental health. Policy makers and programme planners must increase attention to this link and consider ways to strengthen the mental health component (Massimini & Delle, 2000:24);

- the impact on a child of the parent's chronic illness from AIDS and death needs greater understanding such as in the following questions that can be asked:

  o What are children's perceptions of loss and death from HIV and AIDS as compared to deaths from other causes?

  o How does AIDS prevalence in the community affect children?

  o What can the mental health and social science disciplines contribute to the understanding of the way to strengthen a coping response and provide interventions to reach masses of people at critical developmental stages?

  o What are the mental health needs of the ill parent, and how can interventions mitigate the depth of their own depression and sadness to enhance care giving and planning for their children?

  o How do the medical, psychiatric, psychology, counseling and religious communities and the systems in which they work, view the mental health and psycho-social component?

  o What will it take for various systems to develop a shared mindset that envisions ways to cooperate in meeting the mental health needs of children affected by AIDS?

  o How can various systems implement assistance? For those orphans who can continue schooling, what coping mechanisms, supported

through life skills or other bereavement and group support sessions, can be valuable?

o In systems already desecrated, how can the school as a community and educators respond to the needs of staff, parents and the children in their care?

o Coping is not only an individual but a community issue. With so many people affected, what types of interventions can make a difference at the community level (Dorkenoo, 2001:23; Abi-Hashem, 2001:85)

The next section provides the impact of HIV/AIDS on children and adolescents.

2.4 THE POTENTIAL EFFECTS OF HIV/AIDS ON CHILDREN AND ADOLESCENTS

Ainsworth and Teokul (2000a:56) reveal that children orphaned by AIDS face an increase in poverty, malnutrition, household responsibility and vulnerability to abuse, child labour, sexual risk, stigma, and isolation. The research conducted by WHO (2002f:13) found that children orphaned by AIDS have less:

• access to food than other children;

• health services;

• school opportunities;

• material goods;

• protection; and

• love.

Losing a parent to AIDS diminishes the child's position in the family. Traditionally, the death of the father deprives children of income and male authority, the death of the mother deprives the child of emotional and mental

security. If the child is accepted into the extended family, he or she can be in a weak and tenuous position due to scarce resources and the primary position of existing offspring. Orphans can lose their inheritance or suffer malnutrition in a family already struggling to feed its own members (Lamptey *et al.*, 2002a:19).

The literature review reveals that children orphaned by AIDS tend to be marginalized in the school environment, and they often drop out. A school headmaster, quoted *verbatim* by Gregson *et al.* (2001a:468), observed: "You can tell the orphans: their clothes are worn out, they are dirty, and their hair is not combed." Some learners leave schools because of stigma and discrimination, others because they cannot pay the fees. Other children leave because they must become caregivers or breadwinners. According to a study in Kenya (Hepburn, 2001b:18), 52% of children orphaned by AIDS were not in school, compared to 2% of children in the rest of the population. In Mozambique, only 24% of children whose parents had died were attending school compared to 68% of those with parents still living (Harris & Schubert, 2001:35). Harris and Schubert (2001:35) suggest that remaining in school is one means children may have to overcome their persistent poverty. Even for those who remain in school, school performance studies provide some indication of the debilitating impact of grief and depression on young people's ability to carry out normal school tasks (Carr-Hill *et al*, 2000c:16).

Lovelife (2001:8) estimates that in 2001 2,65 million South African women and 2,09 million men between the ages of 15 and 49 were HIV positive. These figures include educators and learners. According to the 12th Antenatal Survey conducted by the Department of Health (2000c:9) between the 1st and the 31st October 2001 South Africa had the fastest growing epidemic in the world. Lovelife (2001:7) estimates that 4,2 million individuals are infected with HIV in South Africa and it is expected that this figure will rise to well in excess of 6 million by the year 2010. It is estimated that between 1500 and 1700 new infections take place each day. Gow and Desmond (2002:45) claim that there are more people living with HIV/AIDS in South Africa than in any other country.

The physical needs, emotional deprivation and financial desperation of children orphaned by AIDS make them easy prey for exploitation and abuse. They often live on the street, where they are used as cheap labour by day and as sex workers by night. This deadly pattern exposes them to HIV and AIDS, thereby repeating the cycle (Carr-Hill et al., 2000a:16).

The impacts of the HIV/AIDS epidemic on children occur in a number of overlapping and interdependent domains, such as:

2.4.1 Fewer opportunities for schooling and education

The orphans and vulnerable children are less likely to access education opportunities because of costs involved. Even though the government has initiated Universal Primary Education, certain costs still remain to be met by the family. It is worse for those families that have been affected by HIV/AIDS (Peterson & Swartz, 2002:7).

2.4.2 Loss of home and assets

Without the protective environment of their homes, orphaned children face increased risk of violence, exploitation and abuse. They may be ill-treated by their guardians, and dispossessed of their inheritance and property. Those living with foster families are more likely to be malnourished, underweight, or short in length for their age in comparison to non-orphans (Barnett & Whiteside, 2000d:17). In worst-case scenarios, orphaned children may be abducted and enrolled as child soldiers or driven to hard labour, sex work, or life on the streets (Halperin, 2001c:13).

In Cambodia, a recent study by the Khmer HIV/AIDS NGO Alliance and Family Health International found that about one in five children in AIDS-affected families reported that they had to start working in the six months to support their family. One in three had to provide care and take on major household work. Many had to leave school, forego necessities such as food and clothes, or be sent away from their home. All of the children surveyed had

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been exposed to high levels of stigma and psycho-social stress, with girls more vulnerable than boys (Tawfik & Kinoti, 2002a:16).

However, there are many examples of successful help for orphans in these situations. In Zimbabwe, since 1998, the Salvation Army's Mayise Camp has provided psycho-social support to orphaned children. It recently expanded its care services to include stance against violence, exploitation and abuse (Barnett *et al*, 2001:12). Since children often have trouble obtaining medical, psychological and legal services, the Camp started a Mobile Law Clinic that brings essential services to the children. In Cambodia, the non-governmental organization Mith Samlanh ('friends') runs twelve interlinked programmes for 1 500 street children, ranging from HIV prevention and care, to reproductive health education and income-generating activities (Chapman *et al*, 2001:18).

Ensuring access to education is critical in responding to the orphan crisis. Orphans often fall behind or drop out of school, compromising their psycho-social development and future prospects. This also affects a country's long-term recovery from the epidemic. For instance, research in the United Republic of Tanzania revealed that the school-attendance rate among orphans who had lost one parent was only 71%. Among orphans who lost both parents it was even lower at 52% (Opuni, Bertozzi & Bollinger, 2002:58).

Staying in school offers orphaned children the best chance of escaping extreme poverty and its associated risks. Thus, everything possible needs to be done to keep them in school. For example, China's Henan Province recently announced that orphans living with their extended family would receive free primary and secondary schooling, and financial support for further studies. Similarly, Jamaica's National AIDS Committee helps some of the country's orphaned children with school-related expenses, including school fees, uniforms and books (UNICEF, 2003:12; UNAIDS, 2004b:6).

Stories of loss of property by orphans have also been well documented (FAO, 2002a:27). This problem is mainly due to the parents' failure to compile a last will and testament. On the other hand, orphans are illiterate and ignorant of

their legal rights which relatives of the deceased then take advantage to pilfer property (Barnett & Whiteside, 2000a:24).

2.4.3 Health and nutrition

Children affected by HIV/AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet demonstrated increased morbidity and mortality among broadly affected children compared to unaffected control groups (WHO, 2004:32). In this regard, it has been suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic - or alternatively, that orphans may not be worse off than peers living in extreme poverty. Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV/AIDS (Benatar, 2002a:164).

2.4.4 Vulnerability to infection

Apart from other impacts, children affected by HIV/AIDS are themselves often highly vulnerable to HIV infection. Their risk for infection arises from the early onset of sexual activity, commercial sex and sexual abuse, all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape. Some studies of street children, for example, show that vulnerable children do little to protect themselves from HIV infection because the pressures for basic survival such as finding food far outweigh the future orientation required to avoid infection (Bennett & Fairbank, 2003a:36).

2.4.5 Emotional deprivation

The mental health and psycho-social issues of children whose parents have died of AIDS tend to be under-examined and under-treated in the light of demands for basic survival. Yet HIV/AIDS affects children's mental health in many ways. Children's psychological vulnerability begins long before the death of a parent. One of the single most important factors in children's mental health is the mental health of their parents. Unsurprisingly, depression

is very common among mothers who have HIV and AIDS - one study found a 38% prevalence rate of depression among infected mothers (Desmond *et al*, 2000b:16).

Most research to date on the psycho-social effects of parental AIDS and death on children has been conducted in Zimbabwe, Uganda, Zambia, Kenya, and Tanzania (Hanson, 2002c:72). Studies have identified significantly higher rates of depression, anxiety, survivor guilt, loneliness, isolation, low self-esteem, and disruptive, antisocial high-risk behaviours among children orphaned by AIDS compared to other children. Other researchers have noted a general emotional imbalance in children orphaned by AIDS, marked by anxiety, depression, and grief (World Bank, 2002b:26).

For the majority of these children, the trauma from the death of a parent recurs and the risk to mental health may be additive. Children become parentless multiple times because their caregivers keep dying of the disease. Other beloved figures get ill and die. In Malawi and Zambia, for instance, up to 30% of educators are infected with HIV (Kidanu, Nyblade & Rohini, 2003:99).

Some comparative research of psycho-social problems has been conducted. In Uganda, researchers investigated the nature of emotional problems of school-sponsored orphans. In comparing the feelings of children orphaned by AIDS to feelings of non-orphans, investigators found that non-orphans showed more optimism - they expected to live longer and they imagined themselves staying in school, working, and wanting to have children in future. The children orphaned by AIDS were significantly less able to envision a future (Lemma, 2003a:34).

A study in Tanzania found substantial evidence of reduced well-being, with most orphans showing psychological impairment. Orphans were three times more likely than non-orphans to contemplate suicide. The researchers also found that orphans, and particularly female orphans, had more internalizing problems than non-orphans. These problems included depression, anxiety and low self-esteem (Teokul & Ainsworth, 2000b:56).

Children who grow up without the love and care of adults devoted to their well being are at higher risk of developing psychological problems. A lack of positive emotional care is associated with a subsequent lack of empathy with others and such children may develop antisocial behaviours. Not all children are, however, affected or affected to the same degree. Protective factors - in the form of compensating care from other people, including educators, as well as personality predisposition - may lessen the impact on children of reduced care in the home environment (Wallace *et al.*, 2001a:26; Bennett & Fairbank, 2003b:26).

The mentioned effects of the HIV/AIDS epidemic on children are likely to vary considerably by age. It might be expected that preschool-aged children, for example, could show primary effects on growth and health, and school-aged children to show education, work, psycho-social and vulnerability effects. In addition, none of the effects cited have been shown to be specific to children affected by HIV/AIDS, even if such a category of children can be more precisely defined (Benell *et al.*, 2002:38).

It is also impossible to isolate and exclude the effects of conditions that exist prior to the death of a caregiver. Such pre-existing or development influences include poverty and social disorganisation, parental preoccupation, depression and social isolation (Allen, Tainter & Hoekstra, 1999:47).

Of greatest concern, however, is the generality of these effects and their strong association with poverty. The impact of the HIV/AIDS epidemic on children and families is incremental - poor communities with inadequate infrastructure and limited access to basic services is worst affected. Poverty amplifies the impacts of HIV/AIDS on children and renders their effects on children in unrelentful manner (Harries, 2002b:268). At the same time, changes associated with the illness and death of caregivers and breadwinners can impel children into conditions of desperate hardship. As Coombe and Kelly (2001:12) contend: "The common impacts [of HIV/AIDS] include deepening poverty, such as pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets". Psycho-

social distress is another, which has an impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care.

Williamson (2004:301) has developed the model to demonstrate the effects of HIV/AIDS on the psycho-social well being of children (see Figure 2.3 below).

Figure 2.2 indicates that children affected by HIV/AIDS are often traumatized and suffer a variety of psychological reactions to parental illness and death. In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatisation as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus (Case, 2003b:12). Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health (Beresford, 2002:13). Existing studies of childrens' reactions suggest that they tend to show internalising rather than externalising symptoms in response to such impacts such as depression, anxiety and withdrawal, as opposed to aggression and other forms of antisocial behaviour (Aspinwall & Staudinger, 2003a:13).

Figure 2.2: Problems among children and families affected by HIV and AIDS

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┌─────────────────┐
│ HIV infection   │
└─────────────────┘
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┌─────────────────┐                              ┌─────────────────┐
│                 │                              │ Children    may │
│ Increasing      │                              │ become    care- │
│ serious illness │                              │ givers          │
│                 │                              └─────────────────┘
└─────────────────┘


        ⇕              ┌─────────────────┐              ⇕
                       │                 │
                       │ Pscycho-social  │
                       │ distress        │
                       │                 │
                       └─────────────────┘

┌─────────────────┐                              ┌─────────────────┐
│                 │                              │ Death of parents│
│ Economic        │                              │ and       young │
│ problems        │                              │ children        │
│                 │                              └─────────────────┘
└─────────────────┘
                                                        ⇕

        ⇕                                       ┌─────────────────┐
                                                │                 │
                                                │ Problems   with │
                                                │ inheritance     │
                                                │                 │
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┌─────────────────┐                              ─────────────────
│ Children        │                                      ⇕
│ withdraw   from │
│ school          │                              ┌─────────────────┐
└─────────────────┘                              │ Children without│
         ⇕                                       │ adequate   adult│
                                                 │ care            │
┌─────────────────┐                              └─────────────────┘
│ Inadequate food │                                      ⇕
│ and shelter     │
└─────────────────┘                              ┌─────────────────┐
         ⇕                                       │ Discrimination  │
                                                 └─────────────────┘
┌─────────────────┐              ⇕                        ⇕
│ Problems   with │
│ exploitive child│                              ┌─────────────────┐
│ labour          │                              │ Material   needs│
└─────────────────┘                              │ Sexual          │
         ⇕                                       │ exploitation    │
                                                 └─────────────────┘
┌─────────────────┐                                       ⇕
│ Reduced access  │
│ to     health-care│                            ┌─────────────────┐
│ services        │                              │ Life on the street│
└─────────────────┘                              └─────────────────┘
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┌─────────────────┐
│ Increased   │
│ vulnerability   │
└─────────────────┘

Source: Williamson (2004:54)

2.4.6 Poverty

The condition of poverty these children find themselves in compels them to engage in activities that expose them to the risks of HIV infection. This has become more apparent with the emergence of child-headed households. UNAIDS (2005a:13) reported that due to inadequate parenting, children in child-headed households may miss the psychological support needed from an adult. Such children are more likely to engage in pathological behaviours like criminal activities, drug abuse and engage especially in risky behaviours that increase their vulnerability to HIV infection (Kebede, 2004a:40).

According to a variety of measures and without taking into account the effect of the HIV/AIDS epidemic on socio-economic conditions, it is estimated that an average of six out of ten children in South Africa live in poverty. Using the Fifth Labour Force Survey, USAIDS (2004:16) has calculated that an estimated 4.8 million children aged fourteen years and younger, or 33% of all children in this age range, live in households where no one is employed. If a child is defined as a person of eighteen years and younger, then 6.1 million South African children - again 33% of all children in this age range - live in unemployed households.

A rough estimate, calculated with disregard of all kinds for potential obscurities, is that one in five or six children is living with an infected mother. There is likely to be a very large overlap between those children who live in poverty and those living with an HIV-positive mother (Department of Health, 2003:17). Poverty is the undeniable background to the HIV/AIDS epidemic and HIV/AIDS itself deepens the poverty of already vulnerable children. Owing to this, one needs to look beyond AIDS orphans to all vulnerable children. Communities' efforts need to be focused on poor children with tenuous social, institutional and material supports, as the situation of these children is likely to be considerably worsened by HIV/AIDS (Hargreaves & Glynn, 2002b:490).

2.4.7 Loss, separation and bereavement

Many children in the Sub Saharan region are going to be separated from and lose their parents, caregivers and the breadwinners on whom they depend

(USAIDS, 2004:14). Again, without considering associated confounding effects such as residential and school change and worsening socio-economic conditions, the loss of parents and loved ones is associated with internalising psychological conditions including anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Hepburn, 2001c:36).

2.4.8 Cruel and impersonal child-care

Children affected by HIV/AIDS may be subjected to impersonal and abusive child care through such as:

- exploitative family and community care;

- poorly chosen and supervised foster care; and

- long-term institution-based rearing (Page, 2001:42; Gupta, 2001a:26).

In general, and without considering associated effects such as pre-existing home conditions, separation and bereavement, impersonal and abusive care is associated with a range of psychological disorders, including a reduced capacity for affection and compassion, acting out and more aggressive coping styles.

2.4.9 Lack of food and increased malnutrition

There is a close link between families where orphans and vulnerable children live and food security. In fact in such families, especially those affected by HIV/AIDS, plantations have reverted into bush due to lack of labour (FAO, 2002b:36).

2.4.10 Inadequate health-care

Orphans and vulnerable children face inadequate health care due to the economic pressure on the family. It is worse in those families that have been affected by HIV/AIDS (Department of Health, 2003:18).

2.4.11 Increased child labour

Children who have been orphaned or vulnerable get involved in work as a means of survival. There is an increasing number of children especially girls seeking jobs of housemaids or bar attendants. It has also been well documented that children in the labour market tend to enter the market at an early age which affects their growth and well being (WHO, 2003b:12; UNAIDS/WHO, 2005, 16).

Many children in South and Southern Africa already work hard. The Survey of Activities of Young People (SAYP) commissioned in 1999 by the South African Department of Labour found that more than half a million children between five and fourteen years of age work for long hours, mainly collecting wood or water. Close to 400,000 children do night work, 183,000 do three or more hours a week of paid domestic work and 137,000 work with or close to dangerous machinery or tools. About 19,000 children (0.1%) beg for money or food in public for three or more hours a week. More than 70% of children work to help their families, either willingly or unwillingly. About 30% of children's work is in contravention of the law. The International Labour Organisation (ILO) estimates that worldwide approximately 120 million children in the five to fourteen year age group work on a full-time basis, and this figure rises to around 200 million when those for whom work is a secondary activity are included. Other surveys conducted by the ILO have found that, over a twelve-month period, the proportion of economically active children in the five to twelve year age group could rise to as high as 40% in developing countries (ILO, 2003:11; FAO, 2002c:10). Such studies conclude that children's labour contributions are an important component of household income, in some cases amounting to as much as one-third of household income.

While not all child labour is necessarily harmful - a moderate amount of responsibility can have a positive influence - illegal child labour can be damaging to children's physical and mental health, and the fact that it prevents children from attending school it may be seen as cruel and dehumanising. Child labour is likely to increase as economic conditions of children in families affected by HIV/AIDS deteriorate. Instruments dealing with

child labour infringements - such as the Convention on the Rights of the Child and, in South Africa, the constitution and multiple laws - do not in their current form lead to financial assistance for the child or the family to improve the economic conditions leading to child work (USAIDS, 2004:26).

2.4.12 Neurobiological development is affected

Children who lack a secure attachment because of the psychological depression, unavailability or death of a parent or caregiver live in chronic stress, which can weaken the immune system. Moreover, the absence of a loving and attentive caregiver has been shown to alter the development of the brain (Fontana & Rosenheck, 1998b:189). Hamlin and Valikangas (2003:69) research of nearly four decades into the cellular and molecular bases of brain development concluded that the developing child's environment plays a large role in shaping his or her brain circuitry and subsequent behavioural performance. Studies on neurobiology suggest that children are most vulnerable to adversity when their brains are most elastic and developing most rapidly (Kendler, Gardner & Prescott, 2003:195).

At birth, an infant's primitive emotional reactions are already organized by parts of the brain, primarily the almond-shaped amygdala. The pre-frontal cortex, which plays a major role in directing and modifying people's more primitive reactions like anger or fear, develops during the first eighteen months of life (Jang, Poon & martin, 2004:126). The development of this part of the pre-frontal cortex, which relates to thought, language, reasoning and perception, is not automatic but dependent upon the child's environment and it develops only in response to experiences the child has with other people. Positive interactions such as smiles, games, especially touch generate connections in the prefrontal cortex, which help to manage the more impulsive reactions of the amygdala. In simplest terms, the pre-frontal cortex helps to calibrate people's emotional lives. When developed positively, it enables us to develop deep human relationships, to think and to feel (Kiecolt-Glaser, Page, Marucha, Maccallum & Glaser, 1998:26).

Inadequate development of this part of the brain, on the other hand, causes many of human beings' ills such as anxiety, depression, and other forms of mental illness. Lack of stimulation and neglect can short-circuit developing connections within the brain and decrease its size. Too much stress in the absence of a calming, soothing parental figure hinders the child from developing a biological mechanism to regulate his feelings. The studies of Harlow in the 1950's so clearly demonstrated the needs of primates and infants for contact comfort and its soothing effect (Maddi, 1999a:55). Larson's (2000:170) research further concluded that human beings' earliest experiences are not simply laid down as memories or influences but are translated into precise physiological patterns of response in the brain that then set the neurological rules for how human beings deal with their feelings and those of other people for the rest of their lives.

Even people who work with orphaned children do not comprehend the emotional anguish a child experiences as he or she watches one or both of his or her parents die (Keltikangas-Jarvinen, 2000:5). When one parent is HIV-infected, the probability is high that the other parent is as well. Therefore, children often lose both parents in quick succession. An orphan's caregivers may also succumb to AIDS, with the result that children may suffer multiple bereavements. The child's suffering is often aggravated by being separated from his or her siblings (Lyubomirsky, 2001:240).

2.4.13 Sexual exploitation and child trafficking

There is limited data available on the extent and nature of human trafficking in either the region or beyond and much of what is available is based on relatively small-scale research. According to the International Organisation for Migration (IOM), however, the trafficking of women and children is the third most lucrative type of organised crime in the Southern African region, following the sale of arms and drugs. A recent report released by the IOM suggests that considerable numbers of women and children are trafficked annually in the Southern African region (WHO, 2003c:24).

Trafficking in children occurs for the purposes of child prostitution, illegal and false marriage, illegal adoption and child labour. An unknown number of children are trafficked for body parts. In the Southern African Development Community (SADC) region, children are trafficked primarily as bonded labour and for the purpose of sexual exploitation. The IOM report highlights, as examples of trafficking in the region, a European-led child sex tourism industry in Malawi and the trafficking of Mozambican children intended for prostitution in Johannesburg (UNICEF, 2004:15; USAID, 2004:26).

It is likely that as the ratio of dependent children increases as a result of the HIV/AIDS epidemic, so will the chances of children being lured into trafficking and sexual exploitation. Once imprisoned, or left without the means of escape, children are at their most vulnerable (Badcock-Walters, 2001a:8).

2.4.14 School drop out

According to the 2003 South African October Household Survey, as many as 35% of rural African children between the ages of six and 17 years do not attend school. In the sub-Saharan region, an estimated 44 million children, more girls than boys, are not attending school. School drop out is likely to increase as families become unable to afford the costs of schooling and as children's contribution to care and work is required at home (Bradshaw, Johnson, Schneider, Bourne & Dorrington, 2002:15). Experience suggests that the most vulnerable orphans are those in their school years, aged ten years and older. Thus, despite all their shortcomings, schools have significant potential to play a critical role in relieving the worst effects of the HIV/AIDS epidemic on children (Brown, 2003:49). Apart from the accrued personal and social benefits of education for work and national development, schooling provides stability, institutional affiliation and the normalisation of experience for children. It also places children in an environment where adults and older children are potentially available to provide social support (Carr-Hill & Peart, 2003:56).

2.5 CONCLUSION

This chapter provided the literature review on ecological systems theories and resilience models which form the framework for this research, and the potential effects of HIV/AIDS on children and adolescents.

The next chapter provides the empirical design.

CHAPTER THREE

EMPIRICAL DESIGN

3.1 INTRODUCTION

This chapter provides a detailed exposition of the research design utilised in this study. It begins by explaining the reasons why this study was conducted primarily in the form of a case study. In addition, it discusses the sampling methods used, the ways in which data was collected and analysed, the place where the interviews took place, and the ethical procedures followed.

3.2 CASE STUDY

The methodology used for this research project, is the case study (see 1.4.1). Case studies are important instruments to be used in social research. For numerous researchers, case studies are employed in the analysis of qualitative data. They can be used at a number of different levels or scales of social life, varying from individuals through families, workplaces, occupations and formal organisations (such as schools and hospitals) to nations and states. Case studies are 'likely to produce the best theory' (Neuman, 2000: 33). Welman and Kruger (1999:21) formally define a case study as '...empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially if the boundaries between a phenomenon and context are not clearly evident. A case study is, then, an intensive study of a specific individual or specific context'.

The qualitative research approach was used to conduct research with a planned sample of:

- sixteen orphaned learners (n=16) who had to form two focus groups of eight each from two schools;

- sixteen members of School Based Support Teams (SBSTs) (n=16) who had to form two focus groups of eight each from two schools;

- one focus group of eight school principals (n=8) ;

- three families where the first family consisted of a grandmother and three aunts; the second family consisted of a grandmother, an aunt and an uncle who refused to participate in the study, and the third family consisted of two uncles, two aunts and a cousin (n=12);

- one focus group of eight School Management and Governance Developers (SMGDs) (n=8) from the Thabo Mofutsanyana Education District in the Free State Province; and

- one focus group of four members of District Based Support Teams (DBST) (n=4) from the Thabo Mofutsanyana Education District in the Free State Province.

The qualitative approach was used because the researcher wanted to be able to:

- record and understand these AIDS-orphaned learners' experiences from their environmental and socio-cultural contexts; and

- generate richly detailed data from the SBSTs, principals, SMGDs, DBST and their families about these learners and also to provide a contextualised understanding of their experiences within their environment and circumstances (Berg, 2003:12).

3.3 SAMPLING METHODS

Snowball sampling is a special non-probability method used when the desired sample characteristic is rare (Fink, 2002:160). Since this research is purely qualitative, the "snowball" sampling technique was used. It was impossible for the researcher to list all the learners affected by HIV/AIDS and sample randomly from the list. This is the main reason for choosing the snowball technique. When the researcher visited to schools, families and the district office to conduct research, she knew no HIV/AIDS affected learners. The researcher had to rely on informants, who were educators in schools, to supply him with participants' names. The researcher selected participants using his own judgment (learners who according to the attendance register

are absent frequently and look neglected). The informants came up with sixteen learners and the interviewer started interviewing these learners.

This chapter presents the responses of the participants who were involved in this research, namely: sixteen orphaned learners (n=16) who formed two focused groups of eight each from schools A and B, sixteen members of School Based Support Teams (SBSTs) (n=16) who formed two focused groups of eight each from schools A and B, three families where the first family consisted of a grandmother and three aunts, the second family consisted of a grandmother, an aunt and an uncle who refused to participate in the study, and the third family consisted of two uncles, two aunts and a cousin (n=12), eight school principals from circuit 22 of the Thabo Mofutsanyana Education District, eight School Management and Governance Developers (SMGDs) (n=8) and the four members of District Based Support Team (DBST) (n=4). The sample was therefore, N=56.

Snowball sampling is a special non-probability method used when the desired sample characteristic is rare (Fink, 2002:160). It was extremely difficult to locate participants' names because of the sensitivity of the subject the researcher was investigating. Snowball sampling relies on referrals from initial subjects in order to generate additional subjects. The disadvantage of this technique is that it comes at the expense of introducing bias because the technique itself reduces the likelihood that the sample will represent a good cross-section from the population (Crabtree, Nichols, O'Brien, Rouncefield & Twidale, 2000:66). The sensitive nature of investigating a topic such as the one of this research, compelled the researcher to use the snowball technique, as propounded by Fink (2002:163) where he postulates, that snowball sampling is suitable for sensitive research topics such as HIV/ADS.

The snowball technique began when the already selected participant that was drawn by relying on the informant's judgment was, asked to nominate others. She nominated two affected learners who happened to be her siblings, while others refused, claiming that the affected learners they knew preferred to keep their situation confidential. When the sixteen learners agreed to be interviewed the interview was scheduled.

3.4 RESEARCH POPULATION SAMPLE

Neuman (1994:147) defines the research population as all the persons and objects with which the researcher is concerned. In planning this research, the researcher intended to have the following number of participants who had to form the focus groups of his research:

- Sixteen orphaned learners (n=16) who had to form two focus groups of eight each from two schools.

- Sixteen members of School Based Support Teams (SBST) (n=16) who had to form two focus groups of eight each from two schools.

- One focus group of eight school principals (n=8).

- Three families where the first family consisted of a grandmother and three aunts; the second family consisted of a grandmother, an aunt and an uncle who refused to participate in the study, and the third family consisted of two uncles, two aunts and a cousin (n=12).

- One focus group of eight School Management and Governance Developers (SMGDs) (n=8) from the Thabo Mofutsanyana Education District in the Free State Province.

- One focus group of four members of District Based Support Teams (n=4) from the Thabo Mofutsanyana Education District in the Free State Province.

The sample of the research was planned in this manner, because it was conducted in one circuit only of the Thabo Mofutsanyana Education District in the Free State Province. The sample was, therefore planned, around sixty-four (N=64) but the final sample ended at fifty six. Four members of School Based Support Teams (SBSTs), one principal, two SMGDs, and one DBST member did not turn up for the interviews, while one uncle of one of the families refused to participate in the study, on the grounds that he was still emotionally affected and overwhelmed by the loss of his sister. The researcher accepted the refusal of the participant as the empirical study of this

research was based on voluntary participation and the researcher was also not accompanied by a professional psychologist who would debrief the uncle participant .

The interviews with the participants were conducted during March and April 2007.

3.5 DATA COLLECTION

According to Fink (2002:160), the term "group interview" is a qualitative technique, using discussion among a group of 4 – 12 people in a comfortable, non-threatening environment, to explore topics or obtain perceptions about a given problem or topic of interest. The technique makes use of group interaction, in order to provide insight and data, not accessible without the stimulus of the group discussion. Such an interview is conducted with the limited group of persons who have been brought together for the same and specific purpose.

According to Fink (2002:161), the aims with group interviews are to -

- collect data within limited time;
- verify ideas, views and perceptions of participants and synthesise them through the discussions;
- provide insights into the attitudes, perceptions and opinions of participants;
- confine the role of the interviewer to that of initiating discussions rather than playing the directive role. In this way, participants take major responsibility for stating their views and drawing out the views of others in the group; and
- stimulate the interactions among the participants to state feelings, perceptions and beliefs they would probably not express, if interviewed individually.

It was with the above in mind, that the qualitative group interview method was opted for in this study.

Data collection was conducted through a group interview, as all sections of participants as mentioned in section 1.4 above were respectively interviewed

simultaneously. In a group interview, the researcher can get different opinions from different people at precisely the same time. When the researcher conducted the group interview, to which no time limit was set, the length which such an interview could take, was underestimated. Each interview session was planned for an hour. The hour would allow the researcher for an extensive in-depth questioning of participants about complex and multifaceted issues. It is important to note that, though the researcher had proactively planned for an hour for each interview session, the interviewees (participants) had no time limit. Participants could express themselves at length. The interview schedule was followed and questions that developed from the interview sessions, appear in Appendix A. Creswell (2003:424) defines unstructured interviews as '...repeated face-to-face encounters between the researcher and participants directed towards understanding informants' perspectives on their lives, experiences or situations, as expressed in their own words'.

Prior to spending an hour interviewing the participants, the researcher spent half an hour with the participants explaining the purpose of this research and to assure them that their names would not appear in the dissertation and that their responses to the questions that the researcher posed during the interviews, would be used only for the purposes of this research. No matter how much the researcher emphasised the issue of confidentiality, two of the participants were sceptical about giving their real names. They believed that there was a possibility of someone reading the dissertation, tracing their names and finding out whom they were. In a way they were trying to ensure their protection, even though the researcher presented no harm to them. They were probably not worried about the researcher *per se*, but about anyone who might read the dissertation. The participants were assured that the word "participant", would be used to ensure anonymity.

It has to be understood, that these participants had never been exposed to research. They had never had someone visiting them and wanting to write about their experiences. The researcher requested their co-operation in answering questions as fully and in as detailed a manner as possible.

A video-camera was used with the permission of the participants, though only one DBST member refused to appear on camera and her refusal was accommodated by using the audio mode of video-camera to record her responses. The permission was necessary because of the intrusive nature of the video-camera photographing during the interviews. The advantages of using a video camera with the permission of the participants are that -

- the interviewer focuses on responses of participants without having to be distracted by the taking of behavioural and motivational notes during the process of interviewing;

- the interviewer is able to watch the video and refresh his or her mind about the behavioural and motivational responses of participants and the context in which they are told;

- the extrapolation of themes becomes original because, the interviewer can view and compare responses of participants in each question asked; and

- responses captured on the video camera, are more memorable and easy to work with, than those recorded by means of a tape recorder or the taking of notes by the researcher.

3.6 ANALYSIS AND INTERPRETATION

After the collection of data, the responses of the participants were transcribed as per sections of participants, namely: AIDS-orphaned learners, SBSTs, principals, SMGDs, DBST and families of AIDS-orphaned learners (see section 4.2). From their responses, the researcher formulated and developed certain themes.

3.7 INTERVIEWING SETTING

The interviews that were conducted by the researcher, took place in the board rooms of the schools of affected learners, homes of families and a district office located in Qwaqwa in the Free State Province. This means, that the researcher visited them at the places where it would be convenient for them during the interviewing process. The participants chose to be interviewed at

these venues where they would be relaxed and comfortable as this is the environment they are used to. The other advantage of choosing these venues, was the absence of other learners, educators and colleagues, which made it easier for them to "open up" and be themselves during the interviews.

3.8 ETHICAL ISSUES

As this study is about AIDS orphans as human beings and their dignity, and also that it was conducted within the jurisdiction of the Department of Education, it was necessary to take into consideration some ethical issues before, during and after the research, such as obtaining the Department of Education's permission (see Addendum A), and participants' permission (see Addendum B).

Voluntary written consent to participation was secured from the participants prior to the interviews. Sensitivity to, and empathy with HIV affected learners' rights, privacy, self-esteem, emotions, beliefs, values and actions were maintained.

In order to secure ethical issues, the researcher provided participants with information concerning the following.

- The nature and purpose of the research.

- All procedures to be used with the participants.

- Procedures (including methods to ensure confidentiality) for protecting them and minimising potential risks.

- An indication of what information will accrue to science or to society in general as a result of the research.

- Provision of contact details of the researcher and signature along, with the name and location of the researcher's institution and the names and contact details of both her supervisors (Barton, 2000:18; Lincoln & Guba, 1999:24).

To put it briefly, the nature of this research topic calls upon any researcher to take precautionary measures, with a view to protecting the people studied.

3.9 CONCLUSION

This chapter outlined the research design. The research method was described.

The next chapter presents the research data analyses and interpretations.

CHAPTER FOUR

RESULTS OF THE QUALITATIVE INTERVIEWS

4.1 INTRODUCTION

This chapter focuses on the data presentation of responses of participants. Data are presented verbatim from participants in response to questions posed to them. The researcher used focused groups in all instances.

The researcher extrapolated themes from responses of participants. Themes were deduced from each question responded to. Explanation and meaning for themes were given by using extracts from responses

4.2 PROCEEDINGS AND THEMES EMERGING FROM THE QUALITATIVE INTERVIEWS.

4.2.1 Responses of two group interviews with AIDS orphans

The responses of two group interviews with AIDS orphans, are presented.

4.2.1.1 First focused group interviews

4.2.1.1.1 How did you feel after the death of your parent(s)?

Participant 1 said: "I felt hurt and angry by the passing away of my mother first then my father".

Participant 2 said: "I was angry and hurt, too".

Participant 3 said: "I was sad, too".

Participant 4 said: " Sad too, sir".

Participant 5 said: "I felt sad".

Participant 6 said: "I was also sad".

Participant 7 said: I was sad for the loss of my parents within a year".

Participant 8 said: "I was very sad at the death and burial of both parents".

4.2.1.1.2 How do you relate to the family or relatives you are staying with after the death of your parent (s)?

Participant 1 said: "I am treated well".

Participant 2 said: "I am treated well, too".

Participant 3 said: "They treat me very well every day".

Participant 4 said: "Very well".

Participant 5 said: "It is well with me, teacher".

Participant 6 said: "They treat me well, like they do their children".

Participant 7 said: "I am well".

Participant 8 said: " Very well, too".

4.2.1.1.3 How do you interact socially with family members and other children?

Participant 1 said: " I don't interact with anybody socially, I stay with my sister".

Participant 2 said: "Well with everybody".

Participant 3 said: "I interact well with my aunts and uncles".

Participant 4 said: "Everything is well with me".

Participant 5 said: "Very well".

Participant 6 said: " I am well, sir".

Participant 7 said: "I am interacting well with my relatives".

Participant 8 said: "It is well with me".

Participant 1: "Why do you not interact with anybody socially and stay only with your sister?"

Participant 1 said: "My family discriminates against me. They also hit me".

4.2.1.1.4 Briefly describe your health history (orphaned child)?

Participant 1 said: "Sores gives me problems all over my body, but I do not go to see a doctor".

Participant 2 said: "Sores, *ntate*. I visit a doctor".

Participant 3 said: "I am OK, sir. I am healthy".

Participant 4 said: "My eyes are not right and I also see a doctor".

Participant 5 said: "Healthy, too. My body does not have problems".

Participant 6 said: "I also have problems with my eyes and attend to a doctor".

Participant 7 said: "I am troubled by sores and do not go to the doctor. My next of kin does not have money".

Participant 8 said: "I have a problem of sores on the head and body, but I never go to the doctor".

Interviewer: Participant 8, why do you not go to the local clinic?

Participant 8: "They always say that there is no medication".

4.2.1.1.5 What is your performance at school? Focus your answer on both academic and extra-curricular activities.

Participant 1 said: "I perform on average. I will read my books and pass".

Participant 2 said: "My performance is well. I study at home and ask questions in class".

Participant 3 said: "My performance is also well. Teachers give us a lot of work".

Participant 4 said: My performance is average. We study in a group".

Participant 5 said "I do not do well, I stay with my sister and she does not help".

Participant 6 said: "Also doing well with my school work".

Participant 7 said: "I am doing well at school".

Participant 8 said: My work is average".

Do you play? All eight participants responded spontaneously and said: "We play sports".

4.2.1.1.6 What kind of support do you get from your family with regard to your performance at school?

Participant 1 said: "My sister is not helping me. She is also sick".

Participant 2 said: "I get support. My family checks my homework".

Participant 3 said: "I also get support from my relatives".

Participant 4 said: "My relatives give me support with my work".

Participant 5 said: "They give me enough support. They practice me maths".

Participant 6 said: "I also get good support. We work with their children".

Participant 7 said: "They also support me".

Participant 8 said: "My relatives support me, too".

4.2.1.1.7 How does the school assist you with the subject (s) that you are not doing well?

All eight learners responded spontaneously and said: "We are helped after school by teachers".

4.2.1.1.8 How does the school interact with your family with regard to your performance at school?

Participant 1 said: "My sister does not attend meetings. She is not well".

Participant 2 said: "They also come to meetings and my teacher writes a letter".

Participant 3 said: "They come per invitation".

Participant 4 said: "They come to school for meetings".

Participant 5 said: "My parents come to school when invited".

Participant 6 said: "My relatives come to school if they invite them".

Participant 7 said: "My relatives attend all meetings at school".

Participant 8 said: "They also come to school when invited".

4.2.1.1.9 Do you have financial support from any source that you know?

Participant 1 said: "My sister is going too apply for social grant tomorrow".
Participant 2 said: "I do not know whether I get a grant or not".

Participant 3 said: "I get a social grant. The money helps me a lot".

Participant 4 said: "I get it, too. I started receiving it last year".

Participant 5 said: "I also get it."

Participant 6 said: "They give me a social grant".

Participant 7 said: "I get a grant from department".

Participant 8 said: "I also get it".

4.2.1.2 Second focused group interview

4.2.1.2.1 How did you feel after the death of your parents?

Participant 1 said: "My heart was sad and I was not happy".

Participant 2 said: "Sad and unhappy even today. I miss Mom".

Participant 3 said: "I am still hurt, why did they die"?

Participant 4 said: "Hurt and unhappy, too".

Participant 5 said: "I was hurt also".

Participant 6 said: "We are hurt, very much".

Participant 7 said: "I am hurt, I loved them both".

Participant 8 said: "Very sad, *'menee'r*".

4.2.1.2.2 How do you relate to the family you are staying with after the death of your parents?

Participant 1 said: "We are relating well at home".

Participant 2 said: "I have a good relationship in the house; they like me".

Participant 3 said: "I like it; we are well".

Participant 4 said: "I am relating well with all at home".

Participant 5 said: "All is well, we are friendly at home".

Participant 6 said: "I relate well with my cousins and uncle".

Participant 7 said: "The relationship is good and we are all well at home".

Participant 8 said: "I am well at all; they like all".

4.2.1.2.3 How do you interact socially with the family members and other children?

Participant 1 said: "I play and interact well with children at home as well as neighbours".

Participant 2 said:" We are relating well. We go to church together".

Participant 3 said: "Everything is well teacher".

Participant 4 said: "I have good interaction with my relatives, I mean all".

Participant 5 said: "All children are treated well; we play together and sing".

Participant 6 said: "I stay well and relate well".

Participant 7 said: "I am well, too".

Participant 8 said: "They talk to me like their child. I am happy to stay here".

4.2.1.2.4 Briefly describe your health history?

Participant 1 said: "I am suffering from sores. I usually get medicine from the doctor".

Participant 2 said: "My eyes give problems, they hurt. My granny takes me to the doctor".

Participant 3 said: "I have no problem".

Participant 4 said: "I am suffering from sores all over by body, but I go to the doctor".

Participant 5 sad: "I am healthy, no sickness".

Participant 6 sad: "I am OK, I do not get sick".

Participant 7 said: "I do not get sick, I am fine".

Participant 8 said: "No, I am not sick".

4.2.1.2.5 What is your performance at school? Focus your answer on both academic and extra-curricular activities.

Participant 1 said: "I perform well in all my school work. I pass all tests; I also play soccer and do music".

Participant 2 said: "I am right; I do well and play in culture drama".

Participant 3 said: "I am fine, I pass well, but I do not play at school".

Participant 4 said: "No, I do not play, but I just pass tests and exam".

Participant 5 said: "Yes, I play drama, but my work is average".

Participant 6 said: "My results are average and I do not play".

Participant 7 said: "My work is average, too".

Participant 8 said: "I am playing soccer and I sing in a school choir, I just pass at the end of the year".

4.2.1.2.6 What kind of support do you get from your family with regard to performance at school?

Participant 1 said: "A brother next door helps me and other nexts doors".

Participant 2 said: "Nobody helps me, I ask other children at school".

Participant 3 said: "All help me at home with my homework".

Participant 4 said: "I get help from home; I do work with my family".

Participant 5 said:" My granny does not know my work, but helps me with Afrikaans".

Participant 6 said: "I get help, but not always. They are busy".

Participant 7 said: "We do homework together. If I do not know, Uncle does it for me".

Participant 8 said: "Ya, I do get assistance when I ask".

4.2.1.2.7 How does the school assist you in the subject (s) that you are not doing well?

Participant 1 said: "My teachers help during classes, only with other learners. But no help after school".

Participant 2 said: "Teachers do not assist us after school. They say I must learn at home".

Participant 3 said: "No, they do not help us".

Participant 4 said: "Teachers do not assist us after school; they only help all learners in class".

Participant 5 said: "There is no extra teaching for specific subjects. All subjects are taught in class".

Participant 6 said: "Teachers say I must read at home. They say I must work hard".

Participant 7 said: "They teach us in class all, of us".

Participant 8 said: "I get class assistance; I do not get help after school with my homework".

4.2.1.2.8 How does the school interact with your family with regard to your performance at school?

Participant 1 said: "My relatives attend meetings sometimes when invited".

Participant 2 said: "No one attends school meetings; they are busy".

Participant 3 said: "They come to meetings, but not always. They say they forget".

Participant 4 said: "My relatives never attend meetings even if they are invited".

Participant 5 said: "They attend all meetings when invited".

Participant 6 said: "My uncle always visits the school and come to meetings".

Participant 7 said: "My sister attends meetings except when she is busy or sick".

Participant 8 said: "They come all the time when they are called by the principal".

4.2.1.2.9 Do you have any financial support from any source that you know?

Participant 1 said: "My sister is going to apply for the social grant".

Participant 2 said: "My granny receives a social grant for me".

Participant 3 said: "I receive it myself".

Participant 4 said: "Yes, I receive money from the government".

Participant 5 said: "They are going to apply for my birth certificate and money".

Participant 6 said: "We get a social grant".

Participant 7 said: "My family is going to apply for my birth certificate".

Participant 8 said: "I get money from the government, I mean the magistrate".

4.2.2 Themes emerging from the responses of AIDS-orphan participants.

4.2.2.1 Bereavement from AIDS causes emotional disturbance among learners.

This can be deduced from the following verbatim statements of the participants: "I felt hurt and angry" and "I was sad". This shows, that the participants were negatively affected by the passing away of their parents. The participants experienced multiple adversity because they indicated that they were sad because of "the loss of...both parents within a year".

4.2.2.2 Emotional support for the orphaned learners promotes resilience.

Although the participants are emotionally distressed, they do receive emotional support and acceptance from their close surviving relatives. This support is essential in promoting resilience among them. Orphaned learners reported that, they are "...treated well", have "good relationships" and that the relatives are "friendly at home".

4.2.2.3 Discrimination of orphaned children in family social interaction causes withdrawal while acceptance promote a feeling of belonging.

While some children withdraw from social interaction, as indicated by the following statement: "I do not interact with anybody socially..." some enjoy the feeling of belonging as shown by the following responses: "I interact well with everybody" and "I relate well with my cousins and uncle".

4.2.2.4 Illnesses cause physical instability among orphaned learners.

The theme is supported by verbatim responses of participants in the following statements: "Sores gives me problem" and "My eyes give me problems, they hurt..."Learners suffer as a result of families who do not take them to doctors. This does not exclude those who are taken to doctors. The responses indicated, that sicknesses disturb learners.

4.2.2.5 A mediocre performance is experienced among orphaned learners.

This deduction is derived from responses made by most orphaned learners interviewed. These responses are shown in the following statements: "My results are average..." and "...I just pass at the end of the year". The responses further indicate that some of these learners stay with siblings who are not supporting them with schoolwork. This is supported by the statement "I stay with my sister and she does not help".

4.2.2.5 Fragmented support is given to orphaned learners by different families.

Some orphaned learners enjoy family support with their school work. This is supported by the orphans' responses in the statements below.

"Nobody helps...", "My granny does not know my work" and "I get help from home...". These statements indicate, that some surviving families cannot give learners support, due to their literacy level. It is also evident from responses, that other families just have no support for these learners. On the other hand, some of these learners are given enough support by their families.

4.2.2.7 Varying support by schools results in learners receiving dissimilar treatment.

This theme is deduced from verbatim statements of orphaned learners interviewed. The following statements highlight the deduction: "No, they do not help us", "I do not get help after school" and " We are helped after school". It is evident from the statements above, that schools are not uniform with regard to learner support. Some schools support learners with problematic subjects and others do not help

4.2.2.8 Inconsistent approaches to school meetings account for families' failure to attend.

This theme shows, that there are no systems in schools that provide for a uniform approach for schools to interact with orphaned learners' families. Some families attend meetings when it suits them, while others do not attend at all. Absence of the common meeting approaches, resulted in casual attendance by some families. The statements above are supported by statements "They come per invitation"; My sister does not attend..." and "My relatives attend meetings sometimes".

4.2.2.9 The Department of Social Development provides social grants to orphaned learners, even though some are not aware of them.

The theme is derived from responses such as "I get social a grant", Yes, I receive money..." and "I do not know whether I get it or not". It is clear, that learners are provided with social grants on the one hand, while on the other hand, some learners remain doubtful. It becomes evident, that families are not informing learners about their benefits as they are supposed to.

4.2.3 Responses of two focused group interviews with school-based support team participants.

4.2.3.1 First focused group interview

4.2.3.1.1 How does the orphan interact (s) socially with his or her peers at school?

Participant 1 said: "Learners differ. Some learners are shy and do not interact with others".

Participant 2 said: "Learners come to school hungry and then stay away from others during break ".

Participant 3 said: "These learners seem to be hungry during school hours and that why they isolate themselves".

Participant 4 said: "The orphaned learners respond as individuals. It depends on social background. Learners from supportive families interact easily".

Participant 5 said: "These learners are really shy and talk less with others. They avoid talking about their families".

4.2.3.1.2 What is the general performance of these learners in both academic and extra-curricular activities?

Participant 1 said: "Learners do not attend regularly. These learners often get sick and perform poorly. Some do participate in sport, but some not".

Participant 2 said: "Learners from supportive families perform well and also play at school".

Participant 3 said: "These learners are stubborn and display anger. They also refuse to do schoolwork".

Participant 4 said: "They get sick and remain behind and they perform from well to poor. Some play sports and some do not play".

Participant 5 said: "Learners perform as individuals. It depends on each learner's ability and they also play".

4.2.3.1.3 How is his or her attitude towards school work, educators and other learners?

Participant 1 said: "It is good."

Participant 2 said: "They respect teachers and do mix with others, but not all". Participant 3 said: "It is fine and they respect us".

Participant 4 said: "Some are doing well and interact with others".

Participant 5 said: "They are positive. They are involved at school here".

4.2.3.1.4 What support systems do you have to support orphaned learners? Focus your answer on academic and extra-curricular activities.

Participant 1said: "I help these children after school to do their home work. SBST have educators who counsel them".

Participant 2 said: "We support all orphaned learners who need assistance after school, not only those who are caused by AIDS".

Participant 3 said: "It is true that educators help orphaned learners after classes. They do not have parents to help them at home. We also give them psychological support. There are insufficient sports facilities, but they play at skipping and soccer".

Participant 4 said: "They also play netball".

Participant 5 said: "Well, I agree with the team".

4.2.3.1.5 How often do you interact with the families or guardians of orphaned learners, what issues do you discuss?

Participant 1 said: "The school calls meeting for orphaned learners. Yes, they do even if is not for everybody".

Participant 2 said: "It is true that we invite them. Most do attend. We also discuss social issues and needs of learners".

Participant 3 said: "The interaction is regular. We discuss learner performance too".

Participant 4 said: "They told you the truth. We always keep contact with families".

Participant 5 said: "*Ja*, they are right. There are good relations".

4.2.3.1.6 What does the school do to facilitate financial support for orphaned learners?

Participant 1 said: "Our school asks for donations. One tourist who befriends my brother donated R2500 last year. We shared it among orphaned learners, according to their needs".

Participant 2 said: "Yes, we bought clothes and uniforms for needy ones". Participant 3 said: "We also fill in application forms for social grants".

Participant 4 said: "We have taken upon it ourselves to be available for these learners. If we do not, they will we suffer".

Participant 5 said: "I am covered".

4.2.3.1.7 How do help orphaned learners to identify future careers?

Participant 1 said: "We give the worksheets to decide on their careers. These include examples like nursing, policing, doctors".

Participant 2 said: "We teach them life-skills as well".

Participant 3 said: "This is what we all do. We follow the same procedure".

Participant 4 said: "I am using a syllabus".

Participant 5 said: "They have taken all my answers. We really try to make them aware of jobs".

4.2.3.2 Second focused group interview

4.2.3.2.1 How does the orphan (s) interact socially with his or her peers at school?

Participant 1 said: "Orphaned learners are not free".

Participants 2 said: "These learners are stubborn and like to fight".

Participant 3 said: they are quiet, they do not want people to know that they have no parents".

Participant 4 said: "They do not interact easily with other children. They are emotionally disturbed".

Participant 5 said: "These learners are emotionally disturbed".

Participant 6 said: "They are quiet. One does not know whether they know or not".

Participant 7 said: "I am happy with answers given".

4.2.3.2.2 What is the general performance of these learners in both academic and extra-curricular activities?

Participant 1 said: "Orphaned learners do not perform well. Some do not play sports. The school lacks resources, that is why some withdraw".

Participant 2 said: "Those who live with their family members, do well, but those from child-headed families perform poorly".

Participant 3 said: "If schools can buy play resources, orphaned learners will be involved in sports and music".

Participant 4 said: "They said a mouthful. Sports facilities can help them to relax".

Participant 5 said: "I agree with my colleagues".

Participant 6 said: "The problem lies with the families which refuse to come to school".

Participant 7 said: "No comment".

4.2.3.2.3 How is his or her attitude towards schoolwork, educators and other learners?

Participant 1 said: "Their books are not covered and are not clean. Their families have no money to by covers".

Participant said: "Some learners show a positive attitude to school work".

Participant 3 said: "Some are very rude and like fighting with other learners". Participant 4 said: "Yes, some respect other learners and play with them". Participant 5 said: "Your question is answered".

Participant 6 said: "All is said and complete".

Participant 7 said: "Oh yes, we are through. Their attitude is individualistic"

4.2.3.2.4 What support systems do you have to assist orphaned learners? Focus your answer on academic performance, extra-curricular activities, psychological support and physical needs.

Participant 1 said: "We prepare food parcels for the needy".

Participant 2 said: "This is taken from our vegetable garden in summer". Participant 3 said: "The school has a clothes bank for orphaned learners, donated from the community".

Participant 4 said: "We do not have systems to support these learners after school or at home".

Participant 5 said: "We usually support them if a specific problem is identified or when asked".

Participant 6 said: "Some parents of needy children do not visit school; so there is no help".

Participant 7 said: "They have said it all. We struggle to get the parents to school"

4.2.3.2.5 How often do you interact with the families or guardians of orphaned learners; what issues do you normally discuss?

Participant 1 said: "We invite families to collect food parcels and for meetings, but some do not turn up".

Participant 2 said: "We meet with them quarterly to discuss grants, problems with birth certificate and academic performance"

Participant 3 said: "The school have general meetings and all are invited. We do not isolate AIDS orphans".

Participant 4 said: "Yes, we meet them as the SBST and the school management team". Participant 5 said: "I am part of the school management team. So, I am involved". Participant 6 said: "We support meetings, both general and specific".

Participant 7 said: "We sent even other learners to make sure these families receive invitations".

4.2.3.2.6 What does the school do to facilitate financial support for orphaned learners?

Participant 1 said: "We really do not do anything".

Participant 2 said: "She is correct; families interact directly with the Department of Social Development and Home Affairs".

Participant 3 said: "We get orphaned learners' statistics only by using a departmental survey form on the 10th school survey".

Participant 5 said: "Parents do not inform us. We have to find out through surveys".

Participant 6 said: "The school does not have any system to facilitate financial support".

Participant 7 said: "We are really trying to cooperate with families, but we are not yet there".

4.2.3.2.7 How do you assist orphaned learners to identify their future careers?

Participant 1 said: "Learners are given tasks to talk about different people, like policemen, doctors, engineers and others".

Participant 2 said: "We use the Life-Orientation learning area to help them". Participant 3 said: "We follow a syllabus from Life Orientation and discuss careers; they then choose theirs".

Participant 4 said: "We work as a team and plan together, so we do the same things".

Participant 5 said: "I check their work to see if it covers Life Skills".

Participant 6 said: "No, tasks are given where a learner can choose his or her career".

Participant 7 said: "I concur. From tasks, we also help them choose what they would like be".

4.2.4 Themes emerging from the responses of school-based support team (SBST) participants

4.2.4.1 Emotional disturbance is displayed by withdrawal amongst orphaned learners at schools.

Orphaned learners withdraw their inner feelings in social interactions with their peers at schools. This deduction is proved by responses of SBST's, when they said: "They are really shy and talk less..." and "...they do not want people to know that they do not have parents". The theme further deduces, that some orphaned learners display their inner non-acceptance of their loss by anger and fighting. This is supported by SBSTs responses in the following statements "These learners are stubborn and like fighting" and "These learners are emotionally disturbed".

4.2.4.2 Academic performance of orphaned learners lacks behind in schools.

The responses of SBSTs indicated, that orphaned learners dot not perform well academically .This is deduced from their statements, such as "...those from child-headed families perform poorly"; "Learners do not attend regularly", and "The problem lies with those parents who refuse to come to school". These statements support the theme above, that orphaned learners' performance lacks behind. A learner who always absents himself or herself, struggles to catch up with schoolwork. Their health status also contributes to their mediocre academic performance.

4.2.4.3 The attitude of orphaned learners varies in schools.

Orphaned learners display different attitudes towards schoolwork, educators and other learners. This is deducted from the following responses of SBSTs: "...rude and like fighting", "some respect others", "They respect teachers and do mix with others, but not all". It becomes clear from the theme, that learners display different attitudes as individuals. The responses further support the point that learners who are emotionally disturbed, show anger and rudeness.

4.2.4.4 Schools do not have uniform support systems for orphaned learners

The theme is deduced from statements of SBSTs when they said: "...educators help these learners after school", "We prepare food parcels for the needy". It is therefore, deduced that some schools assist orphaned learners with their academic needs after normal school hours, while some focused their support on physical needs. Thus, one school may focus on physical needs, whereas the actually needs of specific learners are emotional or intellectual. Some schools do not even have support systems. These are derived from some participants who said: "...we do not have systems to support these learners after school or at home".

4.2.4.5 Schools' meetings are not synchronized.

Different schools coordinate their meetings with families, based on their view-point. Some hold meetings quarterly, while some meet families regularly. The explanation above, is deduced from the following statements of SBSTs: "We meet with them regularly", and "We meet with them quarterly". There is a need for school to have common known times to interact with families of these learners. This will make schools to coordinate activities, and to identify and consolidate learners' needs.

4.2.4.6 Facilitation of financial support by schools, is not uniform.

Some schools do facilitate financial support for orphaned learners through donations, while other schools do nothing. Their responses also indicated, that some schools help families to fill in application forms for social grants, while others, on the other hand, leave the matter to families. These deductions were derived from participants' responses in the following statements: "Our school asks for donations..." and "We really do not do anything".

4.2.6.7 Future careers of learners are identified at schools.

The theme is confirmed by "...given tasks to talk about different people like policemen, doctors..." and "We give them worksheets to decide on their careers" responses of SBSTs. The responses also indicated, that the Life Skills learning area is implemented in schools

4.2.5 Responses of focused group interviews with school management and governance developer participants

4.2.5.1 What structures are there in schools to support orphaned learners?

Participant 1 said: "Schools have SBSTs".

Participant 2 said: "This structure is used to assist orphaned and vulnerable learners".

Participant 3 said: "There are sister departments like social development and home affairs that also assist these learners in school. They call their own meetings"

Participant 4 said: "The Department of Social Development gives deserving learners grants".

Participant 5 said: "SBSTs help learners with their learning barriers, emotional needs and psychological support".

Participant 6 said: "There are also non-governmental organizations that interact with schools".

4.2.5.2 Is there any monitoring of School Based Support Teams' functionality? Explain

Participant 1 said: "SMGDs have monitoring tools to ensure SBSTs are functional".

Participant 2 said: "The tool used, specifies policies aligned to HIV and AIDS. They check whether these policies do not discriminate".

Participant 3 said: "The tool also assists to set up peer groups when these learners not well".

Participant 4 said: "Schools have registers for orphaned learners' attendance".

Participant 5 said: "We also receive referral of learners who have various problems if SBST cannot solve them. We then give them to the DBST".

Participant 6 said: "Our district has one psychologist and a socio-pedagogue. They are not coping as the district is big".

4.2.5.3 What support do you give to School Management Teams (SMTs) towards supporting and caring for orphaned learners?

Participant 1 said: "We train SMTs on care and support for AIDS orphans. Policies are developed and implemented".

Participant 2 said: "Schools have guardian teachers or contact persons to form a link with orphaned learners' homes".

Participant 3 said: "Some schools have developed adopted a learner policy. One or two learners are adopted by educators for basic needs and support".

Participant 4 said: "SBSTs do not have standing committees. Adopted cops or social workers do sit in the committee in order to address specific needs like abuse and social grants".

Participant 5 said: "Schools have good working relations with Home Affairs and Social Development. Common meetings are held".

Participant 6 said: "I confirm the above discussions".

4.2.5.4 What is your level of interaction with families or guardians of orphaned learners?

Participant 1 said: "We interact with general membership of parents. HIV and AIDS issues are discussed".

Participant 2 said: "We also interact with orphaned learners families referred to us by SBST's".

Participant 3 said: "We also train the SGB in relation to care and support for AIDS orphans". Participant 5 said: "At all our meetings with parents, we specifically train parents about procedures when learners have problems".

Participant 6 said: "Our unit forms a link between the school and the education department; so we do all duties."

4.2.5.5 How do you facilitate financial support for orphaned learners?

Participant 1 said: "We meet the SBSTs and ensure that they assist families to apply for birth certificates and social grants".

Participant 2 said: "School safety committees consist of social workers as well as policemen, and they give guidance".

Participant 3 said: "I agree with these procedures".

Participant 4 said: "Our regular meetings in clusters make it easy for families to raise any query or question".

Participants 5 said: "At our meetings, we sometimes invite social workers to come and explain social grants to school principals".

Participant 6 said: "No further comments. I agree with my colleagues".

4.2.5.6 Do you interact with the Department of Social Development about AIDS orphans at school? What is their role?

Participant 1 said: "Our interaction concerns all orphaned learners. Disclosure of AIDS is still a taboo in our communities".

Participant 2 said: "We generalize, we do not specify".

Participant 3 said: " Ther ole of social workers is counseling and debriefing of orphaned learners".

Participant 4 said: "The Thabo Mofutsanyana District has only one socio-pedagogue and that is why Social Development has to fully engage in schools".

Participant 5 said: "Our district is big; maybe two or more socio-pedagogues are needed".

Participant 6 said: "We all team up to assist these orphans."

4.2.6 Themes emerging from the responses of school management and governance developers (SMGDs)

4.2.6.1 The support structures to assist orphaned learners, exist in schools.

Schools have SBSTs that are known by the Education Districts. This theme is deduced from responses of SMGDs in the statements below.

"Schools have SBSTs" and "...assist orphaned and vulnerable learners".

4.2.6.2 Monitoring tools are used by SMGDs to monitor functionality of SBST's.

The theme is deduced from responses of participants when they said: "SMGDs have monitoring tools..." and "...used specified policies aligned to HIV and AIDS...".Schools make referrals to SMGDs and district-based support team for learners who need extra support emotionally and academically.

4.2.6.3 School management teams (SMTs) enjoy support from SMGDs.

The theme is derived from the responses of participants in statements such as "We train SMTs..." and "...have developed and adopt a learner policy...".

The responses also indicated, that SBSTs have social workers and policemen as members. This assists SMTs to identify a need, once it arises from orphans and resolve it

4.2.6.4 General meetings do not address the particular and specific needs of orphaned learners' families.

The theme is deduced from SMGDs responses when they said: "We interact with the general membership parents". The responses indicated, that families are interacted by referral. It is, therefore, evident that SMGDs rely on referrals for interaction with the families of orphans. General issues are discussed at general meetings and no reference is made to family specific needs.

4.2.6.5 Financial support lacks from the side of SMGDs for orphaned learners.

This theme is deduced from responses in the following verbatim statements "...we sometimes invite social workers to and explain..." and "Schools' safety committees consist of social workers...they give guidance". It is clear, that there are no direct financial support systems from SMGDs.

4.2.6.6 Meetings between SMGDs and Department of Social Development is general.

This theme confirms that the SMGDs interact with Social Development in a generalized manner. The responses of participants indicated, that disclosure is still difficul,t hence meetings are for all orphans. This is supported by the statements "We generalize..."Disclosure is still a taboo...". The theme indicates, that SMGDs contribute to the welfare of orphans in general. It is clear that AIDS orphans do not get the attention and help they deserve.

4.2.7 Responses of focused group interviews with district-based support team participants

4.2.7.1 What structures are there in schools to support orphaned learners?

Participant 1 said: "The DBST is responsible for establishing SBST's. These structures support learners with barriers to learning".

Participant 2 said: "SBSTs are supported by Non-Governmental Organizations (NGOs) and Community Based Organization (CBOs).

Participant 3 said: "Youth Facilities are also appointed by the Save the children Project from the United Kingdom for twenty schools in Thabo Mofutsanyana, as a pilot concern. These youth facilitators are one male and one female for each school".

4.2.7.2 Is there any monitoring of the functionality of the structures mentioned above?

Participant 1 said: "Inclusive Education has no documented monitoring tool. We are drafting it".

Participant 2 said: "If SBSTs are not functional, the DBST must assist it. Inclusive education learning facilitators should check the records of SBSTs".

Participant 3 said: "We will make sure that the tool is available next term".

4.2.7.3 How do you support orphaned learners psychologically and academically?

Participant 1 said: "Districts have psychologists, speech therapists and one socio-pedagogue. They assist learners with problems when referred to them".

Participant 2 said: "District support facilitators visit a school per invitation and on scheduled visits to assist learners with specific problems".

Participant 3 said: "Youth facilitators in pilot schools also assist orphaned learners with homework".

4.2.7.4 What is your level of interaction with orphaned learner(s)' families?

Participant 1 said: "We do make home-visits for identified learners. We find that most are not cared for".

Participant 2 said: "We advise educators to assist these families to be able to access grants at Social Development".

Participant 3 said: "Our unit interview families of orphaned learners to understand their situation. These help us to give appropriate support".

4.2.7.5 How do you facilitate financial support for orphaned learners?

Participant 1 said: "We advise educators and learners' families on procedures to access grants".

Participant 2 said: "We also hold common meetings with sister departments in communities".

Participant 3 said: "My colleagues have outlined the procedure; thank you".

4.2.7.6 How do you identify orphaned learners caused by AIDS? Explain tools used?

Participant 1 said "It is difficult. Only parents may disclose anything before death or families, after death. There is no tool".

Participant 2 said: "Yes, there is no official way for now".

Participant 3 said: "It is true".

4.2.7.7 Who conducts debriefing sessions with affected learners and all affected parties? Why?

Participant 1 said: "This process starts with the SBST. They have trained educators. If they struggle or fail, they refer such learners to the DBST".

Participant 2 said: "The DBST refers such learners to psychologists and socio-pedagogues for further attention".

Participant 3 said: "I agree with the discussion".

4.2.7.8 Do you interact with the Department of Social Development about AIDS orphans at school? What is their role?

Participant 1 said: "Yes, we interact. We invite them to parents' meetings. They explain procedures for one to apply".

Participant 2 said: "We have scheduled meetings with social workers delegated to schools in the district".

Participant 3 said: "We supervise learning facilitators of inclusive education. They need the correct procedures".

4.2.8 Themes emerging from the responses of the distric-based support team (DBST)

4.2.8.1 Several structures support orphaned learners at schools.

The theme is deduced from responses of the DBST in statements such as "SBST's are supported by non-governmental organizations and community-based organizations" The participants further indicated, that twenty schools were given youth facilitators as a pilot project to support orphaned learners. This was derived from their responses when they said that these"...youth facilitators appointed by Save the Children pilot project".

4.2.8.2 Functionality of SBSTs is not properly monitored.

This theme is supported by the following "Inclusive education has no documented monitoring tool" and "We will make sure that the tools are available...". This is further supported by the indication, that learning support facilitators check records of SBSTs, without clearly spelled out instruments.

4.2.8.3 Provision of psychological and academic support is done.

The DBST assist learners referred to them. They also refer these learners to speech therapists, socio-pedagogues and psychologists where necessary. This is deduced from their responses: "District has psychologist..." and "They assist learners with problems...". This theme is, further supported by the responses by referring to the use of youth facilitators.

4.2.8.4 Facilitation of financial support to orphaned learners is indirect.

This theme is deduced from responses such as "We advise educators and families... access to grants" and "...hold common meetings with sister departments". It becomes clear from the above statement, that the DBST give indirect support for financial support.

4.2.8.5 Identification of orphans caused by AIDS, is not yet possible in schools.

The theme is derived from participants' responses: "It is difficult" and "There is no tool". It is, therefore, evident that the DBST do not know which orphans are caused by death of parents, as a result of AIDS.

4.2.8.6 Debriefing sessions are held for affected learners.

The theme is derived from responses of a DBST: "This process starts with SBSTs" and "... if they struggle, they refer to the DBST". The DBST then refer such learners to psychologists and socio-pedagogue.

4.2.8.7 The DBST interact with social development department about orphans.

The theme is deduced from responses of DBST: "Yes, we interact" and "We have scheduled meetings...". The responses indicated, that invited social workers provide procedures for accessing grants.

4.2.9 Responses of focused group interviews with school principal participants

4.2.9.1 How does the orphan(s) interact socially with his or her peers at school?

Participant 1 said: "Some learners do not play during break. Some are reserved and quiet".

Participant 2 said: "I also experience the same observation".

Participant 3 said: "I found these learners come to school hungry".

Participant 4 said: "Orphaned learners cry easily when other learners talk about parents. These learners are also shy and reluctant to mix with others".

Participant 5 said: "Yes, they like standing aside and watching others play".

Participant 6 said: "I have also observed, that some display anger quite frequently".

Participant 7 said: "They are quiet".

4.2.9.2 What is the general performance of these learners in both academic and extra-curricular activities?

Participant 1 said: "Most of these learners show emotional disturbance after the death of their parents. Their performance deteriorates".

Participant 2 said: "I believe, that the cause is, that no one assists them with schoolwork at home".

Participant 3 said: "But such learners from supportive homes, improve their performance".

Participant 4 said: "Most learners perform from average to poor".

Participant 5 said: "At my school this is a trend".

Participant 6 said: "Learners staying with grandparents, perform on average or poorly".

Participant 7 said: "Yes, children need support from school and home. These learners also participate in sports. Attitude of educators is a key".

4.2.9.3 How is his or her attitude towards school work, educators and other learners?

Participant 1 said: "Positive education makes orphaned learners to be relaxed and positive too".

Participant 2 said: "Such educators allow learners to discuss their inner personal issues".

Participant 3 said: "When educators are negative and unapproachable, learners become reserved and quiet"

Participant 4 said: "All above points are an eye-opener to me; I shall check this at my school".

Participant 5 said: "I agree, negative educators cause learners to perform poorly". Participant 6 said: "Orphaned learners are involved in stealing. They say they use it for food. This is common with chil-headed homes".

Participant 7 said: "Yes, this is common in all schools".

4.2.9.4 What support systems do you have to assist learner(s)? Focus your answer on academic performance and extra-curricular activities.

Participant 1 said: "We have a SBST. We have sports committees and the children play."

Participant 2 said: "Our schools have youth facilitators who help these children". Participant 3 said: "My school has both a SBST and youth facilitators. They really assist".

Participant 4 said: "Our situation is similar".

Participant 5 said: "At my school we have the SBST only. We would like to have youth facilitators".

Participant 6 said: "Youth facilitators assist with school work and extra-mural activities after school".

Participant 7 said: "My school enjoys the services of both structures. My school also has adopted a learner policy. It helps".

4.2.9.5 How often do you interact with families of orphan learners; what do you normally discuss?

Participant 1 said: "Youth facilitators do make home visits. The aim is to know how learners do at home".

Participant 2 said: "We also use them in that fashion".

Participant 3 said: "We do not have formal interaction with them, except when they are in a general meeting".

Participant 4 said: "We use youth facilitators, too".

Participant 5 said: "We interact with them through the SBST and at school meetings". Participant 6 said: "We interact through meetings".

Participant 7 said: "There are no formal procedures".

4.2.9.6 What does the school do to facilitate financial support for orphaned learners?

Participant 1 said: "We raise funds for needy orphaned learners. We ask our suppliers who do business with schools, to donate money. We them share the money among need orphans. We do this by buying clothes and food parcels".

Participant 2 said: "As neighbouring schools, we share information and strategies. I do the same".

Participant 3 said: "Our school is not having a formal procedure. We assist families by filling in application forms for birth certificates and social grants".

Participant 4 said: "We also use donations to assist learners. We also work with families to apply for grants".

Participant 5 said: "We apply for social grants for families".

Participant 6 said: "I have a knowledge of teachers who assist orphaned learners and parents with forms".

Participant 7 said: "Yes, I also have procedures like collecting donations from our service providers".

4.2.9.7 How do you assist orphaned learners to identify future careers?

Participant 1 said: "Successful ex-learners are invited to motivate our learners. These learners explain their careers".

Participant 2 said: "We have meetings for clustering with the first speaker and we do the same".

Participant 3 said: "I cannot agree more We fall in the same cluster".

Participant 4 said: "I have learned from them. We are not implementing the SBST correctly. Ours is still dysfunctional".

Participant 5 said: "In my case, we invite successful people from the community. They do a good job"

Participant 6 said: "We further use these people as role models for our school which are all motivating factors. We use professionals like local doctors and business people'.' Participant 7 said: "It was just in March this year, when we had such a session. It was wonderful'.'

4.2.9.8 How do you identify orphaned learners as a result of parents who died of AIDS related illnesses?

Participant 1 said: "Their families disclose. They do this to get our sympathy so as to get help for social grants".

Participant 2 said: "This is true, we also make assumptions from death certificates".

Participant 3 said: "We use a combination of reports from learners themselves, death certificates and family disclosures".

Participant 4 said: "We copy these approaches, because people do not disclose. It is difficult to know. But we get this information for the SBST's use only".

Participant 6 said: "We rely on families' disclosure. We have not used death certificates. They can mislead".

Participant 7 said: "We also use families' information. After the death of orphaned learners' parents, they are desperate for money, so they just tell us."

4.2.10 Themes emerging from the responses of school principals.

4.2.10.1 Emotional withdrawal is experienced among orphaned learners.

The responses of principals such as "...learners do not play...", "some are reserved" and "... reluctant to mix with the others". The theme is also supported by responses that "learners cry easily... and quiet".

4.2.10.2 Academic performance of learners range from poor to good.

The theme is deduced from responses of principals, such as "...their performance deteriorates" and "...perform from average to poor". This theme is supported further by responses that indicated, that emotionally disturbed perform averagely. These orphans are not assisted with their work after

school. Other orphans are also not helped, even at home, due to the inadequate literacy level.

4.2.10.3 Orphaned learners who are supported positively or negatively, respond accordingly, respectively.

This theme is deduced from responses of principals such as "...positive educators make learners to relax and positive", and when "...educators are negative...learners become reserved and quiet". These statements indicated, that learners need emotional support.

4.2 10.4 Schools have support systems for learners.

This theme is derived from responses of principals such as "...we have SBSTs" and "Youth facilitators...".This theme is supported by responses that indicated, that schools enjoy policies that make it easy for educators to adapt learners to educational purposes

4.2.10.5 Schools do not have formal meetings with families.

This theme is derived from the responses such as "...no formal interactions..." and "and "...we interact through meetings" Meetings referred to, were not specific. Responses do not show whether these meetings are for orphaned learners families or not.

4.2.10.6 Schools facilitate financial support for learners.

This theme is derived from responses such as "We raise funds,..."We also use donations". Schools also fill in applications for social grants. This was deduced from "We apply for social grants for families "responses of principals.

4.2.10.7 Identification of future careers is done at school.

Responses of principals such as "...invite successful people..." and "...use professional people like doctors" indicated identification of careers. This theme is also supported by "...we use these people as role models". However, some schools do not have such systems. This is derived from responses such as "Ours is still dysfunctional".

4.2.10.8 Schools use arbitrary deductions to identify orphaned learners, caused by AIDS.

This theme is derived from the responses such as "...we make assumptions from death certificates" and "We rely on families who disclose" This approach could be misleading. Families can manipulate schools in order to access grants.

4.2.11 Responses of focused group interviews with families of orphaned child participants

4.2.11.1 First focused group interview

4.2.11.1.1 How did the child behave or respond after the death of the parents?

Participant 1 said: "All three orphaned children were sad, angry and reserved. These children had a bad experience, especially the two eldest".

Participant 2 said: "We were all sad. But these children were displaying anger. They do not talk freely for days".

Participant 3 said: "It was traumatic. We had sad, angry and quiet kids then." Participant 4 said: "Well, we had to comfort them. The elder one even requested to go to a boarding school. It was sad".

4.2.11.1.2 What is the social interaction of the child towards family members and other children?

Participant 1 said: "The youngest and the one in the foundation phase, are now free. The older one is still very quiet".

Participant 2 said: "She is also reserved. She answers questions and does not initiate discussions. She makes us to be worried".

Participant 3 said: "My daughter and son-in-law had AIDS. It killed them. This is bad. But I am happy with the kids".

Participant 4 said: "I do not want to talk about it".

4.2.11.1.3 Briefly describe health history of the child (orphaned)?

Participant 1 said: "Two of them are healthy. The youngest catches flu frequently. Granny takes him to doctor".

Participant 2 said: "Baby is giving us problems. His health is not good". Participant 3 said: "Well, we will take care of them. They are not a burden". Participant 4 said: "Can we drop this discussion. It makes me sad".

4.2.11.1.4 How is the child progressing at school? Focus your answer on both academic and extra-curricular activities.

Participant 1 said: "The elder one is not doing well. She has gone down since the death of her parents".

Participants 2 said: "The one in foundation phase is doing well. She is free and mixes well with us. The youngest child is still in pre-school".

Participant 3 said: "The elder one does not take part in sports, but the other one is doing well".

Participant 4 said: "For now, I want to listen and you may ask me later".

4.2.11.1.5 What kind of support do you and your family give to the child with regard to performance at school?

Participant 1 said: "I cannot assist them. I cannot read their work".

Participant 2 said: "And I, too".

Participant 3 said: "I help in Afrikaans. I do not know other subjects."

Participant 4 said: "I also help with Afrikaans".

4.2.11.1.6 How do you interact with the school with regard to the performance of the orphaned child (children)?

Spontaneously, all 4 participants said: "We do not attend school meetings". Participant 4 said: "Educators never visit us".

4.2.11.1.7 Do you have an added burden as result of these orphan?

Participant 1 said: "When it started, they were a burden. Now it is better. They are our children".

Participant 2 said: "We are used to the situation".

Participant 3 said: "They were heavy on us, but we now stay together". Participant 4 said: "They will eat what we eat".

4.2.11.1.8 How do you cope with his or her financial support?

Participant 1 said: "When I buy my child clothes, I include them. They also receive social grants and it helps the family income".

Participant 2 said: "Government has given this money. This money is used for school needs".

Participant 3 said: "We appreciate support from government. They really assist". Participant 4 said: "I am happy with the help".

4.2.11.2 Second focused group interview

4.2.11.2.1 How did the orphaned child behave or respond after the death of the parent(s)?

Participant 1 said "He took time to accept the death of his mother. He is very quiet and reserved. His parents died of AIDS. It was too bad".

Participant 2 said: "He took long before talking about his mother. He is not talkative".

4.2.11.2.2 What is the social interaction of the child towards family members and other children in the family?

Participant 1 said: "He has taken us as his family. He talks to us".

Participant 2 said: "He interacts with us freely. He has accepted his condition".

4.2.11.2.3 Briefly describe health history of the child (orphaned)?

Participant 1 said: "He is healthy. No problems".

Participant 2 said: "He is not sick, even in winter".

4.2.11.2.4 How is the child progressing at school? Focus your answer on both academic and extra-curricular activities.

Participants 1 said: "His school work is on average. His is not bright, you know". Participant 2 said: "He is not doing homework regularly, that is why. He never asks for help".

4.2.11.2.5 What kind of support do you and your family give the child with regard to performance at school?

Participant 1 said:" No, I cannot help him. I do not know these subjects". Participant 2 said: "I do assist with homework. He does not ask for help regularly. He does not even tell me at times".

4.2.11.2.6 How do you interact with the school with regard to the performance of the orphaned child (children)?

Participant 1 said: "I attended meetings at his previous school. He has moved to a new school. They have not yet held a meeting".

Participant 2 said: "This new school has not had a meeting since January 2007. We interact with the school only when invited. We do not bother schools".

4.2.11.7 Do you have an added burden as a result of this orphan (s)?

Participant 1 said: "No, no he is not a burden".

Participant 2 said. "He is my family. He is not giving us any problem".

4.2.11.8 How do you cope with his or her financial support?

Participant 1 said: "Yes, he receives a social grant. It help us, too".

Participant 2 said: "The money is helpful for all of us. My father is also working, so this grant boosts the whole family income".

4.2.11.3 Third focused group interview

4.2.11.3.1 How did the orphaned child behave or respond after the death of the parent(s)?

Participant 1said: "Both kids cried much and were sad. They were even reluctant to go to school".

Participant 2 said: "It is true. They were sad for quite a long time. They are now better".

Participant 3 said: "This problem made us to move in with them to comfort them". Participant 4 said: "Yes, this is so true".

Participant 5 said: "I agree".

4.2.11.3.2 What is the social interaction of the orphaned child towards family members and other children in the family?

Participant 1 said: "These two orphans are stubborn. They do not respect elders".

Participant 2 said: "They are also cheeky. But they are now accepting the situation".

Participant 3 said: "They surprise me. In most cases they would talk about their parents".

Participant 4 said: "They do not play freely with us, but enjoy the children of neighbours".

4.2.11.3.3 Briefly describe the health history of the child (orphaned).

Participants responded at the same time and said: "They are healthy".

4.2.11.3.4 How is the child progressing at school? Focus your answer on both academic and extra-curricular activities.

Participant 1 said: "They are performing well. They have never failed".

Participant 2 said: "It is good".

Participant 3 said: "It is average".

Participant 4 said: "I agree. It is on average".

Participant 5 said: "Yes, they perform on average".

4.2.11.3.5 What kind of support do you and your family give to the child with regard to performance at school?

Participant 1 said: "No, I do not help".

Participant 2 said: "I cannot help. They say they have done it at school". Participant 3 said: "When we do our work, they say they are through". Participant 4 said: "They are always through with homework".

Participant 5 said: "I do not know it. It cannot help".

4.2.11.3.6 How do you interact with the school with regard to the performance of orphaned child (children)?

Participant 1 said: "We attend school meetings when invited".

Participant 2 said: "Yes, we do attend".

Participant 3 said: "Our parents attend not us".

Participant 4 said: "No, I am a child, too".

Participant 5 said: "No, I do not attend".

4.2.11.3.7 Do you have an added burden as a result of this orphan?

Participant 1 said: "They are a burden".

Participant 2 said: "I agree".

Participant 3 said: I do not know".

Participant 4 said: "No comment".

Participant 5 said: "No comment".

4.2.11.3.8 How do you cope with his or her financial support?

Participant 1 said: "We are struggling. They do not even have grants. The school is not helping".

Participant 2 said: "Teachers of these orphans do not assist them. It is tough". Participant 3 said: "It is difficult".

Participant 4 said: "We are struggling".

Participant 5 said: "Yes, there is no money".

4.2.12 Themes emerging from the responses of families of orphaned learners

4.2.12.1 Orphans experience emotional disturbance

This theme is deduced from responses such as "...were sad, angry and quiet" and "He is quiet and reserved". The responses show, that the parents' death makes an impact to them emotionally. Anger can also prolong the denial period for these learners and affect their emotional quotient in future.

4.2.12.2 Some learners experience acceptance in families, while others do not interact freely.

This theme is derived from responses of participants when they said that the "...the "older one is still very quiet", "She is reserved" and "She interacts freely with us". These statements show, that in some families, learners are free, while others remain reserved. This theme also reflects lamentation in some families. Participants' responses show, that the loss of a parent is not easily accepted.

4.2.12.3 Orphaned learners experience sickness, while others are healthy.

This theme is derived from "He is healthy", "Two are healthy. The youngest catches flu...".The responses reflected that while some learners enjoy good health, others experience sickness. The theme also reflects, that some family members still lament their loss.

4.2.12.4 Learners' performance ranges from average to good.

The families responded by saying "It is good", "Yes, they perform on average", "...since they stayed with me" and "...not well". It is evident that the learners' performance in schools varies from average to. good. This also depends on the kind of support they get from all focused groups referred to above: the SBST's, the DBST, Principals, SMGD's and families. "

4.2.12.5 Assistance of families to learners is not the same.

This theme is derived from responses such as "I cannot assist....I cannot read", "I assist in Afrikaans", "He does not ask". Some learners get assistance, while others get it partially. It is clear from the above statements, that the literacy level contributes to failure of families to give support. Child-headed families also contribute to these disparities.

4.2.12.6 Families' interactions with schools are not uniform.

This theme is deduced from the following responses: "I attend...", "We do not attend meetings, and "...educators have never visited us". These statements indicated, that there is no uniform way in which schools interact with families. Some families have no interest in attending school meetings and some interact with schools per invitation.

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4.2.12.7 Some families regard orphaned learners as a burden, while others accept them as family members.

This theme is derived from responses such as "No, no he is not a burden" and " When we started, he was a burden...".This shows, that some learners are fully accepted in their families, while others are rejected.

4.2.12.8 Financial support for orphaned learners is given to some learners.

This theme is derived from the responses in the following statements: "Government is giving money", "I include them when I buy my child clothes..." and "Teachers of these learners do assist them". The statements above, show that social development department provides for grants. It also became evident, that some families apply the principles of communalism.

4.3 Conclusion

This chapter extrapolated the themes from responses of participants. The difficulties experienced by AIDS orphaned learners and support given to them were highlighted.

Chapter Five will deal with recomendations, findings and strategic management model.

CHAPTER FIVE

FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This final chapter presents an overview of this research's findings and conclusions from literature study, as well as from the empirical research.

5.2 SUMMARY OF FINDINGS AND CONCLUSIONS FROM THE LITERATURE STUDY

The literature review highlighted that, as a result of HIV/AIDS, new family forms are emerging, such as "skip-generation" families, where the parent generation has succumbed to HIV/AIDS and HIV/AIDS-related illnesses and the families are made up of grandparents, orphaned grandchildren, and child-headed families, where the grandparents are not available to care for orphaned grandchildren (see 2.3).

It also emerged from the literature survey, that children and adolescents affected or orphaned by AIDS, face an increase in poverty; malnutrition; household responsibility and vulnerability to abuse; child labour; sexual risk; stigma, discrimination and isolation; less access to food, health services, school opportunities, material goods, protection and love than do other children whose families have not been affected by HIV/AIDS. The physical needs, emotional deprivation and financial desperation of children affected or orphaned by AIDS, make them an easy prey for exploitation and abuse. They often live on the street, where they are used as cheap labour by day and as sex workers by night. This deadly pattern exposes them to HIV and AIDS, thereby repeating the cycle (see 2.4).

5.3 SUMMARY OF FINDINGS FROM THE EMPIRICAL INVESTIGATION

The empirical research revealed that learner AIDS participants felt hurt, sad, angry by the passing away of parents; are treated well by their next-of-kins or extended family member though one learner participant indicated that she/he

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is discriminated by the next-of-kin which leads him/her to only associate with her/his consanguineous sister; have health problems such as sores all over their bodies and eye problems which they cannot see the doctor for because the extended families cannot afford consultation fee sand that clinics next to their families always run short of medication, and they perform well at school though one learner participant indicated that she/he is not doing well at school (see 4.2.1; 4.2.2).

Interviews with the SBST focus groups revealed the following about AIDS orphans: some learnerAIDS orphans in their schools are shy and do not interact with others; they come to school hungry and then stay away from others during break and as result they seem to be hungry during school hours and that is the reason for their isolating themselves from other learners, they do not attend school regularly, often get sick and perform poorly in their academic activities, do not have psycho-social systems to support these learners after school or at home, do not do anything to facilitate financial support for children orphaned by HIV/AIDS (see 4.2.3; 4.2.4).

Interviews with the SMGD participants revealed the following: The SMGDs reported that they use SBSTs structures to assist orphaned and vulnerable learners and they, also, use governmental departments like Social Development and Home Affairs and non-governmental organizations to assist deserving learners orphaned by AIDS to access social grants; and they further reported that their education districts are big and need more socio-pedagogues and educational psychologists to assist them in their efforts to deal with the difficulties AIDS orphans experience (see 4.2.5; 4.2.6).

Focused group interviews with district-based support team participants revealed the following: The DBSTs reported that they use SBSTs to support learners with barriers to learning as a result of psychopathologies caused by their being orphaned by AIDS; according to them, SBSTs are supported by Non-Governmental Organizations (NGOs) and Community Based Organization (CBOs); they also highlighted that Youth Facilitators are also appointed by the Save the Children Project from the United Kingdom to assist twenty schools in Thabo Mofutsanyana as a pilot project for AIDS

orphans;they further highlighted that the Inclusive Education section of their Department of Education does not have documented monitoring tool for ways to identify discriminatory practices against these children; and they also revealed that parents and relatives at least do disclose their HIV/AIDS status before their death out of desperation for sympathy (see 4.2.7;4.2.8)

Focused group interviews with school principal participants revealed the following: some orphaned learners do not play during break because of being reserved; some display anger quite frequently; and their academic performance at school deteriorates; and they also revealed that they at times discover that some orphans are AIDS orphans from the death certificates of their parents that these children submit at school because, of course, of the fact that there is no diclosure about this disease in South Africa (see 4.2.9).

Interviews with family participants revealed that AIDS orphaned children in their families usually display sadness, anger and reservedness; some catch influenza frequently; some families are unable to support AIDS orphans as a result of their inadequate literacy level; some families do not attend school meetings regardless whether they are invited or not and that some families struggle to access birth certificates for the orphaned children which result in a delay to receive social grants (see 4.2.10).

5.4 RECOMMENDATIONS

From the findings of both the literature review and empirical research, the following recommendations are made.

- School-going children and adolescents affected or orphaned by HIV/AIDS need a socially safe and supportive environment. This requires sensitive attitudes, policies and legislation at school, family, community and national social levels. To build sturdy school, family and community systems capable of providing social prevention and care, will require material resources and skills-building.

- Policy makers must recognize, that the rights of children and young people, especially girls, must be protected and promoted; and that young

people are critical resources for making HIV programmes meaningful to their peers and that information about HIV prevention is relevant to their everyday lives. The Convention on the Rights of the Child, recognizes children as rights holders. Its provisions concerning rights to education, health, protection, non-discrimination, freedom from exploitation and abuse, are all relevant to reducing the vulnerability of children and young people to the epidemic.

- Strong and effective education systems should be accessible to children and young people in most vulnerable circumstances, such as orphans, young girls, and household heads, are important.

- Wide-scale communication and social mobilization efforts are needed to broaden HIV/AIDS awareness within communities who are in the frontlines for providing prevention, care and support for children. Reducing the stigma and discrimination associated with HIV/AIDS, is a fundamental element.

- HIV counselling and support of the children, their parents and siblings, can considerably improve their quality of life, relieve suffering and assist in the practical management of illness.

- Children and adolescents' worries about resources, about being able to study and attend school can partly be met through social security provision. The existence and operation of a social security system or method must be explained to children and guarantees laid out, if it is also to relieve their stress. It should also be noted, that attending school, is not only about paying fees and buying books and materials; having the time to study and not having to work or caring for others full-time is important, as is not experiencing stigma and discrimination from educators and other children, nor bullying or violence that might deter learners from attending school. Clearly also, some means of additional care-giving organised through local voluntary networks, might also be a practical means of supporting children. Also, the stigmatising and discriminatory behaviour of

others must also be addressed, rather than enabling the victim to deal with it them and so putting the pressure on them.

- From the issues concerning study and attendance at school, psycho-social support for orphans and children affected by HIV/AIDS, needs also to consider and include protection issues that should be addressed for all children. This would include protection from abuse (sexual, physical and emotional abuse), bullying, all forms of violence and so on, and recognising the vulnerability of these children, for example to being trafficked, being exploited through unsupported economic migration, and to becoming street children.

- To address children and adolescents' worries and experiences of stigma and discrimination, and children's worries and experiences of isolation, loneliness and exclusion, schools, communities and the government need to work together against the further spread of stigma and discrimination, to reduce these problems, and to change the nature of the social environment in which children and adolescents who are affected or orphaned by HIV/AIDS, are living. Such work needs to be undertaken with children as much as adults, because children's discrimination against their peers, or bullying of those of a younger age, can be particularly nasty. Children themselves, need information about HIV/AIDS and knowledge of prevention: they will soon grow and become sexually active, or they may be or become vulnerable to drug abuse, particularly if they are vulnerable to exploitation or unsupported migration because of poverty. Children's isolation and uncertainties about the present and future can be addressed through children's participation and activities that can also be developed as the basis for other practical interventions in response to their broad needs for social support. Purposeful activities with children, including games and fun in an appropriate and consistent environment (that is, based on quality of adult-child relationships) can enable social interactions which can be beneficial for children. Creating child-friendly environments, taking children seriously, listening to children, reflecting their ideas and views, encouraging children to communicate their experiences and

feelings, all provide support, develop children's self-esteem and confidence, support children's learning, enhance children's capacities in forming relationships and communication, and most importantly, act as a conduit for children's emotions in enabling their self-expression.

- Communities need children and adolescents' activity centres. These centres do not have to be physical buildings, but can simply be regular meeting places, provided they fulfil certain criteria primarily regarding the quality and consistency of adult-child relationships. The centres need to have a developed and child-friendly philosophy, including children's participation and child protection, and children designing their own activities and programmes of work. The centre needs to be inclusive; that is, welcoming and incorporating all children who wish to attend, and not only be free from prejudice and oppression, but actively work against it. The environment needs to enable children to socially support each other and children to feel they can approach adults for confidential, informative discussions on sensitive issues. Various services can be offered through such a centre at different times, including advice, information, guidance, life-skills training, vocational training, as requested by children. If children and adults are working closely together in an informal fashion (not traditional educator and learner or parent-child relationships), then children's ideas and needs can easily be raised and a programme of activities (including play and fun) developed.

- Counselling is necessary for children and adolescents affected or orphaned by HIV/AIDS. These individuals are likely to approach adults to talk about private matters of concern to them; in this way, some sort of `counselling' might in fact be happening. This does not need to be a formal process, but like the principles of the children's activity centres, can be humanistic and perso-centred, based on practice principles of listening, empathy, reflection, and unconditional regard. It is essential that counselling is not undertaken lightly, especially with children. However, there are similarities in the good practice of working with children from an inclusive, empowering and participatory perspective, and elements of

humanistic counselling approaches, and such similarities also strengthen the rationale for taking up the above recommended child activity centres as a method of providing psycho-social support through children's participation and purposeful activities. Thus, in the final analysis, it should be recognised that good quality, child-centred, participatory working practice brings benefits and should be the first resort, and that such work already includes dimensions of what some would call counselling. Because the term counselling includes complex therapeutic interventions that should not be tried lightly, nor by inexperienced individuals, and not on children, it is essential that `counselling' is not conflated with psycho-social support, nor in fact practised as a first intervention.

- Fundamentally, underlying any work with orphans and children or adolescents affected by HIV/AIDS should be some recognition of children's rights, and the role of duty bearers in meeting those rights. The question of providing psycho-social support is then not seen in isolation, away from other aspects of children's lives, but should be and can be fitted in with other problems, such as the rights to health and education. Children's needs for psycho-social support mean addressing both emotional issues and worries, but also their practical concerns. As shown, some of their worries are about material issues such as resources, but others concern problems with relationships (for example, friendships, stigma, discrimination, connections with educators and adults in the community), and need different approaches. Child protection, in a broad sense, from abuse, violence, neglect and problems such as bullying, discrimination, isolation and exclusion, is fundamental to psycho-social support. It can be developed only with children's involvement, with them identifying issues and collaborating on means of resolution. Children's participation is not only important for protection, but has a beneficial impact on the well-being, self-esteem, confidence, through engagement with other children and adults and being able to talk, as demonstrated in these workshops. Thus, children's participation is also a fundamental process in the provision of psycho-social support for children orphaned and affected by HIV/AIDS.

- There is a need of community-based support mechanisms in order to enable orphans and children affected by HIV/AIDS, to stay at home and attend school. Protecting children has often been seen in the past as keeping children away from outside influences and placing them in large institutions. Accumulated evidence, experience and practice, have demonstrated that life in large institutions is detrimental to children's health, well-being and future lives, quite apart from vulnerabilities to abuse and exploitation. Children's resilience has been shown to be enhanced by various protective factors that also contribute to children's development (see 2.3.2). These include a close, nurturing connection to primary caregivers who provide:

  o consistent and competent care;

  o connections to competent caring members of one's own cultural group outside of the extended family;

  o participation in familiar cultural practices and routines; and

  o access to community resources, including effective educational and economic opportunities.

These factors cannot be met through institutional care and show the importance of children remaining with the family, and so the importance of communit-based support mechanisms to enable orphans and children affected by HIV/AIDS to stay at home and attend school. That is, to retain a familiar and consistent caregiver, and familiar surroundings and habits. If living with a grandparent or close relative is not possible, then monitored fostering or the creation of small-group family homes are better able to meet these children's needs.

The children's activity centres recommended above, provide additional means of social support for orphaned children living with relatives or fostered (or in small group homes) and for children with sick parents. They can provide a means of connection to people outside the family, and access to community resources. But fundamentally, the social activities involving children's

participation are group activities and contribute to various characteristics of resilient children, that is, children who have endured and flourish despite extremely challenging and stressful family and social circumstances including for example, emotionally incapacitated parents and extreme poverty. These characteristics include:

- strong attachment to caring peer groups;

- social competence at interacting with adults and children;

- independence and requests of help when necessary; and

- confidence that facilitates control over some parts of his or her life.

These characteristics correspond with some of the aims, methods and practices of working with children through the children's activity centres recommended above. Just as 'counselling' includes interventions that regard skills and training, so too, such quality groupwork with children requires competence that comes from understanding principles and ethics, developing skills, training and reflective practice.

From the assertions the researcher has made above, it is clear that schools have a strategic management role to play in order to deal with the HIV/AIDS epidemic that orphans children and leaves them psycho-socially affected. It is, therefore, imperative for the researcher to, in this concluding chapter the research, also provide a strategic management model for dealing with HIV/AIDS at schools (see 5.5 below). A strategic management against HIV/AIDS can be an effective educative tool to enlighten learners, parents and communities about the dangers of contracting this disease and ways to prevent it, including how to live healthily with it for a prolonged life-span. In this way, schools will be helping communities reduce, if not prevent, the proliferation of AIDS orphans as a result of HIV/AIDS.

5.5 A STRATEGIC MANAGEMENT MODEL FOR DEALING WITH HIV/AIDS AT SCHOOLS

The findings of this research in 4.2.1 and 4.2.2 revealed that learner participants who are AIDS orphans manifest health problems such as sores all over their bodies and eye problems which could be an indication of an opportunistic disease caused by HIV/AIDS. This could mean that some of the learner participants are HIV positive. Schools, therefore, need a strategic management plan of HIV/AIDS. An effective strategic management model of the HIV/AIDS epidemic at schools, can play a major role in shaping the attitudes, opinions and (perhaps most importantly), the behaviour of learner children and adolescents. This is so, because today's generation of learner children and adolescents have been born into and have to grow psycho-socially in a world where the HIV/AIDS epidemic is a harsh and an unavoidable reality. This call is for a social situation wherein the time spent at school can help them to prepare for, as well as providing an environment in which people can be educated about HIV/AIDS. In this regard, schools can often act as a centre-point and a micro-system for community discussions and activities targeted at combating HIV/AIDS. Schools can, therefore, be vital social systems in monitoring the epidemic and co-coordinating appropriate responses to it. With a capacity to reach large numbers of children and adolescents with information that can save their lives, basic school education can have such a powerful preventive effect to an extent, that it has been described as a 'social vaccine' (Lightsey, 1997: 700).

In the light of the foregoing paragraphs it is imperative that school management teams strategically and proactively plan, organize, staff, control, and lead in the fight against HIV/AIDS. This should be done in accordance with the challenges which are brought about by this psycho-socially devastative epidemic. Learners and educators are falling ill, taking time off to care for family members and, in many cases, are dying as a result of HIV/AIDS.

This section provides a management strategy model which school management teams can adopt and adapt in order to concertedly and

effectively plan, organize, staff, control and lead during this era of the HIV/AIDS epidemic with a view of reducing the impact of the epidemic on teaching and learning at schools.

5.5.1 School Management Teams should conduct a situation analysis on the effects of HIV/AIDS epidemic at their schools

In simple terms, a situation analysis can be an effort undertaken by school management teams to gather and analyze information that will help them to design, implement and evaluate interventions which are targeted at combating the HIV/AIDS epidemic. Typically, the kind of information to be collected by school management teams relates, to which educators or learners are infected or affected by the HIV/AIDS and why or how they are infected or affected, the severity of the problem and resources and strategies that might be employed to produce the desired outcomes. The "WHYs" and "HOWs" are important in situation analysis, because they provide answers on whether learners were infected before their birth or they are affected because one or more of their siblings is suffering from HIV/AIDS. Even with educators, it is important to know if they are already suffering from HIV/AIDS or one or more of their siblings are suffering from HIV/AIDS. In order to have effective HIV/AIDS epidemic management interventions at schools, it is important that school management teams should assess learners' and educators' knowledge about the HIV/AIDS epidemic, as well as their socio-culturally founded attitudes and behaviours towards it.

Efforts to reduce the HIV/AIDS epidemic infection through school-based interventions are most likely to succeed when the following conditions are met:

- They are strongly supported by ecosystemic policies which were developed in a collaborative manner by school management teams as strategic decision-makers, the school staff and learners, parents and other members of the community, suc has educational psychologists, social workers, non-governmental agencies, traditional health practitioners and governmental agencies such as the Departments of Health and Social development.

- There is credible information about the need for the educational management interventions and that the resources required, as well as the outcomes expected are taken into account in the planning, implementation and the evaluation of all aspects of the effort undertaken.

At the school level, both the process and results of a situation analysis can help to meet the foregoing conditions. A good situation analysis has several benefits, including the following.

- School management teams and governors of schools need strong arguments, especially when their actions involve allocating both financial and human resources.
- Accurate and up-to-date information can provide a basis for discussion, justification for action, setting of priorities and identifying groups in special need for interventions, such as learners living in geographical areas where HIV/AIDS and substance abuse are prevalent.
- Data obtained through the situation analysis, can help ensure that interventions are tailored and socially contextualized to the specific needs, experience, motivation and strengths of learners, staff, families and community members targeted.
- Data obtained through the situation analysis, provide a baseline against which to measure future trends in HIV-infection rates and HIV-related behaviours. This is essential for evaluating the results of the activities undertaken and for making improvements to on-going programmes.
- Situation analysis can provide data on sexual behaviour, unintended pregnancy, and (psycho-active) substance abuse rates among learners can help to determine the extent to which they are at risk of HIV/AIDS.
- Situation analysis can also provide data about HIV/AIDS-related knowledge, attitudes and skills are also important for planning effective education programmes. These data can be obtained by conducting a survey. Many survey questionnaires exist and the local health agency may be able to provide examples.

The data obtained through situation analysis can be useful in determining the extent to which HIV/AIDS is a health and a social problem in the schools, families, community or society.

It emerged in chapters one and two, that, the HIV/AIDS epidemic is a health crisis. To ensure the success and sustainability of health promotion programmes at schools, there is a need for effective partnerships between education (educationists, educators) and health (educational psychologists, clinical psychologists, counselling psychologists, medical doctors, nurses, occupational therapists etc.) sector workers, and the active participation of learners, parents and other community members in all health promotion activities at schools. It is a good idea to involve a cross-section of all of them in the planning and conducting of a situation analysis. In this way, commitment to the programme will be developed and implemented from the outset. Ideally, two teams of supporters should be assembled: a School Health Team and a Community Advisory Group.

The table below outlines the basic questions that might form the basis of a situation analysis in respect of HIV/AIDS and suggests methods for data collection.

Table 5.1: Planning HIV/AIDS Interventions: Conducting a Situation Analysis

Basic Questions	Sources and Methods for Data Collection
How prevalent are HIV, unintended pregnancy and substance abuse in the community or society?	▪ Review of existing data from a local health authority; ▪ Sample survey by self report
How prevalent are HIV/AIDS and unintended pregnancy among school-age children and adolescents?	▪ Same as above
How many people are thought to be affected by HIV/AIDS?	▪ Same as above
Are there data on HIV-infection rates or AIDS-related deaths among school-age children,	▪ Same as above

adolescents or adults in your community or society?	
What are the important behaviours, behaviour determinants and conditions that place young people and adults at risk for HIV-infection in the community?	▪ Same as above
Do parents, educators and young people have basic knowledge about HIV/AIDS?	▪ Questionnaire; ▪ Focus group discussions
What are the common attitudes and beliefs of educators, parents and youth towards HIV/AIDS?	▪ Same as above
What are the common attitudes and beliefs of teachers, parents and youth towards education about AIDS and HIV/AIDS?	▪ Same as above
Does a school HIV policy pertaining to privacy, learning and employment exist? Are school staff, teachers and students informed of its existence?	▪ Interview with school officials
Are other health programmes and interventions in place into which education about HIV/AIDS can be integrated?	▪ Interview with school and community leaders

5.5.2 Schools should have mandatory HIV testing for all learners and educators

The time has come in South Africa for all learners and educators to undergo a mandated HIV testing in order for all school management teams and school governing bodies to assess the effects of this epidemic on learner and

educator human resources. This means, that both the South African national policy on HIV/AIDS and school policies should be amended in order to accommodate this necessity. It should be mandatory for all learners and educators at schools to be tested for HIV. This could help schools know, from Grade R to Grade twelve, the quantity of learners and educators infected with HIV/AIDS, and to know the quantity of learners who were born HIV-infected because, of having inherited it from their parents and also those learners who are already sick because of HIV/AIDS.

The foregoing paragraph implies, that school management and governance should avail both pre-testing and post-testing counselling and therapeutic services at schools for learners and staff who are tested for HIV/AIDS. In this way, schools will be seen as ideal environments for HIV/AIDS epidemic preventive programmes aimed at learner and educator populations. This process should occur together with:

- giving of information about HIV/AIDS to learners on admission to school, on a continuous basis and during teaching and learning situations. This information should include other sexually transmitted infections and it should cover the following arears regarding HIV/AIDS :- what it is, what are the causes, risk behaviours associated with it, its spread within school environment, its signs and symptoms, stages, complications, prevention, safer sex, *etcetera*.

- informing female learners and educators about mother-to-child contamination during pregnancy, birth and breast-feeding;

- informing female learners and educators about the available reproductive health care services such as termination of pregnancy;

- giving health education to all categories of personnel, that is, to both teaching and non-teaching staff;

- employing a variety of strategies such as pamphlets, lectures, discussions, audiovisuals, debates, workshops, dramas, role-plays, *etcetera* in preventive programmes;

- training learners and educators in life-skills so as to enable them to take responsible decisions regarding their health and lives;

- infusing cultural virtues such as virginity and celibacy in HIV/AIDS programmes and these programmes should also be culture, language, literacy, gender and age specific;

- participating of educators in all phases of the school in HIV/AIDS programmes organization as they are in daily contact with learners;

- commemorating the World HIV/AIDS Day and all other national and international celebrations such as Women's Day, Youth Day, Human Rights Day *etcetera,* in such a way, that the target groups or people are sensitized about HIV/AIDS. These celebrations should be used as opportunities to promote an awareness about the pandemic.

5.5.3 Schools should infuse universal precautions on HIV/AIDS in the school's intra- and extra-curricular activities

This sub-topic means, that learners should be educated on how to handle all body fluids such as blood, urine, vomits, semen, sputum, saliva, faeces, pus, tears, mucus, open wounds, sores, bruises, soiled linen and other skin lesions. These fluids should be considered potentially infectious as some of them may contain the HIV-virus. The schools' intra- and extra-curricular activities should, therefore, teach learners, that when handling these fluids and lesions, protection should be ensured through wearing of gloves, while the linen must be disinfected prior to laundering, in the case of boarding schools.

Universal precautions should aim at the prevention of contamination with, not only the HIV infection, but also with other blood-borne diseases such as Hepatitis B and C, *etcetera.* Learners should be taught that protection should be ensured when performing messy procedures on learners and educators, and that care should be taken so as to ensure that all school laboratory equipment, instruments and toilets are kept clean, including baths, showers and toilets.

The foregoing paragraph also implies, that all learners, parents and staff should be educated and given information about the universal precautions and a copy of the guidelines should be displayed on notice boards and school surroundings.

5.5.4 Availability of condoms

- Condoms should be available at schools and should be accessible to learners and educators who need them, including the information regarding their use.

- Condom dispensers should be secured and placed at accessible areas at all schools.

- The Health Advisory Committees should keep a record of the number of condoms dispensed, for monitoring purposes.

- The availability of condoms should be seen as an integral part of the HIV/AIDS epidemic educational management intervention strategy.

5.5.5 Management of Sexually Transmitted Infections (STIs)

- Learners and educators should be encouraged to seek medical care for early treatment of sexually transmitted infections.

- Provision of proper treatment and health education, including monitoring, is essential for the effective management and treatment of sexually transmitted infections.

5.5.6 Sensitization of learners and educators about the dangers of non-consensual (coercive) sex

- Both learners and educators must be sensitized about the dangers of unprotected sex, violation of others' human rights and the criminalization of any non-consensual (coercive) sex or rape.

- All rapes must be reported and the victim must receive medical intervention. Vulnerable female learners and educators must be

empowered to protect themselves from rapes and abuse by fellow learners and educators.

5.5.7 Management of HIV/AIDS and opportunistic diseases among learners, their families and relatives

- Care and support should be provided to every learner, especially to those infected and affected, their families and relatives.

- The management of opportunistic diseases and infections should be in accordance with the guidelines of the Department of Health.

- There must be effective management of the physical, emotional, social and spiritual needs and problems of learners and educators living with HIV so as to reduce the stress level and retard progression into full-blown AIDS.

5.5.8 School Management Teams should form partnerships against the effects of the HIV/AIDS epidemic with other stakeholders

Both the school management teams and the school governing bodies should counteract the undesirable effects of the pandemic within the general population. They should lobby for a more equitable and just distribution of resources in schools; obtain guidelines on infection control from specific centres in the country which deal with HIV/AIDS, ensure that amongst their membership there are those who have or are prepared to receive the necessary training, education and support, so as to maintain high standards of service to people living with HIV/AIDS.

School governing bodies should exchange knowledge, share experiences, learn from others and encourage other role players to participate in these endeavours. The following could be noted.

- External role players such as non-governmental organizations (NGOs), churches, business sectors, tertiary institutions, unions, professional

organizations, people living with HIV/AIDS and individuals. should be encouraged to render their services at schools.

- Cooperation with relevant organizations and individuals, especially those with expertise in HIV-prevention, counselling, training, support and home-care should be encouraged so as to render services to learners and educators.

- Learners and educators should participate in HIV/AIDS programmes as peer educators and support systems for fellow learners and educators.

- All categories of personnel-nurses, social workers, psychologists, educators, religious officers, employee assistant practitioners and custodial staff, should participate actively in HIV/AIDS programmes.

- Caregivers such as nurses, volunteers and others, should receive care and support, bearing in mind that caring for those who have HIV/AIDS, is stressful.

- School staff should also participate in community HIV/AIDS and other programmes/activities.

- Each school must have HIV/AIDS programmes/activities and identify other community structures so as to assist in the implementation of such programmes.

5.5.9 Capacity building

- Each school should have one or more HIV/AIDS focal person/s who will be actively involved in coordinating programmes. These persons need not necessarily be nurses, however, they must be trained and have sufficient knowledge about HIV/AIDS.

- Each school should have trained counsellors.

- Educators and non-teaching staff should be trained in HIV/AIDS.

- Each school must have an HIV/AIDS plan which is strictly implemented, monitored and evaluated for impact.

- Each school must identify and ensure that resources (human, fiscal and logistical) are available to support HIV/AIDS programmes.

- Each school must have learner and staff peer educators, and the selection criteria for such a task, could include respect by colleagues and learners, respect by fellow learners, ability to communicate, interest in health or HIV/AIDS matters, and sense of maturity.

5.5.10 Promotion of the rights of learners and personnel for protection

- The observance of human rights is critical for the protection of the vulnerable.

- Both the learners and personnel at all schools should be trained in human rights.

- All sexual assaults on learners and educators must be reported and recorded, and criminal action taken against the perpetrators.

- Learners should be empowered to be able to protect themselves and fellow learners.

- Learners and educators must have the right to privacy, bodily autonomy, integrity and safety and these and other rights should be protected.

- The deliberate spread of HIV-infection by learners and educators to fellow learners and educators, should be regarded as a serious crime against which action should be taken.

5.5.11 Tracing contact of HIV

- Measures should be taken at each school to trace contact of HIV, sexually transmitted infection and Hepatitis B and C infections.

- Contacts should be limited not only to sexual contacts, but also include sharing of shaving appliances and others where there is a possibility of coming into contact with the blood of another person.

5.6 LIMITATIONS OF THE STUDY

There is a need to, on comparable bases, investigate the understanding of learners, educators and parents of inclusion in education. Such a study could shed more light on the nature and extent of inclusive education in South African schools, and enlighten the nation on the successes of communities in implementing White paper 6 of the Department of Education.

There is also a need to investigate the way in which the Department of Education and Training can cascade the knowledge on inclusion and inclusive education to parents and community members so that parents can have a clear understanding of inclusive education, as stated in White Paper 6.

5.7 CONCLUSION

This research investigated, by means of a literature review and an empirical research, the psychological experiences of school-going children and adolescents affected or orphaned by HIV/AIDS. On the basis of both the literature review and empirical research methods, recommendations were made in Chapter 5. It is hoped, that this research will make a contribution in the understanding of learners affected or orphaned by HIV/AIDS.

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ANNEXURE A

INTERVIEW SCHEDULE

QUESTIONS:

FAMILY: SIGNIFICANT OTHERS

1. How did the child behave or respond after the death of the parent(s)?

2. What is the social interaction of the child towards family members and other children in the family?

3. Briefly describe health history of the child (orphaned)?

4. How is the child progressing at school at school? Focus your answer on both academic and extra-curricular activities.

5. What kind of support do you and your family give to the child with regard to performance at school?

6. How do you interact with the school with regard to the performance of the orphaned child (children)?

7. Do you have an added burden as a result of this orphan (s)?

8. How do you cope with his/her financial support?

ORPHAN (S)

1. How did you feel after the death of your parents?

2. How do you relate to the family you are staying with since the death of your parent(s)?

3. How do you interact socially with the family members and other children?

4. Briefly describe your health history (orphaned child)?

5. What is your performance at school? Focus your answer on both academic and extra-curricular activities.

6. What kind of support do you get from your family with regard to your performance at school?

7. How does the school assist you in the subject(s) that you are not doing well?

8. How does the school interact with your family with regard to your performance at school?

9. Do have any financial support from any source that you know?

SCHOOL BASED TEAMS (SBST)

1. How does AIDS orphan(s) interact socially with his/her peers at school?

2. What is the general performance of this learner in both academic and extra curricula activities?

3. How is his/her attitude towards school work, educators and other learners?

4. What support systems do you have to assist orphaned learner(s)? Focus your answer on academic performance, extra-curricular activities, psychological support and physical support.

5. How often do you interact with the families or guardians of orphaned learners; what issues do you normally discuss?

6. What does the school do to facilitate financial support for orphaned learners?

7. How do you assist orphaned learners to identify future careers?

DISTRICT BASED SUPPORT TEAM (DBST)

1. What structures are there in schools to support orphaned learners?

2. Is there any monitoring of the functionality of the structures mentioned above?

3. How do you support orphaned learners psychologically and academically?

4. What is your level of interaction with orphaned learner 's family?

5. How do you facilitate financial support for orphaned learners?

6. How do you identify orphaned learners caused by AIDS? Explain tools used.

7. Who conducts debriefing sessions with the affected learners and all

affected parties? Why?

8. Do you interact with Department of Social Development about AIDS orphans at schools? What is their role?

SCHOOL MANAGEMENT AND GOVERNANCE DEVELOPERS

1. What structures are there in schools to support orphaned learners?
2. Is there any monitoring of School Based Support Teams functionality? Explain.
3. What support do you give to School Management Teams towards supporting and caring for orphaned learners?
4. What is your level of interaction with families or guardians of orphaned learner?
5. How do you facilitate financial support for orphaned learners?
6. Do you interact with Department of Social Development about AIDS orphans at schools? What is their role?

SCHOOL PRINCIPALS

1. How does orphan(s) interact socially with his/her peers at school?
2. What is the general performance of this learner in both academic and extra curricula activities?
3. How is his/her attitude towards school work, educators and other learners?
4. What support systems do you have to assist orphaned learner(s)? Focus your answer on academic performance, extra-curricular activities, psychological support and physical support.
5. How often do you interact with the child 's family; what issues do you normally discuss?
6. What does the school do to facilitate financial support for orphaned learners?
7. How do you assist orphaned learners to identify future careers?
8. How do you identify orphaned learners as a result of parents who died of AIDS related illnesses?

ANNEXTURE B

Department of Eduction in the Free state permission letter is attached below.

FREE STATE PROVINCE

2007-05-09

Mr. M.J. Mokoena
P.O. Box 1273
HARRISMITH
9880

Dear Mr. Mokoena

REGISTRATION OF RESEARCH PROJECT

1.   This letter is in reply to your application for the registration of your research proje∢

2.   Research topic: **A strategic management model for ecosystematically dealin
      difficulties experienced by orphans at school.**

3   Your research project has been registered with the Free State Education Departr

4.   Approval is granted under the following conditions:-

4.1   Educators and officials participate voluntarily in the project.
4.2   The names of all schools and educators involved remain confidential.
4.3   The questionnaires are completed and the interviews are conducted outside norn
4.4   This letter is shown to all participating persons.
4.5   A bound copy of the report and a summary on a computer disc on this study is dc
      Free State Department of Education.
4.6   Findings and recommendations are presented to relevant officials in the Departm

5.   The costs relating to all the conditions mentioned above are your own responsibil

6.   **You are requested to confirm acceptance of the above conditions in writing**

      The Head: Education, for attention:
      DIRECTOR : QUALITY ASSURANCE
      Room 401, Syfrets Building
      Private Bag X20565, BLOEMFONTEIN, 9301

We wish you every success with your research.

Yours sincerely

FR SELL
DIRECTOR : QUALITY ASSURANCE

Department of Education ∇ Departement van Onderwys ∇ Lefapha la ʼI