

## HEALTH PROMOTION NEEDS OF HAMMANSKRAAL FAMILIES WITH ADOLESCENTS ORPHANED BY HIV/AIDS

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### ABSTRACT

*Health promotion is regarded as the cornerstone of good health. It is the action expected from individuals and families in order to better their own health situation. Health promotion is an art and science (Edelman & Mandle, 2002:16) that is integrated into the primary health care to reduce existing health problems. The purpose of the research on which this article is reporting, was to explore and describe the health promotion needs of families with adolescents orphaned by human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS). The research was located within a qualitative paradigm that is both exploratory and descriptive. Eight families who were purposely selected participated in the research process. Qualitative methods, such as group interviews and field notes were utilised to collect data. The health promotion needs of the families with adolescents orphaned by HIV/AIDS were explored and described. Tesch's analysis process, which entails a series of steps, was followed (Creswell, 2003:192). Themes, categories and subcategories that form the central focus of health promotion needs emerged during the data analysis. These themes, categories and subcategories are used to develop guidelines for health promotion.*

### OPSOMMING

*Die bevordering van gesondheid is die hoeksteen van gesondheid. Dit is die aksie wat van individue en familie verwag word, sodat hulle hul eie gesondheidstoestand kan verbeter. Die bevordering van gesondheid is 'n kuns en 'n wetenskap, wat geïntegreer is in primêre gesondheidsorg, om bestaande gesondheidsprobleme te verminder (Edelman & Mandle, 2002:16). Die doel van die navorsing, waarna in hierdie artikel verwys word, was om uit te vind wat die gesondheidsorgbehoefes van families, met adolessente wat wees gelaat is as gevolg van menslike immunogebrek virus of verworwe immuungebreek sindroom (MIV/VIGS), is, en dit te beskryf. Die navorsing was binne die raamwerk van 'n kwalitatiewe paradigma, wat eksplorerend en beskrywend is. Agt families, wat vir die doel geselekteer is, het aan die navorsing deelgeneem. Kwalitatiewe metodes, soos groepsonderhoude en veldnotas, is gebruik om data in te samel. Die gesondheidsorgbehoefes van die families, met adolessente wat wees gelaat is as gevolg van MIV/VIGS, is ondersoek en beskryf. Tesch se analiseproses, wat uit 'n aantal stappe bestaan, is gevolg (Creswell, 2003:192). Temas, kategorieë en sub-kategorieë, wat die sentrale fokus van die gesondheidsorgbehoefes vorm, het uit die data-analise na vore gekom. Hierdie temas, kategorieë en sub-kategorieë, is gebruik om riglyne te ontwikkel vir gesondheidsbevordering.*

## INTRODUCTION

Health promotion is recognised as one of the most important components of public health and community health practice. This includes all the efforts that seek to move people closer to optimal well-being or higher levels of wellness (Allender & Spradley, 2005:12). It is the action expected from individuals and families in order to better their own health situation in rural communities because of a lack of resources in these communities. Inadequate health promotion leads to the occurrence of chronic diseases such as infection as a result of the HIV/AIDS. It is, however, not sufficient for only the health-care providers to engage in health promotion activities without the involvement and participation of individuals and families. Therefore, families with adolescents orphaned by HIV/AIDS are expected to be involved in the promotion of the health of their relatives, including adolescents, and these people should be made aware of their role in this.

Health promotion is a component of primary health care that calls upon the resources, skills, time, energy and funds of communities and governments (Department of Health, 2001a:1-2). It is a service that is rendered by health-care providers within the community when chronic diseases such as cancer, AIDS and hypertension occur, in order to minimise further complications. A wide range of diseases and people is therefore involved. For this reason, the South African government invited all the stakeholders from the governmental and non-governmental organisations as well as the community to participate in the rendering of health promotion in home-based care in order to prevent health complications that may result from chronic diseases, such as HIV/AIDS (Department of Health, 2001a:1).

Estimates set out by the Department of Health (2000:6-7) suggest that from all the people living with HIV infection worldwide, six out of every ten men, eight out of every ten women, and nine out of every ten children reside in Sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority (Department of Health, 2000:6-7).

A comprehensive home-based care programme, including health promotion strategies, needs to be established and rendered in areas where children are hard hit by

the HIV/AIDS epidemic. An epidemic of this nature destroys families and leaves orphaned children without care and support. It is of the utmost importance to consider all children orphaned by HIV/AIDS just as unique as all other children in South Africa. As stated in the South African Constitution (Act 108 of 1996), all children, irrespective of the status of the child, deserve good nutrition, education, proper treatment, social security, leisure and recreation (Republic of South Africa 1996, Sections 27 and 28).

Despite the involvement of governmental and non-governmental organisations in mitigating the impact of HIV/AIDS, the impact of the disease places psychological strain on the victims and their families. While the South African government is on track towards prevention and reduction of the impact of the disease, the families on the other hand continue to face the socio-economic burdens of health care and funeral costs when breadwinners become ill and die.

The purpose of the research on which this article was based, was therefore to explore and describe the health-promotion needs of families in the community with adolescents orphaned by HIV/AIDS. A qualitative paradigm was followed where the health-promotion needs of families with adolescents orphaned by HIV/AIDS were explored and described. A brief overview of the background, followed by objectives, conceptualisation, methods, discussions and conclusions is demonstrated.

## BACKGROUND OF THE PROBLEM

The surveys conducted on women attending antenatal clinics provide good estimates of HIV prevalence and trends for the past ten years (Department of Health, 2000:6-7). The incidence of HIV in women attending antenatal clinics has increased by 15.3% (Department of Health, 2000:6-7). The statistics also reveal that one in every pregnant woman attending the clinic, was HIV/AIDS positive (UNAIDS, 2006:17). Even though these women were infected, there was also a gradual escalation of HIV (UNAIDS, 2006:17). Furthermore, the rural areas in the Kwa Zulu Natal, Mpumalanga, Free State and Limpopo provinces are most affected. In comparison with the other provinces in South Africa, KwaZulu-Natal has the highest HIV prevalence among pregnant women 37.5%, followed by Mpumalanga 32.6%, Free

State 30.1%, North West 29.9% and Gauteng 29.6% (Abdool-Karim & Abdool-Karim, 2005: 56). The provinces with the lowest statistics of HIV and AIDS are Western Cape 13.1%, followed by Northern Cape 16.7% and Limpopo Province 17.5% (Abdool-Karim & Abdool-Karim, 2005:56). Mother-to-child transmission (MTCT) of HIV infection can be prevented by appropriate treatment. However, while their infants survive, the mothers do not, and children are left in the care of other family members, often the elderly.

The Department of Health (2000:10) recommends that interdepartmental and intersectoral response to the epidemic should be encouraged. The provision of care to children who have lost their parents through HIV/AIDS is a priority for the national government. In addition to the mobilisation of financial and material resources, health-care services have to be developed to meet these children's unique needs.

In response to the increase of the HIV/AIDS epidemic and the limited health-care resources in South Africa, the government took the initiative to shift the care of these patients from hospital settings to community and home-based care settings. Patients and their families are empowered to control their own health situation. The promotion of health of the families and thus also that of the orphaned children is therefore indicated. The care should be holistic, person-centred and sensitive to the patient's culture, religion and value system concerning respect, privacy and dignity (Department of Health, 2001a:4-5). Health promotion in rural communities should be seen as an empowerment strategy that will allow capacity building and that will promote the autonomy and functional independence of the individual and family (Department of Health, 2001a:4).

Families who take care of HIV/AIDS-orphaned adolescents are faced with challenges concerning health promotion as the latter forms part of home-based health care. Guidelines and strategies need to be formulated to assist families to engage in health promotion of families with special emphasis on that of orphaned adolescents.

## PROBLEM STATEMENT

The lack of health-related resources, such as the lack of health-care services, lack of information on health

care and poor access to health-care services in South Africa makes home-based health promotion inevitable. Health promotion in home-based care is a priority in the sense that there is a shortage of hospital beds as a result of chronic diseases such as AIDS, the escalating cost of institutional care, and the lack of resources for treatment (Department of Health, 2001a:2). The implementation of health promotion strategies in rural communities will therefore enable families with adolescents who have lost their parents as a result of HIV/AIDS to give relevant care to their own members.

As yet there is no formal, written health promotion guidelines for families with adolescents who were recently orphaned by HIV/AIDS in rural Hammanskraal. The question below is therefore applicable: *What are the health promotion needs for Hammanskraal families with adolescents orphaned by HIV/AIDS?*

The focus is on adolescents as they will be the parents of the next generation and will therefore have to be role models in health promotion.

## THE OBJECTIVE OF THE RESEARCH

The following specific objective forms the basis for the research, namely:

- To describe the health promotion needs of families in rural Hammanskraal with adolescents orphaned by HIV/AIDS.

## DEFINITIONS OF CONCEPTS

### Health promotion:

O'Donnell ((1987) in Edelman & Mandle, 2002:16) defines health promotion as the science and art of helping people to change their lifestyle in order to move towards a state of optimal health.

### Adolescent orphaned by HIV/AIDS:

For the purpose of the study on which this article is based, a recently orphaned adolescent refers to any adolescent who has lost his/her last surviving parent and who is between the ages 10 and 17 years old. The HIV/AIDS status of these orphans is not known and is not part of the current research focus.

## RESEARCH METHOD

The researcher worked within a qualitative paradigm. An exploratory, descriptive and contextual method was utilised to explore the needs related to the health promotion of adolescents orphaned by HIV/AIDS.

## RESEARCH POPULATION AND SAMPLING

The research population had to meet certain inclusion criteria. Families with adolescents orphaned by HIV/AIDS who are residing in rural Hammanskraal villages were involved in the research interviews. The participants who were involved in this research were grandmothers, a grandfather, related adults such as siblings, as well as orphaned adolescents aged between 10 and 17 years old. The families who were chosen to participate in the research were poor and could not survive on their own. The researcher included only adolescent orphans between the ages of 10 and 17 years, who had lost their last surviving parent not long before the research was conducted. Families with older adolescents were not involved as well as families with surviving parent. Because of ethical reasons that involve confidentiality, a social worker of the Moretele Sunrise Hospice was involved in order to select families that meet the criteria set for the research and these families form part of the research population. All the families with adolescents between ten and seventeen years old who have been orphaned by HIV/AIDS and who were living in Hammanskraal and who were in a way associated with the hospice were included in the study population.

Purposive sampling was used to sample the population for participation. For the purposes of this study, the researcher requested a knowledgeable social worker to handpick study participants. This method was used to select families to be included in the study and all participants were included irrespective of their HIV status. This type of sampling is based on the belief that a researcher's knowledge about the population can be used to handpick cases to be included in the sample (Polit, Beck & Hungler, 2001:234; Burns & Grove, 2003:43).

## DATA COLLECTION

Data were collected by means of group interviews until

saturation was achieved. Group interviews were conducted with families with adolescents orphaned by HIV/AIDS. Eight groups of families participated in the discussions. A tape recorder was used to record all the discussions of the groups. The participants were arranged in smaller family groups and they provided the researcher with data of a qualitative nature.

The interviews were conducted in the homes of the participants in 2005. Interviews were conducted for 45 minutes to an hour. Follow-up interviews were conducted until data were saturated. Three to four interviews with each group were conducted. The researcher also created a favourable and non-threatening environment for the interviews by warmly thanking the participants for their willingness to participate in the research (Rossouw, 2003:146-147). The participants were interviewed in Tswana, as it was their preferred home language. The transcripts were then later translated and typed into English. Each family group was interviewed separately.

A tape recorder was used during the interviews in order to capture all the data available. Various communication skills, such as paraphrasing, probing and reflecting, were employed during the interviews.

Paraphrasing was used frequently during the interviews in order to ensure that the research question was understood. The research question: "What do you need in order to promote your own health" was posed clearly and the participants were expected to restate the ideas contained in the question clearly and concisely (Burns & Grove, 2003:491).

Probing was also used to draw more information from the participants during the interviews. This involved repetition of the original question and long pauses, which were intended to communicate with the participants (Babbie & Mouton, 2007:253). The question "What do you need in order to promote your own health?" was frequently asked. During the research process, various methods, such as asking "Anything else?", were also used to get as much information from the participants as possible. These neutral probing methods were used in order to avoid affecting the nature of the responses (Babbie & Mouton, 2007:253-254).

Reflection was used in order to remind the participants of what had been previously said and in order to link

this with current discussions. During subsequent visits, the researcher encouraged the participants to reflect on their health promotion needs (Burns & Grove, 2003:495).

Interviews were conducted until data were saturated. After data were collected, it was transcribed and analysed. A comprehensive report on the findings of the research was written. After the initial interviews, appointments with the participants were made for two months' time in order to ensure member checking and the validity of data. The reason for the appointment was explained to the participants. Constant checks with participants have been conducted to verify the data. The researcher visited individual families, and explained and clarified the results. The participants confirmed that no incorrect data had been collected or added. The conclusions formulated from the data were discussed to ensure the validity of the findings.

Field notes were made in the forms of personal notes during the interviews with the families. These notes included both empirical observations and interpretations, and contained an objective description of events, times, places, activities and non-verbal cues. Persistent observations regarding health promotion activities during interview visits were conducted. During the research interviews, the participants were consistently observed in their homes regarding their health promotion activities. The researcher conducted several visits to collect data from the participants. The field notes were also compiled during interactions and discussions with the families.

## **ETHICAL CONSIDERATIONS**

Permission to conduct the research in the North West Province was granted by the Jubilee District Deputy Director (Mr D Baloyi). The Ethics Committee of Faculty of Health Care Sciences of the University of Pretoria further evaluated and approved the proposal. Principles of research ethics were always applied. The following principles served as a guide in this study: beneficence, respect for human dignity, justice, informed consent, respect for vulnerable subjects and protection of human rights.

All participants were respected and treated with dignity. They were given the opportunity to make informed

voluntary decisions. Freedom of decision-making was granted to all participants. The participants were treated fairly and their privacy always maintained. The participants were also guaranteed confidentiality of the information they provided. The researcher tried by all means to avoid any harm to the participants. The participants were assured that the information would not be used against them in any way (Polit, Beck & Hungler, 2001:73-89).

The researcher made use of the second information leaflet to assist the representatives of the families who were interested in becoming research participants in making informed decisions. The visit took place one week prior to commencement of the research process. The prospective participants were fully informed of the purpose of the study, the type of data to be collected and the procedure to be followed, as well as their rights regarding participation, the nature of the commitment, potential risks and potential benefits.

The guarantee of confidentiality, voluntary consent, the right to withdraw and contact information were discussed before the data collection commenced (Polit *et al.* 2001:73-89). The concept of health promotion was analysed and described to enable the participants to understand it. The dissemination of the results of the research was thoroughly explained. The family representatives signed the consent form on behalf of their families before data were collected. The family members selected the representatives.

During the research process, the researcher adhered to all ethical principles applicable to the research. Standards for ethical and sound research were adhered to. The rights of the children who participated in the research were respected. Sensitive questions, such as the cause of their parents' death, were avoided (Polit *et al.* 2001:83).

## **DATA ANALYSIS**

Qualitative methods of data analysis were used. Data analysis began when the first data were collected, which in turn guided decisions towards further data collection (Burns & Grove, 2001:66). It is an ongoing process, which involves continual reflection about the data, analytical questioning and the writing of notes throughout the study (Creswell, 2003:190).

Two independent coders who were experienced qualitative researchers and who have been involved in various research report evaluations were purposely selected and coded the transcribed and translated data. The role of the researcher was to ensure that the codes were formulated within the context of the data collected. Two coders as researchers were chosen to take part in the analysis and coding as they had not been involved in the data collection and were therefore less biased. The researcher and one co-coder could speak, read and write Tswana and English. The analysis of the data was done in English. Coders checked each other on the themes classification in the data analyses discussion. A consensus discussion was held with co-coders. The three sets of coded data were compared, discussed and adjustments were made.

Tesch's analysis process, which entails a series of steps, was followed (Creswell, 2003:192). The first interview with the first family was chosen and analysed. The coders got a sense of the transcripts by reading them repeatedly. All ideas were highlighted. Thoughts and ideas about the content of the interview were written down. Each coder completed their analysis of the transcribed interviews before comparing it with that of the others. Themes, categories and subcategories were identified through the clustering of descriptive phrases derived from the data. After a comparison, a final decision on the description of each theme was made. The data of each theme were assembled. Data were recoded when necessary to ensure credibility (Creswell, 2003:192). The description of themes and categories were presented in tables as adjuncts to the discussions. Interpretation of the meaning of data was conducted. ‘

## TRUSTWORTHINESS OF THE FINDINGS GENERATED

Trustworthiness refers to how a researcher can convince her/his audience that the findings are correct and worth paying attention to and taking account of (Lincoln & Guba, 1985:290). Guba's model for trustworthiness was utilised to ensure validity and reliability within the research on which this article is reporting. In this research, to establish the trustworthiness, the following strategies were used: confirmability, credibility,

transferability and dependability (See Table 1).

## DISCUSSIONS OF THE RESULTS

Thirteen themes, twenty-six categories and forty-five subcategories emerged from the data analysis. The themes and categories reflecting the participants' expressions are displayed in Table 2.

### PHYSICAL NEEDS

The first theme that emerged relates to physical needs. Two categories, namely basic needs and unmet basic needs, emerged from the discussions. Physical needs play a major role in the survival of the individual person. These needs are also regarded as basic needs for all people irrespective of age, status or cultural background. The focus of the discussion on basic needs in this category was on food and nutrition, water and sanitation, housing, sleep and rest, elimination of body waste, stimulation and activity and the participants expressed their needs in this regard as follows: *“We are suffering with hunger. We need food to feed ourselves and be alive. We need water for daily activities in the home. We need a house that belongs to us. We need our own yard. We need blankets and mattresses; the mattresses we use are too old and the springs are pointing out. Usually we use traditional exercises and games but they are not enough. I want to train to be fit”*.

Literature suggests that basic needs as mentioned in Table 2 need to be provided by governmental and non-governmental organisations (Ramsden, 2002:14 & Department of Health, 2001b:10). Emphasis was on nutrition and water as major basic needs. Allender and Spradley (2005:635) mention that adequate nutrition, as one of basic needs, should begin at birth and extend to young children and women. De Haan, Dennill and Vasuthevan (2005:210) add that correct and quality food is essential for health and life itself. It was also emphasised in the United Nations Convention on the rights of the child that all children have a right to have basic needs such as provision of food fulfilled (Ramsden, 2002). President Thabo Mbeki, in his address to the public, supported and emphasised the need for clean running water to reduce local health problems (South African Government Information, 2003:1-5).

**Table 1: Strategies to ensure trustworthiness**

STRATEGY	CRITERIA	TECHNIQUE
<b>Confirmability</b>	Confirmability audit	-The objectivity of the researcher ensured confirmability. -The researcher has various years of experience in the community environment. -The use of raw data.
<b>Credibility</b>	Prolonged engagement	-The researcher spent 3-6 months with participants. -Field notes were kept.
	Triangulation	-The use of different families in collecting data. -Information was gathered by making use of interviews, field notes, observations and literature reviews to ensure triangulation. -The use of three co-coders in analysing the data.
	Member checking	-Constant check with participants to verify findings. -Coders check each other on the themes classification.
	Persistent observations	-Persistent observations regarding health promotion activities. -Several visits to collect data from participants
	Peer examination	-Independent co-coders were used to code and verify.
<b>Transferability</b>	Dense description	-Various interview visits were conducted.
	Selected sample	-The use of purposive sampling.
<b>Dependability</b>	Code-recode procedure	-Consensus was held with co-coders. -Field notes were taken and non-verbal cues were noted.

Adapted from Lincoln and Guba (1985:290), Lehana and Van Rhyn (2003:30-31), Richter and Peu (2004)

Unmet basic needs are the second category that emerged during the data analysis. These needs are the challenges that are experienced by families in rural Hammanskraal with adolescents orphaned by HIV/AIDS. These challenges are encountered when an individual family experiences a lack of resources for basic needs. Solutions might be available but not accessible to the people at ground level. The participants in the study emphasised a lack of resources or facilities and this serves as a barrier to survival. The participants revealed that: *"We have inability to pay for what is needed"*.

Siaens, Subbarao and Wodon (2003:2) mention that there is evidence to suggest that, on average, orphans in Africa live in poorer households compared with non-orphans. According to African tradition, the majority of these orphans are placed either in extended families or in fostering households (Siaens *et al.* 2003:2). It is not surprising to see poor living conditions amongst families with orphans. It can be suggested that families with a number of children without support experience poverty.

**Table 2: Themes, categories and sub-categories identified**

<b>NO.</b>	<b>THEMES</b>	<b>CATEGORIES</b>	<b>SUBCATEGORIES</b>
1.	Physical needs	Basic needs  Unmet basic needs	Food and nutrition Water, sanitation and elimination Housing Sleep and rest Stimulation and activity Lack of resources
2.	Safety/security needs	Physical and personal security  Financial security	Fence surrounding house Own stand Employment with sufficient income Clothes Money for healthcare and clothing purposes Money for educational purposes
3.	Love and belonging needs	Internal environment  External environment	To be loved by family members To be loved by non-family members
4.	Emotional needs	Conflict  Recreational facilities  Concerns	Fights House chores Disrespect toward grandmothers Boredom Teen pregnancies Worry about not be given a decent funeral Stigma attached to being an orphan
5.	Family structure	Internal family structure External family structure	Need for parental care Need an elderly person
6.	Healthcare needs	Clinics Personnel General health problems and intervention needs  Illnesses	Utilisation of clinics Doctors and nurses Treatment Counselling Better hygiene Epilepsy Arthritis Epistaxis Asthma



7.	Esteem needs	Self and others	Need for respect, recognition and dignity
8.	Educational needs	Facilities Constraints	Need for school materials Long distance to school Lack of libraries and facilities for career guidance
9.	Spiritual needs	Church services and other related needs	Prayer, attending church ceremonies and religion
10.	The need to be a whole person	Fit into the family and society	Emotions because of limited choices
11.	Support needs	Internal support External support	Family members Community Government
12.	Social needs	Social needs related to interaction with others Social needs that professionals can help with	Recreational activities Social service
13.	Needs related to technology	Telecommunication Other appliances	Computers, telephones Microwave and kettle

## SAFETY/SECURITY NEEDS

Participants regarded safety or security needs as an important aspect of human survival. The participants are of the opinion that a healthy family has a need to reside in a physically secure environment and families should be financially stable. The participants expressed that: *“There is no security and the place is not safe, because there is no fence. One member is working and the pay is insufficient”*.

It was indicated that in South Africa, every 23 seconds a child is molested and every passing minute of the day a child as young as five months is gang raped (Crime Buster, 2004:1). It shows that children in this country are vulnerable and are at high risk to abuse. It is even more so in the case of this research due to their status as orphans.

South Africa is a country with a high unemployment rate. In the year 2001, the unemployment rate was 29.5% (Van Rensburg, 2004:206). In rural areas, the unemployment rate was 30.2% (Van Rensburg, 2004:206). Kingdom and Knight (2005:1) mention that in South Africa, unemployment is extremely high and

rising. Kingdom and Knight (2005:2) further indicate about 40% of adults in South Africa are unemployed.

Although money is an important need for these families, money needs to be used well and saved properly when it is available to the people. In support of how the participants have expressed themselves, the government today advocates a better life for all through a variety of strategies (Mbeki, 2004).

## LOVE AND BELONGING NEEDS

Love and belonging needs emerged during data analysis. Internal and external environments emerged from love and belonging. The participants mentioned that love is needed in order to belong to a particular unit. The families with adolescents orphaned by HIV/AIDS emphasised the need to be loved, to belong to a family kinship, and also to be acceptable to, and accepted by the society. The participants indicated that they need to be loved by their family members. Family members such as uncles, aunts and grannies play an important role in love and belonging. Loving and love stimulate self-worth and self-actualisation as principles of a healthy person. The participants mentioned that: *“We*

also need good attention from our schoolmates and attention from other people and our parents”.

Graca Machel in the year 2003 confirmed that orphaned children cannot wait and their rights cannot be postponed (Kalideen, 2003:1). Graca further indicated that it is the responsibility of individuals, families and groups to start acting in a caring and responsible manner (Kalideen, 2003:1).

Similar ideas and opinions were expressed in Murray and Zentner (2001:160). It was stated that a family is constituted to provide an opportunity for the expression of love and support in a stable relationship benefiting all its members. The orphans also need to be loved by family members to promote their self-worth or self-esteem. If these needs are not taken into account individuals become unfriendly, and they feel unloved, rejected, abandoned and even restless (Marker, 2003:1).

## EMOTIONAL NEEDS

Emotional needs as a theme emerged and was further categorised into conflict, recreational facilities and concerns. Conflict in the form of fights as a result of house chores and no respect for grandmothers are major concerns among these orphans. Participants mentioned that: *“We need an elderly person who can advise us or even to stop us when we are fighting. These children are fighting and we are unable to handle the situation. We fight frequently. I always think too much, I remember my mother. I think where she has rested. We need funeral society with funeral plans, if one member dies, we must be able to bury her/him”*.

Death of loved ones is described by Mengel (2003:31) as emotional numbness, inner sorrow and longing, which result in a refusal to accept the changes that are associated with death. It also influences the way in which people react to death. During the current research the death of parents made the adolescents very aware of how necessary it is to prepare for death, funerals and the associated costs.

## FAMILY STRUCTURE NEEDS

A family is a unit with different sub-units. The internal and external family structures emerged from family structure. Each sub-unit contributes towards the sur-

vival of the whole family. Interference of one of the sub-units will affect the functions of other sub-units. Family structure was mentioned as an important aspect for the survival of the family when the theme family structure emerged during data analysis. The participants mentioned that: *“A complete family is necessary. There is a need for parental care”*.

Andrews and Boyle (2003:170) also mention that elderly individuals can provide multiple care-giving roles, such as caring for orphans. It should be noted that from an African perspective elderly community members are preferred to take care of orphans because they have the ability to transfer traditional norms to the adolescent and thus ensuring that the cultural traditions and norms are passed on to the next generation.

## HEALTH-CARE NEEDS

Health-care needs specifically emerged during data analysis. It was further categorised into sub-categories namely: clinics, personnel, interventions and illnesses. Health care as a need was emphasised in the research. The participants mentioned that: *“We need health care such as clinics. All clinics should be accessible for the care needed in promoting the health of these families. We need a doctor or medical aid because one of our family members is sick”*. *“We need doctor or medical aid because one of our family member is sick”*. *“We need good health to live longer”*. *“She (an epileptic) is receiving treatment from the clinic”*.

In the strategy for the implementation of primary health care, Dennil, King and Swanepoel (2002:6) emphasise that health services such as clinics should be accessible, affordable, available, effective and efficient, and it should be supplied equally to all in the community. Geographically the community should have a clinic within five-ten km and there should be transport available. Dennil *et al.* (2002:6) further emphasise that special attention should be given to disadvantaged regions of the country, especially rural areas.

Murray and Zentner (2001:560) add that adolescents experience difficulty when dealing emotionally with chronic disease or illness because they feel different from and set apart from peers. They tend to isolate themselves from peer activities and become isolated and lonely.

According to the Batho Pele principles, the members of the community should be consulted, and treated with courtesy. Health-care personnel, including nurses and doctors, should render a client friendly service to all people of South Africa, and high standards of services are guaranteed by the Minister of Health (Department of Public Service and Administration 1997). Good treatment could be ensured through appropriate primary health care, the implementation of the Batho Pele principles, the use of guidelines for good clinical practice, implementation of applicable legislation and adhering to treatment protocols for illnesses such as epilepsy, arthritis, epistaxis and asthma (Department of Public Service and Administration 1997).

## **ESTEEM NEEDS**

The need for esteem and self-worth was identified. When it was explored, it became clear that the participants experienced problems regarding self-worth and esteem. The participants focused on their needs regarding respect, recognition and dignity. The majority of teenage adolescents commented that: *"I want to be something when I grow old. I think if we can find a kind person, we can share our problems. The one who is approachable and sharp"*.

It was indicated that an adolescent needs respect and privacy (Month of the Young Adolescent, 2005:1). Carpenito-Moyet (2003:3-4) mentions that adolescents need support for the development of self-respect, recognition, honour, glory, status, independence, freedom, appreciation and dignity because these are necessary in the healthy life of an adolescent.

## **EDUCATIONAL NEEDS**

Education as a need emerged during data analysis. The participants in this research mentioned education as a need that has an effect on the promotion of health. Education was also regarded as a right to all participants. The participants regarded education as a pathway to better their lives. The participants further added and emphasised that even though there are constraints in education, education still remains a right to all individuals irrespective of life situations. The participants expressed that: *"We have no textbooks, we need school uniform, clothes as well as raincoat and umbrellas for rainy days. I travel a long distance"*.

The current school system in South Africa aims to produce learners who participate in their learning activities to become more responsible for their studies. They should be creative in their learning environment but the government should provide them with learning resources. Section 29 of the South African Constitution stipulates that no one should be subjected to discriminatory actions and that South African institutions such as schools have to be registered institutions in order to assist in promoting the health of the people (South Africa, 1996).

## **SPIRITUAL NEEDS**

Spiritual needs also emerged during data analysis. The focus of discussion was on the church service-related needs and other spiritual needs. Health promotion and spirituality are concepts that are related and interlinked. When one is spiritually satisfied, that person's health is promoted. People's spiritual need is fulfilled through praying together, attending churches, the nurturing role of family members, the use of values and residing in a safe environment. The participants indicated that: *"We also want to attend the church. The church enables people to pray for each other and love each other"*.

In view of the above comments, Spector (2004:104) suggests that religion plays a vital role in one's perception of health and illness. He further mentioned that culture and ethnicity are strong determinants in an individual interpretation of the environment and the events within the environment. The families who participated in this research have their own cultures and belong to various ethnic groups that assist them to survive. In addition, Spector (2004:116) indicates that when someone is experiencing an illness of the spirit, spiritual healing applies. Andrews and Boyle (2003:436) add that few studies conducted on African-Americans have found that they use religious beliefs to help them to cope with stress during provision of care.

## **THE NEED TO BE A WHOLE PERSON**

The need to be a whole person emerged as a category during data analysis. The participants expressed their need to be fitted into their families and society. Due to a lack of health promotion needs, the participants emphasised that it is really difficult to align oneself with other people. The participants had the idea that the

only way to fit into the family is to have belongings, such as a house and furniture. The participants expressed emotions and volition as: *"We want a brick house. We need chairs to give visitors. We need clothing to be like other children"*.

Exponents of humanistic theory emphasise that an individual as a whole person, particularly in learning environment, should be considered and respected (Quinn, 2000:44), the participants wanted to be whole persons. According to humanistic learning theorists people learn better in an encouraging environment (Allender & Spradley, 2005:289). Therefore in Maslow's Hierarchy of Human Need theory, it is asserted that meeting self-esteem needs contribute towards a feeling of self-worth thus leading to self-actualisation (Allender & Spradley, 2005:289). Individuals are becoming beings and will never attain a state of wholeness. It is difficult to replace a lost parent, but it is however negotiable to provide a substitute parent to provide in the needs of the orphans regarding the promotion of health so that these children can be well fitted in the family and society.

## **SUPPORT NEEDS**

The participants mentioned the need for support in health promotion. The focus was on the need for support and focused on the family, the community and the government. The participants mentioned that: *"We need a person to encourage us because we are fighting. At least if the government can help to reduce the load from me. It should provide us with food and school materials"*.

In support of the above statements, Ramsden (2002:23) suggests that families who care for other people's children should be financially supported. He further expresses that families with orphans need financial support, such as state grants. Many of these children will be taken care of by a grandmother or other elderly relative, who may need extra help to match the responsibility. The support as it is emphasised, is needed to promote the health of the orphans.

Ramsden (2002:24) emphasises that any person, such as a neighbour or a teacher, can act as a foster parent through a children's court. The case will however be reviewed every two weeks to check whether the child is cared for. Various researchers are striving towards

investigating the support that is relevant to specific communities. Amongst those researchers, Richter and Peu (2004:38-39) assisted in the investigation of the supportive needs of informal caregivers who are serving families of this nature. Richter and Peu (2004) mentioned that government should help with finance, water, security and medicines. These comments suggest that there is a need for government to support disadvantaged families.

## **SOCIAL NEEDS**

The focus of discussion was on the social needs related to interaction with others as well as the social needs that the professionals can help with to promote the health of the families. These social needs are relevant to both orphans and substitute parents. These social-related needs would assist the orphans in thinking critically and at the same time these social-related needs will contribute to the recreational opportunity of the mentioned party. The participants expressed that: *"We want basic needs such as recreation centres. We need music system because it is too quiet at home"*.

Elfituri, Elmahaishi and MacDonald (1999:2) indicate that the radio as a medium could influence the behaviour of people positively. They further emphasise that there is a need to use different educational and recreational media in future planning. In support of the value of recreation, Ramsden (2002:14) indicates that children have the right to play, to recreation and to participate in cultural activities. The involvement of adolescents in traditional games, however, if encouraged regularly, will promote the health of these families and their ability to cope with stressors.

## **NEEDS RELATED TO TECHNOLOGY**

The needs related to technology were the 13<sup>th</sup> theme that emerged during data analysis. It focused on telecommunication and other appliances. Telecommunication can be used as a medium for providing health education as it is used to contact people when necessary. The participants expressed the need for telecommunication in promoting their health. The participants explored and described telecommunication as: *"We need telephone in the house in order to communicate with social worker to help us. We need telephone container where the community can come and use mobile*

*telephones because I want to run a telephone business."*

Telecommunication refers to communication over a distance by cable, telephone, or broadcasting (Pearsall, 2002:1472). According to the research on which this article is based, telecommunication can be used by families to exchange or share information with their external environment, such as family members. Kessler (2002:6) mentions similar information in learning communication skills, as the adolescents can express themselves more effectively, fully and authentically. The participants in the research mentioned communication as a system that carries messages on health promotion.

Communication refers to the process of exchanging feelings, desires, needs, information and opinions (McCubbin & Dahl, 1985, *in* Friedman, Bowden & Jones, 2003:267). In conclusion, families with adolescents orphaned by HIV/AIDS need to be provided with some form of communication, for an emergency or any other important incident. Their intense feelings regarding the past need to be shared in a communication process. The research, on which this article is reporting, could also assist policy-makers to integrate a need for communication in promoting the health of rural families.

## CONCLUSION

The research question, *What are the health promotion needs of families in rural Hammanskraal with adolescents orphaned by HIV/AIDS?* guided the researcher to focus on the content of the research on which this article is reporting. Based on the above question, the researcher and participants followed the process of research. The participants were therefore expected to explore and describe their health promotion needs, which focused on the following: physical needs, safety or security needs, love and belonging needs, emotional needs, family structure needs, health-care needs; esteem needs; education needs; spiritual needs, needs to be a whole person; support needs; social needs as well as the needs related to technology. It can therefore be concluded that the majority of participants emphasised the importance of promoting their health with the help of available resources.

A small sample, including eight rural families, was used in this research. The results cannot be generalised because families are dynamic and can be influenced by their environmental settings. An urban family might, for instance, have different challenging needs as compared to a rural family.

Despite the limitations of this research, it is recommended that the identified needs be used to develop guidelines for the health promotion of families with adolescents orphaned by HIV and AIDS.

In view of the findings of the research, the researcher also recommended that:

- All government officials (legislators, traditional leaders and administrators) should respond harmoniously according to the application of relevant policies and legislation when nurses lobby towards provision for health promotion needs for families with adolescents orphaned by HIV/AIDS.
- Through social action the government and nurses should mobilise resources in order to facilitate social change and collaborative networks in health promotion regarding basic needs of families with adolescents orphaned by HIV/AIDS.
- Involvement of nurses, legislators, traditional leaders and administrators in community development to enhance health promotion behaviours in families with orphaned adolescents.
- Organisational stakeholders (managers and traditional leaders) should be consulted regarding application of policies and allocation of resources with emphasis of Maslow's Hierarchy of Human Needs.
- Nurses should influence organisational managers and traditional leaders to train the community to utilise available support programmes responsibly.
- Nurses should develop and utilise networks consisting of accessible and relevant services to the benefit of orphaned adolescents.
- Health education should be provided continuously to conscientise families with adolescents about health promotion needs and behaviours.
- Families with adolescents orphaned by HIV/

AIDS should be screened to identify their health promotion needs that promote their healthy lifestyle.

- Nurses should ensure that families with adolescents orphaned by HIV/AIDS are counselled to cope with loss and limited resources and to meet the needs of these families.
- Nurses should provide culturally sensitive guidance regarding access to resources and support in utilising available resources to satisfy basic, safety and security, love and belonging, self-esteem and self-actualisation needs of these families.

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