THE NEEDS OF CHILDREN IN MIDDLE CHILDHOOD ORPHANED BY HIV/AIDS

BY

THOBEKA S. NKOMO

STUDENT NUMBER: 24179125

Submitted for the partial fulfillment of the degree

Master of Social Work (Health Care)
MSW (Health Care)

In the

Department of Social Work and Criminology

Faculty of Humanities

University of Pretoria

SUPERVISOR: Dr Charlene Laurence Carbonatto

April 2008

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

RESEARCH PROPOSAL & ETHICS COMMITTEE

DECLARATION

Full name: Thobeka Sweetness Nkomo

Student Number: 24179125

Degree/Qualification: Master of Social Work (Health Care)
MSW (Health Care)

Title of thesis/dissertation: THE NEEDS OF CHILDREN IN MIDDLE CHILDHOOD ORPHANED BY HIV/AIDS

I declare that this thesis / dissertation is my own original work. Where secondary material is used, this has been carefully acknowledged and referenced in accordance with university requirements.

I understand what plagiarism is and am aware of university policy in this regard.

_____ _____

SIGNATURE DATE

ACKNOWLEGDEMENT

My appreciation and thanks goes to:

My supervisor, Dr Charlene.Laurence Carbonatto Thank you so much for your support and guidance in keeping me focused. Your encouragement and insight helped me along the way and I believe through your input, I have succeeded in outlining concise findings that will inform all professionals and non professionals who intervene in this area.

My Husband, Daniel, and children, Sanelisiwe and Thandolwethu and my helper, Cecilia Beje, you are the best. Thank you for your constant encouragement and interest, you gave me space and time to focus. My first goal has been attained.

Child Welfare South Africa (Potchefstroom) Thank you for sharing my enthusiasm, and your dedication in striving to create the opportunity for the possibility of implementing this project. The research respondents, for their time, honesty and commitment.
Above all, I thank God for providing me with good health and for sustaining me throughout.

ABSTRACT

The needs of children in middle childhood orphaned by HIV/AIDS

By

Thobeka Sweetness Nkomo

Supervisor: Dr Charlene Laarence Carbonatto

Department of Social Work and Criminology

University of Pretoria

Degree: Master of Social Work (Health Care)

The goal of this study was to explore the needs of children orphaned by HIV/AIDS in middle childhood

The objectives were:

- To describe phenomenon of HIV/AIDS
- To describe the phenomenon of children in middle childhood affected by HIV/AIDS in South Africa
- To explore the specific needs of children in middle childhood orphaned by HIV/AIDS by means of an empirical study
- To make recommendations for professionals and non-professionals intervening with children in middle childhood orphaned by HIV/AIDS in South Africa.

This is an applied, qualitative research study. The research design used is phenomenology. The study was conducted at Child Welfare South Africa (Potchefstroom) in the North West Province. The goal of this study was to explore the needs of children orphaned by HIV/AIDS in middle childhood. The sample consisted of ten black children aged between 6 – 12 years, of both genders, who are orphaned by HIV/AIDS and are clients of Child Welfare, South Africa in Potchefstroom. This sample was selected using purposive sampling where the researcher used her judgment to select the ten respondents. Before conducting the main research a pilot study was conducted. Two children who are in the same age group were interviewed but did not form part of the sample.

The researcher did her best to adhere to ethical considerations. She ensured that the respondents understood the goal of the study, their roles in the study and the experience that they may have to go through during the study. In order to ensure anonymity in research reports aggregated information rather than individual information will be used. A semi-structured interview schedule was used to collect data during the one-to-one interviews, which was tape recorded. At the end of the session the researcher transcribed the audio - taped interview recordings. The transcribed interview notes were used to organize information by applying labels, themes and sub themes that will draw different parts of the information that had been collected. The findings were released in a mini-dissertation and the data collected remained anonymous. The report is accurate and reflects the true facts. All sources and assistance were acknowledged.

KEY WORDS

HIV

AIDS

ORPHAN

CHILD

PARENT

NEEDS

MIDDLE CHILDHOOD

CAREGIVER

HIV/AIDS ORPHAN

DEATH

TABLE OF CONTENTS

CHAPTER 1
GENERAL INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The Human Immuneodeficiency Virus (HIV) and acquired immune deficiency syndrome (AIDS) have emerged as the most challenging health issues of modern times. The pandemic has created not only medical, but also ethical, legal, social and political issues with economic and human rights implications. Today, an estimated 14 million children have lost one or both parents to AIDS. Approximately 80% (of 11 million) of these children live in sub-Saharan Africa. Forecasts indicate that the number of children orphaned by AIDS will rise dramatically in the next 10 to 20 years, especially in Southern Africa. In South Africa alone, it is estimated that by 2010, there will be 1.5 million children orphaned as a result of AIDS (*Report on the Global HIV/AIDS epidemic*, 2002:10).

The most recent and comprehensive survey of HIV/AIDS prevalence in South Africa (The Nelson Mandela/HSRC study of HIV/AIDS (2002: 67-68) includes a small section on the question of orphans and child-headed households. The study confirms that HIV/AIDS contributes to orphan hood and, for this reason, there is an interest in estimating the magnitude of the orphan hood problem. Furthermore, the above-mentioned study found that 13% of children aged from 2-14 years had lost a mother, a father or both. The study also indicates that 3% of the children had lost a mother, and that 8.4% of these children had lost their father. The report states further that many community-based assistance programs report an increase in households headed by children or consisting only of children. However, no national data on child-headed households has yet been provided. In this survey, just 3% of the households were reported as being headed by a person between the ages of 12 and 18 years, and could thus be called child-headed households. The percentages observed were 3.1% in urban formal areas, 2.8% in tribal areas and 1.9% on farms.

The most recent studies on a similar topic conducted in the Department of Social Work and Criminology at the University of Pretoria were by Louw (2005) and Mogotsi (2005). Their focus was on the young adolescent and adolescent AIDS orphans. In contrast, this study focuses on HIV/AIDS orphans in their middle childhood. Schoeman (1997:22) defines middle childhood years as from 6 to 12 years and states that this is when the child learns to live in harmony with his/her peers. This is also when parents, friends and teachers have a strong influence on the molding of the child and his/her attitude to life. The Researcher thus feels that this stage is difficult for children without parents, strengthening the reason for this study.

A survey commissioned by the Kaiser Family Foundation conducted by Abt Associates in conjunction with several other organizations. Found that of the 771 households surveyed, almost a quarter (22%) of all the children under the age of 15 in the sample was maternal orphans in that they had lost either their mother or both parents. Most of these orphans were girls (Hulting Home Magazine, 2002:23). Given the above scenario, it is clear that far more research into both the conditions and the extent of the impact of HIV/AIDS on children is required in order to explore the needs of the children orphaned by HIV/AIDS. In summary, the researcher is of the opinion that there is a need to conduct research on the needs of children in middle childhood orphaned by HIV/AIDS. This process will enable the researcher to explore the children's needs during their experience of having lost their mother/father or both parents. In her 10 years of social work practice, the researcher became aware of child-headed families in Ikageng in the Potchefstroom community. Unassisted the children deal with the trauma of multiple familial deaths, as no one in the family or the community has been well equipped in identifying and attending to the children's needs during the bereavement stage.

This experience is rubber-stamped by Mouton (in Fouché, 2002a:96). As he mentions that people who are aware of, and sensitive to, their surroundings are more likely to come up with topics of interest in their research. In such instances a concrete problem was observed in reality and, from this, a topic for research emerged.

The pressure on the family unit prior to HIV/AIDS means that many children have only one parent to lose, generally their mother, as many fathers have long since abandoned the family, prior to the mother's illness. Where both parents are present prior to the onset of HIV/AIDS, they frequently die within a short period of each other, leaving children to come to terms with the death of a mother and a father in quick succession. Therefore, the researcher is of the opinion that it would be of value to obtain knowledge about the needs of the children in middle childhood orphaned by the pandemic, in order to help them to deal with the crisis. The researcher feels that the above-mentioned issues exist in different countries, but they need to be reviewed constantly to cater for the existing needs of children in middle childhood orphaned by HIV/AIDS.

According to Celliers (in Strydom, 1998:181), the utilization of experts could help to delineate the problem more sharply and obtain valuable information about the more technical and practical aspects of the report. In view of this opinion, the researcher consulted some experts to determine the extent of the problem and found the following:

A telephonic interview with social worker Ms N Ngidi (2005) indicated the need for research on the selected topic, as she works directly with children orphaned by HIV/AIDS in Chesterfield Hospice in KwaZulu-Natal. She directly observes the children's reactions to the situation in which they find themselves (orphans), and listens to their comments as they express their needs in the support group activities that she runs.

Mrs J. Pieterson (2005) also confirmed the need for research, as she runs a soup kitchen for children orphaned by HIV/AIDS at the Methodist church in Johannesburg east. The chief magistrate, Mr D Humpel, of the Children's Court (2004) held in Potchefstroom also raised his concerns about the rate of foster care placement and grants. He doubted whether the foster care grant was really used to cater for the needs of the children in question.

Researchers who are experts in the field of HIV/AIDS have repeatedly mentioned that this is a global problem with unique implications on each

continent. In view of this background, the prospective researcher sees conducting this research as imperative. It would benefit the children orphaned by HIV/AIDS, the community at large and government authorities in terms of making some adjustments to the policies and procedures pertaining to the needs of these children.

1.2. PROBLEM FORMULATION

Three factors that determine how research problems are formulated are the unit of analysis, the research goal and the research approach (Mouton & Marais, (in Fouché, 2002b:107). Collins (1999:42) refers to “an area for investigation of the important questions which have not yet been answered, and in terms of the additional information still needed”.

From the above literature the researcher is of the opinion that the needs of children in middle childhood orphaned by HIV/AIDS have emerged as one of the key aspects in service rendering to people affected by or infected with HIV/AIDS. Compared to adults, children react differently to stressors or traumatic events (Lewis, 1999:37). In this research, the needs of children in middle childhood orphaned by HIV/AIDS will be explored. The stresses and anxieties children experience would be the loss of parents, leading to them being orphaned, having no direct support system, and in some cases no assistance with material needs, e.g. food, clothes, shelter and financial needs.

Lewis (1999:37) further mentions that when children experience trauma (crisis) such as the loss of parents, especially due to HIV/AIDS, the remaining parent or significant others, e.g. uncles, aunts and grandparents, experience feelings of inadequacy in their inability to help these children deal with their loss. They may use the children as assets to obtain social grants or the children may be susceptible to abuse. In some instances, these relatives use children to achieve their own goals, e.g. children do household chores in exchange for food, while adults are doing nothing. The children are deprived in terms of educational needs. Therefore, by conducting this study, an awareness and understanding could be gained of the needs of these children in middle childhood orphaned by HIV/AIDS.

1. 3. AIM AND OBJECTIVES OF THE STUDY

1. 3.1 AIM

Webster (in Fouché, 2002b:107-108) defines the word aim as "the end towards which effort or ambition is directed". Aims are defined as the formulation of what we undertake to achieve (Van Dyk, 1991:7). These formulations are broad and frequently abstract, but give some direction to what we wish to achieve. The major aim of research is to communicate to others the knowledge that has been derived from a particular study (Tavent, 1983). In this case the particular study involves the needs of children in middle childhood orphaned by HIV/AIDS. Fouché (2002b:107) found that the terms purpose, aim and goal are often used interchangeably or as synonyms of each other. This research is exploratory. Based on this understanding gained from the above definitions and descriptions of aim (goals), the researcher formulates the aim of her study as follows:

The aim is to explore the needs of children in middle childhood orphaned by HIV/AIDS.

1. 3.2 OBJECTIVES OF THE RESEARCH STUDY

Fouché (2002b:107) defines objectives as being "more concrete, measurable and more speedily attainable". Furthermore, she regards objectives as formulations, but differentiates between these formulations and those of a goal in that they clearly state the how of achieving a goal.

The researcher presents the following objectives:

- To describe the phenomenon of HIV/AIDS.
- To describe the phenomenon of children in middle childhood affected by HIV/AIDS in South Africa.
- To explore the specific needs of children in middle childhood orphaned by HIV/AIDS by means of an empirical study.
- To make recommendations for professionals and non-professionals intervening with children in middle childhood orphaned by HIV/AIDS in South Africa.

1. 4. RESEARCH QUESTION

The researcher has chosen the qualitative method and will therefore formulate a research question rather than a hypothesis (Fouché, 2002b:106). According to De Vos & Van Zyl (1998:267), the research question that this study will attempt to answer is: ***What are the needs of children in middle childhood orphaned by HIV/AIDS?***

1. 5. RESEARCH APPROACH

At present, there are two well-known recognised approaches to research, namely qualitative and quantitative paradigms (Struwig & Stead, 2001:3). The researcher used the qualitative approach for the purposes of this study. According to Fouché and Delport (2002a:79), qualitative research aims to understand social life and the meaning people attach to everyday life. They further state that the approach is idiographic and thus holistic in nature. In other words, this approach deals with meanings, experiences and perceptions. It also produces descriptive data in the participant's own written or spoken words. It thus involves identifying the participant's beliefs and values that underlie the phenomena. Qualitative research is, therefore, concerned with an understanding rather than an explanation; a naturalistic observation rather than a controlled measurement; and the subjective exploration of reality from the perspective of an insider, as opposed to the outsider that is predominant in the quantitative paradigm. A qualitative study is therefore, concerned with non-statistical methods and small samples often purposively selected (Mc Roy, 1995:2009-2015). Strauss and Corbin (1998:11) share this idea in the definition of the qualitative approach. They state that qualitative research is about people's lives, lived experiences, behaviour, emotions and feelings, and that it is often chosen by researchers as it "attempts to understand the meaning or nature of experiences of persons with problems".

Fouché (2002b:106) outlines reasons proposed by Creswell for undertaking qualitative research. The researcher is able to identify a number of these reasons as relating to her research study. Firstly, according to Creswell (in Fouché, 2002b:106), the research question in qualitative research relates to

the “what” or “how”. In this research study, the research question is related to “what.” In other words, the study is focused on establishing the needs of children in middle childhood orphaned by HIV/AIDS.

Secondly, Creswell (in Fouché, 2002b:106) states that qualitative research is undertaken when, “a topic needs to be explored”. In her research study, the researcher explored the needs of children in middle childhood orphaned by HIV/AIDS. Therefore, the outcome is not an exploration of why the needs occur, but rather a description of what these needs are. Furthermore, the researcher studied the individuals (children in question) in an office environment at Child Welfare, South Africa in Pochefstroom. The children, therefore, were, observed in their natural environment. Finally, in presenting the results of the study, the researcher “tells the story from the viewpoint of participants, rather than an expert witness who passes judgment on participants” (Creswell in Fouché, 2002b:106).

Reid and Smith (in Fouché & Delport, 2002a:80) emphasize this point as they state that a valid understanding can be gained only through knowledge that is acquired and accumulated first - hand by the researcher. The researcher herself conducted all the interviews, has gathered the data in this qualitative study, and was aided by a research assistant to help with the tape recorder.

1.6. TYPE OF RESEARCH

The type of study can either be basic or applied. Basic or pure research seeks an understanding of social reality or increases the knowledge base, whereas according to Fouché (2002b:107-108), “applied research is aimed at solving specific policy problems or helping practitioners accomplish tasks. It is focusing on solving problems in practice”. Huysamen (1994:34) agrees with this description of applied research in stating that, “applied research is undertaken specifically with a view to solve some or other psychological, educational or social problem”.

In her experience as a social worker, the researcher has come across a number of families where children are heading the family, because the mother or both parents have died due to HIV/AIDS-related diseases. As a result of these unfamiliar but expanding phenomena, the researcher has decided to undertake this specific research study to gain a better understanding of the needs of HIV/AIDS orphans and make recommendations on the options available to alleviate stresses that occur in practice. Therefore, the research that has been undertaken is applied research, as the aim is to improve service delivery.

"Applied research, however, is aimed at solving specific policy problems or at helping practitioners accomplish tasks. It is focused on solving problems in practice" (compare Fouché, 2002b:109; Rubin & Babbie, 1993:79.). This information clearly indicates to the researcher that applied research is found to be relevant because the aim of this study is to explore the needs of HIV/AIDS orphans and make recommendations for intervention.

1.7. RESEARCH DESIGN AND METHODOLOGY

Struwig and Stead (2001:9) define research design as, "strategies" that can be used to address research questions. A research strategy refers to the "formula" that the qualitative researcher selects in order to study the phenomena related to the research goal. The researcher is of the opinion that a research design is a form of planning that has to be done by the researcher before a research project is undertaken. This implies that this planning will guide the research process from beginning to end.

Fouché (2002d:272) further identifies the strategies that could be used to design qualitative research as a biography, phenomenology, grounded theory, ethnography or case study. The qualitative research strategy that the researcher has used to use in this study is the phenomenology. Phenomenology as a qualitative research strategy aims to understand people's perceptions, perspectives and understanding of a particular situation (Fouche & Delport, 2002b:265). The researcher used phenomenology

strategy to explore the needs of children in middle childhood orphaned by HIV/AIDS.

1. 7.1 METHODS OF DATA COLLECTION

The research procedure refers to the method of data collection and the entire research procedure to be followed (Greeff, 2002:302). In her research study, the researcher used semi-structured one-on-one interviews as the means of data collection. Semi-structured one-on-one interviews are used to gain a detailed picture of a participant's beliefs about, or perceptions of, a particular topic (Greeff, 2002:302). Through these interviews, the researcher wished to gain an in-depth understanding of the needs of children orphaned by HIV/AIDS in middle childhood.

These semi-structured one-to-one interviews were conducted in a child-friendly office at Child Welfare South Africa in Potchefstroom. The researcher took notes, while a research assistant helped in operating a tape recorder to record the interviews.

1.7.2 METHODS OF DATA ANALYSIS

Data analysis refers to the way in which data will be analysed and the statistical procedures used (Weinbasch & Grinnell, in Grinnell & Williams, 1990:275). The processing of data is intended to reduce the collection of data to simple and more understandable terms without distorting or losing too much of the valuable information collected (compare De Vos, 2002:340-346; Mouton, 2003: 108 & 110; and Neuman, 2003:430). In this regard, Kruger, De Vos, Fouché & Venter (2002:222) state the following: "One reason is that, in a well-designed research study, the question of what to do with the data was anticipated and the analysis planned well before the data was collected".

Qualitative data analysis is a process of bringing order, structure and meaning to the mass of collected data. Qualitative data analysis and interpretation will be done through themes, recurring ideas and patterns of beliefs, and will be interpreted to demonstrate credibility (De Vos, 2002:354). For data processing and analysis, some of the five steps of qualitative data analysis identified by

Creswell (in De Vos, 2002:340) were used. These steps are not as linear as they appear, but are outlined as such for the purposes of this study. The researcher has used reasoning to reach conclusions based on evidence collected (De Vos, 2002:340), which comprises of the following aspects:

Collecting and recording data: Field notes should, according to Greeff (2002: 317-318), include the following **details:** seating arrangements and the order in which the people speak to aid voice recognition. The researcher has therefore, ensured that these aspects were considered with the help of a research assistant. A tape recorder will also be used to record the interviews. Thereafter, these tape recordings were transcribed. The research assistant assisted with the taking of notes and in operating the tape recorder.

Themes that are striking: were assessed as part of the conversation and group dynamics. These were taken from the transcribed interviews and grouped into common themes.

Managing data: Index cards were used, and all the relevant data collected were placed in files and kept in a safe secure area. No identification, such as name or address, appeared on any of the files. The researcher evaluated the merits of the data and determined whether the data was authentic, valid, true and worthy, so that it could be managed and would be of value to this research.

Reading, writing memorandums: After the data had been collected, it was studied to enable the researcher to become familiar with the content as a whole, before it was categorized it to see whether similarities existed.

Comparison with literature: The themes observed and communicated were compared with literature.

Data Analysis: The data was then finalized and the findings were recorded and will also be published.

1. 8. PILOT STUDY

A pilot study involves a “dress rehearsal of the main investigation” (Strydom, 2002b:211). Bless and Higson-Smith (1995:43) indicate that a pilot study involves assessing the feasibility of a research project. According to *the New Dictionary of Social Work* (1995:45), a pilot study is defined as the “process whereby the research design for a prospective survey is tested”. It can be regarded as a small-scale trial run of all the aspects planned for use in the main inquiry (compare Monette *et al*, 1998:9; and Mitchell & Jolley, 2002:13-14). The researcher believes that a pilot study is a study conducted on a small scale prior to a large piece of research, with the intention of determining whether the methodology, sampling instrument and analysis are adequate and appropriate. This is done to determine the feasibility of conducting a study.

The pilot study begins with a literature study, which highlights the experiences of various experts, and an overview of the actual, practical situation where the prospective investigation will be executed as well as an intensive study of strategic units, which will allow for feedback from the respondents. Strydom (2002b:210-214) adds that the pilot study is one way in which prospective researchers can orientate themselves to the project in mind. The researcher has planed to adhere to the following aspects of the pilot study:

1.8.1 FEASIBILITY OF THE STUDY

William *et al***.** (1995:58) indicate that a study is feasible “if all the necessary data can be collected and analyzed by the particular researcher, given his or her own resource situation. The researcher considered that she had sufficient resources to complete the study in one year. Marshall and Rossman (1999:183) advise researchers to plan for more time than initially appears necessary. The researcher was motivated and prepared to budget her time in such a way that she was able to achieve her goal. Leave has been granted by her employer, the Gauteng Department of Health, as there was a need for the researcher to travel to Potchefstroom where she intended to conduct her study. The researcher mainly financed the research study herself. She obtained a postgraduate study bursary from the University of Pretoria in 2004.

The researcher intends to do the research work herself. However, she requested the services of a research assistant that she had already recruited to operate the tape recorder. The respondents were been identified before hand and the researcher requested permission to conduct her study at Child Welfare South Africa, Potchefstroom. The social worker at Child Welfare South Africa, Potchefstroom had regular contact with the children, therefore, it was not problematic to engage with them.

In order to undertake scientific research on a specific problem, the researcher should have thorough background knowledge of it. The pilot study is one way in which the prospective researcher can orientate herself to the project she has in mind. Permission to conduct the research has been obtained from the University of Pretoria, Department of Social Work and Criminology Research Panel and the Research Proposal and Ethics Committee of the Faculty of Humanities. The caregivers were given letters of informed consent.

1.8.2 PRE-TEST OF THE INTERVIEW SCHEDULE

Bless and Higson-Smith (2000:50) maintains that the pilot testing of the data collection instrument enables the researcher “to identify any difficulty with the method or materials and to investigate the accuracy and appropriateness of any instrument that has been developed”. Strydom (2002b:216) support this, by asserting that thoroughly pilot-tested questionnaires ensure that errors are rectified immediately at little cost and that necessary modifications are made before the questionnaire is presented to the full sample. Strydom (2002b :216) further state that “if a measuring instrument has been tested thoroughly during the pilot study, certain modifications can be made for the main investigation, if deemed necessary”.

For this study, the researcher conducted the pilot study with two respondents. All the respondents were recruited in a similar manner to that used for the respondents of the empirical study. The respondents involved in the pilot test were not included in the empirical study. Recommended changes were made to the measuring instrument.

1. 9. DESCRIPTION OF THE POPULATION, SAMPLE AND SAMPLING METHOD

According to Arkava & Lane in Strydom and Venter (2002:198), the universe is “all potential subjects who possess the attribute in which the researcher is interested”. All children in middle childhood between the ages of 6 and 12 years orphaned by HIV/AIDS in Potchefstroom constituted the universe of this study. According to Neuman (2003:201), in defining the population, the researcher must specify the unit being sampled, i.e. the geographical location and the temporal boundaries of situations. The population in this study has been children in middle childhood, orphaned by HIV/AIDS, and known to Child Welfare South Africa, Potchefstroom. Marshall and Rossman (1999:69) provide some criteria for selecting the population:

- Entry should be possible.
- The researcher should be likely to be able to build trusting relationships with participants of the study.
- Data quality and credibility of the study should be reasonably assured.

1. 9.1 BOUNDARY OF SAMPLE

Since it was not possible to include the entire Potchefstroom population, the researcher selected a sample. A sample comprises of those elements of the population that are actually included in the study (Strydom and Venter, 2002:199). Before selecting the respondents, the sample size must be chosen. The ideal is for the sample to be as large as possible, since this makes the sample more representatives (Bless and Higson-Smith, 2000:96). For this study, the researcher will take a sample of ten children in middle childhood orphaned by the HIV/AIDS pandemic in North West Province, specifically in Potchefstroom. Permission to get the names of HIV/AIDS orphans from Child Welfare South Africa was requested from Potchefstroom.

1. 9.2 RESEARCH SAMPLING METHODS AND PROCEDURES

There are two broad categories of techniques for selecting a sample, namely probability and non-probability sampling (Bless and Higson-Smith, 1995:88). A probability sample refers to a sample in which each unit of the population is known and has an equal chance of being selected. In a non-probability sample, the researcher does not know all the population units. Therefore, the units do not have an equal chance of being selected. For the inclusion of the respondents in the qualitative research, the researcher used the purposive sampling technique, which is classified as a non-probability sampling technique (Strydom & Venter 2002:201). Strydom and Venter (2002:207), define the purposive sampling technique as existing "when a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population".

The criteria for the selection of this sample were as follows:
10 respondents

- Black children in middle childhood between the ages of 6 and 12 years.
- Both genders will be included.
- These children should have lost their parent/s due to HIV/AIDS in 2006 prior to the year (2007) of the study.

1. 10. ETHICAL ISSUES

Ethical issues are concerned with the question of right and wrong (Babbie, 1998:438). Ethical guidelines, "serve as the basis on which each researcher ought to evaluate her own conduct" (Strydom, 2002a:63). The fact that human beings are the objects of study in social science brings unique ethical problems to the fore that would never be relevant in the pure, clinical laboratory settings of natural science. For researchers in social science, the ethical issues are pervasive and complex, since data should never be obtained at the expense of human beings (Williams *et al.,* 1995:30).

Anyone involved in research needs to be aware of the general agreements about what is proper and improper in scientific research (Babbie, 2001:470).

Researchers tend to relate to respondents from a position of superior expertise and status, and may think that the respondents do not need to be fully informed about the research goals, process and outcomes.

According to Levy (1993:2), ethics imply preferences that influence behaviour in human relations. Values indicate what is good and desirable, while ethics and morality deal with matters of right and wrong (Babbie, 2001:470). Being late for an appointment, for example, is unprofessional, but not necessarily unethical. Different authors share approximately the same attitudes/beliefs when describing the concept of ethics. In summary, the concept of ethics is defined as a set of moral principles that are suggested by an individual or groups, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students.

Ethical principles should thus be internalized in the personality of the researcher to such an extent that ethically guided decision-making becomes part of his/her total lifestyle (Botha *et al.;* 1993:3). In the following section, the researcher discuses the ethical issues that pertain to this particular research study.

1. 10.1 HARM TO EXPERIMENTAL SUBJECTS AND/OR RESPONDENTS

According to Strydom (2002a:64), subjects can be harmed in two ways during research investigations, namely physically and/or emotionally. However, in social science, it should not be ignored that physical injury is likely to occur. The main injury that may occur is that of emotional injury. Psychological harm may also occur (Rubin & Babbie, 1993:61). According to Strydom (2002a:64), this kind of harm is often difficult to predict or determine. According to (Dane in Strydom, 2002a:64), “an ethical obligation rests with the researcher to protect subjects against any form of physical discomfort that may emerge. The researcher should not only try to minimize the harmful effects after the research has been conducted, but also inform the respondents of the possible harm due to the investigation, thus preparing them for any possible dangers

and affording them the opportunity to withdraw from the investigation if they choose to do so.

All the respondents' caregivers or home authorities were informed of this information via the consent form. The respondents will be informed during a pre-interview session and were given sufficient opportunity to ask questions. Due to the sensitive nature of the investigation, while conducting the research study with the respondents, the researcher had to show sensitivity to the issue and the experience of the respondents, and treat them sensitively. Should emotional harm occur or be observed, the respondents would been referred to other professionals (social worker or psychologist) had already been identified at Child Welfare South Africa, Potchefstroom.

1. 10.2 INFORMED CONSENT

This refers to obtaining informed consent, which implies all possible or adequate information about the goal of the investigation, the procedure that will be followed during the investigation, the possible advantages and dangers to which the respondents may be exposed, as well as the credibility of the research to be conveyed to potential subjects or their legal representatives (Williams in Strydom, 2002a:65). It should be in writing. As the researcher has been worked with children, consent for the interviews was obtained from their next of kin and/or guardians. Letters of informed consent were given to guardians and a copy was given to the home authority where other children resided. The children have signed and received a copy of the consent form.

1. 10.3 DECEPTION

This refers to giving incorrect information or withholding it from the respondents (Struwig & Stead, 2001:69). Taylor (2000:9) includes that preferably no hidden agenda should be reflected in the research study. The researcher, in summary understands deception as deliberately not telling the truth for personal gain. No deception took place in this study. All the respondents were fully informed about the study and what it entails.

1. 10.4 PRIVACY AND CONFIDENTIALITY

The respondents in research studies should be protected through confidentiality and anonymity (Babbie, 1998:440). Confidentiality means that the respondent's information will neither be used nor published without his/her permission. It is the responsibility of the researcher to communicate this information clearly to the respondents and their next of kin. Anonymity, on the other hand, means that the respondent's information will not be used for any purpose other than the stated purpose and that no other person will have access to the interview data (Bless & Higson-Smith, 2000: 103). All the respondents' information was kept confidential and anonymous.

1. 10.5 ACTIONS AND COMPETENCY OF THE RESEARCHERS

According to Strydom (2002a: 69), researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. The researcher is certain that she is competent and adequately skilled, supported by the undergraduate training and theory in conducting research. The BA (SW) Honours and the theoretical modules of MSD (Social Health Care) have been completed successfully.

1. 10.6 CO-OPERATION WITH CONTRIBUTERS

Strydom (2002a:72) emphasises that the research report should be written in an "accurate, objective, clear, unambiguous manner and that it should contain all essential information," Struwig & Stead (2001:70) warn against plagiarism, the practice of "and using the work of others without proper acknowledgement of their contribution". The researcher attempted to write her final report in such a way that it abides by the above-mentioned standards and that it does not present a biased picture. In writing the report the researcher undertook to acknowledge any work that she cited in her report.

1. 10.7 RELEASE OR PUBLICATION OF THE FINDINGS

The findings of the study must be introduced to the reading public in written form, otherwise even a highly scientific investigation will mean very little and will not be viewed as research (Strydom, 1994:18-19). In this research, the findings were recorded in a research report and submitted to the University of

Pretoria in a mini dissertation format. A copy will be handed to the authorities of Child and Welfare South Africa, Potchefstroom . The researcher will publish an article, with her supervisor as co-author in an accredited journal, to acknowledge her supervisor's input in the study.

1.10.8 DEBRIEFING OF RESPONDENTS

Judd, Smith & Kidder (1991:501) summarise debriefing interviews as follows: "To be constructive, [they] must take place in a supportive or a therapeutic context rather than in a brief and threatening laboratory confrontation". For the purpose of this study, should any emotional problems arise, the respondent would have been referred to a social worker in Child and Welfare South Africa, Potchefstroom for debriefing.

1. 11. DEFINITION OF KEY CONCEPTS

The following concepts were identified as central to the research topic, namely:

1. 11.1 Orphan/s

"Refers to children who have become vulnerable because their parents or caregivers can no longer care for them because they are either very ill or have died because of HIV/AIDS"

"One deprived by death of father or mother or both" (Oxford English Dictionary, 1992:1465)

"An orphan is defined as a child below 18 years who has lost one (single parent) or two (married couple) biological or adoptive parents, Children who are abandoned or dumped and their parents cannot be traced are termed as social orphan/s" (Division of Social Welfare, Botswana, 1999:02).

"In the context of the HIV/AIDS epidemic in South Africa an orphan is defined as a child under the age of 18 years whose primary caregiver has died" (Department of Social Development, 2003:33).

The researcher defined an orphan in the following manner:

The term orphan refers to a child between 0 and 18 years, after the death of his or her primary caregivers, or the death of one caregiver and the disappearance of the other.

1. 11.2 HIV/AIDS

"Acquired Immune Deficiency Syndrome- is a collection of diseases that results from infection with HIV" (Smart, Pleaner & Dennil, 2001:4).

"HIV affects the body by affecting the immune system. The immune system is the body's defense against infection by micro-organisms (bacteria and viruses) that cause disease.. HIV is able, by attaching to the surface of the CD4 lymphocyte, to enter, infect and eventually destroy the cell. Over time, this leads to a progressive and finally profound impairment of the immune system, resulting in the infected person becoming susceptible to infections and diseases such as cancer" (Smart, Dennil & Pleaner, 2001:35).

1. 11.3 NEEDS

According to Barnard, (2001:9) this term refers to circumstances without which a person can survive.

In Richter, where a national study was conducted on the Needs Assessment of Orphans and Vulnerable Children in AIDS affected areas (2001), the term is defined as: "…the most immediate necessities for a person to survive, i.e. food, shelter and clothes". The researcher defines "needs" as basic needs as well as psychosocial needs of children orphaned by HIV/AIDS in middle childhood.

1. 11.4 MIDDLE CHILDHOOD

The researcher defines middle childhood as a stage that involves physical, behavioural, cognitive and emotional development.

Middle childhood is characterised by three significant outward drive and growth motions, namely: social movement outward from the family towards the peer group; the physical movement towards a world of play and labour,

and the psychic movement towards a world with adult concept, logic, symbolism and communication (Bender 2000:33).

1. 11.5 CHILD

Child is defined as the person under the age of 18 years in terms of the Child Care Act, 1983 (Act 74 of 1983).

1. 12. LIMITATIONS OF THIS RESEARCH STUDY

The literature study revealed that in the past, not much attention has been given to HIV/AIDS orphans and their needs in middle childhood. The existing literature focuses mainly on the infected person, his or her psychosocial status and treatment and its after effects.

The sample that has been utilized for this study comprised of ten respondents, both genders and predominantly black. Although the findings of this research study cannot be generalized to the broader population, valuable information was obtained. The respondents answers were short and to the point as if they were uncertain or afraid of something. It is recommended that a further study to be conducted on other different cultures.

CHAPTER 2

HIV/AIDS AS A SOCIAL PHENOMENA

2.1 INTRODUCTION

Children on the brink, a UNICEF Report (2004:16), which is a joint UNICEF-UNAIDS publication on orphan estimates and programme strategies, they predicted that by the year 2015, roughly 15% of all children in South Africa are expected to be orphans. This UNICEF Report (2004:10) reported that 370 000 children were orphaned in South Africa in 2003, which brought a number of orphans to 1.1 million. The South African National Council for Child Welfare reported that the number of children with HIV/AIDS increased by 162% in 2002, while the number of orphaned children increased by 43%. Children orphaned by AIDS in South Africa comprise 48% of all orphans, and the majority are in the 10-14 age categories, (Barolsky, 2003:10)

The 2005 HSRC Study, (cited in Richter, Manegold, & Pather 2004:14) estimated the overall orphan prevalence rate in South Africa to be 14.4% for the children aged 2-18, equating to a total of 2 531 810 orphans. These children are facing an uncertain future and many more children are vulnerable to being in the same position. It is clear that South Africa's capacity to deal with current numbers of orphans is very limited.

At the heart of the social context is the family. The family, both as an ideal and as a structural phenomenon, constitutes probably one of the fundamental building blocks of society. On the other hand, the family, as a pre-existing network of care, could constitute one of South Africa's most important social resources in the countries attempts to address the consequences of the HIV/AIDS epidemic (Barolsky, 2003:14). However, it is clear that in a country such as South Africa family's are impoverished – AIDS is such that most families lack the capacity to feed, clothe and educate the family members on the income and social support available.

In this chapter, HIV and AIDS is discussed, focusing on the following issues: the definition of HIV and AIDS; the transmission of the virus; the phases of the disease, and the impact of the disease on the patient, children and affected significant others.

2.2 DEFINITIONS

2.2.1 AIDS

The acronym AIDS stands for acquired immune deficiency syndrome. According to Van Dyk (2001:4), the term acquired is used for the disease, because it is not inherited. The human immunodeficiency virus (HIV), which enters the body through body fluids, causes the disease (AIDS) (Van Dyk, 2001:4). Even though there are conflicting beliefs about the cause of the disease, for the purpose of this study we accept that HIV causes AIDS.

The disease is a collection of many different conditions that manifest in the body as a result of a weakened body immune system. The weakened immune system results in the body failing to defend itself against invading pathogens (Gordon & Klaud, 1991:4 and Van Dyk, 2001:4-5). AIDS is, therefore, a syndrome, caused by HIV, characterised by opportunistic diseases that take advantage of the compromised immune system.

2.2.2 HIV

The Human Immunodeficiency Virus (HIV) is known to attack the important body cells directly, which serve to defend the body against intruding organisms. These cells are known as CD4 or T cells. As the virus attacks the body, it slowly diminishes the total number of healthy CD4 cells in the body. (Compare McDougal, Mawle & Nicholson, 1989:18; Nell, 1990:16; Gould, 1993:5-9 and Van Dyk, 2001:7).

In summary, HIV is a virus that enters the body and attacks the CD4 cells; the result is that the body's immune system is eventually unable to defend itself against opportunistic and other diseases.

2.3 THE HISTORICAL BACKGROUND OF HIV and AIDS

The general public has known about HIV and AIDS and its effects since the 1980s. In the medical field there is, however, conflict surrounding the question of when and where it originated. According to the existing literature, the first AIDS cases were recognised in the United States of America in 1981 during

summer, when a rare form of pneumonia and Kaposi sarcoma (a rare form of skin cancer), suddenly appeared simultaneously in several patients.

These patients had a number of common characteristics – they were all young homosexual men with compromised immune systems (Eloff, 1998:5-7; & Van Dyk, 2001:5). On the other hand, Nell (1990:21) believes that AIDS is not a new illness and notes that some researchers claim that AIDS has existed longer than presumed. Van Niekerk (1991:7), however, is of the opinion that AIDS is a new disease that results from an infection with a retrovirus called the human immunodeficiency virus, which causes a total breakdown of the body's natural immune system.

Eloff (1998:6) mentions that initially the disease was thought to have originated in Haiti, due to the fact that a large number of the first cases were reported to be from Haiti. The said area is also a favourite holiday destination for homosexual men. At present it is assumed that the disease originated in Central Africa. The two viruses associated with AIDS are HIV-1 and HIV-2. The characteristics of these two viruses might resolve some of the issues around the place of origin. HIV-1 is associated with infection in Central, East and Southern Africa, North and South America, Europe and other parts of the world. HIV-2 was discovered in West Africa in 1986 and it is mostly restricted to West Africa. All current indications are that while HIV-2 is as dangerous as HIV-1, it acts more slowly (Van Dyk, 2001:5).

Although the literature offers different opinions as to where and when HIV/AIDS originated, it seems from the abovementioned authors that the first case was diagnosed in 1981 in a homosexual man, and the fact remains that HIV/AIDS and its effects, affect every country in the world.

2.4 TRANSMISSION OF HIV

The virus is primarily transmitted through unsafe sexual intercourse, which means intercourse with an HIV infected person without using a condom, including multiple sex partners or high-risk sex partners, e.g. prostitutes. The second most common mode of transmission is through blood transfusion or

contact with HIV-infected blood; is passed directly into the body of another person; the third is mother-to-child transmission. The latter implies that a mother can infect her child during pregnancy or childbirth. The virus may also be transmitted through breast milk during breastfeeding. HIV has been associated with various body fluids, but is most highly concentrated in blood, semen and vaginal fluids – hence the high risk of infection through sexual intercourse. (Compare Eloff, 1998:19; Nell, 1990:21; Evian, 1995:15; and Van Dyk, 2001:19).

In summary, there are mainly three ways in which HIV/AIDS can be transmitted from one person to another, namely, through unsafe sexual intercourse, mother-to-child transmission and blood transfusions or contact with an infected person's blood. Even though other body fluids may cause infection, it should be noted that the concentration of the virus in those fluids is very low (compare Eloff, 1998:19; Nell: 1990:21; Evian, 1995:15 and Van Dyk, 2001:19).

What follows is a brief discussion of the mentioned modes of transmission, followed by the researcher's own opinion on cultural, gender aspects applicable to RSA.

2.4.1 Sexual intercourse with an HIV-infected person

Sexual behaviour is the main driver of the South African HIV epidemic. It is shaped by personal, interpersonal, environmental, cultural, gender and structural forces. The personal factors influencing sexual risk behaviour include feelings and cognitions related to sexuality, HIV/AIDS, and the self. Factors related to interpersonal relationships, such as negotiating condom use, coercive male dominated sexual partnerships and peer pressure to be sexually active, are also important. Cultural factors, such as, shared beliefs and the norms of the larger society also play a role, for instance some cultures do believe that more than one wife does not have any negative impact, whereas contrary to this it does have negative impact, as when there is safe or unprotected sexual practices in multiple relationships, the risk of contracting HIV is high.

HIV infection is primarily transmitted through unprotected vaginal and anal intercourse and through oral sexual contact under certain conditions. Because the membrane linings of body cavities, especially the anal-rectal area, and to a lesser extent the vagina, are very delicate, they can be torn as a result of friction during sexual intercourse. Such tears make it easy for the virus to enter the sex partner's bloodstream (Gennerich, 2004: 26).

Approximately 70% of all HIV/AIDS cases worldwide fall in this category. The statement does not exclude the increase/incidence of HIV/AIDS among heterosexual people (Nell, 1990:2). Eloff (1998:19) is of the opinion that the reason for this is the high level of promiscuity in certain homosexual groups and the myth that should an infected person have sex with a child he will then be cured. While homosexuality exists amongst both sexes, HIV transmission is less likely among lesbians as there is no penetrative sex involving the exchange of body fluids. The discussion therefore focuses primarily on men involved in homosexual behaviour. The skin of the penis is very thin; allowing small quantities of blood and/or semen to infiltrate the body (Eloff, 1998:19).Therefore, exposure to many sexual partners without any protection puts one at high risk of contracting HIV.

When it comes to gender issues and cultural sexual practices, many ideas and expectations regarding male and female (sexual) behaviour neither encourage men to act responsibly and protect themselves and their partners from infection nor stimulate women to challenge notions of female inferiority and social structures which keep women vulnerable. Low social status and economic dependence prevent many women and young people from controlling their own risk as with little negotiation power, they may have no choice other than to barter sex for survival (CSA, 2006: 32).

The researcher is of the opinion that, in order to change the way we think and act, we need to explore how gender is related to prevention by addressing beliefs, relationships and power between women and men and sexuality.

2.4.2 Blood transfusions and contact with blood products

According to the UNAIDS (2000), there is a 90-95% chance that a person receiving blood from an HIV-infected donor will become infected herself/himself. All donated blood should be screened for HIV antibodies to reduce the risk; this is essential, even if the donor is a member of the medical staff, clergy or somebody that is known to the doctor (Snidle & Welsh, 2001:36). Note should be taken of the fact that blood tests are, unfortunately not 100% accurate. The window period (the period after infection, but before the antibodies are formed), according to Van Dyk (2001:24), still poses a problem for blood transfusion services, as infected blood donated during this period will not reveal the presence of HIV antibodies during testing. Nonetheless, the question of blood transmission cannot be overlooked, as it is generally considered as one of the risk modes. In most countries, excluding developing countries, blood is tested and is 100% safe, though in developing countries blood is considered as one of the risk modes. The policies to ensure a safe and adequate blood supply, therefore, must be in balance.

The virus can be transmitted from one person to another when surgical instruments, which are contaminated with HIV-infected blood, are used. This includes injuries incurred with blood-contaminated needles and syringes. There is debate around the time that the virus survives outside the human body and its fluids. Therefore; this mode of transmission is scientifically questionable. Despite the debate, an example has been cited where a soccer player from Italy tested HIV -positive after colliding with a player who happened to be HIV- positive. During the incident both players bled severely and the virus was transmitted.

The researcher is therefore of the opinion that it is, imperative for individuals helping in a bloody situation to take precautionary measures.

In indigenous African practises such as circumcision, scarring, traditional healers releasing the snake from the body, it is important to use new, sharp instruments for every client/person they deal with, especially with young men

at the initiation schools for removal of the fore- skin /circumcision or (ulwaluko/imiphazo).

In conclusion, the researcher further believes that HIV/AIDS educational activities should be holistic in terms of the stakeholders involved. A practical example would be the active involvement of religious and traditional healers in these activities, as they do have some influence in the community. Many people with HIV approach traditional healers, even if they have access to other health services.

2.4.3 Vertical transmission

Mother-to-child transmission (MTCT) occurs in-utero during pregnancy, labour and delivery, as well as during breastfeeding. These are of the causes of HIV infection in children. It is estimated that about 600 000 children are infected in this way each year (WHO, 2000). HIV can be transmitted from an infected mother to her baby via the placental feeding and support system for the child during pregnancy, through blood contamination during childbirth or by breast milk during breastfeeding, especially when the mother's viral load is high. However, transmission may occur even at low viral load and the relationship between viral load and breastfeeding is not absolute (Centre for the Study of AIDS, 2006:10).

There are various antiretroviral regimens that are known to prevent MTCT, the most effective involving more than one drug. However, many countries, for reasons of cost, use only one drug, such as in SA where Neviropine is used. The researcher is of the opinion that a much wider approach to the prevention of MTCT of HIV is needed that provides for the interests of the infected mother, her partner and their infected and uninfected children. Examples include pasteurising mother's milk and cleansing the vaginal area prior to giving birth for instance.

In conclusion, the researcher's viewpoint is that there is no way that vertical transmission of the HIV/AIDS virus can be underestimated or not be considered as being of risk for babies to contract HIV.

2.5 PHASES OF HIV DISEASE

According to Van Dyk (2001:36), HIV infection cannot be precisely demarcated into separate and distinct phases with easily identifiable boundaries, but in theory certain phases occur. (Compare Gordon & Klaud, 1991:5-9; Adler, 1993:55; Libman & Witzburg, 1993:404; 1994:31 and Van Dyk, 2001:36-41). HIV progresses to AIDS in a gradual process that moves through the various phases. The World Health Organization as cited in Van Dyk (2001:36) divides HIV infection into four stages. These divisions should act only as a guide.

2.5.1 STAGE I: PRIMARY HIV INFECTION PHASE /SEROCONVERSION

HIV enters the body, duplicating itself rapidly in the CD4 cells. There are few or no signs that the person is infected – for example, swollen lymph glands are common, but it is not usually a cause for alarm. Approximately 30-60% of infected people will develop a glandular fever-like illness, and the symptoms of this fever will usually last one to two weeks. This stage lasts for approximately three months (compare Centre for the Study of AIDS, 2006:26; Gordon & Klaud, 1991:5-9; Adler, 1993:55; Libman & Witzburg, 1993:404 and Schoub, 1994:31). The researcher is of the opinion that at this stage an infected person can only be identified after he/she has done the blood test, as some of the symptoms may be an indication of something else other than HIV/AIDS.

2.5.2 STAGE II: THE ASYMPTOMATIC LATENT PHASE

Minor skin problems, head or chest colds and generalised lymphadenopathy or swollen glands typically characterise this stage. People infected by the virus may have many years of productive, normal life, although they can infect others during this stage. It is not certain how long this period lasts, but estimates range between five and fifteen years (Van Dyk, 2001:37). This could be an ideal stage for disclosure for the purpose of support and early treatment interventions (ART) depending on the level of viral load.

It is in this very stage where a person can be advised to take an HIV test. But before the test, a person needs pre-test counselling or be educated about voluntary counselling (VCT) and a post-test counselling be provided in a case of positive HIV results. The researcher is of the opinion that, if these precautionary measures are taken a person will then be informed and make an informed decision rather than an imposed one.

2.5.3 STAGE III: THE MINOR SYMPTOMATIC PHASE:

During this period, the amount of HIV in the body, or the viral load, increases. In the process it destroys more and more CD4 cells. More serious problems begin to occur, such as mild, moderate swelling of the lymph nodes in the neck, armpits and groin, weight loss, herpes zoster or shingles, occasional fever, oral ulcerations, recurrent upper respiratory tract infections (Van Dyk, 2001:38). The researcher is of the opinion that this stage can be infectious and a patient needs to be treated with precaution.

2.5.4 STAGE IV: MAJOR SYMPTOMATIC PHASE OF INFECTION AND OPPORTUNISTIC DISEASES

Very serious diseases, some of which are seldom found in HIV-negative people, occur. These include oral and vaginal candida, recurrent herpes zoster, bacterial skin infection and rashes, constant unexplained fever, generalised lymphadenopathy, oral leucoplakia, chronic diarrhoea and profound weight loss. Later the opportunistic diseases of various kinds set in as well as AIDS defining conditions. These include: a pneumonia called pneumocystis carinii pneumonia (PCP), marked weight loss and wasting of tissues, infections of the brain such as toxoplasmosis and neurological abnormalities, TB and cancers such as Kaposi's sarcoma.

Only when a patient enters the final phase of infection can he/she be said to have AIDS. It usually takes about 18 months for this stage to develop into AIDS (compare Evian, 1995:15 and Van Dyk, 2001:38-39).

In summary, it is clear that HIV infection progresses over certain stages before a patient can be declared to have AIDS. It is also clear that a person

diagnosed with the disease can live for years, without presenting with any symptoms that would reveal that he/she is HIV positive. It is, therefore, imperative for one to know one's status in order to take precautionary measures.

2.6 THE IMPACT OF HIV/AIDS

The impacts of HIV/AIDS on children, families and communities is influenced mainly by the legal and policy environment, access to basic services, socio-economic status, the social and cultural environment, and the extent of knowledge about and acceptance of HIV/AIDS as a problem that affects everyone. Following is the discussion on psychosocial impact of HIV on patients, children, families and communities.

2.6.1 THE PSYCHOSOCIAL IMPACT OF HIV ON THOSE INFECTED AND AFFECTED

In this paragraph the impact of HIV on the patient will be discussed with special attention on social, emotional and psychological aspects. The diagnosis of HIV infection or AIDS evokes severe emotional reactions not only in the infected person, but also in his/her affected significant others. The illness has direct and indirect implications for the patient and the affected family.

Schwartz (1997:15-31) and Van Dyk (2001:256-259) cite the following experiences or needs as the most prevalent:

2.6.1.1 Fear and Anxiety

People who are HIV infected or affected are particularly fearful of being isolated, stigmatised and rejected. The researcher has dealt with patients who refused to disclose their status to their loved ones, because they feared that the treatment and the love they were getting from their loved ones would then be withheld.

In some instances fear might be the result of not being adequately informed about the disease and how to deal with the problems that might arise (Van

Dyk, 2003:256). The researcher is of the opinion that many HIV- infected or HIV affected people have experienced the pain and death of loved ones who have already died of HIV/AIDS related conditions and they know and fear what awaits them.

HIV-infected people, including their children often become anxious firstly because of the diagnosis, as they do not know what to expect next. They are also anxious, about the prognosis of the illness, the risk of infecting their loved ones, and the risk of infection with other opportunistic diseases. They also become more anxious as they become uncertain about how to keep as healthy as possible in the near future. Mostly, they become anxious about their declining ability to function efficiently and independently and about their loss of physical and financial independence (Van Dyk, 2003: 258).

Children at this stage may be more vulnerable, especially that they also need parental support and guidance of which at this stage, an ill parent may not be able to provide. The children are also anxious in terms of their future: should the parent die, where will they go and who will be taking care of them.

2.6.1.2 Loss

People infected or affected by HIV/AIDS, experience loss of control of their autonomy, dreams, physical attraction, sexual or intimate relationship status, and respect from the community, financial independence and stability (Van Dyk, 2003: 256). They further fear the loss of the ability to care for themselves or their loved ones. Most painfully, they fear the loss of their friends and relatives. For some people, a process of anticipatory loss begins almost at once. People infected or affected by HIV, including their children often feel that they have lost everything that is most important and beautiful to them. Children may be victims of child labour, prostitution and human-trafficking specifically to try and meet their financial need.

2.6.1.4 Grief

HIV infected and affected people endure profound feelings of grief about the losses they have experienced and those that they are anticipating. They grieve for their loved ones who have passed away, and for those who stay

behind and have to try and cope with the loss (Van Dyk, 2003:257). As someone who was grieving for his partner, who had died of AIDS, asked the researcher: "How am I going to survive without her? She was my source of strength." Counselling during this period, the researcher found, is mainly based on the fact that the affected person has to accept the loss, as that is considered to be the beginning of the healing process. The children also often wonder who the source of support is going to be. How are they going to make ends meet in terms of their material, financial and emotional needs now that the parent who used to be there for them is no more?

2.6.1.5 Denial

The stages, through which one passes upon experiencing loss, before one reaches an adaptation stage, are listed as follows: denial, anger, aggression, and bargaining (Van Dyk, 2003:257). Although this is true, the researcher finds it important to remember that these stages need not necessarily follow any particular order, as people's reactions to crises vary.

Individuals should be given the chance to deal with, or cling to their denial as long as they are not ready to accept their diagnosis, because denial is said to give them space to breathe, rest and gather their strength.

The researcher's opinion is that the very same denial can, however, make patients and affected people delay in taking proper care of them after being diagnosed, as they might still believe that the diagnosis is wrong, or that it will change with time. It is important that, even at this point in time, loved ones should provide support especially to children who may eventually be without a parent due to the illness.

2.6.1.6 Anger

People infected or affected by HIV, including their children are often very angry with themselves and others, and this anger is sometimes directed at the people who are closest to them. They are angry because there is no cure for AIDS and because of uncertainty of their future. They are often also angry with those who infected them and with society's reaction of hostility and

indifference (Van Dyk, 2003:257). This is moreover so with children, as they may be angry with the parent, wanting to know why he/she had allowed him/herself to be infected with HIV/AIDS.

2.6.1.7 Suicidal behaviour or thoughts

Social isolation due to immobility when the person's condition starts deteriorating manifests itself. At this stage, the patient's activity and involvement in his/her community or social circle decreases (Van Dyk, 2003: 258). The loss of the patient's role at work or home due to the deterioration of his/her health, in the researcher's opinion, may now lead to his/her dependency on the family, even in terms of decision-making. In general, the patient ends up being dissatisfied with life as a whole and may harbour suicidal thoughts that may be enacted upon if they are not noticed and dealt with therapeutically. According to the researcher the same applies to the children as they are likely feeling they are better off to also not live rather than dealing with the pain of loosing a parent.

2.6.1.8 Spiritual concerns

People often feel negative and depressed because they have assumed a negative attitude about the disease either before or after diagnosis (Finkelstein, 1993:31). The researcher agrees with Finkelstein, having noticed that the situation is aggravated by other people's attitudes and the fact that in most religious cultures the disease is associated with promiscuity. Lack of resources or access to resources compounds the problem, because this means that help is not available. It is then not uncommon for people to bargain with God – as one patient of researcher once said: "If God would only give me another chance – then I will reorganise my finances and my life as a whole, and I will preach His gospel"

It is the researcher's opinion that the impact of the HIV -AIDS pandemic affects the South African society in different spheres like the economy, health, and social services, and the demographic profile of the country. However, it also has some psychosocial implications for the infected person and those affected around them. The children in some instances, blame or even deny

the fact that God does care about them, as they would wonder why, He has allowed the death of their parent.

Hunter and Williamson (2000, 2002) have outlined the impacts on children, families and communities as follows:

TABLE 1: The potential impact of AIDS on children, families and communities.

Potential impact on children	**Potential impact on families and households**	**Potential impact on communities**
Loss of family and identity	Loss of members	Increased poverty
Depression	Grief	Reduced labour
Loss of health status	Dissolution	Inability to maintain infrastructure
Loss of educational opportunities	Stress	Reduced access to health care
Increased street living	Demoralisation	Psychological stress and breakdown
Exposure to HIV infection	Inability to provide parental care for children	Loss of skilled labour, including health workers and teachers
Homelessness	Lack of income for health care and education	
Loss of inheritance	Impoverishment	
Increased malnutrition and starvation		

Direct impacts of HIV/AIDS on children as highlighted by Richter, (2004 :9) occurs in the domains of material problems leading to poverty, food security, education and health, as well as non-material problems related to welfare, protection and emotional health as indicated below:

2.6.1.9 MATERIAL PROBLEMS

Direct impacts of HIV/AIDS on children occur in the domains of material problems affecting poverty, food security, education and health, as well as non-material problems related to welfare, protection and emotional health, Richter, *et al.,* (2004:9) as indicated below:

- **Livelihood**

Increased poverty

Loss of property

Loss of food security, especially in rural areas

Loss of shelter

- **Health**

Lower nutritional status

Less attention when sick

Less likely to be immunised

Increased vulnerability to disease

Less access to health services

The researcher concurs with the above author, as orphans may be additionally disadvantaged by their pre-existing low socio-economic status at the time of their parents' deaths as well as by their biological distance from breadwinner and decision makers in households in which they are placed.

Furthermore, orphans tend to live in poorer households than non-orphans. Orphans are less likely to attend school than non-orphans. However the scenario is not always the same. Children also require preventative health services such as access to treatment for the variety of ailments, injuries and infections to which children in marginal conditions are liable. Apart from poverty, children affected by HIV/AIDS are sometimes victims of stigmatisation that may prevent their access to health services Louw, (2003:92).

2.6.1.10 NON-MATERIAL PROBLEMS

According to Richter, *et al.,* (2004: 9) the following are considered as non-material problems for children orphaned by HIV/AIDS in middle childhood**.**

- Protection, welfare, emotional health

Decreased adult supervision

Decreased affection, encouragement

Increased labour demands
Harsh treatment
Stigma and social isolation
Grief and depression
Anti-social and difficult behaviour
Abandonment

The neglect, harsh treatment, labour exploitation and sexual abuse of orphans and other vulnerable children has been noted under the conditions where children are insufficiently protected. It is therefore imperative that that all stakeholders for example churches, volunteers and teachers are sensitised to abuse and made aware of referral options.

The Convention on the Rights of the Child as cited in Richter, *et al*, (2004:10) places a duty on government to protect children's rights. The impact of HIV/AIDS on families deprives children of any of their rights by removing them from parental care, separating them from family and possessions, and exposing them to abuse and exploitation.

In parts of Africa, children are traditionally the responsibility of the father's family. Especially when marriage rites have not been completed and when the kin are close, the father's family may seize the family's possessions when the father dies and leave the mother and the children without a home. This might occur when the mother dies. In this instance external agencies can help local community groups to understand inheritance rights and how they can be protected. It is important that the succession planning involves the extended family and a traditional leader to ensure that they will comply with the parents wishes Richter *et al*., (2004: 41).

It is widely agreed that the problems of HIV-affected children, families and communities overlap considerably with the problems associated with poverty. However, HIV and AIDS exacerbates these problems, partially because of stigmatisation and partly because multiple stressful events are repeated in affected families and communities.

2.7 THE IMPACT OF HIV/AIDS ON CHILDREN IN MIDDLE CHILDHOOD

The UN Joint Programme on HIV/AIDS (UNAIDS, 2005:34) defines an orphan as a child under the age of 18 years who has lost either a mother (maternal orphan), a father (paternal orphan), or both parents (a double orphan), to any cause. By this definition there were over 12.3 million children in sub- Saharan Africa orphaned by AIDS by the end of 2003. HIV/AIDS contributes to orphan hood primarily due to the premature death of mostly young biological parents. Thus it is estimated that by 2010 there will be 20 million children orphaned by AIDS in sub- Saharan Africa.

Affected significant others, including children, experience similar psychosocial feelings as the infected person, namely anxiety, depression, loss and anger (Van Dyk, 2001:260).

According to Love Life (2001:10-11) and Van Dyk (2001:260-261), the impact can be summarised as follows:

- Children suffer tremendously when parents are infected, and their needs are often neglected. In most instances the children are excluded from counselling sessions, because their significant others do not realise the importance of including them. Or in South Africa, there is no counselling due to poverty, ignorance, or even lack of skill in working with children during the grieving process.
- The reality is that the needs that the affected children experience, are often the same as those experienced by the infected person, as they also need acceptance, support, respect, love and care – to mention but a few of these needs.
- Affected individuals often feel furious with the infected person for the caring responsibility with which they are being burdened:
- There are misplaced family roles, as children who are not infected by the disease will be expected to head families at a stage in their lives when they should not have such a responsibility.

According to Louw, (2005:102), the possibility of exploitation, such as child labour, prostitution and child trafficking of vulnerable children by members of

the extended family or caregivers, is also very real. The researchers experience is that the decision to take a child is sometimes influenced by one's selfish motives, for example, how useful will a child be to the family and, what kind of labour and household duties can he/she perform in return for what amount of care?

Although the literature is divided on where and when HIV/AIDS originated, researchers do agree that its effects, affect South Africa as a whole and that a joint venture between Western and traditional cultures is the key to reducing the risk. The researcher holds the opinion that HIV and AIDS is real and that its effects on the individual, family, children and the community at large should never be underestimated. In summary, the impact of HIV and AIDS on children clearly leaves the welfare plight of the client and the caregiver in turmoil and devastation. According to the researcher, the social worker with experience in this field would intervene with exceptional skills to try and alleviate the trauma and crisis experienced by the client and the caregiver.

The following graphs show the reality of HIV/AIDS-related deaths, and the statistics give an indication of the number of children affected and orphaned by HIV/AIDS.

HIV/AIDS ORPHANS IN SOUTH AFRICA

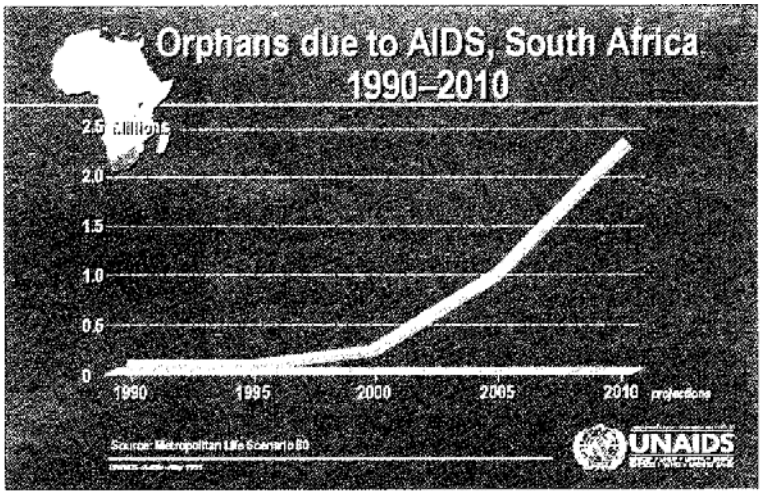


Figure 3:
Graph showing the number of orphans due to AIDS in South Africa and future predictions. 1990 - 2010[19]

(Gennerich, 2004:10)

2.8 THE ROLE OF THE SOCIAL WORKER

According to the researcher, the social worker has to help the HIV/AIDS affected and orphaned children gain new information or knowledge regarding the status, by giving information on the services available and helping the client to access the services.

The social worker has to address the client and the caregiver on what the impact of the disease may be and prepare them for what they are likely to be dealing with. Therefore, the social worker can offer counselling to the clients and their caregivers suffering or experiencing emotional problems. By treating the client in a humane way so that he can hold onto his/her integrity, the outcomes will be more positive. By just calling a person a client, the emphasis is shifted from less courtesy, rather call the client by name (Auslander, 1997:32).

According to Forrester, (2006:134-140), the following guidelines are applicable to clinical practice and are presented in an attempt to guide, inform, and equip the professional social work practitioner in dealing with children affected by HIV/AIDS pandemic:

2.8.1 Promote positive communication and provide information to/ among significant others

Care giving implies the acceptance of a high level of responsibility. Feelings of guilt, where the caregivers or children feel that more can be done for the patient, follows a natural consequence of accepting the responsibilities for providing care. The social worker has an important role in this context.

Knowledge about the resources to assist caregivers and children should be transferred by the social worker, while doubt and feelings of helplessness should be a primary focus of therapeutic intervention.

2.8.2 Involve significant others in care giving and in exploring the future.

Although effective communication within the terminal situation does appear to become easier over time, the social worker must bear in mind that not all

families are offered this opportunity due to the progress of the illness. Therefore, the social worker needs to accompany the family including the children in refocusing their thoughts on a brief future, where the present and its immediately available resources becomes the pivotal focus of their functioning.

2.8.3 Counsel and/ or refer the children

It is the on-going duty of a social worker to familiarise her/him with all sources of professional support in the environment of the family, and the children.

2.8.4 Monitor stress and discomfort as a means of sustaining the children

In terms of prognosis, and the offering of life expectancy statistics to the patient and family especially the children, the social worker needs to remain sensitive to the individuality of each terminal situation. The social worker also needs to create a fine balance between prognosis as an opportunity for children to make realistic adjustments, and prognosis which will impact negatively on the functioning of the family.

2.8.5 Reassure and provide emotional support to children and other care givers

Caregivers tend to compare the quality of their care with that of other caregivers, in the event of a negative evaluation by the caregiver; the need for reassurance in terms of the quality of their care giving in order to combat compounding feelings of guilt needs to be addressed by the social worker.

Reassurance in terms of providing care can also be enhanced by the social worker who becomes involved in the preparation of children and family members to care for the loved one. This implies a responsibility on the side of the social worker to become familiar with the demands posed by the situation.

2.9 SUMMARY

In this chapter the following was discussed: HIV, AIDS, psychosocial implication, and the role of a social worker**.**HIV/AIDS have a particular

disturbing clinical course and concurrent social implications. The illness creates amongst other, feelings of grief, anger and depression for the infected and affected person. HIV/AIDS is an illness of loss, with severe consequences for all affected family members. One specific group, namely children, appears to be particularly vulnerable because of the role changes and stigma.

In this manner, the professional needs of the entire system will be adequately addressed as opposed to focusing professionally on a single element or a number of single elements that form part of the support system of the terminally ill patient.

It is in this light that the researcher will discuss the middle childhood developmental phases in the next chapter in order to be able to fully understand the complex interplay between “normal middle childhood development and the needs very specific to the children orphaned by HIV/AIDS in middle childhood.

CHAPTER 3
THE DEVELOPMENTAL PHASE IN MIDDLE CHILDHOOD

3.1 INTRODUCTION

In this chapter, a general background on child development in middle childhood is discussed, followed by the child's needs during this stage. The child's understanding of death will also be discussed with regards to the needs of children orphaned by HIV/AIDS.

South Africa has a population of over 43 million people, approximately 36% are children (aged 0-14 years) 63% are working age (aged 15-64) and 5% are elderly (aged 65 and older). With the likelihood that 30-35% of all children might be orphans in Southern Africa by 2010, failure to support children to overcome trauma will have a negative impact on society and might cause dysfunctional societies, jeopardizing years of investment in national development (USAID, 2000).

The AIDS pandemic is regarded as the greatest social disaster in Africa since slavery (USAID, 2000). It is becoming increasingly important to look at the long-term impact of Aids on the economic, social and the psychological factors of countries and individuals. One of the key factors regarding the long-term impact is psychological and mental health of children who have nursed and lost their parents under traumatic conditions due to AIDS. The focus, therefore, in this chapter is children in middle childhood.

Middle childhood is the developmental stage between the age of six and twelve years. Freud refers to this developmental stage as the psychosexual stage; a child in this age group according to Freud's theory is concerned with learning the appropriate sex role identity. Erickson refers to the stage as the period of industry versus inferiority (Louw, Schoeman, Van Ede & Wait, 1996:325). According to Erickson (compare Moore & Viljoen, 1994:169 and Benokraitis, 1999:302) this period of Industry versus Inferiority stretches from

the age of six to approximately twelve years. Erickson is of the opinion that if this stage is not completed successfully; the child may develop feelings of inferiority.

3.2 DEFINITION

3.2.1 MIDDLE CHILDHOOD

The researcher defines middle childhood as a stage that involves physical, behavioural, cognitive and emotional development. A child in middle childhood would, therefore, be between the age of six and twelve years. During this stage, the child must develop feelings of industry in order for the child to successfully transfer to the next developmental stage.

Developmental tasks are the things a person must learn if he or she is to be judged or in order to judge him or herself in order to be a reasonably successful person (Thomas, 1992:78). Middle childhood is characterised by three significant outward drive and growth motions, namely: social movement outward from the family towards the peer group; the physical movement towards a world of play and labour, and the psychic movement towards a world with adult concept, logic, symbolism and communication (Bender 2000:33).

The following developmental tasks are mentioned as the ones which the child in middle childhood needs to complete:

- Establish a sense of Industry versus Inferiority.
- Further development of the fine motor skills and other physical skills that are necessary for basic play.
- The development of a positive self- concept
- The child must develop skills aiming to maintain a healthy relationship with her/his contemporaries and the art of give and take relationships.
- The child must learn how to fulfill the masculine or feminine role in an applicable manner.
- The child must acquire the basic skills that are expected from school, for example reading, and writing.

The developmental tasks of the child in middle childhood can be summarised as follows: the child needs to gain skills in order for her/him to function independently, be it at school or in the family environment.

In the following section, a brief description of a child in middle childhood will be given, with reference to the physical, cognitive, moral, emotional, social, and personality development, as well as what the family's role is in middle childhood.

3.2.2 MORAL DEVELOPMENT

Moral development refers to the process whereby one learns the principles which enable him or her to determine which behaviour is right and which is wrong, and to direct one's behaviour according to these principles (Van der Zanden, in Louw, 2005:357). Piaget and Kohlberg believe that a child's cognitive development is an important factor in the development of a child's moral comprehension. Kohlberg is of the opinion that moral development from the age of five years until maturity develops in three phases, namely the pre-conventional, conventional and post conventional levels. Each of these levels has two stages (Louw, Schoeman, Van Ede & Wait, 1996:360). According to Bender (2000:31) the pre-conventional level develops during middle childhood.

During this level, the child decides whether an action is right or wrong on the basis of punishment or reward: that is, if the child is rewarded then whatever she has done is right, and if the action is punished then it means she has done wrong. During this stage a child will then obey authority to avoid punishment. During stage two a child will conform to rules in order to obtain reward or to satisfy personal needs.

The child becomes aware of the fact that people can hold different opinions regarding moral dilemmas. A child will further obey rules if it is for the benefit of others, for the children it is therefore right to behave according to own gain. The primary goal of obedience is to obtain a reward and to relieve own

desires (Louw, Schoeman, Van Ede & Wait, 1996:361; and Bender, 2000:31-33).

In summary it is clear that during middle childhood the child develops principles, which direct the child's behaviour in what is right or wrong. According to (Bender 2000:31) pre-conventional level is defined as the stage where the child decides whether an action is right or wrong on the basis of punishment or reward. During the first phase of pre-conventional level a child's consideration of whether an act is right or wrong is based on whether or not the behaviour or action is rewarded or punished. During the second phase of pre-conventional level a child will conform to rules in order to obtain rewards to satisfy personal needs. Therefore a child who is an orphan will then be deprived of this golden opportunity as there would be no parent to instill the value of choosing or knowing what is right or wrong.

3.2.3 EMOTIONAL DEVELOPMENT

The child's emotions are triggered more easily and react with rage, intense fear and unreasonable jealous outbursts. Rage is the emotion that manifests most often in a child in middle childhood. As they progress through middle childhood a strong motivation to control emotions develops. The desire to be accepted by others encourages the child to control his or her emotions (Louw, Schoeman, Van Ede & Wait, 1996:363 and Bender, 2000:36). Concrete fears decline during middle childhood, but fear of the unknown, the unnatural and the imaginary increases. The child is also afraid to be different from others, to be a failure and not to be accepted by others. At the end of middle childhood the child is able to control his or her emotions. The motion behind this is for him or her to be accepted by others. It is commonly believed that children can easily express their emotions around their parental environment; therefore an orphan will withhold the realistic emotions as they may not feel secured.

3.2.4 SOCIAL DEVELOPMENT

The child in middle childhood increasingly spends her or his time away from the family and as a result she or he will encounter more social learning experiences in his or her relationships with other people. One of the most

important social groups in middle childhood is that of the peer group. The child at this stage is more likely to interact with children of the same sex and age (Louw, Schoeman, Van Ede & Wait, 1996:377-379).

According to Dacey and Travis (1994:269), children in middle childhood search for friends who are psychologically compatible. The peer-group also plays an important role during the child's development and serves the following functions:

- It provides companionships.
- It provides the opportunity for new behaviour.
- It transfers knowledge information
- It helps the child to learn rules and regulations
- It strengthens sex-role differences.
- It causes the emotional bond with his parents to weaken.

This is a necessary step even to an orphan, as it will enable the child to separate from his parents during late adolescence and early adulthood.
It provides the experiences whereby the child must compete with others in a relationship on an equal level (Louw, Schoeman, Van Ede & Wait, 1996:377-379).
Friendship in middle childhood develops in four different phases, namely:

- A friend is someone who does what one asks him or her to do (4-9 years).
- A friend is seen as someone that can help one (6-12 years).

Friendship is seen as something more than as just someone who keeps someone else's secretes, and problems are shared (9-15 years); children respect their friends' needs for dependence and autonomy. They still lean on one another for emotional support, but are not as possessive (Louw, Schoeman, Van Ede & Wait, 1996:383).

In summary peer groups serve important functions for socialization experiences. The child in middle childhood spends increasingly more time away from the family. One of the most important social groups in middle childhood is that of the peer group. The peer group also plays an important

role in the child's development and serves various functions even more so in the case of orphans

3.2.5 COGNITIVE DEVELOPMENT

The typical child in this developmental stage, according to Louw, Schoeman, Van Ede & Wait (1996:330), will spend most of the day in school and therefore improvement of the cognitive skills can be expected. Cognitive development during middle childhood, according to Cunningham (1993:198), is marked by a reduction in the problems related to thinking found in the pre-school era.

Piaget calls this period the Concrete Operational Period, because although the child does have concrete thoughts, he cannot think abstractly. At this point the child's brain has matured sufficiently and she/he has had the environmental experiences needed to understand how the world works, without making the cognitive errors that are present in the earlier stages. At this stage the child can understand and use certain principles or relationships between events and things. (Compare Cunningham, 1993:199: Louw, Schoeman, Van Ede & Wait, 1996:341 and Bigner, 1999:322).

The characteristics of the concrete operational period are the following (Compare Cunningham, 1993:199-201: Louw, Schoeman, Van Ede & Wait, 1996:331-340 and Bigner, 1999:27)

- Logical thoughts and insight in transformation: A child does not only concentrate on the end result of the transformation, but considers the nature of the transformation.
- Decline in egocentrism: A child can see someone else's perspective, because he is able to place himself in the shoes of the other person.
- Decentralization: A child can consider a variety of aspects of a situation simultaneously. He therefore does not concentrate on one specific aspect of a case.
- Concept of reason: A child does not confuse the meaning of cause and consequence, and realizes that certain events can happen accidentally.

- Realism: A child can differentiate between psychic and the physical, as well as between what is internal and what is external.
- Classification: A child is able to think of the whole as well as the different parts of the whole.
- Syncretism and juxtaposition: Between the ages of seven and eight years syncretism is (a term that is used to refer to ideas or facts that are combined in a confusing whole) is found more in the use of the child's language as in their reasoning. Juxtaposition (facts that have no connection towards one anther) is still found in the child's language use, especially in the use of the word "because".
- Number comprehension the child realizes that numbers can be combined through adding and multiplying and that the whole can be defined though subtraction and division.
- Classification: A child is able to think of the whole as well as the different parts of whole.
- Conservation this means that the child is able to understand that quantitative connection between things remains the same, even if there is perceptual change that might take place.
- Series creation the child can arrange objects from small to big.

In summary for the child in middle childhood the above- mentioned characteristics are needed for the child to successfully complete primary school. It is therefore important for each child to complete the above-mentioned developmental process irrespective of whether the child is an orphan or has parents.

3.2.6 PERSONALITY DEVELOPMENT

According to Neuman and Neuman (in Louw, Schoeman, Van Ede & Wait, 1996:387) middle childhood is the most critical period for the development of self-concept. During this developmental stage, children develop a concept of how they are and how they want to be. Thus the child in this stage does not only describe herself/himself in terms of what he is able to do, but also how well can she/he master the task.

The self-concept of a child is influenced by the manner in which he can regulate his behaviour. It is therefore important that the child develops trust in him/her, so that personal and society's expectations can be met (Louw, Schoeman, Van Ede & Wait, 1996: 388). The characteristic of a child with a positive self-concept is described as follows (Geldard & Geldard, 1997: 169):

- Children at this stage have a creative component;
- They accept active roles in the social group with ease;
- They have less of a burden relating to feelings of self regret, anxiety and ambivalence;
- They move more realistically and directly towards achieving personal goals;
- Differences between one's own levels of ability and others are more easily accepted. The positive self concept for a child who is an orphan may be affected.

In summary, self- concept develops during the middle childhood and it is at this stage where children develop a concept of how they want to be. The children at this stage do not only describe themselves in terms of what they can do, but also how they can do an activity.

3.3 THE ROLE OF THE FAMILY IN MIDDLE CHILDHOOD

During the developmental stages of a child from infant to toddler to preschool age, the parent's role changes from that of a caregiver to the one of a protector. It further continues to that of a nurturer and an encourager. Both parents and children play a crucial role in the resolution of psychological crises, and the behaviour of one member continues to influence the behaviour of another (Hanner & Turner, 1996: 72 and Bigner, 1999: 326).

According to Carter & McGoldrick (1999: 514), the stage in the life cycle that is particularly challenging is that of family with young children. The reasons for this being that with the birth of the first child, a profound realignment of family relationships occur. The parents face a huge challenge, as they attempt to adjust to their new roles of being mother and father.

The family, therefore, plays an important role in middle childhood. The family has specific tasks that they need to perform in order to help the child in middle childhood to successfully complete the middle childhood development stage. In the case of orphans, the foster parents play this role and the reality is that it impacts on these children, as they also have to learn to adjust in a new parental setting.

3.3.1 FAMILY TASKS IN MIDDLE CHILDHOOD

The family also has certain developmental tasks that need to be accomplished, namely:

- Providing for children's activities and parent's privacy.
- Keeping the family system solvent
- Continue to maintain an effective degree of marriage satisfaction between adult partners.
- Connect with others in the community beyond the family system
- Encourage effective communication among the family members.
- Enforce and maintain cooperation among family members to accomplish tasks.
- The family is also responsible for stimulating the child's development. That means the child must be able to consistently complete activities on her/his own.
- The family also encourages the child to socialize; the family involvement in the child's school, sport and church activities instills this socializing value.
- The family needs to encourage the child in education, for example to study, use language correctly and also to provide the child with activities that stimulates mental growth (compare Pretorius in Bigner, 1999:344; Benokraitis, 1999: 5 and Bender, 2000:38-39).

In summary, the researcher believes that the family has an enormous responsibility in ensuring that the child completes his/her middle childhood stage successfully. Whereas a child who is an orphan all these beneficial activities may not be catered for.

3.3.2 DEVELOPMENTAL TASKS OF SIBLINGS IN MIDDLE CHILDHOOD

During middle childhood, particularly daughters, contribute to the care of younger children. This is especially in large families, single-parent families and low-income families (Hammer & Turner, 1996:73 and Carter & McGoldrick, 1999:166). Furthermore, Hammer & Turner, (1996: 73) states that siblings primary role throughout their life is to provide companionship and emotional support.

The child in middle childhood can play an important role in the family towards his/her siblings, especially in times of need but the child is an orphan the situation may be different as there would also be inadequate parental care.

3.4 CHILDREN'S UNDERSTANDING OF DEATH

According to Lendrum & Syme (1992:64) magical thinking begins to diminish at 8-12 years as the child now understands and is more orientated towards the future. The child, therefore, has the cognitive ability to realise what loss will mean to him. The death of, or separation from a parent, threatens the child and can evoke feelings of childishness and helplessness. Therefore loss of a parent has profound significance for a child (compare Lendrum & Syme 1992:64 and Sheidman, 1998:225). The death of a mother, in particular, has dramatic psychosocial consequences. Children lose love and nurturing, and their household may break up, with siblings sent to live with different members of extended family members. Loss of a father often means the loss of income and results in economic deprivation. When a father dies of AIDS, the children often lose their mother as well, to illness or for social reasons like re-marriage) Hunter and Williamson, 2002:2).

Furthermore, Hunter and Williamson (2002:3) are of the opinion that the growing number of orphans will have a profound impact on the societies in which they live. Orphans may suffer the loss of their families, depression, and malnutrition, lack of health care, increased demands for labour, lack of schooling, homelessness, starvation and crime. Orphans eventually comprise up to a third of the population under the age of 15 in some countries. Thus the

outgrowth of the HIV/AIDS pandemic may therefore, create a lost generation, an under- educated and a less than healthy youth.

The following, however, became clear from the available research: Smart, *et al*. (2003:33) indicate that affected children are vulnerable to malnutrition, both due to scarcity of food and to the weak position they occupy within their guardian homes. This is equally true for the educational needs, like books, school fees, and uniforms. The researcher is of the opinion that the HIV/AIDS pandemic creates a number of social problems, and poverty resulting from the devastation. Orphans are less likely to have proper schooling.

According to Lendrum & Syme (1992:64) and Lewis, 1999:152) it is at this stage of development too that children come to recognize the possibility of their own death. This identification with death may make the subject particularly frightening for them. This probably intensifies the tendency towards denial, and it may be necessary to be quite firm with this age group to give them the opportunity to share feelings, longings (including their memories) with others. According to Papadatous & Papadatous (1991:18) children in this developmental stage are interested in objective observation, in concrete physical and mechanical aspects of things and processes, and laws that describe them.

By this age, they clearly understand death as the cessation of functions. They would for example answer question “What happens when people die? As follows, “When people die they stop living. The heart stops beating, the brain and everything stops working.” They are interested in the distasteful details of death and post mortem physical changes that adults don’t like to think about. They can understand death as a result of inner process such as disease and old age. Their interest may start to focus on the processes of dying and decomposition and the cause of death (Dyregrov, 1991:11).

Demmer (2004:40) is of the opinion that affected members are at risk of prolonged grief and psychiatric problems as they mourn an AIDS death. However, there is very limited research conducted in Sub-Saharan Africa on

psychological issues in general and related to HIV/AIDS in particular. In addition, research suggests that existing psychometric tools, mainly developed in Europe or USA, should not be used in culturally different settings, as results cannot be validated (German, 2004:2,19). The researcher's opinion is that it is imperative that children between the ages of 6–12 years be under parental guidance to complete the middle childhood developmental process effectively, for it is in this stage that they need emotional, material and social support in crisis times.

3.4.1 THE GRIEVING PROCESS

Grief refers to the emotional component of the bereavement process and includes specific emotions and behaviours in response to the loss, such as depression, loneliness, yearning and searching for the deceased (Goodkin *et al.,* in Demmer, 2004:40).

- The researcher believes that this is a universal and normal response to loss and it affects all aspects of an individual's life: physical, cognitive, spiritual, emotional and behavioural. Nonetheless grief is an individualized experience and is influenced by a number of factors, including its context and concurrent stressors. A bereaved child needs: information, companionship, emotional expression and more specifically they need:
- Clear information on the cause of death. Without it, they will fill the blanks with their own information/imagination;
- The child needs re-assurance that she/he did not cause the death.
- To know that they will be taken care of;
- They also need an adult they trust to model what you do when you loose someone through death. They need to be talked through the process, prepared for what happens next;
- They need someone to listen to their fears, concerns, questions; to respect it and answer them with honesty;
- To be involved with the funeral.

In the unique situation of a loss due to AIDS, survivors are at increased risk of complicated bereavement. Research has indicated that individuals who grieve an AIDS death confront a lot of issues that may complicate the grieving process; including the nature of the disease, the HIV status of the bereaved,

multiple losses and inadequate support due to the social stigma associated with AIDS (Maasen, 1998 in Demmer, 2004:40).

Smart *et al.* (2001:93) and Van Dyk (2003:257) also describe the difficulties AIDS orphans may experience in the grieving process. Most of the children struggle to come to terms with the reality of being orphaned and feel loss of parental attention and physical and social security. The normal grieving process is complicated by guilt of children who were unable to save their parents. Behavioural problems may result from this situation. Furthermore, necessary support for a child's mourning can be lacking, especially when it is the child's mother who died. When the child's caregiver is struggling with grief over losing a spouse or when well-established patterns of family secrecy do not allow open communication of the child's feelings of loss more problems come up (Geballe & Gruendel, 1995:54). Even more so in children's home they have to establish new relationships.

The stages through which one passes before an adaptation stage are listed as follows: denial, anger, aggression and bargaining (Kübler-Ross, 1970). It is therefore important to realize that these factors are applicable to children orphaned by HIV/AIDS in middle childhood. The researcher is of the opinion that the grieving stages or phases need not follow the stipulated order as individuals reactions to crises differ. Once the orphaned child reaches the adaptation phase this does not mean he/she will remain there. The support of the significant others is well documented as an essential aspect in the child's life (Sands, Hudson & Clark, 2000:344).

The role of the social worker in this field would be to intervene with exceptional skills to try and alleviate the trauma and crisis experienced by the child and the significant others. The social workers role would then include the following intervention skills:

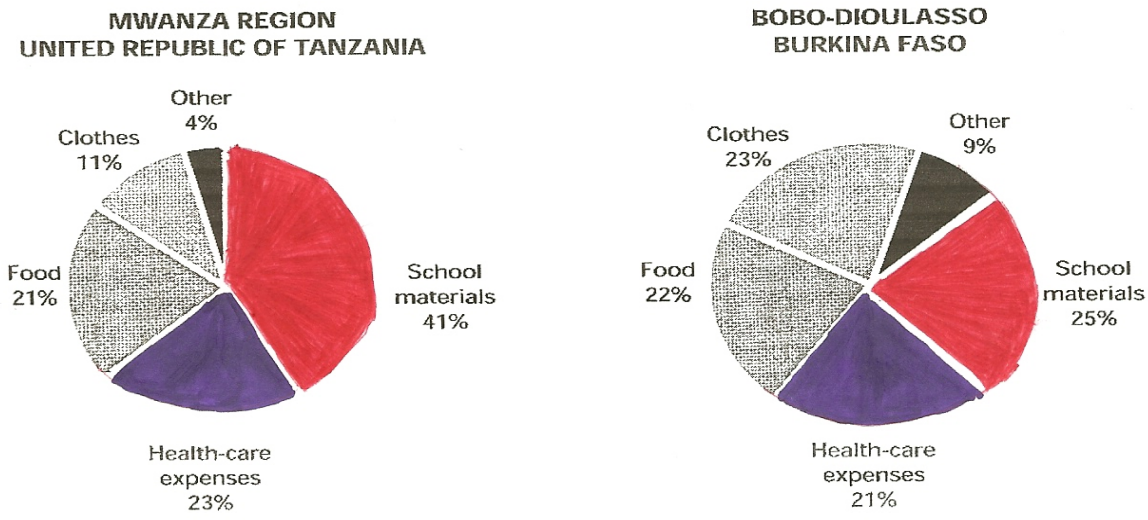
- As a counselor, she/he can render therapeutic service to the child. The literature has clearly indicated the burden felt by children orphaned by HIV/AIDS in middle childhood. For example, they may experience financial difficulties, physical health deterioration and disruption of daily

routine. In this case, the social worker would be to provide an ongoing support.

- ❖ As a liaison officer, in a case where the elder child has to look after her/his siblings, the social worker may link the child or the significant others with community resources that can provide an alternative care.
- ❖ The social worker as an encourager: Lombard (1992:185) says final removal from home, a familiar physical environment and routine can be as traumatizing as a loss of a significant relationship. Daily routines, such as taking a walk or doing homework will become affected, and this result in an increased problem of loneliness and isolation. The social worker may encourage the child and help him/her to adjust in the new environment. The social worker is therefore seen as playing a central role in the care of children orphaned by HIV/AIDS in middle childhood.

Middle childhood is s period in which physical, sexual, psychological and cognitive, combine with changes in social demands. Family, friends and parents, play a major role in the successful achievement of middle childhood developmental tasks. It became clear that at this stage children need guidance and reassurance. Premature withdrawal or loss of this parental or family support will cause stress in the life of a child in middle childhood stage. Furthermore, this chapter clearly indicated that, the absence of a parental figure, grief and abnormal stress would present a major obstacle in the life of a child orphaned by HIV/AIDS in middle childhood.

In summary, children affected by HIV/AIDS in their families exhibit behavioural actions signaling the need for mental health and social support. Whether households with orphans will be able to meet basic needs depends on their circumstances. Some families may still have sufficient income to cope; the extended family or community may support others. But a large and increasing share of families is impoverished to the point where basic needs go unmet. The most common unmet needs are education, food, medical care and clothes. Attached are the results indicating some of the needs of HIV/AIDS orphans in middle childhood, followed by the empirical findings in chapter 4.



Source: Whitehouse, A., *A situation analysis of orphans and other vulnerable children in Mwanza Region, Tanzania*, Dar-es-Salaam, Catholic Relief Services, Dar es Salaam, and Kivulini Women's Rights Organisation, Mwanza, Tanzania, 2002; *Needs Assessment of Orphans and Vulnerable Children in AIDS affected areas, in Bobo-Dioulasso, Burkina Faso*, Axios, 2001.

In summary, chapter 3 covered the developmental phases in middle childhood, the role of the family in middle childhood development and the understanding of death and grieving process.

In conclusion, it is evident based on the above findings that children orphaned by HIV/AIDS in middle childhood are not exempted to the basic needs on life.

CHAPTER 4

EMPIRICAL STUDY, DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

Data analysis and interpretation entails breaking down data into constituent parts to obtain answers to research questions, to test assumptions and to draw conclusions (De Vos, 1998:86). The purpose of this study is to explore the needs of children orphaned by HIV/AIDS in middle childhood. In chapter one of this research report, the researcher explained the relevance of the topic as well the research methodology which would be implemented. Chapter two dealt with HIV/AIDS as social phenomena. The middle childhood developmental stages and the impact of HIV/AIDS during this phase were discussed in chapter three.

In this chapter the research findings will be presented and analysed. The data was collected during interviews conducted in Potchefstroom, which were tape recorded and transcribed. The findings will be presented using common themes and sub themes which the researcher interpreted from the findings and direct quotes from the interviews will be used and discussed and then substantiated with the relevant literature.

The **goal** of this study was to explore the needs of children orphaned by HIV/AIDS in middle childhood

THE OBJECTIVES OF THE STUDY WERE AS FOLLOWS:

- To describe the phenomenon of HIV/AIDS
- To describe the phenomenon of children in middle childhood affected by HIV/AIDS in South Africa
- To explore the specific needs of children in middle childhood orphaned by HIV/AIDS by means of an empirical study

To make recommendations for professionals and non-professionals intervening with children in middle childhood orphaned by HIV/AIDS in South Africa

4.2 RESEARCH METHODOLOGY

A phenomenological strategy was used to conduct the research. Cresswell (In De Vos, 2002:273) regards a phenomenological study as one that describes the meaning; experiences of a phenomenon, topic or concept have for various individuals. The experiences of the participants were reduced to a central meaning of their needs. The product of the research is an exploration of the needs of children orphaned by HIV/AIDS in middle childhood. The researcher undertook applied research, as one of the objectives of the study is to improve service delivery. In the data collection process, the participants were interviewed and these interviews were tape recorded. In this chapter, some quotes from the transcribed interviews will be reflected. Themes that were striking were taken from these transcribed interviews and were grouped into common themes.

4.2.1 DATA COLLECTION

The empirical study was carried out through conducting personal interviews with ten respondents, according to a semi-structured interview schedule during April 2007 at Potchefstroom Child Welfare South Africa, using the qualitative research approach. The goal of this research was not to determine the quantity of the needs of children orphaned by HIV/AIDS in middle childhood, but what the specific needs are of children orphaned by HIV/AIDS in middle childhood, which makes a qualitative approach more valuable. The researcher was responsible for the interviews and did not make use of any research assistant to interview respondents.

The researcher utilised applied research with an exploratory design to conduct the study. The researcher used non-probability purposive sampling to select a sample of ten respondents through the appointment set with them prior to the actual interview at Potchefstroom Child Welfare South Africa. The respondents had to meet the following criteria:

- Aged between 6 to12 years old.
- Either gender- boys or girls.
- One or both of their parents must have died of HIV/AIDS a year prior to the research being conducted.

- Participant and circumstances of the family must be known to the social worker in Potchefstroom Child and Welfare Society offices.
- Willingness to participate.
- Ability to understand English, Afrikaans or Setswana.

Interviews were conducted in English and Setswana and one in Afrikaans. An interpreter was utilized to ensure the quality of translations. On completion of this process, data analysis commenced. Interviews were conducted in Potchefstroom in April 2007. These interviews were recorded and the data was then transcribed into English. It is important to note the context in which the interviews took place. The participants were relaxed, as they were introduced to the researcher by their social worker prior to the actual interviews. The time taken per interview varied from one participant to the other.

4.2.2 DATA ANALYSIS

According to De Vos (1998:48), data analysis follows after data collection. Mabutho (2004:28) defines data analysis as a search for a pattern in recurrent behaviors or objects of a body of knowledge. Once a pattern is identified, it is interpreted in terms of social theory or the setting in which it occurred. According to Alpaslan and Mabutho (2005:285), data analysis should include examining; categorising, tabulating or otherwise recombining the evidence to address the research question. Data analysis is, therefore, a process of bringing order, structure and interpretation to the mass of data collected. The researcher conducted interviews, recorded the interviews, transcribed these interviews and then identified themes and quotes. For the purpose of this discussion, the researcher will identify respondents by numbers for the respondents to maintain anonymity and confidentiality. However, where applicable, exact quotes obtained during the interview are stated verbatim.

4.3 PRESENTATION OF RESEARCH FINDINGS

The empirical data gathered during interviews was tape recorded and transcribed. The transcribed notes were analysed and themes were identified. The findings of the study are presented in the following order:

- The Demographic profile of the research participants,
- A presentation of observed emotions, individual responses and themes. These emotions and themes will be discussed and will include the verbatim quotes from research interviews.

4.3.1 BIOGRAPHICAL DATA

The following table presents the findings of the study according to the following outline:

- Key to the abbreviations used in the table.
- A biographic profile of the participants.
- Individual verbatim responses of respondents, as well as
- Observed emotions
- The themes that emerge from the process of data analysis. These themes are discussed followed by relevant literature.

TABLE 1: Biographical data

Respondents	Age	Gender	Guardianship	Schooling	Parental status
Respondent 1	9	M	F/C	Gr4	Mother deceased (2006)
Respondent 2	12	F	F/C	Gr7	Mother deceased (2006)
Respondent 3	6	M	F/C	GrR	Mother deceased (2006)
Respondent 4	12	F	F/C	Gr6	Mother deceased (2006)
Respondent 5	10	F	F/C	Gr4	Mother deceased (2006)
Respondent 6	8	M	F/C	Gr3	Mother and father deceased (2006)
Respondent 7	11	M	F/C	Gr5	Mother deceased (2006)
Respondent 8	10	M	F/C	Gr5	Mother deceased (2006)
Respondent 9	9	F	F/C	Gr4	Mother deceased (2006)
Respondent 10	8	F	C/H	Gr3	Mother deceased (2006)

Key for the abbreviations in the table.

M-Males

F-Females

F/C- Foster care placement

C/H- Children's home

Gr – School grades

4.3.1.1 AGE

The ten respondents ranged between 6 and 12 years and were all from Potchefstroom. All the respondents were African children, a combination of girls and boys and could all speak and understand Setswana and limited English, and one could speak Afrikaans. Thus the main language used for interviews was Setswana. Children between 4 and 6 years, according to Geballe & Gruendel, (1995:54), exhibit excessive dependency and clinging behaviour and marked oppositional behaviour is another result. Anxious attachment may interfere with the child's ability to form and sustain relationships with peers and adults increased anxiety may present as regression, like thumb-sucking, baby-speech, wetting and soiling.

By school-going age, which is from 6 years, the child in the HIV affected family may also have been exposed to further stress, like serious illness of parents or relatives and the death of a sibling. This may lead to further erosion of self esteem, increasing depression, and this may lead to difficulties in keeping up in school. Oppositional and disruptive behaviour may follow the failure to resolve emotions and fears (Geballe & Gruendel, 1995:57).

THEMES

The following themes emerged from the biographic data and the verbatim responses from the semi-structured interview schedule. Several sub-themes formed part of these themes. Below is the discussion on themes and sub-themes.

4.3.1.2 EDUCATIONAL LEVEL OF RESPONDENTS

Education and knowledge, or rather the lack thereof, have been identified as important factors in HIV/AIDS education. The researcher has also identified educational level as an important factor in understanding the pandemic, especially with children. Thus the intention was to establish the educational level of the respondents, because insight into this complicated disease is the key. Since South Africa is a developing country, the assumption exists that the profile of people with HIV/AIDS is linked to low education or lack of literacy.

Respondent's educational profile

Respondents	Level of education
1 respondent	Pre-primary (grade R)
7 respondents	Primary school (grade 3-5)
2 respondents	Senior Primary school (grade 6 and 7)

The above research results reveal that the majority of respondents in the sample could be regarded as primary school children. According to Richter *et al*., (2004:13) children will be affected in different ways depending on their age as it determines their level of understanding on various aspects. The above information reflected that the age, knowledge and the level of education go hand in hand, therefore the assumption that the profile of people with HIV/AIDS is linked to low education or lack of literacy is questionable.

Theme 2: Education influences the respondents' level of understanding regarding HIV/AIDS matters.

Sub-theme:

Education and knowledge plays a key role when dealing with HIV/AIDS matters.

The above research findings are supported by the following literature:

The respondents were subjected to limited HIV/AIDS education, especially since their caregivers did not consider informing them regarding their parents' cause of death. Abdool Karim & Abdool Karim (2005:268) corroborates this view on HIV/AIDS and education: "Widespread education and associated high levels of knowledge have done little so far to contribute to a decline in HIV prevalence."

The view of the researcher is that it is not the level of literacy, but rather, the lack of HIV education, training, and counselling by experienced counsellors, as well as the cultural beliefs that are upheld by certain ethnic groups.

4.3.1.3 HOME SETTING

The intention of the researcher was to establish whether respondents were living in rural or urban areas. The home setting of each respondent is as follows:

Respondent 1 is a 9 year old boy, living in Sarafina informal settlement in Potchefstroom. He is the second eldest of three. The children are in the foster care of their aunt. His eldest sister is 15 years old and the younger is 6 years old. Their mother passed away in 2006. The children are currently all attending school and respondent 1 is in grade four. He was casually dressed and appeared to be confident and he spoke English during the interview.

Respondent 2 is a 12 year old girl in grade 7, living in Potchehstroom. She is the eldest in a family of two. They are in the foster care of their maternal aunt and her younger sister is 8 years old. Her mother passed away in 2006.

Respondent 3 is a 6 year old boy, living in Potchefstroom. He is in the foster care of his maternal grandparents. His mother passed away in 2006. Currently he is in grade R.

Respondent 4 is a 12 year old girl, residing in Arksie Park, an informal settlement in Potchefstroom. She is residing with her sister and she enjoys staying with her, as she cooks for them. Her mother passed away in 2006.

Respondent 5 is a 10 year old girl residing with the grandmother in Promosa, which is a location in Potchefstroom. She is in grade 4 and often misses her mother, her grandmother always comforts her. Her mother passed away in 2006.

Respondent 6 is an 8 year old boy in grade 3. He resides with his maternal grandmother at Sonderwater, an informal settlement in Potchefstroom. His parents passed away in 2006.

Respondent 7 is an 11 year old boy in grade 5 and he resides with his grandparents in Ikageng, which is a location in Potchefstroom. His mother passed away in 2006.

Respondent 8 is a 10 year old boy in grade 5; he is staying with her elder sister in Sonderwater an informal settlement in Potchefstroom. His mother passed away in 2006.

Respondent 9 is a 9 year old girl in grade 3 and she resides with her grandmother at Promosa which is a location in Potchefstroom. Her mother passed away in 2006.

Respondent 10 is an 8 year old girl in grade 2, she resides in a children's home in Potchefstroom her mother passed away in 2006.

Distribution regarding informal settlement, urban and rural area

Informal settlement	**Semi-rural and urban**
4 respondents	5 respondents; 1 urban

n=10

The above table indicates that the majority of respondents reside in a semi-rural area, i.e. 6 respondents. Households in rural and urban areas face different challenges. Rural areas tend be poorer, with fewer working-age adults as compared to urban households. Children in rural areas carry a substantial burden of subsistence activities. In informal urban areas, social networks are less developed and less supportive, caregivers are frequently absent as a result of livelihood activities, and this leaves children less protected, Richter *et al.,* (2004:13). In view of the above information the following theme and sub-theme emerged:

Theme:

- Residential area influences knowledge and education regarding HIV/AIDS matters.

Sub-themes:

- Rural people or residents of informal settlements have fewer chances of accessing information, let alone understanding the information.
- Urban and semi-urban people have better chances in accessing information on health matters.

The above research findings are supported by the following literature:

The researcher concurs with Frohlich in Abdool Karim (2005:351) that HIV/AIDS, coupled with urbanization, has a major impact on individuals and community structures, such as the family. Traditionally, the family has been the fundamental unit of any society, but as the epidemic progresses, this structure is steadily being eroded. One of the most obvious changes has been the increase in single-parent households. The researcher has experienced, within her working environment, which HIV infection presents a medical and psychosocial crisis of unparalleled proportions for the majority of infected and affected.

In chapter one, the researcher defined the term orphan as a child between 0 and 18 years, following the death of his or her primary caregiver, or after the death of one parent or both parents. All participants were orphans, and therefore suitable according to this research selection criteria. Strode and Grant (2001:13) mentioned that the extended family structure is a primary support mechanism in African societies: a social safety net for children. The table indicates that all except one of the respondents were in foster care placement. This respondent was placed in a children's home. All of the respondents had lost a mother in the past year, while the fathers did not play a role in their lives or had died. Some of the children knew the cause of death, while others were never informed by their significant others. All participants were at school and all the respondents were receiving financial assistance

either in a form of child support, foster care grant or children's home subsidy from the South African government.

The researcher is of the opinion that orphaned children experienced their current environment as supportive. Current caregivers are the most trusted sources of support. **The following quote reflects the above**:

Respondent 1 is a 9 year old boy living in Sarafina informal settlement in Potchefstroom. He is the second eldest of three. The children are in the foster care of their aunt his eldest sister is 15 years old and the younger is six years old. His mother passed away in 2006. The children are currently all at school and respondent 1 is in grade four. He was casually dressed and appeared to be confident and he participated in an English interview. The researcher is of the opinion that this is the reflection of support obtained by the children from their current caregiver.

4.3.2.1 Sub-theme: RELATIVES AS A SOURCE OF SUPPORT

The following verbatim quotes relating to the children's source of support confirmed the researcher's opinion.

Respondent 1: 'I am staying with my maternal grandmother, my two aunts and their two children and my younger brother. My mother passed away in January 2006 my grandmother said she had HIV and I don't know who my father is'.

Respondent 2: "'I am staying with my aunt and I love staying with her she is so helpful"'.

Respondent 3: "I was staying with my grandparents, but because they could not afford looking after me I am now at the children's home, but I frequently do visit them as I like spending time with them. My grandmother loves story telling and I enjoy listening to her. When I cry, she hugs me".

Respondents 3 and 4: “We are staying with our sister; we love her, she cooks, washes and looks after us.”

Respondent 5: “I am staying with my grandmother and I miss my mother, I often feel sad and when I cry my grandmother holds me and we talk about my mother”.

Respondents 6 and 7: We are staying with our grandparents, and we are proud of it because they treat us well.

Respondent 8: “I am staying with my elder sister”

Respondent 9: My grandmother is taking care of us. Since my mother’s death we are staying with her in her house. We love her, she looks well after us.

Respondent 10: I have grandparents, but because they are older I have been placed in a children’s home. I do visit my grandparents when arrangements have been made with the social worker.

The above research findings are supported by the following literature:

Barnette and Blakkie (1992:119) are of the opinion that orphans are mostly cared for by grandparents. In this study, 50% of the participants are cared for by grandparents, while 20% are cared for by children’s homes and 30% live in child-headed households. This study clearly indicates that maternal families often take on more responsibility for the care of orphans. Participants experience the guardians as supportive, especially in terms of providing emotional support.

4.3.2.2 Sub-theme: FRIENDS AND PEERS AS A SOURCE OF SUPPORT

- **Source of support**

Respondents shared the feeling that they draw their support from their next of kin, friends or the church. They thought though, that their respective parents

would have done more, but they were happy as they have someone to talk to. Each form of support was stated as follows:

- **Friends**

Respondent 1: 'My best friend is Ella; I like her because she has good morals.'

Respondent 2: 'I have lots of friends and I love them all.'

Respondent 3: 'My best friend is Tebogo; we share the name, attend same school and play together.'
Respondent 4: 'My friend is the best, because she helps me with school things when my grandmother cannot afford.'

Respondent 5: 'I really do not have specific friends; I mix with anyone good to me'

Respondent 6: 'I play with the children I meet.'

Respondent 7: 'My school mates are my friends'

Respondent 8: 'I do have friends, but I cannot tell who the best is as they are all good to me.'

Respondent 9: I have a friend, and I visit a lot.

Respondent 10: 'I have girl friends and I love them all.'

The above research findings are supported by the following literature:

The role played by peers in middle childhood is very critical (Castrogiovanni, 2004). The role of peer groups at this developmental stage provides the opportunity to learn how to interact with others, opportunities to witness the strategies others use to cope with problems and emotional support. It appears

however, that the strain of being an orphan may make young people even more dependent on friendships as would normally have been the case. Most participants in the study identified friends as sometimes the most important source of support to them.

The following theme was also linked to a form of support:

4.3.2.3 Sub-theme: RELIGION

- **Attendance of church**

The participants shared positive reactions towards going to church; most of them saw a church as one of the sources of support, as can be seen on the following verbatim quotes from the interviews:

Respondent 1: 'Yes, and I love it I am a server. In church we learn about God and good morals. My pastor teaches us how to look after each other and how important it is to do that'.

Respondent 2: 'Yes, I like going to church because I meet other children and talk about many things'.

Respondent 3: 'Yes, the priest comes to see us at times.'

Respondent 4: 'of course and I love it'

Respondent 5: 'I enjoy listening to the church choir and I also sing so well'

Respondent 6: 'my mother, used to say, "Children who attend church are always free from trouble" so I believe it's a good thing to do'.

Respondent 7: 'Yes, I do'

Respondent 8: 'Yes and I love going to church.'

Respondent 9: "Yes, I love GOD."

Respondent 10: 'Yes, and I meet friends there'

Subsequently, another theme linked to religion:

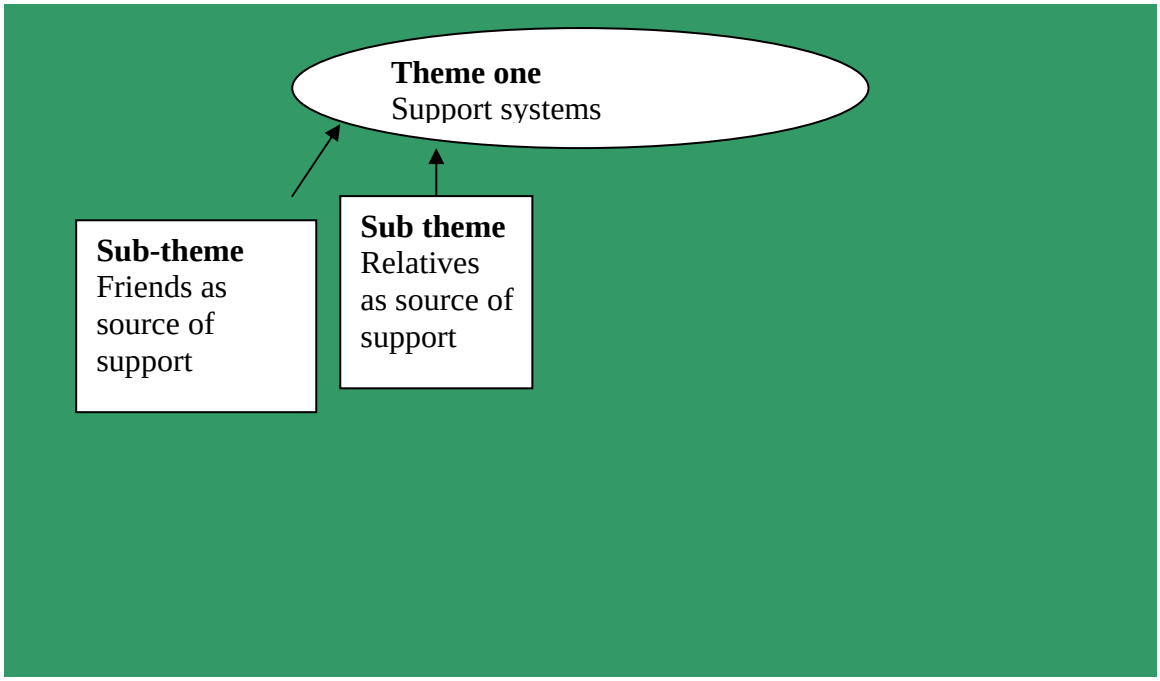
- **Sub- Theme – Religious belief is important in their lives for support**

In this study most participants enjoyed and felt good about going to church as they got support from religious leaders and also met their good friends. The church was also viewed as the source of empowerment. Despite some negative views regarding faith based organisations their role and impact offer some of the most viable programmes to address the impact of HIV/AIDS on children and families. According to Richter *et al.,* (2004:21) in a recent study which sought to measure the impact of care in projects run by FBO's, it was reported that they run initiatives that are more numerous, and are reaching more orphans and vulnerable children, than previously thought.

The above section focussed on how participants viewed the church and its role in their time of need.

These research findings discussed above provided the following answers to the research question, namely "What are needs of children orphaned by HIV/AIDS in middle childhood"?

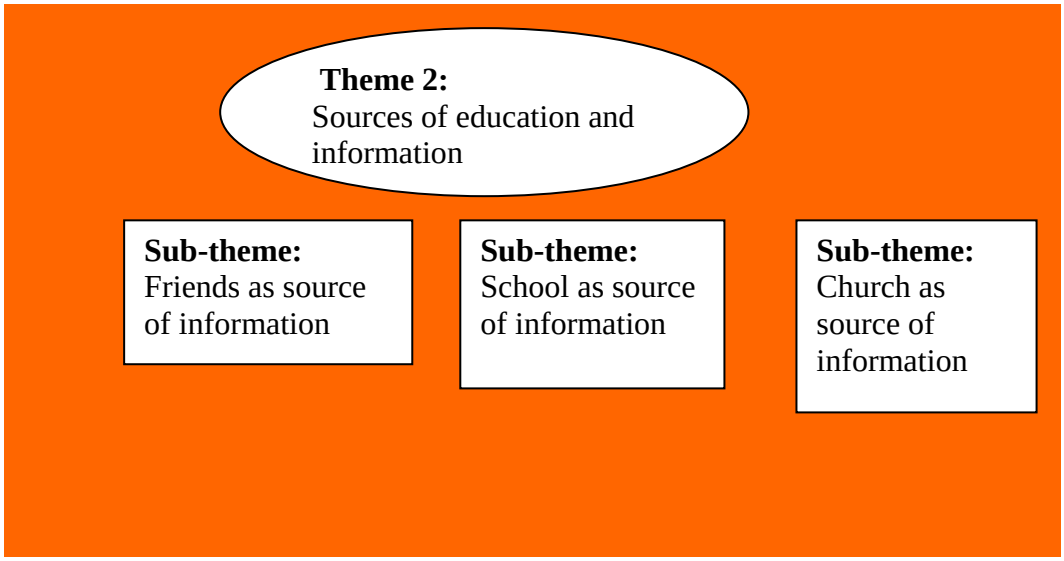
***Diagram 1: Theme 1: Support systems*: Religion**



The participants experienced the following:

- The community and the church were perceived as supportive to the orphaned children.

Diagram 2: Theme 2: Education and information:



The children mentioned that, the church, peers and school are their source of education information. It is still a taboo to African families to discuss death and its causes with children; hence most children were not informed about their parent's cause of death or status.

Respondents shared the feeling that they draw their support from their next of kin, friends or the church. They thought though that their respective parents would have done more but they were happy for they have someone to talk to.

4.3.3. GENERAL KNOWLEGDE ABOUT HIV/AIDS

The reason for this theme in the interview was to explore quality of knowledge, the participants had regarding HIV/AIDS. The response of the respondents to the question of: what they understood by HIV AIDS was as follows:

The direct quotes from the interviews were as follows:
Respondent 1: "It is a punishment".

Respondent 2: "It is a disease".
Respondent 3: " nna ha ke itse", meaning I don't know.

Respondent 4: "Ke bolwetse", meaning it is a disease.

Respondents 5 & 6: "ke bolwetsi bathobalwano tshomi yaka impoleletsi" meaning it is a sexual disease my friend told me.

Respondents 7 & 8: shared the same views with respondents 5 & 6

Respondent 9: Was silent.

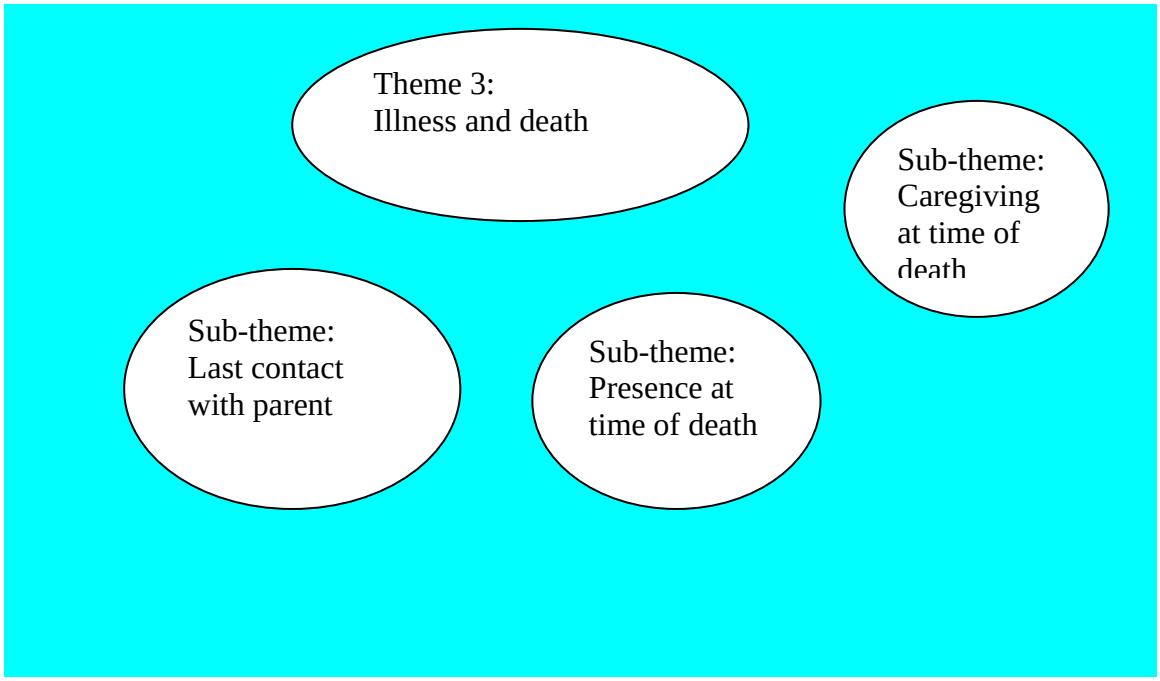
Respondent 10: "nna ha ke boleli", meaning I don't want to say anything.

The responses given by respondents clearly indicate that some children at their age have limited information regarding HIV/AIDS. It is interesting though to note that the children associate HIV/AIDS with a death sentence and this perception has contributed to people becoming ignorant in seeking the correct information. Education and knowledge, or rather the lack thereof, have been identified as important factors in HIV/AIDS education. The researcher has also identified educational level as an important factor when dealing with children.

The above research findings are supported by the following literature:
Orphans are less likely to have proper schooling. The death of a prime-age adult in a household will reduce a child's attendance at school (Louw, 2004:88). Therefore the researcher is of the opinion that these children are likely to then have limited information, especially if the school is considered as the source of information regarding HIV/AIDS matters.

4.3.4 ILLNESS, DEATH AND EMOTIONS

Diagram 3: Theme 3 Illness, death and emotions:



The following verbatim quotes support the above themes and sub-themes:

“My mother died a week after I visited her”.

“Seeing my mother in the sick bed was the saddest’

“I helped my grandmother in nursing my mother”

Respondent 5. She is in grade 4 and often misses her mother, her grandmother always comforts her. Her mother passed away in 2006.

This is an indication that the death of her mother had affected her emotionally and she has not come to closure with the situation.

The researcher is of the opinion that a number of the participants in the study suffered from Post-traumatic Stress Syndrome at the time of the interviews. The clinical course of HIV/AIDS can be upsetting to the affected family members and the findings of the study concur with this statement, as most participants responded in fear and anxiety about what they had witnessed. It appeared as if they dealt with the trauma by suppressing their memories and emotions. Cultural boundaries, for example, make it inappropriate in Setswana to display photos of the dead or talk about the dead, leaving the orphaned children with unresolved grief.

4.3.5 FEELINGS/ EMOTIONS REGARDING HIV/AIDS RELATED DEATH.

The emotions explored in the interview will be shared and then compared with literature at the end of this section.

4.3.5.1. Feelings related to the news that one of your parents was dying of HIV/AIDS related disease

The direct verbatim quotes were as follows:

Respondent 1: ‘I have mixed feelings’

Respondent 2: ‘I am uncertain’

Respondent 3: ‘I do not know’.

Respondent 4: ‘I really do not believe that it happened to her’.

Respondent 5: ‘I am sometimes nervous’

Respondent 6: Silent

Respondent 7: ‘I am angry’.

Respondent 8: ‘I sometimes feel lonely, she passed away a week after I had visited her’.

Respondent 9: ‘I am worried, what is going to happen about me’.

Respondent 10: ‘I feel sad and anxious’.

Thus from the quotes above the researcher concludes that illness and death of these children’s parents, had a serious impact on their lives.

The following emotions were explored:

4.3.5.2 Anger

The question focussed on in the interview was, when last were you angry, why were you angry and what did you do? The direct verbatim quotes were as follows:

Respondent 1: Last week, ‘my grandmother did not fulfil her promise.’

Respondent 2: ‘Every time when we are running short of something, I always remember my mother because she would always provide.’

Respondent 3: ‘I cannot remember’

Respondent 4: ‘I seldom become angry’

Respondent 5: She was silent

Respondent 6: ‘I become angry when I am teased by other children’

Respondent 7: “When things seem not to be going right, I become angry.”

Respondent 8: “Whenever I think of mother”

Respondent 9: “sometimes I become angry”

Respondent 10: There was silence and deep breath

The quotes above clearly indicate that, living with uncertainty poses a great challenge to the secure psychological base which is essential to a child’s development.

4.3.5.3 Emotional Reaction to news of death

Respondent 1: ‘I told my grandmother and she apologized.’

Respondent 2: ‘I talk to my church friends’

Respondent 3: She was silent

Respondent 4: ‘I cried ‘

Respondent 5: Silence

Respondent 6: when I get home I tell my grandmother about it

Respondent 7: “I wish that my mother was around”

Respondent 8: “I talk about it”

Respondent 9: “I share the feeling”

Respondent 10: Silence

Thus from the quotes above the researcher concludes that illness and death of these children’s parents, had a serious impact on their lives. They still have a need to talk, they long for their parents and are they still grieving.

4.3.5.4 Sadness

The question was asked in order to establish whether do experience sadness.

Respondent 1: “Yes”

Respondent 2: “I do at times”

Respondent 3: Yes, I do

Respondent 4: Yes,’ I had visited my sick mother, a week later she passed and I was so sad.’

Respondent 5: I do become sad, especially at home.

Respondent 6: “Yes”

Respondent 7: “I am sad that my mother died.”

Respondent 8: “of course”

Respondent 9: “Yes”

Respondent 10: “I do become sad when I think of my mother”.

Based from the quotes above, it can be concluded that, the emotional demand of HIV/AIDS on children's lives is sad and heart breaking.

Reason for sadness

The question was asked in order to establish what was the respondents reason for their sadness.

Respondent 1: 'My mother passed away in my presence'

Respondent 2: 'I lost my mother'

Respondent 3: 'My parent passed away'

Respondent 4: 'I lost my mother'

Respondent 5: 'I lost my parents'

Respondent 6: 'I do not have parents'

Respondent 7: "When I am lonely"

Respondent 8: "Not sure"

Respondent 9: "When I cannot get what I need, I feel sad"

Respondent 10: "When I think of my mother"

The quotes indicate that when traumatic event occurs such as the death of a parent, it does have an impact on the emotional status of the children.

4.3.5.5 Happiness

The aim for this question was to establish how the respondents express their happiness.

Respondent 1: 'I share the feeling with friends'

Respondent 2: 'I laugh a lot'

Respondent 3: 'I play with my friends'

Respondent 4: 'I sing'

Respondent 5: 'I visit friends and share my feelings'

Respondent 6: 'I just show it'

Respondent 7: 'I laugh'

Respondent 8: 'I sing gospel music'

Respondent 9: I make jokes, and make everybody laugh

Respondent 10: 'I talk a lot even at home they know that'

As the researcher started relating the facts to the children about HIV/AIDS the emotion of fear and anxiety emerged clearly among the respondents.

Fear and Anxiety:

Fear and anxiety was one of the emotions that was experienced by all the respondents, as they kept on mentioning their unwillingness to die. Anxiety was the second emotional expression as respondents were more concerned on how are they going to die, who are they going to leave behind and will they also contract HIV/AIDS? Respondent 10 said "ka hore mama ona nale yona e kabe lena ke nale yona" meaning: now that my mother has died of HIV/AIDS does this mean I also have it? Anxiety and fear were the most common emotions expressed and experienced by the orphaned children.

The emotional demand of HIV/AIDS on children's lives is heartbreaking.

The above research findings are supported by the following literature:

Literature shows that parental death reduces children's self-esteem and increases depression, anxiety, conduct disturbance, academic difficulty and

suicidal acts in the long term (Griesel-Roux, 2004:38). They suggest that the impact of HIV/AIDS on a household level, may lead to sequential trauma associated with continuous stress.

Many children suffer multiple losses - a father, a mother, siblings, grandparents, uncles, aunts and other relatives. In addition, they may lose friends, familiar surroundings, schooling, and their hope for the future and their remaining childhoods and are subject to surges of loneliness and sadness, triggered by some memory (Medical Research Council AIDS Bulletin, 2004:2, 19).

In children ambivalent feelings toward the ill or surviving parent or caregiver may manifest in severe behavioural and psychological problems. Acts of destruction, self destruction and thoughts of suicide may occur. Impulsive solutions like uncontrolled defiance and running away may be the result of unresolved emotions and ambivalent feelings. The child's fear of the outcome of the illness of the adult or others may lead to counter-phobic risk taking that includes high risk sexual encounters or drug abuse (Geballe & Gruendal, 1998:56).

As was found in the above quotes, these children expressed emotions such as anxiety, which can be an indication of lowered self-esteem and depression. The emotional experiences as noted by researcher and the most explicit ones were anger anxiety and uncertainty. Anger was directed towards God who to some was considered unfair, friends who were assumed to be source of stigma, while others just experienced a normal situation.

Lorey & Sussaman (2001: 6) in family and community interventions for children affected by AIDS concurs with the researcher, as they have depicted the impact of HIV/AIDS at the level of individual children in the following way:

Increased psychosocial distress caused by:

- Grieving illness and death of parent;
- Worsening economic circumstances;

- Anxiety about future;
- Separation from siblings;
- Being removed from school and required to be caregivers or to work, leading to deprivation of healthy social interaction;
- Diminishing love, attention and affection.

All respondents reported that they were happy and treated well by their caregivers at home. One of the respondents, said “I am happy to be with my grandparent”, while the other said “I know my mother would have done more for us, but I am grateful to my grandmother as she ensures that our needs are met as far as she is able”, The above statements, also show that children emotion grieving process, are still grieving but seem to be coping and supported.

4.3.6 Care giving

The respondents were asked whether they were to share their experiences in caring for a sick family member, and the direct verbatim quotes were as follows:

Respondent 1: Yes, ‘I was helping my grandmother to look after my sick mother until the day she died.’

Respondent 2: No

Respondent 3: No

Respondent 4: “Yes, but not on full time basis.”

Respondent 5: Sometimes

Respondent 6: No

Respondent 7: “No”

Respondent 8: "Yes"

Respondent 9: "Yes"

Respondent 10: "Yes"

It appears that, most children in this study had a direct or indirect experience of caring for a mother or father infected by HIV/AIDS.

4.3.7 NEEDS:

The respondents were requested during the interview to rate their basic needs in order of importance. The results were as follows:

4.3.7.1 Material Needs

Food

Clothes

Shelter

Money

Educational needs

Their direct verbatim quotes supporting these were as follows:

Respondent 1: 'I believe educational needs are the most important, as they prepare one for the better future.'

Respondent 2: "Was of the opinion that clothes are most important, because a person has to look nice and beautiful"

Respondent 3: "Was of the opinion that food and nice food is the most important need for one to be able to play. "You cannot play when you hungry hey sister" he giggled.

Respondent 4: "A shelter'

Respondent 5: "Clothes'

Respondent 6: “Food because sometimes I just miss schools, and when the teacher asks why I was absent I just say I was sick. I cannot tell her that granny had no food in front of the whole class”.

Respondent 7: “Clothes”

Respondent 8: “Shelter”

Respondent 9: “Money because presently the money I receive cannot buy all school things”

Respondent 10: “Educational needs and shelter, I cannot separate them.”
All the participants reported some form of significant change in their life as a result of the death. Most of the children reported feeling sad and depressed most of the time, struggling to understand what has happened to them.

Sub-theme: **Physiological needs play a vital role in meeting the needs**.
The above findings are supported by literature, as Maslow’s hierarchy clearly states that the physiological needs are basic human needs that are to be fulfilled. Smart*. et al.,* (2003:33) indicate that affected children are vulnerable to malnutrition, both due to scarcity of food which is one of the human basic needs and to the weak position they occupy within their guardians homes in the household resource distribution process. This is equally true for educational needs, like books, school fees, uniforms, shoes, school trip funds and aftercare facilities for younger children. Denmer (2004:40) quotes research that shows that AIDS-affected families have little money to spend on food, clothing and education and all these are the basic needs.

Thus, it can be concluded that when the physiological needs of man are satisfied and his or her safety and security are reasonably well assured, his social needs begin to motivate him or her.

4.3.7.2 SCHOOLING AND FINANCIAL NEEDS

The question focused on, in the interview was, who pays for your school needs and from where do you receive the money?

School clothing

The direct verbatim quotes were as follows:

Respondent 1: "I am receiving a grant"

Respondent 2: "I am getting government money"

Respondent 3: "My grandmother"

Respondent 4: "My grandmother, from the grant that I am receiving and it is not enough."

Respondent 5: "My grandmother tries her best and she said she has applied for government money, I hope things will be much better then".

Respondent 6: "My family friends do provide sometimes".

Respondent 7: "Church people make donations".

Respondent 8: "I receive the money and buy the uniform".

Respondent 9: "School friends share with me".

Respondent 10: The home provides for my needs

The relevance of the above quotes clearly indicates that when man's physiological needs are satisfied and his/her safety and security are reasonably well assured, his social needs begin to motivate him/her.

Sub- Theme: school friends viewed as a source of support for certain needs:

Schools are seen as a source of support by most orphaned children. One hundred percent of the participants reported their school teacher/s is or are a source of support. None of them reported discrimination because of unpaid school fees or poor school uniforms.

The researcher knew that all the participants were known to social workers at Potchefstroom Child Welfare, South Africa. She was therefore certain that all respondents do receive assistance from the government, however not all of them were adequately benefiting from the government.

- 3 of the respondents were receiving grants,
- 2 were in the children's Homes, which are subsidized by the Government,
- foster care grant applications that are pending and
- 2 solely depend on their grandparent's income, due to loss of documentation.

When evaluating the above scenario, it is clear that 5 of the participants are in receipt of government assistance in the form of a Foster Care Grant, Children's Home subsidy and next of kin for financial support. However, these results cannot be directly transferred to the rest of the orphan population, as all of the participants already received social work attention. The researcher concurs with Demmer (2004:40) who indicated that the South African Social Welfare system is unable to adequately meet the needs of children orphaned by HIV/AIDS, as there are still thousands of children who are still on waiting list for services. The provision of care for orphans when their foster grant parent passes away is also a factor of concern, as it appears from this study that children will then depend on children's home or child headed families for care.

4.3.8 Social worker

The following question was to establish the children's understanding regarding the social worker's role and to determine the need for professional intervention.

Theme- Needs are viewed as basic means of survival

The focus in the interview was on if a social worker requests your needs, what would you mention?

Respondent 1: “A computer, because my teacher said it can teach a person so many things.”

Respondent 2: “Clothes because even though my grandmother is doing her best, I still feel I do not have enough and I am not demanding.”

Respondent 3: “Food and I mean nice food, like meat, chocolates and other nice food, because we have seldom had.”

Respondent 4: “A bigger house for my grandmother, just to get more space.”

Respondent 5: “Clothes, clothes please because I like looking nice.”

Respondent 6: “Food and School uniform, so that I have more sets and my grandmother does not have to wash every time.”

Respondent 7: “Clothes “

Respondent 8: “Shelter”

Respondent 9: “Money because the money I receive buys food and it is not enough, even though it is a regular income.”

Respondent 10: “All school needs”

It is evident from these verbatim quotes that the respondents strongly believe that the social worker can play a vital role with material needs her or his intervention. His or her specialised networking skills can assist children and their caregivers with confidence to access all relevant resource to meet their needs.

The above research findings are supported the following literature:

Maslow's hierarchy of needs is used to describe mans' innate progression from the lowest levels of pure survival to the higher search for meaning and transcendence in life (Johnson: 2000:122). As we can see from the above, we all have needs ranging from the most basic for physical, to the survival, to the more complex emotional and psychological and spiritual needs. The relevance of the above quotation clearly indicates that when man's needs are satisfied and his/her safety and security are reasonably well assured, he becomes motivated.

4.4 DISCUSSION

4.4.1 SOCIAL ASPECTS

In exploring the needs of children orphaned by HIV/AIDS in middle childhood, it was clear their experiences were different**.** The researcher is of the opinion that preserving some sort of family life is extremely important for children who have lost one or both parents to HIV/AIDS, whether the family is headed by a grandparent or other relative. The empirical data clearly illustrated what an important role these family systems play.

4.4.2 PROFFESSIONAL INTERVENTION

The majority of respondents showed a need for counselling. It is evident from the research that the emphasis placed on counselling should focus on trained, skilled and experienced counsellors who can deliver a comprehensive service. The researcher is of the opinion that these findings indicate that the social work profession could focus on education and information, particularly with skills in communicating with children.

4.4.3 THEMES AND SUB-THEMES

THEMES	SUB-THEMES
Support systems	**Relatives as source of support.** **Church as a source of support.** **Friends as a source of support.**
Sources of education and information	**School as a source of education and information** **Church as a source of information.**

Illness and emotions/ emotional experience of illness **Death and emotions / emotional experience of death**	**Deal with illness , death , emotions** **made children to express emotions: sadness, anger, fear, anxiety, one respondent said: my mother died in my presence.**
Sense of belonging	**Maternal grandparents provide sense of belonging.**

4.4.3.1 RELATIVES AS A SOURCE OF SUPPORT

From this study it became clear that maternal families often take on more responsibility for the care of orphans some relatives become reluctant to foster a relatives child because it would compromise in their own children's standard of living suffering, Foster (1997:5).

4.4.3.2 THE CHURCH AS SOURCE OF SUPPORT

The participants were positive about the support they received from the church.

4.4.3.3 THE SCHOOL AS SOURCE OF SUPPORT

None of the children reported discrimination because of the unpaid school fees or poor school uniforms. This was contrary to the expectation of the researcher, who expected some discrimination at school. Most participants reported pride in their ability to continue scholastically, despite their circumstances**.**

4.4.3.4 SENSE OF BELONGING AND MEANS TO MEET THE CHILDRENS PERCEIVED NEEDS

The children were positive about the fact that they do experience a feeling of belonging, and they do have people who care for them. The support they receive from friends and family was appreciated**.**

An example of the above can be found in the following description, from res 2:

Respondent 2 is a 12 year old girl living in Potchefstroom. She is the eldest

in a family of two. They are in the foster care of their maternal aunt and her younger sister is eight years old. She is currently in grade seven. Her mother passed away in 2006. She adores her grandmother.

Thus from the above, the sense of belonging was specifically linked to grandparents, siblings and family. The following chapter (5) entails the summary, conclusions and recommendations for this research report.

4.5 SUMMARY

Ten children, who are registered as clients with Potchefstroom Child Welfare South Africa, were interviewed over a period of two weeks. Different emotions, themes and needs were identified, interpreted and discussed in the above chapter.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter provides an overview of the research report. A summary is provided of the research methodology and its effectiveness. The qualitative process was employed successfully to answer the research question, “What are the needs of children orphaned by HIV/AIDS in middle childhood.”

In chapter one of this research report, the researcher explained the relevance of the topic.

Chapter two dealt with HIV/AIDS as a social phenomenon, where the psychosocial impact of the disease on the patient as well as his or her family or significant others was also discussed. A detailed discussion on middle childhood developmental stages was found in chapter four. The researcher deemed this necessary in order to improve her understanding of the characteristics of this developmental phase, as well as that their needs cannot be indiscriminately related to the fact of being an orphan, because of HIV/AIDS related conditions. Being orphaned by HIV/AIDS related conditions appears however, to be a serious and significant form of stress added to their challenging life.

Chapter three gives a theoretical background of middle childhood. The chapter is divided in two parts: a discussion of the child in middle childhood and the family role during middle childhood. Attention is given to the developmental tasks, developmental characteristics, their needs and children's understanding of death.

In chapter four, an empirical study of qualitative nature was undertaken and the study explored the following research question: What are the needs of children orphaned by HIV/AIDS in middle childhood? A literature study relating to the background of HIV/AIDS and middle childhood was conducted. The empirical investigation was done through semi-structured interviews with ten respondents from Potchefstroom Child Welfare South Africa offices. The collected data was analyzed and themes were identified, including sources of support system, sources of education and information, illness, emotions and death and sense of belonging.

The purpose of this chapter is to summarise the whole research project, and to provide the conclusions and recommendations derived from this study. This chapter will also evaluate the achievement of each objective and the goal of the study.

This chapter will consist of:

- Research methodology
- Evaluation of the research goal and objectives and research questions
- Findings regarding the needs of children orphaned by HIV/AIDS in middle childhood.
- Conclusions
- Recommendations

5.2 SUMMARY

The following discussion, presents the summary of the overall research report.

5.2.1 RESEARCH METHODOLOGY

The research process utilized by in this study was derived from the five phases of the qualitative research framework outlined by Fouché & Delport (2002a:84-85).

5.2.1.1 PHASE 1: SELECTION OF A TOPIC

The identified research problem formed the basis of this study. This research problem was identified from literature, personal experience and a felt need within the Department of Health and Social services. The researcher is of the opinion that the topic was researchable and the strategy could address the research problem.

5.2.1.2 FORMAL RESEARCH FORMULATIONS

The qualitative research approach was chosen, as the study intended to explore and describe the needs of children orphaned by HIV/AIDS in middle childhood. This approach was appropriate as the data collected could answer the research question. **What are the needs of children orphaned by HIV/AIDS in middle childhood?**

The following quotes indicated specific needs:

Respondent 1: ‘I believe educational needs are the most important, as they prepare one for the better future.’

Respondent 2: “Clothes because even though my grandmother is doing her best, I still feel I do not have enough and I am not demanding.”

Respondent 3: “Food and I mean nice food, like meat, chocolates and other nice food, because we have seldom had.”

Respondent 4: “A bigger house for my grandmother, just to get more space.”

5.2.1.3 PHASE 2: PLANNING

5.2.1.3.1 Research strategy:

The researcher decided on phenomenological study as the most appropriate strategy to conduct the research, in order to describe the experiences of the phenomenon (HIV/AIDS related conditions) have for children who are orphaned because of these conditions. This proved to be appropriate as their needs could be described in order to create better understanding of their world.

5.2.1.3.2 Preparation for data collection and analysis:

The preparation for data collection involved decisions about the sites of data collection, the population as well as sampling procedure. The researcher’s decision to focus on the Potchefstroom in North West proved suitable, as this area was the most accessible to her. Purposive non-probability sampling was decided upon as the sampling procedure and this was proved to be appropriate as suitable participants could be identified.

Sampling criteria used was:

- Ability to understand English
- Age: Middle childhood between 6 and 12 years
- Care status (orphans)
- Willingness to participate
- Orphaned for a period of no less than a year
- Registered as a client at Potchefstroom Child Welfare South Africa.

The researcher found the criteria to be suitable, and English proficiency was not a factor because of the availability of an interpreter.

5.2.1.4 IMPLEMENTATION

The researcher conducted a literature study as first part objective of the study of the implementation process in order to assess the research findings against the background of existing literature (Fouché & Delport, 2002a:91).

Semi-structured interviews were conducted with 10 participants. Interviews were conducted in English with seven participants and one in Afrikaans and two in Setswana. The data was then transcribed into English. The researcher is of the opinion that the data collection method was appropriate.

5.2.1.5 ANALYSIS, INTERPRETATION AND PRESENTATION

The qualitative study consisted of tape recordings of interview conducted with 10 participants from Potchefstroom. The researcher transcribed the interviews and sorted them into themes and sub-themes. The researcher is of the opinion that the findings of the study would be transferable to a similar setting with a similar population. Analysis was done according to qualitative process.

5.3. ATTAINMENT OF GOAL AND OBJECTIVES

5.3.1. GOAL

The goal of this research study was to explore the needs of children orphaned by HIV/AIDS in middle childhood.

The researcher has successfully achieved the goal, as she was able to interview the respondents over a period of 2 weeks using semi-structured interviews. The result was an ability to identify the needs of children orphaned by HIV/AIDS in middle childhood. This information can also be utilized in the improvement of services to these affected children, as it indicated some of their actual felt needs. The needs that were explored included psycho-social support, basic human needs i.e. food, accommodation and clothes.

The study appeared to have been able to answer the question, as the following themes were identified:

Theme one: Sources of support systems

Theme two: Sources of information

Theme three: Illness, emotional experiences

Theme four: Sense of belonging

It can be concluded that children orphaned by HIV/AIDS in middle childhood do have specific needs.

5.3.2 OBJECTIVES

This study had four objectives, namely:

- ***OBJECTIVE ONE***
  - **To describe HIV/AIDS as a social phenomenon**

The researcher having conducted the literature study about HIV/AIDS in chapter two, was able to discuss this phenomenon and the impact the pandemic can have both on the infected and affected, thus achieving objective one.

- ***OBJECTIVE TWO***
  - **Describe the phenomenon of children affected by HIV/AIDS in middle childhood in South Africa.**

The researcher achieved the second objective by discussing in chapter 2 HIV/AIDS basic facts, the psychosocial implications both to the patient and the family as well as the role of a social worker. HIV-infected people are affected psychologically, spiritually and economically by the infection, which renders them inadequate to attend to the needs of significant others around them, especially their children.

The affected significant others experience more or less the same feelings of depression, loneliness, fear, uncertainty, anxiety, anger, emotional numbness and at times, hopelessness. Children suffer when their parents are infected, and the needs of children with infected parents are neglected. These children are largely excluded from the counselling process, because people may not know how to approach them.

HIV/AIDS does not only have a psychological effect on the patient with the disease, but also on significant others. Significant others may experience the

following: depression, fear, anxiety and anger. Various myths exist relating to transmission of HIV and that contributes to the stigma attached to AIDS. This contributes to the fact that affected/infected children often being isolated in their grieving process. The importance of successfully completing developmental stages and progressing to the next and the role-played by parents during this stage was also illustrated.

- ***OBJECTIVE THREE***
  - **To explore the specific needs of children orphaned by HIV/AIDS in middle childhood by means of an empirical study.**

The researcher has achieved objective number three as the respondents' during the interview process identified needs, portrayed in the central themes as discussed in chapter 4. This research thus enabled the researcher to identify the needs of children orphaned by HIV/AIDS in middle childhood. Subsequently the **explicit identified needs identified:**

Basic needs: access to shelter, adequate food, clothes and financial assistance.
Social needs: sense of belonging, support, access to education
Psychological needs: Healthy relationships, coping mechanisms
Religious needs: church support, bereavement counselling
Emotional needs bereavement counselling and emotional support: Security,

- **OBJECTIVE FOUR**
  - **To make recommendations for professionals and non-professionals intervening with HIV/AIDS orphans in middle childhood in South Africa.**

The researcher has achieved objective number five as conclusions and recommendations were made through reference to the literature and the empirical study conducted. The needs of children orphaned by HIV/AIDS in middle childhood were identified and can be addressed by means of

intervention. From this study recommendations were made including practical steps that professionals can consider during intervention process.

5.4 TESTING OF THE RESEARCH QUESTION

The research question for this research was:

What are the needs of children orphaned by HIV/AIDS in middle childhood?

The research question was answered as the respondents explicitly revealed their needs during the interviews namely **basic needs, social needs, psychological needs**, **religious needs and emotional needs** and these findings were discussed in chapter 4.

5.5 CONCLUSIONS

The qualitative approach proved to be appropriate in this study, as the information gathered was in the form of words and descriptions to give meaning to the social reality as experienced by orphaned children. The researcher was able to obtain first- hand information during the interviews with the respondents, as it allowed freedom to explore this topic further. It can therefore be concluded that the semi-structured interview as a method of data collection worked effectively in collecting data in order to answer the research question.

HIV and AIDS are key challenges to our country. The one big solution we have against it is education, getting educated about the pandemic will mean all professionals dealing with affected children should be equipped to make proper assessment and intervention**.**

The necessity to understand the needs of children orphaned by HIV/AIDS in middle childhood was explored in-depth, as previous studies conducted on the topic focused less on the needs of children orphaned by HIV/AIDS in middle childhood. The number of HIV/AIDS orphans in SA and specifically Africa is rising dramatically. Due to the stigma that is associated with the epidemic, one can expect that these children will be isolated in their grieving

process, or they might not be able to disclose all the facts regarding the parent's death and the feeling accompanied by this. It was therefore important to determine what the needs of these children are, so that they can be addressed properly through appropriate services.

The explored needs of children orphaned by HIV/AIDS show that an intensified effort is needed from social welfare service providers, in order to address their basic needs.

The research question: **"What are the needs of children orphaned by HIV/AIDS in middle childhood"?** Was answered as the respondents explicitly revealed the following needs:

- Counselling to attend to traumatic memories that are suppressed.
- Social needs: sense of belonging, support, access to education
- Psychological needs: Healthy relationships, coping mechanisms
- Religious needs: church support, bereavement counselling
- Emotional support and security.

It may be concluded that, children orphaned by HIV/AIDS in middle childhood do have needs, as the following quotes indicated some of those needs:

Respondent 6: "Food because sometimes I just miss schools, and when the teacher asks why I was absent I just say I was sick. I cannot tell her that granny had no food in front of the whole class".

The following themes were identified in this study:

5.5.1 THEME: SUPPORT SYSTEMS

The researcher is of the opinion that orphaned children experience their current environment as supportive. Current caregivers and friends are the most trusted sources of support. Social workers featured as a source of support in terms of accessing the relevant resources.

5.5.2 THEME: SOURCES OF EDUCATION AND INFORMATION

The children mentioned that, the church, peers and school are their source of education information. It is still a taboo to African families to discuss death

and its causes with children; hence most children were not informed about their parent's cause of death or status. Thus it had an effect on them

5.5.3 THEME: ILLNESS, DEATH AND EMOTIONS

The clinical course of HIV/AIDS can be upsetting to the affected family members and the finding of the study concurs with this statement, as most participants responded in fear and anxiety about what they have witnessed. It appeared as if they dealt with the trauma by suppressing their memories. Cultural boundaries, for example that it is inappropriate in Setswana to display photos of the dead or talk about the dead, leaves the orphaned children with unresolved grief.

5.5.4 THEME: SENSE OF BELONGING

The children were positive about the fact that they do belong, and they do have people who care for them. The support they receive from friends and family was appreciated**.** Most of the participants' reported some form of significant change in their lives as a result of the death of a parent. Some experienced food shortage, sadness and depression most of the time and are still struggling to understand what has happened.

It can be concluded that the HIV/AIDS pandemic has a damaging impact on the emotional, social and physical status of the children orphaned by HIV/AIDS in middle childhood in this group of respondents in Potchefstroom.

5.6. RECOMMENDATIONS

An intensive effort is required from social services, regarding legal documents and material support to be applied for, and the improvement of all social support and social relief programmes to meet the specific needs of children orphaned by HIV/AIDS in middle childhood.

The social work profession is urged to take up the psychosocial challenges of HIV/AIDS patients, children and families and become leaders in the field of service rendering.

Social workers working with the affected and infected persons of HIV/AIDS need to have an understanding of the different phases of the HIV infection in order to prepare them for what lies ahead.

Affected children should be involved in the counselling process. Social workers need to convey empathy to the affected and infected. Affected and infected people need support and social workers need to assist, however, they first need to create a mutual trust environment for infected people to come forward and reveal their status.

Social workers need to convey to the community that their intention will not be to remove the child from parental care if the HIV-status is known, but that the support will be provided to the family.

The following recommendations are made to address some the needs of orphaned children in South Africa. These recommendations are posed to Government on Macro levels and to other Social Work Service Providers on Meso levels. (Middle or minor operational activities):

5.6.1 IMPROVEMENT OF SERVICES FUNCTIONAL OR OPERATIONAL MESO LEVEL

On Micro-level, it is recommended that there should be improved foster parent screening, life skills camps for children orphaned by HIV/AIDS in middle childhood, Improved awareness campaigns about foster parenting and the establishment of support groups for prospective foster parents would also have a positive impact for fostered children.

On Macro-level, the researcher is of the opinion that the strengthening of Home- based care groups should be seen as a source of diversified service rendering, combined with after school care and increased Children's Home capacity to provide a whole range of suitable services to affected children.

On a Meso-level, the researcher suggests legislation changes in order to improve access to Social Assistance, as well as increased access to suitable medication in order to improve the life expectancy of affected parents.

- **Improved awareness and prevention campaigns**

  Assistance of children should be considered when educational and awareness campaigns are planned. Child friendly language and understanding should not be overlooked. A strategy to move away from a traditional taboo that death may not be intensively discussed with children, should be revised.

- **After-school centres as respite care**

  Some of the participants indicated that they either stay with the grandparents or elder siblings, the scenario may pose challenges in terms effective educational assistance. The provision of after-school centres, where younger children can play, and be assisted with homework will provide more free time to adults to discuss other family issues with their children.

- **Improved Foster Parenting Screening**

  The researcher is of the opinion that some family members are not suitable as foster parents and that it is not always in the best interest of the children to be placed with extended family members. Even though in this study most participants where happy in their stay.

5.6.2 IMPROVEMENT OF SERVICES ON ADMINISTRATIVE AND LEGISLATIVE MACRO LEVELS

- **Legislative changes**

Changes such as children in child headed children at the age of could be able to initiate application for government grants as per the Social Assistance Act as cited in Louw, L (2003: 199). This process would then result in the quality of life for thousands of South African children.

- **Increased children's Home capacity as a last resort caregiver**

Several HIV/AIDS orphans will eventually need institutional care, even though care within the community would be an ideal option. The government has to consider increasing the capacity in order to provide for escalating numbers of children orphaned by HIV/AIDS. This process can prevent some of the children from living in child-headed households or falling prey to inconsiderate community or even family members who take in children in order to obtain the Foster Care Grant.

5.5.3 PRACTICE RECOMMENDATIONS

Following are some practical steps that professionals service providers or non professional service providers can consider during intervention process:

- **Promoting positive communication among significant others**

  The lack of effective communication that often prevails between the client and the caregiver has a significant effect on all parties concerned. The researcher is of the opinion that an active involvement in the establishment of functional and positive communication should be a main area of focus for the social worker. This will serve to effectively break down the escalating negative effects of a conspiracy of silence. Furthermore, positive communication may decrease the emotional impact during the grieving process, as the child would have been informed about the condition of the parent.

- **Involving significant others in care giving**

  Care giving, by its very nature, places excessive demands on the person who is involved in rendering care, such as siblings and grandparents in this study. The significant others involvement will lead to a more comprehensive understanding of the specific coping needs of each individual member of the family.

- **Helping the family to access available resources**

  Professional support through active engagement in available resource systems represents the very essence of successful coping with all aspects of the terminal situation. It is the ongoing duty of social work professionals

to firstly familiarize themselves with all sources of professional support in the environment of the family, and secondly, to engage these resources in the intervention process**.**

- **Further research topics or questions.**

  It recommended that further research studies be conducted on a larger scale, to see if the findings are the same. Extensive research should be conducted on the following:

  - Experiences of social workers, who are directly involved with HIV/AIDS orphans in middle childhood.
  - Emotional needs for significant others who look after children orphaned by HIV/AIDS in middle childhood.

5.6. CLOSING REMARK

There is a necessity to understand the needs of children orphaned by HIV/AIDS in middle childhood, as the number of HIV/AIDS orphans is rising dramatically. Due to the stigma that is associates with the epidemic, one can expect that these children will be isolated in their grieving process, or they might not be able to disclose all the facts regarding the parent's death and the feeling accompanied by this. It is therefore, important to address these needs efficiently and appropriately.

Social work practitioners, nevertheless, have to accept the challenge of first and foremost, equipping themselves both academically as well as emotionally, and to extend a system of support that is embraced by empathy, understanding, compassion and knowledge. Only then will the social worker be in a favorable position to assist adequately in accompanying both patients, as involved loved ones including children, to stop striving for unreal ends, and to make a good job of a real ending. (Murray Parkes in Kübler-Ross, 1970:8).

13. REFERENCES

Abdool Karim S.S. & Abdool Karim. Q. (2005*), HIV/AIDS in South Africa: new and emerging epidemics.* Cambridge: Cambridge University Press.

Adler, M. W. 1993. *ABC of AIDS*. London: BMJ Publishing Group.

Alpaslan, N. & Mabutho, S. L., 2005. The experience of elderly grandmother caregivers and AIDS orphans. *Social Work/Maatskaplike Werk*. 41 (3) 276-285.

Arkava, M.L. & Lane, T.A. 1983. *Beginning Social work research*. Boston:

Allyn & Bacon.

Babbie, E. 1998. *The practice of social research*. Belmont: Wardsworth.

Babbie, E. 2001. *The practice of social research*, 9th ed. Belmont:

Wardsworth.

Barnett, T & Balkie, P., 1992. *AIDS in Africa: Its presence and future impact.* London: Belhaven Press.

Barolsky, V. 2003. *(Over) extended: AIDS Review: 2003* Center for the Study of AIDS. Pretoria: University of Pretoria.

Bender, C. J. G. 2000. *Kinder Ontwikkeling vanuit n opvoedkunige perspektief vir M .A. (MW) spelterapie.* Pretoria: Universiteit van Pretoria: Departement Psigopedagogiele.

Benokratis, N. V. 1999. *Marriages and families, changes, choices and constraints.* 3rd Ed. New Jersey: Prentice Hall.

Bigner, J. J. 1999. Parent-child Relations. *An introduction to parenting*. United States: Prentice Hall.

Bless, C. & Higson-Smith, C. 2000. *Fundamentals of Social Research*

Methods: An African perspective. 3rd ed. Cape Town: Juta & Co, Ltd.

Botha, N.J. 1993.Values, attitudes and ideologies in social work practice.

Social Work/Maatskaplike Werk, 29(1):1-6.

Castrogiovanni, D., 2004. *Adolescence: Change and Continuity- Peer Groups.*Accessed on http://inside.bard.edu/academic/specialproj/adpeerl.htm.

Carter, B. & McGoldrich, M. 1999 (Eds). *The expanded family life cycle: Individual, family and social perspectives*. 3rd ed. Boston: Allyn and Bacon.

Center for the Study of AIDS 2006., *HIV/AIDS in South Africa.*

Collins, K. 1999. *Participatory Research*: a primer. Johannesburg:

Prentice H&O.

Cunningham. 1993. *Child Development*. New York: Harper Collins Publishers, Inc.

Creswell, 2002. Qualitative data analysis. In De Vos, A.S., Strydom, H., Fouché, C.B. and Delport, C.S.L. *Research at grass roots*: For the Social Sciences and Human Service Professions 2nd Ed. Pretoria: J.L. van Schaik Publishers.

Dacey, J. and Travers, J. 1994. *Human Development, across the lifespan.* United States of America: Wm c Brown Communications, Inc

Dane, B.O. & Levine, C. 1994. *AIDS and the new orphans. Coping with death*. United States of America: AUBURN House.

Demmer, P. 2004. Loss and grief following the death of a patient with AIDS. *Social work/ Maatskaplike Werk*., 40(3):294-315.

Department of Social Development, 2003. *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS*. Pretoria: National Department of Social Development.

De Vos A.S. (Ed.). 1998. *Research at grass roots*. *A primer for caring professions.*: Pretoria:J. L. van Schaik Academia.

De Vos A.S. 2002. Qualitative data analysis and interpretation, In De Vos, A.S. (Ed.). Strydom, H., Fouché, C.B. and Delport, C.S.L. *Research at grass roots*: *For the Social Sciences and Human Service Professions.* 2nd Ed. Pretoria: J.L. van Schaik Publishers: 339-355.

De Vos, A.S., Fouché, C.B. & Venter, L. 200*2.* Qualitative data analysis and interpretation. In De Vos, A.S. (Ed.). Strydom, H., Fouché, C.B. and Delport,

C.S.L. *Research at grass roots*: *For the Social Sciences and Human Service Professions.* 2nd Ed. Pretoria: J.L. van Schaik Publishers:222-246.

Dyregrov, A. 1991. *Grief in children. A handbook for adults,* London: Jessica Kingsley Publishers.

Egan, G. 1994. *The skilled helper: a problem management approach to helping.* 5th Ed .California: Books/Cole Publishing Company.

Eloff, F.P. 1998. *AIDS.* Hammanskral: Unibook Publishers.

Encarta Encyclopedia.2005 dictionary [DVD] Available: Microsoft.

Evain, C. 1995. *Primary AIDS Care*. Houghton: Jacana.

Forrester, C. 2006: Terminal care: Psychosocial needs of significant others. *The Social Work Practioner-Reseacher*

Fouché, C.B. 2002a. Selection of a researchable topic. In De Vos, A.S. (Ed.). Strydom, H., Fouche` C.B. and Delport, C.S.L. *Research at grass roots*: *For the social sciences and human service professions*. 2nd Ed. Pretoria: J.L. Van Schaik Publishers: 95-103.

Fouché, C.B. 2002b. Problem formulation. In De Vos, A.S. (Ed.). Strydom, H.,Fouché C.B. and Delport, 2002. C.S.L. *Research at grass roots*: *For the Social Sciences and Human Service Professions.* 2nd Ed. Pretoria: J.L. van Schaik Publishers: 104-113.

Fouché, C.B. 2002c. Writing the research proposal. In De Vos, A.S. (Ed.).
Strydom, H., Fouche` C.B. and Delport, C.S.L. 2002. *Research at grass roots: For the Social Sciences and Human Service Professions*. 2nd ed. Pretoria: J.L. van Schaik Publishers: 111-120.

Fouché, C.B. 2002d. Research strategies. In De Vos, A.S. (Ed.). Strydom, H., Fouche` C.B. and Delport, C.S.L. 2002. *Research at grass roots:* For the Social Sciences and Human Service Professions. 2nd ed. Pretoria: J.L. van Schaik Publishers: 267-272.

Fouché, C.B. & Delport, C. S. L 2002a. Introduction to the research process. In De Vos, A.S. (Ed.). Strydom, H., Fouché, C.B. and Delport, C.S.L. *Research at grass roots: For the social sciences and human service professions.* 2nd Ed. Pretoria: J.L. Van Schaik Publishers:77-92.

Fouché, C.B. & Delport, C.S.L 2002b. The place of theory and literature review in qualitative approach to research. In De Vos, A.S. (Ed.). Strydom, H., Fouché, C.B. and Delport, C.S.L. *Research at grass roots: For the social sciences and human service professions*. 2nd Ed. Pretoria: J.L. Van Schaik Publishers:265-269.

Fulfz, T. 1998. *HIV/AIDS*. Pretoria: Kagiso Tersier.

Geballe, S. & Gruendel, J., 1995. *Forgotten children of the AIDS epidemic*. London: Yale Universty Press.

Geldard, K. & Geldard, D. 1997. *Counseling children: a practical introduction.* London: Sage.

Gennerich, D. 2004. *The church in an HIV positive world: a practical handbook.* [sl], [sn].

German, S., 2004. Psychological impact of HIV/AIDS on children*. Medical Research Council AIDS Bulletin.* Vol. 13 (2): 18-22.

Gordon, G. & Klaud, T. 1991. *Talking AIDS*: A guide for community work. New York: Macmillan Education.Ltd.

Gould, J. A. 1993. *The withering child.* Athens: University of George Press.

Greeff, M. 2002 Information collection: interviewing. In De Vos A.S. (Ed.). Strydom, H., Fouché, C.B. & Deport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* 2nd Ed. Pretoria: J L van Schaik Publishers: 291-319.

Grinnell, R.M., (Ed.). 1988. *Social work research and evaluation*, 3rd Ed.

Itasca, IL: Peacock Publishers, Inc.

Grinnell, R. M., & Williams, M. 1990. *Research in social work: a primer*. Itasca, IL: Peacock.

Griesel-Roux, E. 2004. *A case study exploring learners experiences of HIV/AIDS programmes*. Unpublished D. Phil (Psych) dissertation. Pretoria: University of Pretoria.

Hamner, J.t. & Turner, P.H. 1996*. Parenting in contemporary society.* Boston: Allyn & Bacon.

HIV/AIDS 2000, Durban AIDS conference, Durban, July.

HIV/AIDS 2003, *Global Focus: International Conference.* Durban

Hulting Home Magazine, 2002. October:23.

Hunter, S & Williamson, J. 2002. *Children on the Brink. Strategies to support children isolated by HIV/AIDS.* Arlington, USA: US. Agency for international Development (USAID)

Judd, C.M., Smith, E.R. & Kidder, L.H. 1991. *Research methods in social relations.* London: Holt, Rinehart & Winston.

Kübler-Ross, E. 1970. *On death and dying*. London: Tavistock.

Leedy, P.D. & Ormond, J.E. 2001. *Practical research*: *planning and design*, 7th Ed. New Jersey: Merrill Prentice Hall.

Lendrum, S. & Syme, G. 1992. *Gift of tears: A practical approach to loss and bereavement counseling*. London: Tavistock/Routledge.

Lewis, S. 1999. *An adult's guide to childhood trauma. Understanding traumatized children in South Africa.* Claremont: David Phillip Publishers (pty) Ltd.

Levy, C.S. 1993. *Social work ethics on the line*. New York: Haworth.

Libman, H. & Witzburg, R .A. 1993. *HIV infection. A clinical manual.* London: Littele, Brown & company.

Lombard, A. 1992. Enhancing a human rights culture through social work practice and training. *Social Work/ Maatskaplike Werk*. Vol. 36 (32).

Lorey & Sussams, J. E. 2001. *How to write effective reports*. Vermont: Gower.

Louw, D. A., Schoeman, W. J., Van Ede, D. M. & Wait, J. 1996. *Die middle kinderjare, in Louw (editor). Menslike ontwikkeling.* Pretoria: Kagiso Tersier.

Louw, L. 2005. *Experiences of adolescent orphaned by HIV/AIDS related condition. Pretoria Department* of Social Work. University *of* Pretoria

Love Life. 2001. *Impending catastrophe. Revisited. An update on the HIV/AIDS epidemic in South Africa.* Sunday times, 24 June 2001.

Mabutho, S., 2004. *The experience of elderly grandmother caregivers and AIDS orphans.* Unpublished M.A. (S.W.) dissertation. Port Elizabeth: University of Port Elizabeth.

Marshall, C. & Rossman, G.B. 1999. *Designing Qualitative Research.*

3rd ed. Thousand Oaks, London and New Delhi: SAGE Publishers.

Mitchell, M. & Jolley, J. 2002. *Research design explained*. London: Harcourt

College Publishers.

McDougal, J., Mawle, A.C. & Nicholson, J. K. A. 1989. The Immune System*:* Pathophysiology, in Kaslow, R.A. & Francis, D. P. (Eds.). *The Epidemiology of AIDS*. New York: Oxford University Press.

McRoy, R.G. 1995. Qualitative research. In Edwards, R.L. & Hopps, J. G.

(Eds), *Encyclopaedia of Social work*, 19th ed. Washington, DC: National

Association of Social Workers.

Mogotsi, M. 2005. *A life skill programme for early adolescent AIDS orphans*.

D. Phil (Social Work) thesis. Pretoria: University of Pretoria.

Monette, D.R. Sullivan, T.J. & De Jong, C.R. 1998. *Applied Social research: tool for the human sciences*, 4th Ed. Fort Worth: Harcourt Brace.

Moore, N. & Viljoen, M. 1994. *The basics of writing reports etcetera*. London: Clive. Bingley.

Ngidi, Nkosazana, 2005. *Telephone interview with social worker at Chartsworth Hospice*, KwaZulu Natal.

Nelson Mandela/HSRC Study of HIV/AIDS, 2002. Pretoria: HSRC.

Nell.M.A.1990. *Pedagogies-verantowoorde evaluering van voorligtingsinligting vir die voorkoming van die verworwe-immuniteitsgebrek-sindroom.* Pretoria: Ongepubliseerde MA-verhandeling.

Neuman, W.L. 2003. *Social Research Methods-Qualitative and Quantitative Approaches*, 5th ed. United States of America: Pearson Education, Inc.

New Dictionary for Social Work, 1995. *Revised and comprehensive edition: Terminology committee for social work,* CTB Book Printers (Pty) Ltd, Caxton Street, Parow, 7500 Cape Town.

Papadatou, D. & Papadatos, C. 1991. *Children and death*. New York: Hemisphere Publication Corp.

Pietersen, Lewis, 2005. *Interview conducted with a Methodist Church member.* on the 12 February. Johannesburg North.

Report on the Global HIV/AIDS epidemic, 2002. University of Pretoria.

Richter, L., Manegold, J., & Pather, R, 2004. *Family and community interventions for children affected by AIDS. Research monograph,* University of Pretoria, HSRC Publishers.

Rubin, A, & Babbie, E.R. 1993. *Research Methods for Social Work*. California: Wadworth, Inc.

Schoeman, J. P. 1996. Sensory contact with the child. In Schoeman, J, P. & Van der Merwe, A*. Play therapy approach*. Pretoria: Kagiso Publishers.

Schoeman, J.P. 1997. *Play Therapy Short Course Manual.* Pretoria: Department of Social Work, University of Pretoria.

Schwartz. 1997. *Responding to AIDS*. Psychological Initiatives.USA: library congress.

Seidman, T. 1998. *Interviewing as qualitative research*, 2nd ed. New York: Teachers College Press.

Schoub, B. D. 1994. *AIDS and HIV in perspective*. Cambridge: University Press.

Smart, R., Pleaner, P. & Dennil, S., 2001. *A Primary HIV/AIDS capacity Development Course for Government Planners.* Pretoria: Department of Social Development

Smart, R., Pleaner, P. & Dennil, S., 2003. *A Primary HIV/AIDS capacity Development Course for Government Planners.* Pretoria: Department of Social Development.

Snidle & R. Welsh, 2001. *Meeting Christ in HIV/AIDS*, 2001. Salt Water, Cape Town.

Straus, A.L. & Corbin, J. 1998. *Basics of qualitative research*: *grounded theory procedures and techniques*. Newbury Park: Sage.

Strode, A. & Grant, k., 2001. *The role of stigma and discrimination in the vulnerability of children and youth infected with and affected by HIV/AIDS. Report commissioned by Save the children (UK).* Pretoria: Save the children.

Struwig, F.W. and Stead, G.B. 2001. *Planning, Designing and Reporting Research.* Cape Town. Pearson Education South Africa.

Strydom, H. 2002a. Ethical aspects of research in the social science and Human service professions. In De Vos A. S. (Ed.). Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* 2nd ed. Pretoria: J.L. Van Schaik Publishers: 62-75.

Srydom. H. 2002b. The pilot stidy. In De Vos A. S. (Ed.). Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* 2nd ed. Pretoria: J.L. Van Schaik Publishers.

Strydom, H. 2002c. Information collection: Participant observation. In De Vos, A.S. (Ed.). Strydom, H., Fouché, C.B. & Delport, C.S.L. 2002. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 2nd ed. Pretoria: J.L. van Schaik Publishers:278-289.

Strydom. H. & Venter. A. 2002. Sampling and sampling methods. In De Vos .A. S. (Ed.). Strydom. H., Fouché, C.B. & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions.* 2nd ed. Pretoria: J.L. van Schaik Publishers:197-208.

Taylor, G.R. 2000. Introduction and Overview of the research process. In Taylor G.R. (ED). *Integrating Qualitative Quantitative Methods in Research*. Lanham, New York: University Press of America, Inc.

Thomas, R. M. (Ed.). 1992. *Comparing theories of child development*. 3rd ed. Belmont, California: Wadsworth Publishing Company.

Turner, J. S. & Helms, D. B., 1995. *Lifespan Development* 5th ed. Fort Worth: Harcourt Brace College Publishers.

USAID, 2000. *Action Today: A Foundation For Tomorrow:* Annual Report, USAID.

UNAIDS/ WHO. 2005. *AIDS epidemic update*: December 2005. Geneva.

UNICEF. 2004. C*hildren on the Brink. A joint report of new orphan estimates and a framework for action.* 2004. New York: UNICEF.

Van Dyk, A. 2001. HIV/AIDS. *Care and Counseling. A multidisciplinary approach.* 2nd Ed. Cape Town: Pearson Education South Africa.

Van Dyk, A.C. 2003. *HIV/AIDS Care & Counseling a Multidisciplinary Approach*. 3rd Ed. South Africa: CTP Book Printers.

Van Niekerk, A. 1991. *AIDS in context*. A South African perspective. Cape Town: Lux Verbi.

Whitehouse. A., 2001. *A Situational analysis of orphans and other vulnerable children in Mwanza Region.* [Sl], [sn}.

William *et al*. 1995. *Research in Social Work*: *An Introduction*. 2nd Ed. Itasca: Peacock Publishers, Inc.

World Health Organization, 2000a. Durban, South Africa

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

LETTER OF INFORMED CONSENT
THE NEEDS OF CHILDREN IN MIDDLE CHILDHOOD
ORPHANED BY HIV/AIDS

PARTICULARS OF RESEARCHER:

NAME: THOBEKA NKOMO
0824459411
011 9338858 (W)
011 9338340 (FAX)

Participant's name: ----------

Date: ----------

TITLE OF THE STUDY: The needs of children in middle childhood orphaned by HIV/AIDS.

PURPOSE OF THE STUDY: The purpose is to explore the needs of children in middle childhood orphaned by HIV/AIDS.

BENEFITS: There may be no direct benefits from participating in this study, although the child's participation may improve the understanding in dealing with/ fulfilling these orphans' needs.

DISCOMFORTS: There may be emotional discomforts and the respondent will be referred to the social worker at Child Welfare SA in Potchefstroom.

PARTICIPANTS RIGHTS: I understand that my child will be participating voluntarily and has a right to withdraw at any time.

CONFIDENTIALITY: I understand that the data gathered during the course of this study will be kept confidential. The identity of the respondents will not be revealed, unless on legal grounds. Should the results of the study be published, my child's identity will not be revealed. All signed letters of informed consent will be kept in a confidential file.

ETHICAL APPROVAL: This study has to be approved by the Research and Ethics Committee of the Faculty of Humanities, University of Pretoria.

INFORMED CONSENT

I hereby confirm that I have been informed about the nature, conduct, benefits and
risks of this study. I have also received, read and understood the above information regarding the study. I agree to take part in this study and understand that all personal details regarding my child's name and address will not be processed in the research report.

I agree that my child may at any stage withdraw participation in the study and I have had an opportunity to ask questions and hereby give consent to the participation of my child in this study.

Parent/Guardian name ----------

Parent/Guardian signature ----------

Date----------

I hereby confirm that the above parent or guardian has been fully informed about the nature, risks and benefits of this study.

Researcher's name ----------

Researcher's signature----------

Date----------

CHILD ASSENT LETTER

THE NEEDS OF CHILDREN IN MIDDLE CHILDHOOD ORPHANED BY HIV/AIDS

RESEARCHER: T.S NKOMO

I,----------(PARTICIPANT), declare herewith that:

I understand that I will participate voluntarily and have a right to withdraw participation from the study at any time.	PARTICIPANTS RIGHTS I am not forced to take part.
I understand that the outcomes of the study will be kept confidential and should the results be published for any professional reasons, my identity will not be revealed unless on legal grounds.	My name will be kept secret.
I know that information will be treated as confidential and issues that are recorded shall only be used by a social worker to assist me further	The information I share will be between me and the social worker
I understand that I will not receive any gift for my participation in the interview. I am also aware that I will not be penalized if I choose to withdraw my participation.	I will not receive any money or gift
I am aware that the researcher has a responsibility to arrange follow-up intervention for me with Child Welfare social workers at no cost to me, should it be required.	I understand that my needs during this process will be taken care of.
SIGNED: At----------on this------ day ----------2006 Participant's signature---------- Guardian's signature----------	

	RESEARCH TOPIC: THE NEEDS OF CHILDREN IN MIDDLE CHILDHOOD ORPHANED BY HIV/AIDS. **RESEARCHER: T.S NKOMO**	**DATE--------**
THEMES	**SEMI-STRUCTURED INTEVIEW SCHEDULE QUESTIONS**	**COMMENTS**
1.BELONGING	Tell me about your family. Can we draw pictures of your family members?	
	Tell me about your living circumstances?	
	Who cares about you the most in your family?	
	Tell me about the things you do together as a family to have some fun?	
2.FRIENDS, PEERS AND EDUCATION	Tell me about your friends.	
	Who is your best friend?	
	What is it that you like about your best friend?	
	Do you have time to spend with your friends?	
	Which school do you attend?	
Tell me about a day you had to miss school?		
	How is your relationship with your teacher?	
3. RELIGION	Which church do you attend?	
	Tell me about your church?	
	What is your greatest fear?	
	What do you do when you are happy and when can you remember feeling happy?	
4.EMOTIONS	Tell me about when you were really angry?	
	How did you react?	
	Did this action make you feel better? Did it make the situation better?	
	Have you experienced sadness? What was it that made you sad?	
	Have you ever experienced looking after a sick family member? Tell me about it?	
	Who encourages you or gives you hope?	
	Tell me about problems you sometimes experience? How do you solve them?	