- CHAPTER 7 -

EMPIRICAL RESEARCH FINDINGS

7.1 INTRODUCTION

South Africa has one of the most severe HIV/AIDS epidemics in the world. There are 40 million people living with HIV globally, of which it is estimated that 5.3 million South Africans are HIV positive with a possible range of between 4.4 million and 6.2 million (Medical News Today, 2005: 1). AIDS has taken its toll in South Africa and will continue to do so, especially among those who do not have the knowledge, skills or resources to protect themselves against its slow march. Of particular concern is the impact of AIDS on AIDS orphans. Most orphans will grow up without adequate parental supervision, guidance and discipline under impoverished condition – an environment that exposes them to being infected with HIV themselves.

It has been established in the previous chapters that the absence of basic knowledge and life skills contribute to the vulnerability and exploitation of AIDS orphans. Anderson and Okoro (2000: 2) note that the only solution will be to purposefully employ a continuous positive preventive approach in order to stabilize or change the life-styles of the youth. Life skills teaching promote the learning of abilities that contribute to positive health behaviour, positive interpersonal relationships and mental well-being. Effective acquisition and application of life skills contribute to the prevention of drug abuse, child abuse, infection with HIV and teenage pregnancy. Therefore the ability of life skills programmes to assist AIDS orphans to cope is seen as critical (Anderson & Okoro, 2000: 26). However such programmes should be supported by research-based information.

In response to this crisis in South Africa, the researcher endeavours to craft an innovative programme to help early adolescent AIDS orphans to develop necessary life skills that will improve their capacity to cope with problems they encounter.

The researcher has formulated the goal of the study as:

To develop and empirically test a life-skills programme for early adolescent AIDS orphans.

Accordingly study objectives included:

- To conceptualise theoretically the phenomenon of HIV/AIDS and AIDS orphans, the specific characteristics, needs and problems of early adolescents as well as life skills programmes for early adolescents;

- To explore and identify the nature and prevalence of socio-emotional needs and problems of early adolescent AIDS orphans;

- To explore and identify the life skills which AIDS orphans, in their early adolescent phase need to improve their coping capabilities;

- To develop a life-skills programme for early adolescent AIDS orphans;

- To empirically test the effectiveness of the developed life skills programme for early adolescent AIDS orphans; and

- To suggest practical recommendations for further utilisation of the newly developed life skills programme for early adolescent AIDS orphans.

According to the main goal and objectives, the following research questions were formulated:

- **What is the nature and prevalence of socio-emotional needs and problems of early adolescent AIDS orphans?**

- **What are the life skills needed by early adolescent AIDS orphans?**

The following hypothesis was thus formulated:

If early adolescent AIDS orphans undergo a life-skills programme then their skills will be enhanced in order to cope better with their socio-emotional needs and problems.

In the context of applied research the type of research conducted in this study was **intervention research**. This type of research was relevant for this particular study because it is a problem-solving process seeking an effective intervention programme for the promotion of life skills for early adolescent AIDS orphans. In view of the fact that the AIDS orphan situation is a crises for the whole nation innovative preventative positive educational programmes for children orphaned by AIDS are pivotal.

The selected research approach that was utilized in this study was the combined quantitative-qualitative approach according to one of Cresswell's three models of combination, which is the two-phase model (De Vos, 2002: 366). The researcher commenced with a qualitative phase of the study then followed by a quantitative phase of the study. She undertook a qualitative study to gain a holistic understanding of the phenomenon HIV/AIDS, the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans. She then proceeded to the second phase where she primarily developed a life-skill programme for early adolescent AIDS orphans based on the qualitative first phase and an in-depth literature study. She further empirically tested the effectiveness of the newly developed programme.

The researcher used semi-structured interviews with a schedule to collect qualitative data during the first phase of the research. During the second phase, the researcher utilised a self-constructed group administered questionnaire to collect quantitative data before and after implementation of the life skills programme (pre-test and post-test).

In this chapter, the results of the empirical study are presented according to both the qualitative data collected by means of semi-structured interviews (during the first phase of the research) and quantitative data collected by means of questionnaires (during the second phase of the study). The primary aim of this chapter is to present, analyze and interpret the qualitative data in the first section (Section A) and then quantitative data in the second section (Section B).

SECTION A

7.2 QUALITATIVE FINDINGS (FIRST PHASE)

In order to explore the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans, a phenomenological design seemed appropriate. According to Fouché and Delport (2002: 268) "a phenomenological study is a study that attempts to understand people's perception, perspectives and understanding of a particular situation. The goal of this approach is to understand and interpret the meaning the subjects give to their every day lives". The phenomenological design was used because in South Africa there is little information on children orphaned by AIDS. The specific nature of their needs has not been fully documented. Therefore, the design is appropriate because it enabled the researcher to explore and give insight to the phenomenon of AIDS orphans; the socio-emotional needs and problems of AIDS orphans; and the life skills needed by AIDS orphans. Focus was on the essence of the meaning that subjects give to their daily lives.

The researcher implemented thus the phenomenological design to get answers for the following research questions:

a) What is the nature and prevalence of socio-emotional needs and problems of early adolescent AIDS orphans?

b) What are the life skills needed by early adolescent AIDS orphans?

The researcher conducted semi-structured interviews with a schedule with social workers, caregivers and AIDS orphans in the North-West Province. The goal and procedure of the study were explained to each of the respondents. Participation was voluntary and data was gathered during semi-structured interview with a schedule. The researcher will first describe the appropriate research methodology and then present the results of semi-structured interviews conducted with social workers, then caregivers and finally AIDS orphans.

7.2.1 Research methods

This section describes the sample and sampling technique, methods of data collection as well as data analysis used during the qualitative phase of this research study.

In this stage the researcher interviewed 10 social workers who have experience in working with AIDS orphans and 10 caregivers who are involved in caring for AIDS orphans from the major two cities of the North-West Province namely Rustenburg and Mafikeng. The researcher also interviewed 20 AIDS orphans from Ledig one of the villages in Rustenburg (North-West Province). They were all selected from one primary school.

The researcher used **availability sampling** to select the 10 social workers and 10 caregivers while **purposive sampling** was used to select the 20 AIDS orphans. The sampling method seemed appropriate since the researcher was interested in selecting

the sample on the basis of her knowledge of the population and the nature of research aims: in short based on her judgement and the purpose of the study. The criteria for selection of AIDS orphans were the following:

- Population: AIDS orphans who have lost parent/s to AIDS;
- Development phase: Early adolescence (11-14 years old);
- Permanent residence: North West Province (Mafikeng and Rustenburg);
- Population group: Black.
- Language: Fluent in Setswana

Before collecting data the researcher obtained permission from the relevant governmental departments namely the Department of Education and Culture as well as the Department of Social Services Arts and Sport in the North West Province to conduct the study. She then contacted the principal of the relevant primary school and social workers either personally or telephonically to make appointments. On the day of appointments, the researcher introduced the study herself. The researcher worked with social workers and the principal to identify 20 AIDS orphans and 10 caregivers to participate in the first phase of the study.

The data collection method was semi-structured interviews with a schedule. According to Berg (2001: 70) this type of interview involves the implementation of a number of predetermined questions and/ or special topics. These questions are asked of each interviewee in a systematic and consistent order, but the interviewers are allowed freedom to degress i.e. to probe far beyond the answers to their prepared and structured questions.

The researcher developed the semi-structured interview schedule utilizing the information through literature review as discussed. The interview schedule was comprised of four sections that included: demographic information of the participants; social needs and problems of AIDS orphans; emotional needs and problems of AIDS orphans; and life skills that AIDS orphans need to enhance their personal well-being (See Appendix 5: Semi Structured interview with a schedule).

The researcher conducted the semi-structured interview with the caregivers and AIDS orphans in Setswana while interviews with social workers were conducted in English. This was done after concerns were raised during the initial meetings with participants. According to Bailey (1994: 175) interviewer bias in which the interviewer may misunderstand the respondents' answer or the respondents' answers can be affected by his or her reaction to the interviewer's sex, race, social class etc. In this research study language was very important element to avoid bias. As the researcher is Setswana speaking and the North-West Province is primarily characterized by Setswana speaking people, the interviews with caregivers and AIDS orphans were conducted in Setswana (all respondents were fluent in Setswana). The researcher conducted the interviews herself.

Analysis of qualitative data was done by means of text analysis. The data was first analyzed in the language in which the interviews were conducted namely Setswana. Transcripts were written first in Setswana and then translated into English. The entire transcripts were given a code and the researcher went through all the transcripts to get a sense of the whole. The researcher continued to write down ideas as they came to mind while writing thoughts in the margin and identifying the major themes. The themes were put into major categories while at the same time identifying subcategories within major categories. During the process of analysis relationship between major and subcategories were also identified. The researcher then categorized the responses based on the four sections of the semi-structured interview. Data was analysed based on literature control. The goal was to integrate these themes into a theory that offers an accurate, detailed interpretation of the study.

In conclusion the researcher addresses the soundness of this qualitative study. According to Marshall and Rossman (1995) as mentioned by De Vos (2002: 351) it is of cardinal importance that the research must respond to canons that stand as criteria against which the trustworthiness of the project can be evaluated. There are different ways in which the soundness of qualitative study can be tested. For this study validation of the qualitative research was executed against Guba's model of

truthfulness, which applies the following criteria to the assessment of qualitative data, i.e. truth-value, applicability, consistency and neutrality (Compare De Vos, 1998: 348). This assessment is discussed below:

- **Truth-value**

The aim of truth-value is to determine whether the researcher has established confidence in the truth of the finding for the subjects or informants and the context in which the study was undertaken. It demonstrates how confident the researcher is with the truth of the findings (De Vos, 1998: 349).

The researcher considers the first phase of the study to be credible as interviews were conducted with AIDS orphans and people who are directly in contact with AIDS orphans i.e. social workers and caregivers. Information obtained from the respondents regarding needs and problems experienced by AIDS orphans is the same as information collected with literature review (See chapter 3).

- **Applicability**

De Vos (1998: 349) describes applicability as the degree to which the findings can be applied to other context and settings or with other groups. It implies that the researcher should be able to generalize qualitative findings to other settings and other populations. In this study this criterion is met since information obtained from the respondents i.e. AIDS orphans, social workers and caregivers is transferable into context outside the study situation.

- **Consistency**

According to De Vos (1998: 350) consistency refers to the extent to which repeated administration of a measure will provide the same data or the extent to which a measure administered once, but by different people, produces equivalent results. This

criterion was met in this study because the same interview schedule was used in three different groups of people i.e. AIDS orphans, caregivers and social workers with the same results.

- **Neutrality**

The fourth criterion of trustworthiness is neutrality. This implies the freedom from bias in the research procedures and results. This captures the traditional concept of objectivity. Linchon and Guba (1985) as mentioned by De Vos (2002: 352) note that with this criterion there is a need to ask whether the findings of the study could be confirmed by another. In this study this criterion was met as information obtained confirm the general findings conducted in other countries regarding the needs and problems of AIDS orphans (See Chapter 3).

In summary, the four criteria as set in Guba's model were met. It can thus be said that the trustworthiness of this study has been established.

In the following section the responses of social workers, caregivers and AIDS orphans are discussed respectively: The researcher will first describe the guideline of semi-structured interviews and then focus on the discussion of responses. Each section will be discussed according to different questions asked. The demographic information of the respondents will also be presented.

7.2.2 SOCIAL WORKERS' RESPONSES

Semi-structured interviews with social workers contained questions on the following:

- **Demographic information**
  - Age
  - Gender
  - Qualifications

- Position at work
- Years of social work experience
- Years of experience with AIDS orphans
- Geographical Area

- **Social needs and problems of AIDS orphans regarding:**

- Education
- Relationships
- Upbringing
- Health-care
- Subsistence/Finances
- Housing/Security

- **Emotional needs and problems of AIDS orphans regarding:**

- Personality
- Emotions
- Mental-health
- Support systems
- Loss of parent(s) and identity

- **Life skills that AIDS orphans need to enhance their personal well-being regarding socio-emotional needs.**

The discussion of social workers' responses follows below. The researcher will first describe the demographic information of the ten respondents (social workers) namely age, gender, qualifications, position held at work, years of social work experience, years of experience with AIDS orphans and geographical area. This will be followed by participants' responses regarding the **social** needs and problems of AIDS orphans,

the **emotional** needs and problems of AIDS orphans as well as **life skills** that are needed by AIDS orphans. Lastly the section will give a summary of responses made.

7.2.2.1 DEMOGRAPHIC INFORMATION OF SOCIAL WORKERS

The study population consisted of 10 social workers in the major two cities of the North-West Province namely Rustenburg and Mafikeng. All of the respondents (100%) were females and the majority (50%) were of the age group 31-40 followed by respondents (30%) of the age group 20-30 then lastly respondents (20%) of the age group 41-50 years.

The social workers (100%) were all employees of the Department of Social Services, Arts, Sports and Culture (North-West Province) with graduate (60%) and postgraduate (40%) degrees in social work. The level of education made the respondents knowledgeable about the problems and needs of AIDS orphans as well as life skills that are needed to enhance their social functioning. Therefore, all the respondents were appropriate to engage in discussions related to the topic.

All the respondents (100%) had more than five years experience in the Social Work field. Five of the respondents were social workers, four senior social workers and the remaining one a chief social worker. The working experience of respondents with AIDS orphans varied. The majority of respondents (80%) have 6-10 years experience followed by respondents (20%) with more than 10 years experience. The years of experience qualified them to be knowledgeable about the problems and needs of AIDS orphans. The respondents' knowledge about the needs and problems of AIDS orphans was extensive.

Finally all of the respondents (100%) resided in the North-West Province and were evidently exposed to the dynamics of the Province. They had reasonable experience and exposure of what is happening in their communities.

In the following table identified needs and problems experienced by AIDS orphans as mentioned by social workers are described.

7.2.2.2 Social needs and problems of AIDS orphans as described by social workers

Table 9 gives a clear description of the social needs and problems of AIDS orphans as identified by social workers. The researcher gives direct quotes in inverted comas“ ” of some of the respondents to verify qualitative information.

Table 9: SOCIAL NEEDS AND PROBLEMS OF AIDS ORPHANS (SOCIAL WORKERS)

CATEGORIES	PROBLEMS	NEEDS
Education	➢ Financial problems, which lead to unpaid, school fees. “Because many AIDS orphans come from impoverished families, they cannot afford to pay for their school fees and experience shortages of uniform, books and food” ➢ “They do not have money to pay for sports and other activities taking place at school”. ➢ Poor performance at school and high failure rate. “Most of the children do fail at school, their performance at school is not	➢ Financial support such as bursaries and sponsorships. ➢ Material support (school uniform). ➢ Supervision “Orphaned children need constant supervision by parents or caregiver”. ➢ Parental guidance. “AIDS orphans need someone who will assist them with their schoolwork”.

CATEGORIES	PROBLEMS	NEEDS
Education	satisfactory due to lack of supervision, care, and support as well as lack of assistance with schoolwork". ➢ Malnutrition. "Some of the children go to school on an empty stomach and spend the whole day hungry". ➢ No motivation. "To tell the honest truth most of the children become demoralized after the death of their parents". ➢ High absenteeism and dropping out of school. ➢ Lack of rest and time to study because there is no one to assist them at home. "Some of the children are responsible for all the housework, they clean cook and take care of their siblings".	➢ Guardians/Caregivers to look after the children. ➢ Emotional support. "AIDS orphans need someone like a mentor who will motivate and encourage them".
CATEGORIES	**PROBLEMS**	**NEEDS**
Relationships	➢ Stigma. "AIDS is a disease that is still surrounded by stigma and	➢ Education. "Community needs to be educated about

	discrimination. Because of lack of knowledge there are some people who refuse to have any relationship with children orphaned by AIDS". ➢ Conflict and communication problems. "The relationship of foster parents and AIDS orphans is often characterized by conflict". "A foster parent is constantly compared with the deceased parent and is viewed as someone who wants to replace the parent". "Foster parents are also viewed as controlling and not caring enough". ➢ Conflict with peers especially when they are teased about their situation. ➢ Community and relatives ill treatment because of stigma. "Some of the foster parents and community members do not give	HIV/AIDS so that stigma is properly dealt with". ➢ Family and community support. "Like all other children AIDS orphans need to be accepted, understood and supported". ➢ Affection. "Unconditional love is a primary thing". ➢ Harmony in foster parent-child relationship. ➢ Respected. "They need to be listened too and respected by family and community members". ➢ Parent figure. "AIDS orphans need someone they can trust and depend on". "They need someone they can share inner thoughts without being critically judged".
CATEGORIES	**PROBLEMS**	**NEEDS**
Relationships	AIDS orphans the same treatment as other children. They are often	➢ Mentors. "They need good role models who also believe

	isolated and discriminated against". ➢ Most of the children end up being withdrawn. Withdrawing from others (friends etc.). ➢ Lack of time to spend with friends due to extra responsibilities at home. "AIDS orphans who reside in child-headed households and those living with their elderly grand parents have extra responsibilities at home. They are often expected to run their homes i.e. see to it that their houses are clean". ➢ Discrimination and rejection. "Some of the children are rejected because of stigma". "People ill-treat AIDS orphans through isolation". "These children experience serious emotional problems such as loneliness and poor self esteem".	in their capabilities".
CATEGORIES	**PROBLEMS**	**NEEDS**
Upbringing	➢ Forced to occupy adult roles of parenting.	➢ Supervision, love and care of parents or guardians.

CATEGORIES	PROBLEMS	NEEDS
Upbringing	➢ Children living on their own. "Some relatives refuse to stay with AIDS orphaned children due to stigma. Some children especially those without grandparents, live in child-headed households". ➢ Lack of supervision. "They lack of parental guidance". ➢ Poverty. "Poverty in South Africa is widespread. AIDS orphans are children who are affected the most. ➢ Vulnerability to the life of crime. "Some end up in criminal activities such as prostitution and theft to fend for themselves". ➢ Dropping out of school. "They take care of the younger children and ailing parents". ➢ Lack of commitment and dedication by foster parents and relatives to raising the children. "The majority of	➢ They need to be treated as children not adults. "All children regardless orphaned or not deserve to be children. They need to enjoy childhood as a developmental stage". ➢ Discipline. "There is a need of parental figure at home to enforce discipline". ➢ Basic needs. "Their basic needs such as food, clothing, shelter and water should always be provided for". ➢ Community, family and government support. "Home based care activities should be promoted to relief the children from taking care of their ailing parents". ➢ Protection from any harm. "Orphaned children especially those living alone are at risk of being sexually molested, therefore they

	relatives who volunteered to raise these children are doing it for money reasons. The grant offered by government is the motivating factor". ➢ Vulnerability to being street kids. "Some of the street children are children orphaned as a result of AIDS. The streets become their last option especially if there is no one prepared to accommodate them after their parents' death". ➢ Getting married at an early age. ➢ Heightened exposure to HIV infection. "AIDS orphans are at risk of being infected due to sexual abuse and prostitution".	should be offered some form of protection".
Health-care **CATEGORIES**	➢ Ill health "Exposure to infection and diseases because of lack of parental care". ➢ Infected AIDS orphans **PROBLEMS**	➢ Health education ➢ Infected children need regular checkups and treatment that is free. **NEEDS**
Health-care	experience ill health. "AIDS orphans who are infected with	➢ Parental care. "AIDS orphans need someone to

	HIV often weak and sick because of their deteriorating health-status. ➢ "Poor and no medical treatment since most of them are not covered in medical aids". ➢ Children are also at risk of being infected with HIV when caring for their ailing parent. "Some children especially the eldest end up being sick as a result of stress. These children have too many responsibilities and that can be strenuous". ➢ Missing regular medical check-ups. "Some guardians fail to take orphaned children for medical check-ups due to insufficient funds or failure to pay for medical bills."	take them to clinics when they get sick". ➢ Medical assistance. "AIDS orphans need government supported medical aids, which cater for the health needs of AIDS orphans". ➢ Government financial support "Support from government will ensure that all of the children' health care needs are met".

CATEGORIES	PROBLEMS	NEEDS
Subsistence/ Finances	➢ "Insufficient funds to provide for basic needs such as food and clothing". ➢ Delayed approval of social grants. "Some of the children do not receive social grants due to the fact that they do not have birth certificates". ➢ Mismanagement of social grants by relatives or caregivers. "Most of the guardians are irresponsible in the sense that they spend the grants on themselves rather than the children". ➢ Mismanagement of the children inheritance. "Due to the fact that most orphans are still young, some relatives steal their possessions." ➢ Street children. "children end up on the streets"	➢ Financial support to ensure that their basic needs are met. ➢ Social grants to be approved in a short period of time. ➢ Responsible guardians. "Children need to be brought up by guardians who will manage their finances with wisdom. Proper measures need to be taken to ensure that money is used for the benefit of the children". ➢ "Thorough assessment should be done before appointment of a foster parent". ➢ Financial management skills. "Orphans together with their guardians be taught financial management skills".
Housing/Security	➢ Child-headed households. "Children living on their own, being at risk of being attacked	➢ A home, which is safe and secured. "Child-headed households should be

CATEGORIES	PROBLEMS	NEEDS
Housing/Security	and abused. These children are also in danger of household accidents". ➢ Lack of family and community support. ➢ Taking over of property by family members (house and livestock). "Due to the fact that most AIDS orphans are still young some relatives end up stilling their property after their parents' death". ➢ Loss of property due to unpaid rent or bond. "Some of the children do have a proper home, they stay in shacks without furniture. It is a horrible situation". ➢ Being in danger of harm. "Most of the children are taken care of by grandparents who are often too old to provide sufficient protection". Sexual abuse and molestation.	discouraged. Relatives should be encouraged to be foster parents". ➢ Parental support, love and care. "Children need to be constantly supervised. They also need to be loved, cared for and supported". ➢ Shelters or foster care homes where their basic needs will be catered for. "In cases where there is no one take care of the children, AIDS orphans need to be placed at shelters or foster homes".

In the following section the emotional problems and needs are highlighted as mentioned by respondents (social workers).

7.2.2.3 Emotional problems and needs of AIDS orphans as described by social workers

Table 10 gives a clear description of the emotional problems and needs of AIDS orphans as described by social workers. Direct quotes " " will be given as mentioned by some of the respondents to verify qualitative information.

Table 10: EMOTIONAL NEEDS AND PROBLEMS OF AIDS ORPHANS (SOCIAL WORKERS)

CATEGORIES	PROBLEMS	NEEDS
Personality	➢ Low self esteem lack of poor confidence. "AIDS orphans self-worth and confidence become seriously threatened due to being isolated and rejection". ➢ Inferiority complex. "Children orphaned by AIDS look down on themselves because of lack of clothing and other things". ➢ Isolation. "Most of the children withdraw from interacting and relating with others".	➢ Community and family acceptance. "AIDS orphans need to be accepted and loved by the community and their relatives". ➢ Community and family support. ➢ Supervision and care of their caregivers. "AIDS orphans need someone to believe in them (mentor and a role model) who will

CATEGORIES	PROBLEMS	NEEDS
Personality	➢ Passivity. "Not active at all" ➢ Lack of reassurances. "AIDS orphans lack appreciation and affirmation". ➢ Rebellion. "AIDS orphans are rebellious as a way of expressing bitterness and anger". ➢ Aggression. "AIDS orphans become involved in fights as they are teased about the cause of their parents' death".	encourage and appreciate them". ➢ Foster parent's love. ➢ Self esteem. "AIDS orphans need to be equipped with skills that will boost their self-esteem and confidence".
Emotions	➢ Loneliness. "Most of them are lonely and have no one to confide in". ➢ Pain, sadness and hurt. ➢ Stress. "AIDS orphans become stressed as a result of stigma and treatment they receive from others". ➢ Frustration and confusion. "Some of the children become frustrated and confused	➢ Emotional support of all stakeholders. "AIDS orphans need support of pastors, relatives, teachers, social workers and all other community members". ➢ Therapeutic counseling. "Counselling is a necessity because of the emotional trauma AIDS orphans experience".

CATEGORIES	PROBLEMS	NEEDS
Emotions	especially if the family is not prepared to disclose the cause of the parents' death and at the same time hearing rumors from outside". ➢ Grief over their loss. ➢ Anger and bitterness. ➢ Rejection ➢ Blaming God and others. "Some of the children end up blaming God and others i.e. relatives and the government due to unmet needs". ➢ Guilt. "Some of the children feel guilty blaming themselves of failing to help their parents".	➢ Children should be prepared before the parent's death. ➢ Honesty. "Children need to be told the truth regarding the cause of their parents' illness". ➢ Emotional healing. "AIDS orphans need to be helped to deal with unresolved feelings of hurt, pain and bitterness make them susceptible to illness". ➢ Spiritual counseling. "Spiritual counseling is necessary especially if the children are blaming God".
Mental health	➢ Stress. "Most of the children become stressed as a result of being unable to cope with problems encountered". ➢ Constant worrying. "AIDS orphans worry a lot and this affect their school	➢ Therapeutic counseling. "I recommend that children should be counseled on regular basis until they are able to cope". ➢ Support of family and community members.

CATEGORIES	PROBLEMS	NEEDS
Mental health	performance. Their concentration declines". ➢ Depression. "Some end up being depressed as a result of unresolved stress". ➢ Suicide. "Some children are traumatized after witnessing their parents' daily deterioration. Some even attempt suicide".	➢ All of their basic needs to be met (food, shelter, clothing etc.) "I think food should always be available. Children should never worry about this things". "No child should go to bed on an empty stomach. Children need to be well taken care of".
Support systems	➢ "Lack of support and ill treatment of their guardians and some community members". ➢ Stigma. "Stigma leads to children being rejected by family and community members". ➢ Poor supervision. "Most of the caregivers are grandparents and some of them are too old to raise these children".	➢ Acceptance, love and respect of foster care parents. "Like all other children, AIDS orphans need to be accepted, loved and cared for". ➢ Support of family and community members. ➢ Pastoral care "spiritual counseling helps especially to deal with the grief". ➢ Teachers' support.

CATEGORIES	PROBLEMS	NEEDS
Support systems		➢ Support. "Family members should be encouraged to take care of orphans". "It is not the responsibility of the aged alone". ➢ Support groups. "Children should be part of support groups, where they will encourage and support one another".
Loss of parents and identity	➢ Relocation to unfamiliar places. "Some of the children end up being relocated to unfamiliar places due to the death of their parents. This implies change of the school and friends". ➢ Separation. "Sometimes children are separated after the death of their parents". "They have no sense of belonging". ➢ Adjustment problems. "Adjusting to a new family and	➢ Changes to be done if there is no alternative. "The government should ensure that relocation is done if there is no other alternative". ➢ Changes should be minimized. "A foster care parent should be someone related to the child". ➢ Shared decision-making. "Children should be involved in all decisions that concern them".

CATEGORIES	PROBLEMS	NEEDS
Loss of parents and identity	to an environment they are not used to is problematic to most AIDS orphans". ➢ Identity crisis. " Many children end up confused, not knowing whom to identify with –their deceased parents or new guardian in their lives". ➢ Loss of family history, culture, values and other valuable information. "Some parents die having not shared this important information with their children". ➢ Loneliness. "Most of children orphaned by AIDS are lonely and have no one to confide in". ➢ Confusion regarding change of religion and belief system. "Some children become confused with regard to their faith especially if the caregiver's belief system is different from that of their deceased parents".	➢ Listened too. "Like every person AIDS orphans need to be given an ear". ➢ Knowledge of family history and values. "Relatives need to share information with these children regarding their family history". ➢ Be in contact with their families. "Children living in shelters should have regular contact with remaining family members". ➢ Healthy family environments. "They need family environments characterized by love and care". "They should be surrounded by caring and loving people".

CATEGORIES	PROBLEMS	NEEDS
Loss of parents and identity	➢ Confusion as a result of different parental styles. ➢ Identity confusion. "Making use of different surname from that of the foster home also confuses most of AIDS orphans".	

In the following section life skills needed by AIDS orphans are explored as mentioned by respondents (social workers) in this study.

7.2.2.4 Life skills needed by AIDS Orphans as described by social workers

The respondents identified the following skills:

- **Coping skills**: Coping skills are essential especially for those children who do not receive any support from those close to them. "Coping skills will enable them to cope and adjust to being orphans". "Facing death is not easy for adults what more for children".

- **Self-esteem**: "Most of the children have low self esteem. Their self-esteem needs to be boosted". " They should be taught to believe in themselves".

- **Thinking skills**: "AIDS orphans need to be taught to think independently so that they are not easily negatively influenced".

- **Assertiveness training skills**: "People have a tendency of abusing orphans and taking advantage of them. Children orphaned by AIDS need to be encouraged to know their rights and not anyone to ill-treat them". "AIDS orphans should be empowered so that no one should take advantage of them. They should be in a position to say no".

- **Stress management skills**: "Stress contributes to major health hazards. Children should be taught ways of managing stress".

- **Communication skills**: "Healthy relationships are vital for normal development. These children should be taught how to express their inner feelings and dissatisfactions. "They should be equipped with communication skills such as attending, listening, questioning etc."

- **Conflict management skills**: "These skills enable AIDS orphans to manage conflict. They need these skills because their parents are no longer there to intervene when they quarrel".

- **Problem-solving skills**: "Problems are part of life. All people need to know how to solve problems. Problem solving skill cannot be neglected. It is a skill that they will need throughout their lives".

- **Decision-making skills**: "Life is all about making decisions. AIDS orphans need decision-making skills. These skills will enable them to make right choices in life".

- **Self-awareness**: "All children especially AIDS orphans need to know themselves. They should be encouraged to understand their qualities, strengths as well as weaknesses".

- **Time management skills**: "AIDS orphans need to know how to balance their time schoolwork and home chores".

- **Parenting skills**: "The death of parents automatically makes the eldest child parents. They need to be equipped with these skills to look well after their younger siblings. These are especially important to children living in child-headed families".

- **Budgeting skills**: "Budgeting skills will enable the children who live in child headed households to manage their finances".

The following discussion summarizes and elaborates on the responses given by social workers as participants in this study and verified with literature control.

7.2.2.5 SUMMARY OF SOCIAL WORKERS' RESPONSES (N=10)

- **Social needs and problems:** All of the respondents (n-10) mentioned that the AIDS orphans experience socio-economical problems such as **financial problems**, **malnutrition**, being street kids and high risk of being infected with HIV themselves. Because many of AIDS orphans come form impoverished families, they often cannot afford to pay for their school fees and experience shortages of school uniform, books and food. These lead to **poor school performance, high rate of absenteeism, high failure rate and dropping out of school.** The children become demotivated after their parents' death. Many authors such as Avert (2004: 7); Hall (2005: 1), Robbins (2004: 1), Van Dyk, (2001: 153), UNICEF (2003: 2) and UNICEF (2004: 1) confirm this by agreeing that AIDS orphans are less likely to have proper schooling. The presence of HIV/AIDS in the family has devastating impact on school-going children. As the parent with HIV/AIDS progresses with illness, children are likely to drop out of

school temporarily or permanently and some might not even start because their parents cannot afford to pay the fees and other expenses.

This is also supported by studies on problems encountered by AIDS orphans conducted in Cambodia (UNAIDS, 2004: 4), Swaziland (Hall, 2005: 1), Zimbabwe (Van Dyk, 2001: 154), Uganda (Deame, 2001: 2), Kenya (Avert, 2004: 3) and Zambia (Ruiz-Casares, 2003: 1). These studies confirm that orphan learners face enormous financial hardship and have great difficulty in paying for school fees, uniforms and books and many orphans are dropping out of school because of lack of finances.

Some of the respondents (n-4) mentioned that children do not have sufficient time to rest and study at home because of **heightened home chores**. It was further mentioned by all of the respondents (n-10) that the children do not receive constant supervision and assistance with their schoolwork. According to Barnett and Whiteside (2002: 206) for the orphaned child there is often a premature entrance to burdens of adulthood. Children often find themselves taking the role of a father or mother or both, doing the housework, looking after the siblings and caring for ill or dying parent(s).

Vulnerability to the life of crime was viewed by other respondents (n-5) as a risk that most AIDS orphans are faced with. Parental loss at early childhood creates negative social pressures. Children may find their way into the streets where they are exposed to a number of risks. This is supported by Bezuidenhout and Dietrich (2004: 67) who state that the physical environment in which adolescents find themselves may, together with its social context, also trigger **risk-taking behaviors.** Barnett and Whiteside (2002: 212) also argue that AIDS orphanhood lead to a rise in the number of children living on the streets, begging, scavenging and descending into a life of crime. Such recreation may expose them to risk-taking behaviors associated with negative consequences for the adolescent and his or her family.

Other problems that were identified as commonly experienced by AIDS orphans included **stigma, isolation, ill treatment by others, interpersonal problems** such as conflict with peers, cousins and teachers. Potgieter (2004: 228) states that the interactional difficulties, which people commonly experience such as lack of openness, struggles of power, vagueness and accusations, are associated with lack of interpersonal skills. According to Mukoyogo and Williams (1991: 8) AIDS orphans are disadvantaged since they suffer from lack of guidance and affection, which are vital for their social and emotional development.

The respondents (n-8) also highlighted that children suffer tremendously when their parents die. **They often live on their own** or have to **be relocated to unfamiliar places** as well as being **separated from their siblings**. This information is supported by UNICEF that notes that in South Africa, many relatives are often reluctant to take in the children of AIDS victims because of the stigma attached to the disease (Barnett & Whiteside, 2002: 209; Du-Venage, 2003: 2). Although the government offers some additional support for orphans, carers are sometimes reluctant to accept this assistance particularly if acceptance may identify the dead parent as having died of AIDS; or it may suggest that the family cannot cope-another stigma (Barnett & Whiteside, 2002: 209).

The other significant issue raised by participants' concerns **child-headed-households**. Most of the respondents (n-7) mentioned that there is an increase of child-headed households in many communities. Whiteside and Sunter (2000: 80) support this by stating that South Africa is witnessing the emergence of child headed households. According to Mike Waters of the Democratic Alliance (Mesatywa, 2005: 1) there were an estimated 83 000 child-headed households in South Africa, run by children under the age of 18.

These orphans were also viewed as exposed to **household accidents, sexual abuse and molestation**. According to Van Dyk (2001: 154) sexual initiation may

occur at a very early stage for some children, especially in marginalized communities where sexual abuse and rape are relatively common. This is supported by a number of studies. In South Africa for example, 10% of respondents in a study in six provinces indicated that they had started having sex at age 11 or younger. Another study conducted in Kwazulu-Natal reported that 76% of girls and 90% of boys are sexually experienced by the time they are 15 or 16 years of age (Coombe, 2000 in Van Dyk, 2001: 154).

Sexual abuse occurring during childhood has been widely documented as contributing to later adolescent and adult adjustment problems. Long-term effects include depression and low self-esteem. Children may experience feelings of depersonalization, and may regard themselves as sexual objects. Sexual victimization of children contributes to the risk of suicidal attempts and delinquency, which may later develop into more serious criminal activity (Dollar & Dollar, 2002: 386-387; Geldard & Geldard, 1999: 20).

Poverty was also identified as serious problem that AIDS orphans are confronted with by all (n-10) of the respondents. HIV also undermines the caring capacity of families and communities by deepening poverty due to loss of labour, the high medical treatment and funerals. Due to insufficient funds the children basic needs such as food and clothing are not met. According to Bezuidenhout (2004: 181) in South Africa the majority of the population does not live in responsive environment; poverty is still deep and widespread (Bernstein & Gray, 1997: 27). However, Walker and Walker (2000: 50) note that certain groups of people are particularly vulnerable because of their economic or family status. Of the many vulnerable members of society, young people who have lost one or both parents are among the most exposed of all (Avert, 2003: 4). Orphans generally are often thought to run a greater risk of being malnourished, stunted of not receiving the care they need than children who have parents to look after them.

The majority of respondents (n-7) mentioned that some AIDS orphans **loose their property and inheritance** after their parents' death. This could be due to unpaid rent or bonds, mismanagement of their inheritance by their guardians or even theft by their relatives. This is supported by Van Dyk (2001: 334) who points out that after the parent's death, children often loose their rights to the family land, property and house. The inevitable death of the parents, cause unscrupulous relatives and friends sometimes succeed in claiming land and other property that orphaned children are legally entitled to inherit from their parents. In some instances land, home, and possessions may be appropriated by banks, leaving children homeless and with no protection by customary laws of inheritance. Du-Venage (2002: 1-2) has evidence to show that in urban areas other investments like mortgaged houses are also at risk of being repossessed and auctioned due to non-repayment.

The social needs of AIDS orphans mentioned by respondents included **financial and emotional support, unconditional love, care, acceptance, respect, certainty, and affiliation.** The orphans also need to be supervised and mentored by adults who will enforce discipline. This is supported by Webb (1997: 4) who argues that like all children, AIDS orphans need to acquire the cultural values and behavioural norms necessary for their integration into society. But because of lack of supervision, neglect from relatives and community may result in unhealthy options to meet basic needs. The respondents emphasized the need for healthy guardian-child relationship as well as conducive home environments as of prime importance. It is indispensable that these attributes be catered for in the lives of AIDS orphans. If these needs are gratified, they will grow up in an environment which affords them identity, self-respect and a sense of living.

- **Emotional problems and needs:** The majority of respondents (n-9) indicated that the self-esteem and confidence of AIDS orphans are often severely threatened. They often experience **rejection, lack of appreciation, affirmation and encouragement**. They are rejected on the basis of the perceived immoral

sexual habits of their parents coated with fear of contracting the disease. According to Van Dyk (2001: 258) rejection by significant others such as loved ones, friends and family can cause one to lose confidence and a sense of ones social identity – and thus experience reduced feelings of self-worth. This was also highlighted by the respondents (n-4) who noted that many AIDS orphans suffer from **inferiority complex, depression, passivity, bitterness, stress and some even attempt to commit suicide**. Rebellion and aggression are commonly expressed as a way of expressing bitterness.

Emotional problems that were highlighted included **pain, hurt, sadness, loneliness, stress, guilt, frustration, anger, grief, self blame and blame towards God.** According to UNICEF (1998: 3) when parents die, their children often act out their feelings of anger resentment in anti-social behaviour towards their guardians, teachers and friends. Some may be angry with God. However, if there is no opportunity for children to express these emotions, then the psychosocial issues lie buried, only to be displayed at a later date, often in distorted and/or destructive way.

Some of the respondents (n-5) mentioned that many AIDS orphans are **stigmatized**. As already highlighted some relatives are not prepared to be foster parents due to the stigma attached to HIV/AIDS. This is also emphasized by Doka (1994: 36) who notes that AIDS orphans may have to struggle with issues of multiple losses. Many of these orphans may have lost both parents through AIDS, abandonment, and inability of others to care for them. They may have been separated from their siblings, friends, neighbours, and classmates. This result in the children feeling left out and rejected. Their value as normal citizens is threatened, as they have no sense of belonging. According to Anderson and Okoro (2000: 12-13) belonging plays a key role in the growth and development of self-esteem and social skills. Each person is born with a natural desire to belong to a group, such as family or culture, and to contribute to the growth and well being of that group. It allows a person to express his or her social interest in a

healthy and mutually reciprocal manner that builds upon strength of all group members. Without the right opportunities this need can be distorted or destroyed (Brack & Hill, 2000: 24; Baron & Byrne, 2003: 268).

Change of residence to unfamiliar places was seen as having a negative effect on the children' development by half of the respondents (n-5). It is characterized by **change of family religion, culture, values and in some cases, even a surname.** Children also encounter adjustment problems since they have to change schools, friends and even neighborhoods. They end up with a failure identity. Geldard and Geldard (1999: 8) and Zastrow (2000: 65) state that failure to achieve a satisfying person identity is almost certain to have negative implications. People with a failure identity are likely to be depressed, lonely, anxious, reluctant to face everyday challenges. Escape through drugs or alcohol, withdrawal, criminal behavior and the development of emotional problems are common.

All of the respondents (n-10) alluded that AIDS orphans have **emotional needs such as acceptance, love, respect and appreciation**. This is supported by Black (1991: 10) who argues that the deepest and most irreplaceable loss experienced by any orphaned child is the loss of parental love. Support from significant others was also mentioned as an important need. AIDS orphans need to be supported by their families, members of their communities such as pastors, teachers, social workers and even their neighbors.

According to Van Dyk (2001: 153) there is evidence that emotional difficulties suffered by AIDS orphans combined with social stigma tend to block their ability to learn at school. They often have little ability or motivation to contribute to their educational development. The death of the parent(s) due to HIV/AIDS has meant that these children face deteriorating family conditions that hinder personal development and successful integration into society as productive citizens.

It was also indicated by all of the respondents (n-10) that AIDS orphans have **need for counseling.** Most of AIDS orphans were regarded as wounded by the early death of their parents and ill treatment from some members of their communities hence emotional healing is important. They need mostly emotional support and counselors such as social workers and psychologist are best equipped to occupy that role. This was supported by the executive director of UNAIDS Peter Piot in Boseley (2002: 1) who noted that the impact of HIV/AIDS on the lives of children is one of the most tragic aspects. With the loss of their parent(s), these children have few resources to help them deal with bereavement and its repercussions. Therefore it is important that necessary structures be in place to offer necessary assistance.

Finally the majority of respondents (n-8) indicated that AIDS orphans **need to be equipped with skills that will boost their self-esteem and confidence**. Children with poor self-esteem feel helpless and inferior, incapable of improving their situation. They strive for social approval by behaving in ways that are over-compliant, or by pretending to be self-confident when they are not. They are struggling to feel good about themselves. They are also easily discouraged in whatever they do. If this situation is allowed to remain unchecked it becomes extremely difficult to reverse and may lead to severe emotional problems in later life (Gillis, 1994: 80; Geldard & Geldard, 2002: 210; Thompson & Rudolph, 2000: 153).

- **Life skills:** The respondents alluded that skills needed by AIDS orphans include **coping, self-esteem, self-awareness, assertiveness training, thinking, communication and conflict management skills**. These skills were seen as pivotal because many children were viewed as incapacitated to function independently. Brack and Hill (2000: 2) and Herbert (1988: 182) support this by emphasizing that life skills help children to become more flexible and socially competent so that they may have fewer resources to self-defeating behaviors and feelings. Furthermore, they help young people to develop skills for interacting

with people and for them to change specific person-to-person behaviors that influence the quality of relationships.

The following section explores the caregivers' responses. The section will first describe a guideline that was used during semi-structured interviews, followed by demographic information of caregivers; presentation of their responses and finally a summary of those responses will be given.

7.2.3 CAREGIVERS RESPONSES

Semi-structured interviews with caregivers contained questions on the following:

- **Demographic information**

- Age
- Gender
- Marital Status
- Language spoken
- Years of care giving
- Own children under your care
- AIDS orphans under your care
- Do you receive assistance?
- Type of assistance
- Geographical area

- **Social needs and problems of AIDS orphans regarding:**

- Education
- Relationships
- Upbringing
- Health-care

- Subsistence/Finances
- Housing/Housing

- **Emotional needs and problems of AIDS orphans regarding:**

- Personality
- Emotions
- Mental-health
- Support systems
- Loss of parent(s) and identity

- **Life skills that AIDS orphans need to enhance their personal well-being regarding socio-emotional needs.**

The demographic information such as age, gender, marital status, home language, years of care giving, own children, AIDS orphans under care, assistance received, type of assistance and geographical area regarding caregivers who participated in the research is discussed below.

7.2.3.1 Demographic information of caregivers

The study sample consisted of 10 caregivers in two major cities of the North-West Province namely Rustenburg and Mafikeng. They were all residents of the North-West Province and were all Setswana speaking. All of the respondents (100%) were females and the majority of respondents (80%) were grandmothers and the remaining 20% were respondents' sisters. This is supported by Avert (2005: 2) who notes that typically, half of the people with HIV become infected before they are aged 25, developing AIDS and dying by the time they are aged 35, leaving behind a generation of children to be raised by their grandparents. Furthermore, a study of 300 orphans in Zimbabwe found that nearly half of caregivers of orphans were grandparents and most ere already generally poorer (Ruiz-Casares, 2003: 1). These grandparents care for

their own children, who are sick, then they bury them and eventually they become surrogate parents to their bereaved grandchildren, often with few resources. AIDS in Africa is therefore often referred to as "the grandmother's disease" as it is in most cases elderly women who have to attend to ailing children and provide care and support for grandchildren.

The majority of the respondents (70%) were of the age group 46-60 followed by (those of the age group 20-45 (20%) and (10%)respondents of the age group 61-75 years. The marital status of the respondents revealed that the majority of them were married (50%) followed by widows (30%) and then never married (20%). This correlates with the number of people in the age group 46-60 which was the highest. This is not surprising because the majority of people of that age group are either married or widows.

All of the respondents (100%) were Setswana speaking. The majority of respondents' years of care giving were more than five years (60%). All respondents (100%) had more than one child under their care whose parents have already died. This is not surprising when one considers the increasing number of AIDS orphans in the country. Presently there are about 250 000 AIDS orphans in South Africa (Mesatywa, 2005: 1) and this number is expected to rise to 1.5 million by 2010 (Avert, 2005: 1; UNAIDS, 2004: 1).

Most of the respondents (60%) did not receive any assistance. Only few (40%) were receiving assistance from government in the form of social grants. Teachers are considered helpful in helping families with applying for birth certificates and identifying children in need. Only few respondents (30%) indicated that some members of their family assist them financially in taking care of the children.

In the following section the social needs and problems of AIDS orphans are presented as mentioned by caregivers.

7.2.3.2 Social needs and problems of AIDS orphans as described by caregivers

Table 11 gives a detail description of social needs and problems of AIDS orphans as mentioned by caregivers. Direct quotes " " will be given as mentioned by some of the respondents to verify the qualitative information.

Table 11: SOCIAL NEEDS AND PROBLEMS OF AIDS ORPHANS (CAREGIVERS)

CATEGORIES	PROBLEMS	NEEDS
Education	➢ No supervision. "Most of us fail to assist the children with schoolwork because of age. At my age my eyes are failing me (grandparent)". "It is so difficult to assist the children because I come home late due to lack of transport". ➢ Lack of support and love. "Although I try to give the two children my love, it is difficult to make them understand why my other relatives are treating them as they do. They never visit". ➢ Unpaid school fees as a result of financial problems. "I'm	➢ Family support and love. "I would appreciate it so much if my blood brothers and sisters can show some interest and assist me with the children". ➢ Tutor assistance. "If I had enough money I would pay someone just to help my children with their schoolwork". ➢ Financial support. "Late payment of school fees frustrates the children. Their school fees should be paid on time". "Money is a serious need. The

CATEGORIES	PROBLEMS	NEEDS
Education	presently not receiving grants for the three children I am fostering hence I find it difficult to pay their school fees". ➢ No school uniform, shoes etc. and shortage of schoolbooks. "My pension fund is to little to cover all the school expenses". ➢ No money for lunch box. "I feel bad because most of the time my grand children go to school on an empty stomach". ➢ Dropping out of school because of financial problems. ➢ Lack of interest to attend school. "My two brother have no interest in studying and doing their homework". "I have never seen my grandson studying". ➢ Lack of concentration at school. "I think my grandson has problems, his teacher	children should have school uniform and books". ➢ Constant supervision with their schoolwork. ➢ Balanced meal. "Children need to be well fed".

CATEGORIES	PROBLEMS	NEEDS
Education	called me complaining that he sleeps at school. He cannot concentrate". "He always sleeps when it is time to study" ➢ Poor performance at school.	
Relationships	➢ Withdrawal. "My grand daughter is too withdrawn and does not want to relate with others e.g. peers". "I really do not understand this boy, he does not enjoy the company of others". ➢ Parent-child conflict as a result of bitterness the children feel towards the caregiver. "I am not only speaking about the orphans I'm raising but all of them. They are manipulative. They take advantage of their situation". "My brother does not want to be reprimanded and scolded". ➢ Misbehaviour: "They are often involved in fights at school".	➢ They need to be shown love and support. "They need someone to help them open and talk about their concerns". ➢ Support. "They need a strong support group" ➢ Skills on relationship building. "I think that they need to be taught ways of starting developing and maintaining relationships". ➢ They need discipline when they make mistakes. "They should take responsibility of their own deeds and treat others with respect".

CATEGORIES	PROBLEMS	NEEDS
Relationships	➢ Competition. They always compare themselves to others. "My grandchildren always compare themselves with our neighbours. They forget that we are poor". "I dislike it when my grand daughter compares herself with others". ➢ Poor choice of friends. "My grandson is keeping wrong and bad company". "I do not like the friends who always hang out with my grandchild. They are criminals". ➢ Lack of respect. "My granddaughter sometimes forgets who is an adult between herself and I".	
CATEGORIES	**PROBLEMS**	**NEEDS**
Upbringing	➢ Lack of care and support. ➢ Insufficient provision of food, which leads to poor nutrition. "To tell the honest truth I do not always serve a balanced	➢ Community and family support. "AIDS orphans need a home environment full of love". ➢ They need to be educated.

	meal, food is expensive". ➢ Living in the streets. "Some children are forced to live in the street due to lack of care". ➢ Marrying at an early age. "I cannot mention names but I know teenagers who were forced to marry at an early age. Marriage became their rescue". ➢ Child abuse. "Physical, sexual and emotional abuse are rive in our country. It is AIDS orphans who are mostly at risk". ➢ Poverty. "Most of us are poor and we find it difficult to maintain all of the children. Remember, I am also taking care of my sisters children".	"No child should be deprived of education". ➢ Parental (caregivers') love. "They need encouragement and to be loved". "All people have a need to be loved". ➢ Equal treatment. " These children need to be the same way as other of children in the household". ➢ Proper care. " Children need to be well fed." "There is a need for sufficient provision of food." "All children must have sufficient clothing and all other basic needs".
CATEGORIES	**PROBLEMS**	**NEEDS**
Health-care	➢ Ill health especially after the parents' death. ➢ Ill health as a result of stress. "My grandson is stressed most of the time, he keeps quite and	➢ Constant medical examination. ➢ Health care education. "AIDS orphans and their guardians need health education especially with

	refuses to communicate with all of us". "My two grandchildren always complain of headaches and stomach aches. I think that it is the result of stress. They cannot cope". ➢ No medical aid. "I always take my children to a clinic. I cannot afford paying specialist". "The hospital is very far. Because I do not have money for bus fair I always take my children to the nearest clinic".	regard to HIV/AIDS". "They need to know how to protect themselves against HIV/AIDS". ➢ Healthy food. "Children have a right to a balanced nutritional meal". ➢ Home assistance. "Home-based care is important. It assists families with very sick members".
Subsistence/ Finances **CATEGORIES**	➢ Financial problems. "Some students drop out of schools because of unpaid school fees". ➢ Lack of equal opportunities. **PROBLEMS**	➢ Financial support. "Social grants are not enough. Other relatives must assist". ➢ "Financial assistance to **NEEDS**

Subsistence/ Finances	"Priority is always given to own children than orphans". ➢ Conflict between family members. "Relatives fight over social grants". ➢ Delays in issuing of social grants. "I've been waiting for the grant for more than six months". "My grandchildren do not receive social grants because they do not have birth certificates". ➢ Mismanagement of the grants by some caregivers.	provide for material needs". ➢ Financial assistance in the form of bursaries. "The private sector needs to be involved by issuing bursaries, because attending school is expensive". Accountability. "They need responsible caregivers to manage their funds".
Housing/Security	➢ Improper houses. "Most of the children live with grandparents in improper house structures such as shacks". "We live in a two bedroom shack, we are used to it". ➢ Security in a shack is an issue. "Shacks are in close proximity	➢ Proper house structure. "Children need to be brought up in homes that are homely and conducive for their development". ➢ A house with space. "They should stay in a big and a well secured house".
CATEGORIES	**PROBLEMS**	**NEEDS**

Housing/Security	to each other, not fenced hence children are not safe at all". ➢ Overcrowded household. "Although we are four in my house. In some families there are ten members staying in a two-roomed house". ➢ No furniture. "We only have one bed, therefore children sleep on the floor". "My brother and sister share a bed because there are not enough beds".	➢ Supervision of a parent or caregiver. "Children cannot be allowed to stay on their own. They need to be supervised". ➢ Accountability of guardians. "The court should be involved in ensuring that relatives do not misuse the children's property".

Following is a presentation of the emotional needs and problems of AIDS orphans as given by caregivers.

7.2.3.3 Emotional needs and problems of aids orphans as described by caregivers

Table 12 gives a description of the emotional needs and problems of AIDS orphans as mentioned by caregivers. Direct quotes " " will be given as mentioned by some of the respondents to verify qualitative information.

Table 12: EMOTIONAL NEEDS AND PROBLEMS OF AIDS ORPHANS (CAREGIVERS)

CATEGORIES	PROBLEMS	NEEDS
Personality	➢ Being withdrawn. "My grandchildren spent most of their time in the bedroom, they refuse to relate with others". "My sister is to quiet, I really do not like it". ➢ Poor self-esteem. "Children who are rejected often feel left out especially if the child is regarded as an outcast". ➢ Isolation. "They prefer being alone rather than befriending others". ➢ Poor self-confidence. "The children I stay with are very shy. They are unable to put opinions and ideas across". ➢ Being rebellious and defying authority. ➢ Stubbornness. "My grandchild refuses to take advice". "All of them are stubborn".	➢ Counseling and support. "AIDS orphans need counseling and support". "Professional help cannot be overemphasized". ➢ Need to be loved and accepted. "All children deserve parental love and care".
CATEGORIES	**PROBLEMS**	**NEEDS**

Personality	➢ Being bully especially if name-calling is involved. "Most of the AIDS orphans get involved in fights. Those that live with me are not excluded. I find myself always mediating".	
Emotions	➢ Hurt and pain. "Most of the children experience hurt and pain especially if they were close to their parents". "My granddaughter is often hurt when bad comments I made about her parents". ➢ Blame. "Some blame God for not preventing death". ➢ Grief especially after the burial. "The death of their parents is too much for them". ➢ Frustration and confusion. 'Many parents do not disclose the health status of the mother and it confuses the child because she/he does not understand why her/his parents do not get healed even if they	➢ Counseling. "They need someone to help them in opening up and talking about what is bothering them". ➢ Honesty with regard to cause of their parents' death. "I think children should be told the truth regarding their parents' death". ➢ Emotional support and acceptance. "AIDS orphans are very sensitive. You need to handle them with care". "They need emotional healing".
CATEGORIES	**PROBLEMS**	**NEEDS**

Emotions	go to hospital". ➢ Anger. "My grandchild once told me that she is angry towards her parents who hid the cause of their illness to them". "My grandchildren are often angry towards people who ill-treat them". ➢ Bitterness especially if the relatives ill-treat them. ➢ Rejection. "They feel rejected because of stigma".	
Mental health	➢ Depression and suicide. "I once heard of two children who attempted suicide because of failure to cope with their parents' death. Thanks that they did not die".	➢ Counseling. "They need social workers' help in a form of counseling". ➢ Parental acceptance. ➢ Family support. "All family members need to be involved in the care of the children".
Support systems **CATEGORIES**	➢ Lack of support and commitment. "Although it is **PROBLEMS**	➢ Support of all relatives. **NEEDS**

Support systems	bad and hard to admit, there are some foster parents who stay with the children for the sake of the social grants". ➢ Failure of some relatives to help the caregiver in raising the children. "Some of the children suffer from rejection especially if other family members are not there for them".	➢ Proper care. "All foster parents should be taught about proper care giving".
Loss of parents and identity **CATEGORIES**	➢ Adjustment problems. "I remember very well, two years back when my granddaughter and grandson came to stay with us here, it was not easy for them. Although they new me, they were not used to my family environment". "My grandchildren found it difficult to adjust when they moved in with us". ➢ Relocation problems. "Being removed from a known environment to an unknown one can cause anxiety. What **PROBLEMS**	➢ Changes should be minimized. "Relocation process should be done with care". ➢ A stable home. "AIDS orphans should stay with one caregiver rather than being shifted from one home to the other". **NEEDS**

Loss of parents and identity	more for a child". ➢ Change of surname. "Using a different surname from that of the foster home is confusing to the child. Fortunately my daughter was not married therefore her children are using my surname". ➢ Loss of friendship and association due to relocation. ➢ Changing schools. "Change of schools affects the children negatively especially if it is in the middle of the year".	

In the next section life skills needed by AIDS orphans are presented as given by caregivers. Direct quotes will be given to verify qualitative information.

7.2.3.4 Life skills needed by AIDS orphans as described by caregivers

The respondents identified the following skills.

- **Communication skills**: "Communication is basic to healthy relationships. These children need to be taught important elements of good communication such as respect".

- **Coping skills**: "Coping skills will enable them to cope with the changes that took place over a short period of time". "Coping skills are a must. AIDS orphans suffer rejection, stigma and discrimination. They should to be taught how to handle the situation".

- **Stress-management**: "AIDS orphans need to be taught about stress management and inner healing".

- **Self-esteem and self-confidence**: "Some of the children like mine have poor confidence. They need to be boosted with skills relating to self- esteem and confidence". "Self-esteem as a skill is important because it helps the children to believe in themselves".

- **Budgeting and financial management skills**: "Children need to be taught about the importance of social grants. Sometimes they think we are mishandling their money but we use it to provide their basic needs".

- **Home-management skills**: "Some of us are too old (grandparent over 50 years) children orphaned by AIDS need to be taught basic skills of cleaning baking and gardening because their parents are no longer there to play the role".

- **Decision-making skills**: "Decision-making skills will enable AIDS orphans to understand some of the decisions that are taken about them". "My grandchildren at the beginning did not understand why they had to stay with me and not their aunt. With decision-making skills they would have understood reasons behind the decision taken".

- **Parenting skills**: ''Foster parents need parenting skills. We are taking care of many children, therefore we need to be equipped".

- **Sex education**: "The knowledge that many teenagers have about sex is superficial. They need detailed information".

The following discussion summarizes and expands on the responses as given by participants (caregivers) in the study during the semi-structured interviews and integrate a literature control.

7.2.3.5 Summary of caregivers' responses (N-10)

- **Social needs and problems:** All of the respondents (n-10) mentioned that they encounter **financial problems** in the children upbringing. Furthermore they mentioned that since they are old (8 respondents were grandparents) **they find it difficult to help the children with their schoolwork**. Therefore the children do not receive sufficient support hence they are not motivated to study. Almost all of the respondents (n-9) mentioned that there is **high school drop rate** because many AIDS orphans show lack of interest and perform poorly at school. Without adequate material, economic and nutritional support the children are vulnerable to malnutrition and infectious diseases. Mukoyogo and Williams (1993: 8) support this by stating that the quality of childcare also suffers as AIDS invades the family. Inevitably children also suffer from lack of guidance and affection, which are vital for their social and emotional development.

  All of the respondents (n-10) indicated that children experiences problems such as **insufficient provision of food** due to their impoverished status. The majority of respondents (n-7) complained **the social grant is not enough** and few respondents (n-3) complained that **the process of issuing grants is too slow** hence they are still waiting for the grants of their grandchildren to be approved. he respondents (n-10) highlighted that their homes are also not equipped with all the resources the children need. Some (n-6) indicated that they experience **overcrowding** and children are forced to sleep on the floor. Barnett and Whiteside (2002: 201-202) state that AIDS-affected households tend to be poorer,

consuming less food and with smaller disposable incomes; it is hardly surprising that children in these households are usually less well nourished and have a greater chance of being wasted. Resources available in AIDS-affected households decrease because of the deaths of productive members and the increased demand for household expenditure – medicine and food.

According to Bezuidenhout and Dietrich (2004: 79) as well as Zastrow (2000: 140-142) living in an environment characterized by poverty, crowded housing, and serious family and social disorganization often exposes children to many forms of deviant behavior at a very young age. Further, poverty leads to despair, low self-esteem and stunted growth including physical, social, emotional, and intellectual growth. Poverty hurt most when it leads to a view of the self as inferior to others. Because poverty relates to nearly every other social problem, almost every effort should be taken to tackle the problem and people should be encouraged to improve their circumstances.

It is also important to highlight that some of the respondents (n-6) acknowledge that there are **other caregivers who misuse the social grants**. They agree that they are not committed in proper upbringing of the children but the money. This is confirmed by Tshukudu as quoted by Irin News (2003:1) who mentions that within the South African traditional society there is a certain standard of care that is expected, but people are no longer willing to do that. The care that the children receive is unacceptable and most of the time the family members use these children to benefit from the government orphan packages (Irin News, 2003:1).

A feeling of loss of hope on the children prevailed amongst most of the respondents (n-6). They highlighted that the children have **poor choice of friends** hence misbehave are rebellious most of the time. Others gave various responses such as that the children are manipulative and have lack of respect. This is not surprising because clearly adolescence is a time of change and crisis, which may be adaptively, encountered by some but for others presents the possibility of

undesirable psychological, social and emotional consequences. Therefore Corey (2004: 7), Geldard and Geldard (1999: 15) as well as Potgieter (2004: 217) note that the importance of adequate socialization during childhood and adolescence cannot be overemphasized. During this process the adolescent should be equipped with life skills that will stand him or her in good stead for the rest of his or her life. Children, who are deprived adequate or sufficient socialization, fail to learn these vital social skills and are at risk to experience a variety of personal and interpersonal difficulties. Deficiencies in life skills result in strained interpersonal relations.

It was clear from participants (n-6) that their relationship with the children was characterized by **parent-teen conflict.** Early adolescence is a time when conflict with parents escalates beyond childhood levels. Adolescence is considered the stage in which parents or adults and their adolescent counterparts are meant never to understand each other. Teenagers beginning with puberty at age 12-13 become somewhat oppositional, secretive, and fight with family members. Geldard and Geldard (1999: 11) argue that the parents' negative response towards their children may create negative feelings and catapult the adolescent into anti-social behavior. In addition UNICEF (1998: 3) noted that when parents die, their children often act out their feelings of anger resentment in anti-social behaviour towards their guardians, teachers and friends.

With regard to health care the respondents (n-10) did not experience serious problems because they mentioned that clinics are available for medical examinations etc. However, the respondents indicated that some children experienced **ill health** after the death of their parents (i.e. headaches and lack of sleep).

The social needs that were described included: **family support, love and acceptance, constant supervision, proper care of children, counseling, education, equal and same treatment of all children in the household, healthy**

food, constant medical examination and conducive home environment. According to Doka (1994: 38) it is critical that the child have support. Each child should have a supportive adult whose main function is to maintain the child's emotional comfort. This person can answer questions and provide nurturing. The child needs to be assured that he or she is not responsible for the illness or death.

- **Emotional problems and needs:** All of the respondents (n-10) mentioned that children experience **feelings of hurt, pain, frustration, grief, bitterness and anger after their parents' death**. They mostly **blame God** for failing to prevent their parents' death. Other respondents (n-3) indicated that they children f**eel betrayed by their parents** especially because of not disclosing the cause of their illness.

A tendency of AIDS orphans to isolate themselves was also mentioned by some respondents (n-6). Avert (2004: 5) and (Doka, 1994: 35) state that the death of a parent is certainly a profound psychological and social crisis for a child, especially when the parent dies from AIDS. The process of losing parents to HIV/AIDS for the children often includes the pain and the shame of the stigma and the fear that the disease carries in most of the societies. The tremendous fear and stigma attached to AIDS generate a context where children find it difficult to seek support either from peers or from adults hence isolate themselves. They may personally experience the stigma of AIDS related illness, as they are teased by classmates or ostracised by peers and other parents. The distress and social isolation experienced by these children, both before and after death of their parents(s) is strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS.

Some of the respondents (n-7)) indicated that the children **suffer rejection** especially from other relatives. They attributed the problem to stigma associated with HIV/AIDS. Because of the above-mentioned feelings most of the children experience **loneliness, poor self-esteem and lack of confidence, stubbornness**

and being withdrawn. This is supported by Thompson and Rudolph (2000: 228) who states that some people's typical response to everyday interactions is withdrawal. These people may have low self-esteem or feelings or inferiority that inhibits them or have experienced negative consequences as a result of speaking out or are inhibited by from doing so by anxiety. They further state that people who are withdrawn and passive need to be encouraged to recognize their rights as people as well as accept the right of others

Stress was also indicated as a problem amongst AIDS orphans. Some respondents (n-3) indicated that the children they were raising experienced **serious depression** and one even attempted to commit **suicide**. According to Geldard and Geldard (1999: 8) this is not uncommon since adolescents continually have to adjust to new experiences, encounters and situations while at the same time adjusting to biological, cognitive and psychological changes. Stress management is especially suitable because adolescents can identify the causes of stress, discover that they are not unique in their struggles, and learn how to cope with stress.

There was a general feeling among the respondents (n-7) that the children experience **lack of support** from both the family and community. **Change of residence and relocation** were indicated as a noticeable problem. In addition to loosing their parents, the children also loose their friends and familiar environments such as the school and the neighborhood that they were used too. They however, acknowledged the help received from the school principals and social workers in their communities.

The emotional needs that were mentioned included **counseling, love, acceptance, and encouragement.** AIDS orphans need the **emotional support** of the community and their relatives. Furthermore, it was highlighted that relocation of AIDS orphans should be done with care. Doka (1994: 36) state that losing a parent is considered hard to handle however it is even more difficult to cope with

multiple losses. Relocation that requires a change of neighbourhood or school can disrupt supportive friendship networks that could buffer the loss.

- **Life skills needed by AIDS orphans:** The responses given by caregivers were the same as those given by social workers. The skills included **communication skills, coping skills, stress management, decision-making skills, self-esteem and self-confidence.** These skills were viewed as important as place over a short period of time. WHO (1994: 1) states that life skills enable individuals to deal effectively with the demands and challenges of everyday life. They enable people to make positive contribution that can lead to improvement of their lives.

  Other skills that were regarded as important included **budgeting and financial management skills** as well as **home-management skills**. It was indicated that the children need to be taught about the importance of social grants. They also emphasized the importance of teaching the children basic skills of cleaning, baking and gardening.

  All of the respondents (n-10) highlighted the need for children to be taught about **sex education**. The knowledge they have about sex is superficial. Various studies found that boys and girls become sexually active from the age of 14 years (Anderson, 1994; Mogotsi, 1996). This is supported by a survey conducted by Brack and Hill (2000: 3-4) at schools in North West Province, which revealed that children start experimenting with sex at an early stage without realizing the possible consequences of their actions. This was reflected for instance where the majority of learners expressed their acceptance of pre-marital sex. It was also revealed that many young people lack informed knowledge concerning the potential dangers of engaging in sexual activities. Finally the researchers concluded by stating that young people need life skills to help them to identify deviations and efficiently deal with them.

In the following section AIDS orphans responses are discussed. The section will first describe the semi-structured interview guideline, followed by the demographic information of the respondents, then responses that were given by AIDS orphans and lastly a summary of those responses.

7.2.4 AIDS orphans responses (N-20)

Semi-structured interviews with AIDS orphans contained questions on the following:

- **Demographic information**

- Age
- Gender
- Highest educational standard passed
- Residential area
- Language spoken
- Parent(s)
- Who is your guardian?
- Siblings
- How long have you been an orphan?

- **Social needs and problems of AIDS orphans regarding:**

- Education
- Relationships
- Upbringing
- Health-care
- Subsistence/Finances
- Housing/Security

- **Emotional needs and problems of AIDS orphans regarding:**

- Personality
- Emotions
- Mental-health
- Support systems
- Loss of parent(s) and identity

- **Life skills that AIDS orphans need to enhance their personal well-being regarding socio-emotional needs.**

The following section focuses on the demographic information of AIDS orphans who participated in the study.

7.2.4.1 Demographic information of AIDS orphans

The study population consisted of 20 AIDS orphans from Ledig one of the villages in Rustenburg (North-West Province). They were all selected from one of the primary schools. All of the respondents (100%) were Setswana speaking and could clearly communicate in Setswana.

All of the respondents (100%) who participated in the research fell within the age group 11-14 and the majority of respondents (60%) were in grades 3-4 followed by those in grades 5-6 (40%). There was equal representation of gender. 50% of respondents were females and the other 50% were males. People who fall under this age group are regarded as early adolescents. Most of the physical, emotional and social changes of adolescence occur in the early adolescent years. For the majority of young persons, these years are the most eventful ones of their lives so far as their growth and development is concerned. They are undergoing the bodily changes of pubescence and mental changes of cognitive maturity (Gallahue & Ozmun, 2002: 296; Geldard & Geldard, 1999: 3; Louw, 1992: 383; Louw, van Ede & Louw, 1998: 388; Simons, 1994: 256).

The majority of respondents (85%) lost both parents to AIDS. The death rate in the country and the increase in the number of HIV infection are of concern to the government. South Africa has the highest HIV/AIDS caseload in the world, with 5.3 million people or one in five adults, living with HIV (Sunday Times, 2005: 1; AIDS Epidemic Update, 2004: 5). The consequences of the escalation of AIDS are serious for the children and the society at large. Many children are left parentless by AIDS. These orphans and the communities to which they belong face a heavy financial and emotional burden. Orphans generally are often thought to run a greater risk of being malnourished, stunted of not receiving the care they need than children who have parents to look after them (Newsweek, 2000:15; Robbins, 2004: 1; UNAIDS, 2004: 3; UNICEF/UNAIDS, 1999: 4; UNICEF, 2003: 2).

One significant response concerns the number of siblings AIDS orphans had. The majority of respondents (90%) stated that they had two and more brother(s) or sister(s). These statistics reflect that a serious situation exist in South Africa. This clearly shows that the increase in AIDS orphaning is one of the major challenges facing the country. The epidemic has vastly increased the numbers of orphans in South Africa. This is confirmed by the North-West Population Trends and Development Report - HIV/AIDS Perspective (2004: 37), which states that one of the worst consequences of AIDS, is that large numbers of children are orphaned as a result of parents dying from AIDS. AIDS is generating orphans so quickly that family structures can no longer cope.

The period of being orphans differed. The majority (75%) have been orphans for about three years with few (25%) being orphans for more than three years. This is not surprising since it has now become common for children and adolescents to lose members of their immediate family such as parents or siblings. From the above-mentioned findings it has become clear that parents die in great numbers living many orphans.

The majority of respondents were living with their grandparents (70%) followed by those who were staying with their aunts and uncles (20%) and finally there were children who were staying on their own (4%). The results are not surprising because as already highlighted in theory increasingly, grandparents are raising the infected and uninfected offspring of their own children who have died of AIDS (Avert, 2004: 2; Barnett & Whiteside, 2002: 218; Hope, 1999: 96; UNAIDS, 2004: 3; UNICEF, 2003: 1). Sometimes these elderly grandparents are the only relatives left as AIDS largely affects the most economically active age group, the 15-45 year olds.

In the following section the social needs and problems of AIDS orphans are presented as identified by participants (AIDS orphans).

7.2.4.2 Social needs and problems of AIDS orphans as described by AIDS orphans

Table 13 gives the responses of AIDS orphans regarding their social needs and problems. Direct quotes " " will be given to verify qualitative information.

Table 13: SOCIAL NEEDS AND PROBLEMS OF AIDS ORPHANS (AIDS ORPHANS)

CATEGORIES	PROBLEMS	NEEDS
Education	➢ Financial problems. "My grandmother does not have sufficient income. This leads to unpaid school fees, shortage of school uniform and books". "The thing that hurt me most is	➢ Financial assistance which will ensure that children have all the needed uniform, school fees, transport money, books and lunch box money. "I
CATEGORIES	**PROBLEMS**	**NEEDS**
Education	when I go to school on an empty stomach. My aunt	always pray to God to send an angel to help". "We are

	never gives me money for lunch box". ➢ Lack of supervision, care and support. "There is no one to help us with homework and other school activities". "I always go to my neighbours for assistance. My grandmother is too old to help". ➢ Walking a long distance to school. "My friend and I walk to school because we do not have money for transport". ➢ High failure rate. "I find it difficult to concentrate at school because I remember my mother a lot. If she was here, I would not be suffering. She was the best mother". "It is difficult to study on an empty stomach".	in desperate need for money". ➢ Caregivers' assistance. "They need to be assisted with ironing school uniform and helping with school homework.

CATEGORIES	PROBLEMS	NEEDS
Relationships	➢ Sibling conflict. "My cousins are disrespectful, we always fight". "My younger brother and I always argue, I wish that could change". ➢ Parent-child conflict. "My aunt and uncle do not understand me". "My grandmother does not give me the same treatment as other children. I'm always scolded". ➢ Poor relationship with other relatives (suffer rejection). "My uncles never visit". ➢ Poor relationship with learners and friends especially at school, due to being teased especially about not having uniform and lunchbox money.	➢ Love and acceptance. ➢ Harmony at home. "There is a need for peaceful relationship especially with caregivers and other siblings especially cousins". ➢ Need of friendship "Every person needs a friend". ➢ Community and family support.
Upbringing	➢ Poverty, which is characterized by financial problems. ➢ No nutritional foods and clothing. "We always eat porridge and potatoes. We	➢ Financial assistance. "I think money is the key to solving our problems at home". "We need money". ➢ Good nutritional food.

CATEGORIES	PROBLEMS	NEEDS
Upbringing	never eat meat and fruits". "My grandmother always cooks porridge and tomatoes or cabbage". "I always do not look forward for meals. They are not delicious". ➢ Poor education due to lack of funds. "There are serious financial shortages at home, I have not yet paid school fees". ➢ Child headed household. " My grandmother passed on last year since then with have been living alone". "My sister takes care of us. I think she is 14 or 15years of age". ➢ Occupying adult roles while still children (taking care of the grandparents and other siblings, cooking, cleaning etc.	➢ Caregivers' supervision, care, love and support. ➢ Community support. ➢ Care givers to be employed. "My aunt always say that if she were to be employed our problems would be changed".
Health-care	➢ Poor health care. "Because my aunt is working there is no to take me to the clinic when I get ill". "Hospitals are expensive, we always go to a local clinic".	➢ Medication should be available at all times. ➢ Caregivers to take them to the clinic when they need

CATEGORIES	PROBLEMS	NEEDS
Health-care		medical attention. ➢ "Our clinic does not open in the evening. We need a clinic that open 24 hours a day".
Subsistence/ Finances	➢ Financial problems, which lead to no provision of food. "Social grants money is too little to meet all of our needs". ➢ Problems with issuing of social grants due to unavailability of birth certificates. ➢ Mismanagement of money. "I am staying with alcoholic relatives especially my aunt. She wastes our money on alcohol".	➢ Financial support of government and other relatives.
Housing/Security	➢ Financial problems, which leads to shortage of electricity in the house. ➢ Improper house structures (shacks). "We stay in a two roomed house". I stay with my	➢ "A house that has electricity at all times". ➢ "A proper house structure that is fully furnished". ➢ "A bigger house".

CATEGORIES	PROBLEMS	NEEDS
Housing/Security	grandmother who is blind in a two roomed house". "We stay in a four room shack house but we are eleven at home". ➢ Small house. "Our house is too small and has no furniture especially beds. I'm tired of sleeping on the floor". ➢ Overcrowded house.	

The following section gives emotional problems and needs of AIDS orphans as given by AIDS orphans who participated in the study. Direct quotes are given to qualify information.

7.2.4.3 Emotional needs and problems of AIDS orphans as described by AIDS orphans

Table 14 describes the emotional needs and problems of AIDS orphans as given by AIDS orphans who participated in the study

Table 14: EMOTIONAL NEEDS AND PROBLEMS OF AIDS ORPHANS (AIDS ORPHANS)

CATEGORIES	PROBLEMS	NEEDS
Personality	➢ Poor self-esteem. "I have never admitted this to anyone, but the truth is I often look down on my	➢ Need to be loved and not teased all of the time.

CATEGORIES	PROBLEMS	NEEDS
Personality	self". "I always pretend when I am with others, I am a shy person, I do not talk a lot".	➢ Need not to be reminded of their parents' death not all of the time.
Emotions	➢ Pain/hurt "It hurts that I do not have parents like other people". ➢ Sadness and loneliness. "I am missing both of my parents and other family members who have passed away". "No one can replace my mom, I miss her a lot and it makes me sad". ➢ Being withdrawn. "I do not feel comfortable playing with other children who are well provided for". "I do not have friends". "I am not interested in befriending others. I am afraid they will leave me too". ➢ Feel rejected (relative who do not visit). ➢ Blame: "I sometimes blame God for what happened to my family i.e. loosing both parents".	➢ A listening ear. "I often need someone to listen and not judge". ➢ Counseling. ➢ Support. "I need a family that cares"

CATEGORIES	PROBLEMS	NEEDS
Mental health	➢ Depression	➢ Counseling
Support systems	➢ Lack of support from other members of the family and being rejected by other members of their families. "I miss my relatives a lot but they never visit". "The last time I saw my uncles and aunts was during my mother's funeral, they never visit". "My relatives do not love me, they are to busy to visit us". ➢ "My grandparents are too old to offer proper care".	➢ Support of members of the family. "I need to be in constant contact with all of my relatives". ➢ Support of community members especially teachers.
Loss of parents and identity	➢ Adjustment problems as a result of relocation. ➢ Loss of friends and change of schools. "I have lost contact with some of my friends and their other relatives due to relocation". ➢ Separation of siblings. "I miss my sister. She stays at a welfare agency".	➢ Familiar environments. Not to be relocated. ➢ Stability: "I don not like to be moved from one place to the other". ➢ Support of caregiver. "I need someone like my mom, someone who cares".

7.2.4.4 Life skills that AIDS orphans need (AIDS orphans)

All of the respondents could not answer questions pertaining to life skills indicating that they did know the skills that they needed. According to Anderson and Okoro (2000: 1- 2) as well as Brack and Hill (2000: 3-4) the absence of basic knowledge and life skills contribute to the vulnerability and exploitation of people, especially young people with regard to social and health problems. Deficiencies in life skills contribute to low self-esteem, loneliness, and parent child relationships. This condition also handicaps the development of satisfying interpersonal relationships and influences the effectiveness of role performance. However, it is possible to rectify this deficiency by giving young people access to skills development programmes.

The following section summarizes and elaborates on the responses given by AIDS orphans who participated in this study and verified with literature control.

7.2.4.5 Summary of AIDS orphans' responses

- **Social needs and problems:** All of the respondents (n-20) highlighted that they experience problems such as **financial constraints**, which lead to shortage of school uniforms, books and lunch box. As already highlighted AIDS orphans are less likely to have proper schooling. Orphan learners may face enormous financial hardship and have great difficulty in paying for school fees, uniforms and books. According to Barnett and Whiteside (2002: 202) the death of a prime age adult in a household will reduce a child's attendance at school. The household may be less able to pay for schooling. UNICEF (2003: 2) stresses that children who drop out of school are vulnerable to substandard education and reduced chances for life success. This has devastating effect, as these children who do not go to school lack the vocational skills needed to earn a decent living and support their younger brothers and sisters. They also lack information about

how they can look after their own health, and especially about how they can protect themselves from HIV/AIDS and other sexually transmitted diseases (Avert, 2004: 7; UNAIDS, 2004: 3).

All of the respondents (n-20) mentioned that they are from **impoverished families** and hence **do not receive proper care**. They mostly stay in shacks with no electricity, water, and furniture or poor quality furniture. They walk long distances to school. These responses are similar to those given by social workers and caregivers. A new UNICEF report (2004: 1) shows more than half the world's children are suffering extreme deprivations from poverty, war and HIV/AIDS conditions that effectively deny children a childhood and hinder the development of nations. AIDS orphans are among the largest segments of the poor population. Illness and loss of a parent reduce the capacity of families to provide for the children most basic needs (Hope, 1999: 98).

Their financial problems are heightened by the fact that **only few (n-7) receive social grants.** The reasons that were given include unavailability of birth certificates and the slow process of issuing the grants. Some guardians were mentioned as irresponsible because they spend the money on alcohol and themselves rather than buying grocery and other needed resources. Neumark-Szatainer et al, (1997) in Geldard and Geldard (1999: 17) mentions that when parents give their own needs priority without adequate regard for the needs of their children family systems becomes dysfunctional as a result children will be affected in a variety of ways. Unfortunately when parents engage in anti-social and maladaptive behavior they increase the possibility of their children doing the same. Alcoholism in parents is related to adolescent anti-social behavior. Children may experience emotional problems and may run away from home in search of stability and security (Bezuidenhout, 2004: 10).

The participants (n-9) also indicated that they **experience problems when coming to relationships.** Their relationship with their cousins most of the time is

characterized by conflict. They allude that many do not understand them especially their relatives. Most of the male participants (n-8) highlighted that they have **poor relationship** with friends and others. UNAIDS (2004: 3) states that many people do not understand the emotional anguish experienced by AIDS orphans. Even people who work with orphaned children struggle to understand the emotional anguish a child experiences as he or she watches one or both of his or her parents die. The illness and loss of a parent is very traumatic for a child and lack of consistent nurture can have serious developmental effects.

It was noted that few (n-2) of the **respondents lived on their own**. The majority (n-18) of the respondents were living with extended families. This is in line with UNICEF (2003: 1) that mentions that extended families are already caring for 90% of all orphans. However, a number of authors Avert (2004: 2), Barnett and Whiteside (2002: 199), Deame (2001: 2), Robbins (2004: 1), Van Dyk (2001, 334) as well as UNICEF (2003: 1) have noted that in recent times, the strands of the safety net provided by the extended family system have become increasingly frayed. Even those children, who are taken in by remaining extended relatives, still remain at risk. Caring for children has costs. AIDS orphans increases demands on household resources. Many extended families that have accepted orphans cannot afford to send all their children to school, and orphans are often first to be denied education and are required to work for the upkeep of the family.

The majority of respondents (n-14) indicated that their guardians are their **grandparents who are too old to offer proper care**. Many authors such as UNICEF (2003: 1), Chachkes and Jennings (994: 84) as well as Hope (1999: 96) agree that caring for a grandchild or grandchildren may be an unwanted or difficult burden, an intrusion into family life. The grandparents may be unprepared to take on the burden of total care for an orphan. Often, these grandparents do not have an income of their own and are progressively less able to adequately provide for the children in their care.

The respondents mentioned that their **roles are reversed** because most of the time they take care of them (grandparents and other siblings). They complained that **they occupy adult roles** and that affect their school performance as they are **deprived of time to study at home**. This is supported by Nyandiya-Bunddy (1997: 15) and Barnett and Whiteside (2002: 206) who state that becoming an orphan of the epidemic is rarely a sudden switch in roles. When AIDS takes a parent, it usually takes childhood, too, for if no other relatives' step in, the oldest child becomes the head of the household taking on the responsibility of supporting and caring for their siblings and other members of the family and this has serious consequences for a child's development.

Finally the **social needs** highlighted by the respondents (n-34) **included financial assistance, responsible caregivers and family as well as community support**. According to Siegel and Freund (1994: 54) and Avert (2004: 5) children deserve a childhood filled with comfort, security and hope. The death of a parent is certainly a profound psychological and social crisis for a child, especially when the parent dies from AIDS. Growing up in communities disrupted by the epidemic; orphans are more likely to cope if they can live in surroundings that are familiar, stable and as nurturing as possible.

- **Emotional needs and problems:** Participants (n-20) alluded that they experience various emotions such as **sadness, loneliness, rejection, blame especially towards God,** and all of them mentioned that they miss their parents very much. These emotional problems are the same as those identified by social workers and caregivers. Many authors agree that the emotional suffering of the children usually begins with their parents' distress and progressive illness. Eventually the children suffer the death of their parent(s) and the emotional trauma that results. This intensifies as HIV/AIDS cause drastic changes in family structure resulting in a heavy economic toll, requiring children to become caretakers and breadwinners (Avert, 2004: 5; Hope, 1999: 98; UNICEF, 2003: 2; UNICEF, 2004: 1).

According to UNAIDS (2004: 3) and UNICEF (2003: 2) depression and alienation become common in most AIDS orphans. It is not surprising that the majority of respondents (n-12) noted that they **feel depressed** most of the time due to ill treatment they receive from others compared to the love and care they used to feel when their parents were alive. Amanat and Beck (1994: 200) further supports this by stating that children turn to feel depressed if they receive little stimulation, attention, or affection. Furthermore, children or adolescents may also learn depressed behaviors such as self-criticism and low self-esteem from their parents through modeling or where approval is contingent upon making self-deprecating remarks. They can feel self-worth only when they have received approval, love and support from someone else.

The majority of respondents (n-15) also highlighted that they experienced **adjustment problems after being relocated**. They mentioned that they lost friends and miss some of their relatives. Some respondents (n-5) highlighted that they **had to be separated with their siblings**, which was very hard at the time. Barnett and Whiteside (2002: 206) note that being separated from their siblings often compounds AIDS orphans. For example, in a report from Zambia, separated siblings said they see each other less than once a month (Family Health International, 2002 in UNAIDS, 2004: 3). This is confirmed by UNICEF (2003: 2) who states that AIDS related death may be particularly problematic. The children have to adjust to a new situation, with little or no support at all.

The **emotional needs** that respondents (n-20) mentioned included **support of both family and community members, counseling, stable family environments, and not to be teased as well as always being reminded of their parents' death.** According to Avert (2004: 5) and Robbins (2004: 1) children grieving for dying or dead parents are **stigmatised or ostracised** by society through association with HIV/AIDS. Many experience depression, anger, guilt and fear for their futures; hence they need the support and understanding of significant others.

Finally it is important to highlight that throughout the interviews the participants (n-20) were **emotional and kept on crying**. The researcher had to stop allowing the social worker to render counseling. It was quiet evident that most of the respondents still missed their parents very much and were still grieving. According to Black (1991: 10) the deepest and most irreplaceable loss experienced by any orphaned child is the loss of parental love. Many doctors and social scientists have warned against assuming that children recover quickly from bereavement simply because they start to play and smile again. The fact is children experience grief and depression, which are hidden and in time they may find expression in behavioural disturbance. Furthermore, Papadatou and Papadatos (1991: 43) are of the opinion that coping with death is difficult for most adolescents because both death and adolescence are transitional phases. In this ground they further argue that adolescents who loose their loved ones experience a double crisis owning to the death of a loved one and their developmental age. Therefore Geldard and Geldard (1999: 23) suggest it is important for adolescents to work through the grieving process so that their developmental process is not impeded by their grief.

In conclusion Section A has established that indeed AIDS orphans are experiencing problems. Section B presents findings of the second phase of the research study regarding the implementation and evaluation of the developed life skills programme.

SECTION B

7.3 QUANTITATIVE FINDINGS (SECOND PHASE)

The present reality of the increase in mortality rate as a result of HIV/AIDS presents a growing problem in South Africa. Government is facing the challenge of dealing with those debilitated by HIV/AIDS and the numbers of AIDS orphans. The shrinking

resources and rather unstable socio-economic climate in South Africa highlights the urgency of a comprehensive life-skills programme for early adolescent AIDS orphans. As already highlighted in the previous chapters, the pandemic has caused the collapse of the extended family and the loss of knowledge traditions that usually passed on to children by their parents. Additionally, children in such situations grow under impoverished conditions and are likely to be abused, exploited and stigmatised. The consequence of this is that AIDS orphans are often socially isolated and deprived of basic social services such as education. Most will grow up without adequate parental supervision, guidance, and discipline (Bartholet, 2000: 13; Deame, 2001: 1-2; Frost, 2005: 1; Report on the Global AIDS Epidemic, 2004: 5; Tjaranda, 2005: 1; UNICEF, 2005: 3; Van Dyk, 2001: 334).

The basis of life skills programmes is that early adolescents get assistance in taking charge of their own future instead of being a drain on the community. They are empowered to handle their future, improve their livelihoods and become able agents of their own change. Therefore, the need for adequate socialisation of life skills during early adolescent years cannot be overemphasised. During these years the adolescent should be equipped with life skills that will stand him or her in good stead for the rest of his or her life.

Based on an in-depth literature review and the information collected in the first phase of this study, as described in Section A of this chapter the researcher developed a life skills programme for early adolescent AIDS orphans. The programme has been developed especially for AIDS orphans in their early adolescent years (11 – 14 years). The objective of the programme is to help this group of people increase the probability of making good rather than poor choices in targeted skills. The point of departure is based on efforts to internalise an accepted life-style (primary prevention) and avoid dangerous behaviour. It provides them with a repertoire of life skills in a number of different areas. The programme deals with key topics that early adolescent AIDS orphans need to know about namely:

- A good sense of identity
- The capacity to develop healthy relationships (communication and assertiveness training skills).
- Self-awareness and self-esteem.
- Coping and stress management skills.
- The ability to make informed and responsible decisions.
- Knowledge about HIV/AIDS
- Problem solving and conflict management skills.
- Independent, critical and creative thinking skills.

In order to empirically test the effectiveness of the developed life skills programme the researcher used the quasi-experimental comparison group pretest-posttest design. This design is the equivalent of the classical experimental design, in that two groups (experimental and comparison groups) are used, as well as pre-and-post tests. However a randomised allocation of subjects is lacking (De Vos, 1998: 79). In this design although the two groups receives both the pre-test and the post-test at the same time only the first group (experimental group) receive treatment (Fouché & De Vos, 2002: 145).

This design was selected because it made it possible to determine how the independent variable (AIDS orphans' life skills programme) affected experimental group by comparison of pre-and post-test results. The researcher utilised the quasi-experimental comparison group pretest-posttest design to test the research hypothesis of the study namely:

If early adolescent AIDS orphans undergo a life-skills programme then their skills will be enhanced in order to cope better with their socio-emotional needs and problems.

In the following section research methods are reviewed.

7.3.1 RESEARCH METHODS

This section describes the sample and sampling techniques and method of data collection used during the quantitative phase of this research study.

In the second phase of this study a sample of 60 early adolescent AIDS orphans in the North-West Province specifically in Mafikeng and Rustenburg were purposively selected according to the following criteria:

- Population: AIDS orphans who have lost parent/s to AIDS;
- Development phase: Early adolescence (11-14 years old);
- Permanent residence: North West Province (Mafikeng and Rustenburg);
- Population group: Black.
- Language: Fluent in Setswana.

These respondents were then equally divided into two main groups, one of which became the experimental group (30 respondents) and the other the comparison group (30 respondents). Both groups were measured at the beginning of the study, i.e. before implementation of the life skill programme (pre-test) by using a questionnaire. The experimental group was then equally divided in three groups of ten. According to WHO (1997: 10) the teaching of life skills is effective when conducted in small groups. Thereafter, the experimental group was subjected to the intervention AIDS orphans' life skills programme.

Following the intervention both (comparison and experimental) groups were measured again (post-test) by using the same questionnaire. This enabled the researcher to measure the effectiveness of the intervention (AIDS orphans' life skills programme) by comparing the results of pre-and post-tests.

The researcher made use of a **self-constructed group-administered questionnaire** to collect data from the 60 identified early adolescent AIDS orphans who were the sample in this study. According to Oppenheim (1992: 83) the group administered questionnaire is given to groups of respondents assembled together such as school children or invited audience. Delport (2002: 174) notes that with group-administered questionnaires the respondents who are present in a group complete a questionnaire on their own without discussing it with other members of the group. As in the North-West Province Setswana is a predominantly spoken language amongst Blacks, the researcher administered the questionnaire using the local language.

In the following section quantitative data is presented, analysed and interpreted according to demographic information and the identified life skills.

7.3.2 Data analysis and interpretation

According to De Vos, Fouché and Venter (2002: 222-223) quantitative data can either be analysed manually or by a computer. Data from this study was analysed using computer application softwares, namely Microsoft Excel and Access. Information gathered from group-administered questionnaires was statistically analysed and then displayed by means of tables and graphic presentations. Univariate and where applicable, bi-variate distributions were used.

The questionnaire contained information pertaining to the demographic information and the identified ten life skills (See Appendix 6). The results of empirical study will be presented according to both demographic information and the ten identified life skills.

- **Demographic information**

Demographic information regarding respondents' age, gender, race, home language, level of education and family variables such as living arrangement of respondents and respondents' parent status are discussed below.

7.3.2.1 The respondents' age group

The target population of this study is early adolescent AIDS orphans in North-West Province. WHO (1997: 16) describes early adolescents as a group of children that seem to be most vulnerable to behaviour–related health problems. They seem to lack the support required to acquire and reinforce life skills. To safeguard people against the onslaught of health and social pathologies, focus should be on efforts to internalise accepted life style or to change the life styles of people (Anderson & Okoro 2000: 36). Since the study is about AIDS orphans in their early-teenage years this section presents the respondents age group.

According to Sdorow and Rickabaugh (2002: 115) change marks the entire life span; however it is more dramatic at certain stages than others. Most of the physical, emotional and social changes of adolescence occur in the early adolescent years. Adolescence is a critical juncture in the adoption of behaviors relevant to successful living. Therefore, Anderson (2000: 4) notes that teenagers must acquire good and healthy habits to live by. The early formation of life skills and healthy behavioural patterns enable them to learn the patterns of action required for participation in society. They must learn to allocate attention to various activities in a manner acceptable to adults. If they do not learn to concentrate on these tasks at the prescribed times in the prescribed ways, they will not be able to function as adults.

Table 15 gives the age composition of the respondents.

Table 15: Age composition of respondents participating in the study

AGE		Respondents		TOTAL
		Experimental group	Comparison group	
11 years old	Frequency	7	9	16
	Percentage	23.3%	30%	53.3%
12 years old	Frequency	9	8	17
	Percentage	30%	26.7%	56.7%
13 years old	Frequency	8	7	15
	Percentage	26.7%	23.3%	50%
14 years old	Frequency	6	6	12
	Percentage	20%	20%	40%
TOTAL	Frequency	30	30	60
	Percentage	100%	100%	200%

The above table reflects that:

- All of the respondents fall under the category of early adolescents i.e. all of the respondents are in the age group 11 to 14 years of age.
- There is a reasonably equal representation and distribution of respondents for the ages 11 years (26.7%), 12 years (28.3%), 13 years (25%) and 14 years (20%).

- The majority of respondents are 12 years old (28%) with 15% of respondents in the experimental group and 13.3% in the comparison group.
- The minority of the respondents (20%) are 14 years old, with equal representation of 10% of respondents in the experimental group and 10% in the comparison group.
- The age of 13 years old account for 25% of respondents with 13.3% of respondents in the experimental group and 11.7% in the comparison group.
- The age 11 years account for 26.7%. Representation in the experimental group is 11.7% and comparison 15%.

Figure 2 shows a column chart of the age of distribution of respondents who participated in the study.

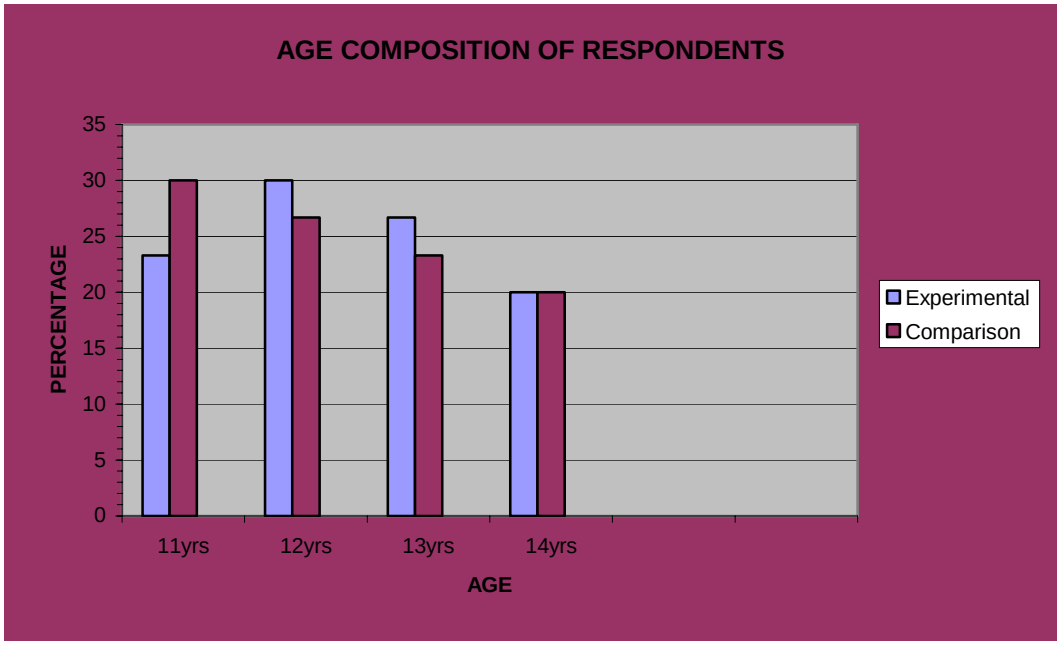

Figure 2: A column chart of the age of respondents participating in the study

Figure 2 clearly reflects that development phase for all the respondents is early adolescence. According to WHO (1994: 10) the teaching of life skills should occur at

a young age, ideally during adolescence, before negative pattern of behaviour and interaction have become established. Usually people in this age group have reasonable exposure of what is happening in their community and can engage in discussions related topic. Life skills teaching to this age group promotes the learning of abilities that contribute to positive behaviour, positive internal relationships and mental well-being.

7.3.2.2 The respondents' gender

In this section information on the respondents' gender is presented. Information on the respondents' gender was sought to show that both sexes (males and females) were represented in the target group.

Table 16 gives representation of the respondents according to their gender.

Table 16: Gender of respondents participating in the study

GENDER		Respondents		TOTAL
		Experimental group	Comparison group	
Male	Frequency	9	10	19
	Percent	30%	33.3%	63.3%

GENDER		Respondents		TOTAL
		Experimental group	Comparison group	
Female	Frequency	21	20	41
	Percent	70%	66.7%	136.7%
TOTAL	Frequency	30	30	60
	Percent	100%	100%	200%

The above table, Table 16 indicates the following:

- Males and females were represented in the sample. However it is clear from the sample that the majority of respondents in both the experimental and comparison groups were females. The sample consisted of 60 respondents of which 68.3% (n=41) were females and 31.7% (n=19) were males.

- In the experimental group 30% of respondents were males and 70% were females whereas in the comparison group 33.3% of respondents were males and 66.7% were females.

Figure 3 provides a graphic display of this variable for all respondents participating in the study.

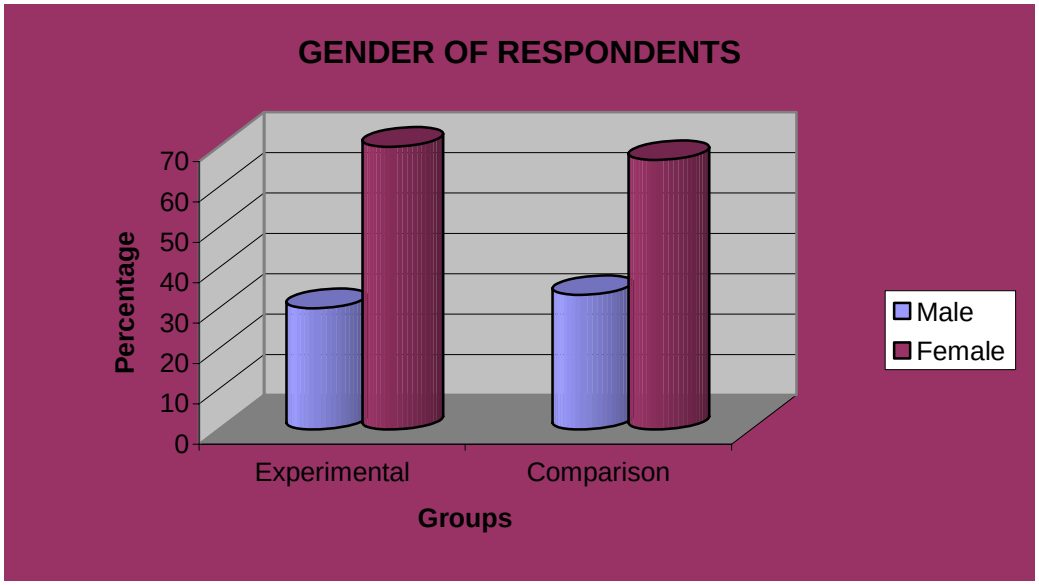

Figure 3: A cylinder chart of the gender of respondents participating in the study

It is clear from the above figure, Figure 3 that female representation is higher than male representation in both the experimental and comparison groups.

The researcher saw it deemed to also describe the relationship or correlation between the variables age and gender. Table 17 gives and reflects the relationship between the respondents' age and gender.

Table 17: The respondents age by their gender

AGE	Experimental group		Comparison group		TOTAL
	GENDER				
	Male	Female	Male	Female	

11 years old	Frequency	2	5	2	5	14
12 years old	Frequency	1	8	1	8	18
13 years old	Frequency	3	5	3	5	16
14 years old	Frequency	3	3	3	3	12
TOTAL	Frequency	9	21	9	21	60

Table 17 shows the following:

- The female and male representation in both the experimental and comparison groups is exactly the same for in each of the identified four age groups.

- In the age category 11 years there are 14 respondents. 4 respondents are males with 2 in the experimental and 2 in the comparison group. 8 respondents are females with 4 respondents in each group. This implies that female representation is higher in this category.

- The total number of respondents in the 12 years age group is 18. There are 8 females in both the experimental and comparison groups. There is only 1 male in each group. This makes the female representation in this age category also higher for females than males.

- From the youth that are 13 years old, 6 respondents are males (3:3) and 10 are females (5:5). This also reflects that the majority of respondents are females in this age group.

- There is equal representation and distribution of respondents in age category of 14 years old. 6 respondents are males (3:3) and 6 females (3:3).

Figure 4 gives a graphical view of respondents' age by their gender.

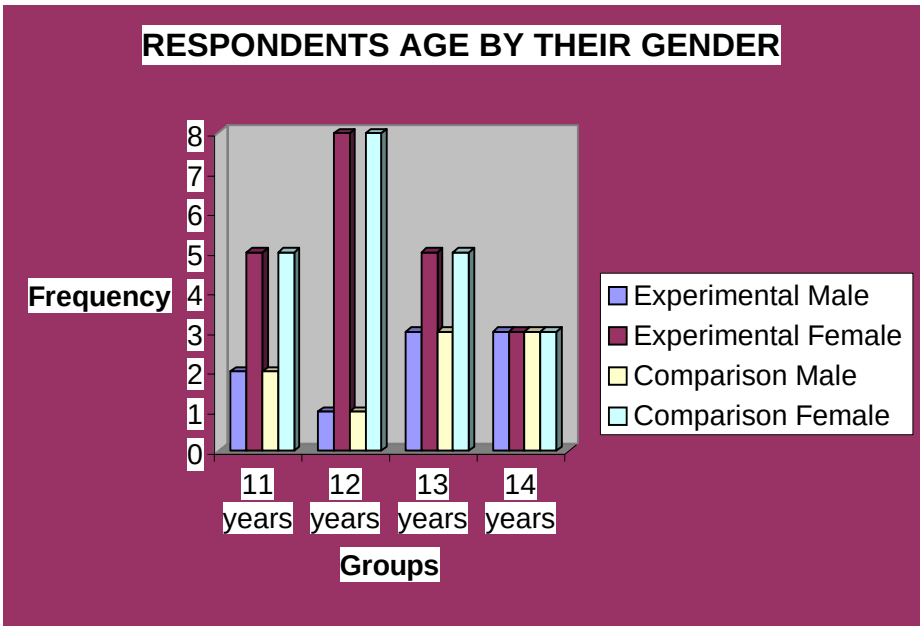

Figure 4: A column chart of respondents' age by their gender

It is clear from the above figure, Figure 4 that the biggest number of female respondents in both the experimental and comparison group is in the category of 12 years old, whilst the smallest number of male respondents is also present in that age category. It is also evident that there is equal representation of female respondents in age categories of 11 and 13. Herewith male representation is low for age category of 11 when compared to age category of 13. Finally the figure indicates that for the age-group 14 there is equal representation of males and females in both the experimental and comparison groups.

7.3.2.3 The respondents' race

All of the respondents (100%) who participated in this research project were Blacks.

7.3.2.4 The respondents' home language

Even though the respondents are all from the same race, information on their home language was sought. It was important to determine the language that the participants spoke to ensure that the interviews were conducted in a language that the respondents understood. This was important as in the North-West Province there are various languages spoken, for example Setswana, Sesotho, Zulu, Xhosa and Afrikaans. However, the language that is mainly spoken is Setswana. According to Bolaane and Mgadla (1997:2) and Branford (1987: 883) Setswana is spoken by an ethnic group known as Batswana and they live in countries of Botswana and South Africa. As already highlighted the respondents in this study reside in South Africa (North-West Province).

Table 18 indicates the home language of respondents.

Table 18: Home language of respondents participating in the study

HOME LANGUAGE		Respondents		TOTAL
		Experimental group	Comparison group	
Tswana	Frequency	27	28	55
	Percent	90%	93.3%	183.3%
Zulu	Frequency	2	2	4
	Percent	6.7%	6.7%	13.4%

HOME LANGUAGE		Respondents		TOTAL
		Experimental group	Comparison group	
Xhosa	Frequency	1	0	1
	Percent	3.3%	0	3.3%
TOTAL	Frequency	30	30	60
	Percent	100%	100%	200%

It is clear from the above table that the majority of respondents in both the experimental group (90%) and comparison group (93.3%) are Setswana speaking. Only 6.7% of respondents respectively in both the experimental and comparison groups indicated they speak Zulu at home and the rest i.e. 3.3% speak Xhosa. It is however, important to mention that although 16.7% respondents speak either Zulu or Xhosa, all respondents are fluent in Setswana.

Figure 5 shows a cone chart of respondents' home language.

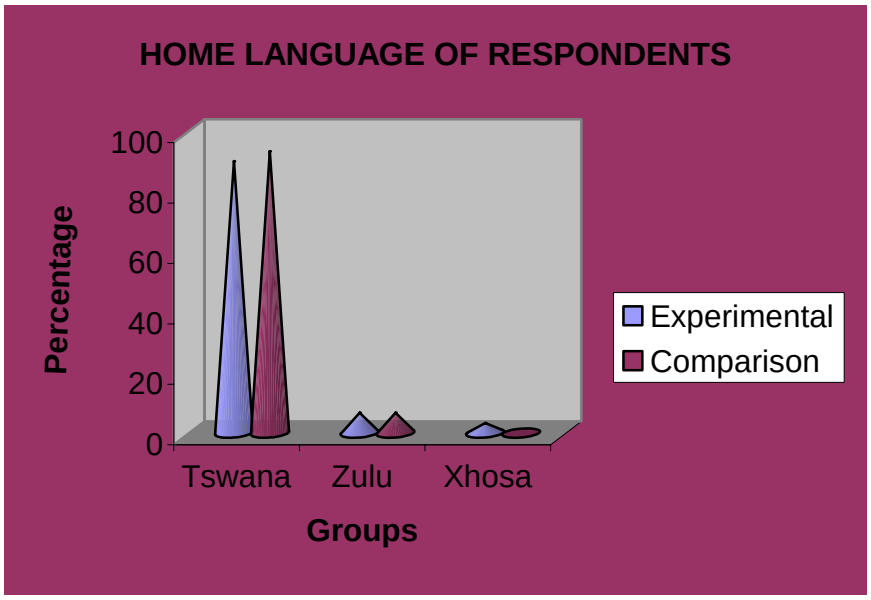

Figure 5: A cone chart of respondents' home language

Figure 5 reflects clearly that the majority of respondents (92%) are Setswana speaking. A life skills programme for early adolescent AIDS orphans was thus conducted in Setswana. It was very important to observe the language of respondents because in life skills education, children are actively involved in a dynamic teaching and learning process. The children are given opportunities to discuss the issued raised in more detail in small groups (WHO, 1997: 4**).** Communication in Setswana enabled the respondents to express themselves and participate at ease.

7.3.2.5 The respondents' level of education

According to Tracey (2005: 1) education is regarded as one of the ways that can be used to help battle the AIDS crisis at the grassroots level. Education can empower the children and give them the skills and hope for the future. Education and information are fundamental human rights, and young people may not be denied the basic information and skills they need to protect themselves (Avert, 2004: 7). However, the presence of HIV/AIDS in the family has devastating impact on school-going children. As the parent with HIV/AIDS progresses with illness, children are likely to drop out

of school temporarily or permanently. Resources may be lacking for children to continue or enrol in school (Avert, 2004: 7; Van Dyk, 2001: 153).

Table 19 gives an indication of respondents' level of education.

Table 19: The respondents level of education

LEVEL OF EDUCATION		Respondents		TOTAL
		Experimental group	Comparison group	
Grade 6	Frequency	11	12	23
	Percent	36.7%	40%	76.7%
Grade 7	Frequency	12	7	19
	Percent	40%	23.3%	63.3%
Grade 8	Frequency	7	11	18
	Percent	23.3%	36.7%	60%
TOTAL	Frequency	30	30	60
	Percent	100%	100%	200%

Table 19 reflects the following:

- There is a reasonably equal representation of respondents in the three grades represented: grade 6 (37.2%), grade 7 ((30%) and grade 8 (31.7%).

- From the experimental group 36.7% respondents attend grade 6, 40% respondents attend grade 7 and only 23.3% attend grade 8. Whilst the comparison group included 40% grade 6 learners, 23.3% grade 7 learners and 36.7% grade 8 learners.

The respondents' level of education is displayed in Figure 6.

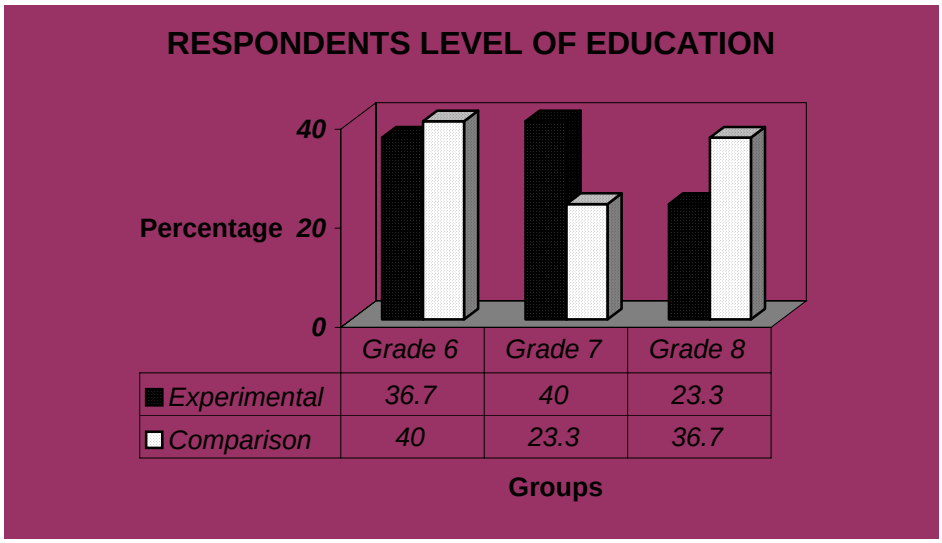

Figure 6: A column chart of respondents' level of education

It is clear from the above figure that all of the respondents are in grades 6, 7 and 8. This was not a surprise since respondents in this study were either attending primary or secondary schools.

7.3.2.6 Respondents' parental status

Every year tens of thousands of children lose their parents to AIDS. The impact of HIV/AIDS on children is seen most dramatically in the wave of AIDS orphans. Ruiz-Casares (2003: 2) notes that for every adult who die as a result of AIDS, four or five orphans are left behind. For the purpose of this study AIDS orphans are children who before the age of 15 have lost either one or both parents to AIDS. Maternal orphans

are children whose mothers have died. Paternal orphans are children whose fathers have died. Double orphans are children whose mothers and fathers have both died. According to Webb (1997: 187) the issue of paternal, maternal and double orphans is important in that the average conditions of the different orphans will vary and double orphans are potentially in the most vulnerable situation.

Table 20 gives an indication of the parent status of respondents.

Table 20: Parent status of respondents

BOTH PARENTS PASSED AWAY		Respondents		TOTAL
		Experimental group	Comparison group	
Yes	Frequency	25	23	48
	Percent	83.3%	76.7%	160%
No	Frequency	5	7	12
	Percent	16.7%	23.3%	40%
TOTAL	Frequency	30	30	60
	Percent	100%	100%	200%

From the above table the following is concluded:

The majority of respondents in both the experimental group (83.3%) and comparison group (76.7%) have lost both their parents due to HIV/AIDS. Only 16.7% of respondents in the experimental group and 23.3% of respondents in the comparison group have one parent still alive.

The respondents' parental status is displayed in Figure 7.

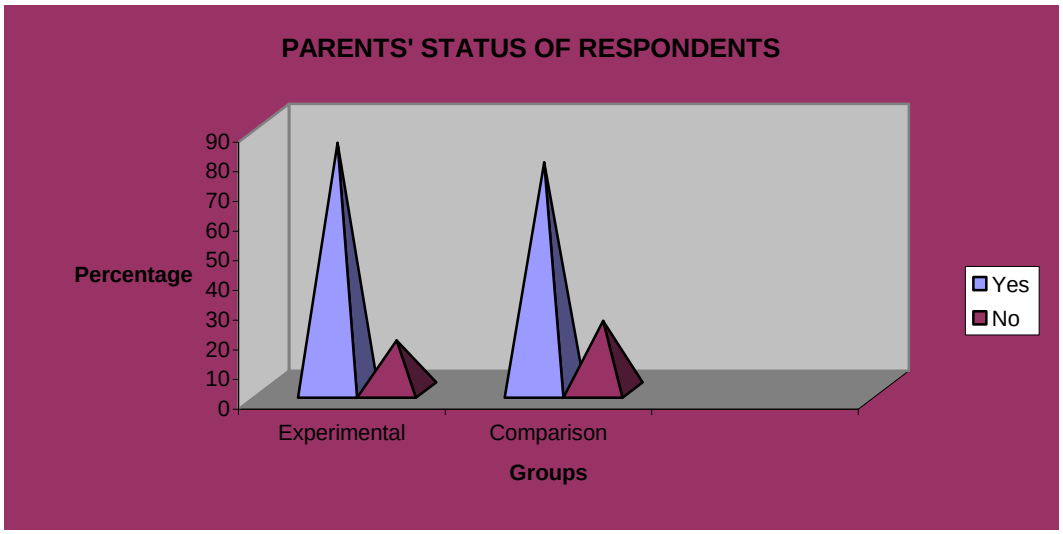

Figure 7: A paradigm chart of respondents' parental status

From the above figure, Figure 7 it is evident that majority of respondents have lost both parents to AIDS. This is not a surprise since according to Barnett and Whiteside (2002: 206) as well as Nyandiya-Bundy (1997: 13) the death of a spouse in HIV/AIDS related cases is usually followed by the other. Since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, children are far more likely to lose the remaining parent. The absence of parental protection and care leave these children in particularly vulnerable situations. There is often a premature entrance to burdens of adulthood, all without the rights and privileges – or the strengths – associated with adult status (Avert, 2005: 1; Barnett & Whiteside, 2002: 206; UNAIDS, 2000: 2).

7.3.2.7 Respondents' remaining parent

In this section consideration is given to respondents who indicated that not all of their parents have passed away. Figure 8 provides a graphic display of this variable.

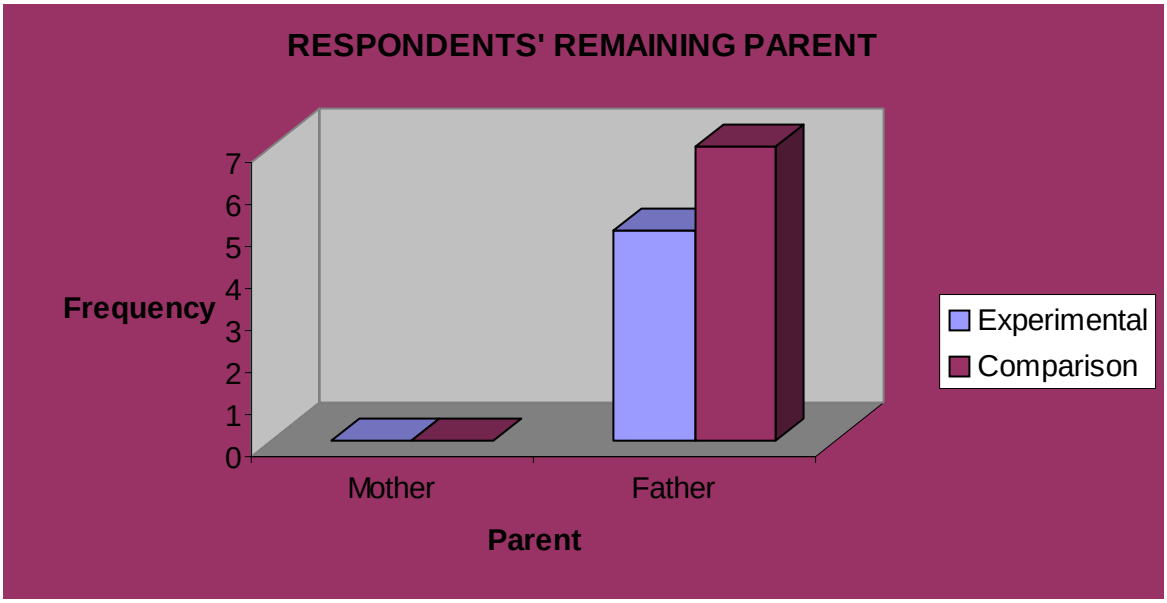

Figure 8: A column chart of respondents' remaining parent

It is clear from all of the respondents (n=12) five from the experimental group and seven from the comparison group who mentioned that they still have one parent remaining that the parent who is still alive is the father. Williamson (1996: 2) states that the death of a mother has dramatic psychosocial consequences as children loose love and nurturing. This is in general recognition of the role the mother plays in taking care of the whole family. Even though the father may be there, his attention in all areas of childcare and upbringing may not be compared to those of a mother. In most cases women are the producers of resources, which service the household. Children usually develop a greater amount of emotional attachment for their mother than they develop for their father (Hope, 1999: 94).

7.3.2.8 Living arrangements of respondents

Living arrangements create a family context or living environment for the adolescent that can build a sense of resiliency and protect him/her against unhealthy lifestyle. However, Bezuidenhout and Dietrich (2004: 67) note that the physical environment in which adolescents find themselves may, together with its social context, trigger risk-taking behaviors which leads to crime, unemployment, imprisonment and diseases.

The home environment of South African adolescents has gradually changed increasing adolescents' potential exposure to unhealthy behavior (Bezuidenhout & Dietrich, 2004: 66). This family variable was thus considered.

Table 21 presents the living arrangement of respondents who participated in the study.

Table 21: Living arrangements of respondents participating in this study

LIVING ARRANGEMENT		Respondents		TOTAL
		Experimental group	Comparison group	
Maternal grandparents	Frequency	16	19	35
	Percent	53.3%	63.3%	116.6%
Paternal Grandparents	Frequency	4	2	6
	Percent	13.3%	6.7%	20%
Brother/Sister	Frequency	2	2	4
	Percent	6.7%	6.7%	13.4%
Relatives	Frequency	8	7	15
	Percent	26.7%	23.3%	50%
Living alone	Frequency	0	0	0
	Percent	0	0	0
TOTAL	Frequency	30	30	60
	Percent	100%	100%	200%

Table 21 highlights the following:

- Of the total sample, most of the respondents (58.3%) live with their maternal grandparents. 25% of respondents live with their relatives whilst (10%) live with their paternal grandparents. Only a small portion (6.7%) lives with their brother or sister.

- There is a noticeable difference in the living arrangement of respondents in the category **"maternal grandparents**" since there are 53.3% respondents in the experimental group and 63.3% respondents in the comparison group.

- The living arrangement of respondents in the category "**paternal grandparent"** for the experimental and comparison group is respectively 13.3% and 6.7%. This implies that representation is higher in the experimental group that in the comparison group.

- There is equal representation of respondents in the category "**brother/sister**". 6.7% respondents indicated that they live with their brother/sister in both the experimental and comparison groups.

- In the category "**relatives**" representation in the experimental group is 26.7% and 23% in the comparison group.

It is interesting to highlight that there are no respondents who indicated that they were living alone. This conclusion differs from what many authors are suggesting that many children are already raised by other children throughout Africa and that the emergence of orphan households headed by siblings is an indication that the extended family is under stress (Avert, 2003: 10; Hope, 1999: 98; Ruiz-Casares 2003:1; UNICEF, 2003: 2; Van Dyk, 2001: 337).

Figure 9 shows a column chart of respondents' living arrangement.

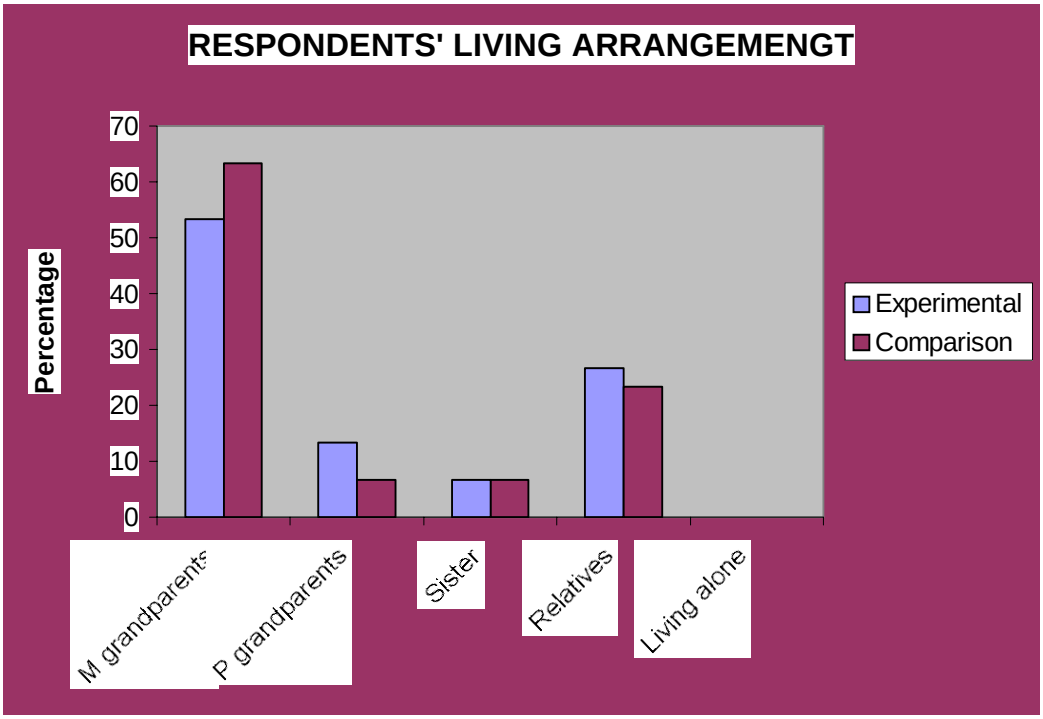

Figure 9: A column chart of respondents' living arrangement

From the above figure, Figure 9 the researcher arrives at the following conclusions:

- The majority of respondents (68.3%) live with their grandparents. This result concur with information obtained in the first part of the study (See page 406) that increasingly, grandparents are raising the infected and uninfected offspring of their own children who have died of AIDS. According to Avert (2005: 2) typically, half of the people with HIV become infected before they are aged 25, developing AIDS and dying by the time they are aged 35, leaving behind a generation of children to be raised by their grandparents. These grandparents care for their own children, who are sick, then they bury them and eventually they become surrogate parents to their bereaved grandchildren, often with few resources.

- In this study it has become clear that all of the AIDS orphans have been absorbed into extended families. In addition to 68.3% of respondents who live with their grandparents, 25% of respondents live with their relatives and 6.7% of respondents live with their brothers/sisters. This implies that the deep-rooted kinship system of extended family networks of grandparents, aunts and uncles still exists. However, according to UNICEF (2003: 1) extended families are already caring for 90% of all orphans. Overstressed and in many cases already overwhelmed, these networks will face ever-greater burdens as the number of orphans continue to spiral upward. Capacity and resources are now stretched to breaking point, and those providing the necessary care are in many cases already impoverished, often the elderly and have often him or herself depended financially and physically on the support of the very daughter or son who has died (Avert, 2004: 2- 4; Robbins, 2004: 1).

The researcher was also interested in the following relationships between the variables:

- Living arrangement and gender
- Living arrangement and age, and
- Living arrangement and parent remaining

Table 22 gives the distribution of scores for living arrangement and gender.

Table 22: Living arrangement by the gender of respondents participating in this study

LIVING ARRANGEMENT		Respondents				TOTAL
		Experimental group		Comparison group		
		GENDER				
		Male	Female	Male	Female	
Maternal grandparents	Frequency	4	12	7	12	35
	Percent	44.5%	57.1%	70%	60%	231.6%
Paternal grandparents	Frequency	1	3	0	2	6
	Percent	11.1%	14.3%	0	10%	35.4%
Sister	Frequency	1	1	1	1	4
	Percent	11.1%	4.8%	10%	5%	30.9%
Relatives	Frequency	3	5	2	5	15
	Percent	33.3%	23.8%	20%	25%	102.1%
TOTAL	Frequency	9	21	10	20	60
	Percent	100%	100%	100%	100%	400%

The researcher interprets the data as follows:

- The living arrangement of respondents with **maternal grandparents** comprises the majority of male and female respondents (58.3%). These include 18.3% of male and 40% female respondents of the total sample. Male and female representation in the comparison group (31.7%) is greater than that in the experimental group (26.7%).

- In the category "**paternal grandparents**" there are 11.1% of male and 14.3% of female respondents in the experimental whilst there are only 10% of female respondents in the comparison group. Note that male representation in this category is limited to the experimental group and thus makes female presentation the highest in this category.

- From 30.9% respondents who indicated that they live with **sister/brother**, there are 11.1% male and 4.8% female respondents in the experimental group. In the comparison group there are 10% male and 5% female respondents. Comparatively, the proportion of respondents in the experimental group (11.1%: 4.8%) and the comparison group (10%: 5%) is thus even. However, males are better represented in this category.

- In the category **"relatives**" 33.3% of respondents are male and 23.8% are females. In the comparison group, 20% of respondents are male and 25% female. Female representation in this category is also high in this category.

Figure 10 gives a column chart of respondents' living arrangement by gender.

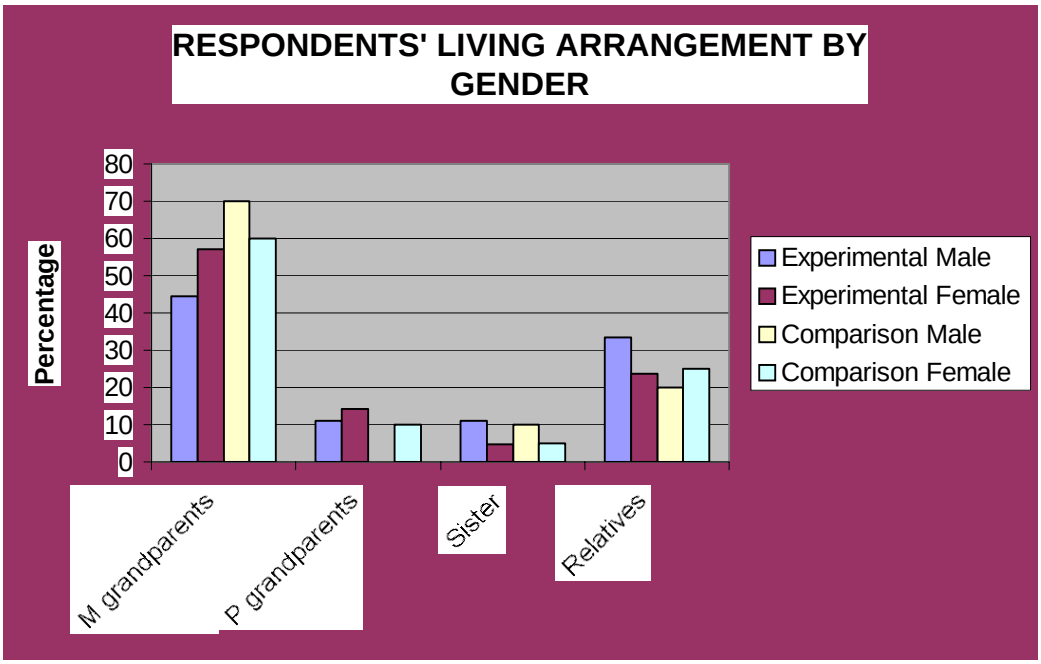

Figure 10: A column chart of respondents living arrangement by gender

In table 23 the living arrangement of respondents by age is presented.

Table 23: Living arrangement by the age of respondents participating in this study

LIVING ARRANGEMENT	Respondents		TOTAL
	Experimental group	Comparison group	
	AGE		

		11 years	12 years	13 years	14 years	11 years	12 years	13 years	14 years	
Maternal Grandparents	Frequency	2	6	5	3	7	6	3	3	35
	Percent	28.6%	66.7%	62.5%	50%	77.8%	75%	42.8%	50%	453.4%
Paternal grandparents	Frequency	2	0	1	1	0	1	0	1	6
	Percent	28.6%	0	12.5%	16.7%	0	12.5%	0	16.7%	87%
Sister	Frequency	2	0	0	0	0	0	2	0	4
	Percent	28.6%	0	0	0	0	0	28.6%	0	57.2%
Relatives	Frequency	1	3	2	2	2	1	2	2	15
	Percent	14.2%	33.3%	25%	33.3%	22.2%	12.5%	28.6%	33.3%	202.4%
TOTAL	Frequency	7	9	8	6	9	8	7	6	60
	Percent	100%	100%	100%	100%	100%	100%	100%	100%	800 %

From the above table the following is clear:

- Respondents' representation in the category "**maternal grandparents**" is very high. Respondents indicated representation of 28.6% 11 year olds, 66.7% 12 year olds, 62.5% 13 year olds and 50% 14 year olds in the experimental group. In the comparison group there are 77.8% 11 year olds, 75% 12 year olds, 42.8% 13 year olds and 50% 14 year olds. The researcher concludes that representation of the 14 year olds is the same in both the experimental and comparison group. Representation of the 12 year olds and 13 year olds is higher in the experimental than in the comparison group. Living arrangement

of the 11 year olds with maternal grandparents is less in the experimental than in the comparison group.

- In the category "**paternal grandparents**" there are 28.6% 11 year olds, 12.5% 13 year olds and 16.7% 14 year olds in the experimental group. Representation in the comparison group is 12.5% 12 year olds and 16.7% 14 year olds. Of interest is that there is no representation of the 12 year olds in the experimental group as well as 11 and 13 year olds in the comparison group. The researcher concludes that the experimental group include most of the respondents in this category.

- The lowest representation of respondents' living arrangement is in the category "**sister/brother**". There are only 28.6% 11 year olds in the experimental group and 28.6% 13 year olds in the comparison group. The researcher concludes that there is equal representation of respondents in this category.

- A living arrangement with **relatives** according to the age of respondents comprises 202.4% of respondents in total. Representation in the experimental group is 14.2% 11 year olds, 33.3% 12 year olds, 25% 13 year olds and 33.3% 14 year olds. The comparison group include 22.2% 11 year olds, 12.5% 12 year olds, 28.6% 13 year olds, and 33.3% 14 year olds. The researcher concludes that representation of the 14 year olds is equal in both the experimental and comparison group. The experimental group include most of the representation for this category with majority (105.8%) of respondents.

7.3.2.9 Siblings under respondents care

As indicated in the Table 21 there was no respondent who lived alone. The respondents were either living with their grandparents, sister/brother or relatives.

In the following section consideration is given to analysis and interpretation of data obtained regarding the ten identified life skills.

- **Life skills**

Life skills are self-helping skills that enable people to help themselves. They help people to acquire necessary tools to take charge and effectively manage their lives. As such they are aimed at empowering people. People who possess life skills are more adequate to fulfil their potential and meet their needs (Anderson & Okoro, 2000: 1- 2). The absence of basic knowledge and life skills contribute to the vulnerability and exploitation of people, especially young people with regard to social and health problems. Deficiencies in life skills contribute to low self-esteem, loneliness, and good parent child relationships. Potgieter (2004: 217) notes that a wide variety of skills can be selected for inclusion in a life skills programme for adolescents. The selection depends largely on the target condition, which the client system faces.

Since the study is about AIDS orphans in their early-teenage years this section focuses on analysis and interpretation of ten identified life-skills that are needed to stabilize or change their life-styles. It is divided as follows:

- A good sense of identity and self esteem
- Communication skills
- Assertiveness skills
- Self-awareness
- Coping and stress management
- Decision making skills
- Problem solving skills
- Conflict management skills
- Critical and creative thinking skills
- Maintaining a healthy life style

The empirical results regarding these ten identified life skills will be discussed in the following paragraphs. Each variable (life skill) was operationalized in items that represent the specific life skill as reflected in the questionnaire (See appendix 4). The questionnaire was compiled by formulating questions that represent each life skill. The discussion of the empirical results therefore is based on an established questionnaire with more or less precise indications of how to answer each question.

By use of the group administered questionnaire (self constructed questionnaire) much time and costs were saved. However it is important to mention that the questionnaire was lengthy with 60 questions organized based on the ten skills identified..

7.3.2.10 A good sense of identity and self esteem

One of the most fascinating aspects of development through adolescence years is the way in which the individual evolves a sense of self and self in relation to others in the social environment. The goal of adolescence is establishing personal identity and having this chosen identity confirmed by others. However, evidence suggests that young adolescents show a marked disturbance of self-image, including heightened self-consciousness, instability of self image, low self esteem, and negative sense of perceived self, that peaks between the ages of 12 and 14. If children hold on to inappropriate beliefs about themselves, they may become disempowered, anxious and also have difficulty with interpersonal relationships. Further, this could be quite destructive, and might set the child up for failure. Their fear of failure raises their anxiety and their self-esteem is threatened (Stevens-Long & Cobb, 1983: 187; Geldard &Geldard, 2002: 116; Thom, Louw, van Ede & Ferns, 1998: 393).

Table 24 presents a frequency distribution of the participants' responses towards a good sense of identity and self esteem by employing a pre-test and post-test for both experimental and comparison group.

Table 24: Frequency distribution of the respondents to a good sense of identity and self esteem

STATEMENT	A Good Sense of Identity and Self Esteem											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I am OK being myself.	9	19	2	8	17	5	26	2	2	10	18	2
Everybody makes mistakes; that's normal, so I am normal.	20	6	4	24	4	2	28	1	1	27	2	1
I feel embarrassed when others look at me because I worry about my body image.	22	6	2	19	5	6	10	19	1	22	7	1
I usually believe people when they compliment me.	7	21	2	9	20	1	25	1	4	10	17	3
I need other people's respect to feel good about myself.	18	8	4	19	9	2	5	22	3	22	5	3
I am an insecure teenager.	20	8	2	18	8	4	6	18	6	23	3	4
When things go wrong I usually blame myself.	16	10	4	15	12	3	4	24	2	17	10	3
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	0	1	26	3	1
People sometimes criticize me, but that's OK because nobody is perfect.	5	24	1	12	18	0	27	2	1	16	13	1
It is scary to stand up in a crowd and be different.	22	6	2	20	7	3	8	18	4	23	4	3

STATEMENT	A Good Sense of Identity and Self Esteem											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
Sometimes I keep quite in conversation because I am afraid of how others will react.	24	5	1	23	7	0	4	26	0	25	4	1
I am scared of being on my own.	18	6	6	23	6	1	7	20	3	24	3	3
I am willing to defend that, which I believe in.	10	16	4	12	16	2	27	1	2	14	15	1
If I differ with my peers I am able to go against them.	6	21	3	7	20	3	28	1	1	6	24	0
I enjoy telling people what I think of them.	7	22	1	5	24	1	25	4	1	9	20	1
My friends think I am a leader.	4	18	8	4	19	7	15	3	12	2	24	4
I often feel loved and accepted by my friends.	4	18	8	2	23	5	14	8	8	4	23	3
I often share with my friends about how I feel.	4	25	1	7	23	0	24	6	0	1	29	0
I ought to please my friends rather than do what I want.	16	10	4	20	8	2	4	25	1	21	6	3
I always believe in myself.	9	14	7	8	14	8	22	2	6	7	20	3
My yes is always yes and my no is always no.	5	24	1	7	22	1	22	6	2	4	25	1

STATEMENT	A Good Sense of Identity and Self Esteem											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
Sometimes people are disrespectful; I can cope with that because I know that I am OK.	8	21	1	8	22	0	25	4	1	9	21	0
I never succeed in anything and I think I am a failure in life.	13	11	6	16	10	4	8	17	5	10	17	3
Other people are better than me.	20	8	2	17	9	4	4	24	2	18	8	4
I am unlovable	21	3	6	23	4	3	16	10	4	20	4	6
I am a helpless person	26	2	2	19	6	5	10	15	5	16	9	5
TOTAL	**359**	**336**	**85**	**370**	**335**	**75**	**423**	**279**	**78**	**386**	**334**	**60**

The following is concluded:

- In the category "**Agree**" the sum of the pre-test scores for the experimental and comparison group is respectively 359 and 370. After taking part in life skills programme for early adolescent AIDS orphans the post-test results for the experimental group is 423. The comparison group's post-test results are 386. Both the experimental and comparison group show increases in this category however increase in the experimental group is much higher. This implies that the

respondents' knowledge regarding a good sense of identity and self-esteem was highly enhanced from 359 to 423.

- The sum of the pre-test scores for the category **"Disagree"** of the experimental and comparison group are rather similar for both the experimental and comparison group with responses of 336 and 335 respectively. Post-test results for the experimental group show a sharp decline from 336 to 279 whilst the post-test result of the comparison group basically remained the same with the post-test result of 334. This indicates clear increase in changes regarding a good sense of identity and self esteem in the experimental group with no noticeable changes in the comparison group.

- The total numbers of "**Uncertain**" responses to questions regarding a sense of identity and self esteem in the experimental and comparison groups during the pre-test are 85 and 75 respectively. After participation in the project the post-test result for the experimental group is 78. The comparison group post-test result is 60. This indicates that the results for uncertainties lessen in both the groups.

In the following section, the researcher presents the mean scores of respondents' life skills i.e. a sense of identity and self-esteem. The researcher is also interested on the association between variables. According to Babbie (1990: 301) tests of significance provide an objective yardstick against which researchers can estimate the significance of associations between variables. It allows us to formulate a clear notion of a link between variables. The researcher made use of the Student's Paired t test. Wright, (1997: 49) notes that the paired t test can be used to compare scores when one is doing a before-after study. In this study the Student's Paired t test is implemented to test if there is any significant differences between the average differences (pre-and post-test) for the experimental and comparison group.

Table 25 summarizes the mean scores of respondents' life skills regarding a sense of identity and self-esteem.

Table 25: Mean scores of respondents' life skills regarding a sense of identity and self-esteem

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.26	8.32	-12.75	12
Comparison group	30	0.14	2.63	-4.5	5.25

The mean scores for the experimental and comparison groups are respectively 0.26 and 0.14 with the standard deviation of both groups respectively 8.32 and 2.63.

The Student Paired t test statistic is 0.75 with a P-value of 0.4605. Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's sense of identity and self-esteem with a 95% chance that the results are due to AIDS orphans life skills programme and not to chance.

7.3.2.11 Communication skills

Effective communication is essential for good relationships. Communication skills have been shown by researchers to be effective in developing helping relationships and assisting people in improving their lives. Learning to communicate effectively helps adolescents to build positive relationships with others and it also increases their self-esteem. Young people who have poor communication skills are unlikely to have the ability to stand up for themselves and to assert their rights (Geldard & Geldard, 2002: 228; Potgieter, 2004: 228).

The frequency distribution of respondents' communication skills is presented in Table 26.

Table 26: Frequency distribution of communication skills

STATEMENT	Communication Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
When someone makes me angry I keep quiet. I don't confront the problem.	18	12	----	22	7	1	5	23	2	17	12	1
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	----	1	26	3	1
I feel upset when people do not understand what I say.	26	3	1	23	5	2	8	20	2	29	1	----
When I am sad or worried I try to talk to someone about it.	7	23	----	7	20	3	24	4	2	5	25	----
Sometimes I keep quiet in conversation because I am afraid of how others will react.	24	5	1	23	7	----	4	26	----	25	4	1
I am willing to defend that, which I believe in.	10	16	4	12	16	2	27	1	2	14	15	1
I enjoy telling people what I think of them.	7	22	1	5	24	1	25	4	1	9	20	1

STATEMENT	Communication Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I often share with my friends about how I feel.	4	25	1	7	23	----	24	6	----	1	29	0
I enjoy socializing with others.	16	10	4	12	13	5	24	4	2	15	12	3
My yes is always yes and my no is always no.	5	24	1	7	22	1	22	6	2	4	25	1
Making and keeping relationship with people is very important to me.	12	10	8	9	16	5	23	5	2	9	14	7
I work well with other people.	15	4	11	17	6	7	27	1	2	14	4	12
I respect other people's views even if they are different from mine.	24	2	4	25	2	3	28	----	2	27	2	1
I listen carefully to what other people have to say.	21	1	8	26	1	3	28	1	1	25	3	2
When I talk to others, I look into their eyes to show my interest and full attention.	6	22	2	4	26	----	24	5	1	2	28	----
I try to understand and react to other people's feelings in a caring and responsible way.	22	3	5	27	2	1	29	1	----	28	1	1

STATEMENT	Communication Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I usually observe people's facial expression when I'm talking with them.	5	24	1	27	3	----	25	4	1	1	28	1
Actions speak louder than words.	25	2	3	28	2	----	27	2	1	27	2	1
TOTAL	**272**	**212**	**56**	**306**	**197**	**37**	**403**	**113**	**24**	**278**	**228**	**34**

From the above table the following is thus clear:

- On adding the pre-test scores of "**Agree**" the results for the experimental and comparison group is respectively 272 and 306. After participation in a life skills programme for early adolescent AIDS orphans the post-test results for the experimental group is 403. The comparison groups' post-test results are 278. This result shows a high increase in responses regarding communication skill in the experimental group. This reflects that participating in the project enhanced their life skill pertaining to communication. The comparison groups' post-test shows a decline from 306 to 278.

- The total number of pre-test results for the category "**Disagree**" of the experimental group is 212 and comparison group is 197. Post-test results for the experimental group show a decline from 212 to 113. Post-test results for the

comparison group shows an increase from 197 to 228. It can thus be seen that after participating in the programme the experimental group effective communication skills were enhanced whilst the comparison group's disagrees increased.

- The sum of the scores on "**Uncertain**" responses to the statements of communication by the experimental group during the pre-test are 56 and post-test are 24. For the comparison group are pre-test results are 37 and post-test result are 34. Both the experimental group and comparison group show a decline in their uncertainties about effective communication. However, it is important to note that the decline in experimental group is higher than that of the comparison group.

Table 27 presents the mean scores of respondents' communication skills.

Table 27: Mean scores of respondents' communication skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.47	7.79	-10.75	14.5
Comparison group	30	0.04	4.27	-10.25	9

The mean scores for the experimental and comparison groups are respectively calculated as 0.47 and 0.04 with the standard deviation of both groups 7.79 and 4.27.

The Student Paired t test statistic is 1.72 with a P-value of 0.1035. Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's communication skills with a 95% chance that the results were due to AIDS orphans life skills programme.

7.3.2.12 Assertiveness skills

Steinberg (2003: 90) notes that sometimes problems are created in relationships because people lack the communication skills needed to express emotions, needs, and opinions assertively. Assertiveness involves the ability to express feeling and opinions openly and honestly without offending others. Assertiveness training aims at teaching clients to stand up for their rights. Assertiveness training is concerned with the building of self-confidence and esteem, and the ability to translate this into improving communications. Assertiveness training skills are utilized to assist individuals who are unduly hesitant about expressing their wants or feelings, or in standing up for their personal rights (Anderson & Okoro, 2000: 24; Geldard & Geldard, 1999: 173; Gillis, 1994: 41).

Table 28 reflects a distribution of the respondents' responses to statements on assertiveness training skills.

Table 28: Frequency distribution of assertiveness skills

STATEMENT	Assertiveness Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I feel embarrassed when others look at me because I worry about my body image.	22	6	2	19	5	6	10	19	1	22	7	1

STATEMENT	Assertiveness Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I need other people's respect to feel good about myself.	18	8	4	19	9	2	5	22	3	22	5	3
When someone makes me angry I keep quiet. I don't confront the problem.	18	12	----	22	7	1	5	23	2	17	12	1
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	----	1	26	3	1
I respect myself and I do not allow people to try to push me around.	10	18	2	13	16	1	28	2	----	15	14	1
It is scary to stand up in a crowd and be different.	22	6	2	20	7	3	8	18	4	23	4	3
I am willing to defend that, which I believe in.	10	16	4	12	16	2	27	1	2	14	15	1
If I differ with my peers I am able to go against them.	6	21	3	7	20	3	28	1	1	6	24	----
My friends think I am a leader.	4	18	8	4	19	7	15	3	12	2	24	4
I often share with my friends about how I feel.	4	25	1	7	23	----	24	6	----	1	29	----

STATEMENT	Assertiveness Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I ought to please my friends rather than do what I want.	16	10	4	20	8	2	4	25	1	21	6	3
I always believe in myself.	9	14	7	8	14	8	22	2	6	7	20	3
My yes is always yes and my no is always no.	5	24	1	7	22	1	22	6	2	4	25	1
I find it difficult to set limits on what I will and will not do.	26	4	----	27	1	2	6	22	2	27	3	----
I am motivated to succeed in life.	19	7	4	24	5	1	29	----	1	26	2	2
TOTAL	**214**	**193**	**43**	**234**	**174**	**42**	**262**	**150**	**38**	**233**	**193**	**24**

From the above table the following is clear:

- In the category "**Agree**" the sum of the pre-test scores for the experimental group and comparison group is respectively 214 and 234. After taking part in a life skills programme for early adolescent AIDS orphans' results for experimental group is 262. The comparison groups' results are 233. The experimental groups'

responses increased from 214 to 262 and the comparison basically remained the same.

- The sum of the scores on "**Disagree**" responses to assertiveness training skills statements by the experimental group during the pre-test are 193 and post-test are 150. For the comparison group the pre-test results are 174 and post-test results are 193. The experimental groups' responses showed a decline in the score of disagrees whilst the comparison groups' responses increased.

- The total number of pre-test scores for the category "**Uncertain**" for the experimental group and comparison group is 43 and 42 respectively. Post-test results for the experimental group show a decline from 43 to 38. Post-test results for the comparison group also declines form 42 to 24.

Table 29 gives a summary of the mean scores of assertiveness training skills.

Table 29: Mean scores assertiveness skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.07	8.75	-12	11.5
Comparison group	30	0.3	2.63	-2.75	5

Table 29 shows that the mean scores for experimental and comparison groups are respectively 0.07 and 0.3. Consequently the standard deviation of both groups is 8.75 and 2.63.

The Student Paired test statistic is 0.77 with a P-value of 0.4534. Compared with the 0.05 level of significance there is a statistical difference in the experimental group's assertiveness skills after exposure to AIDS orphans life skills programme.

7.3.2.13 Self awareness

According to Corey and Corey (2002: 308) between the ages of 10 and 14, young people are prone to denial and externalization; are self conscious, and may not show great interest in the process of self-awareness. They may have a confused, distorted knowledge of themselves and need help to overcome this confusion and distortion. They may need assistance in learning to become more aware of themselves (Doyle, 1992: 112). Developing self-awareness is viewed as a prerequisite for effective communication and interpersonal relations. The individual who has self-awareness is aware of the realities of life and feel responsible for self, others, and the well being of society (Stewart et al, 1996: 169).

Table 30 shows the frequency distribution of the respondents' responses to self-awareness specific statements

Table 30: Frequency distribution of the respondents' statements to Self-awareness

STATEMENT	Self Awareness											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I am an insecure teenager.	20	8	2	18	8	4	6	18	6	23	3	4
I am a very unhappy person.	26	2	2	27	2	1	13	15	2	28	1	1

STATEMENT	Self Awareness											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I am unlovable.	21	3	6	23	4	3	16	10	4	20	4	6
I am usually a calm person.	10	14	6	18	6	6	24	4	2	17	8	5
I am lonely.	22	7	1	24	5	1	5	20	5	26	3	1
I am motivated to succeed in life.	19	7	4	24	5	1	29	----	1	26	2	2
I am a helpless person.	26	2	2	19	6	5	10	15	5	16	9	5
I am tolerant of others beliefs.	13	11	6	18	11	1	25	3	2	21	6	3
I feel no good at anytime.	11	12	7	12	14	4	4	25	1	9	16	5
I am fearful of new challenges.	26	3	1	23	2	5	6	21	3	25	3	2
TOTAL	**194**	**69**	**37**	**206**	**63**	**31**	**138**	**131**	**31**	**211**	**55**	**34**

This table indicates the following:

- In the category "**Agree**" the sum of the pre-test scores for the experimental and comparison group is respectively 194 and 206. After participation in a life skills programme for early adolescent AIDS orphans the post-test results for the

experimental group is 138. The comparison group's post-test results are 211. The results of the experimental group's responses show a decline from 194 to 138, indicating that their view of self has changed from the negative to the positive.

- On adding the pre-test scores of "**Disagree**" the results of the experimental group and comparison group are respectively 69 and 63. Post-test results for the experimental group show a noticeable increase from 69 to 131. Post-test results for the comparison group declined from 63 to 55.

- The sum of the scores on "**Uncertain**" responses to self-awareness' specific statements by the experimental group during the pre-test is 37 and post-test 31. For the comparison group pre-test results are 31 and 34. The results of the experimental group show a decline in their uncertainties about self-awareness whilst the comparison group show an increase in their uncertainties about self-awareness.

In the next table, Table 31 the mean scores of respondents' responses on self-awareness are highlighted.

Table 31: Mean scores of respondents' responses to statements on self-awareness

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.25	7.82	-10	10.5
Comparison group	30	-0.08	2.25	-3.5	3.5

From the above table, Table 31 it can be seen that the mean score for the experimental group is 0.25 and for the comparison group is 0.08. The standard deviation of both groups respectively is 7.82 and 2.25.

The Student Paired t test statistic is 1.44 with a P-value of 0.1832. This compares favourably with the 0.05 level of significance as a P-value is smaller and 0.05 indicates a statistical difference. The researcher thus concludes that there is a statistical difference in the experimental groups' self-awareness with a 95% chance that the results are due to AIDS orphan life skills programme.

7.3.2.14 Coping and stress management skills

As adolescents progress on their journey of self-discovery, they continually have to adjust to new experiences, encounters and situations. Adolescents often experience stressors associated with pubertal changes, demands for and engagement is sexual activity, and fears of early unwanted pregnancy. They are also often pressured to succeed and are expected to perform, frequently up to others. These can lead to a range of behaviors that cause problems for adolescents such as dependence of drugs or alcohol in order to cope with the pressure. Stress management is especially suitable because adolescents can identify the causes of stress, discover that they are not unique in their struggles, and learn how to cope with stress. Young people need assistance to deal with stress and to enable them to make decisions to protect themselves in the future (Corey & Corey, 2002: 307; Doyle, 1992: 21; Geldard & Geldard, 1999: 8 & 202).

The frequency distribution of respondents' coping and stress managements skills is presented in Table 32.

Table 32: Frequency distribution of coping and stress management skills

STATEMENT	Coping and Stress Management Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
Everybody makes mistakes; that's normal, so I am normal.	20	6	4	24	4	2	28	1	1	27	2	1
I am an insecure teenager.	20	8	2	18	8	4	6	18	6	23	3	4
I worry about my future a lot.	29	1	----	30	----	----	10	19	1	28	2	----
I get headaches and stomach pains when I am worried or upset.	21	8	1	21	9	----	16	14	----	18	12	----
When things go wrong I usually blame myself.	16	10	4	15	12	3	4	24	2	17	10	3
I am easily discouraged by new challenges.	21	4	5	25	4	1	7	19	4	27	1	2
When someone makes me angry I keep quiet. I don't confront the problem.	18	12	----	22	7	1	5	23	2	17	12	1
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	----	1	26	3	1

STATEMENT	Coping and Stress Management Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
When frustration builds up I lose my temper and I fight.	16	14	----	12	18	----	2	23	5	9	18	3
I feel upset when people do not understand what I say.	26	3	1	23	5	2	8	20	2	29	1	----
When I am sad or worried I try to talk to someone about it.	7	23	----	7	20	3	24	4	2	5	25	----
People sometimes criticize me, but that's OK because nobody is perfect.	5	24	1	12	18	----	27	2	1	16	13	1
It is scary to stand up in a crowd and be different.	22	6	2	20	7	3	8	18	4	23	4	3
I enjoy telling people what I think of them.	7	22	1	5	24	1	25	4	1	9	20	1
I often share with my friends about how I feel.	4	25	1	7	23	----	24	6	----	1	29	----
Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.	8	21	1	8	22	----	25	4	1	9	21	----
It's all too much I just can't cope anymore.	13	15	2	14	13	3	6	22	2	10	15	5

STATEMENT	Coping and Stress Management Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I am depressed much of the time and find myself crying and moping around.	21	7	2	23	6	1	8	20	2	22	5	3
I become hurt and experience extreme pain when I feel unappreciated by my friends.	27	3	----	25	5	----	7	21	2	27	2	1
TOTAL	**326**	**216**	**28**	**336**	**207**	**27**	**269**	**262**	**39**	**343**	**198**	**29**

The following is thus indicated:

- The sum of the scores on "**Agree**" responses to the above mentioned statements regarding coping and stress management skills by the experimental group during the pre-test are 326 and post-test 269. For the comparison group the total number of pre-test results is 336 and post-test results are 343. Post-test results for the experimental group reflect a lessening of responses from 326 to 269. Post-test results for the comparison group increased from 336 to 343.

- The sum of the pre-test results for the category "**Disagree**" of the experimental and comparison group are 216 and 207. After participation in a life skills programme for early adolescent AIDS orphans the post-test results increased from 216 to 262. The post-test results for comparison group decreased from 207 to 198.

- The total number of pre-test results for the "**Uncertain**" category is rather similar for both the experimental group and comparison group with the scores of 28 and 27 respectively. Both the post-test results for the experimental group and comparison group show an increase in uncertainties. Post-test results for the experimental group are 39 whilst the post-test results for the comparison are 29.

Table 33 reflects mean scores of coping and stress management skills.

Table 33: Mean scores of respondents' coping and stress-management skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	-0.04	8.42	-12.5	12
Comparison group	30	-0.03	2.48	-4.5	4.25

The mean scores for the experimental and comparison groups are respectively -0.04 and -0.03 with the standard deviation of both groups respectively 8.42 and 2.48.

The Student Paired t test statistic is 0.93 with a P-value of 0.3651. Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's coping and stress-management skills after exposure to AIDS orphans life skills programme.

7.3.2.15 Decision making skills

Life itself consists of a multitude of decisions that people are expected to make in their daily lives. Inability to make decisions results in stress and coping problems for people. Healthy personal functioning depends to a large extent on the ability of

people to make good decisions. Geldard and Geldard (1999: 178) note that adolescent decision-making processes are often influenced by pressure from peer groups to conform; they may also be influenced by beliefs about other people's motives, abilities and characteristics. They are likely to make decisions impulsively and /or defensively in response to situational demands without carefully following a properly thought out decision-making process. Learning to make decisions is an important task of adolescence. It enables adolescents to make good decisions that will help them to establish their identity and independence (Janis & Mann, 1982 as quoted by Geldard & Geldard, 1999: 178; Tsatsi, 2001: 39).

Table 34 reflects a distribution of the respondents' responses to decision-making skills.

Table 34: Frequency distribution of decision-making skills

STATEMENT	Decision Making Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I usually solve problems by carefully thinking things through before making any decision.	3	23	4	3	27	----	27	2	1	7	21	2
I usually do things at a spur of the moment.	20	10	----	21	8	1	4	24	2	20	7	3

STATEMENT	Decision Making Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I can make my own decisions about what to do.	10	14	6	13	17	----	28	----	2	12	15	3
Once I have made a decision I believe in, I usually stick to it.	4	24	2	3	27	----	26	2	2	2	28	----
My yes is always yes and my no is always no.	5	24	1	7	22	1	22	6	2	4	25	1
I find it difficult to set limits on what I will and will not do.	26	4	----	27	1	2	6	22	2	27	3	----
When I have to make a decision I find it difficult to make up my mind.	24	3	3	28	1	1	4	26	----	27	2	1
When I make a mistake, I take responsibility and learn from what went wrong.	26	2	2	27	3	----	29	1	----	28	1	1
I listen carefully to what other people have to say.	21	1	8	26	1	3	28	1	1	25	3	2
Planning is very important to me.	6	18	6	2	24	4	27	1	2	5	19	6
TOTAL	**145**	**123**	**32**	**157**	**131**	**12**	**201**	**85**	**14**	**157**	**124**	**19**

- In the category "**Agree**" the sum of the pre-test scores for the experimental and comparison group is respectively 145 and 157. After participation in a life skills programme for early adolescent AIDS orphans the post-test results for the experimental group increased from 145 to 201. Post-test results for the comparison group basically stayed the same, i.e. 157 to 157.

- The sum of the scores on "**Disagree**" responses regarding decision-making skills of the experimental group during the pre-test are 123 and post test-test 85. For the comparison group pre-test are 131 and post-test results are 124. Both the experimental group and comparison group show a decline in their disagreements to statements regarding decision-making skills.

- The total number of pre-test results for the category "**Uncertain**" of the experimental and comparison group are respectively 32 and 12. Post-test results for the experimental group show a decline from 32 to 14. Post-test-results for the comparison group show an increase in their uncertainties from 12 to 19.

In Table 35 a distribution of the mean scores of respondents decision-making skills are presented.

Table 35: Mean scores of decision-making skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.45	10.05	-12.75	14
Comparison group	30	-0.18	2.22	-3.25	3.75

From Table 35 it can be seen that the mean score for the experimental group is 0.45 and for the comparison group is -0.18. The standard deviation of both groups is respectively 10.05 and 2.22.

The Student Paired t test statistic is 0.93 with a P-value of 0.37878. This compares favourably with the 0.05 level of significance. The researcher concludes that there is statistical significant difference in the experimental group's decision-making skills, with a 95% chance that the results are due to a positive influence of AIDS life skills programme and not to chance.

7.3.2.16 Problem solving skills

Many of the conditions that people encounter are the result of inadequate problem solving capacities. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strain. Problem solving skills enable people to deal constructively with problems in their lives. According to Potgieter (2004: 224) knowledge of the problem solving skills does not guarantee a life free from problems, but it offers people the chance to face life concerns directly and openly while it also alleviates many negative consequences.

From Table 36, frequency distribution on decision-making skills can be seen.

Table 36: Frequency distribution of problem-solving skills

STATEMENT	Problem Solving Skills			
	Pre-test		Post-test	
	Experimental group	Comparison group	Experimental group	Comparison group

	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
When someone makes me angry I keep quiet. I don't confront the problem.	18	12	----	22	7	1	5	23	2	17	12	1
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	----	1	26	3	1
When frustration builds up I lose my temper and I fight.	16	14	----	12	18	----	2	23	5	9	18	3
People sometimes criticize me, but that's OK because nobody is perfect.	5	24	1	12	18	----	27	2	1	16	13	1
I often share with my friends about how I feel.	4	25	1	7	23	----	24	6	----	1	29	----
I usually solve problems by carefully thinking things through before making any decision.	3	23	4	3	27	----	27	2	1	7	21	2
I usually do things at a spur of the moment.	20	10	----	21	8	1	4	24	2	20	7	3
I can make my own decisions about what to do.	10	14	6	13	17	----	28	----	2	12	15	3
Once I have made a decision I believe in, I usually stick to it.	4	24	2	3	27	----	26	2	2	2	28	----
My yes is always yes and my no is always no	5	24	1	7	22	1	22	6	2	4	25	1
I find it difficult to set limits on what I will and will not do.	26	4	----	27	1	2	6	22	2	27	3	----

STATEMENT	Problem Solving Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
When I have to make a decision I find it difficult to make up my mind.	24	3	3	28	1	1	4	26	----	27	2	1
When I make a mistake, I take responsibility and learn from what went wrong.	26	2	2	27	3	----	29	1	----	28	1	1
I respect other people's views even if they are different from mine.	24	2	4	25	2	3	28	----	2	27	2	1
I listen carefully to what other people have to say.	21	1	8	26	1	3	28	1	1	25	3	2
It is good for problems to be solved peacefully.	21	8	1	25	2	3	30	----	----	26	----	4
TOTAL	**252**	**194**	**34**	**283**	**179**	**18**	**319**	**138**	**23**	**274**	**182**	**24**

- On adding the scores of "**Agree**" the total amount of pre-test results for the experimental and comparison group are 252 and 283 respectively. After participation in a life skills programme for early adolescent AIDS orphans the post-test results show a clear increase from 252 to 319. The comparison group post-test results show a decline from 283 to 274 in their responses regarding problem-solving skills.

- The total number of pre-test results for the category "**Disagree**" of the experimental and comparison group are respectively 194 and 179. Post-test results for the experimental group are 138 whilst the post-test results for comparison group are 182. This indicates that results on the category "disagree" of the experimental group declined whilst the results of the comparison group increased.

- The sum of the scores on "**Uncertain**" responses to the statements regarding problem-solving skills by the experimental group during pre-test are 34 and post-test are 23. For the comparison group the total number of pre-test results are 18 and post-test results 24**.** Post-test results for the experimental group show a lessening of uncertainties whilst uncertainties in the post-test results of the comparison group increased.

In the following table, Table 37 the mean scores of problem-solving skills are reflected.

Table 37: Mean scores of problem-solving skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.17	9.23	-14.23	14
Comparison group	30	-0.09	2.31	-4	4

Table 37 reflects that the mean score for the experimental group is 0.17. The comparison group's mean score is -0.09. The standard deviation of both the groups is respectively 9.23 and 2.31.

The Student Paired t test statistic is 1.22 with a P-value of 0.2417. Compared with the 0.05 the researcher concludes that there is a statistical significant difference in the experimental group's problem-solving skills after exposure to AIDS orphans life skills programme.

7.3.2.17 Conflict-management skills

Conflict normally results from situations where parties seek maximum personal gain and there is lack or rules to resolve the issue. The sources of conflict are multiple and complex and they include: styles of decision-making and problem solving techniques, struggle for power, personality clashes, competition for limited resources, poor task performance, changes in roles, status and leadership, changing norms and expectations etc. Some people have difficulty dealing with conflict. They avoid, ignore, or minimize it, hoping it will go away. Avoiding conflict rarely leads to satisfying and meaningful dialogue. When conflicts are avoided, true feelings and opinions are not expressed. Before conflict can be dealt with and constructively worked through, it must first be recognized (Anstey, 2002: 13; Corey, 2004: 98; Cumming & Davies, 1994: 16; Potgieter, 2004: 233-234; Toseland & Rivas, 2001: 340).

The frequency distribution of respondents' conflict-management skills is presented in Table 38.

Table 38: Frequency distribution of conflict management skills

STATEMENT	Conflict Management Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
Everybody makes mistakes; that's normal, so I am normal.	20	6	4	24	4	2	28	1	1	27	2	1
When someone makes me angry I keep quiet. I don't confront the problem.	18	12	----	22	7	1	5	23	2	17	12	1
I usually pretend to be okay even when I am not.	25	4	1	25	2	3	29	----	1	26	3	1
When frustration builds up I lose my temper and I fight.	16	14	----	12	18	----	2	23	5	9	18	3
When I am sad or worried I try to talk to someone about it.	7	23	----	7	20	3	24	4	2	5	25	----
I enjoy telling people what I think of them.	7	22	1	5	24	1	25	4	1	9	20	1
I often share with my friends about how I feel.	4	25	1	7	23	----	24	6	----	1	29	----
I usually solve problems by carefully thinking things through before making any decision.	3	23	4	3	27	----	27	2	1	7	21	2

STATEMENT	Conflict Management Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I usually do things at a spur of the moment.	20	10	----	21	8	1	4	24	2	20	7	3
I find it difficult to set limits on what I will and will not do.	26	4	----	27	1	2	6	22	2	27	3	----
When I have to make a decision I find it difficult to make up my mind.	24	3	3	28	1	1	4	26	----	27	2	1
When I make a mistake, I take responsibility and learn from what went wrong.	26	2	2	27	3	----	29	1	----	28	1	1
Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.	8	21	1	8	22	----	25	4	1	9	21	----
I respect other people's views even if they are different from mine.	24	2	4	25	2	3	28	----	2	27	2	1
I listen carefully to what other people have to say.	21	1	8	26	1	3	28	1	1	25	3	2
It is good for problems to be solved peacefully.	21	8	1	25	2	3	30	----	----	26	----	4
TOTAL	**270**	**180**	**30**	**292**	**165**	**23**	**318**	**141**	**21**	**290**	**169**	**21**

The researcher concludes the following:

- The sum of the pre-test scores for the category "**Agree**" of the experimental and comparison groups are 270 and 292. Post-test results for the experimental group show a sharp increase from 270 to 318. Post-test results for the comparison group remain basically the same, i.e. 292 to 290.

- In the category "**Disagree**" the sum of the pre-test scores for the experimental and comparison groups are 180 and 165. After participation in a life skills programme for early adolescent AIDS orphans the results for the experimental group is 141. The comparison groups' post-test results are 169. The experimental group show a decline in their responses whilst the comparison group show a noticeable increase in their responses.

- The total numbers of pre-test results for the category "Uncertain" of the experimental and comparison groups are respectively 30 and 23. Post-test results for the experimental group show a decline from 30 to 21. Post-test results for the comparison group also lessoned from 23 to 21.

In the next table, Table 39 the mean scores of conflict-management skills are reflected.

Table 39 Mean scores of conflict-management skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.33	8.98	-14.25	13.75
Comparison group	30	0.03	2.38	-4	4.5

From the above table, Table 39 it can be seen that the mean score for the experimental group is o.33 and the comparison group is 0.03. The standard deviation of both groups respectively is 8.98 and 2.38.

The Student Paired t test statistic is 0.87 with a P-value of 0.3963. This compares favourably with the 0.05 level of significance, as a P-value is smaller than the test statistic. The researcher therefore concludes that there is a statistical significant difference in the experimental groups conflict management skills with a 95% chance that the results are due to AIDS orphans life skills programme and not to chance.

7.2.3.18 Critical and creative thinking skills

The ability to be spontaneously creative, approaching situation with fresh ideas is important to adolescents. Creative thinking involves divergent thinking, flexibility, originality, the consideration of remote possibilities and the ability to consider a variety of solution to the same problem (Geldard & Geldard, 1999: 6). Critical thinking skills on the other hand are described as the ability to analyse information and experiences in an objective manner (Brack & Hill, 2000: 10). Many authors agree that young people need to develop the ability to think logically and to use their capacity for logical thinking to make judgments and decisions for themselves (Geldard & Geldard, 1999: 6; Gillis, 1994: 72-75; Gladding, 1997: 10-108).

The frequency distribution of critical thinking and creative thinking skills is presented in the next table, Table 40.

Table 40: Frequency distribution of critical and creative thinking skills

STATEMENT	Critical and Creative Thinking Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I enjoy telling people what I think of them.	7	22	1	5	24	1	25	4	1	9	20	1
I usually solve problems by carefully thinking things through before making any decision.	3	23	4	3	27	----	27	2	1	7	21	2
I usually do things at a spur of the moment.	20	10	----	21	8	1	4	24	2	20	7	3
When I have to make a decision I find it difficult to make up my mind.	24	3	3	28	1	1	4	26	----	27	2	1
I never succeed in anything and I think I am a failure in life.	13	11	6	16	10	4	8	17	5	10	17	3
I find it difficult in remembering things.	30	----	----	26	4	----	5	23	2	27	2	1
I enjoy generating new ideas.	4	17	9	7	19	4	24	2	4	2	19	9

STATEMENT	Critical and Creative Thinking Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
I am fearful of new challenges.	26	3	1	23	2	5	6	21	3	25	3	2
When I get an idea I run with it.	9	16	5	9	20	1	24	3	3	6	21	3
TOTAL	**136**	**105**	**29**	**138**	**115**	**17**	**127**	**122**	**21**	**133**	**112**	**25**

This table reflects the following:

- In the category "**Agree**" the sum of the pre-test scores for the experimental and comparisons group are rather similar i.e. 136 and 138. After taking part in a life skills programme for early adolescent AIDS orphans the experimental group show a decline from 136 to 127. The comparison post-test results also declined from 138 to 133, but not to the same extent as the experimental group.

- The total amount of the experimental groups' scores in the category "**Disagree**" increases from a pre-test score of 105 to a score of 122 in the post-test. The comparison groups' scores however decline from a pre-test score of 115 to 112 in the post-test.

- On adding the scores of "**Uncertain**" the pre-test scores for the experimental and comparison groups are 29 and 17 respectively. Post-test results for the experimental group show a decline from 29 to 21. Post-test result results show a clear increase from 17 to 25.

Table 41 shows the mean scores for critical thinking and creative thinking skills.

Table 41: Mean scores for critical and creative thinking skills

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	0.22	10.93	-12.8	14
Comparison group	30	-0.22	0.69	-0.86	6.42

The score for the experimental and comparison groups is respectively calculated as 0.22 and -0.22 with the standard deviation of both groups 10.93 and 0.69.

The Student's Paired t test statistic is 0.39 with a P-value of 0.70718. Compared with the 0.05 level of significance, the researcher concludes that there is not a statistical significant difference in the experimental critical and creative thinking skills.

7.3.2.19 Maintaining a healthy life style

Healthy individuals are regarded as committed to some meaningful goals or objectives that will both enhance the self and contribute to their overall well-being. Adolescents are at a stage in their lives when they are confronted by new experiences and situations. The focus here is to maintain a healthy life style. Matters such as nutrition, rest, constructive leisure time activities and safe living in general are included in this section.

Table 42 reflects a distribution of the respondents' responses to the statements on maintaining a healthy life style.

Table 42: Frequency distribution of maintaining a healthy life style

STATEMENT	A Healthy Life Style											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
When I've had a bad day or things are going wrong I relieve tension by doing some exercise.	4	24	2	3	27	----	27	3	----	4	26	----
I sleep properly.	6	19	5	3	24	3	22	6	2	1	20	9
It is good for young people to say no to sex.	25	2	3	22	4	4	29	1	----	26	1	3
I look after myself so that I live longer.	10	4	16	14	5	11	30	----	----	13	4	13
Smoking is not healthy for the body.	21	5	4	25	3	2	28	1	1	25	3	2
Laughing is good for the soul.	20	2	8	18	5	7	24	3	3	20	5	5
I do not always eat healthy food.	23	4	3	25	2	3	20	8	2	19	6	5

STATEMENT	A Healthy Life Style											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
Safe sex means always using a condom when having sex.	12	14	4	21	1	8	27	3	----	19	1	10
Drinking alcohol is an exciting thing to do.	12	11	7	11	14	5	1	27	2	10	12	8
I would go for an HIV test if I had had an unsafe sex.	3	16	11	3	23	4	24	2	4	3	22	5
TOTAL	**136**	**101**	**63**	**145**	**108**	**47**	**232**	**54**	**14**	**140**	**100**	**60**

From the above table the following is clear:

- The total numbers of pre-test scores for the category "Agree" of the experimental and comparison groups are 136 and 145. After participation in a life skill programme for early adolescent AIDS orphans' post-test results show an acute increase from 136 to 232. Post-test results for the comparison declines from 145 to 140.

- The sum of the pre-test scores for the category "**Disagree**" of the experimental and comparison groups are 101 and 108. Post-test results for the experimental group show a sharp decline from 101 to 54. Post-test results also decline from 108 to 100.

- The sum of the scores on "**Uncertain**" responses for the experimental and comparison groups is 63 and 47 respectively. Post-test results for the experimental group show an acute decline of uncertainties from 63 to 14. Post-test results for comparison group also show an acute increase from 47 to 60.

Table 43 presents the mean scores of statements on maintaining a healthy life style.

Table 43: Mean scores of maintaining a healthy life style

	N	Mean	Standard Deviation	Minimum	Maximum
Experimental group	30	2.67	13.05	-15.29	28
Comparison group	30	-0.19	3.36	-6.88	5.42

The mean score for the experimental group is 2.67 and the comparison group mean score is –0.19 with the standard deviation of both group respectively 13.05 and 3.36.

The students' paired t test is 3.74 with a P value of 0.0046. Compared with the 0.05 level of significance there is a statistical difference in the experimental group's healthy life style with a 95% chance that the results are due to AIDS orphans life skills programme.

7.3.3 Collective summary of life skills

A collective summary of life skills includes the composition of the sum of scores of the ten identified life skills discussed earlier in the chapter. Table 44 gives a summary of the results.

Table 44: Frequency distribution of life skills as a whole

STATEMENT	A Collective Summary of Life Skills											
	Pre-test						Post-test					
	Experimental group			Comparison group			Experimental group			Comparison group		
	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain	Agree	Disagree	Uncertain
A good sense of identity and self-esteem	359	336	85	370	335	75	423	279	78	386	334	60
Communication skills	272	212	56	306	197	37	403	113	24	278	228	34
Assertiveness skills	214	193	43	234	174	42	262	150	38	233	193	24
Self-awareness	194	69	37	206	63	31	138	131	31	211	55	34
Coping and stress management skills	326	216	28	336	207	27	269	262	39	343	198	29
Decision making skills	145	123	32	157	131	12	201	85	14	157	124	19
Problem solving skills	252	194	34	283	179	18	319	138	23	274	182	24
Conflict management skills	270	180	30	292	165	23	318	141	21	290	169	21
Critical thinking and creative thinking skills	136	105	29	138	115	17	127	122	21	133	112	25
A healthy life style	136	101	63	145	108	47	232	54	14	140	100	60
TOTAL	**2304**	**1729**	**437**	**2467**	**1674**	**329**	**2692**	**1475**	**303**	**2445**	**1695**	**330**

The following is thus clear:

- On adding the pre-test scores of "**Agree**," the results for the experimental and comparison group is respectively 2304 and 2467. After exposure to AIDS orphans life skills programme the post-test results for the experimental group is 2692. The comparison group's post-test result is 2445. The post-test results for the experimental group show a sharp increase in responses from 2304 to 2692 whereas the comparison group shows a lessening of responses from 2467 to 2445.

- The total number of scores for the category **"Disagree**" of the experimental and comparison group are respectively 1729 and 1674. Post-test results for the experimental group show a decline from 1729 to 1475 whilst the comparison group's responses reflect an increased from 1674 to 1695.

- The sum of the pre-test results for the category "**Uncertain**" is 437 for the experimental group and 329 for the comparison group. After participation in the AIDS orphans life skills the post-test results for the experimental and comparison group are respectively 303 and 330. The experimental group shows a decline in uncertainties about life skills as whole. Post-test for the comparison group basically stayed the same, i.e. 329 t0 330.

Finally consideration is given to a summary of the test of significance of the key elements of AIDS orphans life skills programme.

7.3.4 Collective summary of the test of significance

Table 45 gives a summary of test of significance:

Table 45: Collective summary of the tests of significance

Life skills	Test statistic	P-value	Results
A good sense of identity and self-esteem	0.75	0.4605	Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's sense of identity and self-esteem with a 95% chance that the results are due to AIDS orphans life skills programme and not to chance.
Communication skills	1.72	0.1035	Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's communication skills with a 95% chance that the results were due to AIDS orphans life skills programme.
Assertiveness skills	0.77	0.4534	Compared with the 0.05 level of significance there is a statistical difference in the experimental group's assertiveness skills after exposure to AIDS orphans life skills programme.

Life skills	Test statistic	P-value	Results
Self-awareness	1.44	0.1832	Compared with the 0.05 level of significance there is a statistical difference in the experimental groups' self-awareness with a 95% chance that the results are due to AIDS orphan life skills programme.
Coping and stress management skills	0.93	0.3651	Compared with the 0.05 level of significance there is a statistical significant difference in the experimental group's coping and stress-management skills after exposure to AIDS orphans life skills programme.
Decision making skills	0.93	0.3788	Compared with the 0.05 level of significance there is statistical significant difference in the experimental group's decision-making skills, with a 95% chance that the results are due to a positive influence of AIDS life skills programme and not to chance.
Problem solving skills	1.22	0.2417	Compared with the 0.05 the researcher concludes that there is a statistical significant difference in the experimental group's problem-solving skills after exposure to AIDS orphans life skills programme.

Life skills	Test statistic	P-value	Results
Conflict management skills	0.87	0.3963	Compared with the 0.05 level of significance, as a P-value is smaller than the test statistic. There is a statistical significant difference in the experimental groups conflict management skills with a 95% chance that the results are due to AIDS orphans life skills programme and not to chance.
Critical thinking and creative thinking skills	0.39	0.7072	Compared with the 0.05 level of significance, there is not a statistical significant difference in the experimental critical and creative thinking skills.
A healthy life style	3.74	0.0046	Compared with the 0.05 level of significance there is a statistical difference in the experimental group's healthy life style with a 95% chance that the results are due to AIDS orphans life skills programme.

Nine out of ten key elements of AIDS orphans life skills programme was thus successful in that it promoted life skills amongst early adolescent AIDS orphans. The programme is perceived as having had the impact that was hoped for. Although the programme took place within a short period of time participants were influenced

positively. Skills however, need to be practiced continuously to be effective in the long run.

7.4 CONCLUSION

In this chapter the researcher presented, analysed and interpreted the qualitative findings through semi-structured interview with a schedule (Section A) and the quantitative findings (Section B) based on the evaluation of AIDS orphans life skills programme.

Chapter 8 will thus focus on a general summary, conclusions and recommendations.