

Title: Holistic Care of Vulnerable Children.

Subtitle: Determining the fundamental needs of children, orphaned and otherwise made vulnerable by the HIV/AIDS pandemic, in the household.

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## Summary

The aim of this dissertation is to contribute to the development of a strategy for church involvement in the care of vulnerable children in low income households.

The extent and nature of the problems caused by HIV/AIDS is inconceivable. Of particular concern is the children affected by HIV/AIDS. There is little consensus as to whether institutionalised care can be replaced by community-based care. The church needs an informed approach for future intervention.

Existing research covers the needs of children to a certain extent, but does not have conclusive answers as to how these needs should be met. There is little, if any research examining the totality of the child's needs. This research will determine what the vulnerable child's unmet needs are, and get a first indication of the extent to which they are being met in the low-income household.

Missiology is the field within which this study is undertaken. A good understanding of mission and the link between mission and the holistic study of the needs of vulnerable children is discussed as basis for further reflection.

In an attempt to determine the *totality of the child's needs*, the fundamental human needs theory, developed by Manfred A. Max-Neef is used. According to Max-Neef, all human beings have 10 fundamental needs: subsistence, protection, affection, creation, idleness, understanding, participation, identity, freedom and transcendence. These needs can be satisfied by an infinite variety of satisfiers.

The findings of the study include:

- Caregivers perceive the quality of life of vulnerable children to be high, but fieldworkers' perceive it to be poor;
- Denial of the vulnerability of children is associated with the denial of the existence of HIV/AIDS in the community;
- There is a lack of knowledge of the importance of early childhood, accompanied by a lack of parenting skills for optimal early childhood development;

- Children are not provided with opportunity and skills to manage grief;
- The protection of children against abuse and crime is questionable, and
- The needs of the children in the safe-house do not seem to be satisfied more or less holistically than those who live in families, or vice versa.

The church can play a pivotal role in addressing the needs of vulnerable children. Apart from providing care herself, the role of the church is to be a catalyst of holistic care:

- The first task of the church is to develop a thorough and holistic understanding of the total context, such as the fundamental needs of vulnerable children and the roles of different care-givers;
- The second task is to promote understanding of the nature of vulnerable children's needs amongst all role-players, and
- The third task is to facilitate the best possible use of existing resources to satisfy the prevailing fundamental needs.

The most important interventions recommended are:

- Development of skills and knowledge for early childhood development.
- Development of knowledge and skills in age-appropriate grief management, and
- Further study to develop integrated community-based, institutional care.

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## Terminology

### Vulnerable Children

Children who are in many ways disadvantaged in fulfilling their potential to adequately satisfy or actualise their fundamental human needs, which leads to an inferior quality of life

### Orphans

Children (0-21 years old) who have lost one or both parents.

### HIV/AIDS

Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome. HIV causes AIDS, which is a life-threatening disease, which is spreading rapidly throughout the world and has devastating effects in South Africa.

### Needs

What people require in order to maintain a certain quality life.

### Household

A micro system that occupies a specific place (eg. A site) and consisting of all aspects involved, including the occupants or residents, the physical structures, the land and the social relationships

### Community-Based Care

A model of care through which children reside in the community and are cared for by the community.



## Institutionalised Care

A model of care through which children are taken out of the community to reside in an institution and are cared for by the institution.

## Satisfiers

Things/ systems/events/people that contribute to the actualization of certain needs.

## Children's Rights

Rights of children as defined by the Convention on the Rights of the Child (CRC).

## Mission

A comprehensive ministry with various dimensions including; praising and worshipping God, communication between believers, evangelism and the building up of the church, and service and ministry to people by the Christian community

## **Abbreviations**

NOVA (Navorsing en Ontwikkeling vir die Voorkoming van Armoede)

FHP (Functional Household Program)

QOLA (Quality of Life Assessment)

OVC (Orphans and Vulnerable Children)

PLWA (People living with HIV/AIDS)

CRC (Convention on the Rights of the Child)

HIV (Human Immunodeficiency Virus)

AIDS (Acquired Immune Deficiency Syndrome)

## Chapter 1

### Introduction

This chapter provides an introduction to the dissertation, explaining the aim of the dissertation, stating the problem, and giving an overview of the existing research. This is followed by an overview of the contribution this study aims to make, the approach, and methodology used, and finally an outline of the following chapters.

#### 1.1 Aim of the Dissertation

The aim of this dissertation is to contribute to the development of a strategy for church involvement in the care of vulnerable children in low income households, by providing reliable information on the fundamental needs that are not being satisfied.

#### 1.2 Problem Statement

The problem that is addressed in this study is that the church has to respond to the plight of vulnerable children, especially in the light of HIV/AIDS, but the church lacks an informed understanding of the needs of these children.

The extent and nature of the problems caused by HIV/AIDS is inconceivable. Of particular concern is the children affected by HIV/AIDS. The church can either play a prophetic role (Defending the rights of children, or putting pressure on the state to improve its service delivery to children.), and/or the church itself can provide a care service. In this study the focus is on the service that the church itself can provide. The church's identity and infrastructure puts the church in a unique position to get involved in the service and care of vulnerable children. The church's *identity* is in Christ, the author of love. We are to emulate Christ, and be His hands and feet on earth. The church is an organization with unparalleled *infrastructure*, reaching into every place imaginable. In both cases the church can only do so with integrity if it understands the needs of the children.

However, the church seems to lack the ability to do what it is called to do. Because of both the immense scope and the intricate and sensitive nature of the HIV/AIDS epidemic,

strategies of the past will not be sufficient in the future. No other pandemic in the past has affected as many people as the HIV/AIDS pandemic. As far as the nature of the pandemic is concerned, it deals with sensitive aspects of human life, namely sex and death. Other diseases, like Malaria does not carry the same stigma as HIV/AIDS. Previous experience does not tell us how communities will cope with its impact. Research is needed in order to provide the church with the best possible understanding of what is happening in society. This has led to the need for a deliberate effort to draw up an effective strategy for church involvement, as one, albeit a multi-functional role-player, among many in the care of children affected by HIV/AIDS and other orphans and vulnerable children.

Caring for vulnerable children is a multi-faceted problem. The first issue is whether children are better off in an institution or at home, in their communities. There is little consensus as to whether institutionalised care can be replaced by community-based care. Are low-income households able to cope with the added burden of care? Are current development efforts, based on a basic needs approach, sufficient, or are we delivering a second-rate service? The church needs an informed approach for best-practice future intervention. These are the issues central to the problem statement.

### **1.2.1 The Extent and Nature of the Problems Caused by HIV/AIDS**

In South Africa, as in most other sub-Saharan African countries, HIV/AIDS is killing parents. World-wide, a child is orphaned every 14 seconds, by the AIDS related death of a parent. Most of these occur in sub-Saharan Africa. Recent statistics claim that there are 11 million children orphaned by AIDS in Africa (Save the Children, 2004). 12 per cent of all sub-Saharan African children are orphans (UNICEF, 2003:9).

The most recent annual AIDS Review 2004 (Kometsi, 2004:9), gives recent estimates of the prevalence of HIV/AIDS infection in South Africa at more than 20% of the population.

As astounding as these numbers already are, the orphan crisis in sub-Saharan Africa is only now beginning to unfold. The death rate of young adults is increasing, therefore leaving behind increasing numbers of orphaned children. It is estimated that by 2010 the

worldwide number will have risen up to 25 million and 17% of children in South Africa will be orphaned by AIDS (UNICEF, 2003:9-10).

The challenges faced by orphaned children are traumatic and numerous. They face multiple losses; they watch parents suffer and die, they are often caught up in poverty and ill health. Their education and development are compromised and they are more likely than children with parents, to be subjected to the most horrible forms of child labour (UNICEF, 2003:6).

Despite these alarming statistics, our discussion does not concern orphans only. Orphans are only part of a much bigger health and development crisis brought about by the HIV/AIDS pandemic in sub-Saharan Africa. It is believed that the epidemic is having a far reaching detrimental influence on a much bigger number of children who are not orphans, destroying health and opportunities and rendering them vulnerable too. They are made vulnerable by their own HIV status, or by the infection and illness of their parents or caregivers. They are made vulnerable by discrimination and poverty due to illness in the family, even in the extended family (UNICEF, 2003:13).

### **1.2.2 Community-Based versus Institutional Care**

All of this has resulted in multiple child sponsorship schemes, community care programs, orphan trusts, safe homes and other outreach initiatives (cf. Dunn, Jareg & Webb, International Save the Children Alliance: 5). There are differences of opinion among relief and development organizations, community workers and researchers as to how care should be provided for the vast numbers of orphans. The old system of orphanages is questioned. Many researchers and development workers believe that orphans should stay in their communities, but often there is no family left to look after them. In the urban areas, the traditional extended family is no longer a strong support system. Those who do look after orphans are financially and emotionally stretched to the limit (cf. Crewe, 2001:13-14, Vallender & Fogelman 1987: 67-70, Berry & Guthrie, 2003: 6, Gow & Desmond, 2002: 63 - 64). This issue is discussed in detail in Chapters 4 and 5.

### 1.2.3 Future Intervention

With regards to the challenges of children orphaned by AIDS, Mary Crewe (2001: 9-19) from the Centre for the Study of Aids, University of Pretoria argues that we have to change the way we think and that we need to have new ways of operating. She states:

Current plans for orphans lock them into second-best and second-rate lives. People say we must teach them marketable skills, we must develop small income-generating programmes, we must strengthen the communities. It all sounds good until one asks: where are these communities? We're setting up a second-rate, second-best approach to orphans, and I think we need to ask how we can ensure that orphans get equity rather than charity.

The question is what we should do about it. How should these vulnerable children be cared for? Are their needs being met? Can they be cared for holistically in the household? Can they stay in their communities? Or should they be cared for in institutions? What is a first-rate, best approach to orphan and vulnerable children care? What is the role of the church? What strategy can the church use to reach out to vulnerable children, and should they? The Bible tells us that: "Pure and undefiled religion is this: to look after orphans and widows in their distress..."(James1:27, CSB translation). God expects us to take care of orphans and vulnerable children. Holistic intervention is to minister to the whole child (Kilbourn,1996:190). If vulnerable children's unmet needs can be determined, it can serve as a base to develop a holistic care program, which can minister to the whole child.

### 1.3 Overview of Existing Research

It is hard to find research that covers the needs of children. There are no conclusive answers as to how these needs should be met. Studies focus mostly on physical, educational, and emotional wellbeing and do not look at the child holistically (cf. USAID, 2000). Research is fragmented and scattered. There are plenty of statistics on the scope of the orphan crises (cf. Gow & Desmond, 2002: 63,99). There is little, if any research examining the totality of the child's needs. Most studies focus on orphans but some take into consideration that not only orphans are vulnerable (cf. Dlamini *et al.* 2004:12). Researchers seem divided on whether the African traditional extended family can and

should still take the burden of the increasing numbers of orphaned and vulnerable children (cf. Crewe, 2001:13-14, Vallender & Fogelman 1987: 67-70, Berry & Guthrie, 2003: 6, Gow & Desmond, 2002: 63 -64). According to Dunn, Jareg & Webb (International Save the Children Alliance: 4) there is a lack of up-to-date research on institutional care, fostering and other forms of childcare in developing contexts. Yet, it is generally assumed by governments and development agencies that children are better off when they stay within their communities.

#### **1.4 Contribution**

This study aims to contribute to the development of a strategy for church involvement in the care of vulnerable children in low income households, by addressing the lack of research that considers the vulnerable child as a whole, taking into account all of his/her needs and how they are being met. Assuming that the household is the best place for orphaned and vulnerable children (as opposed to institutionalized care) this research will determine what the vulnerable child's unmet needs are, and get a first indication of the extent to which they are being met in the household, specifically the low income household. The study will also look at how these households can be assisted, particularly by the church in providing holistic care for vulnerable children.

#### **1.5 Approach**

The researcher chose to approach the subject of vulnerable children from a holistic point of view, in relation to the households in which they live. This is done within the field of missiology, and the role of the church in reaching out to vulnerable children.

#### **1.6 Methodology**

The methodology used in this study is practice research. Practice research requires the researcher to be involved with reality. Practice research asks how to be successfully involved with that reality. The end result of practice research is an action or product in the first place, and a publication in the second place (Van Niekerk, 2006, unpublished).

This study uses the Quality of Life Assessment Instrument (QOLA Instrument) that was developed in the Functional Household Programme, of ISWEN and the NOVA Institute. The QOLA instrument is based on the 10 fundamental human needs as identified by Manfred Max-Neef. It is an instrument for creating a well developed, holistic questionnaire, for gathering empirical data. The instrument was used by the researcher to develop a questionnaire (See Questionnaire, Appendix 1). The questionnaire was used to gather data from low-income households, in fieldwork done in collaboration with NOVA institute's "Household-based Care Research Group". This data was then integrated with extensive literature study, resulting in a comprehensive list of the unmet needs of vulnerable children within their households. The fieldwork also includes a focus group with care-givers and interviews with field-workers involved in ministries to vulnerable children. .

Five types of households have been identified for the purpose of this study:

- a) Child headed households;
- b) Granny headed households (with 4 or more children);
- c) Households where a parent is ill;
- d) Households with 8 or more children cared for by an individual or couple, and
- e) Two parent, stable Christian family with at least two children.

Chapter 7 gives a further description of the actual fieldwork done, in **7.2 Description of Collection of Empirical Data.**

### **1.7 Framework (Outline of Following Chapters)**

The first chapter defines the problem statement and gives an overview of existing literature, identifies the research gap and explains the methodology. The second chapter gives a background to the study, looking at theology, missiology and why this type of research is done. Chapter three defines Holistic Care in terms of Max-Neef's theory of Fundamental Human Needs. It also deals with the Functional Household Programme, which was used to structure this study. The fourth chapter will explore the nature of the vulnerable child, their needs as well as the challenges and issues involved in caring for them. The fifth chapter will look at the different existing approaches to caring for vulnerable children and chapter six looks at additional role-players. In the seventh chapter the researcher will describe the

empirical data collection, interpret the empirical data and attempt to integrate all of the information. The findings of the research will be discussed in chapter eight and chapter nine gives the conclusion.



## Chapter 2

### Approach

#### 2.1 What is Theology?

In my very first year of studying in the Department of Theology I had to write an assignment titled: “What is Theology?” (Reyneke-Barnard, 2002). A synopsis of what I learned about Theology and what I believe about theology will be given here as an introduction to the approach used in this dissertation.

A definition of Theology.

Theology can be simply defined as thinking and reasoning about God. The Greek form of the word Theology can be translated as ‘God’ and ‘Word’, in other words, ‘discourse about God’ (McGrath, 2001:137). The term *theology* originated among the Greeks and is older than Christianity itself. The term referred to the concept of teaching about God and it had mythical and cultic connotations. The term was adopted by Christians to refer to discussions on the Christian faith (Eybers, König & Stoop, 1978:1). Today a definition of the nature and scope of Theology could be worded as follows; “Theology deals with the basic questions of our lives: how God and our faith influences our lives here on earth.” (Taken from an article on the subject of Theology in Die Perdeby, January 2002).

The Bible and Theology

“The ultimate source of Christian theology is the Bible, which bears witness to the historical grounding of Christianity in both the history of Israel and the life, death, and resurrection of Jesus Christ.” (McGrath, 2001:142). Theology is not limited to the Bible, yet the Bible determines it (Eybers, König & Stoop, 1978:13). Since the Bible is the word of God and Theology is talking about God, it is almost in conversation with the Bible. The Bible is the starting point of theology. Theology is involved in the; “...direct study of the Bible as texts about God.” (Eybers, König & Stoop, 1978:9).

## The Development of Theology as Academic Subject

Before the 12<sup>th</sup> century theology was purely a Spiritual discipline, experiencing and worshipping God. Around the 12<sup>th</sup> century Universities came into existence due to a need for training in theology and theology became academic, intellectual and theoretic, and can even be called a; "...comprehensive scientific system." (Eybers, König & Stoop, 1978:3). Yet it was and is not an isolated discipline. Theology is sensitive to culture and still exists outside the academic institutions.

### Theology as Radical Involvement

People who intellectualise theology assumes that one can practice theology objectively. Yet, it is impossible to study or talk about God objectively. We talk about God from within our experience of and meeting with Him. The knowledge and understanding gained in the study of theology starts with the meeting between the individual and God, and his or her personal testimony. A promotional article on the faculty of Theology in the January 2002 issue of Die Perdeby said that theology helps you to become a mature well-rounded person. Then Missiology, as a discipline within theology helps you to become a well-rounded missionary.

If spirituality is defined as; "...the experiencing of God and the transformation of lives as outcomes of that experience." then a close link between spirituality and theology exists and is described by Merton; "Unless they are united there is no fervour, no life and no spiritual value in theology; no substance, no meaning and no sure orientation in the contemplative life." (McGrath, 2001:147). "To study Christian theology as a purely academic subject, from a disinterested standpoint, is to lose sight of the fact that Christianity is about proclamation, prayer, and worship. It is these activities which give rise to theology – and if a theologian does not proclaim the faith, pray to God, and worship the risen Christ, he or she cannot really be said to have understood what theology is all about." (McGrath, 2001:151).

König states that studying God from the perspective of faith demands radical involvement; "...only the person who really lives under the Lordship of God will be able to reflect theoretically on the nature and implications of that Lordship." In his view all Theology

should be in the service of Jesus Christ (Eybers, König & Stoop, 1978:25-30). Studying ways of practically serving people is in the service of Jesus Christ.

The primary purpose of the study of theology is therefore understanding or gaining insight. (Eybers, König & Stoop, 1978:21-23). Applied to missiology, our purpose is gaining insight in practical ways of serving Christ in the world. The book of James is one example of God's view of serving Him.

## Conclusion

We have seen that theology is not a cold, objective impersonal subject. For the writer of this dissertation theology is about studying and understanding the Bible as the inspired Word of God, accepting it as the only Truth. Secondly theology is to learn about the History and Dogma of the Christian Church in an effort to discover the ways in which God has dealt with His people and to know and understand the testimony of the church. Lastly theology is about equipping myself to serve God better through Practical Theology, Mission Science and the Science of Religion. I personally like the phrase of Anselm of Canterbury, quoted by McGrath (2001:150); "*faith seeking understanding*", but add to that, "*and learning how to do*".

## 2.2 What is Missiology?

Missiology is the field within which this study is undertaken. A good understanding of mission and the link between mission and the holistic study of the needs of vulnerable children is essential as basis for further reflection.

Studying missiology is to study what mission is or ought to be (Eybers, König & Stoop, 1978:11). What mission is may not necessarily be what it ought to be. Neither will everybody be in agreement as to what mission is. Not even the Bible has one single definition of mission (Bosch, 1991:16). Mission history is filled with paradigm shifts, starting with the coming of Jesus as the first major shift (See Bosch, 1991) Bosch (1991: 9) states that "Ultimately, mission remains undefinable; it should never be incarcerated in the narrow

confines of our own predilections. The most we can hope for is to formulate some approximations of what mission is all about.”

The student’s approximation of mission is discussed below, with reference to the New Testament, the holistic approach of Kritzinger, *et al.* (1994), and Contextualism as discussed by Bosch (1991).

### **2.2.1 New Testament**

Bosch (1991: 15-16) argues that mission is “the mother of theology”, since the early church’s history and writings, as recorded in the New Testament are fundamentally, missiological in nature. This writing will focus on Jesus and Paul as missiological figures.

Jesus is our ultimate role-model and was responsible for the first paradigm shift in missiology:

In surveying paradigm shifts in missionary thinking I wish to suggest that the first and cardinal paradigm change took place with the advent of Jesus of Nazareth and what followed after that. (Bosch, 19991:15)

Jesus brought grace and love, in place of rules and law. He brought salvation in place of damnation. He also made all people equal, lifting up the poor, and ‘lower class, the children and women. (Cf: Bosch, 1991: 25-41)

Jesus came and lived among humans, loving and restoring them. He healed, he helped, he comforted. He had a compassionate ministry. This example he gave through his own life is what we should use as a plan for mission today.

Lastly, the Great Commission together with the Great Commandment are key summarizing statements of Jesus’ which gives direction to my understanding of mission;

*Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you.*

Matthew 28:19-20

*'Love the Lord your God with all your heart and with all your soul and with all your mind' This is the first and greatest commandment. And the second is like it: 'Love your neighbor as yourself.'*

Matthew 22:37-39

These two statements point us to a holistic approach to mission.

Paul is often described as the first missionary. Paul was the earliest writer of the New Testament (Duling & Perrin, 1994:131), and a major figure in early Christianity, his understanding of Christian faith laid the foundation for Christian theological history. My favorite Pauline writing is Romans and Romans is a key writing on the foundation for Christian theology. (See Duling & Perrin, 1994:178). The book of Romans, undisputedly written by Paul is a book that deals with God's grace.

*For he says to Moses,*

*"I will have mercy on whom I have mercy,*

*and I will have compassion on whom I have compassion."*

*It does not, therefore, depend on man's desire or effort, but on God's mercy.*

Romans 9:15-16

Pelser states that there are few other books, if any that pronounce the gospel of Jesus Christ as strongly and clearly, or with as much conviction as the book of Romans (Du Toit, 1978:41). Pronouncing God's grace and the gospel of Jesus Christ is mission. Paul was the one who was appointed as 'apostle to the gentiles. He is the one who, following Jesus' lead, and echoing the prophet Joel (see Joel 2:32) announced that:

*"Everyone who calls on the name of the Lord will be saved."*

Romans 10:13

After this statement Paul continues to set the stage for mission as we understand it;

*How, then, can they call on the one they have not believed in? And how can they believe in the one of whom they have not heard? And how can they hear without someone preaching to them? And how can they preach unless they are sent? As it is written, "How beautiful are the feet of those who bring good news!"*

Romans 10:14-15

### **2.2.2 A Holistic Approach to Mission**

Kritzinger, *et al.* (1994: 36), explain the threefold goal of mission as follows:

The Christian mission is a comprehensive ministry with various dimensions which can be distinguished, but never separated. We believe, therefore, that the goal of mission can only be accomplished through a holistic approach. This is not a novel approach. The Social Gospel approach was developed in reaction to the perceived one-sidedness of the kerygmatic and sacramental-eucharistic approaches. In reaction, however, the Social Gospel approach neglected the important transcendent dimension and therefore failed to develop a truly holistic approach.

A more acceptable attempt at developing such an approach can be found in what became known as the comprehensive approach. The basic point of departure of this approach was stated thus by Hoekendijk (...): "The intense universality of salvation and the radical application of Christ's kingship over the whole of life demand that we address people in their total environment" (our translation). The various dimensions of this comprehensive approach were expressed in terms of the church's task of kerygma (proclamation), diakonia (ministry of service), and koinonia (communion or fellowship). Under these three rubrics, it was argued, the total missionary task of the church could be accommodated: preaching, witnessing, healing, teaching, developing, and the building up of the church. The threefold goal of mission, as we have described it here, can indeed largely be accommodated in this

approach. We will, therefore, link up with this approach, but wish to extend it by adding a fourth rubric: leitourgia (the public worship of God).

Kritzinger *et al.* (1994: 36-39) then expounds the 4 dimensions of this holistic approach:

#### The Kerygmatic dimension

This dimension deals specifically with evangelism and the building up of the church, through proclaiming the word of God, the message of the Bible, by preaching, witnessing, theological education and distribution of Christian literature.

#### The Diaconal dimension

This dimension is concerned with service and ministry to people by the Christian community. Bosch(1991:399-400) is quoted, arguing that we should "...minister to people in their total need, that we should involve individual as well as society, soul, and body, present and future...". It is the Christian's "...expression of sacrificial compassion and solidarity...with suffering and oppressed human beings".

This study is takes the diaconal dimension of holistic mission as starting point.

#### The Fellowship dimension

The Fellowship dimension is concerned with communication between believers. The church's existence should invite people to join and belong.

#### The Liturgical dimension

Praising and worshipping God is the focus in this dimension. It also places the other dimensions in perspective; "We proclaim not because we know better, we serve not because we are more privileged, we have fellowship not in order to patronize; we do all this gladly because the greatness of God's love leaves us no other option."

This holistic approach to mission enables us to view the care of the vulnerable child from a missiological point of view, and compels us to work within a very holistic and transdisciplinary approach (bringing together academics and professionals from different disciplines, i.e. social work, psychology, theology, sociology), working towards enabling the

church to improve its mission in serving vulnerable children, witnessing through compassion, providing fellowship, and ultimately worshipping God.

Endeavoring to define missiology more holistically, Bradshaw (1993:16-18) brings evangelism and development together under one umbrella of holistic ministry. For him, *shalom* is the key to understanding holism, and connecting evangelism and development. The concept of *shalom* is described as peace, in relationships, in creation, in the person's state of being, and includes justice and protection for vulnerable children. It comes down to restoring the harmony on earth, which God intended from the start. The mission of the church is then to work towards this restoration which Christ will complete in the end. Holistic mission implies working towards giving hope now and for the future. It implies revealing God and the peace that He embodies. This will include the restoration of creation so that it may accomplish what it was created for, leading to the life which God intended for us on earth.

Therefore development is part of mission. It cannot be separated from or valued less than evangelism. In Bradshaw's (1993:17) own words: "Holism affirms that ministering to the poor, sick, naked, hungry and oppressed and preaching the message of eternal salvation is Good News."

### **2.2.3 Contextualism**

Bosch (1991) discusses the paradigm shifts in the Theology of Mission. Relevant to this discussion is the discussion on Contextual theology, which is regarded as a major paradigm shift in theological thinking. Contextual theology recognizes that; "...*all* theology (...) is, by its very nature, contextual", with Third World theology as central to contextual theology (Bosch, 1991: 423).

Contrary to traditional theology, Contextual theologies emphasizes 'praxis', not theory and defines theology as "critical reflection on Christian praxis in the light of the word of God." (Bosch, 1991: 423). Within this paradigm "...doing is more important than knowing or speaking." (Bosch, 1991: 425). The point of theology is to change the world (Bosch, 1991:



424). We cannot change the world with theories and reflection, if these theories and reflections are not implemented in praxis.

This paradigm shift is reflected in the writer's views on theology and missiology. Therefore this dissertation is focused on practice research, in interaction with theoretical reflection. Considering the tension that exists between praxis and theory, the writer believes that praxis is equal to theory and that practice research is, and should be recognized by the academia as equal to theory.

However, theory remains vital; the practice research needs to be grounded and therefore sound theory needs to be expounded to ground the practice research.

In this regard liberation theology serves as a grand illustration of the 'fundamental paradigm shift' currently happening in the practice of and reflection on missiology (Bosch, 1991: 432).

This dissertation has to do with development in Africa. It is written by a South African. Development is meant to liberate people. If development that comes from the West is applied directly in South Africa, it may obstruct their liberation. What we need is development that is born in South Africa. Therefore the theology that is being developed in this dissertation is grounded in the African context.

In Western theology; "Development implied evolutionary continuity with the past; liberation implied a clean break, a new beginning." (Bosch, 1991: 434) Perhaps a clean break is needed because of the unprecedented challenge of HIV/AIDS.

Theology that focuses on theories are not dealing with the root causes of injustice (Bosch, 1991:434). Why theorize about God and mission and development, if we are not going to change the world with what we learn? (cf. Van Niekerk, 2006 unpublished)

Van Niekerk (unpublished, 2006) refers to Andrew Kirk's observation; viz. that there is a fundamental difference in the approaches of the theologies of the North and the South. In the North the validity of theology is tested by the question: does it meet the requirements of science? In the South, the focus is on "its ability to inspire people to be agents and

embodiments of the life of God's new creation in Jesus Christ". Van Niekerk concludes that because we are practicing a Northern theology in a Southern context, our theological training leaves churches unable to get involved with the communities and their realities. Yet, he does not call for a complete break with the disciplined scientific approach of Northern theology, rather that we should put it in service of the goal of Southern Theology, giving equal value to the contribution of the practice research focus of the Southern theology.

This dissertation is third-world theology. What matters in the South African context is the existential needs of the people, in this case the vulnerable children. We will therefore now turn to what matters, and look at the reason why this practice research will focus on vulnerable children.

### **2.3 Priority of the Poor**

Bosch (1991: 435) states that the bible communicates God's "preferential option" for the poor. Both the Old Testament and the life of Jesus has a strong focus on the poor. The poor not only being those who lack materially, but those who are marginalized, those who cannot participate in society, and feel that they are unable to and lacking resources to do anything about it (Bosch, 1991: 436-437). This includes people and children affected by HIV/AIDS and children otherwise made vulnerable.

Below are a few scriptures which illustrate God's preference for the poor;

*Religion that God our Father accepts a pure and faultless is this: to look after orphans and widows in their distress...*

James 1:27a

*Do not take advantage of a widow or an orphan. If you do and they cry to out to me, I will certainly hear their cry. My anger will be aroused, and I will kill you with the sword; your wives will become widows and your children fatherless.*

Exodus 22:22-24

*Cursed is the man who withholds justice from the alien, the fatherless or the widow.*

Deuteronomy 27:19

*The Spirit of the Sovereign Lord is on me, because the Lord has anointed me to preach good news to the poor. He has sent me to bind up the brokenhearted, to proclaim freedom for the captives and release from darkness for the prisoners,*

Isaiah 61: 1

The above scripture was read by Jesus in Luke 4:18-19, after which he said:

*Today this scripture is fulfilled in your hearing.*

Luke 4: 21

Bosch (1991: 436) states that; “In a sense, then, the rediscovery of the poor in our time is also a reaffirmation of an ancient theological tradition.” The focus of this study is on improving the quality of life of the ‘poor’, following the tradition and the call we find in the Old Testament and the life of Jesus, whom we, as Christians, are called to emulate. “Once we recognise the identification of Jesus with the poor, we cannot any longer consider our own relation to the poor as a social ethics question; it is a gospel question.” Therefore the search for a holistic model of intervention that will lift the ‘poor’ out of ‘poverty’ (see definition of ‘poor’ above), is a gospel issue, is theology in essence!

## **2.4 Priority of Children**

Not only does the Bible communicate God’s preferential option for the poor, but also a preferential option for children, more so through the life and teaching of Jesus.

Scripture...

*Let the little children come to Me, and do not hinder them; for the kingdom of God belongs to such as these.*

Mark 10:14

*And he took the children in his arms, put his hand on them and blessed them.*

Mark 10:16

*Whoever welcomes one of these little children in my name welcomes me; and whoever welcome me does not welcome me be but the one who sent me.*

Mark 9:37

*But if anyone causes one of these little ones who believe in me to sin, it would be better for him to have a large millstone hung around his neck and to be drowned in the depths of the sea.*

Matthew 18:6

Brant (Kilbourn, 1996: 107) stresses the importance of integrating children's ministry into our mission philosophy, especially the local church's ("national church's") involvement in meeting children's needs (albeit in partnership with agencies). He refers to children as the greatest uncreached people group that ever existed (Kilbourn, 1996: 103). So does Martin (Kilbourn, 1996: 110); responding to statistics on rejected and suffering children he writes:

... from a biblical perspective we must do something, and from the perspective of evangelical Christianity we cannot ignore those who make up the largest "unreached people group" in the world – children! Yes, globally children need Jesus Christ.

Of the world's under -15 population, over 1.4 billion are growing up in non-Christian homes or in areas and countries where little if any outreach focuses on them. The world's children present the church with perhaps its greatest challenge and greatest opportunity.

A Statement of an International Consultation at Oxford, January 1997, on Children at Risk (Samuel and Sugden (eds.) 1999: 419), states that "God is clearly outraged about what is happening to children."

## 2.5 Conclusion

All of the above discussion on the nature of theology and missiology, the paradigm shifts and God's word itself, lead to the conclusion that practice research focused on ministering holistically to the needs of children is an essential contribution to the theological discourse.

## Chapter 3

### Defining Holistic Care

The aim of this chapter is to lay the foundation for the study by the establishment of a framework for holistic intervention based on Max-Neef's Theory of Fundamental Human Needs and the Functional Household Program.

#### 3.1 Theology and Human Needs

Pauw (2005: 309-315), in his PHD asks the question; *what are the implications of the Christian faith for a teaching on human needs?* He critically evaluates the content of key theories on human needs of the 20<sup>th</sup> Century to bring about a basic structure for a Christian Needs Theory. This structure includes the following components:

- Humans need God as the foundation and purpose of our existence.
- Humans need their fellow humans in the satisfaction of all of their needs.
- Humans need creation as the foundation for life

He refers to the following scripture, quoting Jesus;

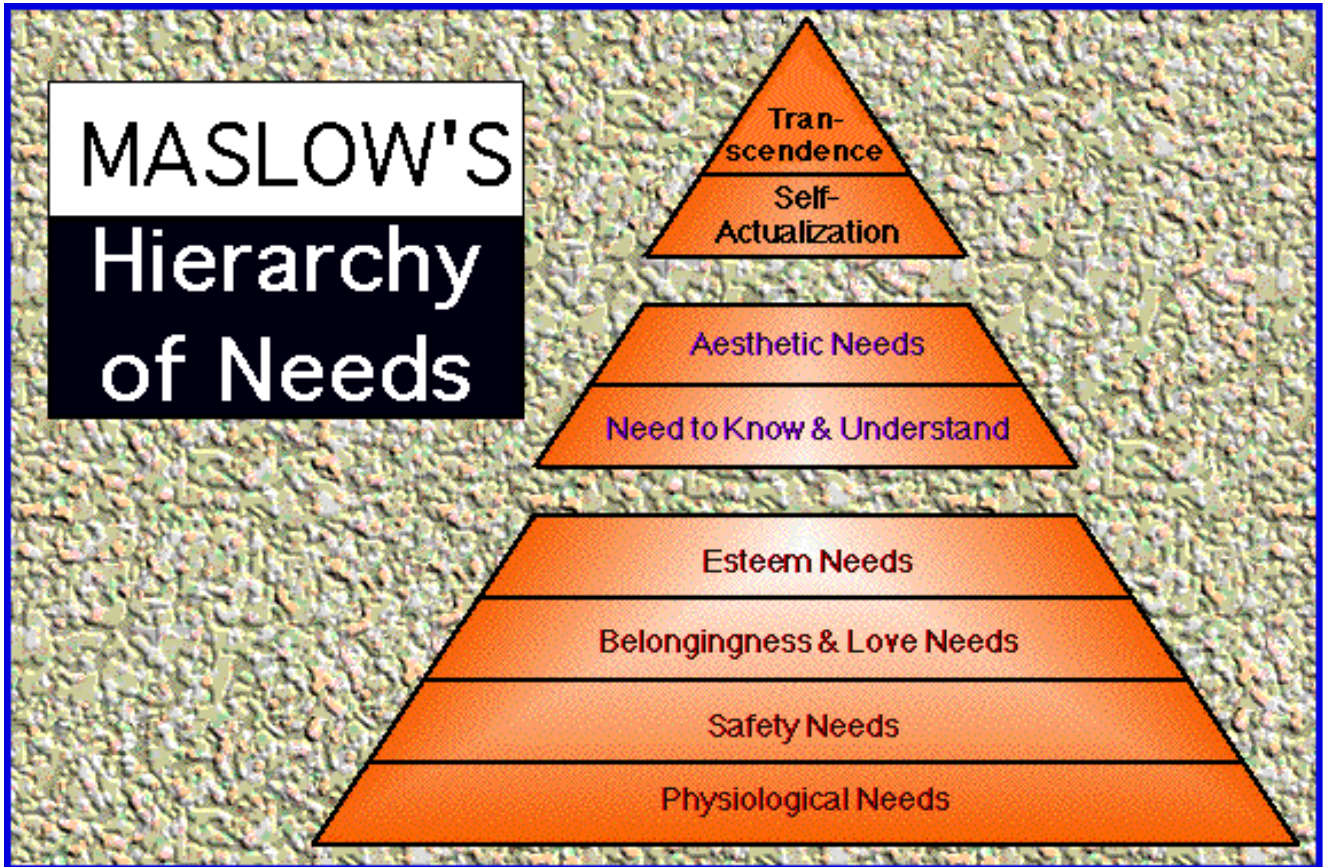
*Jesus answered, "It is written: Man does not live on bread alone, but on every word that comes from the mouth of God.*

Matthew 4:4

Pauw (2005: 315-316), explains that the earliest scientific view of humans, as described by Freud and Pavlov were an attempt to illustrate that humans are equivalent to animals. All human behavior was explained in biological terms. Maslow was educated in this theory, but partly rejected it later, recognizing higher level functioning in humans, and developed a new, and influential theory of human needs.



Because of the influence Maslow's theory has, I include a description of it below. The excerpt also refers to the popularity of the theory. The description and the graphic is taken from the *Educational Psychology Interactive* (Huitt, W. 2004), as retrieved from <http://chiron.valdosta.edu/whuitt/col/regsys/maslow.html>.



Maslow posited a hierarchy of human needs based on two groupings: deficiency needs and growth needs. Within the deficiency needs, each lower need must be met before moving to the next higher level. Once each of these needs has been satisfied, if at some future time a deficiency is detected, the individual will act to remove the deficiency. The first four levels are:

- 1) Physiological: hunger, thirst, bodily comforts, etc.;
- 2) Safety/security: out of danger;
- 3) Belonginess and Love: affiliate with others, be accepted; and
- 4) Esteem: to achieve, be competent,

According to Maslow, an individual is ready to act upon the growth needs if and only if the deficiency needs are met. Maslow's initial conceptualization included only one growth need--self-actualization. ... Maslow later differentiated the growth need of self-actualization, specifically naming two lower-level growth needs prior to general level of self-actualization (Maslow & Lowery, 1998) and one beyond that level (Maslow, 1971). They are:

- 5) Cognitive: to know, to understand, and explore;
- 6) Aesthetic: symmetry, order, and beauty;
- 7) Self-actualization: to find self-fulfillment and realize one's potential; and
- 8) Self-transcendence: to connect to something beyond the ego or to help others find self-fulfillment and realize their potential.

Maslow published his first conceptualization of his theory over 50 years ago (Maslow, 1943) and it has since become one of the most popular and often cited theories of human motivation. An interesting phenomenon related to Maslow's work is that in spite of a lack of evidence to support his hierarchy, it enjoys wide acceptance (Wahba & Bridgewell; Soper, Milford & Rosenthal).

An interesting application of Maslow's theory in human development is found in a briefing note prepared by the Program on Humanitarian Policy and Conflict Research (2004), of the Harvard School of Public Health for the UNRWA Conference on Humanitarian Assistance to Palestinian Refugees Geneva, June 2004. This note explores key aspects of the human security perspective on the protection of Palestinian refugees

The Program on Humanitarian Policy and Conflict research (2004) takes a multidisciplinary approach to addressing the humanitarian consequences of conflict situations as part of a new understanding of security and humanitarian requirements known as "human security."

Human security can be defined as "... a complement to state-centric security models with a focus on individual and community needs as an important guarantor for sustainable peace and stability" (<http://www.hpcr.org/>)



Maslow's theory is used in developing a model for categorizing needs to prioritize assistance, but also to argue the importance of addressing all human needs in a systematic manner;

What exactly are refugees' security needs? A useful model can be developed from Abraham Maslow's early writings on basic human survival needs.<sup>1</sup> Maslow's 'basic needs' model is often invoked in debates concerning interventions on behalf of refugees and other populations in difficult circumstances. Maslow argued that there is a hierarchy of human needs – the most important and basic are survival needs: food, water and shelter. Basic safety needs follow – sufficient security to permit the satisfaction of the 'higher order' needs of love, belonging and ultimately, esteem and self-actualization.

Such a model can be used to categorize the security needs of Palestinian refugees, in particular those living in the Occupied Palestinian Territory. Like Maslow, one may stress the importance of fundamental physiological needs in terms of investment of resources (e.g. in projects targeting food, water, and shelter). On the basis of the provision of assistance to such needs, further programs need to be developed to address the need for personal safety and integrity, which lie at the core of the human security agenda. These two basic conditions are central, but by themselves they do not sufficiently establish the security of refugees. The life of refugees is also characterized by dependence on others for survival. Under social needs, connection, belonging, and relationships with others are an essential component of the survival and development of any individual. Furthermore, refugees particularly need a sense that they have a viable future and opportunities for self-sufficiency (Esteem and Self-Actualization). For adolescent refugees for example, prospects for educational and vocational opportunities are vital components of their security, development and emancipation.

Maslow's hierarchy of needs is far more than a model for the prioritization of assistance. On the contrary, it aims to demonstrate the coherent nature of human needs and underlines the importance of addressing all these needs in a systematic manner. Programs of assistance that provide food without safety, safety without social interactions, social interactions without development opportunities, or development opportunities without the promotion of the refugee's identity and culture are simply doomed to fail in their security objectives. In this context, assisting

Palestinian refugees is much more than a charitable endeavor, it is participating in their development and emancipation as Palestinian individuals and communities, and contributing to the rebuilding of a nation.

(Program on Humanitarian Policy and Conflict Research, 2004),

This interpretation of Maslow's hierarchy is appealing in that it can help in the development of a systematic approach. However it is not the norm for development workers to apply the theory as such. There is a general tendency for development workers to feel that it is not necessary to go beyond the basic needs. Pauw (2005: 313), states that humans are not only oriented towards the so-called basic needs alone, the satisfaction of these needs are important, but also leads the individual to pursue his or her the potential in satisfying the so-called higher needs. Despite the fact that Maslow pointed this out, the popular interpretation of his theory places the focus on a need hierarchy. However, Pauw, (2005: 317), argues that the hierarchal view of human needs are not compatible with a Christian view of humans, which does not recognize a separation of spirit and body. The Christian faith believes that humans do not live on bread alone, whereas the hierarchal view of Maslow believes that humans live on bread first and foremost. In the Christian faith, the physiological needs are recognized as a prerequisite for life but not the basis of life.

Therefore we cannot and must not base our Christian development and relief efforts on the popular hierarchal view of needs. We cannot say that only the deficiency needs or the basic (physiological and safety) needs should be met. If we say that the other needs are luxuries, we rank humans with animals. As Christian we have a higher view of humanity. We believe that humans were created in the image of God.

*So God created man in his own image, in the image of God he created him; male and female he created them.*

Genesis 1:27

Also, God's working in us, cannot be limited to, or contained in the steps of the Maslow hierarchy.

We need to find another approach, one that is closer to a Christian view of humanity and a Christian view of needs. One theory that the student and the researchers at NOVA believes is more appropriate, is Manfred Max-Neef's theory of Fundamental Human Needs (Max-Neef, 1991). This theory may not be a Christian based theory but is a useful bridge for theology to move towards a more Christian view of humanity and human needs (with recognition to Pauw, 2005). This theory does not view needs as hierarchal, and has a completely different approach.

### **3.2 Max-Neef's Theory of Fundamental Human Needs**

Bosch, as quoted above, argues that the church should "...minister to people in their total need...". How do we determine the *totality of the child's needs*? According to Manfred A. Max-Neef human beings have 10 fundamental needs. These needs are not only fundamental, but also unchanging and trans-cultural. Different cultures may satisfy the needs in different ways but the needs are the same for all people from all cultures. The 10 fundamental human needs are: subsistence, protection, affection, creation, idleness, understanding, participation, identity, freedom and transcendence. There are positive and negative ways of satisfying these needs (Max-Neef, 1991:17).

It is necessary to distinguish between basic human needs and fundamental human needs. Basic needs are traditionally defined as the most important needs, implying that there is a hierarchy of needs. Basic needs are often listed as being food, water, clothes and shelter. As an alternative, Max-Neef argues that there are 10 fundamental needs, all equal with the one exception that without subsistence none of the others can be addressed.

Building on the global trend to equate development with the satisfaction of basic human needs, Max-Neef took a transdisciplinary approach (an approach by which multiple disciplines work together) "to make a theory of human needs understandable and operational for development." Max-Neef says that development is about people, not objects, and that we need an indicator of the qualitative growth of people in order to measure the success of a development approach. He goes on to state that this indicator is improvement in people's quality of life. He argues that quality of life is dependent on a

person's potential to adequately satisfy their fundamental human needs (Max-Neef, 1991: 13-16).

Max-Neef proposes that what has traditionally been called needs are in reality only satisfiers of needs. Examples of satisfiers are food and shelter, which are satisfiers of the fundamental need for subsistence. Education is a satisfier of the fundamental need for understanding. Needs and satisfiers do not correspond one to one, but one satisfier can cover several needs and one need may require several satisfiers, depending on time, place and circumstance. This theory proposes human needs as a system, all interlinked and interactive; each operating in 4 dimensions, that of being, having, doing and interacting, and with no hierarchies, except for the need of subsistence being the most fundamental need (Max-Neef, 1991: 17).

Finally, the theory suggests that there are different types of satisfiers, listed and defined below;

### **Violators/ Destroyers**

This satisfier is employed under the pretext of satisfying the need, but destroys the probability of satisfying the particular need over time and also damages the sufficient satisfaction of other needs, e.g. authoritarianism as supposed satisfier for protection.

### **Pseudo-Satisfiers**

These satisfiers produce a false sense of satisfaction of a particular need, and could over time destroy the possibility of satisfying that need, e.g. charity as satisfier of the need for subsistence.

### **Inhibiting Satisfiers**

These are the satisfiers that over satisfy a particular need, thereby acutely restricting the likelihood of satisfying other needs, e.g. television as satisfier of the need for leisure can restrict the satisfaction of the needs for understanding, creation and identity.

### **Singular Satisfiers**

These satisfiers satisfy one particular need, being neutral to the satisfaction of any other needs, e.g. programs that provide food only satisfy the need for subsistence.

### **Synergic Satisfiers**

These are the satisfiers that satisfy a particular need, and at the same time promote and contribute to the satisfaction of other needs, e.g. breast-feeding as satisfier for the need for subsistence, also satisfies the needs of protection, affection and identity (Max-Neef, 1991:31-34).

The following chart that was drawn up by the student with the help of the NOVA Institution researchers, shows the 10 basic human needs identified by Max-Neef with their aspects and the functions and dimensions of holistic care (of orphans and vulnerable children) as generic satisfier of those needs.

Needs	Aspects of needs that require attention	Generic satisfier	Functions and dimensions of satisfier
Subsistence	Body	<b>Holistic</b>  O R P H A N  and  V U L N E R A B L E  C H I L D  C A R E <b>Approach</b>	Healthy Food Healthy water Adequate clothing Having a healthy caregiver Employment/Income
Protection	Environment People Illness Health		Shelter (homes/bedding) Clothing Hygiene Health-care Employment /Income Government/services
Affection	To be special to someone Loyalty Feel good		Love Touch Friends Mentors Care-givers Family
Understanding	To be schooled To be wise Education		School Read Therapy
Participation	Decisions Work/school Community Society		Have a say in future Be part of a family Active in community
Idleness	Body Enjoyment		Sports Hobbies Relax/rest Friends
Creativity	create		Hobbies Crafts Talents Music, Drama
Identity	Heritage Knowing parents Culture		Memory Book Contact with family Culture exposure
Freedom	Freedom to play Choices Freedom of movement		Space Respect Choices
Transcendence	Knowing God Salvation Spiritual Growth		Spiritual programming Christian care-givers

Using Max-Neef's theory of needs helps us to distinguish between needs and satisfiers, and to see a more comprehensive picture of children's needs, leading to a truly holistic view of children's needs.

### 3.3 The Functional Household Program

The Functional Household Programme (FHP) was developed by NOVA researchers.

The following is taken from a draft NOVA manual (work in progress).

The Functional Household Programme is an attempt to understand the functioning of households in relation to their quality of life. We aim to understand the way in which successful households function to achieve a certain quality of life for its members. We also aim to understand which factors undermine the functionality of the household and thus the quality of life of its members. The most basic distinction made by the functional household framework is the difference between a need and a satisfier. A need is a basic dimension of human life. Needs are related to the way in which we exist as human beings who have bodies, are social beings with thoughts and feelings and exist within time and space. In our definition all people have the same needs, because we are all people. Satisfiers are ways of being, doing, having and interacting that we use to satisfy (or actualize) our needs. We differ not in the things that we need, but in the way we satisfy these needs through different modes of being, doing, having and interacting. Economic goods facilitate the satisfaction of needs... The functional household framework is a conceptual tool that allows in-depth and multi-dimensional analysis of the functioning of the household in meeting the needs of its members...

The NOVA researchers identified 25 aspects of needs from previous research, literature study and in dialogue with other experts. These aspects are; self, intimate partner, household members, non-household members, house, air, water, food, clothes, waste removal, care, work, rest, faith, thought, learn, communication, hope and motivation, beauty, values, land, light, sound, gender, and development phase. In the Functional Household Programme, these aspects, together with the ten fundamental needs, as defined by Max-Neef are used consistently to analyze any synergic satisfier. A synergic satisfier is a type of satisfier humans employ to satisfy their needs and are almost always related to the actualization of more than one (if not all) need(s). An example of a synergic satisfier is a house. Synergic satisfiers do not have to be positive. War can also be a synergic satisfier. In the case of the current study the synergic satisfier of *care* was analyzed to determine how well the care of vulnerable children actualizes (satisfies) their

needs. The needs and aspects of the needs are placed on the vertical and horizontal axis of a matrix, and the matrix is then used to generate questions for a questionnaire for research. The questionnaire is also stimulated by the literature study. The result is a very thorough and holistic questionnaire for studying the household.

Is there an orphan-care system in which all ten fundamental human needs are satisfied appropriately and if not, can it be done? Which approach to the care of vulnerable children is most successful, most holistic?



## Chapter 4

### What Makes Children Vulnerable

This chapter explores the nature of the vulnerable child through the lens of children's rights and attempts to define the concept of vulnerable children. It looks at the challenges and issues involved in caring for vulnerable children with particular reference to the effects of HIV/AIDS on children, their households and the extended family.

#### 4.1 Children's Rights

Measuring the infringement of children's rights is one way of determining the quality of children's lives, and therefore determining their vulnerability. The Children's Institute of the University of Cape Town has done an assessment of "The situation of children in South Africa." (Berry, L. and Guthrie, T., 2003). The report gives an overview of the situation of the children of South Africa, focusing on the "non-fulfillment and violation" of the rights of children as defined by the Convention on the Rights of the Child (CRC). Although it might not be as holistic an approach as Max-Neef's approach, it can be useful in that it shows us which needs are attended to, and in giving us a picture of the situation of vulnerable children in South Africa.

First I will attempt to compare (match) the 10 fundamental needs (in the first column) with the children's rights as defined by the CRC (in the second column), then give a summary of the situation of Children in South Africa (in the third column), as described in the above mentioned report:

Need (as defined by Max-Neef)	Right (as determined by the CRC)	Summary (as described in report)
Subsistence	<p>Children’s right to an adequate standard of living.</p> <p>Children’s right to the enjoyment of a high standard of health.</p>	<p>Three quarters of children in South Africa live in poverty, ie. they do not have access to enough food, and access to water is problematic in rural areas. Wood and paraffin are not always the best energy choices for children’s health.</p> <p>South Africa’s under 5 mortality rate is high and increasing. HIV is causing more children to live with chronic illness, and more child deaths. Inequality exists in health care services.</p>
Protection	<p>Children’s right to an adequate standard of living.</p> <p>Children’s right to the enjoyment of a high standard of health.</p> <p>Children’s right to protection from violence, abuse neglect and exploitation.</p> <p>Children’s right to special</p>	<p>Overcrowded households brings abuse. Lack of appropriate sanitation puts children at risk of disease.</p> <p>Children are assaulted, raped, abused, neglected, exploited and trafficked. Numbers are alarming and increasing. Poverty is the major cause for children’s right to protection to be violated.</p> <p>Number of orphaned children increasing. Number of children caring for sick and dying adults increasing. Assistance</p>

	care, special protection and assistance. Children's right to a safe environment.	minimal. Parents' smoking affects children's health. Burning coal and wood, dust, refuse burning and industry smoke affects children's health. Other hazards are falling, motor accidents and poisoning.
Affection	Not covered by CRC defined rights.	
Creation	Not covered by CRC defined rights.	
Idleness	Not covered by CRC defined rights.	
Understanding	Children's right to education.  Children's right to an adequate standard of living.	Only 15% of children between 3 and 5 attend early childhood education centers. Schools are in poor condition. Over 1.2 million children of school going age cannot afford school fees or uniforms. There are high levels of violence in schools. School fee exemptions are not implemented adequately.  Children spend long hours fetching wood and water
Participation	Children's right to participation.	Children believe they are not listened to, not respected by adults, and not allowed to express opinions or make decisions.
Identity	Not covered by CRC defined rights.	
Freedom	Not covered by CRC defined rights.	
Transcendence	Not covered by CRC defined rights.	

Even though the above shows that a rights-based approach is not truly holistic, it gives a picture of the quality of life of South Africa's children in some important aspects, including rural areas and all provinces. The Children's Institute's report concludes that the key issues that affect children are; HIV/AIDS, poverty, access to education and protection from abuse. Other factors rendering children vulnerable are having lost parents, being without caregivers, living in rural areas, being girls and being disabled (Berry, L. and Guthrie, T., 2003:60).

## 4.2 Defining Vulnerable Children

It is expected that by 2010 one in five children of school-going age will be orphaned. By 2015, between 9 and 12 percent of the population of South Africa will be AIDS orphans (Gow & Desmond, 2002: 63,99). But who are the orphaned children? And are they the only ones in need of help?

Some studies define orphans as children who have lost both parents (cf. Gow & Desmond, 2002: 99). Others distinguish between maternal (mother died), paternal (father died) and double (both mother and father died) orphans (cf. International HIV/AIDS Alliance Building Blocks Manual ).

The definitions of orphans also differ as to what ages are included. Do we include children up to eighteen in statistics or only up to fourteen years of age? UNICEF (2003:13) gives an age distribution of orphans indicating; "...that on average only 2 per cent of children were orphaned before their first birthday. Overall, about 15 per cent of orphans are 0-4 years old, 35 per cent are 5-9 years old, and 50 per cent are 10-14 years old." No mention is made of the 15-18 year olds. Interviews in this study indicate that in the African culture you are considered to be a child well into your twenties (at least up to 21, some say 25).

Most care programs are directed at *Orphans and Vulnerable Children* (OVC). However, OVC is a loosely used term which is not always defined. Dlamini *et al.* (2004: 12) propose that African countries need to determine their own definition of OVC so as to be able to target programs most effectively. They argue that global estimates (such as that there will be 40 million orphans by year 2010) are high, but these estimates do not give us a true

picture of the needs as "...they only defined children as orphans up to the age of 15, and did not include children in affected communities that were rendered vulnerable by HIV or other factors in their environments." In Many African countries where they are involved, around 60 per cent of children are living in poverty, which increases the vulnerability of children dramatically.

Dlamini *et al.* (2004: 13) highlight the following areas of focus when dealing with vulnerable children:

- The psychosocial needs of children are very important and need to be addressed in addition to their material needs;
- Support for OVC and other children with HIV is of paramount importance;
- Single parent families that are struggling should be included in support programmes;
- The term 'vulnerability' needs to be defined so that no children would be inadvertently left out of interventions that could benefit them;
- Poor resources, unclear policies and legislation affecting OVC (such as questions of inheritance) must be addressed in implementing OVC intervention programmes;
- The focus should also be on prolonging the parents' lives so as to reduce the number of orphans. The ARV-rollout policies in Botswana and South Africa were hailed as important steps in the right direction;
- Safety measures must be put in place to protect OVC against incest and/or child abuse by the caregivers or those around them;
- It was noted that some children were vulnerable even though their parents were alive and that courses to improve parenting skills are required.

## **Conclusion**

HIV/AIDS is a major and devastating factor in the vulnerability of children, directly and indirectly, and will be a major focus of this study, but it is not only HIV/AIDS and orphan hood that makes children vulnerable. It is not only children under the age of fourteen years that are vulnerable. If we only focus on HIV/AIDS affected children under 14 years in our interventions we are going to miss a lot of children who are extremely vulnerable.

In keeping with the focus on satisfaction or actualization of needs in the Functional Household Program and Max-Neef's theory, the vulnerable child could be defined as the child who is in many ways disadvantaged in fulfilling his or her potential to adequately satisfy or actualise his or her fundamental human needs, which leads to an inferior quality of life.

From experience and literature study I propose the following as a list of vulnerable children (this list is not necessarily exhaustive);

- Children who have lost one or both parents (through death)
- Children in large low-income families
- Children of caregivers with no or low-income jobs
- Children who are themselves very ill
- Children who are HIV positive
- Children with sick siblings
- Children with sick parents
- Children in child-headed households
- Children in grandparent-households
- Children in single-parent households
- Children in households who have taken orphans in
- Children in refugee families
- Children with disabilities
- Street children

#### **4.3 The Challenges Presented by Vulnerable Children - An Overview:**

If we accept the above list as a true reflection of who vulnerable children are, we have to consider the implications of this broader definition of vulnerable children. Often, churches, NGO's and aid agencies are eager to help but focus only on AIDS orphans or AIDS infected children. This creates a situation where children who are in dire need are being excluded from relief and development. These same children then become more vulnerable, putting them at risk of becoming HIV infected themselves. This focus on children orphaned or infected by HIV/AIDS also leads to unethical practices with regards to disclosure of HIV status.

Even before the HIV/AIDS epidemic, certain children were vulnerable. HIV/AIDS came along and added more children to the list of vulnerable children, but also compounded the vulnerability of those already vulnerable. Therefore a conscious decision to include all vulnerable children in our ministries, and our relief and development efforts will enable us to exercise a holistic approach.

The enormity of the problem evades most of us. If you do comprehend the severity of the situation it is difficult to visualize the reality and practical implications of the threat and dealing with the threat. Considering this broader definition of vulnerable children, it would be difficult to find statistics to substantiate the scope of the problem. With the prevalence of HIV/AIDS infection in South Africa at more than 20% of the population (Kometsi, 2004:9), the numbers of children made vulnerable by HIV/AIDS would be staggering. Added to that we have children made vulnerable by poverty, which is estimated at 55% (Sake-Rapport, 9 October 2005). Add to that all the other factors that cause vulnerability (other illnesses, divorce, disability, refugees, etc.). Where does that leave us? All of this means that a strategy for intervention cannot be aimed at individuals, but because of the magnitude of the problem communities must be reached. Intervention must become a top priority to the government of our country, but also to the church. The crisis of vulnerable children is a community issue, not an individual issue. Society needs changing. How can the church help to improve our society?

This perspective on vulnerable children changes the scope and the dimensions of the problem presented by vulnerable children, and it also changes the quality of the approach. It necessitates a structured, inclusive and holistic strategy.

The plight of vulnerable children presents serious challenges on many levels; individual, family, community and government. And the above argument is not meant to discount the serious impact of HIV/AIDS on our communities. Alison Rader writes: "South Africa faces an ominous future unless all of us combine our resources and efforts in fighting the spread of HIV in our communities. Although HIV/AIDS has severe medical consequences, it is a community issue, a development issue and even a human rights issue."

(Kilbourn,1996:76). The *Millennium Declaration*, rightly states that HIV/AIDS is a severe threat to development (Jones, 2001:12).

Neither does the above argument want to dismiss the serious plight of orphans and the challenges presented by orphanhood. Orphanhood is devastating and brings about many disadvantages. Children are often traumatized by witnessing the illness and death of one or both parents. Furthermore they tend to be poorer and are unhealthier than non-orphans are. Their cognitive and emotional development are likely to be impaired, they are less likely to go to school, and more likely to be subjected to the worst forms of child labour (UNICEF 2003:6).

Both HIV/AIDS and orphanhood will continue to be major concerns in this discussion and future discussions on vulnerable children, and so it should be, but without discriminating against children made vulnerable in other ways.

All of these vulnerable children are growing up, being moulded and formed to become adults. If they are not cared for, and their needs not adequately satisfied they will become dysfunctional adults and parents.

HIV/AIDS does not only affect the infected individual's physical health, it reaches far beyond physical deterioration. All family members are seriously affected by HIV/AIDS as it impacts on their mental health and interferes with the family structure." (Report of a National Conference sponsored by Casey Family Services and the Annie E. Casey Foundation, 1997:37) Children, who are either infected or affected, both need safe places and relationships which will help them understand the disease and its consequences. (Kilbourn, 1996:81)

#### **4.3.1 Effect of HIV/AIDS on Children**

Children are directly affected by HIV/AIDS, in many ways when their parents or other close family members are infected, when those infected become very ill and die, when they themselves are infected and when their family takes care of others who are ill or orphaned. No doubt, the whole family suffers, but it is clear that children suffer most intensely (Crewe,



2001:12). A 2000 Horizon Report on Children and Youth Affected by AIDS cites earlier research which showed that children who are orphaned by AIDS; “...suffer physical, educational, and emotional setbacks.” (USAID, 2000).

#### **4.3.1.1 Multiple Losses**

HIV/AIDS brings along multiple losses. Death of one parent usually leads to the death of a second parent. Stigmatization means a loss of dignity. Illness brings a loss of income. Loss of income brings loss of nutrition which leads to a loss of good health. Alternative care could lead to a loss of siblings. Sometimes caregivers walk out on families, or children are abandoned by caregivers (Gow & Desmond, 2002: 62). All of these losses compound, resulting in a loss of hope.

#### **4.3.1.2 Care**

Parents who are ill, parents who are grief stricken and parents who take care of ill family members are not always able to provide good care to children. Dedicated adult supervision is a luxury which they cannot afford (cf. Crewe, 2001:12). Without good care, none, or few of the child’s fundamental needs will be met in appropriate ways (cf. Jewitt, 2002:11).

#### **4.3.1.3 Development and Education**

UNICEF (2003:27) found that orphans are less likely to be in school and more likely to fall behind or drop out, compromising their abilities and potential. Jewitt, (2002:11) suggests that AIDS affected children miss out on developmental stages due to the absence of normal play and school activities. Children in HIV affected households are deprived of education. HIV/AIDS often causes financial constraints which leave the family unable to pay for school fees, uniforms, books, stationary and transport. Sometimes children are required to help at home or find employment to contribute to the family income. Should they be lucky enough to still be attending school, they are often suffering from poor health, malnutrition and psychological trauma, which critically affects their ability to concentrate and learn (Gow & Desmond,2002: 97). Gow & Desmond (2002: 61) report that children living in HIV-infected households are commonly underdeveloped and suffering from poor

health, either due to being HIV infected themselves, or being exposed to the opportunistic diseases of other infected household members, or aggravated poverty.

It is not only school attendance that is important. Early childhood development (the pre-school years) is foundational and extremely important. Babies and children need to develop many skills which will enable them to relate, to learn, to read and write long before we consider teaching them consciously. Stimulation and play is needed from the very first year of life, to learn these elementary skills.

#### **4.3.1.4 Hunger**

Sub-Saharan Africa has the highest percentage (and increasing) of people who are hungry and young children are affected most. Inadequate nutrition in the early years can cause permanent damage to mind and body, and also death (Beckmann & Simon, 1999: 16-17). UNICEF (2003:29) found that children orphaned by HIV/AIDS face a higher risk of malnutrition and stunting. Children need to eat enough, and also need to eat balanced meals for optimal growth and development. Different foods do different things; i.e. provides energy, promotes growth and regulates body functions (Marotz, *et al.*, 1993: 313-361). A variety of nutritious foods, from each of the different food groups should be eaten every day. It is recommended that children eat three meals a day with midmorning and midday snacks in between, because they have small stomach capacity and a great need for nutrients (Marotz, *et al.*, 1993: 383-385).

#### **4.3.1.5 Work**

HIV/AIDS in the household causes children to work more than they should, assuming responsibilities which should be reserved for adults. As their parents' illness progresses, children are generally forced to take on an increasing number of responsibilities. Girls take the responsibility for household chores. Boys take over the agricultural tasks of bringing in income by working, for example, as street vendors (UNICEF, 2003:29).

UNICEF (2003:30) reported on the International Labour Organization's assessments to investigate the situation of working children, which found that orphaned children are much

more likely than non-orphans to be working in commercial agriculture, domestic service, commercial sex and as street vendors.

#### **4.3.1.6 Death, Loss and Grief in AIDS Orphans**

Losing a parent is one of the worst things that could happen to a child. The emotional crisis of orphans must be addressed. Death, loss and grief is compounded by the multiple losses, fear and stigma associated with AIDS.

Grief is one's emotional response or feelings toward an event that affects one, usually the loss of a person, thing, or idea (MAI resources). "It is a natural and healthy reaction to loss." (De la Porte, 2003:11) Grief is as intense and serious for a child, as it is for an adult (Wells, 1993:1) The grief that children experience due to HIV/AIDS is compounded by the multiple losses. If grief is not dealt with, it will influence the child's emotional and spiritual development. If there are no counseling services available to the child, as we might expect in vulnerable children's communities, and when parents are consumed with their own grief, the children will not be helped to deal with their grief.

The most distressing aspect of death in any setting is the amount of preparation or lack thereof for the impending death. Death is a part of life, which few consider preparing for. As one prepares for life, so one should prepare for death. Children who have lost a parent to death should have an opportunity to work through their feelings, thoughts and fears regarding death. ...Children should be given the opportunity to treat death openly, in order to acknowledge fears and other distressing emotions.

(Jewitt, 2002:11)

If we consider the stigma surrounding HIV/AIDS it is possible that children will not be prepared for the death of a parent.

Most people have experienced some grief. Recovery after the death of a loved one takes time. "The death of a loved one brings grief, poignant sorrow, and pain." (Lampman,

1997:229-230). Emotionally, and medically, it is healthier for those who are grieving to show it and express it together as a family (Wells, 1993:4).

Lampman (1997:17-22), identifies ten stages of grief:

1. Shock and denial;
2. Loneliness and vulnerability;
3. Tears and weeping;
4. Pain and hurt;
5. Panic and anxiety;
6. Guilt and regret;
7. Anger and frustration;
8. Depression and sadness;
9. Hope and fulfillment, and
10. Recovery and readjustment.

J. William Worden, identified four tasks of mourning (Klein, 1998:19):

1. To accept the reality of the loss;
2. To experience the pain of grief;
3. To adjust to an environment in which the deceased is missing, and
4. To find an appropriate place for the person who died in the emotional life of the bereaved.

(cf. Anderson, *et al.*, 2000: 245- 249)

Anderson, *et al.* (1999: 155-156) reason that children of HIV-infected parents are in particularly uncertain and complex circumstances; “They must maintain the precarious balance of continuing the normal routine of daily life while acknowledging that within several months or years, their parent could be lost to them forever.” It should also be noted that children grieve differently from adults. “The main difference is that a child’s periods of intense grief are shorter (...) but the grieving period may last much longer. ...long after the adults in the family are living their changed lives with calm acceptance of a tragedy, a child can suffer despairing sadness.” (Wells, 1993:5)

Intervention is essential to lessen the risk for serious medical, behavioral, developmental, and learning problems, and to reduce the intergenerational patterns

of risk-taking that may have led to the parents contracting HIV. Unless a supportive and stable environment is created to improve short-term and long-term mental health outcomes in orphaned children, a viable custody plan may not endure.” (Anderson, *et al.*, 1999: 81)

This supports Max-Neef’s needs theory. If all needs are not met appropriately, the individual will find pseudo-satisfiers or become totally dysfunctional.

Barbara O. Dane states that; “Bereavement clearly ranks high among stressful life events” and she gives 6 features of an AIDS death that influences grieving which should be considered to improve effectiveness of interventions:

1. Cultural attitude towards death and the mourning process;
2. Socially unacceptable death (stigma, fear, discrimination, secrecy);
3. Relationship to the deceased parent (and availability of alternative parent);
4. The child’s understanding of death;
5. Survivor guilt, and
6. Social support.

(Dane & Levine, 1994: 13-28)

Sandra Jacoby Klein (1998:33-34) lists more factors that contribute to complicated grief and bereavement of AIDS:

1. Shortage of caregivers willing to work with PLWA;
2. Inferior health care;
3. Suicidal thoughts that are common among PLWA;
4. Fear of forming new relationships because friends are infected – more losses;
5. Difficulty in differentiation between symptoms of grief and depression, and symptoms of HIV;
6. Over-utilised, under-funded community resources;
7. Uncertainty around medications – false hope, and
8. Family conflicts due to unfaithfulness.

To further complicate the matter, there is always the possibility that the new caregivers of orphans themselves will surrender to HIV/AIDS, leaving children to be ‘orphaned’ a second time. Research in Uganda, among caretakers of orphans who knew their HIV status revealed that one third were themselves HIV-positive. Therefore the number of potential caregivers is steadily shrinking (UNICEF, 2003:22).

In an effort to protect children from pain, adults sometimes do not tell children of a parent’s or sibling’s terminal illness. But children know something is amiss, and build up “terrifying fantasies” in their own minds. When the illness is acknowledged, and children included in the nursing of the patient, the child is gradually prepared for the eventual death and bereavement (Wells, 1993:19).

Wells (1993:9-16) suggests a few practical ways to help a grieving child;

- Support groups – sharing experiences;
- When informing a child of a death, preferably the person, emotionally closest to the child, should do it. Hold the child. Listen to the child, reassure. Children assume they are guilty or responsible. Reassure them that it is not their fault. Take their fears seriously and answer questions;
- They might be angry at the one who breaks the news. Be patient. “Don’t ask a child to postpone, deny or cover up her feelings”;
- Older children might want to be alone. Just be available. Don’t tell them they have to be the adult now, and
- Try to keep family’s routine unchanged.

#### **4.3.1.7 Spirituality**

Kenneth J. Doka (Eds. B. O. Dane and C. Levine, 1994:33-37) writes;

Death is a spiritual crisis. It demands answers beyond the realm of immediate experiences.

A child’s development will affect the ways he or she understands and expresses spirituality. This is particularly important when dealing with orphans of the HIV

epidemic, some of whom, given their pre- and postnatal environments, may have developmental deficits. But the question is not at what age of developmental level children can understand spiritual concepts. Rather the question should be how does the child, at this age and developmental level, understand and express his or her spirituality?

Any death, especially the death of a parent, raises spiritual questions for the child. Questions such as “Why did this happen?”. “Why did it happen to me?” and “Why did he, she, or they have to die?” are inherently spiritual. Even questions such as “What will happen to me?” and “Who will take care of me?” have spiritual dimensions.

Because AIDS engenders such dread, survivors of AIDS-related deaths are often reluctant or ashamed to share their secret with others. And that can make the quest to find meaning even more difficult. To complicate the issue further, for many, AIDS has profound moral implications. A second complicating factor is the chaotic nature of the lives of many orphans of the epidemic. “Poverty, deprivation, drug abuse, neglect, illness, living with different people, child’s needs ignored because of parent’s illness, multiple loss”.

Religion and spirituality can complicate or facilitate a child’s response to illness, loss, and death. In order to understand the ways that the child’s spirituality affects his or her response to loss, caregivers have to explore the child’s beliefs, understand the rituals the child has participated in or could find meaningful, and assess whether or not the child might be connected to a supportive faith community.

#### Guidelines for nurturing faith in children:

- Treat children with respect;
- Teach the God’s Word;
- Model the truth in your life;
- Enter into relationship with them and love them, and
- Pray for the children.

(Kilbourn, P. (ed.) 1996:197-203)

#### 4.3.1.8 Summary

The effects of HIV/AIDS on children are numerous and overwhelming;

..., they are removed from education, they have inadequate nutrition, and they don't have dedicated adult supervision. They face the trauma of the death of their parents, and an uncertain future. But increasingly they have less and less, so that when they are orphaned they are more than just children who have lost one or more of their parents. They are children who have already been removed from the mainstream and are now faced with the stigma, not only of AIDS but also of being a problem, and a burden to the family who's going to take them in. They're destitute in every sense: emotionally, economically, and in terms of the community.

(Crewe, 2001:12)

Multiple losses that children experience restrict the potential for satisfaction of the needs of subsistence, protection, affection, identity, freedom. Sub-standard care due to parental illness and death threatens the adequate satisfaction of subsistence, protection, understanding, creation. Development and education are impaired in children affected by HIV/AIDS which especially restrict the potential to satisfy their needs of understanding and creation. Hunger leads to inadequate satisfaction of the needs of subsistence and understanding in particular. Although working functions as a satisfier for the need of subsistence, children who are forced to work prematurely might be denied opportunities to satisfy their needs for understanding and idleness. Inappropriate management of grief leads to unsatisfied needs of identity, understanding, affection, transcendence, participation, and creation. Lack of spiritual guidance and development threatens the satisfaction of the needs of transcendence, understanding, and participation. HIV/AIDS seriously threatens the quality of life of the child.



### 4.3.2 Effects of HIV on Households

The concept of a household is not a strange one, but needs defining for our study's purposes. The Oxford dictionary defines a household as follows:

1. occupants of a house as a unit
2. house and its affairs

It is therefore not quite the same as a family, but includes any people, whether related or not who occupy the same space/ house. The reference to house could be misleading as the occupants of a hut or a shack or other informal dwelling also form a unit and become a household. Very few households in South-Africa, especially in informal and poorer areas are consisting of what Westerners view as the traditional family (i.e. mother, father and children.) Circumstances in Southern Africa have brought about different types of families and today, because of dying parents, there are many granny-headed households and child-headed households. The term also includes many aspects of everyday life as related to the occupants, as can be seen in the 25 aspects identified by NOVA researchers. NOVA researchers define the household as being more than a family. The household is defined as a micro system that occupies a specific place (eg. A site) and consisting of all aspects involved, including the occupants or residents, the physical structures, the land and the social relationships. The household is shaped by the interaction between internal factors such as religion, culture, values, capacity and external factors such as politics, economy, ecology, media, etc.

Since people with HIV/AIDS are part of households, their illness and death must have a serious impact on households. Households are disadvantaged and even disappear, leaving the children displaced and alone. Gow & Desmond (2002:111) states that the degree to which HIV/AIDS will impact South African households has not been empirically investigated, although it will be of particular concern. The primary reason being that HIV/AIDS impacts the household's financial situation. HIV/AIDS is most common in the "...economically productive segment of the population (15-49 years old)." which means that there is less income, and the infected person's costly medical care and death results in more expenditure.

By 2011, 56% of the population will live in households where at least one person is HIV-positive or has died of AIDS. The burden of caring for the sick and destitute will have an impact on the 44 per cent of uninfected households.

At the household level, the impact of HIV/AIDS on children is exacerbated by the fact that HIV usually strikes more than one member of an infected household and this usually includes the primary caregiver and/or breadwinner. (Gow & Desmond, 2002: 60)

#### **4.3.2.1 Poverty**

Poverty complicates HIV/AIDS, and HIV/AIDS complicates poverty. Treatment costs money. Illness prevents one from earning money. Piot (T.T. Jones, 2001: 38) underscored the fact that it “would be a terrible mistake to position AIDS simply as a disease of poverty.” Admitting that there “is a profound link between AIDS and poverty” he reversed the causal connection attributed by Mbeki: “AIDS creates poverty, AIDS deepens poverty, and AIDS makes poverty harder to escape from.”

Although it is a controversial subject, there is no denying the relationship between poverty and HIV/AIDS.

A simple example of the complication is schooling. There is a link between school attendance and emotional wellbeing in children. Adult illness can cause children to drop out (USAID, 2000). Children who are uneducated are less likely to break out of the cycle of poverty.

Household incomes plummet when adults fall ill from HIV/AIDS and can no longer work full-time or even part time. Households who take in orphans suddenly have more dependants and become poorer. The costs of treating HIV/AIDS related illnesses is a huge economic burden on families. There is an increased ‘dependency ratio’, meaning that in these affected households the income of fewer earning adults is sustaining more dependents. Even after death, funeral expenses contribute to the financial burden caused by HIV/AIDS

(UNICEF, 2003:17). The most common unmet needs are education, food, medical care and clothes (UNICEF, 2003:20).

#### **4.3.2.2 Grandparent-Headed Households**

In South Africa, the majority (64%), of double orphans (and children not living with a surviving parent) are being raised by their grandparents (UNICEF 2003:17). A survey of 178 households in KwaZulu Natal has shown that many orphans become part of their grandmother's households. Researchers state that: "The reliance on grandparents to provide care after the death of parents is dangerous and will become increasingly so as the epidemic progresses. When the grandparents die, these children face being orphaned again. The question of who will care for them then remains unanswered." Limited income and health status of grandparents further complicates their status as caregivers (Gow & Desmond, 2002: 124). This same survey shows that the majority of households do not have access to resources "...beyond the most basic needed to survive." (Gow & Desmond, 2002: 128) These grandparents are most often grandmothers. UNICEF (2003:22) studies have shown that households headed by women are more likely to take responsibility for orphans. Women are more likely to look after their own children and they are also more prepared to take care of other orphans.

#### **4.3.2.3 Child-Headed Households**

An average of 3.0% of households in South Africa were determined to be child-headed.

- 3.1% in urban formal areas
- 4.2% in urban informal areas
- 2.8% in tribal authority areas
- 1.9% in farms

(Nelson Mandela/HSRC Study of HIV/AIDS South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002: 28)

These households face extreme challenges as their heads are not recognized as caregivers by South-African law, and therefore they do not qualify for grants. They are vulnerable to exploitation and abuse.

#### **4.3.2.4 Urban Complications**

The 2000 Aids Forum held in Johannesburg recognized the devastating effect which the AIDS epidemic is having on urban environments.” (Crewe, 2001: 10) The workforce is worn-out, poverty is worsened, children are left to live on the streets. A major impact is the large numbers of vulnerable children left by ill and dying caretakers, unable to provide care or arrange care by someone else because of the isolation caused by urbanisation

It seems that there is a big outcry to keep vulnerable children in their communities and move away from institutions. Orphan trusts are operating well in rural communities, where communities are taking collective responsibility for the kids, and use micro-enterprise projects to sustain the children, but what about the children in the overcrowded urban areas? Where are their grandparents, where are their community gardens? What should the approach be in the city?

It's very difficult for families in large urban settings to plan for what's going to happen to their children. It's much easier in rural communities, where the community is often much more closely knit. In urban areas we're looking at lots of children who have no extended families, and there's nowhere for them to be sent. If urban centres wait until the children are orphaned, it's too late. People have to start planning now. ...As children become more vulnerable, they have less access to the kinds of preventative work and education needed to ensure that they don't become infected as well. They are in danger of becoming dysfunctional adults-alienated and deprived individuals, unable to live peaceably and work productively in a society that has failed them.

(Crewe, 2001:12)

Mary Crewe (2001:14) from the centre for the Study of Aids, University of Pretoria also states we have failed the large numbers of street children in our urban areas and “...unless

we take some serious action about orphans, the numbers of street children will simply explode.”

#### **4.3.2.5 Disclosure and Permanency Planning**

A major issue involved in the care of vulnerable children, especially those affected by HIV/AIDS, is the issue of disclosure of a parent’s (or child’s) HIV status to children and other family and community members. This in turn complicates the issue of permanency planning.

There are very few programs or methods for dealing with these difficult issues of disclosure and permanency planning. Studies (Anderson, *et al.*, 1999: 80-81) show that more than half of parents with AIDS die without having made a formal plan for their children’s long term care. Even fewer parents will actually legalize plans for their children’s care. Traditionally, there was no need for legal documents, which may partly be why it is not done today, but unwillingness to disclose one’s health status would also prevent such action. Often, the children are not told when a parent is living with HIV/AIDS. They are not prepared for the parent’s death, and not helped to deal with the grief of losing a parent either.

Non-profit organizations, development workers, pastors and professional people like lawyers, social workers, and psychologists all have important contributions to make in helping HIV/AIDS –affected families develop permanency plans for their children, before they are orphaned. Ultimately, ideally, long term care decisions should be made by families themselves, but the above mentioned role players can help parents, care-givers and children; “...explore their options and consider the potential roles of extended family members and friends.” (Report of a National Conference sponsored by Casey Family Services and the Annie E. Casey Foundation, 1997:113) As good as this sounds, it is not always easy;

“Practitioners must recognize how extraordinarily difficult disclosure can be for clients and must acknowledge and respect clients’ feelings about it. At the same time, clients must be guided toward a recognition of the value of illness

disclosure as a necessary step in completing permanency planning.

“(Anderson, *et al.*, 1999: 91)

The Report of a National Conference sponsored by Casey Family Services and the Annie E. Casey Foundation, (1997:113,114) states that permanency planning is difficult for HIV/AIDS affected families because:

- (1) it has the potential to strain relationships and complicate family configurations, and
- (2) it may require finding homes for HIV-infected children.

Therefore “...permanency planning should be guided by the “best interest standard,” an ethical standard that bases decisions on the child’s best interests.” The child’s trauma is minimized if custody arrangements are in place before parent/caregiver dies. Permanency planning provides the child with security and a permanent bond with one culture and community (Kleyhans, 2000:26).

Anderson, *et al.* (1999: 92) say that the: “... relationship between the future caregiver and the parents also demands great delicacy”, and that often, a discussion about permanency planning forces parents to face the realities of their illness and to recognize that eventually they might have to surrender the care of their children to others. This may cultivate feelings of resentment toward the future caregiver, as well as great sadness. For some parents, their parenting role is what keeps them going which make facing these realities easier said than done. “...yet parents are likely to feel a tremendous sense of relief when adequate custody arrangements are put in place.”

Comprehensive and holistic care of vulnerable children should start long before they are actually orphaned. The child becomes vulnerable and is impacted as soon as the parent tests HIV positive or falls ill.

An orphan support program in Uganda is experimenting with an intervention which reaches children before their' parents' deaths. It includes guidance and assistance with the writing of wills, and appointing of guardians, counseling for both children and adults, and family memory books. The study reinforces the finding that: "...setbacks begin before parental death." Children report that their education is affected due to household responsibilities, financial setbacks, as well as their own "psychosocial distress" (USAID, 2000).

In the book; *Children and HIV/AIDS* (Anderson *et al.* (eds),1999, Chapter 5) Draimin, Gamble, Shire and Hudis wrote a chapter called; "Improving Permanency planning in families with HIV Disease." This chapter describes and evaluates 2 models of permanency planning, one where councilor visits mother and child at home and another where set workshops are held for parent and teenager. They assume that different families need different models. Both have carefully worked out modules/curriculums. Both seem good. They conclude on p. 92-93 that "Other approaches, such as residential programs and buddy programs, may also be appropriate for some families; pilot projects should be developed to learn more about them. Only by implementing and evaluating multiple models for providing services to families can funders and practitioners expect to identify the most suitable opportunities for building a stable future for the children orphaned by HIV disease."

### **4.3.3 Effects of HIV on Extended Families**

Traditionally, in Africa, the extended family served as safety net for orphaned and vulnerable children. Sending a child to a (richer) relative is still quite a common phenomenon. I see it with friends, neighbours and even read about it in Mr. Mandela's (Mandela, 1994) bibliography.

The vast majority of orphans in sub-Saharan Africa continue to be taken in by the extended family. Here, the extended family has historically formed an intricate and resilient system of social security that usually responds quickly to the death of a mother or father. In nearly every sub-Saharan country, extended families have assumed responsibility for more than 90 per cent of orphaned children. But this traditional support system is under severe pressure – and in many instances has already been overwhelmed, increasingly impoverished and rendered unable to

provide adequate care for children. Most worryingly, it is precisely those countries that will see the largest increase in orphans over the coming years where the extended family is already most stretched by caring for orphans.

(UNICEF,  
2003:15)

Mashologu-Kuse (2005:8) found that with the exception of a few cases, the “...support that was traditionally characteristic of African families is on the wane” and she questions the capacity of the extended family to take on the added responsibility.

The extended family can no longer be assumed to be willing or able to care for children. The numbers of HIV/AIDS orphaned children are over-extending the extended family networks. Urbanisation and refugee immigration have severed many (though not all) family networks. A further complication of relying on extended family networks is the fact that the extended family can be affected by poverty prior to taking in more children or become poor by taking in more children. Families do not necessarily have the resources to cope with extra children. “It (is) necessary to look at how the children into whose homes orphans were brought (are) being short-changed. In a family unit with five children who were being loved and supported, adding another five would damage the future and possibilities of ten children.” (Crewe, 2001:19). Therefore, the number of vulnerable children is increased, and the problem is not being addressed effectively.

#### **4.4 Summary**

When comparing the ‘Children’s rights’ approach to that of Max-Neef’s Fundamental Human Needs, it is clear that not all the fundamental needs of vulnerable children are addressed by the Convention on the Rights of the Child, which is often used as an indicator of the quality of children’s lives. Even so, using the ‘Children’s rights’ approach, paints a bleak picture of the quality of life of the children of South-Africa.

Children with a sub-standard quality of life are viewed as vulnerable children, and can be further defined as children who are at a disadvantage in their potential to adequately satisfy their fundamental human needs.



It is also clear that the effects of HIV/AIDS are numerous and impact the satisfaction or actualization of the fundamental needs of vulnerable children, and households, and that each factor somehow impacts another. HIV and AIDS compound the problems greatly. All of these need to be addressed in a holistic care program which will address each of the fundamental human needs.

## Chapter 5

### The Different Existing Approaches to Care for Vulnerable Children

This chapter looks at the different existing approaches to caring for vulnerable children; community based programs, institutions/ residential care, child-headed households and foster care.

#### 5.1 Framework

The core of a framework of action, developed by a number of international agencies, including UNICEF, UNAIDS and USAID, highlights the need for strong action on five fronts.

1. Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS. In sub-Saharan Africa, extended family relationships are the first and most vital source of support for households affected by HIV/AIDS, including for orphaned children.
2. Mobilizing and strengthening community-based responses. After families, communities provide the next level of support.
3. Ensuring access to essential services for orphans and vulnerable children. Orphans and other vulnerable children need a number of services to ensure their rights and well-being, including education, birth registration, health care and nutrition, psychosocial support, safe water and sanitation, and strong and independent justice systems.
4. Ensuring that governments protect the most vulnerable children. While the family has primary responsibility for the care and protection of children, national governments have ultimate responsibility for guaranteeing the rights of children.
5. Raising awareness to create a supportive environment for children affected by HIV/AIDS. Action against HIV/AIDS has to be a shared national

responsibility. The orphan crisis in sub-Saharan Africa has implications for stability and human welfare that extend far beyond the region, affecting governments and people worldwide. Wealthy nations must recognize that in the spirit of the Convention on the Rights of the Child and in terms of global interests, they have a vital role to play in accelerating the response to the orphan crisis. They must mobilize substantially increased resources, keep this issue high on the global agenda, provide technical and material support, and ensure that progress towards global goals is monitored and that stakeholders are held accountable. Their commitment and participation is essential, for the children of Africa, orphaned by HIV/AIDS, are the world's responsibility. (UNICEF, 2003:7)

## **5.2 Community Based Programs**

According to Loening-Voysey and Wilson (Gow & Desmond, 2002: 63) the South African government favours approaches to the care of orphans which are community based or home-based, as opposed to residential care. The large numbers of children orphaned have saturated most of the available residential care. The government: "... wishes to rely on the extended family or other members in communities to care for orphans. The decision to scale up family and community support mechanisms and scale down statutory foster and residential care ties in with the international research findings. It also flows naturally from the shift of the Department of Social Development from a residential care approach to a developmental approach in the delivery of services. It has been found that the extended family and kinship networks are able to provide better services to orphans than residential-based models of care."

South Africans believe in 'uBuntu'. In my own words I will define 'uBuntu' as a spirit of community members caring for each other and providing for each other's needs. Professor Thobeka Mashologu-Kuse (2005:7) states that 'uBuntu' is a "fundamental value that underpins the general functioning of African people and their families in South Africa." While presenting her paper "Indigenous Support Structures for AIDS Orphans", at the 2005 Conference of the Association of South African Social Work Education Institutions, Professor Thobeka Mashologu-Kuse from the Nelson Mandela Metropolitan University

remarked; 'uBuntu' is still there, but the resources are not." A romanticized value will not take care of vulnerable children, despite the best of intentions. The community must be empowered to return to this fundamental value, and effectively care for the vulnerable children in their midst. Mashologu-Kuse (2005:13) concludes that: "More indigenous resources must be tapped in order to address the problems of the children realistically and effectively."

The extended family/community based approach is the lower cost option, but the stigma that AIDS brings to its orphans can prevent this strategy from working (Gow & Desmond, 2002: 64)

Gow & Desmond (2002: 63) also argues that even though it is generally accepted that the extended family and community-based care is the preferable approach to caring for orphans, the huge numbers of orphans caused by the HIV/AIDS epidemic might be saturating the opportunities of community based support, as evidenced by the large number of child-headed households.

However, funders, researchers and government policies still prefer the community based approach and therefore we should investigate the possibilities and find the successful programs.

Attention will be given to Orphan Trusts as example of a possible community based approach:

### **Orphan Trusts**

An international relief and developmental organization; World Hope International Zambia (WHIZ) runs a community based care program for orphans in Zambia, called Orphan Trusts. A community of need is identified by local staff and church leaders. WHIZ staff works with the community to select an appropriate income-generating project. This project then supports additional AIDS orphans to live in the community and assists with education, care-giving and other essentials. WHIZ staff works with the community in additional training and capacity building (World Hope Australia website).

Through this trust, care givers of orphans are provided with resources to care for their children and orphans they take in. They work a garden plot, oversee a pig multiplication (farming) project, are taught sewing skills, learn basic literacy and receive training to care for those sick and dying of AIDS (World Hope International website).

### 5.3 Institutions/ Residential Care

According to the *International Save the Children Alliance* (Dunn, *et al.*, International Save the Children Alliance:1) one of the world's leading independent children's rights organizations, the use of residential care in sub-Saharan Africa is on the increase, due to the many deaths of parents from HIV/AIDS (Dunn, *et al.*, undated:1). This document seems to have been written recently (2002) and therefore such a finding, if it reflects South Africa would be contrary to the South African government's "decision to scale up family and community support mechanisms and scale down statutory foster and residential care" as quoted above.

The reality is that children must be cared for and many concerned people start safe homes (small scale residential care), and this might account for the rise in residential care that has been noted above.

*Save the Children's* working definition of residential care is: "a group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society". This definition implies a purposefully designed structure to the living arrangements for children and portrays "...a professional relationship between the adults and the children rather than one that is parental." (Dunn, *et al.*, International Save the Children Alliance:1) The Children's Institute's rapid assessment on *The situation of children in South Africa* found that "...the quality of care given to children in residential facilities is often substandard." (Berry & Guthrie, 2003: 6)

"Although a home for abandoned babies is an emergency need in many HIV-infected communities, that solution is not ideal." These programs exist "...because the family links are not visible." Rader pleads for programs to seek out "family lines" and find extended family willing to care for the orphaned child, because of the importance of family life (Kilbourn, 1996:79).

There are plenty of arguments against institutions. Some writers paint a very negative picture of the effects of institutionalised care. Vallender & Fogelman (1987: 67-70) state:

Research evidence shows that life in institutions has damaging effects on the inmates...The younger the 'inmate', the more harmful the consequences for emotional, intellectual and educational development are likely to be. First, and perhaps more lasting and pervasive, is the loss of a sense of identity. There are three basic questions to which, all too often, the child receives no answer: Who am I? Why am I here? And where am I going? Not only does the child in long-term care have no reliable past; equally devastating, he has no predictable future, except that he will come out of care at the age of eighteen.

The constantly shifting population militates against establishing dependable and lasting relationships, either with staff or other children. ...Another ill effect is loss of privacy and the surrender of individuality....children in residential homes have to bear a stigma which is no less painful for being irrational ...

In my view, institutions should not be expected to provide substitute parental care either on a short- or a long-term basis. Neither should they be considered suitable placements for children while appropriate long-term plans are being worked out' nor, worst of all, as a 'last resort' because no other alternatives are available or have not yet produced the desired results. Instead they must be given a positive and well defined role.

Save the Children (Dunn, *et al.*) argues that many features of residential care are an abuse of children's rights and would like to see a significant global reduction in the use of institutional care as a solution for children who are in need of care and protection, together with the growth of durable and sustained forms of community care. Their main concerns are child abuse and exploitation by personnel, discrimination and stigmatisation, and the way that residential care does not prepare them for adulthood in the community (Dunn, *et al.*, International Save the Children Alliance:1-3).

However, there are those who hint at the possibility that there is still a role for intuitions in the care of vulnerable children, albeit an altered and minimized role:

What then should this role be? I see it as being parallel to that of special schools in the educational and hospitals in the health field; places where special knowledge and skills are employed to remedy or at least ameliorate appropriately diagnosed needs. Just as hospitals and special schools now aim to return patients or pupils to their own homes or ordinary schools at the earliest possible time, so residential care would aim to enable children to return to ordinary family life, whether with their own or substitute parents. (Vallender & Fogelman, 1987: 67-70)

Mary Crewe from the centre for the Study of Aids, University of Pretoria, is a key proponent of this perspective. I will expound her viewpoint extensively, because it balances the opposite viewpoint and might lead us to a solution.

Crewe questions the wisdom of expecting families to take children in. Families, often already disadvantaged, are often put at an even bigger disadvantage when taking children in. They often don't have space for more children, which contribute to the already very high levels of abuse, of sexual violence, of violence against children, and all the social conditions that come from overcrowding and lack of privacy. They do not have the resources to care for more children. In Crewe's own words: "So we need to ask, what are we condemning our children to? "

Crewe suggests that there is a need to move away from blurred notions of strength in the community. Rather, we should focus on monitoring and providing skills training, as there will be many people in need of protection and support. " (Crewe, 2001:13-14).

Mary Crewe (2001:16) says:

Certainly in urban areas we have to revisit the question of institutionalized care. I do not believe we can rely on families or communities that are enormously fractured. There isn't necessarily community identification and a sense of belonging, and we're doing an enormous disservice when we claim

that there is. This is contrary to conventional wisdom, but I think this is because we're looking at institutionalized care as we know it, rather than at new and previously unseen forms. No one would suggest that orphans be housed in large and impersonal buildings without love and affection, but I think it's clear that the notions of community we have are likely to leave the orphan short-changed.

Current work suggests that institutionalized care is much more expensive than family and community care, but I'm not sure that the costs of putting children into carefully designed institutions cannot be offset against a stable, secure, well-educated and well-fed community.

Many people argue against institutional care on the basis of previous failures. But why would they have to be more dreadful than the hunger and overcrowding in emotionally and economically stretched family units? Why should extended families be excluded from that kind of care? Why could they not be part of it?

I think we would have to look at extending beyond the children we classify as AIDS orphans. You could assign such communal care to a whole range of existing institutions, ensuring that they were embedded within communities. The extended family would still hold the primary responsibility for the children, but the orphans would be in care that ensured security, warmth, love, affection, and socialization. The children could move between two homes' the community in which they are living, and the family to which they belong.

She calls for "creative planning" in orphan care: "Even if this is in the form of some kind of collective institutionalized housing, which formerly we would call institutions. But perhaps we can call them something different now, something where the community is an important role player but doesn't assume the primary responsibility for dealing with the children." She does not disagree with the assumption that the household or home is the best place for a child to grow up, but believes that we are romancing the situation. She simply does not believe that these homes and extended families exist everywhere, or can afford to take children in, especially in the urban areas. Crewe says:



I'm not sure that they can, and we need to start addressing this issue and move away from the notion that there is an existing and intact extended family system.

When I look at the realities in our country, especially the cities and townships, I believe she has a point. Indeed, what are we condemning our children to?

Attention will be given to Orphanages and Safe homes as examples of a residential approach:

### **Orphanages and Safe Homes**

An orphanage is traditionally a home for orphans. Today's orphanages are also home to previously abused and abandoned children. I would define an orphanage as a formal, bigger type of residential care.

Another type of residential care that is becoming common in South Africa is what I will term 'Safe Homes' Many couples/ women are so grasped by the plight of vulnerable children that they take children in and provide safety, leading to their registration as non-profit organizations whereby they then become formal places of safety. These places of safety usually care for 10-25 children. They either employ caregivers to help with daily care of the children, or use volunteers.

### **5.4 Child-Headed Households**

Child-headed households are becoming an accepted reality of South African urban areas. They are often accepted and treated as community-based solutions. It is believed that the community will take care of the child-headed households in their midst, in the spirit of "uBuntu". Both Mashologu-Kuse (2005:7) and Barolsky (2003:58) reports incidences of neighbours providing food and protection for child-headed households. Nevertheless, those are only two needs being provided for, and we cannot assume that all child-headed households receive this help from their neighbours.

Mary Crewe from the centre for the Study of Aids, University of Pretoria.” (2001:16) says that: “None of us should morally accept child-headed households, despite the argument that it is the only way to protect children’s inheritance rights. There must be other ways of doing so. We have to look at different forms of communal housing, so that orphans can be integrated.”

## **5.5 Foster Care**

Foster care is substitute care arrangements for children, as ordered by a court of law, for children who are either orphaned or abused or neglected by their parents. Someone else acts as daily caregiver, whether related or not. In Africa, informal foster care arrangements are common (see Kleynhans 2000: 16-18). The purpose of foster care is two-fold: to give the parents an opportunity to spend their resources on solving their problems and to provide the children with a normal family environment in which to develop as normally as possible (Kleynhans 2000: 17).

It is commonly believed that children in more informal foster care placements are often abused and exploited, having to work in the house, denied schooling and other opportunities. It is also commonly reported that people will take in orphaned family members, in order to receive the child grant from the government, which is not used to support the child in the end. On the other hand, under good supervision and management, foster care programs can provide children with an improved quality of life.

## 5.6 Summary

The literature shows differences of opinion regarding community-based care versus institutionalized care. It seems that institutional care might compromise the needs of participation, freedom, identity and in some cases even affection and protection. However, community-based care does not guarantee that those needs will be satisfied appropriately, and other needs, such as subsistence, understanding, creation, and idleness might be at risk. These concerns have led to the inclusion of safe-house in the empirical data collection of this study, discussed in chapter 6 of this document. If we consider the fundamental human needs we might take the best of both approaches and arrive at a best practice solution.

## Chapter 6

### Additional Role-Players

This chapter investigates additional role-players, including the church, schools, memory books, and support groups.

#### 6.1 Role of the Church

The church has enormous potential to impact the lives of vulnerable children. In her introduction to the book; *'It Takes a Church To Raise a Village'*, Dr. Marva Mitchell (2001:xix) quotes an old African proverb; "It takes a village to raise a child." She then describes that village which the old proverb refers to as one of order, in which the child experienced the comfort of security, and assimilated the power of its traditional morality. That village was capable of raising gifted and secure children.

Today, in South Africa, that village no longer exists. Our communities are no longer stable and morality is an old-fashioned word. Few children know security and comfort. Communities in South Africa have lost its cohesiveness and lost its spirit of 'Ubuntu'. Poverty has exhausted its resources. These are the communities in which our churches exist. These are the communities in which our churches must play a role. The title of Dr. Mitchell's book suggests the answer to the deterioration of the capability of the village characterized in the old proverb quoted above; *"It takes a Church To Raise a Village"*. The church should take responsibility for restoring communities where order and morality prevails. The church should take responsibility for restoring the community's capability of raising gifted and secure children. Dr. Mitchell(2001:xxii) says; "If the Church is to raise the village, it must stop *having* church and start *being* the Church."

In my opinion, to be Church is to be the hands and feet of Jesus on earth. To reach out and touch, help and serve. In the context of this study, to be church is to empower families and or households to provide for all of the needs of their children. To restore communities who will then be able to raise their children.

Churches seem to be involved in compassionate ministries to children in various ways. Within low-income communities individual congregations often offer low-cost or free care of pre-schoolers, and sometimes safe-homes/orphanages and feeding schemes. Congregations in affluent communities often support safe-homes/orphanages, feeding schemes and other efforts financially. Sometimes the affluent churches become more directly involved in the low-income communities. Congregations in affluent communities also support Non Profit Organizations and interdenominational faith based organizations financially.

In chapter 2 we determined that development is part of the mission of the church, and that the church should minister to the needs of people in its entirety. However, there are few denominations with comprehensive approaches, involving all of their congregations in a focused, but holistic approach to the care of vulnerable children.

## **6.2 Role of Schools, and Other Institutions**

The establishment of school-based mental health groups is a good possibility, because schools "...provide safe, destigmatized places where students facing similar issues can support each other and ultimately concentrate on school work more effectively. Schools also are places where "healing can occur because that's where the issues really come up,..." Communication, connecting, collaboration, and commitment are essential aspects of facilitating joint efforts between community based organizations and schools (Report of a National Conference sponsored by Casey Family Services and the Annie E. Casey Foundation, 1997:37-39).

Crewe (2001:15) suggests that "Libraries, recreation centres, sports facilities and community halls are all underutilized, and could all become focal points for dealing with AIDS orphans."

### 6.3 Role of Memory Books

The Horizon Reports on Children and Youth Affected by AIDS (WWW, USAID, 11/08/2000) shows that parents and guardians alike articulate a need for support and advice in discussing difficult issues with children. It is important to respond to this demand, as the psychosocial needs of these children are often overlooked. Memory books albums with photos, anecdotes, and other family memorabilia provide a good medium for disclosure and planning for the future.

Memory books can be done by HIV parents for their children, or the children can create the books themselves, or they can work on it together.

The 'Report of a National Conference' sponsored by Casey Family Services and the Annie E. Casey Foundation (1997:125-126) testifies to the 'powerful therapeutic intervention' value of legacy projects like memory books and boxes for HIV/AIDS infected people and their families. According to Medical Ambassadors International, a legacy is ...

1. the memories or values that are left behind when a person dies, and
2. things that are handed down from one generation to the next.

A terminally ill parent can create a legacy that gives the child lasting memories of the parent's love, even after the parent is no longer alive. Children, creating memory books, can work through the difficult feelings that are associated with the loss of a parent to AIDS (Casey Foundation, 1997:125-126).

In Africa, "...tradition is often handed down face to face through stories and songs and ceremonies." *Urbanization and AIDS* is making this impossible, leaving the younger generation without roots. Children are growing up without memories. Memory books handed down from parents helps to "...reduce the emotional void orphans face in the future,..." A Ugandan lady, who teaches seminars on memory books, says; "you can't leave your children with half-baked memories from your deathbed." (Lacey, 2003)

Jane Waldegrave (Morgan, 1999: 178-179) proposes that connection, rather than detachment is needed in dealing with the death of a loved one. She believes that grieving family members should be encouraged to "...connect with one's own and other's responses

about what has happened and to connect with or about the one who has died...(and that) creating possibilities for people to honour their ongoing connections and relationships with their special person who has died also allows for connections with themselves, family and friends.” (Morgan, 1999: 180) The creation of Memory Books could be a way in which orphans and grieving families can be assisted in this ongoing connection with the deceased parent. It should be noted that ‘ancestor veneration’ is not the intention here.

Simone Weil is quoted in Müller(1996:162); “To be rooted is perhaps the most important and least recognized need of the human soul.” This ‘being rooted’ may be symbolical but it is built on concrete places and things. Photos, pictures and stories of childhood homes, communities and events could contribute to the orphaned child’s ‘being rooted’.

Even if they write only basic information, it will help their children have something to hold on to. It will give the children roots. I would compare this “need for being rooted” with Max-Neef’s need for Identity, and therefore, creating memory books satisfies the need for Identity by giving a feeling of “being rooted”.

Writing down the memories is therapeutic in a way, and the Memory Book approach is akin to the narrative therapy approach.

Narrative therapy is based on stories. Creating Memory Books involves telling your own life story. According to Stroup (Müller, 1996:21) a story is a narrative report which unites events and people in an understandable pattern. A story is a description as well as an explanation or clarification of why things are the way they are. Therefore it is possible to meet God in the storytelling process. When the unexplained things need explanation, God appears.

According to Müller, (1996:134); the way to self-understanding is through the narrative. This telling of the past should lead to a reconstruction of the individual’s vision for the future, which in turn could change the present and lead to motivation, excitement and goal orientation

In a previous study I have found the value of memory book projects to be;

- A tool in creating a support programme for PLWA (People living with HIV/AIDS).
- The creative story-telling is a therapeutic process.
- Children orphaned by HIV/Aids are left with memories, connections and heritage.
- Could become a document of faith (spiritual heritage).
- Sharing life stories can lead to emotional, social and spiritual growth.

(Reyneke-Barnard, 2003:10-11)

## 6.4 Role of Support Groups

Support groups for children can help them cope with their needs for understanding, belonging, affection, creation, participation, identity and transcendence. Support groups also help care-givers to identify issues children need to deal with.

Common issues in Support Groups for HIV/AIDS-affected children have been identified as

- Disclosing that a family member has HIV/AIDS
- Coping with grief and bereavement over the death of a loved one.
- Engaging in self-destructive or disruptive behavior.

(Report of a National Conference sponsored by Casey Family Services and the Annie E. Casey Foundation, 1997: 30)

Eds. Anderson, *et al.* (1999:156) underscores the value of groups in working with adults;

Many adolescent therapists consider group psychotherapy to be the treatment of choice for adolescents. Sheidlinger[1994] attributes this to “adolescents’ well-known hunger for peer group involvement.” Adolescence is a time of rising psychosocial vulnerability where either psychopathology or self-actualizing can occur. Group therapy can provide the therapeutic environment wherein adolescents can work through interpersonal problems and examine the four basic identity questions: Who am I? With whom do I identify? What do I believe in? Where am I going?



## 6.5 Summary

All the above role-players can contribute to the quality of life of vulnerable children, providing satisfiers for the fundamental human needs.

The church, especially, can contribute significantly. The obvious need for the church to satisfy is the need for transcendence, but the church can contribute to the satisfaction of all of the fundamental needs. The church should contribute to those needs that are neglected or not adequately addressed by other role players. The church can also help to co-ordinate other role-players in addressing the needs of vulnerable children.

Schools contribute to the need of understanding, but can also make a positive impact on the needs of protection, affection and identity. Memory books can contribute to the needs of identity, creativity, affection, participation, understanding and transcendence. Support groups can contribute to the needs of identity, understanding, participation, affection, transcendence.

## Chapter 7

### Results of Fieldwork

#### 7.1 Introduction to Fieldwork

As student I did my research as part of the NOVA institute's "Household-based Care Research Group". Firstly, I collected empirical data from 4 households in Mamelodi and 2 households in Olievenhoutsbosch, through the questionnaire (Appendix 1). The same questionnaire was taken to the director of a safe house in Silverton. The responses are interpreted below. Secondly I conducted a focus group with a different group of caregivers in Mamelodi and thirdly I interviewed 2 fieldworkers. The data from these additional methods are discussed below. A report back meeting with all the different researchers from the Household-based Care Research Group also influenced my interpretation of the data.

The fieldwork is a preliminary investigation to gain insight into the needs of vulnerable children, therefore the data is not statistically representative, but it gives an important insight into the types of problems that vulnerable children face. From a typical low-income area, available participants were identified to participate in the study.

#### 7.2 Description of Collection of Empirical Data

Five types of households have been identified for the purpose of this study:

- f) Child headed households.
- g) Granny headed households (with 4 or more children).
- h) Households where a parent is ill.
- i) Households with 8 or more children cared for by an individual or couple.
- j) Two parent, stable Christian family with at least two children.

The researcher planned to identify 2 households of each type, to be asked to complete the questionnaire voluntarily. Most households were planned to be in Mamelodi area.

There were a total of 7 respondents. All respondents were female, of different ages.

Fieldwork was done in the July holidays of 2005. Local church leaders were asked to identify families with vulnerable children, according to the types of families identified in the research proposal. Four individuals from families with vulnerable children were identified who were willing to be respondents.

*One single adoptive mother/guardian headed household; guardian was respondent (R1)*

*One granny-headed household; granny was respondent (R2)*

*One Sibling-headed household; 29 year old eldest sister/mother/aunt was respondent (R3)*

*One single-parent household; grandmother was respondent (R4)*

The researcher also identified a 'safe house' where 29 children are being cared for; the director was the respondent (R5) (They used to live in Mamelodi, but recently moved to Silverton)

Finding that the data is not enough, the researcher then found two more respondents in another township called Olievenhoutsbosch. These respondents were approached through a care center where they are registered as patients, and are familiar with the researcher;

*One widowed HIV+ (ill) mother headed household (R6)*

*One HIV+ (ill) mother of a 20 year old son, separated from her husband (R7)*

The researcher explained the purpose of the study to respondents, gave them an opportunity to ask questions or refrain from taking part, and then asked respondents to sign consent forms. (See Consent Forms; Appendix 2)

Respondents were then asked to answer questions of the questionnaire(Appendix 1), by way of interview. The researcher wrote down their answers as accurately as possible. In Mamelodi, the local church leader served as interpreter for many of the respondents. Three respondents were visited twice, some preferred to complete the 150 questions in one interview/visit.

The respondents represented 22 children living within families and 29 children living in the safe house. The average family size, excluding the safe house is 5.6 (3.6 children and 2 adults). The safe house has one adult for every 3.6 children. Of the 22 children not in the

safe house, 2 are abandoned, 6 are double orphans and 8 are paternal orphans. The average age of children was 10.9, with ages ranging from 0 to 22. The safe house children were abandoned, abused or orphaned before admittance to the safe house.

### **7.3 Interpretation of Empirical Data (Questionnaires)**

The empirical data (questionnaires) will now be interpreted according to the ten fundamental human needs;

#### ***Subsistence***

Two satisfiers which are perceived as lacking for the need of subsistence, is income and food. There is no home based production to subsidize income. Employment is either unavailable or low-paid, resulting in poverty.

Another satisfier that is lacking is the care of the caregivers. Only 2 of primary caregivers/respondents indicated being cared for, and they are the two caregivers/respondents who are registered as patients with King's Hope Care Center in Olievenhoutsbosch. One of them enthusiastically indicated that the care center cares for her. The other 5 respondents do not experience being cared for and their comments are telling; "no, I take care of myself", "no, husband is old, we old women care for ourselves" and "no, there is nobody cares for us".(sic)

#### ***Protection***

The satisfiers which are perceived as lacking for the need of protection, is employment, income, child-services, warm bedding, clothes and shoes. Only one primary caregiver interviewed is employed.

All respondents indicated that children are protected against abusive adults and criminals. It would be interesting to compare this with abuse and crime rates in these particular communities. Are the children really protected against abusive adults and criminals or is it just their caregivers' perception? The care-giver interviewed reported significant alcohol

abuse in Olievenhoutsbosch over weekends. The safe-house takes children in from Mamelodi over weekends to protect them from weekend alcohol related abuse and violence.

### ***Affection***

Families all indicated good relationships between household members. Few of the caregivers are involved in stable relationships. However, this does not indicate that they are involved in unstable relationships. They are single, widowed or estranged from their marriage partner and might not be involved in relationships at all. Therefore it does not necessarily have a negative impact on the satisfaction of the need of affection of the children, but could be negative for the caregiver.

### ***Participation***

Satisfaction of the need for participation of families in the community seems to be met through participation in church activities. Children involved in the study participate well in family activities and chores. Some children are able to participate in sports activities. One issue identified through the questionnaire is a lack of socialization with other families. Families do not socialize (share meals) with other families.

Children do not participate in cultivation of land much, and gardening does not seem to be practiced in these two areas.

### ***Understanding***

Development and education, as satisfiers of the need for understanding are operating well. Understanding with regards to sickness and death was measured with several questions. Most parents indicate that they do talk about illness in the household and that they will and do help children deal with grief. However, one respondent (R7), who is facing death, answered; "I don't know." when asked if her son will be able to deal with death in the household. Others indicated that the children will be taken care of in the event of the

caretaker's death, which indicates that 'preparing children for death', mentally and spiritually' might be an alien concept to respondents.

Not all families have counseling available to them.

Some of the younger children are not in daycare. Respondents indicated that they are stimulating the children adequately at home, but the question remains if the caregivers are really stimulating the children adequately or if it is just adequate in their perception. This issue needs further investigation. In response to the question; "Do you read to younger children?" one respondent answered; "No, she is only one", which indicates a possible lack of understanding on the caregivers' part of the development of young children.

### ***Creation***

Drama and music are indicated as popular activities to satisfy the need for creation. Not everybody does creative activities as a family. In fact, the concept of hobbies and crafts seemed alien to respondents. One respondent indicated that the child likes to paint at home.

### ***Idleness***

Responses indicate that the need of idleness is being satisfied appropriately for both caregivers and children.

### ***Identity***

Responses indicate that the need of identity is being satisfied appropriately. All children in the study are taught about their spiritual and cultural heritage. Yet, questions in the transcendence block of the questionnaire reveal that many of the children have lost at least one parent and do not have memories of the parent. Many also lack the means of preserving memories of the deceased parent.

## ***Freedom***

Respondents' answers to the questions indicate a fair amount of freedom for families and children. They perceive the neighbourhood as a safe place for children to live and play. The only inhibiting factor showed is a lack of car ownership. However, respondents merely indicated that they do not own cars, and indicated that public transport is safe and accessible. The assumption that not owning a car is inhibiting the need for freedom is that of the researcher, and might be incorrect for the community represented by the respondents.

## ***Transcendence***

Not counting the safe house, the majority of families have lost the father of the children to death. The one family who did not report the death of the father is a single-mother family. Therefore there are no father-figures. Most children do not have memories of their deceased parents and often do not have a way to keep the memories alive.

Those households who have experienced a recent death reported talking about death a lot. One indicated the children's fear.

## ***Safe House versus Households***

Most of the literature reviewed, insist that keeping children within families and communities are best practice. None of the literature refers to any research done on the subject matter. For that reason the safe house was included in the study and the responses of the safe house director will be compared with those of the households below.

The safe house director's responses indicate that they are experiencing the same problems with the need of subsistence. They do not have enough income to cover living expenses, there is no home production to supplement income, in fact there is a total reliance on donations. They are receiving very few child grants. The caregivers also do not experience being cared for.

With regards to the need of Protection, the safe house has more child care services/ orphans support services available to help their household , also churches, NPO's and social workers are involved. They also indicated not having enough blankets for winter. Children in the safe house are not receiving vaccinations as required, while respondents in the other households indicated that all children's vaccinations are up to date.

The safe house has more clothes and shoes available for the children than the other households.

The need of affection is satisfied within the safe house family, they operate as a family. Friendships outside of the household are limited to church for preschoolers, and to church and school for primary school goers.

The need for participation seems to be met within they safe house, but the children are not part of the wider community. Some children do not leave the safe house, except for church, occasional outings and emergencies. Some visit their parents, or extended families. The older children go to school and are sometimes invited to go for a swim or visit at someone's house.

Mother tongue education as a satisfier of the need for understanding is impossible in the safe-house setting, since children come from different language groups. Because the safe house has moved out of it's original community the oldest is now being taught in Afrikaans, which is not even her second language. The majority of the children in families are taught in their home language. At the safe house, the importance of early childhood education is appreciated.

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The need for creation seems to be adequately satisfied in the safe house, as opposed to the families.

With regards to the need for idleness, the children's need is satisfied similarly to those in the community. However the caregivers in the safe house are reported not always able to rest and relax enough.



The need for identity seems to be inadequately satisfied in the safe house setting. Children are from different cultures and cannot be taught their specific cultural heritage. Some children do not know their parents and there are few photos or other means to remember them by.

Freedom is restricted in that the children can not leave the house often. Coordinating 28 children requires keeping them together. They also do not go out at night. Within the borders of the property of this specific safe house there is ample room for play and moving around.

The need for transcendence is frustrated by the death of or abandonment by parents and inability to preserve their memories, but it is the same for children in households. Maybe in families there is more possibility for retaining memories through talking about deceased or missing parents. Responses indicate that they do not talk about death at the safe house. Safe house children are being taught about faith of their caregivers, same as the children in families.

#### **7.4 Focus Group**

A focus group was held on the Sunday after church. Five mothers (not the same ones who completed the questionnaires) from the local church congregation were present. The researcher asked the following questions;

1. What do you think makes a child vulnerable?

(I had to define the term vulnerable, which I did on the spot as follows;

When I walk down the street alone, I am vulnerable to danger. Children are vulnerable when they are in circumstances and in a situation where they will not be able to grow up to become well-functioning adults.)

2. Should orphaned children stay in the community or go to orphanages/ safe house?  
Whose responsibility are they?
3. Is Stanza Bopape (the specific area of Mamelodi where they live) a good environment for your smaller children?
4. What do you think are the needs of vulnerable children?

A summary of responses are as follows;

1. "It is the friends teaching them other things. Friends who do not attend church. All these problems start from the school, they learn the wrong things."  
"Our children does not want to respect us. When I correct them, they threaten to go to the police. They say I abuse her, don't want to listen. Babies are all right, from 12 years our children are out." (sic)
2. Government should be responsible for orphans. Welfare should help. "I take family's children with government's help. Better to stay with me." (sic)
3. "Yes, safe, we look after them. Community looks after children." "When I go to work there are many people at home." (sic)
4. Clothes, food, medicines, toys, outings.

The focus group gave some insight in the perceptions of the mothers in Mamelodi. The main insights are in relation to their relationships with their teenagers, their perception of their children's vulnerability and needs, and who should look after orphaned children.

## 7.5 Interviews

The researcher also interviewed 2 fieldworkers who actively work with vulnerable children in ministries; one runs a Child Community Based Care Ministry for *Botshabello* in Olievenhoutsbosch (Respondent A) and the other runs *Pennies* Pre-school in the inner city of Pretoria (Respondent B).

Their summary of the needs of vulnerable children are as follows;

Respondent A:

Food, clothes.

To be loved and be in a family that loves them.

Protection from abusers.

Guidance and good role models.

Respondent B:

Basic needs; food, housing, water, electricity, clothing, education

Needs are overwhelming – those who do help tend to be overwhelmed by needs and extremely frustrated by lack of support.

This lead to a discussion about problems in their respective communities:

Respondent A identified alcoholism in the community as a major problem. Alcohol is cheaper in Olievenhoutsbosch than in other areas. People drink all weekend, which makes children vulnerable. Children are not fed during weekends. She also said that there is very little opportunity for sport and recreation. There is nothing for children to do during school holidays. Lastly she discussed the pre-school conditions. Creche's/pre-schools have very little equipment, no space to play, lack of stimulation and the teacher-child ratio is 1 to 60. At least they are being fed at school.

Respondent B listed the following problems:

- Neglect, parents not available due to working hours. Mothers working long hours or selling their bodies at night to be able to feed the family.
- Squatting e.g. 17 people living together in a bachelor flat.
- No access to financial support e.g. grants due to not having identity documents
- Unemployment: absent fathers, going away to seek work
- Social problems going with poverty: Substance abuse, child abuse, molestation
- Single parent families, frequent change of father figure
- Emotional and health problems: very limited access to help
- Lack of social services. Government has cut all help to NGO's like Child Welfare, resulting in closing of offices.
- Lack of recreation, due to limited living and play space in flats.

I asked Respondent B a couple of additional questions in the light of the results from the questionnaire. These are reported below with the respondent's answers.

Question: Do you think children who stay at home are developing appropriately? Why/why not?

Answer: Poor development in case of vulnerable children, due to lack of stimulation. Parents battling daily to survive often show little interest in stimulating their children. Also a lack of knowledge. It is not possible to give something that you do not possess.

Question: Do you think children are prepared to deal with death in the family? Explain

Answer: Children are not prepared, although they live with dying people and see death. Little explanation is offered and children are simply sent to extended family members to take over care. Access to therapeutic services does almost not exist.

Question: Are they helped in dealing with grief in the case of death? Who helps, how effective?

Answer: The only help most of the children receive is from family members grieving with them. Outside help is almost non-existent.

Both of these ministries reach out to vulnerable children through educational institutions. They seek to provide quality education, but use the institution to provide in several other needs as well, for example nutrition. *Pennies* also provides play-therapy and occupational therapy.

It is clear that the fieldworkers have a different perception of the vulnerability of children from that of the mothers. The fieldworkers gave valuable insight into the circumstances of the vulnerable children in their communities. It is interesting that the fieldworkers' views of the needs of vulnerable children are not much broader than the traditional view of basic needs. Their descriptions of the needs are in terms that we classify as satisfiers of the fundamental needs. If translated into Max-Neef's terms, they recognize only subsistence, protection, understanding and affection as needs.

## 7.6 Evaluation of Research Methods

Firstly, the nature of the results of the research was influenced by the fact that all families (In Mamelodi) were linked to the church. (They were identified through the church leadership) Church going people usually hold to positive, Christian values and are likely to provide better care and protection to their children.

Secondly, the empirical data does not cover children in child-headed households. The family identified as a child-headed household was not a true child-headed households, as the older siblings were adults. No alternative household could be found.

## Chapter 8

### Findings

In this chapter I integrate the literature study with the research data, using the 10 fundamental human needs to categorise the findings of the study. I discuss the findings of this study, with particular reference to: the perceived quality of life and vulnerability, denial, early childhood development, grief management, protection and institutions.

#### Perceived Quality of Life and Vulnerability

As researcher, I was surprised by the indication of satisfaction of most needs in the questionnaires. The quality of life is reported to be better than I expected. My perception was that most of these needs are not satisfied or at least not satisfied appropriately. However, the main satisfiers lacking indicated were those that are traditionally known as the basic needs, i.e. income, food and clothes. If this is an accurate picture of the satisfaction of needs, effective income generating community projects are all that are needed to bring about long-term holistic care for vulnerable children. However, if we consider the literature study as well as the reservations of the fieldworkers (Respondents A and B) and the NOVA Household-based Care Research Group there are more unsatisfied needs that require attention.

Furthermore, my background in child development leads me to think that maybe the average caregiver in lower income areas are not knowledgeable enough with regards to early child development to realise that needs are not being met. This reservation on my part is supported by the interviews with the two fieldworkers, referred to as Respondents A and B above.

The focus group discussion also illustrates this. According to the participants there are no problems with children younger than 12, therefore children are perceived as being not vulnerable before 12. My Western mindset and background in early childhood development tells me that most children in low-income communities, where HIV/AIDS is rampant, where jobs are scarce, and crime-rates high, are vulnerable. Yet, the concept of a vulnerable child was not well-understood by participants of either the focus group or the questionnaire

participants. The focus-group interpreted the concept only in terms of older children who are out of control. When, defined it seemed that some people were not keen to have their children defined as vulnerable. Possibly, denial is the pseudo-satisfier of many needs.

## **Denial**

In Mamelodi I got the impression that people did not want to talk about HIV/AIDS. This is in keeping with the general perception that HIV/AIDS still carries a stigma. Denial of the problem keeps the problem manageable and the stigma at bay, but the Olievenhoutsbosch respondents were open and clear about their status and the related problems. These two respondents were both registered with a local care center and have both completed Memory Books. Denial is no longer a problem. They were also more worried about their children's ability to cope with the impending death and grief, and more perceptive of their children's vulnerability.

## **Subsistence**

As noted in the interpretation of empirical data section above, two satisfiers which are perceived as lacking for the need of subsistence, are income and food. The focus group identified food as a need of vulnerable children. They stated that they need income from the government (grants) when taking other vulnerable children into their families. The inner city fieldworker stated that there is a lack in social services. Government has cut all help to NGO's like Child Welfare, resulting in closing of their offices in the inner city.

The fieldworkers both listed food as a big 'need' (satisfier) of the children in their areas. They were concerned about unemployment.

Income and food are both synergic / generic satisfiers, with the actual potential of actualizing the need of subsistence while possibly contributing to many of the other needs. Income, which can supply food, amongst other things is therefore a very important satisfier for these households.

The literature study described community orphan trust programs whereby community members are empowered to earn and income, thereby enabling them to provide for the

orphans and vulnerable children in their midst. This program is administrated by churches in Zambia with the help of an international development organization. As income was identified as a lacking satisfier, this program might have merit and should be investigated further.

## **Protection**

Employment, income, child-services, warm bedding, clothes and shoes are the satisfiers identified as lacking for the need of protection. Both the focus group and the fieldworkers listed clothes as serious 'needs' (lacking satisfiers) Employment and income was covered above. Bedding, clothes and shoes are self-explanatory. The focus group participants believe that the community looks after the children. Both fieldworkers listed protection from abusers as lacking. Both fieldworkers were concerned about substance abuse which will naturally lead to a decrease in children's protection. The inner-city fieldworker noted that parents are not available to protect their children due to long work hours. Granted, the inner city community looks different from the township community but it is worth taking note of. She also mentioned the crowded living conditions which leads to abuse.

Are children really protected from abusive adults and criminals or is it just the perception of caregivers?

## **Affection**

Respondents to questionnaires all indicated good family relationships. However the focus group felt that teenagers no longer respected parents, and came across as being unhappy with the teenage children. That does not mean that they do not love their children but affection might not be communicated as it should be. The Olievenhoutsbosch fieldworker strongly felt that children in the community needed to be loved, and that this need was not being met.



## **Creation**

Doing hobbies and crafts (especially as a family) seemed an alien concept to questionnaire respondents.

## **Idleness**

Idleness is being satisfied appropriately according to the questionnaire respondents.

## **Understanding**

### *Early Childhood Development*

Child development specialists believe that the first three years of a child's life is foundational for the rest of his/her life. Responses to questionnaires indicate a possible lack of knowledge and understanding on the caregivers' part of the development of young children. One respondent said that they do not read to the child, since she is only one year old. Reading to children is the first step in their learning to read, becoming literate and educated.

The fieldworkers indicated inadequate satisfaction of the need of Understanding. The Olievenhoutsbosch fieldworker (Respondent A) expressed concern over preschool conditions in the township. The inner city fieldworker (Respondent B) provides pre-school education but believes there is a lack of stimulation at home (and many children do not attend pre-school), due to a lack of interest by overworked parents and a lack of knowledge.

Caregivers' knowledge of child development should be investigated and improved if necessary. Since the first three years of a child's life is foundational to their development, proper stimulation and teaching, both at home and in daycare or pre-school should be investigated and developed if further study proves it necessary. In my experience, the need for and knowledge of proper stimulation of babies and toddlers is not common knowledge in any community. Yet, it could give vulnerable children a head start, improving their chances of developing into well-functioning, productive adults.

Teaching parents basic child development is an approach I strongly recommend, especially early childhood development. The WK Kellogg Foundation Report on HIV/AIDS in Southern Africa stated that courses to improve parenting skills are required (Dlamini, *et al.*, 2004:13). In the research report discussion of the NOVA Household-based Care Group, the suggestion was made that it is the grandparents that need training in early childhood development, as they are the ones raising the children.

The development of a course for low-income caregivers would have to consider the predominantly Western culture in which caregivers are caring for children, allowing for the impact of traditional African worldview and practices which still exist in the culture of the people. The course should cover all ten fundamental human needs and look at the satisfaction of these needs from an assumption of a merger of the two cultures, and therefore the (new) culturally specific satisfiers of the needs. This should be communicable to parents and caregivers, allowing them to understand early childhood development and empowering them to empower their children. Such a curriculum should be developed in dialogue with caregivers from African, low-income urban communities, like Mamelodi to ensure its relevance and comprehensibility.

### *Grief Management*

In spite of questionnaire responses I believe that it is questionable whether children are adequately prepared for death and helped to understand illness and dying. This needs to be examined more thoroughly. The inner city fieldworker does not believe that children are adequately prepared and reported that therapeutic services almost do not exist. Children are not helped to deal with grief. The literature study has shown that children are as much affected by grief as adults, if not more. The child's development could be affected by grief when grief is not well managed.

When a loved one dies, we expect a person to grieve and provide support in counseling and therapy. Responses to the questionnaire indicate that people think children will somehow manage with the grief of a death in the house. They think children are prepared for death, but they cannot expand on how children will deal with it. It seems as though they just

expect it to happen. Are children really prepared to deal with grief at the death of a loved one? Is death addressed in the church? Are children taught a Christian view of life and death? Are the shortcomings just shortcomings in terms of a Western approach to grief management or are they real? We've established that the needs are fundamental and trans-cultural. Different cultures may satisfy the needs in different ways. The need for Understanding is trans-cultural, but counseling and 'talking through' of events and grief is not necessarily a culturally acceptable satisfier for this need. Is this need met in another, culturally appropriate way then? Or have the culturally appropriate satisfier been destroyed by Western civilization without being replaced by another appropriate satisfier? Is there a destroyer/ pseudo-satisfier or inhibiting satisfier in place? A recent presentation (30 September 2005) by a psychologist (Johanna Kistner) working with vulnerable children in Johannesburg, at the AIDS Forum of the Centre for the Study of Aids at the University of Pretoria highlighted the high incidence of children's inability (not being allowed) to discuss feelings of grief at home.

## **Participation**

Questionnaire respondents reported a fair amount of participation in church activities. Both fieldworkers reported a lack of sport and recreation opportunities for children.

## **Freedom**

Questionnaire respondents indicate a reasonable amount of freedom. Focus group respondents collaborated, saying that the community looks after children. Fieldworkers do not believe that children are safe in communities.

## **Identity**

Orphaned children represented by the questionnaire respondents do not have memories of the deceased parents. Many also lack the means of preserving memories. The inner city fieldworker reported a frequent change of father figure. The literature study has shown the importance of children's ability to connect with their heritage.

## **Transcendence**

All of the questionnaire respondents were churchgoers and reported having faith and a relationship with Christ.

## **Safe Homes**

The majority of the reviewed literature indicates a negative attitude towards residential care. The data shows that children in safe homes have similar unsatisfied needs, and therefore a similar quality of life as those living in their households. The needs of the children in the safe-house do not seem to be satisfied more or less holistically than those who live in families, or vice versa. Their situations appear to be similar with the exception of the children's socialization with the outside world, which is one of the main critiques against institutionalizing of children. Yet, these children might be living in abusive situations, on the street or dead if not for the safe house. Unfortunately the data does not reflect the quality of life of street-children and children in child-headed households, and the question by Mary Crewe remains: which is worse?

If proper management can eradicate the problems of child abuse and exploitation by personnel, discrimination and stigmatisation, then the only disadvantages remaining are the lack of freedom, friendships and bonds outside the institution and the inadequate preparation for adulthood in the community. If these limitations are known, surely they can be addressed through adequate planning, yet, inadequate resources might still impede such plans.

## Chapter9

### Conclusion

In conclusion I will summarise the findings of this study on the extent and nature of the problems caused by HIV/AIDS. This is followed by a suggested strategy for future church intervention, with reference to the issue of community-based versus institutionalised care.

#### 9.1 The Extent and Nature of the Problems Caused by HIV/AIDS

Participants perceive their children to be well-cared for and do not recognize their vulnerability. Either the needs of children represented in the study's needs are being adequately satisfied (with the exception of the basic satisfiers, i.e. food, clothing and income), or the caregivers are not adequately knowledgeable as to the needs of young children. The cultural impact on satisfiers of needs should be investigated further. It is also possible that the merging of traditional African culture with Western culture has eradicated traditional satisfiers without being able to assimilate new adequate satisfiers of needs.

Care of orphans and vulnerable children is extremely complex. Their needs are much wider than what is often described as their basic needs, i.e. food, accommodation and education. They are hurting and in danger of becoming dysfunctional adults. Drastic measures are needed to intervene. However, there is probably not one approach or model that can be applied everywhere. One thing is clear, a multi-disciplinary approach or model is necessary to attempt to address all their basic needs. A multi-disciplinary approach requires partnerships. "The necessity of establishing partnerships has been broadly acknowledged. Peter Piot, executive director of UNAIDS, put the case very clearly in May 2000: "Partnerships are not an optional extra, but the foundation of taking forward effective work against the epidemic." (Jones, 2001:9) The use of the trans-disciplinary model of Max-Neef in this study, to examine the needs of orphans and vulnerable children holistically, lends itself to be useful in establishing a multi-disciplinary approach, built on partnerships that can address the needs.

## 9.2 Future Intervention

An approach to care for vulnerable children should be holistic, aimed at addressing all of the fundamental human needs, preferably employing synergic satisfiers (satisfiers which satisfy a particular need, and at the same time promotes and contributes to the satisfaction of other needs).

Dr. Marva Mitchell was quoted above (p. 47) saying '*It Takes a Church To Raise a Village*'. The question is what is the church of South Africa going to do? What should its strategy be? The church can and should play a pivotal role as it can be the first line of contact for children, ensuring that their needs are met holistically by bringing in different partners from the different disciplines. The church can also become directly involved on different levels.

A recommended strategy for church involvement in care of vulnerable children in low income households, taking all of the above into consideration, would therefore include acting as catalyst for professionals and para-professionals to access vulnerable children, providing them with a holistic service with special attention to the following areas:

1. Enabling households to become self-sustainable through micro-enterprise development in effective community based income generating programs, thereby securing long-term income, which secures food and clothing.
2. Addressing the possible denial of problems, reinforcing HIV/AIDS awareness campaigns, teaching child caregivers the importance of early childhood development, grief management and the importance of protection of children.
3. Studying the cultural components of the satisfiers of grief management and early childhood development.
4. Teaching mothers and grandmothers the skills and knowledge necessary to stimulate young children for optimum development.
5. Teaching the community (especially the child caregivers) the skills of helping children deal with grief and implementing permanency plans before children are orphaned.
6. Providing quality pre-school care and education.
7. Providing programs that will help children deal with grief.

### **9.2.1 Recommended Policy**

1. It is important for the church to make a conscious decision to provide care to all vulnerable children (See chapter 2), not only HIV/AIDS orphans.
2. A holistic approach should be followed.
3. It would be helpful to prioritise the type of care that the church will support and develop.

It is recommended that the first priority be to strengthen families (households), enabling them to provide children with the best possible quality of life. After families comes community-based initiatives, including the development of community based residential care where families and communities are not coping with the demands created by growing numbers of vulnerable children.

### **9.2.2 Recommended Strategy**

From the study it emerged that we can divide vulnerable children into groups according to their life phases:

- Early Childhood (aged 0-6)
- Middle Childhood (aged 7- 11)
- Teenagers (aged 12-18)

The early childhood phase is fundamental to the development of children and therefore it is a priority to attend to the needs of this group, giving them a headstart. The teenagers are closest to adulthood and greatly at risk of contracting HIV/AIDS, therefore their needs are also of paramount importance.

The three groups are dealt with below, followed by general strategies relevant to all age groups, and a strategy for intervention outside the household:

## **1. Early Childhood**

Parenting skills and early childhood development knowledge should be developed. This intervention should be a priority.

Quality pre-school care should be provided. (Where churches already run pre-schools for vulnerable children, the quality should be examined and improved, if necessary.)

## **2. Middle Childhood**

Parenting skills and knowledge should be developed relevant to this age group.

After-school centers could help to improve child protection during the afternoon hours.

## **3. Teenagers**

The church should petition the South African government to define children up to 18 years as orphans or vulnerable children for the sake of their ability to receive grants.

At the same time the government should be petitioned to ensure that grants reach child-headed households as well.

The teenage group needs love and understanding.

Teenagers can be included in income generating projects, preparing them for future responsibilities.

## **4. All Groups**

In each of the above groups, great attention should be given to age-appropriate grief management. This intervention should be a priority.

Households need to be equipped and strengthened to become self-sustainable, through income-generating activities.

Ongoing teaching on HIV/AIDS for all community members, fighting stigma and denial, is a necessity.



### **9.3 Community-Based versus Institutional Care**

Without disregard for the excellent arguments in favor of community based care, which I support fully, the need for institutionalised care can not be contested. There is no reason why we should continue to have an “either or” mentality when it comes to these approaches. Community based care can be enriched by institutions and visa versa. A good example is where children spend weekends only in a safe house, or visit extended families over weekends, whichever arrangement is in their best interest. The household and institution (Safe house) can complement each other, ensuring holistic care. Further study needs to be done to develop a new model of integrated community based, institutional care, building on indigenous resources, in which all of the fundamental human needs are attended to.

## Appendix 1

# Questionnaire for Vulnerable Children Needs Research

Family Classification\_\_\_\_\_

1. How many children in household?
2. How many adults in household?
3. Are household members relatives?
4. Why are non-relative children part of household?
5. Are children orphaned?
6. What are the ages of the children?
7. Have any household members died in the last 5 years?
8. Is the head of the household male or female?
9. What is the relationship between the children and the head of the household?
10. Who is the primary caregiver – the person responsible for children's daily care?
11. Describe the home you live in. (How many rooms, made of what materials, etc.)

### **Subsistence**

12. Is household receiving adequate income to cover living expenses? Why/why not?
13. Are the meals meeting the child's needs(enough)?
14. Are meals balanced and nutritious?

15. Is the household receiving any financial contributions from non-household members, eg. Grants, maintenance? Explain.
16. Have children learned basics about protecting themselves?
17. Do children have access to clean drinking water?
18. What is the main water supply?
  - Tap in the house
  - Tap in the yard
  - Tap in the street
  - Other (please describe)
19. Do you have fresh clean air to breathe?
20. What energy sources are used in the household?
21. Anybody in household involved in home production(making and selling something)?
22. Is the primary caregiver healthy?
23. Is the mother (primary caregiver) so busy caring for the sick that the children are neglected?
24. Are the primary caregivers (the one looking after the children most of the time) being cared for?

### **Protection**

25. Are children sometimes left alone? Explain
26. Is the primary caregiver (the one who is responsible for children's care) employed?
27. Is there a primary provider(the one who usually provides most of the household's the money), earning an income?

28. Do children know what their rights are?
29. Are children protected against natural elements by their housing?
30. Are there any child care services/ orphans support services available to help the household?
31. Are children being taught about basic hygiene and health care?
32. Are children protected from abusive adults?
33. Are children protected from criminals?
34. Do they have medical conditions /illnesses that need special care?
35. Are children healthy?
36. Is medical care available?
37. Is the medical care affordable?
38. Are children receiving vaccinations as required?
39. Do children have adequate clothes and shoes?
40. Do you have enough warm bedding for winter?
41. Are girls receiving less care than boys, or vice versa?
42. Do caretakers' know children's rights?

## **Affection**

43. Who takes care of children?
44. How do you think children see themselves?
45. Do children see themselves as special/valuable?
46. Do household members express love for each other?
47. Does the child have good friendships outside the household?
48. Are caregivers/ household adults involved in stable relationships?
49. Do siblings (children in household) have good relationships? Do they care about each other?
50. Are children experiencing acceptance or rejection in the community?
51. Do children respect caregivers?
52. Is there domestic violence in the household?
53. Do members trust each other?
54. Do you eat together as a family and have fellowship?
55. Do household members believe that God loves them?
56. Do you have hopes and dreams for the children?
57. Do care-givers communicate their love to children?

## Participation

58. Are children caring for sick adults?
59. Are children caring for sick/healthy siblings?
60. Do children participate in making household decisions?
61. Do the children play with friends outside the household?
62. Are children involved in fetching water?
63. Are children involved in waste removal tasks?
64. Do family share meals with other community members?
65. Are any children of school going age contributing to the household income through any type of work?
66. Do you go on outings as a family, can you relax together?
67. Do you belong to a loving faith community?
68. Does the faith community give any moral or physical support to you/ your children?
69. Do children take part in any school/club activities after school hours?
70. Do children participate in cultivation of the land, eg. Vegetable gardens?
71. Are children's speech and hearing well developed?
72. Are older children given choices?

## Understanding

73. Are there any ill household members, requiring extra care? Please describe.
74. Do all household members know their HIV status (including children)?
75. Do you talk to your children about the illness in the household? Explain.
76. If a family member dies, will the children be prepared to deal with it?
77. Are they being taught to understand their own feelings and deal with grief?
78. Are your children being taught about your faith?
79. Are children in appropriate grades? List grades.
80. Are children absent from school due to financial shortfalls? Explain.
81. Is there counseling available to household members?
82. Can the children do what they should be able to do at their age?
83. Are children enjoying school/learning?
84. Are small children in good daycare?
85. If children are not in daycare, are they given attention at home, played with and taught simple skills? Explain.
86. Is there enough light for studying at night?
87. Is there adequate space for concentrated study?
88. Do children receive education in their mother tongue?

89. Can children understand their teachers? Explain.
90. Is there someone at home/or in community to help with homework?
91. Does school-going children read books?
92. Do you read to younger children?
93. Are books available?

### **Creation**

94. Are younger children engaging in imaginative play (do they pretend to be something they are not in their games, eg. Pretending to be a mother, animal, car, etc.)?
95. Is there space in the house to be creative, eg. Paint, draw?
96. Do you do creative activities - hobbies/trades as family, ie. Adult with kids?
97. Are children involved in any forms of creation –art/music/drama?
98. Are children being taught life skills? Explain – (Gardening, cooking, cultural skills like beading, etc?)

### **Idleness**

99. Are children able to sleep well, do they wake up rested?
100. Are caregivers able to rest and relax appropriately?
101. Are children involved in sports?
102. Are girls also given opportunities to be involved in sports?



103. Do you ever, sit and dream of a better future?
104. Can you sometimes sit and talk about nothing important? Just be together listening to each other's stories?
105. Do you (the caretaker) have time to meditate on faith/ bible without being hurried by caretaking/working?
106. Do children have time to rest, or do they have too much chores at home?

### **Identity**

107. Do each child have a birth certificate or identity document?
108. Do your children know who they are? Explain
109. Do children like themselves?
110. Do children know their biological parents?
111. Do children live with people they identify with? (People they feel they can learn from, people they like to be with)
112. Are children being taught about their heritage? Explain.
113. Are you able to communicate values and beliefs to children? Explain.
114. Are boys proud of being boys and girls proud of being girls?
115. Do they have good role models(older people who are an example to them) of the same gender to spend time with and learn from?

## Freedom

116. Do children play?
117. What do children play?
118. Where and when do children play?
119. Can children play freely and safely in the neighborhood? Explain.
120. Is illness of a household member restricting freedom of himself or other family members?
121. Do babies have the space to learn to crawl/walk?
122. Are children giving appropriate amounts of freedom?
123. Is household's freedom restricted at night?
124. Do you have the freedom to attend church? Is your family stigmatized by church members?
125. Does employer provide caretaker with enough freedom to cope with problems at home?
126. Are children restricted in choice of clothes?
127. Are there ample choices in preparing meals or are choices limited?
128. Is there freedom to move in the house?
129. Is there space in the garden to walk, visit and play? Explain.
130. Does anyone in the household own a car?

131. Is public transport safe and accessible at all times?
132. Do children have the freedom to express their feelings?

### **Transcendence**

133. Have children lost one or both parents? Explain.
134. Do children have memories of deceased parents?
135. Is there a way for them to keep memories alive, eg. Photos/journals?
136. Does your family have access to a spiritual advisor, like a pastor?
137. Does family attend church?
138. Do children accompany you to church?
139. Do you attend other church-related activities during the week? Explain.
140. Do children go with you to church related activities during the week?
141. Are older children involved in youth groups? Explain
142. Have you communicated your faith to children?
143. Do children talk about death? Explain.
144. Are children exposed to age related teaching on religion?
145. Does your faith provide hope and motivation?

146. Do you find help and acceptance at church?
147. Does everyone in the household share the same faith?
148. What do you believe about God?
149. Do you have a relationship with God?
150. Do you know Jesus Christ as your personal saviour?

## Appendix 2

### **CONSENT FORM**

Dear Sir or Madam,

We are doing research to determine the needs of vulnerable children in your area. The information we gather will help us to know what vulnerable children need and can assist us to develop a program for vulnerable children in your area and other similar areas.

#### **Statement concerning participation in a Research Project.**

**Name of Project: Holistic Care of Vulnerable Children**

**Name of Project Leader: Elske Reyneke-Barnard**

**Contact details for questions or comments: 083 5662915**

I have heard the aims and objectives of the proposed study.

I was provided the opportunity to ask questions and given adequate time to think about the project.

The aim of the study is sufficiently clear to me.

I have not been pressurised to participate in any way.

I understand that participation in this Project is voluntary and that I may withdraw from it at any time and without supplying reasons.

I am aware that a final report of the study will be used by the University of Pretoria. My name will not appear in the report.

I hereby agree to participate in this Project.

.....  
Name of respondent

.....  
Signature of respondent

.....  
Place.

.....  
Date.

.....  
Witness

#### **Statement by the interviewer:**

I provided verbal and/or written information regarding this Project.

I agree to answer any future questions concerning the Project as best as I am able.

I will adhere to the approved protocol.

.....  
Name of interviewer

.....  
Signature

.....  
Date

.....  
Place

## Appendix 3

Summary of data collected through questionnaires.

The questions are in column 1 and the responses of each respondent in columns 2-8.

Responses indicating that needs are being satisfied, are highlighted in green, responses indicating inadequate satisfaction of needs are highlighted in yellow. Neutral responses are highlighted in blue. The first 11 questions are only background information and are not colour coded.

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