A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

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A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

by

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Dedicated to my husband Peter
and daughter Lemogang-Zoë

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SUMMARY

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by

MAUREEN MABASADI MOTEPE

PROMOTER: PROF. C.S.L. DELPORT

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

DEGREE: DOCTOR PHILOSOPHIAE (D.PHIL)

In this study an attempt was firstly made to define, describe and explicate the phenomenon of HIV/AIDS providing a basis for understanding the multidimensional nature, key characteristics and impact of HIV/AIDS in terms of its background, the current status as well as the future of the epidemic. Literature concerning HIV/AIDS in general, global and in particular the South African situation was discussed. Secondly the concept AIDS orphans was investigated after which grounding, description and explanation of the problems and needs of AIDS orphans were presented in order to give a clear picture of challenges faced by these children. Problems of orphan-hood such as legal and ethical issues, socio-emotional issues, educational issues, financial issues and child-headed households were identified. The study focused on early adolescent AIDS orphans therefore adolescence, as a life phase with specific emphasis on early adolescence was reviewed. Hereafter, the researcher presented a newly self-developed life skills programme for early adolescent AIDS orphans (i.e. AIDS ORPHANS LIFE SKILLS PROGRAMME) followed by all the empirical research findings, a general summary, conclusions and recommendations.

The broad aim of the study was to develop and empirically test the effectiveness of a life-skills programme for early adolescent AIDS orphans.

Two research questions and a hypothesis were formulated for the study. The research questions included: (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? Accordingly the hypothesis of the study read: 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 deemed pivotal.

The focus of this research study was two-folded using a combination of quantitative and qualitative methods. The first phase of the study was qualitative and explorative in nature. The aim of the researcher was to have a broader understanding of the phenomenon HIV/AIDS, the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans in South Africa. The focus of the second phase was to develop a life skills programme for early adolescent AIDS orphans, based on the information collected in the first phase of the study and then to empirically test the effectiveness of the newly developed life skills 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 order to explore the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans, a phenomenological design seemed appropriate.

The research design was selected to reach the first three objectives of the study, namely:

a) 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 for early adolescents;
b) To explore and identify the nature and prevalence of socio-emotional needs and problems of early adolescent AIDS orphans;
c) To explore and identify the life skills which AIDS orphans, in their early adolescent phase need to improve their coping capabilities;

Qualitative data through semi-structured interviews with a schedule was collected. The sample thus included 40 respondents i.e. 10 social workers, 10 caregivers and 20 AIDS orphans. The empirical research findings based on the first part of the study confirmed that HIV/AIDS has forced vast numbers of children into precarious circumstances, putting them at high risk of becoming infected with HIV. AIDS orphans are especially vulnerable to HIV infection for a host of social and economic reasons including poverty, sexual exploitation, violence, and lack of access to HIV information and prevention services. The consequence of this is that children are often socially isolated and deprived of basic social services. The findings further confirmed that there are currently no life skills programmes specifically designed for early adolescent AIDS orphans in South Africa. Deficiencies in life skills contribute to the vulnerability and exploitation of these children. Life skills were viewed as crucial in improving the quality of life of AIDS orphans. Life skills can enable adolescents to develop sound and positive view of life.

The researcher also applied the comparison group pretest-posttest design (i.e. a quasi-experimental comparison group pretest-posttest design) with respondents to reach the last three objectives of the study, namely:

d) To develop a life-skills programme for early adolescent AIDS orphans;
e) To empirically test the effectiveness of the developed life skills programme for early adolescent AIDS orphans; and
f) To suggest practical recommendations for further utilisation of the newly developed life skills programme for early adolescent AIDS orphans.

The researcher developed a life skills programme for early adolescent AIDS orphans namely AIDS Orphans Life Skills Programme. The evaluation of the self-developed life skills programme for early adolescent AIDS orphans was done by a self-constructed group administered questionnaire in the pre-test i.e. before implementation of AIDS orphans life skill programme, and post-test with both the experimental (30 respondents) and comparison group (30 respondents). The sample thus included a total of 60 early adolescent AIDS orphans and the empirical data was collected to include 2 measurements once before and once after the intervention (AIDS orphans life skills programme).

The findings confirmed that there was a statistical significance difference in the experimental groups life skills (i.e. sense of identity and self-esteem, communication, assertiveness, self-awareness, coping and stress management, decision making, problem solving, conflict management and a healthy life style) with a 95% chance that the results were due to AIDS Orphans Life Skills. There was not statistical difference in the experimental groups critical and creative thinking skills. Nine out of ten key elements of AIDS orphans life skills programme were thus successful in that they promoted life skills amongst early adolescent AIDS orphans. AIDS orphans life skills programme is perceived as having had the impact that was hoped for.

Key words

Life skills, programme, life skills programme, AIDS, HIV, Orphan, AIDS orphan, adolescence, early adolescence.

OPSOMMING

'N LEWENSVAARDIGHEIDSPROGRAM VIR VROEE ADOLOSSENTE VIGS WEESKINDERS

deur

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In hierdie studie is 'n poging aangewend om die fenomeen van MIV/VIGS te definieer, te beskryf en te verduidelik ten einde 'n basis daar te stel om die multi-dimensionele aard, kenmerke en die impak van MIV/VIGS ten opsigte van die agtergrond, huidige status sowel as die toekoms van die epidemie te verstaan. Literatuur in verband met MIV/VIGS in die algemeen asook hoe dit werelwyd en spesifiek in Suid Afrika voorkom, is bespreek. Tweedens is die konsep VIGS weeskinders ondersoek waarna die begronding, beskrywing en verklaring van die probleme en behoeftes van hierdie kinders weergegee is ten einde 'n duidelike beeld van die uitdagings waarmee hulle gekonfronteer word, te bied. Probleme in verband met ouerloosheid soos wetlike en etiese -, sosio-emosionele -, opvoedkundige – en finansiele kwessies asook kinderhuishoudings is geidentifiseer. Aangesien die studie op vroeë adolessente VIGS weeskinders fokus, is adolessensie as lewensfase met spesifieke klem op vroee adolessensie bestudeer. Hierna het die navorser die nuut ontwikkelde lewensvaardigheidsprogram vir vroeë adolessente weeskinders (AIDS ORPHANS LIFE SKILLS PROGRAM) beskryf en ten slotte die empiriese resultate, gevolgtrekkings en aanbevelings weergegee.

Die bree doel van die studie was om 'n lewensvaardigheidsprogram vir vroeë adolessente VIGS weeskinders te ontwikkel en die effektiwiteit daarvan empiries te toets.

Twee navorsingsvrae en ‘n hipotese is vir die studie geformuleer. Die navorsingsvrae was die volgende: (a) Wat is die aard en voorkoms van die sosio-emosionele behoeftes en probleme van vroeë adolessente VIGS weeskinders? (b) Watter lewensvaardighede benodig VIGS weeskinders? Die hipotese is soos volg geformuleer: Indien vroeë adolessente die lewensvaardigheidsprogram deurloop, sal hulle lewensvaardighede bevorder word wat hulle in staat sal stel om hul sosio-emosionele behoeftes en probleme beter te hanteer.

In die konteks van toegepaste navorsing is daar van intervensie navorsing gebruik gemaak. Hierdie tipe navorsing was toepaslik vir die studie aangesien dit gerig is op ‘n probleemoplossende proses naamlik die ontwikkeling van ‘n intervensie program om die lewensvaardighede van vroeë adolessente te bevorder.

‘n Gekombineerde kwalitatiewe en kwantitatiewe benadering is in hierdie studie gevolg. Die eerste fase van die studie was kwalitatief en eksplorerend van aard. Die doel van hierdie fase was om ‘n bree begrip vir die verskynsel van MIV/VIGS te ontwikkel asook om die behoeftes, probleme en lewensvaardighede van vroeë adolessente VIGS weeskinders te eksploreer. Die fokus van die tweede fase was kwantitatief aangesien die doel daarvan was om ‘n lewenvaardigheidsprogram, gebasser op die inligting wat in die eerste fase ingesamel is, te ontwikkel en die effektiwiteit daarvan empiries te toets. Die navorser het van semi-gestruktureerde onderhoudvoering gebruik gemaak om kwalitatiewe inligting tydens die eerste fase van die studie in te samel. Gedurende die tweede fase het die navorser ‘n self-ontwerpte groepvraelys gebruik om kwantitatiewe data by wyse van ‘n voor- en na-toets in te samel.

Ten einde die sosio-emosionele behoeftes en probleme van asook die lewensvaardighede wat vroeë adolessente VIGS weeskinders benodig, te eksploreer, is daar van die fenomenologiese navorsingsontwerp gebruik gemaak. Hierdie ontwerp is geselekteer ten einde die volgende navorsingsdoelwitte te bereik:

(a) Om die fenomeen van MIV/VIGS en VIGS weeskinders asook die spesifieke kenmerke, probleme, behoeftes en lewensvaardighede van vroeë adolessente teoreties te konseptualiseer;

(b) Om die aard en voorkoms van die sosio-emosionele behoeftes en probleme van die vroeë adolessente VIGS weeskinders te ondersoek en te identifiseer;

(c) Om die lewensvaardighede wat vroeë adolessente VIGS weeskinders benodig te eksploreer en te identifiseer met die oog op bevordering van hul hanteringsvermoens.

Ten einde kwalitatiewe inligting in te samel is semi-gestruktureerde onderhoude met 10 maatskaplike werkers, 10 versorgers (caregivers) en 20 VIGS weeskinders gevoer. Die empiriese bevindinge het bevestig dat ‘n groot aantal kinders in gevaarvolle omstandighede geforseer word wat hulle in ‘n risiko situasie plaas om self HIV geinfekteer te raak. HIV weeeskinders is om verskeie sosio-ekonomiese redes kwesbaar vir HIV infeksie naamlik onder andere armoede, seksuele blootstelling, geweld asook ‘n gebrek aan HIV inligting en voorkomings dienste. Die gevolg hiervan is dat hierdie kinders dikwels isoleer en van basiese maatskaplike dienste ontneem word. Die bevindinge het verder bevestig dat daar tans geen lewensvaardigheidsprogram spesifiek vir vroeë adolessente VIGS weeskinders in Suid Afrika bestaan nie. ‘n Gebrek aan lewensvaardighede dra by tot die kwesbaarheid en blootstelling van hierdie kinders. Lewensvaardighede word beskou as noodsaaklik om die lewenskwaliteit van VIGS weeskinders te bevorder en hulle in staat te stel om ‘n gesonde en positiewe lewensbenadering te ontwikkel.

Die navorser het die kwasi-eksperimentele vergelykende groep voortoets-natoets ontwerp gebruik om die laaste drie doelwitte te bereik naamlik:

(a) Om ‘n lewensvaardigheidsprogram vir vroeë adolessente VIGS weeskinders te ontwikkel;
(b) Om die effektiwiteit van die ontwikkelde lewensvaardigheidsprogram vir vroeë adolessente VIGS weeskinders empiries te toets;
(c) Om praktiese aanbevelings vir verdere benutting van die nuut ontwepte lewensvaardigheidsprogram te maak.

Na die ontwikkeling van die lewensvaardigheidsprogram is die effektiwiteit van die program getoets deur ‘n steekproef van 60 respondente doelgerig te selekteer en in ‘n eksperimentele groep (30 respondente) en ‘n vergelykende groep (30 respondente) te verdeel. Toetsing van die effektiwiteit van die program is gedoen deur middel van ‘n self-gekonstrueerde groepvraelys wat as voor- en natoets op beide groepe benut is. Slegs die eksperimentele groep het egter die lewensvaardigheidsprogram deurloop. Effektiwiteit is bepaal deur die verskillende metings met mekaar te vergelyk.

Die bevindinge het bevestig dat daar ‘n statistiese verskil in 9 lewensvaardighede van die eksperimentele groep waarneembaar was (naamlik ten opsigte van self-identiteit en self-waarde, kommunikasie, selfhandhawing, self-bewussyn, selfhelp en stres bestuur, besluitneming, probleemoplossing, konflikbestuur en ‘n gesonde lewensstyl) met ‘n 95% kans dat die resultate aan die betrokke program toegeskryf kan word. Daar was egter geen statistiese verskil by die eksperimentele groep ten opsigte van die vaardigheid van kritiese en kreatiewe denke waarneembaar nie. Nege uit die tien lewensvaardighede waarop die program gefokus het was dus suksesvol bewys en kon daar gevolglik tot die konklusie gekom word dat die progam die impak het waarna in hierdie studie gestreef is.

Sleutel woorde:
Lewensvaardighede, program, lewensvaardigheidsprogram, VIGS, HIV, weeskind, VIGS weeskind, adolessent, vroeë adolessent.

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GENERAL INTRODUCTION

1.1 INTRODUCTION

HIV/AIDS is currently an epidemic disease that has become a global problem and has profound social, economic and demographic effects. As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. According to estimates from the AIDS Epidemic Update (2004: 1), 37.2 million adults and 2.2 million children were living with HIV at the end of 2004. During 2004, some 4.9 million people became infected with HIV and the year also saw 3.1 million deaths from AIDS – a high global total since AIDS was discovered (Avert, 2005: 1).

Around half of the people who acquire HIV become infected before they turn 25 and typically die before their 35th birthday (Avert, 2005: 1; Whiteside & Sunter, 2000: 37). This age factor makes AIDS uniquely threatening to children. The impact of HIV/AIDS on children is seen most dramatically in the wave of AIDS orphans that has now grown to 15 million worldwide (UNICEF, 2005: 3). The AIDS pandemic has developed new family structures across the globe, especially in Africa where many children have lost a mother or father or in some cases both parents to AIDS. By the end of 2004, the epidemic left behind 15 million AIDS orphans worldwide (AIDS Epidemic Update: 2004: 3; Avert, 2005: 1).

According to Africa's Child (2005: 1), Frost (2005: 1), Robbins (2004: 1) and The Report on the Global AIDS Epidemic (2004: 1) the worst orphan crisis is in sub-Saharan Africa, where 12 million children have lost one or both parents to AIDS. These numbers are projected to increase since millions more children currently live with sick and dying parents. By 2010, this number is expected to climb to more than 18 million. By the end of this decade it would take 80, 000 orphanages, holding 500 orphans each, just to house the children orphaned by AIDS (Network for Good, 2002: 1).

In South Africa it is estimated that one in five young South Africans is HIV positive (UN International Regional Information Network, 2005: 1). According to UNAIDS figures released in July 2004, about 5.3 million HIV positive people live in South Africa with a possible range of between 4.4 million and 6.2 million (Medical News Today, 2005: 1). Forty-four per cent of deaths in South Africa last year (2004) were caused by HIV/AIDS according to projections from the country's Medical Research Council (World Bank, 2005: 1). In addition, the Medical Research Council stated that the number of people dying of AIDS-related illnesses in South Africa is at least three times the number suggested by official figures (AIDS Journal, 2005 in Business Africa, 2005: 1).

Particularly disturbing are indications of progressive increase of HIV infection in South Africa. The World Health organisation predicts that seven million South Africans will have died of HIV/AIDS-related illnesses within the next five years (Bridgland, 2003:1). This will produce a large number of children orphaned by AIDS. AIDS orphans are thus expected to rise in this country. For example, Avert (2005: 1) and UNAIDS (2004: 1) estimate that in 2010, there will be 1.5 million children orphaned as a result of AIDS in South Africa alone.

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. 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, are abused, exploited, stigmatised and have poor self-esteem. 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; Tjaranda, 2005: 1; UNICEF, 2005: 3; Report on the Global AIDS Epidemic, 2004: 5; Van Dyk, 2001: 334).

According to research conducted by UN Integrated Regional Information Network (2005: 2) a lack of information about the disease, low levels self-esteem and the loss of family members prompted risk-taking behaviours amongst the youth. Furthermore, Anderson and Okoro (2000:25) note that there is a growing recognition that with changes in many families and lifestyles many young people are not sufficiently equipped with life skills to help them deal with increased demands and stresses they experience. A Human Sciences Research Council study into the needs of children in child-headed household found in December 2002, that these children lacked not only the basics like food, clothing and shelter, but also the guidance, support and love generally offered by parents (Garson, 2003: 1). Prof Arvin Bhana, director of the HSRC Child, Youth and Family Development Unit mentions that it is important to reach children early, when they are still young to prevent them from becoming a risk group (UN Integrated Regional Information Network, 2005: 1).

Children are often ignored in development processes and interventions (Eade, 2000: 60). 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. As these problems are becoming more serious, it has become necessary to find new ways of preventing them. 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).

According to WHO (1997: 2) life skills education is a comprehensive educational system, which promotes abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. Life skills enable the individuals to translate knowledge, attitudes and values into actual abilities i.e. “what to do and how to do it.” It is therefore clear that this study will fit in the developmental paradigm of social work. For this study life skills include all those skills that will enable AIDS orphans to maximise their choices, to enhance their personal well-being and to improve their quality of life. The basis of this programme 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. The importance of

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.

1.2 RATIONALE FOR THE STUDY

The rationale for undertaking research should be honourable and professional. Anderson (2003: 3) notes that the research should not be taken for personal gain such as prestige or receiving research funds but it must be done and motivated to help people as part of the social worker's professional service.

The researcher has chosen to study this particular topic following the concern over the reported statistics on HIV infection and increasing number of AIDS orphans in South Africa. According to Nicholas, Grassly and Timeaus (2002: 1) the death of large numbers of young and middle-aged adults from AIDS produces a parallel rise in the number of orphaned children. South Africa presently has a high proportion of orphans due to history of displacement and poverty. With escalating statistics of AIDS orphans and the youth's vulnerability and risk proneness with regard to being infected with HIV/AIDS themselves the need for this study is highlighted. This fact, as well as the present rather unstable socio-economic climate in South Africa creates a great pressure for cost-effective innovative positive preventive educational programmes for people especially the youth (Anderson & Okoro, 2000: 3).

Another reason for the choice of study is that the research is inspired by real life experiences. The researcher has had first hand experience with the effects brought about by HIV/AIDS. Knowing close and personal (blood) orphans create great pressure for the researcher to develop, implement and evaluate a life skills programme specifically for AIDS orphans. This study is a concrete investment in the lives of AIDS orphans as they are part of the major proportion (the youth) of the South African population and represent the future.

Further, motivation of the study is the limited extend of South African based research regarding the needs of AIDS orphans. The research will enable the researcher to

develop relevant local literature for the South African nation in general. Literature that is home-grown will lead to more realistic planning and understanding of AIDS orphans in the context of the South African environment.

There is social policy implication with the rise in the number of children orphaned by AIDS. Thus, there is a need to study the AIDS orphan's situation in Africa so as to come up with a clear picture of their survival and coping strategies. The consideration of their situation will help in coming up with other possible solutions to address their needs.

Lastly the very nature of professional Social Work requires that the researcher undertake research, gathering data that can help answer questions about various aspects of society. Through this research the knowledge base of Social Work can be extended and a basis provided for future or further study.

1.3 PROBLEM FORMULATION

The initial phase of any research project involves transforming an interesting research idea into a feasible, researchable research problem (Mouton, 2001: 48). This phase of research is known as problem formulation. According to Bless and Higson-Smith (2000: 26) the formulation of a problem introduces the necessity of identifying clearly all the concepts used and determining the variables and their relationship. Without an identified research problem important enough to investigate, there would be no need to conduct research. Furthermore, Terre Blanche and Durrheim (1999:18) note that to be practical the identified research problem has to be clearly stated with explicit parameters.

Whiteside and Sunter (2000: 95) note that South Africa's population is young; 54 per cent are below 25 years of age. As already mentioned AIDS primarily kills young and middle aged adults during their productive years. The death of a large number of young and middle-aged adults from AIDS is producing a parallel rise in the number of orphaned children. This age factor makes AIDS uniquely threatening to the bringing-

up of children. The death of the most economically active people implies that many children are being left orphaned and homeless as HIV/AIDS sweeps this age group.

According to Viva Network (The AIDS Topical Forum Effects, 2003: 1), every 50 seconds a child becomes infected with HIV and another dies from an AIDS related illness worldwide. More than 1600 children are infected with HIV everyday and 1.4 million children are living with HIV/AIDS. In 2004, an estimated 640, 000 children aged 14 or younger became infected with HIV and in 2003 over 90% of newly infected children were babies born to HIV positive women (Avert, 2005: 1). By the end of 2004 an estimated 15 million children – around 80% of these orphans in Africa – lost their mother or both parents to AIDS. As already highlighted it is estimated that in 2010, there will be 1.5 million children orphaned as a result of AIDS in South Africa alone (Avert, 2005: 1; UNAIDS, 2004: 1; UNICEF, 2005: 2).

According to a Report on the Global AIDS Epidemic published by UNAIDS (2004: 1) at the end of 2003, there were, for example, an estimated 1.8 million orphans living in Nigeria, 650,000 in Kenya and 980,000 in Zimbabwe. These numbers will increase as the epidemic develops. It has been estimated that the number of children orphaned by AIDS will rise dramatically in the next 10-20 years, especially in Southern Africa. This implies that the number of AIDS orphans will rise dramatically over the coming years.

The consequences of the escalation of AIDS orphans are serious for the children and society at large. Children orphaned by AIDS have been shown to be more vulnerable than children orphaned in other ways. The death of parents means the child is likely to suffer from: loss of family and identity, psychological distress, increased malnutrition, illness and loss of health care, increased for labour, fewer opportunities for schooling and education, loss of inheritance, forced migration, homelessness, vagrancy, starvation and exposure to HIV infection (Avert, 2005: 1; Robbins, 2004: 2; UNAIDS, 2004: 5).

According to Van Dyk (2001: 334) after the parents' death, children often lose their rights to the family land or house. Relatives move in and often exploit the children by taking possession of their property and by not providing any support for them.

Because these children no longer have access to education, and because they lack work skills and family support of any kind, they often end up living on the streets. Some studies have shown that death rates among AIDS orphans are 2.5 to 3.5 times higher than those for non-orphans (HIV Infant Care Programme, 2000: 1).

If the child is not directly infected with AIDS the infection of a parent can be equally as devastating. The loss of a parent is hard enough for any child to bear, but this damage is made worse if the bread- winner dies. The family is left with no form of income or outside support. This leads to many children taking on the role of adults because a generation has disappeared. Many are growing old before their years, looking after younger siblings, working to earn money and sometimes living on the streets, assuming responsibilities that no child should have to deal with (Tracey, 2005: 2; UNAIDS, 2004: 5; UNICEF, 2005: 2). According to Frost (2005: 1) and Viva Network (The Topical Forum Effects, 2003: 2) already there are households headed by children as young as 9 years old. With a disrupted or non-existent education, children have very little chance of earning money.

These children can't go through normal development. According to Bosely (2002: 1) the very fabric of society is disappearing and family structures are crumbling as a result of AIDS. HIV/AIDS has caused orphans crises. In some societies the stigma of AIDS is so intense that parents can make little preparation for their children's futures. Mothers are reluctant to seek out someone else to look after their children even members of their own family, if it means revealing she has HIV. Children also have to cope with the stigma of their parents having died of AIDS and the suspicion that they may be HIV positive themselves. They often bear the brunt of discrimination and ostracisation from the community because of the stigma and are vulnerable to harassment, violence and sexual abuse (Garson, 2003: 1; UNAIDS, 2004: 5).

The traditional pattern of caring for orphans in many societies is for the children to be taken into the families of relatives (Hubley, 1995: 76; UNAIDS, 2004: 3). However, as the AIDS epidemic develops, families can find it increasingly difficult to take in orphans unless help is provided (Robbins, 2004: 2; UNAIDS, 2004: 3; Van Dyk, 2001: 334-335). Many African governments simply cannot cope. Their health budgets are eaten up by adults dying of AIDS, and lack the infrastructure and

resources to care for millions of children. And there are many more AIDS orphans on the way. South Africa which is one of the countries with the highest number of people living with HIV in the world will have to cope with a large number of children orphaned by AIDS by the end of the decade.

According to Whiteside and Sunter (2000: 80) South Africa currently has a high proportion of children who are not continuously cared for by either parent or relatives. This is due to the history of poverty, apartheid and the migrant labour system. The epidemic inserts itself into this already fragile family environment, and one of its worst consequences is the creation of AIDS orphans. With increasing number of children orphaned by AIDS an urgent action is needed to tackle the escalating crises.

Suffice is to say that many health and social problems are constantly on the increase in South Africa. According to Anderson and Okoro (2000: 1) measures to combat these problems (e.g. AIDS education programmes, awareness programmes, community as well as residential care) have proved unsuccessful. Possible reasons for the failure of programmes are amongst the others the following: the tendency to mainly concentrate on curative and rehabilitative measures instead of primary preventive efforts, concentration on short-term programmes hoping for miracle results. What is not realised is that social and health pathologies are the consequence of a specific life style, which demands a more holistic approach. The mode of living is influenced by factors such as culture, values, and socialization.

Therefore, whatever the nature of the problem, it is the product of a specific life-style that causes concern. 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. According to Anderson and Okoro (2000: 26) life skills to adolescents also include prevention of drug abuse, child abuse, infection with HIV and teenage pregnancy. Furthermore, this

learning should occur at a young age, before negative patterns of behaviour have been established.

According to WHO (1997: 16) life skills can be developed for all ages of children and adolescents. Experience gained in other countries where life skills programmes have been successfully developed and implemented suggests 6-16 years as an important age ranging for life skills learning. Pre adolescent and early adolescent years seem ideal to instil skills as a positive response since young people of this age group seem to be most vulnerable to behaviour-related health problems.

A life Skills education programme increases children's knowledge of the systems and structures of the body and focuses on its wonder and beauty as a human machine (Anderson & Okoro, 2000: 7). It focuses on coping skills, self-awareness, interpersonal relationship skills, refusal skill etc. to help children to say "No" to another person and walk away unscathed and with dignity. Furthermore, such programmes examine friendships, for children to identify both positive and negative influences of friends and the importance of making decisions independently.

Effective acquisition, and application of life skills can influence the way people feel about themselves and others, and equally will influence the way they are perceived by others. Life skills contribute to a person's perceptions of self-efficacy, self-confidence and self esteem (WHO, 1997: 16-17). Life skills therefore play an important role in the promotion of mental well-being. The promotion of mental well-being contributes to people's motivation to look after themselves and others, hence the prevention of health and behaviour problems.

Life skills programmes are viewed as important to AIDS orphans. These children in most cases live without basic human rights and dignity (Van Dyk, 2001: 335). Furthermore, these children have gone through a traumatic experience of watching their parents succumb to the disease. As already mentioned, their loss is exacerbated by prejudice and social exclusion. The ability of life skills programmes to assist AIDS orphans to cope is seen as critical.

Presently, in South Africa, the Department of Education has taken more interest in promoting life skills. As early as 1995, a policy framework for education and training set the trend that all forms of education should include the teaching of generic life skills in schools (Brack, 2000: 16). Although the teaching of generic life skills has been incorporated in the education system of this country there are many children such as school-drop outs, orphans and street children who can not be reached by the formal educational system (Van Dyk, 2001: 9). In this regard it is also important to note at this stage it seems that there are also no life skills programmes specifically designed for AIDS orphans in this country.

According to Hepworth and Larsen (1993: 454) children who are deprived of life skills experience a variety of personal and interpersonal difficulties. Deficiencies in life skills contribute to low self-esteem, loneliness and strained relationships. This condition also handicaps the development of satisfying interpersonal relationships as well as the effectiveness of role performance. Based on what has been mentioned it is clear that there is a need for life-skills programmes for AIDS orphans. Education and information are fundamental human rights, and young people may not be denied the basic information and skills they need to protect themselves. The point of departure is based on efforts to internalise an accepted life-style (primary prevention) or to change the life-styles of people. Consequently the focus of this study was directed at the development and empirical testing of a life skills programme for AIDS orphans.

1.4 GOAL AND OBJECTIVES OF THE STUDY

1.4.1 GOAL

According to Fouché (2002: 107) the term goal, aim and purpose are often used interchangeably. The term implies "an end toward which effort or ambition is directed" (Webster's third international dictionary, 1993). Terre Blanche and Durrheim (1999: 55) also state that the research aims should be brief and concrete.

The broad aim of this study is to develop and empirically test the effectiveness of a life-skills programme for early adolescent AIDS orphans.

1.4.2 OBJECTIVES

Anderson (2003: 13) states that sensible and successful implementation of the research findings can only take place in terms of clearly defined objectives. They enable the researcher to establish the specific type of data to be collected and the hypothesis to be investigated. The objectives of a research study therefore serve as guidelines to the research collection of data. The objectives of the proposed study are:

a) 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 for early adolescents;

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

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

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

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

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

1.5 RESEARCH QUESTIONS AND HYPOTHESIS

According to Fouché (2002: 106) it is important to formulate a research question when a study is qualitative and a hypothesis when a study is quantitative. Reid and Smith as quoted by De Vos (1998: 116) note that often in social work research, not enough is known about a phenomenon to be studied to justify the formulation of a

hypothesis. What is more, there may not even be sufficient knowledge to identify and define relevant variables. Before a hypothesis can thus be formulated and tested, it may be necessary to explore and describe the phenomenon of interest.

The focus of this research study was two-folded using a combination of quantitative and qualitative methods. The first phase of the study was qualitative and explorative in nature. The aim of the researcher was to have a broader understanding of the phenomenon HIV/AIDS, the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans in South Africa. The focus of the second phase was to develop a life skills programme for early adolescent AIDS orphans, based on the information collected in the first phase of the study and then to empirically test the effectiveness of the newly developed life skills programme.

1.5.1 RESEARCH QUESTIONS

Research questions are a set of defined questions that a researcher wants to explore, setting priorities and focuses of attention, thus excluding a range of unstudied topics. Research questions direct the literature review, the framework of study, data collection and the analysis (Potter, 2002: 46). According to Morse (1994: 226) the wording of the question determines the focus and scope of study.

Based on the fact that the first part of the study was qualitative and explorative in nature. It was guided by the following research questions:

- **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 researcher continued by moving from this exploratory part of the study, organised around the above-mentioned research questions, to more definite, hypothesis-testing research (i.e. the second phase of the research study).

1.5.2 HYPOTHESIS

Anderson (2003: 14) describes a hypothesis as a statement about the relationship between two variables, which implies that its truth can be tested. It attempts to explain or to predict a phenomenon. Babbie and Mouton (2001: 643) as well as Mouton and Marais (1990: 137) define the term hypothesis as statement that specifies an assumed relationship between two or more phenomena or variables. According to Bailey (1987: 41) and Potter (2002: 50) a hypothesis is a preposition that is tested in testable terms and predicts the relation between two or more variables. It provides the researcher with a guide as to how the original hunch might be tested. This simply means that a hypothesis is a tentative and testable statement that predicts what we expect to find about the way variables are related. Bless and Higson-Smith (2000: 33) note that when a hypothesis is not supported by empirical evidence it should be rejected.

The study therefore adopted the following hypothesis:

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.

1.6 RESEARCH APPROACH

According to Fouché and Delport (2002: 78) there are two main recognised research approaches, namely the quantitative approach and the qualitative approach. In his attempt to differentiate between quantitative and qualitative approaches Dabs (1982) as quoted by Berg (2001: 2) indicates that the notion of quality is essential to the nature of things. It refers to the what, how, when and where of a thing – its essence.

On the other hand, quantity is elementally an amount of something. Qualitative research thus refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things. The primary goal of qualitative studies is to describe and understand human behaviour (Babbie & Mouton, 2001: 270). In contrast, quantitative research refers to counts and measures of things. The quantitative researcher believes that the best way of measuring the properties of phenomena is through assigning numbers to the perceived qualities of things (Babbie & Mouton, 2001: 49).

Fouché and Delport (2002: 78) state that the quantitative approach is based on positivism, which takes scientific explanation to be nomothetic (i.e. based on universal laws). It is aimed at measuring the social world, to test hypothesis and to predict and control social behaviour. It relies strongly on measurement to compare different variables (Bless & Higson-Smith, 2000:37). In contrast the qualitative approach is anti-positivistic, meaning that it is interpretative, is idiographic and holistic in nature. It is aimed at understanding social life and the meaning that people attach to everyday life (Fouché & Delport, 2002: 78). In other words, qualitative research uses qualifying words or descriptions to record aspects of the world.

Fouché and Delport (2002: 81) mention that most authors prefer using a combination of quantitative and qualitative research approaches. Creswell (1994) as mentioned by De Vos (2002: 364) states that using both paradigms in a single study could be expensive, time-consuming and lengthy. However, Mouton and Marais (1990: 169) are of the opinion that the phenomena that are investigated in the social sciences are so enmeshed that a single approach can most certainly not succeed in encompassing human beings in their full complexity. According to De Vos (2002: 364) by adopting the point of view of convergence and complementarity's the researcher might be in a position to understand more about the human nature and social reality. Based on the complexity of the problem, for this study, the combined qualitative-and quantitative approach was selected.

According to Creswell (1994) as mentioned by De Vos (2002: 365-366) there are three models of combining qualitative and quantitative approaches namely, the two-phase model, the dominant-less-dominant model and the mixed methodology design

model. For this study the two-phase model was used. 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 information collected in the first phase of the study, and empirically test the effectiveness of the newly developed programme.

The two-phase model was used because it was necessary to first explore qualitatively the phenomenon of AIDS orphans in more depth. The specific nature of their socio-emotional needs and problems has not been fully documented. The qualitative phase of the study enabled the researcher to come up with comprehensive information for the second phase namely to create and test quantitatively an innovative life skill programme targeting early adolescent AIDS orphans.

1.7 TYPE OF RESEARCH

In the context of applied research the type of research conducted in this study was **intervention research.**

Rothman and Thomas (1994: 4) describe intervention research as an integrative perspective for human service research. De Vos (2002: 396) defines intervention research as "studies carried out for the purpose of conceiving, creating and testing innovative human services approaches to prevent or ameliorate problems, or to maintain quality of life." The new Dictionary of Social Work (1995: 35) defines intervention research as "Research directed at the establishment of procedures for designing, testing, evaluating and refining techniques and instruments with a view to intervention in social problems in communities and groups." According to Babbie and Mouton (2001: 88) these interventions are programmatic in nature are structured in such a way that their successful implementation would lead to clearly identifiable outcomes and benefits. Typically this would include various kinds of courses and programmes: training, educational, awareness and skill development.

1.7.1 TYPE OF INTERVENTION RESEARCH

According to Rothman and Thomas (1994: 4) there are three types of intervention research i.e.

- Empirical research to extend knowledge of human behaviour relating to human service intervention (referred to as Intervention Knowledge Development – KD);

- The means by which findings from intervention knowledge development research may be linked to and utilised in practical application (referred to as Intervention Knowledge Utilisation – KU); and

- Research directed towards developing innovative intervention (referred to as Intervention Design and Development – D&D).

In the light of the study's focus, it is clear that the type of intervention research relevant for this study was Intervention Design and Development (D&D). 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. According to WHO (1997: 15) the promotion of mental well-being contributes to the adolescents' motivation to look after themselves and others. The prevention of mental disorders and the prevention of health and behaviour problems are essential.

1.7.2 THE PROCESS OF INTERVENTION RESEARCH

According to Rothman and Thomas (1994: 9) there are six main phases in the Intervention Design and Development Model namely:

- Problem analysis and project planning;
- Information gathering and synthesis;
- Design;
- Early development and pilot testing;
- Evaluation and advanced development; and
- Dissemination.

Each of the above-mentioned phases comprises a series of steps. It is important to mention at this stage that although performed in a stepwise sequence, some or many of the activities associated with each phase will continue after the introduction of the next phase. According to Rothman and Thomas (1994: 9) there is sometimes looping back to earlier phases, as difficulties are encountered or new information is obtained.

A detailed explanation of the Intervention Design and Development Model according to the different phases and steps, as proposed for application in this study is presented in the following paragraphs.

1.7.3 APPLICATION OF THE INTERVENTION DESIGN AND DEVELOPMENT MODEL IN THIS STUDY

1.7.3.1 PROBLEM ANALYSIS AND PROJECT PLANNING

According to Fawcett, Suarez-Balcazar, White, Paine, Blanchard and Embree in Rothman and Thomas (1994: 28) this phase comprises of the following steps:

- Identifying and involving clients;
- Gaining entry to and cooperation from settings;
- Identifying concerns of the population;
- Analysing identified concerns; and
- Setting goals and objectives.

- **IDENTIFYING AND INVOLVING CLIENTS**

This step involves choosing a population with whom to collaborate. According to Fawcett et al. (1994: 28-30) research that addresses the critical strengths and problems of important constituencies has a greater chance of receiving support from the target population, professional community and general public. Key informants in this study included AIDS orphans, caregivers and social workers. AIDS orphans were respondents in the first and second phase of the study and other abovementioned key informants were used as experts in the first phase of the study.

- **GAINING ENTRY AND CO-OPERATION FROM SETTINGS**

De Vos (2002: 399) notes that key informants can assist researchers to gain access to a particular setting. Initial contacts were made with primary and secondary schools, social workers and social welfare agencies explaining the purpose and process of the research. By working together with those who can facilitate access to the respondents the researcher gained the cooperation and support necessary to conduct the research. These contacts enabled the researcher to identify possible respondents i.e. AIDS orphans.

The following activities were undertaken:

- A written letter of approval from the Department of Education in the North-West Province was obtained. (See Appendix 1). Accordingly two schools were supportive and accommodating to the study.

- A written letter of approval from the Department of Social Services, Arts, Sports and Culture was obtained (See Appendix 2). Accordingly social workers in various welfare offices were supportive and participated in the first part of the research. The social workers also helped in identifying caregivers who participated in the study.

- **INDENTIFYING CONCERNS OF THE POPULATION**

According to De Vos (2002: 402) once they have access to the setting; applied researchers must attempt to understand the issues of importance to the population. To understand issues of importance in the first phase of the study (qualitative phase) ad hoc meetings were arranged with social workers and caregivers. Both the caregivers and social workers were satisfied with the format and contents of the semi-structured interviews with a schedule.

The researcher further held ad hoc meetings with school principals, caregivers and AIDS orphans who would participate in the qualitative and quantitative phase of the study. The purpose of these meetings was to brief the attendants about the research project and then provide them with the opportunity to refuse or agree to participate in the project. These meetings were held prior to the commencement of the project; hence both AIDS orphans who would be participants in the qualitative and quantitative phase were invited.

The main concerns which were raised during these ad hoc meetings were the language to be used in the study as well as the time slot that would be convenient for learners (respondents) since the study was accommodated at schools. It was agreed that for the first part of the study (qualitative phase), interviews with caregivers and AIDS orphans will be conducted in Setswana and for the second part of the study (quantitative phase) questionnaires will be translated in Setswana because the respondents' language is Setswana. It was further agreed that the researcher meet learners (respondents) after school or during break times for the project.

- **ANALYSING CONCERNS AND PROBLEMS IDENTIFIED**

This step involves analysing conditions that people label as community problems. De Vos (2002: 403) views the step as the critical aspect of this phase. It is a follow-up of what transpired in the previous step of identifying concerns of the population. Based on identified concerns during this stage, the researcher translated the interview

schedule that would be used in the first phase of the study into Setswana (See Appendix 3) and then proceeded to translate the questionnaire in Setswana in preparation of the second phase of the study as agreed in the ad hoc meetings held with the role players (See Appendix 4).

- **SETTING GOAL AND OBJECTIVES**

Goal and objectives setting is regarded as the last step in this phase. Stating goal and objectives clarifies the proposed ends and means of intervention research project (De Vos, 2002: 404). The study goal and objectives were explained thoroughly to participants (social workers, caregivers and AIDS orphans) before commencement of both the first and second phases of the research project (See goal and objectives of study, section 1.4).

1.7.3.2 INFORMATION GATHERING AND SYNTHESIS

The second phase of the D&D model assists the researcher in discovering what others have done to understand and address the problem. According to De Vos (2002: 405) the outcome of this phase is a list of functional elements that can be incorporated in the design of the intervention. Information gathering and synthesis comprises of the following steps:

- Using existing information sources;
- Studying natural examples; and
- Identifying functional elements of successful models.

These steps are briefly discussed as follows:

- **USING EXISTING INFORMATION SOURCES**

This step encapsulates various sources the researcher used to collect information. In this study the researcher used literature review and respondents in the first phase of

the study i.e. social workers, caregivers and AIDS orphans to collect information as enunciated below:

Literature review: According to Babbie (1992: 11) review of literature can be defined as a systematic identification, location and analysis of documents containing information related to the research problem. In general terms, however, a literature review is a critical summary and assessment of the range of existing material dealing with knowledge and understanding in a given field. Its purpose is to locate the research project, to form its context or background and to provide insights into previous work. The review of literature contributes to a clearer understanding of the nature and meaning of the identified problem by enabling a person to be familiar with resources material that exists in which the problem falls (Blaxter, Hughes & Tight, 2000: 110). An in-depth literature study of the phenomena HIV/AIDS and AIDS orphans, the characteristics, socio-emotional needs and problems of early adolescents as well as life skills for early adolescents was undertaken.

Social workers, caregivers and AIDS orphans: The researcher used semi-structured interviews with a schedule to collect qualitative data regarding the socio-emotional needs and problems of as well as life skills needed by early adolescent AIDS orphans.

- **STUDYING NATURAL EXAMPLES**

According to De Vos (2002: 406) interviews with people who have actually experienced the problem such as the clients or those with knowledge about it such as service providers, can provide insights into which interventions might or might not succeed and the variables that might affect success. Studying unsuccessful programmes and practices may be particularly valuable since non-examples help us to understand methods and contextual features that may be critical to successes (Fawcett et al., 1994: 32-33).

In this study the researcher contacted social workers and welfare organisations to gain information on possible successes and failures of life skills programmes targeting

early adolescent AIDS orphans. The researcher discovered that there are presently no lifeskills programmes targeting early adolescent AIDS orphans.

- **IDENTIFYING FUNCTIONAL ELEMENTS TO SUCCESSFUL MODELS**

This step involves analysing the critical features of life skills programmes that have previously addressed the problem in question. By studying successful and unsuccessful programmes that have attempted to address the problem, the researcher will identify potential useful elements of intervention. The information gained is instrumental to the development of new interventions (Fawcett et al., 1994: 33). As already highlighted earlier the researcher discovered that there are presently no lifeskills programmes targeting early adolescent AIDS orphans.

1.7.3.3 DESIGN

The two main important tasks of the researcher during this phase are designing an observational system and specifying procedural elements of the intervention (De Vos, 2002: 407).

- **DESIGNING AN OBSERVATIONAL SYSTEM**

During this stage focus is on designing an observational system, which assists the researcher in observing events related to the phenomenon naturalistically. Furthermore, the researcher has the task of developing a method system for discovering the extent of the problem and detecting effects following intervention (De Vos, 2002: 408).

The researcher developed an observational system by using two social workers with practical and research experience to assist in the critical evaluation of the designed prototype. The practitioners helped the researcher in specifying what needs to be changed or emphasised in the prototype life skills programme. Hence the social workers served as feedback for refining the prototype life skills programme.

The following social workers participated in this stage of the study:

- Thapelo Tawana: Chief Social Worker (Department of Social Services, Arts, Sports and Culture in the North-West Province).
- Petronella Thekisho: Senior Social Worker (Department of Social Services, Arts, Sports and Culture in the North-West Province).

- **SPECIFYING PROCEDURAL ELEMENTS OF THE INTERVENTION**

De Vos (2002: 409) states that by observing the problem and studying naturally occurring innovations and other prototypes, the researcher can identify procedural elements for use in the intervention. These elements often become part of the final product of the research.

During this stage the researcher specified guidelines and procedures to be used in the life skills programme for early adolescent AIDS orphans. The guidelines and procedures are described in the presentation of the life skills programme (See Chapter 6).

1.7.3.4 EARLY DEVELOPMENT AND PILOT TESTING

This phase includes the important operations of developing preliminary intervention, conducting a pilot test and applying design criteria to the preliminary intervention concept (De Vos, 2002: 410).

- **DEVELOPING A PROTOTYPE OR PRELIMINARY INTERVENTION**

Piloting is a process whereby the researcher tries out the research techniques and methods which are in his mind, see how well they work in practice, and if necessary modify the plans accordingly (Blaxter, Hughes & Tight, 2000: 121). According to Bless and Higson-Smith (2000: 155) a pilot study is conducted prior to the larger piece of the study to "determine whether the methodology, sampling, instruments and analysis are adequate and appropriate". Pilot tests assist to determine the

effectiveness of the intervention. Pilot tests allow the researcher to determine the community likely response to the actual programme when it is implemented.

The researcher designed a prototype of a life skills programme for early adolescent AIDS orphans for pilot testing during this stage.

- **CONDUCTING A PILOT TEST**

According to De Vos (2002: 410-411) pilot tests are executed in settings convenient for the researchers and should be similar to the ones in which intervention will be used.

In this study the researcher identified four AIDS orphans from Rustenburg, who were not included in the main study, to participate in pilot testing the life skills programme and the questionnaire that will be used to test the effectiveness of the programme. The identified AIDS orphans experienced no problem with either the programme or the questionnaire.

- **APPLYING DESIGN CRITERIA TO THE PRELIMINARY INTERVENTION CONCEPT**

Applying design criteria to the preliminary intervention concept is regarded as the last step of the design phase. It involves specifying guidelines and values for intervention research. Fawcett et al. (1994: 37) note that these guidelines help to guide the design of interventions that are subjected to pilot testing and formal evaluation. For the implementation and evaluation of the life skills programme the researcher used the following criteria:

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 and it produces equivalent 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) mention 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 are satisfied. It can thus be said that the trustworthiness of this study has been established.

1.7.3.5 EVALUATION AND ADVANCED DEVELOPMENT

According to De Vos (2002: 412) this phase comprises of four steps namely:

- Selecting an experimental design;
- Collecting and analysing data;
- Replicating the intervention under field conditions; and
- Refining the intervention.

- **SELECTING AN EXPERIMENTAL DESIGN**

Experimental designs are very important in intervention research. According to De Vos (2002: 412) experimental designs whether single subject or between group designs assist in demonstrating causal relationships between the intervention and the behaviours as well as related conditions targeted for change. Breakwell, Hammond and Fife-Schaw (1998: 59) state that the selection of a particular design rests on the nature of the research as well as pragmatic concerns.

For this study the researcher made use of a quasi-experimental design namely the comparison group pretest-posttest design. This quasi-experimental design has a built

in strategy of comparing pre-tests with post-tests. In this design although the two groups receive 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).

In this study the quasi-experimental design was used to test the effectiveness of the developed life skills programme for AIDS orphans. 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. See section 1.8.2 for a detailed description of the specific design.

- **COLLECTING AND ANALYSING DATA**

This step involves continuous collection and analysis of data. According to De Vos (2002: 413) "ongoing graphing of the behaviour and related outcomes helps to determine when initial interventions should be implemented and whether supplemental procedures are necessary."

In order to identify the socio-emotional needs and problems of and life skills needed by early adolescent AIDS orphans, the researcher used semi-structured interviews with a schedule to collect qualitative data during the first phase of the research (See Appendix 5 for the English version of the semi-structured interview with a schedule). 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 (pretest and posttest) (See Appendix 6 for the English version of the self-constructed group administered questionnaire). A full discussion of data analysis is presented in section 1.9.2.

1.7.3.6 DISSEMINATION

Dissemination is the last phase of the D&D model. Babbie and Mouton (2001: 527-528) state that researchers have a responsibility to report their research findings in full, open and timely fashion. According to De Vos (2002: 414) the following operations help to make the process of dissemination and adaptation more successful:

- Preparing the product for dissemination;
- Identifying potential markets for the intervention;
- Creating demand for the intervention;
- Encouraging appropriate adaptation; and
- Providing technical support for adopters.

The last phase of the D & D is not formally part of this study. The researcher will only make recommendations for further utilisation of the life skills programme for early adolescent AIDS orphans as part of the research report.

1.8 RESEARCH DESIGN

Breakwell, Hammond and Fife-Schwa (1998: 21) are of the opinion that having identified the specific research questions, the researcher is then in a position to select possible research designs. According to Mouton (1996: 107) a research design refers to a set of guidelines and instructions to be followed in addressing the research problem. Babbie and Mouton (2001: 647) define a research design as a plan or structured framework of how one intends conducting the research process in order to solve the research problem. The main function of a research design is to enable the researcher to anticipate what the appropriate research decisions should be as to maximise the validity of the eventual results. .

Mouton and Marais (1990: 32) point out that a research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose. It is a strategic framework for action that serves as a bridge between research questions and the implementation of the research. It allows the researcher to draw conclusions about the relationship between variables.

The researcher used a combination of research designs to achieve the objectives of the research project. The designs utilised in this research are the phenomenological

design for the qualitative phase and quasi-experimental comparison group pretest-posttest design for the quantitative phase.

1.8.1 PHENOMENOLOGICAL DESIGN

Exploratory studies are used to make preliminary investigations into relatively unknown areas of research. The goal that is pursued in exploratory research is the exploration of a relatively unknown research area. Exploratory research enables the researcher to have a broad understanding of a situation, phenomenon, community or person (Babbie & Mouton, 2001: 79; Bless & Higson-Smith, 2000: 41; Terre Blanche & Durrheim, 1999: 39).

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 and problems has not been fully documented. Therefore, the design is important 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 employed 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?

1.8.2 COMPARISON GROUP PRETEST-POSTTEST DESIGN

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 subject is lacking (De Vos, 1998: 79). In this design although the two groups receive both the pretest and the posttest at the same time only the first group (experimental group) receive treatment (Fouché & De Vos, 2002: 145).

According to Fouché and De Vos (2002: 146) the experimental and comparison groups formed under this design will probably not be equivalent, because members are not randomly assigned to them.

In this study a sample of 60 early adolescent AIDS orphans 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). 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). 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. Measurement occurred with the use of a self-constructed questionnaire that was administered in the group contexts.

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 study was also successfully implemented within the space of time of the project. The design enabled the researcher to reach the goal and previously mentioned objectives of the study.

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 socio-emotional needs and problems.

1.9 RESEARCH PROCEDURES

1.9.1 DATA COLLECTION

The collection of data is probably the most crucial phase in the implementation of a research project. According to Terre Blanche and Durrheim (1999: 45-46) it is the basic material with which researchers work. To draw valid conclusions from a research study, it is pivotal that the researcher has sound data to analyse and interpret. Researchers are expected to read, understand and critically analyse the writings of others (Blaxter, Hughes & Tight, 2000: 150).

There are different methods of collecting data in social research. Anderson (2003: 20) notes that data may be collected from questionnaires, interviews, observation of direct interaction and using available records such as case records and statistical data. In addition, literature review and experience surveys can be used to gather available data.

Based on the nature of the study data was collected in two phases.

- **FIRST PHASE (QUALITATIVE)**

The researcher used a **semi-structured interview with a schedule** to collect qualitative data regarding the socio-emotional needs and problems of as well as life skills needed by early adolescent AIDS orphans (See Appendices 3 & 5). The respondents were AIDS orphans and the main role players in AIDS issues namely social workers and care givers who are rendering services to orphans as they have the necessary information at their disposal.

In this qualitative phase the researcher interviewed 10 social workers and 10 caregivers from the major two cities of the North-West Province namely Rustenburg and Mafikeng. The social workers were all employees of the Department of Social Services, Arts, Sports and Culture in the North-West Province. The researcher also interviewed 20 AIDS orphans from Ledig one of the villages in Rustenburg (North-West Province). They were all selected from one of the primary schools there (See Chapter 7 - for summary of the interview with AIDS orphans, social workers and caregivers).

According to Berg (2001: 70) this type of interview involves the implementation of a number of predetermined question 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 the prepared and structured questions. The schedule served as a guideline for the interviews and lead to systematic obtained data. The interviews with caregivers and AIDS orphans were conducted in Setswana (See Appendix 3) whereas interviews with social workers

were conducted in English (See Appendix 5). Accordingly the schedule ensured a high response rate and saved time and costs.

This type of data collection has been chosen because it enabled one to record the context of the interview and the non-verbal gestures of the respondents. May (1993: 74) states that there is a "visual-interactional component" between the interviewer and the interviewee. Due to the sensitive nature of the topic undertaken, there was a need to use the semi- structured interview schedule so as to secure the cooperation of the respondents and maintain a rapport with them. The National Association of Social Workers (NASW) Code of ethics (1995:164) specifies that the social worker engaged in research should ascertain that the consent of participants in the research is voluntary and informed, without any deprivation and punishment for refusal to participate.

According to Strydom (2002: 65) obtaining informed consent implies that all possible information on the goal of the study, the procedures that will be followed during investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed may be rendered to potential subjects. No one should be forced to participate. Babbie and Mouton (2001: 520) notes that the researcher has the right to search for truth but not at the expense of the rights of individuals in society. See Section 12 for detailed discussion of ethical guidelines that were adhered to in this study.

- **SECOND PHASE (QUANTITATIVE)**

During the second phase of the study, quasi-experimental pretest-posttest design was used to evaluate the effectiveness of the programme.

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. The same questionnaire was used in the pre-test i.e. before implementation of the life skills programme, and post-test with both the experimental and comparison groups. 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.

The implementation of this procedure is illustrated in Table 1:

Table 1: Group administered questionnaire used with comparison group pretest-posttest design

Groups	First Tests	Intervention	Second Tests
Experimental group: Consisting of 30 AIDS orphans between the ages of 11 and 14	Pre-test	Intervention, i.e. AIDS orphans life skills programme	Post-test
Comparison group: Consisting of 30 AIDS orphans between the ages of 11 and 14	Pre-test		Post-test

By use of the group administered (self-constructed) questionnaire much time and costs were saved. The use of a suitable venue (a school classroom) and time slots (after-school) were negotiated with the School Side Managers involved in the study.

1.9.2 DATA ANALYSIS

Once data has been collected it needs to be assembled in some meaningful way. De Vos (2002: 339) define data analysis as a "process of bringing order, structure to the mass of collected data." Data analysis enables the researcher to determine whether they provide the information needed in order to achieve the goal of the study.

1.9.2.1 DATA ANALYSIS (QUALITATIVE)

According to Berg (2001: 238) there are a number of procedures used by qualitative researchers to analyze data. Analysis of qualitative data was done using the collaborative approach as discussed by (Berg, 2001: 239).

- Data should be collected and made into text, using transcripts and field notes.

Data was first analysed in the language in which the interviews were mainly conducted namely Setswana. Data was then made into text using transcripts.

- Codes should be analytically developed or inductively identified in the data and affixed to sets of notes or transcript pages.

The entire transcripts were given a code and the researcher read 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.

- Codes should be transformed into categoral labels and materials should be sorted by these categories, identifying similar phases, patterns, relationships and commonalities or disparities

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.

- Identified patterns should be considered in light of previous research and theories.

Data was analysed based on literature study. The goal was to verify these themes into theory (literature control) that offers an accurate, detailed interpretation of the study.

1.9.2.2 DATA ANALYSIS (QUANTITATIVE)

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.

1.10 PILOT STUDY

One of the determinants for the successful implementation and completion of any research project is a pilot study. According to Strydom (2002: 210) a pilot study is an integral part of the research process. Its function is the exact formulation of the research problem and a tentative plan of the modus operandi and range of investigation. Breakwell, Hammond and Five-Schaw (1998: 27) mention that it is often useful to conduct pilot work to try out the methods and materials in advance of running the full-scale of the study itself. If the pilot survey uncovers many difficulties in the design programme has to be revised (Tabane, 2004: 12-13).

The New Dictionary of Social Work (1995:45) defines a pilot study as the process whereby the research design for a prospective survey is tested. Bless and Higson-Smith (2000: 155) define the pilot study as small study conducted prior to a larger piece of research to determine whether methodology, sampling and analysis are adequate and appropriate. Subsequently, the pilot study of this proposed research is discussed according to **feasibility of the study and pilot testing of semi-structured interview schedule and questionnaire.**

1.10.1 Feasibility of the study

According to Breakwell, Hammond and Five-Schaw (1998: 18) it is crucial when selecting a research topic to investigate the feasibility of a particular study. One

should be as certain as possible that the project will work before investing large amounts of resources e.g. money, energy, time and materials. Bless and Higson-Smith (2000: 154) define a feasible study as a study designed to determine whether a particular strategy or intervention is likely to reach its stated objectives.

With reference to this study, the following can be stated:

- The proposed study was not difficult to conduct, since the researcher resides in the same province North-West Province and is familiar with children orphaned by AIDS.

- The researcher is presently involved in a church based project which focuses on people living with AIDS in Mafikeng region and are willing to co-operate in this endeavour.

- The fact that in North West Province Setswana is the predominantly used language amongst Blacks and the researcher is Tswana speaking ensured that there was no language barrier when collecting data.

- Due to the fact that the researcher used to be a Provincial member of AIDS Council (in North-West Province) enabled the researcher to have direct access to important documents relevant to the subject matter.

- The availability of respondents is foreseen not as a problem. The researcher gained access to the schools and welfare organisations after obtaining 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.

- The researcher was allocated funding by the University of North-West to the value of R10 000.

1.10.2 Pilot test of data collection instruments

To ensure that the research project was successful and effective the following were done:

1.10.2.1 Semi Structured Interview Schedule

To assess the suitability of the semi-structured interview a schedule was tested before the main investigation. This implies that interviews were arranged with four early adolescent AIDS orphans in Rustenburg. During these interviews a space was given for criticisms or comments on the interview schedule. These participants were automatically excluded from the sample in the main study.

Participants were satisfied with the ordering and length of the schedule. The only main comment was that it would be easier to participate if the interview was conducted in their local language i.e. Setswana. The interview was thus translated in Setswana.

The semi-structured interview schedule was also tested with two social workers from the Department of Social Services, Arts and Sports and two caregivers from Rustenburg who were not part of the main study. During these interviews space was specifically given for criticisms and/ or comments on the interview schedule. From this, it was clear that both social workers and caregivers were satisfied with the schedule as a whole.

1.10.2.2 Life skills programme and questionnaire

Life skills programme and questionnaire were pilot tested with four early adolescent AIDS orphans who were not be part of the study. Respondents were satisfied with both the questionnaire and life skills programme. No adaptations were necessary to be made.

1.11 DESCRIPTION OF THE RESEARCH UNIVERSE, POPULATION, SAMPLE, DELIMITATION/BOUNDARY OF SAMPLE AND SAMPLING METHOD

1.11.1 Research Universe

Arkava and Lane (1983) in Strydom and Venter (2002: 198) define a universe as all potential subjects who possess the attributes in which the researcher is interested. The research universe of this study included all early adolescent AIDS orphans in South Africa. The research focuses on Black children (boys and girls) who have lost parent/s due to AIDS.

1.11.2 Research Population

Diamantopoulos and Schlegelmilch (1997: 10) define a population as "the totality of entities in which we have interest, i.e. the collection of individuals, objects or events about which we want to make inferences." Bless and Higson-Smith (2000: 85) describe the term as the "set of elements that the research focuses on and to which the obtained results should be obtained." According to Strydom and Venter (2002: 198) population refers to the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned. It is the aggregation of elements from which the sample is actually selected (Babbie & Mouton, 2001: 174). For this study it is important to show a distinction between research population during the first phase and the second phase of the study.

Research population (Qualitative): The research population in the first part of the study included the following:

- Early adolescent AIDS orphans in the North-West Province.
- Care-givers in the North-West Province
- Social Workers in the North-West Province

Research population (Quantitative): The research population for the second phase of the study included all early adolescent AIDS orphans in the North-West Province.

1.11.3 Research sample

As the research population in itself is too large to study a sample was drawn. A sample, therefore, is a part of a large population. It is usually selected to be representative of that population. A sample can be defined as subset of population selected to obtain information concerning the characteristics of the population (Hansen, Hurwitz & Madow, 1993: 2). Bless and Higson-Smith (2000: 156) define a sample as " The group of elements drawn from the population, which is considered to be representative of the population, and which is studied in order to acquire some knowledge about the entire population". A sample is thus a representative portion of the population concerned.

The research sample of both the first phase and the second phase of the study is presented below:

Research sample (Qualitative): For the first part of the study the sample included the following:

- 20 early adolescent AIDS orphans in the two cities of the North-West Province namely Mafikeng and Rustenburg.
- 10 social workers in the two cities of the North-West Province namely Mafikeng and Rustenburg.
- 10 caregivers in the two cities of the North-West Province namely Mafikeng and Rustenburg.

Research sample (Quantitative): For this second part of the study a sample included 60 early adolescent AIDS orphans residing in two cities of the North-West Province namely Mafikeng and Rustenburg.

1.11.4 Sampling method

According to May (1993: 69) sampling provides a mechanism whereby we can make an estimate of a population characteristic and get a numerical measure of how good that estimate is. Reid and Smith (1981) as quoted by Strydom and Venter (2002: 199) are of the opinion that the major reason for sampling is feasibility.

As already highlighted for the first part of the study the sample included ten social workers, ten caregivers and twenty AIDS orphans. To identify AIDS orphans the researcher used the non-probability sampling method known as **purposive sampling** and to identify social workers as well as care givers the researcher used **accidental sampling.**

1.11.4.1 Purposive sampling

Purposive sampling is sometimes called judgemental sampling (Berg: 2001: 32; Anderson, 2003: 51; Babbie & Mouton, 2001: 166) or expert choice sampling (Anderson, 2003: 51).

According to Anderson (2003: 51) with purposive sampling the researcher select the cases to be included in the sample on the basis of his familiarity with the situation combined with his presumed expert judgement. In addition, Berg (2001: 32) mentions that when developing a purposive sample the researchers use their special knowledge or expertise about some group to select subjects who represent the population. This type of sampling is based entirely on the judgement of the researcher.

The purposive sampling method has been chosen for this study due to the sensitive nature of the study. Rezenti and Lee (1993: 4) observe, “Sensitive topics are those topics that social scientists generally regard as threatening in some way to those being studied”. The stigmatisation and general beliefs surrounding AIDS makes it difficult for people to come out in the open and offer insight into the AIDS orphans problem.

Therefore contact, in the form of social workers, educators, and welfare organisations was made. These in turn help identify 20 AIDS orphans in the first phase of the study. The researcher and professionals mentioned above jointly identified 60 AIDS orphans who participated in the second phase of the study. These respondents conform to the requirements stated in section 1.11.2 i.e.

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

1.11.4.2 Accidental sampling

According to Nachmias and Nachmias (1981) in Strydom and Venter (2002: 207) this type of sampling method is also known as convenient, availability or haphazard sampling. The respondents are usually the people who are most easily available to the researcher. It involves choosing the nearest and most convenient persons to act as respondents. The process is continued until the required sample size has been reached (Cozby, 2003: 132; Robson, 1994: 141; Strydom & Venter, 2002: 207).

The researcher identified ten social workers who have experience in working with AIDS orphans and ten caregivers who are involved in caring for AIDS orphans in Mafikeng and Rustenburg.

1.11.5 Delimitation/Boundary of the research project

To make the study feasible the following boundaries were selected:

- **The setting**

The study focused on one province in South Africa namely the North-West Province. This province is predominantly rural. Mining, particularly platinum and agriculture

form the basis of its economy. Its unemployment rate stands at 37, 9% and is the fourth highest in country in this regard. It has a socio-cultural environment that is in transition from an intact extended family system to a nuclear one brought by modernisation. The majority of the population in the North-West Province falls within the age group of 15-49 (The HIV/AIDS Strategy Department of Social Services, Arts, Culture and Sport, 2000). This unique characteristic of the province means that there is the possibility that many people are living with HIV/AIDS and many are susceptible to infection.

- **Permanent Residence**

The respondents are residing in Mafikeng and Rustenburg. The two cities were chosen since all have a township and are surrounded by many villages. Large parts of the areas are rural. Since North-West Province is semi urban-rural, the cities give a clear picture of the province.

- **Population group**

The research focus was on one-population group only i.e. Black early adolescent AIDS orphans.

- **Age group (11-14) years: Early adolescence**

The age group that was included is boys and girls between the ages of 11 – 14. The reason for this is to keep participants homogenous regarding their development phase. Furthermore this group is chosen because the researcher believes that at this age children have the ability to comprehend information hence they will be able to understand questions and be in position to react appropriately.

This is supported by WHO (1997: 16) which notes that given the role of life skills in the promotion of positive behaviour, it is worthwhile ensuring that life skills programmes are available in pre-adolescent or early adolescent years since young

people of this age group seem to be most vulnerable to behaviour related health problems.

- **Language**

The research was conducted in Setwana. All of the respondents were fluent in Setswana. According to Mogotsi (1996: 10) the North-West Province is primarily characterised by Setswana speaking people.

1.12 ETHICAL ISSUES

The fact that human beings are the objects of study in the social sciences, the researcher in planning research, needs to be aware of the agreements about what is proper and improper in scientific research. Therefore, ethical concerns are considered as an integral part of the planning and implementation of research. Researchers are responsible for designing and carrying out research both knowledgeably and ethically (Milley, O'Melia & Dubious, 2001: 402).

Beach (1996: 2) defines ethics as the discipline related to what is good and bad or right or wrong behaviour, including moral duty, and obligation, values and beliefs, and the use of critical thinking about human problems. Strydom (2002: 63) defines ethics as a "set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students." The New Dictionary of Social Work (1995: 61) defines the term ethics as "Principles, standards and expectations resulting from accepted values and norms which determine the social worker's professional actions with or in the interest of the client."

According to Terre Blanche and Durrheim (1999: 65) the essential purpose of ethical research planning is to protect the welfare and the rights of research participants.
Breakwell, Hammond and Fife-Schaw (1998: 19) further state that ethical consideration plays an important role in assessing the feasibility to studying a

particular topic. Strydom (2002: 63) stated that ethical guidelines also serve as standards and the basis on which researchers evaluate their conduct.

Ethical considerations in research include issues such as confidentiality, informed consent, competence, reporting results etc. The following ethical considerations are addressed in this study:

1.12.1 Confidentiality

One of the most sensitive aspects of the research process from the perspective of the right and welfare of subjects is the matter of confidentiality (Beach, 1996: 26). All participants in research have the right to expect that the information that they provide will be treated confidentially. This is particularly the case in AIDS related research. Improper disclosure could have most serious consequences for research participants by threatening family and other relationships.

In the light of these, special precautions were taken to preserve confidentiality. Privacy was assured in this study since the respondent's responses were anonymous. Their identity was not displayed on their responses hence it will not be identified as theirs. Anonymity was assured by the use of a number system for comparison of the pre-test and post-test results. Subjects in this study remained anonymous therefore it was acceptable to use tape recorders during the first part of the study (Interviews).

Furthermore, participants were given a clear explanation of how information about them will be handled, and no information may be disclosed without the subject's consent. Participants were also assured that the name of their schools will not be identified.

1.12.2 Harm to participants

According to Oppenheim (1992) the basic ethical principle governing data collection is that no harm should come to the respondents as a result of their participation in the research. Therefore the researcher should protect participants from unwarranted

physical or mental distress, harm, danger or deprivation. HIV/AIDS is still a sensitive issue especially in Black communities. In the light of this special precautions were taken to minimise harm to participants:

- Respondents were prepared through given information by the researcher prior to participation.

- If a respondent has been upset by some questions during data collection, the process was abandoned rather than risk upsetting the respondents.

- Respondents were then offered counselling by an identified social worker to deal with the harm. In this study the researcher was accompanied by two practicing social workers who were very helpful with counselling the children.

1.12.3 Informed Consent

Miley, O"Melia and Dubois (2001:402) state that this ethical principle emphasises that subjects should give their consent to participate only after researchers fully disclose the purpose of the research, what it entails, and its potential effects or consequences. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research. Williams et al., (1995) in Strydom (2002: 65) states that "obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well at the credibility of the researcher, be rendered to potential subject or their legal representatives".

Participants' written consent was sought in advance in this study (See Appendix 7 for the consent form). However, Beach (1996: 22) notes that obtaining consent from research subjects is just having them sign a consent form. The researcher assumed the responsibility for having subjects understand the nature of investigation including the

potential risk involved, as well as the purpose of the research and its expected outcome.

Potential respondents were informed that subjects that will participate in the second part of the study will be divided into the comparison and experimental groups. Although the experimental groups will be the only group that will participate in the newly developed life skill programme, arrangements were already made that after completion of the project the remaining group (i.e. the comparison group) will be given the opportunity to participate in the programme. This will assist in minimising possible emotional harm for being left out of the comparison group.

Since the early adolescents are still minors, direct consent was also obtained from caregivers, guardians of interested early adolescents.

1.12.4 Voluntary participation

According to this ethical principle, participants' involvement in research is strictly by their choice. Researchers never coerce respondents into participating (Miley, O"Melia & Dubois 2001:402). Beach (1996: 22) emphasises that subjects must understand from the beginning of the research that their participation is entirely voluntary, and that they have the right to refuse or withdraw from participation from the study at any time.

Identified respondents were briefed about the research project and then provided the opportunity to refuse or participate in the study.

1.12.5 Collaboration with other role players

According to Strydom (2002: 71) the researcher can sometimes involve colleagues in the research to assist in selecting a relevant problem, drawing the most suitable sampling frame, or even simply in deciding which research design would be most suitable. However, it is noted that whatever the involvement of collaborators a formal contract between participants is preferable.

Key collaborators in this study included caregivers, social workers and schools principals. These contacts enabled the researcher to identify possible respondents i.e. AIDS orphans. Furthermore, the researcher worked closely with two identified social workers with practical and research experience to assist in the critical evaluation of the designed prototype. The practitioners helped the researcher in specifying what needs to be changed or emphasised in the prototype life skills programme. The practitioners also assisted the researcher by offering counselling to respondents if their participation becomes harmful.

1.12.6 Results of research

Miley, O"Melia and Dubois (2001:403) state that researchers are expected to report their findings accurately to avoid misrepresenting them. Furthermore, researchers are expected to conduct studies and report results impartially. According to Babbie and Mouton (2001: 528) unless research is made public, it is not possible for one's peers to evaluate and assess the quality of one's work.

The researcher's aim is to make a useful contribution to the society. The research results are made available in a form of an accurate research report.

1.13 LIMITATIONS OF THE STUDY

The following were viewed as limitations for this particular study:

- **Choice of research design:** A comparison group pretest-posttest design was used to gather quantitative data and realise the aim of the study. A longitudinal approach to the study, focusing on the internalisation of life skills over a time period however is seen as ideal and could lend itself to fundamental findings in social work practice.

- **Selection of respondents:** Respondents in this study were not randomly selected given the fact that a purposive sample of 60 respondents was employed. The findings therefore are inconclusive and cannot be generalised to the larger

population. However, it is important to mention that the sample was representative according to specific characteristics (See section 1.11.2).

- **The need for more comprehensive services:** Although AIDS Orphans Life Skill Programme promotes abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life, it is important to mention that this programme is one of the methods of addressing the needs of the children. More comprehensive services are needed.

1.14 DEFINITIONS OF KEY CONCEPTS

The following definitions are relevant for this particular study:

1.14.1 Life skills

William (1990: 249) defines life skills as those skills needed to help a person to function in society as an independent adult. According to WHO (1997: 2) life skills are abilities and positive behaviour that enable individual to deal effectively with the demands and challenges of everyday life. Life skills therefore are components skills through which people assume personal responsibility for their lives. Anderson and Okoro (2000: 19) note that life skills are self-helping skills that enable people to help themselves. They are aimed at empowering people. Hopsons and Scally (1981) as quoted by the above-mentioned authors, state that life skills are personally responsible sequences of self-helping choices in specific skills areas conducive to mental wellness.

Life skills are thus skills, which enable people to make personal responsible choices. When people are being personally responsible they are able to make choices that maximise their happiness and fulfilment. Life skills are therefore concerned with independence in self-care, understanding of the environment and living with others.

1.14.2 Programme

O' Donnel and Weihrich in De Vos (1998: 367) describe a programme as "a complex of goals policies, procedures, rules, task assignments, steps to be taken, resources to be employed, and other elements necessary to carry out a given course of action;" Readers Digest Word Power Dictionary (2002: 772) defines the term programme as a "set of related measures or activities with a long-term aim." A programme is thus a plan or guideline to carry out a given course of action.

1.14.3 Life skills programme

Brack (2000: 5) defines life skills programme as activities aimed at empowering people to internalise a repertoire of life skills according to their developmental tasks and specific problems of living. According to WHO (1997: 1-2) life skills programmes are educational programmes designed to promote positive health behaviour by enabling individuals to deal effectively with the demands and challenges of every day life. The teaching of life skills is therefore practical and intended to equip the learner with new improved abilities.

For the purpose of this study the term life skills programme refers to a set of related activities aimed at enabling early adolescents to maximise their own choices, to enhance their personal well-being and to improve their quality of life. During this process adolescents should be equipped with life skills that will stand them in good stead for the rest of their lives.

1.14.4 AIDS

AIDS is the acronym for **Acquired Immune Deficiency Syndrome**. It is **acquired** because it is a disease that is not inherited. It is caused by **HIV**, which enters the body from the outside. **Immunity** refers to the body's natural ability to defend itself against infection and disease. **Deficiency** refers to the fact that the body's immune system has been destroyed so that it can no longer defend itself against passing

infections (Van Dyk 2001: 4). A syndrome refers to a range of different diseases, symptoms or condition (Evian, 1993: 268).

AIDS is therefore, defined by Van Dyk (2001: 5) as a syndrome of opportunistic diseases, infections and certain cancers – each or all of which has the ability to kill the person infected with HIV in the final stages of the disease. This means that the body loses the ability to fight against infections because the immune system is weakened. Evian (1993: 267) notes that AIDS is the late and most severe (final) stage of HIV and is characterised by signs and symptoms of severe immune-deficiency. Soul City Lifeskills (2001: 112) concludes by stating that when people who are HIV positive cannot fight viruses or infections any more, they start to get sick often. When this happens, we say that they have AIDS.

AIDS often presents itself with life threatening diseases. It is a collection of infections or different diseases due to the compromised immune system in the body. The immune system in the body fails to fight these infections and therefore the body becomes prone to all illnesses.

1.14.5 HIV

HIV stands for **Human immunodeficiency syndrome -** The virus that causes AIDS. This virus attacks the body's immune system and makes it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens (Van Dyk 2001: 423; The Public Health-Seattle & King County, 2001: 1). According to Evian (1993: 5-6) HIV is a retrovirus which enters and destroys important cells which control and support the immune system. As it does this, it slowly diminishes the immune system's ability to defend itself against attack from exterior pathogens. Thus HIV is viewed as the virus that causes AIDS.

For this study the Human Immunodeficiency Virus, which is commonly called HIV, is a virus that directly attacks certain human organs, such as the brain, heart, and kidneys, as well as the human immune system. Many of the problems experienced by people infected with HIV result from a failure of the immune system to protect them from certain opportunistic infections and cancers.

1.14.6 Orphan

Hope (1994: 94) defines an orphan as a child who is motherless or who has lost both parents. Saoke and Mutemi (1994: 3) suggest that an orphan is a child, not older than 18 who have lost either one or both parents. According to UNAIDS (1991:1) the term orphan is described as a child without parents, a child who is abandoned, and a child without financial, physical and emotional support…(UNAIDS: 1999: 1). The latest definition of an orphan by UNAIDS (2004: 2) is a child under the age of 18 who has had at least one parent die. Webster's 3rd New International Dictionary (1993: 1593) defines an orphan as any child deprived of both father and mother: a parentless child. According to the Concise Oxford Dictionary (1982: 721) an orphan is a child bereaved of parents.

Ruiz-Caseras (2003: 1-2) argues that the differences in orphan definition have programme and policy implications. It is therefore imperative that researchers explicitly state their own understanding to the usage of the term orphan. In this study the term orphan refers to any child bereaved of both father and mother; a parentless child.

1.14.7 AIDS orphan

The definition of AIDS orphan that is used by WHO and UNICEF is of a child who loses his/her mother before reaching the age of 15 years (Ruiz-Casares, 2003: 1). Before 2002, UNAIDS defined AIDS orphans as children who before the age of 15 have lost their mother to AIDS (Avert, 2003: 13). In 2002 UNAIDS changed the definition of AIDS to include children who before the age of 15 have lost either one or both parents to AIDS. The definition was reviewed because if one parent is infected with HIV, it is likely that the other will follow leaving the child parentless (Avert, 2003: 13). The recent definition of AIDS orphans by UNAIDS is children who before the age of 18 have lost either one or both parents to AIDS (UNAIDS, 2004: 10).

For the purpose of this study the term AIDS orphan refers to a child who before the age of 18 has lost parent/s due to AIDS.

1.14.8 Adolescence

According to Jaffe (1998: 19) the term adolescence literally means, "to grow into adulthood". The word adult comes from "adultus", the past participle of "adolescre", which means, "to grow up". Adolescence is defined as the developmental period between childhood and adulthood (A Student's Dictionary of Psychology, 1999: 6). Encyclopaedia of Psychology (1984: 21) describes adolescence as a period of transition from childhood to early adulthood entered at approximately 11-13 years of age and ending at 18-21 years of age. Sdorow and Rickabaugh (2002: 115) note that adolescence is characterised by a period of rapid physical changes known as puberty.

It is clear that the definition of the term adolescence can differ from researcher to researcher. The view that is taken in this study concurs with Jaffe (1998: 25) in that adolescence is the life period that begins with the onset of puberty and ending in adulthood, when an individual has taken several adult roles.

1.14.9 Early adolescence

A dictionary of Education (1981: 74) defines early adolescence as a "period at the beginning of adolescence, 11-16 years of age in which the individual develops mature sexual features and becomes capable of procreation."

For the purpose of this study, the term early adolescence is restricted to the age category 11-14 years of age. Early adolescence is thus the first development stage of adolescence, which is characterised by the onset of puberty.

1.14.10 Need

Johnson and Johnson (2003: 380) define a need as necessity for survival. According to Hull and Kurst – Ashman (2004: 159) a need usually refers to a lack of something,

which lack contributes to the discomfort of members of the group. In other words, needs involve what is missing. For the purpose of this study a need is a condition or situation in which, something necessary or desirable is required.

1.14.11 Problem

A New Dictionary of Social Work (1995: 1) defines a problem as a situation in which the social functioning of the individual, group or community is impeded by obstacles in the environment and/or that individual, group or community that prevent the meeting of BASIC NEEDS, the realisation of values and satisfactory role performance. According to Hull and Kurst – Ashman (2004: 159) a problem usually refers to the presence of something, which presence contributes to the discomfort of members of the group. In other words problems concern negative happenings already in existence. For this study a problem refers to a discrepancy or difference between an actual state of affairs and a desired state of affairs.

1.15 CONTENTS OF RESEARCH REPORT

The research report consists of eight chapters and the arrangement of chapters is as follows:

CHAPTER ONE

The first chapter is an introductory chapter. It starts with general introduction and orientation to the research report. Focus is also placed on formulation of the problem, the rationale for the choice of topic, goal and objectives and a hypothesis formulated. The core of this chapter is explanation of the methodology employed for the research project to be undertaken.

CHAPTER TWO

This chapter is dedicated to literature study focusing on HIV/AIDS. Literature concerning HIV/AIDS in general, global and in particular the South African situation

was discussed. Important issues such as nature of the disease, the background, and impact, the current status of the epidemic as well as the future of the epidemic were looked at. Statistics describing the relationship between HIV/AIDS and AIDS orphans were also described.

CHAPTER THREE

Chapter three explored literature regarding AIDS orphans in general, global and South Africa in particular. Grounding, description and explanation of the needs of AIDS orphans were presented to give a clear picture of challenges faced by these children. Problems of orphan-hood such as legal and ethical issues, socio-emotional issues, educational issues, financial issues and child-headed households were reviewed.

CHAPTER FOUR

The focus of Chapter 4 was adolescent as a life phase with specific emphasis on early adolescence. It described the nature of adolescence and the developmental processes which are involved. Furthermore, the chapter highlighted the characteristics of the stage and adolescents' risk behaviour in order to help understand the factors that motivate their behaviour. Focus was also on problems and challenges experienced by early adolescents.

CHAPTER FIVE

Chapter five gave a review of life skills with specific emphasis on early adolescents. It described the concept life skills in detail. In addition, theoretical perspectives were discussed in order to get a better understanding of how life skills enhance human capabilities i.e. physically, socially and psychologically. The importance of life skills to early adolescents was also outlined. The next sections described the process of life skills education as well as life skills helping.

CHAPTER SIX

Chapter six gave a presentation of the researcher's newly developed life skills programme for early adolescent AIDS orphans in North-West Province (AIDS orphans' life skills programme).

CHAPTER SEVEN

The focus of chapter seven was presentation of research methodology as well as analysis and interpretation of empirical findings. The empirical findings and research results with regard to (a) the qualitative data (interviews with AIDS orphans, social workers and caregivers on the socio-emotional needs of and life skills needed by early adolescent AIDS orphans) and (b) quantitative data (the implementation and evaluation of the developed life skills programme) were given.

CHAPTER EIGHT

Chapter eight presents the main conclusions of the study and recommendations aimed at redressing the identified challenges.

- CHAPTER 2 -

HIV/AIDS AS A SOCIAL PHENOMENON

2.1 INTRODUCTION

HIV/AIDS is currently one of the most devastating health conditions affecting the health of millions throughout the world. Globally it is noted that since AIDS was first described in 1981, well over 20 million lives have been lost, and tens of millions people-increasingly women and young people–are now living with HIV. Most face the prospect of sickness, destitution and premature death (UNAIDS, 2005: 1).

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. The health and social implications of HIV/AIDS on human development are extensive. It is robbing countries of the resources and capacities on which human security and development depend. In the hardest-hit countries, it is erasing decades of health, economic and social progress-reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages. HIV/AIDS in combination with other crises is driving even larger parts of the nation towards destitution (UNAIDS, 2002: 4; UNAIDS, 2004: 1).

The world at large is affected with almost 42 million people already living with HIV/AIDS. By far the most affected areas, the developing countries, have the highest number of people living with the disease and more people are newly infected with the virus daily. In 2003, almost five million people became newly infected with HIV; the greatest number in any one-year since the beginning of the epidemic (UNAIDS 2004: 1-2).

A significant proportion of individuals living with HIV/AIDS reside in Africa. According to Johnson and Morris (2003: 2) about 15 000 infections occur daily throughout the world and more than 95% are in developing countries. This proportion is set to grow ever further as infection rates continue to rise in Africa. In 2003 alone, an estimated 3 million

people became newly infected with HIV. However, the impact differs from one society to the other. In some countries, where information and resources are more readily available, the spread of HIV is being contained. In poorer countries where there is less access to information, lack of education, inequality, poor health systems, lack of help and advance treatment, the disease is continuing to spread at alarming rate (Avert, 2005: 1; UNAIDS, 2004: 3).

As already noted in the previous chapter Sub-Saharan Africa has the world's highest prevalence and faces the greatest demographic impact. Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV – some 25.4 million (AIDS Epidemic Update: 2004: 1). In 2003, 2.2 million people died from AIDS and an estimated 25 million adults and children with living with HIV/AIDS. In 2004 an estimated 3.1 million people in the region became newly infected. It is further noted that in the worst-affected countries of eastern and southern Africa, if current infection rates continue and there is no large-scale treatment programme, up to 60% of today's 15 year olds will not reach their 60th birthday (Avert, 2005: 1; AIDS Epidemic Update: 2004: 1; UNAIDS, 2004: 1).

According to Barnett and Whiteside (2002: 3) the groups at greatest risk are those between 15 and 50 years of age. Around half of the people who acquire HIV become infected before they turn 25 and typically die before their 35th birthday. These are the most productive people in any society. This age factor makes AIDS uniquely threatening to the up-bringing of children. Most people will have had children before they become infected and about 70% children born to infected mothers will not, themselves be infected. These children have a close 100% chance of being orphaned (Whiteside & Sunter, 2000: 3; Barnett & Whiteside, 2002: 3).

Statistics show that the number of AIDS orphans especially in sub-Saharan African countries is set to increase considerably. So far, the epidemic has left behind an estimated 15 million orphans of which 80% of the AIDS orphans live in sub-Saharan Africa. It is estimated that by 2010, the virus will have orphaned 1.5 million children in South Africa alone and the economy of South Africa will be in shambles (Avert, 2005: 1-2; UNAIDS, 2004:1).

HIV/AIDS kills people in the prime of their lives. The fact that young adults die in their productive ages means that families are deprived of their major source of economic support. The rapid increase of mortality due to AIDS has created a crisis in many families. Young children left behind increase the burden of care on other family members and often intensifying poverty and destitution. According to Cable News Network (CNN) report (2001: 1) children are often orphaned two or three times as their parents die and they are placed with aunts, uncles and other relatives who also die from the disease. Many youngsters are forced on the streets and are growing up in an emotional and spiritual vacuum. The report further said that as adults, the orphans would not be equipped to the economic engine of Africa, making the struggle for development and growth on the continent more difficult.

From the above, it is clear that the effects of HIV/AIDS have captured the attention of the world. HIV/AIDS epidemic is the single most import health and development issue facing many countries around the world. It affects not only the health of individual but also the welfare and well-being of households, children, communities and in the end, entire societies. While volumes have been written on the subject, many people are still unclear about what HIV is and how it is spread. This chapter provides a detailed explanation of this extremely complex phenomenon, drawing on information from a wide range of sources. In this chapter focus will particularly be on the following:

- Definition of HIV/AIDS,
- History of HIV/AIDS,
- AIDS as a global problem,
- AIDS in Africa with specific emphasis on South Africa,
- Modes of HIV transmission,
- The AIDS development process,
- Voluntary counseling and testing,
- Treatment of HIV/AIDS,
- The impact of HIV/AIDS,
- Prevention strategies.

2.2 DEFINITIONS OF HIV/AIDS AND UNDERSTANDING OF AIDS

According to Van Vuren (2004: 207) HIV is an abbreviation for human immunodeficiency virus. It is the virus that causes AIDS. HIV is predominantly a sexually transmitted disease that is mainly spread through unsafe sex and like other sexually transmitted diseases such as syphilis and herpes, it affects the whole body. It is a virus that is found in human beings and destroys the human body by attacking and slowly damaging the immune system. The immune system is made up of special cells, "CD4 cells" (also called T-helper cells) which are involved in protecting the body from infections and some terminal cancers. HIV makes the body's immune system weak. It can take few or many years before it causes serious damage (Barnett & Whiteside, 2002: 30; Barrett-Grant, Fine, Heywood & Strode, 2001 in Tabane, 2004: 27; Centre for Disease Control (CDC), 2003: 1; National Institutes of Allergy and Infections Diseases (NIAID) Fact Sheet, 2004: 2; Soul City Life Skills, 2001: 17; Tabane, 2004: 26; Van Dyk, 2001: 7-8).

According to Soul City – Know the Facts (2002) in Tabane (2004: 28) extensive studies around the world, in developed and developing countries have led most scientist and medical practitioners to conclude that HIV is the cause of AIDS. Their conclusion is based on a set of four globally recognised criteria that are used to determine the cause of a disease. They are called the Bradford Hill criteria and they state:

- The cause must always come before the disease.
- There must be strong statistical evidence showing the links between the cause and the disease.
- There must be a biological sound explanation of how the cause results in the disease.
- Higher levels of the cause lead to more disease.

According to Tabane (2004: 28-29) HIV as the cause of AIDS meets all of these criteria and can be explained as follows:

- The cause must come before the disease

  There have been no cases of HIV infection occurring after a person has already become ill with AIDS.

- There must be strong statistical evidence showing the links between the cause and the disease

  Numerous follow-up studies conducted around the world have shown that HIV negative people do not get AIDS. For example, a study in the United States of America of 8 000 participants, found that people with HIV were 1 1000 times more likely to develop a disease associated with AIDS than someone without HIV (Soul City –Know the Facts, 2002 in Tabane, 2004: 28).

- There must be a biological sound explanation of how the cause results in the disease

  As already indicated in this chapter when HIV enters the human body it infects cells known as CD4 cells, the cells that the body uses to defend itself. The HIV reproduces in the cells and in so doing destroys CD4 cells. Once enough of the CD4 cells are destroyed, an infected person is likely to fall ill with diseases that are less serious or very rare in people with healthy immune systems. At that stage, the person is said to have AIDS.

- Higher levels of the cause lead to more disease

  Several studies of HIV infected people show that AIDS starts when there are a certain number of HI viruses in the blood (Soul City – Know the Facts, 2002 in Tabane, 2004: 29). Those with 50-200 copes of the virus per cubic millilitre of blood have long survival time while those with over 100 000 copies show rapid deterioration and faster progression towards sickness and death.

As stated previously HIV is regarded as the cause of AIDS. According to the Centre for Disease Control (2003: 1) researchers have known since 1983 that HIV is the causative agent for AIDS. It is one of the viruses known as retroviruses. These viruses are called retroviruses because they reverse the usual flow of genetic information. Most viruses have genetic material made up of deoxyribonucleic acid (DNA). Unlike other viruses the retroviruses genetic material is in the form of ribonucleic acid (RNA). Instead of using

the DNA, HIV uses an enzyme known as Reverse Transcriptose. This enzyme allows the viral RNA to make its own DNA which is incorporated into the host cell. HIV enzyme converts the single-stranded HIV RNA to double-stranded HIV DNA. A cause for concern for many researchers is that HIV strains mutate and it is possible for one type to transform itself into another within the infected person (AIDSinfor, 2004: 1; Barnett & Whiteside, 2002: 29-30; Daigle, Lasch, McCluskey & Wancho, 1999: 2; Johnson & Morris, 2003: 7; NIAID, Fact Sheet, 2004: 2; South African AIDS Organisation Update, 2003: 2; Van Dyk, 2001: 13-14).

Like other viruses HIV can only reproduce itself inside a living cell which it parasites for purposes of reproduction. HIV can only live and multiply in human cells. The virus enters the human cells through binding with a receptor known as CD4, located on human cells surface. Once inside the body the virus infects a large number of CD4 cells or the T helper cells and replicates rapidly. It attacks the body's defence cells of the human immune system, until they are completely destroyed. When this happens, the CD4 cells are unable to orchestrate and coordinate the body's defences against the HI virus. Instead, they themselves are captured and forcibly turned into small factories to manufacture the very carriers of death (HIV) against which they are supposed to defend the body. T helper cells are a critical part of the body's immune system as they organise the overall response to a variety of infections disease. The virus will persist in the host cell and cannot be eliminated. When a substantial number of cells have been destroyed the body lacks the protection against attack from exterior pathogens. When the CD4 T cell count falls below 200/mm3, a person becomes particularly vulnerable to opportunistic infection and cancers. This result in fewer CD4 cells to organise the immune response, resulting in increased vulnerability to infections. The process may take several years but the person can transmit the virus to others. (AIDSinfor, 2004: 1; Barnett & Whiteside, 2002: 30; South African Aids Organization Update, 2003: 3; NIAID Fact Sheet, 2004: 1-2; 2004: Van Dyk, 2001: 7, 15).

The feature that makes HIV so effective in destroying human lives is the fact that the defensive components of the immune system have no known way of defending themselves against the virus. Furthermore HIV has yet another extraordinary property which makes it virtually untraceable by the immune system. HIV is able to mutate or change very rapidly. The body's immune system relies heavily on its ability to recognise

microorganisms from the outer protein layer. Because HIV ability mutates or changes its outer layer so rapidly, it is extremely difficult to detect any difference in the similarity of one virus to the other. Many of the problems experienced by people infected with HIV result from a failure of the immune system to protect them from certain opportunistic infections and cancers (Van Dyk, 2001: 16).

Although scientists currently have a clear and precise understanding of how HIV destroys the body's immune system, all attempts to eliminate the virus completely from the body, or to make human body immune to the virus, have hitherto failed. Johnson and Morris (2003: 25) maintain that up to now there is no cure for AIDS. At this stage therefore the only way to stop AIDS is to prevent transmission of the virus and to offer treatment to those living with HIV. This can extend the period of a person living with HIV to develop AIDS for about 5-10 years (Johnson & Morris, 2003: 24).

The sad thing about HIV is that it eventually leads to AIDS. Through progressive destruction of the T helper cells, the immune system weakens; a clinical point is reached where the condition is diagnosed as AIDS. Barnett and Whiteside (2002: 28), Lovelife (2003: 1), Van Dyk (2001: 4) and Van Vuren (2004: 2007) agree that AIDS is an acronym for acquired immune deficiency syndrome, which 'A' stands for Acquired. This means that the virus in not spread through casual or inadvertent contact like flu or chickenpox. In order to be infected, a person has to do something (or have something done to them), which exposes them to the virus. The letters 'I' and 'D' stand for Immunodeficiency. The virus attacks a person's immune system and makes it less capable of fighting infections. Thus, the immune system becomes deficient. Finally the letter 'S' stands for Syndrome. AIDS in not just one disease but it presents itself as a number of diseases that come about as the immune system fails. Hence it is regarded as a syndrome. According to Berer and Ray (1993) in Tabane (2004: 26) a syndrome is a group of symptoms or illness originating from cause, in this case HIV.

If HIV reduces immune function to a certain level, and/or when or more serious illnesses related to HIV occur, a person is said to have AIDS. The person living with AIDS experiences a specific group of diseases or conditions that result from suppression of the immune system. From that point forward, numerous opportunistic infections can invade the body with little resistance, ultimately resulting in death. The progression from HIV

infection to AIDS may take several years. In fact there is evidence that a person can remain HIV-positive more than ten years without developing any clinical illnesses that define and constitute a diagnosis of AIDS. Therefore, AIDS is the end stage of the disease process that may have been developing for 2, 5, 10, or 15 years (AIDS Epidemic Update, 2003: 3; Daigle et al., 1999: 3; Stine: 1996: 1).

Acquired Immune Deficiency Syndrome is an evolving phenomenon. The case definition of AIDS has already undergone several minor revisions from 1982 to 1993 (CDC 2003: 1). This was mainly brought about by various research developments. It is reasonable to assume that the database of the disease will continue to change as researches are still investigating the implications of the disease.

The above discussions have established that HIV is an extraordinary virus that attacks the immune system and it is incurable. AIDS on the other hand is a term used to describe a combination of diseases caused by the breakdown of the HIV+ person's immune system, and is potentially fatal. The distinction between HIV and AIDS is subtle, but it is there. A person that is infected with HIV may not have any symptoms of the infection. Someone with AIDS is a person who has both the virus and the associated complications. People infected with HIV can live relatively healthy lives for years before developing AIDS. The next section will give us the history of HIV/AIDS in order to understand the phenomenon better.

2.3 THE HISTORICAL BACKGROUND OF HIV/AIDS

According to Centre for Disease Control (2003: 1) and Van Dyk (2001: 5) the first recognised cases of AIDS occurred in America in the summer of 1981. However, Barnett and Whiteside (2002: 28), National Institute of Allergy and Infectious Diseases Fact Sheet (2004: 2) as well as Mwale and Burnard (1999: 9) note that although the history of AIDS can be dated back to 1981 at the Centres for Disease Control (CDC), in Atlanta Georgia, the first cases were seen in the late 1970s. Between October 1980 and 1981 an alert physician, Dr, Michael Gottlieb together with his colleagues in Los Angeles became intrigued with the physical condition of five young patients under their care. Their age ranged from 29 to 36. All of these men were suffering from a type of pneumonia called

pneumonia cystic carinnii. In addition all these men had evidence of having been infected with a virus called cytomegalovirus (CMV) and thrush, which are common in immunosuppressed patients. A further feature was that all of the five men were sexually active homosexuals. Following investigations by health officials a month later, twenty-six other homosexuals were found suffering from a rare skin cancer called Kaposi-sarcoma (KS). This skin cancer usually attacks elderly men whose immune system has been depressed; however in these cases it was different since all of the twenty-six men were young (Barnett & Whiteside, 2002: 28-29; Van Dyk, 2001: 5).

In September 1982 the Centre for Disease Control (CDC) named the new disease ACQUIRED IMMUNE DEFICIENCY SYDROME (CDC update 2002: 1). The CDC further produced a provincial case of definition of AIDS in the autumn of 1982. AIDS was defined on the basis of its occurrence of usual infections or cancers such as KS in previously healthy individuals due to an immune deficiency of unknown cause. More cases were identified between 1982 and 1983. Data received by the CDC offices from investigators showed that incidence of AIDS was roughly doubling every six months. Certain aspects of this disease were especially alarming; its cause was unknown at the time as well as its means of spread. People with AIDS frequently experienced unexplained persistent and swollen lymph glands, fever, night sweats, fatigue and weight loss. Treatment of the various infections and cancers seen in this disease was ineffective (CDC Update 2003: 1).

Simultaneously or possibly earlier, medical practitioners in Africa came across the unusual symptoms. People were dying from an AIDS-related condition called the slim disease (Van Dyk 2001: 5). Victims especially young people dramatically lost weight as a result of diarrhoea. The same disease was reported in countries like Zaire, Uganda and Rwanda. Outside Africa AIDS cases were identified in all Western countries and in Australia, New Zealand and some Latin American countries – most notably Brazil and Mexico. It seemed likely that the disease found in Africa was the same as the AIDS identified in Western countries (Barnett & Whiteside, 2002: 29).

In 1983, the causative agent of AIDS was discovered. The credit for the discovery is shared between French and American researchers. The virus was then named Human Immune Deficiency Virus (HIV). With the discovery of HIV, the different ways in which

the epidemic was spreading also became clear. The disease seemed confined to particular population groups. It became clear as the roll of fatalities unwound, that those people who had fallen victims to the disease shared two major links that is sex and/or blood. Because the very first case occurred in gay men, it was easy to assume that AIDS was a disease of homosexual men. However, epidemiological data made it evident that other groups were also affected. It became clear that AIDS cases were appearing also in male and female heterosexuals as well as intravenous drug users (Barnett & Whiteside, 2002: 29; National Institute of Allergy and Infectious Diseases Fact Sheet, 2004, 2; Van Dyk, 2001: 5).

Between 1982 and 1986 the definition of AIDS included the presence of specific malignancies such as Kaposi Sarcoma in previously healthy persons. It was in August 1987 that the definition included cases of mild immunodeficiency and persistent generalised lymphadenopathy. The 1987 case definition was amended during April 1992 and became official on the first, January, 1993. The definition was revised to include patients with ARC diseases. A year later WHO produced a case definition for Africa (called the Bangui case definition). AIDS was defined as the existence of at least two of the major signs together with at least one of minor signs in the absence of known causes of immunosuppression. The minor signs included persistent cough for more than a month, itch skin lesions, recurrent Herpes Zoster, oral thrush, chronic herpes simplex and generalised enlargement of lymph nodes. Major signs included chronic diarrhoea leading to significant loss in weight, pneumonia, Kaposi's sarcoma, Crypotococcal meningitis, Tuberculosis and Dementia complex (Hubley, 1995: 10; Johnson & Morris 2003: 23).

The year 1985 marked the introduction of a blood test which could detect antibodies to the virus in the blood (Centre for Disease Control update, 2003b: 1). One of the early tests that were used was known as the Elisa test. By means of this test it became possible to carryout survey of different groups of the public to determine the different levels of the infection. According to Van Dyk (2001: 58) because of false and positive results (where a test result is positive, while the person is actually HIV negative) an HIV test should always be confirmed by means of a second test, TA Western Blot Test. This test can be used for confirmation. Furthermore, these tests also showed that not all individuals infected with the HIV went on to develop AIDS. It was further found that a period of more than five years could take place between being infected with the virus and developing symptoms of AIDS. For each person with the symptoms there could be 50 to

100 others who were carrying the virus but did not have the disease (Van Dyk, 2001: 58; Van Vuren, 2004: 217).

Up to the 18th December 1987, over 46000 cases had been reported to the CDC (CDC update, 2003: 2). The Centre for Disease Control further predicted that more people will be infected and will die of AIDS as years went by. There was no doubt that AIDS posed the most significant public issue. In 1988 the special programme conducted by the World Heath Organisation (WHO) on AIDS became a global programme, which became the focal point for an intense international plan for the prevention and control of AIDS. The cornerstone of the programme has ever since been to stimulate and provide support for AIDS prevention activities with each country (WHO, 2000: 1).

Fifteen years following the establishment of the global programme, the world has seen an escalating development of the disease, which outweighs any other disease experienced in human history. Because of a broader international interest in AIDS the disease can now be studied more easily and effectively than before. Many advances in treatment are being made. According to Van Vuren (2004: 218) drugs such as anti-retroviral (ART) can improve the quality of life and extend life for HIV infected persons. These can enable them to live normal active lives for many years. Unfortunately, they're expensive and not yet freely available in many government clinics especially in developing countries. (Love Life, 2003: 2). Besides these drugs, new ones are being developed through intensive research to strengthen the immune system in the fight against AIDS. Although advances are spectacular, a cure has not yet been found and AIDS still remains a life threat. Lachman (1995: 6) stresses that a global strategy for AIDS prevention incorporates the concept that no country will be able to stop AIDS until it is stopped in all countries.

The overview of HIV/AIDS background demonstrates the complexity of the epidemic particularly in the Third World. There are no soft answers to stemming its spread. Although scientists currently have a clear and precise understanding of how HIV destroys to body's immune system, all attempts to eliminate the virus completely from the body, or to make the human body immune to the virus, have failed to make significant impact, with the result that the HIV/AIDS epidemic will continue wreak havoc in communities where it takes hold. The following section will focus on the extent of HIV/AIDS globally and in Africa with specific emphasis on South Africa.

2.4 AIDS: A GLOBAL PROBLEM

In the third decade of the pandemic AIDS, the society is now confronted with a global problem, which is not only a specific challenge but also a threat to human existence. HIV/AIDS has been reported from every inhabited continent and from every country. The recorded cumulative number of HIV infections to date exceeds 43 million. According to the AIDS Epidemic Update (2004: 1) and the Report on the Global AIDS Epidemic (2004: 1) the total number of people living with HIV rose in 2004 to reach its highest level ever: an estimated 39. 4 million [35.9 million – 44.3 million people] people are living with the virus (Table 2). This figure includes the 4.9 million people who acquired HIV in 2004.

Table 2 provides an overview of the global situation at the end of 2004 as published by UNAIDS/ WHO (2004: 2).

Table 2: GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC

December 2004

Number of people living with HIV/AIDS in 2004	**Total**	**39.4 million (35.9–44.3 million)**
	Adults	37.2 million (33.8–41.7 million)
	Women	17.6 million (16.3–19.5 million)
	Children under 15 years	2.2 million (2.0 – 2.6 million)
People newly infected with HIV in 2004	**Total**	**4.9 million (4.3 – 6.4 million)**
	Adults	4.3 million (3.7–5.7 million)
	Children under 15 years	64 000 (570 000 – 750 000)

AIDS deaths in 2004	**Total**	**3.1 million (2.8 – 3.5 million)**
	Adults	2.6 million (2.3 – 2.9 million)
	Children under 15 years	510 000 (460 000 - 600 000

The ranges around the estimates in this table define the boundaries within which the actual number lie, based on the best available information.

Table 2 shows that the number of people living with HIV has been rising in every region and is high compared to previous statistics. At the end of 1999, there were 2.6 million deaths from HIV/AIDS. This was a higher global total than in any year since the beginning of the epidemic. As of the end of the year 2000, 36.1 million people worldwide were living with HIV/AIDS. The number of people living with HIV continued to grow from approximately 36 million in 2001 to 38 million in 2003. The AIDS epidemic claimed more than three million people in 2002, and approximately 3 million AIDS-related deaths occurred in the year 2003. In the same year approximately 5 million new HIV infections were recorded. Throughout 2003, cumulative AIDS associated deaths worldwide numbered more than 20 million since the first cases of AIDS were identified in 1981 (AIDS Epidemic Update, 2002: 1; Barnett & Whiteside, 2002: 9; NIAID Fact Sheet, 2004: 2; Joint UNAIDS & WHO epidemic update 2000: 3; Love Life, 2003: 6; Whiteside & Sunter, 2000: 1).

Table 2 also indicates that the number of women living with HIV has risen. Women are increasingly affected, now making up half of the 37.2 million adults aged (14-49) living with HIV worldwide. According to UNAIDS (2004b: 1) women are more physically susceptible to HIV infection than men. Male-to-female transmission during sex is about twice as likely to occur as female-to-male transmission. Women and girls also bear the brunt of the impact of the epidemic. They are most likely to take care of sick people, to lose jobs, income and schooling as a result of illness, and to face stigma and discrimination (Report on the Global AIDS Epidemic, 2004: 1).

According to UNAIDS/WHO (2002: 4) unless the world succeeds in mounting a drastically expanded, global, effort, best current projections suggest that an additional 45 million people will become infected with HIV in 126 low and middle-income countries between 2002 and 2010. Further estimates indicated that for every case of AIDS there might be 50 to 100 other persons who are infected but because of being unaware of the fact may possibly spread the disease to others.

Unfortunately it is not easy to estimate the extent of AIDS sufferers and those infected with virus as not all cases are reported. These include people living in remote rural areas who may die from AIDS without even being diagnosed. This would suggest that by merely judging the extent of the problem by means of the cases reported would be misleading.

This section has established that HIV/AIDS is a growing problem throughout the world. The statistics look more and more frightening. As the epidemic unfolds it seems that the scale and consequences will be worst in Africa. The epidemic continues to take its heaviest toll on the continent of Africa. The devastation will be greater in the African continent because it is poorer, both financially and in human resource terms. In the next section the researcher explains why Africa is a special case.

2.5 AIDS IN AFRICA

It is generally accepted that Africa is the continent hardest hit by HIV/AIDS. According to an estimated projection produced by World Health Organization (WHO) on the global programme on AIDS, the AIDS problem in Africa is outstripping the rest of the world. The AIDS pandemic has devastated many families where over 17 millions Africans have died of HIV/AIDS related diseases since the late 1970. The epidemic claimed the lives of more than 2.4 million Africans in 2001 and in 2002 approximately 3.5 million infections occurred. (AIDS Epidemic Update, 2002: 17; Barnett & Whiteside, 2002: 9; UNAIDS, 2002). In 2003, an estimated, three million people in this region became newly infected and 2.2 million died – 75% of the three million AIDS deaths globally (Report on the Global AIDS Epidemic, 2004: 1).

By far the worst affected region in Africa is Sub Saharan Africa, which at the end of 2004 there were 25.4 million [23.4 million – 28.4] as compared to the previous two years. In 2002 there were 29.4 million people living with HIV/AIDS. An estimated 25 million adults and children were living with HIV/AIDS in sub-Saharan Africa at the end of 2003 and 2.2 million people died as a result of AIDS in 2003 (Avert, 2005: 1; Report on the Global AIDS Epidemic, 2004: 2). According to Hope (1999: 9) by the end of this century life expectancy in sub-Saharan Africa could fall to 47 instead of the average of 62 years in the absence of HIV/AIDS.

According to AIDS Epidemic Update (2004: 1) at the end of 2004 just under two thirds (64%) of all people living with HIV were in sub-Saharan Africa. Table 3 gives a summary of how the situation was in eight countries in sub-Saharan Africa by the end of 2003 (Avert, 2004: 1-2).

Table 3: HIV/AIDS STATISTICS OF THE EIGHT TOP COUNTRIES IN SUB-SAHARAN (2003)

Country	People	HIV	Adult Rate (%)	AIDS deaths	Orphans due to AIDS
Kenya	Adults	1.100.000	6.7	150.000	650.000
	Women	720.000			
	Children under 15	100.000			
South Africa	Adults	5.100.000	21.5	370.000	1.100.000
	Women	2.900.000			
	Children under 15	230.000			
Zimbabwe	Adults	1.600.000	24.6	170.000	980.000
	Women	930.000			
	Children under 15	120.000			
Nigeria	Adults	3.300.000	5.4	310.000	1.800.000
	Women	1.900.000			
	Children under 15	290.000			
Botswana	Adults	330.000	37.3	190.000	33.000
	Women	190.000			

Country	People	HIV	Adult Rate (%)	AIDS deaths	Orphans due to AIDS
	Children under 15	25. 000			
Mozambique	Adults	1.200.000	12.2	110.000	470.000
	Women	670.000			
	Children under 15	99.000			
Ethiopia	Adults	1.400.000	4.4	120.000	720.000
	Women	770.000			
	Children under 15	120.000			
Lesotho	Adults	330.000	28.9	29.000	100.000
	Women	170 000			
	Children under 15	22 000			

According to Avert (2004: 3) adults in these statistics are defined as men and women aged 15-49. This age range captures those in their most sexually active years. While the risk of HIV continues beyond the age of 50, the vast majority of people with substantial risk behaviour are likely to have become infected by this age (Avert, 2004: 3).

Infection rates in women are far higher than men. Women and girls make up almost 57% of all people infected with HIV in sub-Saharan Africa where a striking 76% of young age people (aged 15 – 24) living with HIV are female. In addition African women are at a greater risk, becoming infected at an earlier age than men. This unevenness is greatest among young women aged 15 – 24 who are about three times more likely to be infected than young men of the same age. According to recent population-based household surveys, adult women in sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their counterparts (AIDS Epidemic Update, 2004: 1). Although the present statistics are high the worst of the epidemic has not yet passed. In most regions women and girls represent an increasing proportion of people living with HIV, compared with five years ago (AIDS Epidemic Update, 2002: 32; AIDS Epidemic Update, 2004: 1; Report on the Global AIDS Epidemic, 2004: 1).

In addition to being biologically more vulnerable to infection UNAIDS (2004: 1) reports that many women and girls, particularly in Southern Africa, find themselves using sex as a commodity in exchange for goods, services, money or basic necessities – often with older men. This "transactional sex" is driven by poverty and the desire for a better life. This further makes them more vulnerable to HIV infection.

The statistics also confirm that the principal mode of transmission of HIV in sub-Saharan Africa has been heterosexual intercourse. This has been since the disease was first detected and such transmission amounts for more than 80% of infections (Hope, 1999: 2). The fact that there are no geographical limits to the spread of HIV/AIDS, the pandemic has now affected every single country on the African continent. Although Aids is evident in all African countries, there are substantial differences within Africa. In four southern African countries, the national adult HIV prevalence had risen higher than thought possible, exceeding 20% in Botswana (37.3%), Lesotho (28.9%), Zimbabwe (24.6%) and South Africa (21.5%) in 2004 (Avert, 2005: 1-2).

The incidence of AIDS in Africa is worsened by a number of factors namely:

- Africa is a third world developing continent. Developing countries do not have enough resources and infrastructures of health services. An estimated 60% of people in Africa are without access to basic health services with the most acute problems occurring in sub-Saharan Africa. Safe drinking water is unobtainable by some 150 million Africans. Too many scarce resources are centred in urban hospitals rather than in rural primary care. Therefore, people in remote rural Africa are less likely to be informed about HIV/AIDS (Hope 1999: 3).

- The most depressing factor is that some countries are pushed into a battleground, which has led to increased migration; refugee problems and the weakening of traditional stable family patterns. Due to the scarcity of resources there is a tremendous movement of people from rural to urban areas. This movement ensures a more rapid spread of HIV/AIDS in these countries. Hope (1993: 3) writing on this noted that the high number of workers whose wives live in rural areas tend to increase the number of partners and thus the rate of the spread of the virus. Poor people, who

contract HIV, moreover tend to develop AIDS much faster than individuals of higher socio economic status (Hope 1999: 3).

- According to Hope (1999: 3) Africa remains one of the poorest regions of the world. Factors that reduce the body's immune and general level of health make it easier for the spread of HIV/AIDS. These co-factors include low levels of education, crowded living conditions, malnutrition, lack of sanitation and potable water, limited access to basic services, high rate of unemployment and these are all poverty phenomena. The current drought in some parts of Africa is likely to cause malnutrition and increased poverty. The combination of all the aforementioned factors exposes people of Africa to more HIV/AIDS, which without any doubt have contributed greatly to the spread of AIDS in Africa.

In addition Crosson (2002: 1) and Van Dyk (2002: 297) mention that because sexual transmission is the primary way in which people become infected with HIV, infection with HIV is surrounded by an aura of superstition, mystery taboos, fear and double standards that many have with regard to all matters relating to sex. Because of all these accompanying negative conditions it is difficult to talk openly and rationally about HIV/AIDS and counseling people living with HIV.

UNAIDS/WHO (2002: 17) states that a fully-fledged epidemic is only now taking hold in many African countries. Greater numbers of people who acquired HIV over the past several years are falling ill. A tiny fraction of the millions of Africans who are in need of antiretroviral treatment are receiving it. Whiteside and Sunter (2000: 47) maintain that the challenge is to make them affordable to everyone. Many millions are not receiving medicines to treat opportunistic infections, either. In the absence of massively expanded prevention, treatment and care efforts, the AIDS death toll in the continent is expected to continue rising before peaking around the end of this decade. This means that the worst of the epidemic's impact on African societies will be felt in the course of the next decade and beyond.

South Africa remains one of the worst affected countries in sub-Saharan Africa. Since the study is conducted in South Africa it is therefore accurate to review its situation.

2.6 AIDS IN SOUTH AFRICA

HIV/AIDS is a substantial and rapidly growing problem for South Africa. South Africa has the highest HIV/AIDS caseload in the world, with 5.3 million people or one in five adults, living with HIV (AIDS Epidemic Update, 2004: 5; Agence France Presse, 2005: 1; Sunday Times, 2005: 1). In addition the South African Medical Research Council stated in January 2005 that there is a steep rise in AIDS deaths in South Africa, but a large number still go unreported because they are attributed to AIDS-related conditions, without the disease mentioned as the cause of death (Agence France Presse, 2005: 1). Never before in the history of South Africa, have people faced with a potential disaster of this magnitude. Statistics change minute by minute because of new identified infections and deaths. According to the recent report released by Statistic South Africa, South Africa's death rate jumped 57 percent between 1997 and 2003 with HIV/AIDS emerging as one of the main killers in the 15 to 49 age bracket. (Agence France Presse, 2005: 1; Sunday Times, 2005: 1; Venter & Brown, 2005: 2).

Speaking on Friday, 18th February 2005, statistician general, Paul Lehohla highlighted that the study into cause of death in South Africa found that between 1997 and 2003 mortality had increased steadily, up from 318287 deaths to 499 268 deaths. This represented an increase of 57 percent. Adult deaths (15 years and above) climbed by 62 percent from 272 221 in 1997 to 441 029 in 2003. A disturbing trend in the report, was the increase in mortality in the 20-49 age group, which had increased from 121 548 in 1997 to 250 936 in 2003. "The data gathered provides indirect evidence that the HIV epidemic in South Africa is raising the mortality levels of prime-aged adults in that associated diseases are on the increase"(Venter & Brown, 2005: 1-2).

There is now consensus among analysts that South Africa has currently entered a period of explosive growth of HIV/AIDS. Dr Liz Gavin, acting Deputy Director General of Statistics South Africa in the recent press release, said "We have found instances in which certain causes of death have been under-estimated. They may also be misreported on death notification forms" (Venter & Brown, 2005: 2). The British medical journal The Lancet (2005) in Agence France Presse (2005: 1) cited estimates from the South African Medical Research Council showing that the number of deaths linked to HIV/AIDS was

likely to be thrice as much as the one in the government statistical report. The World Health Organisation predicts that seven million South Africans will have died of HIV/AIDS- related diseases within the next five years (Bridgland, 2003: 1). This will definitely be the case as long as no vaccine or effective curative agents are developed and made available.

The HIV/AIDS epidemic has deep historical roots in South Africa. Its impact indicates a long, history-changing trajectory. The epidemic must be seen against this broad background. In the following section the background of HIV/AIDS in South Africa will be examined.

2.6.1 The background of AIDS in South Africa (1982-2003)

The first cases of AIDS in the Republic of South Africa were recognised on two homosexual men in Pretoria in 1982 (Whiteside & Sunter 2000, 4). The pattern of infection in South Africa as revealed by clinical cases and sero-epidemiology excluded South Africa as the original source. For the first eight years, the epidemic was primarily located among white homosexuals. Up until 1988, 178 cases were diagnosed (Sher 1996: 23-24). In July 1991, the number of heterosexually transmitted cases equalled the number of homosexual cases. Since then the homosexual epidemic has been completely overshadowed by heterosexual epidemic and the disease has spread among all race groups (Whiteside & Sunter 2000: 4).

Barnett and Whiteside (2002: 146) note that the HIV/AIDS epidemic began to spread through South Africa in the late 1980s. The 1990s saw an explosion in HIV prevalence and the already extremely high rates continue to rise. Tshukudu (2003:3) mentions that the HIV/AIDS epidemic in South Africa had grown below 1% in 1990 to above 20% in just 10 years.

According to Venter and Brown (2005: 2) HIV/AIDS is shown to have been directly responsible for almost 10 000 deaths in 1999, but no figures were made available. At the end of 2000, about 4.2 million people were living with HIV in South Africa. According to Whiteside and Sunter (2000: 4) the estimates were above the projected statistics. It was

projected that in 2000, 3.6 million would have acquired HIV. South Africa was only expected to reach 4.2 million in 2002. That showed the steady and inevitable rise in the number of infections. By the end of 2001, 4.74 million people between 15 and 45 years were HIV positive. As by the end of 2001 approximately 200 000 South Africans were living with AIDS (Love life 2001: 7).

Kramer (2003: 4) highlights that in 2000 of the nine provinces in South Africa, Kwazulu-Natal remained the province with the highest incidence of AIDS, followed by Mpumalanga then Free State, and Gauteng. Commenting on the North West, the province was rated the fifth. It is necessary to point out that this province is mostly rural and that all cases of Aids are most probably not notified. It is also important to note that while there are large provincial variations in HIV infection levels, the antenatal survey shows similar epidemic patterns for all provinces expect the Western and Northern Cape (Love Life, 2001: 6). This indicates that early and current provincial differences can be attributed more to time lags than an intrinsically lower risk of infection in some provinces.

The Nelson Mandela/Human Research Council (HSRC) study of HIV/AIDS found HIV prevalence in South African population to be high as it showed an estimated HIV prevalence rate of 11.4% at the end of 2003 (Avert, 2005: 6). Table 4 shows the HIV prevalence (%) and numbers of people tested as produced by the Nelson Mandela Study (Avert, 2005: 5).

Table 4: HIV prevalence (%) and numbers of people tested by province in South Africa (December 2003)

Province	**Number surveyed HIV+**	**(%)**
Kwazulu-Natal (KZN)	1579	11.7
Mpumalanga (MP)	550	14.1
Gauteng	1272	14.7
Free State (FS)	540	14.9
North West (NW)	626	10.3
East Cape (EC)	1221	6.6

Province	**Number surveyed HIV+**	**(%)**
Limpopo (LP)	679	9.8
Northern Cape (CP)	694	8.4
Western Cape (WC)	1267	10.7
Total	8428	11.4

The overall 2003 data showed a significant variation on HIV prevalence rate by province. The 2003 statistics compared to the statistics of 2000 reveal that Orange Free State (14.9), Gauteng (14.7), Mpumalanga (14.1) and Kwazulu-Natal still remain the most affected provinces in the country. The results of the study however indicate that Kwazulu-Natal does not have the highest HIV prevalence, as was previously thought, but rather that the Free State had the highest levels of infection followed by Gauteng and Mpumalanga.

The study further showed that in terms of absolute numbers, the majority of people living with HIV/AIDS in South Africa are Blacks. The prevalence amongst Africans, Whites, Coloureds and Indians was estimated to be 12.9%, 6.2%, 6.1% and 1.6% respectively. (Avert, 2005: 5). These statistics reflect that Blacks are possibly more vulnerable to HIV/AIDS in South Africa. However, it should be noted that Black people are the majority population group in the country and will therefore proportionally yield a greater number. There is also evidence that AIDS is spreading through all groups and is breaching class barriers.

Gender differences are also pronounced in the Nelson Mandela/HSRC study (Avert, 2005a: 5). The prevalence amongst males and females was estimated to be 9.5 and 12.8 respectively, with women at highest risk between the ages of 15 and 24, while men achieve their highest incidence some years later (Avert, 2005a: 5). The picture is particularly disturbing when viewed close up. According to UNAIDS in South Africa, young women are three to six times more likely to be infected than young men (AIDS Epidemic Update, 2004: 2). Although this difference is not great, this information is threatening. As already pointed out in the preceding sections, AIDS was first identified amongst men. The fact that presently, more women than men are infected with

HIV/AIDS may be an indication that the disease is spreading more rapidly among women than men.

Furthermore, the Department of Health study of women attending clinics in South Africa, in 2003, reflected that the province that recorded the highest HIV rate amongst all attendees (women) was Kwazulu-Natal which had a rate of 37.5%. The next highest HIV levels were found in Mpumalanga (32.6%) followed by Free State with 30.1% (Avert, 2005: 3). In spite of the differences between the rates of infection what is clear from this study is that the HIV prevalence is very high. Various reasons for the higher estimated prevalence of HIV amongst females have been suggested. One reason may be that the low social and economic status of women affects their ability to control their sexual lives. Another reason may be that women are biologically more susceptible to infection than men (Avert, 2005: 6).

Infection among young people is seen also to be increasing. Young people in South Africa have a greater probability of getting HIV than young people anywhere else in the world. Estimates suggest that more than 50% of today's teenagers will get HIV before they are 25 years old. It is stated that unless something dramatic changes, by the 2010, 128 000 of the girls and 42 000 of the boys who are 15 now will be HIV positive by the time they are 21 (Love life, 2003: 1). In South Africa, where 53% of the population is under 25 years this is a serious concern. Love life (2003: 1) attributes this to the fact that most teenagers practice unsafe sex, starting to have sex while they are too young, having multiple sex partners and not using condoms. Similar to young people around the world, many young South Africans (62%) who learn they are HIV positive believed they had faced little or no risk of contracting the virus. Unfortunately, even with access to AIDS treatment, the average life span of todays 15 year old who contract HIV is 38 years (AIDS Epidemic Update, 2004: 7).

Finally research also shows that the model of transmission in the majority of cases is heterosexual transmission (Avert, 2005: 5). The figures confirm that although the disease was first identified in white homosexual men, HIV is no longer confined to white homosexuals but has spread to all population groups and of all sexes. Whiteside and Sunter (2000: 6) mention that although there was a lot of debate around the issue of the causative agent of AIDS in South Africa, the fact that remains is that HIV causes AIDS

and is spread mainly by sex and poverty is neither a necessary nor a sufficient condition for AIDS. However, poverty perpetuates the spread of HIV.

The above discussions have established that HIV/AIDS has spread rapidly to every corner of South Africa, robbing millions of people of their lives. In the next section focus will be on the current status of HIV/AIDS in the country.

2.6.2 The current status and future projections of the AIDS epidemic in South Africa

As already indicated the most recently available evidence suggests that approximately 5.3 million South Africans are already living with HIV (AIDS Epidemic Update, 2004: 5; Agence France Presse, 2005: 1; Sunday Times, 2005: 1). Studies suggest that this toll could reach 8 million by the year 2010 (Love life, 2003: 1). There is no sign yet of a decline in the epidemic. Overall HIV prevalence among pregnant women was 27.9% in 2003 compared with 26.5% in 2002 and 25% the year before that (AIDS Epidemic Update, 2004: 5). This latest data suggest that prevalence levels are still increasing.

Of the five million infected, 500 000 already have full-blown AIDS and need treatment. According to Whiteside and Sunter (2000) by 2006, there will be as many deaths from AIDS as from all other causes. The South African AIDS Organisation (2003: 2) indicates that within three years almost 250 000 South Africans will die of AIDS each year and by 2008 this figure will rise to about 500 000. The implication is that roughly 3 million South Africans aged between 15 and 30 years today may not be there in 2010, having died of AIDS. Average life expectancy is expected to fall from about 60 years to around 40 years between 1998 and 2008 (Love life, 2001: 6).

Finally, it should be noted that AIDS statistics are provided to the Department of Health on voluntary basis by mainly hospitals. The truth is the figures provided severely underestimate the actual caseload as it is widely accepted that a great number of AIDS cases remain undiagnosed.

In the next section the researcher explores what makes South Africans to be at a greatest risk of HIV infection.

2.6.3 The dynamics of the South Africa's epidemic

According to Barnett and Whiteside (2002: 154) the ending of apartheid and election of the new government in 1994 resulted in relaxation of the draconian control on society. But these were not replaced by a strong civil society. In addition, there was no immediate redistribution of resources or lessening of income inequality. Unemployment has risen since 1994 (Barnett & Whiteside, 2002: 154). Job shedding started in the late 1970, largely due to sanctions. However it increased sharply after 1994 when South Africa joined the World Trade Organisation and import tariffs ceased. A million jobs, mostly unskilled, were lost between 1993 and 1997. This resulted in many becoming poor and poorer raising much susceptibility to HIV infection (Barnett & Whiteside, 2002: 155).

In addition the AIDS Epidemic Update (2003:4) highlights that the South African epidemic is exacerbated by:

- Social and family disruptions as a consequence of apartheid and migrant labour
- High poverty and low education levels, resulting in more risk taking behaviour and commercial sex work. Poverty is considered to a strong determinant of the spread of HIV mortality
- High mobility and a good transport infrastructure, allowing spread of the virus
- A burdened and transforming health system
- An overwhelmed and inadequate welfare system
- High levels of sexually transmitted diseases
- The low status of women in society and relationships, making it difficult for them to protect themselves in sexual relationships
- Shifting social norms which permit high numbers of sexual partners
- A resistance to change high risk behaviour, often centred around notions of culture resistance to condom usage
- A lack of clear and non-judgemental information and services for young people and denial about teenage sexual activity

- Significant denial of homosexuality in the black community and a history of poor government intervention for the gay community.

South Africa has a complex interrelationship of multiple epidemics, a heterogeneous society in transition and a government struggling to meet the needs of a united South Africa. HIV/AIDS adds to this existing situation. At this stage the only way to stop AIDS is to prevent transmission of the virus. This is only possible when one has a proper understanding of exactly how the virus is transmitted from one person to another. The transmission of HIV from person to another is the theme of the next section.

2.7 MODES OF HIV TRANSMISSION

The way in which HIV is transmitted is closely associated with the biomedical nature of the virus. Unlike wind-borne viruses and other sexually transmitted diseases (STDs), where transmission is relatively easy, HIV is difficult to contract. It cannot enter the body through the air in the same way as measles. In order for a person to become infected with HIV, it is necessary for the virus to enter the bloodstream in sufficient quantities. It must pass through an entry point in the skin and/or mucous membranes into the bloodstream (Whiteside & Sunter, 2000: 10; Barnett & Whiteside, 2002: 38; AIDS Epidemic Update, 2003: 5).

Scientists and medical authorities agree that HIV does not survive well in the environment, making the possibility of environmental transmissions remote (Centre for Disease Control, 2003: 2). The outside of the human body is covered with thick skin, which keeps out HIV as long as there are not cuts or sores. HIV can only enter another person when the blood, semen or vaginal secretions of an infected person come into contact with the blood or mucous membranes of another person (Whiteside & Sunter, 2000: 10).

Once HIV has entered the body the virus can be found in a variety of body fluids and substances such as semen, vaginal secretions, tears, saliva, sweat and urine. However, although HIV is present in the above-mentioned fluids, HIV is spread through the exchange of body fluids, primarily semen, vaginal secretions, blood and blood products.

Transmission studies strongly suggest that HIV cannot be transmitted via the following routes: touch; bodily contact; coughing and sneezing; cutlery and food; swimming pools; drinking from same glass; towels; toilets seats; pets; mosquitoes and other insects; sharing baths and showers. Furthermore, AIDS is not transmitted through the upper gastrointestinal tract or through the respiratory tract. It cannot also be transmitted through normal household contact including kissing (Lachmn, 1989: 23; Wilson, Naidoo, Bekker, Cotton & Martens, 2002: 61).

The above-mentioned body fluids are not considered significant routes of infection because they are considered as fluids with low viral concentration. The greatest concentration of the virus is to be found in the blood, and sexual sections of an infected person. As a result there are three modes of transmission – sexual intercourse, blood-to-blood contact, and mother- to-child transmission (AIDS Epidemic Update, 2003: 5-7; CDC, 2003: 1; WHO, 2000: 2).

2.7.1 Sexual transmission

According to Barnett and Whiteside (2002: 38), CDC (2003: 1), NIAID Fact Sheet (2004: 6), WHO (2000: 2), South African AIDS Organization Update (2003: 5) and Van Dyk (2001: 19) HIV is most commonly spread by sexual contact with an infected person. Sexual intercourse is the principle mode of transmission, accounting for an estimated 75 percent of infections. In the third world countries, sexual transmission accounts for even higher proportions of infections. In Africa, Asia, and the Caribbean, infections are overwhelmingly heterosexual, with an estimated less than one percent through homosexual sex (South African AIDS Organization Update, 2003: 5).

With the emergence of AIDS, sexual intercourse has become a major threat to the survival of human beings. According to NIAID Fact Sheet (2004: 6) during sexual intercourse, a number of organisms pass from one partner to the other. The virus can enter the body through the mucousal linings of the vagina, vulva, penis, or rectum or rarely, via the mouth and possibly the upper gastrointestinal tract after oral sex. Having sexual intercourse with a person who is HIV infected may result in the person being infected. It follows that the more sexual partners one has, the more likely it would be to associate with

an infected partner. Sexual promiscuity has been identified as a major factor in the rapid speared AIDS. Hubley (1995: 26) emphasises that a single encounter can be sufficient to transmit HIV. However, some researchers believe that the risk for a single act of intercourse can be as low as one chance in a hundred.

2.7.2 Vertical transmission (Mother-to-child transmission)

After sexual transmission, the next most important mode of transmission of HIV is vertical transmission or mother-to-child transmission. According to NIAID Fact Sheet (2004: 7), Van Vuren (2004: 211) and Wilson et al. (2002: 358) mother to child transmission of HIV is the major cause of HIV infection in children. Estimates by UNAIDS and WHO indicate that more than five million children under the age of 15 have been infected with HIV since the epidemic began. Mother-to-child transmission is responsible for more than 90% of these infections. Two-thirds are believed to occur during pregnancy and delivery, and about one third through breastfeeding. As the number of women of childbearing age infected by HIV rises, so does the number of infected children (Child & Adolescent Health Development Fact Sheet, 2005: 1; Joint UNAIDS/WHO, 2005: 3).

An HIV positive woman has about a 30% chance of transmitting the virus to her infant. There are more than 2 million pregnancies in HIV positive women each year, and more than 1800 infected children are born daily worldwide. Each year, more than 600 000 infants become infected by HIV/AIDS. The overwhelming majority of these births are in the developing world, especially in Sub-Saharan Africa. In several African countries, more that 30% of women attending antenatal clinics are HIV positive. Because HIV infection often progresses quickly to AIDS in children, most of the children under 15 who have been infected have developed AIDS, and most of these children have died (AIDS Epidemic Update, 2003: 7; Joint UNAIDS/WHO, 2005: 3; Hubley, 1995: 44; Van Vuren, 2004: 216).

According to AIDS Epidemic Update (2003: 7), Barnett and Whiteside (2002: 39); Centre of Disease Control (2003: 1), Van Dyk (2001: 28) and Van Vuren (2004: 216) mother-to-child transmission occurs in three ways. The first is at birth when the infant comes into

contact with the blood of an infected mother in the uterus and the second is during birth and the third is through infant breastfeeding. A woman is more likely to transmit the virus to her foetus during pregnancy if she becomes infected just before or during pregnancy, or if she has an HIV-related illness or full-blown AIDS (the last phase of the infection). The reason why a mother is more infectious at these times is because the HIV viral load is useably very high and the CD4 cell count is low during these stages of illness (Van Dyk, 2001: 28).

Babies born to HIV-positive mothers are usually born with HIV antibodies, irrespective of whether or not they have been infected with the virus. These antibodies come from the mother. If the child does not actually have HIV, these antibodies clear out off the body over a period of time. This means that an HIV antibody test is not considered accurate to the first 18 months after birth (WHO, 2000: 2). Those infants that escape infection at birth, nevertheless, run the risk of infection through breastfeeding. There is no way of telling in advance which babies will be infected. This is why women who are infected are advised not to breastfeed their children after birth (AIDS Epidemic Update, 2003: 7).

2.7.3 Blood transmission

HIV also can be transmitted by contact with infected blood. The infection through blood takes place when HIV-contaminated blood comes into direct contact with that of an uninfected person. Transmission through blood however, is apparently not a real risk for most people. For infection to take place HIV infected blood must bypass the barrier of the skin and enter directly into the body. HIV is also spread through HIV contaminated cuttings and piecing of instruments such as needles, razors, syringes and knives. It can also be transmitted through tattooing, ear piercing and contact with infected blood at the scene of an accident (AIDS Epidemic Update, 2003: 6; Lovelife, 2003: 1; NIAID Fact Sheet, 2004: 7; Van Dyk, 2001: 24-25).

The main transmissions occur through the sharing of intravenous drug-injection equipment and through contaminated blood products used in transfusions. Receiving blood contaminated with HIV will most probably lead to infection. The principle problem with injecting drugs use is that the sharing of infected needles is able to introduce HIV

directly into the bloodstream of an infected person – a highly efficient means of transmitting HIV. As a result HIV has grown more rapidly in drug – injecting populations than in any other community (AIDS Epidemic Update, 2003: 6; Barnett & Whiteside, 2002: 40; Lovelife, 2003: 1; NIAID Fact Sheet, 2004: 6; Van Dyk, 2001: 25). According to AIDS Epidemic Update (2003: 2) most of the injecting drug users are young and many are sexually active, risking double exposure to the virus. This has driven the epidemic in most part of the world.

Blood transfusion is now extremely rare because of extensive screening of the blood supply. This has been confirmed by research conducted in many countries, which showed that since the introduction of testing of blood, the number of AIDS cases through blood transfusion have decreased (AIDS Epidemic Update, 2003: 6; Van Dyk, 2001: 24). There is also no risk on contracting HIV infection while donating blood. However, it is noted that in some third world developing countries which have yet to implement such mechanisms, the risk of HIV transmissions through transfusions still remains an issue. However it is noted that despite the risks, HIV transmission through transfusion has never exceeded 10 percent of total infections, even in third world countries world wide (AIDS Epidemic Update, 2003: 6).

The modes of transmission are well documented above. It is however very important to know what factors can predispose or put people at risk of HIV infection.

2.8 RISK FACTORS REGARDING HIV INFECTION

The likelihood of HIV transmission is increased by factors that may damage the mucosal linings of the sexual parts and socio-economic factors that may make it difficult for people to protect themselves. The identified factors are discussed next:

2.8.1 Biological and sexual risk factors

This section briefly examines people's physiological and physical vulnerability to HIV infection.

- **Heterosexual intercourse:** Heterosexual intercourse is regarded as the most common way in which HIV is transmitted (Wilson et al., 2002: 61; Whiteside & Sunter 2000: 10). This is attributed to the fact that this method of sexual intercourse is the most preferred one. Transmission can occur from man to woman or woman to man through penetrative sex without a condom. In addition damage or trauma to the vagina during sex increases the chances of transmission. These conditions usually arise from STDs or from application of other substances to the body (Aggleton et al. 1989 in Tabane, 2004: 35; Whiteside & Sunter 2000: 11; Van Vuren, 2004: 214).

  Women seem to be the group at a highest risk of HIV infection because of their biological make up. Infection of a woman by a man is biologically likely than infection of man by woman. Unprotected vaginal intercourse put women at high risk of HIV transmission. A woman is the receptive partner during sexual intercourse. Infected semen is deposited in the woman's vagina and remains there for some time, which gives the virus an opportunity to gain entry into the body. Therefore, the transmission of men to women is believed to be more efficient than women to men (Van Vuren, 2004: 214; Van Dyk, 2004: 20; Wilson et al., 2002: 61; Hubley, 1995: 43).

  In addition there are many receptors in the vagina, which create a greater possibility for infection. These receptors enable the virus to successfully attach and gaining entry into the body cells. This makes females to be more susceptible to AIDS than men. Disruption of the genital tact epithelium by intravaginal spermicides, herbal agents used for 'dry sex' and violent sex especially rape and gang rape, facilitate the increased transmission of HIV from men to women. It is also believed that when a couple has sex during menstruation, the transmission of HIV from women to men is facilitated (Hubley, 1995: 43; Van Dyk, 2001: 20; Van Vuren, 2004: 214; Wilson et al., 2002: 61).

- **Anal intercourse:** Although the pattern of transmission has changed from mainly homosexual activities to heterosexual activities, anal intercourse remains a high risk-activity. The receptive partner is especially in danger of acquiring infection because of high frequency of trauma to the mucosal lining of the rectum during rectal intercourse. The wall of the lining of the anus is delicate and is easily torn when an object is

inserted which increases the likelihood of the virus to penetrate the bloodstream. Number of instances of intercourse is also related to risk. The greater the number of exposures to infected semen, the higher the risk of HIV transmission (Murphy, Brook & Brichall, 2000: 2; Van Dyk, 2001: 19; Ward, 1999 in Tabane, 2004: 39; Wilson et al., 2002: 61; Schoub, 1994: 90).

- **Oral sex:** According to Centre of Disease Control Update (2003: 1) the risk of becoming infected with HIV through oral sex is lower than that of unprotected anal or vaginal sex. During oral sex, ejaculation may take place into the mouth of the other partner, which may lead to HIV infection. However, it is noted that even a lower risk activity can become an important way people get infected if it is done often enough. The possibility of infection is even heightened if there are sores in the mouth of the recipient. Ward (1999) as mentioned by Tabane (2004: 39) points to some studies, which have suggested that, the use of oral contraceptives, diaphragms, cervical caps or intrauterine devices (IUDs) increase the risk of HIV transmission

- **Masturbation:** Masturbation can either be self-stimulation or mutual stimulation where stimulation takes place between two partners. There is no risk of HIV infection from self-masturbation provided that the semen or vaginal fluids do not come into contact with the sexual organs of another person. Mutual masturbation on the other hand is a vulnerable activity. In addition there is a slight risk if the hand used to stimulant the other person's sexual organs has cuts or sores (Mogotsi, 1996: 42).

- **Sexual transmitted diseases:** According to the South African AIDS Organisation (2003: 6) the spread of HIV in societies where heterosexual intercourse is the main mode of transmission it is largely dependent upon two main factors – the presence of other untreated sexually transmitted diseases (STD's), and uncontrolled sexual behaviour. Diseases such as gonorrhoea, syphilis and graniloma increase the probability of HIV transmission during unprotected sexual intercourse with an infected person. This is thought to occur because these diseases cause inflammation of the mucous membranes of the genital tract. In the HIV-infected partner this increases the amount of free virus and the number of virus infected cells in genital secretions. In the HIV negative partner the risk of acquiring HIV infection is increased because the

inflammation of the genital tract concentrates cells susceptible to HIV infection in the genital tissues (Barnett & Whiteside, 2002: 39; Ward, 1999 in Tabane, 2004: 39).

According to Van Vuren (2004: 215) STDs often go unnoticed or hidden in women than men. These women may therefore not seek treatment. In low socio-economic areas there is also limited access to health facilities where treatment for STDs and other genital may be obtained. This makes people more susceptible to HIV infection.

- **Other biological factors:** According to Ward (1999) in Tabane (2004: 38-39) the presence of either acute HIV infection or advanced HIV disease in the infected partner increases the risk of sexual transmission. Although individuals with symptomatic disease are also infectious to others, people recently infected temporarily have very high levels of virus in their blood and body fluids and secretions, as do people with advance disease, which make them relatively more infections to their partners. The presence of genital tract in either partner also increases the risk (Ward, 1999 in Tabane, 2004: 39).

  Genetic characteristics of the particular HIV strain to which a person is exposed, as well as genetic characteristics of the exposed person affect the risk of HIV transmission. Very small percentages of individuals have remained uninfected despite repeated exposure to HIV. It is now believed that certain individuals have genetically determined natural resistance to HIV. Some stains to HIV appear to be more infections than the others. It has been speculated that some HIV subtypes might be more infectious than other through vaginal intercourse (Ward, 1999 in Tabane, 2004: 39).

2.8.2 The social status of females

Apart from their biological vulnerability, women can also be vulnerable in societies which accord women a lower status than men. It is a well established fact that women are getting HIV infection at a younger age than men all over the world, in line with socio-sexual norms. The status of females within the family and society especially in low socio-economic communities often results in women having less control over their sexual lives.

This makes them particularly susceptible to HIV infection. This social vulnerability especially in the Black culture is related to their generally low socio-economic status. From literature, it is clear that sexuality is one of the main areas in which gender inequality is manifested in the society. Traditionally, women's roles in sexual relationships have been that of passive participants. The inequality between males and females affect women especially with regard to negotiation of monogamy and safer sex. They are not in a position to negotiate safer sex practices because they fear violence and abandonment should they try to do so. Many women are forced into unwanted sexual encounters because of life circumstances (AIDS Epidemic Update, 2003: 14; Van Dyk, 2001: 21; Van Vuren, 2004: 215-216).

Van Dyk (2001: 21) notes that sometimes-dire poverty and need drives women to prostitution. This is often considered the only way they feel they can 'survive. Their low self-image and lack of personal authority also make such women particularly vulnerable to rape. Young girls especially are often coerced, raped or enticed into sex by someone older, stronger or richer than themselves. According to a report by the Medical Research Council of South Africa as mentioned by Van Dyk (2001: 21) the majority of women in their study who reported that they had been raped, were raped between the ages of 10 and 14 years of age, and that the schoolteacher were the perpetrators in 33% of these cases.

It is well known in South Africa that older 'sugar daddies' often offer schoolgirls gifts or money in return for sex. Older men select young girls for sex because the girls were perceived to be clean. Some men begin to look for younger partners in the hope that they will be un-infected. They feel that they will avoid infection themselves if they sleep with virgins, who will inevitable be much younger than them. These young women are perceived as unlikely infected with HIV or STDs. It is mentioned that this is not a surprise in Africa if one keeps track of teenage pregnancies. She asserts that this is confirmed by ongoing studies in Botswana and Zambia (Poku, 2001: 197; Van Dyk, 2001).

In some cultures, men marry women up to ten years younger than themselves for childbearing and other patriarchal reasons. Married men often have extra-marital relation with younger women. These men are obliged to leave their home and travel long distances to find work. Once they have found work, these displaced men frequently seek

out young women and teenage girls for sex and intimacy. These girls become sexually active at a young age and do not understand the serious HIV risk they incur by having sex with older men (Evian, 2000: 193-194; Van Vuren, 2004: 216).

Berer and Ray (1993) in Tabane (2004: 41) also mention that in polygamous marriages, second and third wives are often much younger than the husband. In such relationship, the men have had more chance to be exposed to HIV, both because they are older and because they likely to have had more sexual relationships. Their women partners are then more likely to be exposed. These men may silently transmit the HIV infection to their wives without their knowing (Van Vuren, 2004: 216).

2.8.3 Poverty as a risk factor

According to Wilson et al. (2002: 10) there is clear evidence of a link between poverty and almost any epidemic. AIDS Epidemic Update (2003: 12) and Van Vuren (2004: 211) consider poverty as a strong determinant of the spread of HIV. It contributes to the spread of HIV because of social and economic factors. Poverty is viewed as accompanied by effects such as prostitution, poor living conditions, poor education, alcohol abuse, poor heath care which are major contributing factors to the current spread of HIV/AIDS (Van Dyk, 2001: 33; Van Niekerk, 2001: 146; Webster, 1991: 18-20).

Poverty is also associated with weak endowment of human and financial resources such as low levels of literacy and few marketable skills. People who are economically deprived usually have little access to education, health care facilities and other social services. As a result they are forced into becoming sex orders or to exchange sex for food and supplies. Poverty may also lead people to sell their blood for transfusion – blood which could be well be infected with HIV (Poku, 2001: 195; Van Dyk, 2001: 33; Van Vuren, 2004: 211-212; World Health Organisation, 2000: 12).

According to Evian (2000: 21) AIDS like other sexually transmitted diseases is often more common in lower socio economic countries. He gives the following reasons why low socio-economic conditions promote the spread of sexually transmitted diseases:

- In many communities women have very little control over their sexual lives, and the ways to prevent STDs. Women are often exploited and have more inferior status than men. Poverty often makes this sexual exploitation worse and this further contributes to the spread of sexually transmitted diseases.

- High unemployment promotes migrant work and family disruption. People leave their homes and therefore their loved ones, friends, familiar surroundings and local community life. In the far-away places, migrants often find themselves in lonely, unfavourable, hostile or alienating environments. There is a natural need for sex and intimacy resulting in multiple-partners sexual relationships.

- Women are often forced to sell sex to earn precious money for food and basic needs, and to help raise their children. Young girls may give sex to older men.

- People in poor living conditions often do not have easy access to health care services. Sexually transmitted diseases often go untreated and spread more easily.

- Poor education and low literacy levels help to keep people ignorant of the ways and means to avoid diseases like AIDS.

- Crime and violence is also common in cities and town, and this further stress family and community life.

- Many of the problems described above result in the breakdown of the usual traditions, customs, beliefs and cultural practices in a community. These practices usually determine the accepted sexual behaviour and constraints in a society. When these are broken down, it often results in multiple sexual partners and indiscriminate sexual behaviour.

According to Tabane (2004: 43) the case of South Africa is a good example of the relationship between poverty and HIV. Poverty especially in rural areas and the absence of access to sustainable livelihood are factors in labour mobility. Throughout the past century, men from around the Southern African region were drawn or conscripted to work in South African gold and diamond mines. They left their families behind in rural

villages, lived in squalid all-male labour camps and returned home maybe once a year. Lack of education and recreation, forced them to rely on home brewed alcohol and sex for leisure. They were isolated from traditional cultural social networks and in the new conditions often engaged in risky sexual behaviour, with obvious consequences in terms of HIV infection.

This section has established facts regarding HIV transmission. Once infected with HIV, a person is labelled 'HIV positive" and caries the virus for the remainder of his or her life. At the point of infection, a battle begins between the virus and the body's immune system. This battle proceeds through various stages before the person dies. The following section describes the stages of HIV infection with specific emphasis on signs and symptoms of HIV/AIDS.

2.9 THE AIDS DEVELOPMENT PROCESS

According to Evian (2000: 25) and Van Vuren (2004: 207) a person who becomes infected with HIV will usually go through various clinical stages that occur over a long period of time usually 5-12 years. There are however conflicting opinions as to the different stages in the progression of the disease.

In explaining the progression of HIV/AIDS Wilson et al. (2002: 51) illustrates the central role HIV viral load in disease progression and transmission. They mention that there are rapid progressors, intermediate progressors and slow progressors or long-term progressors. They assert that rapid progressors are a small proportion of individuals who develop AIDS within one to two years following HIV infection. This phase is associated with high levels of viral replication and a precipitous decline in CD4 numbers. Most of these individuals are unable to mount an effective immune response because of the depletion of CD4 cells and are not able to control viral replication. The intermediate progressors are the majority of HIV – infected individuals who are able to regulate viral replication for many years because of an effective immune response. However, over time there is a steady decline of CD4 T-Cell numbers and a slow erosion and eventual destruction of the immune system.

Slow progressors or long-term non-progressors are a small proportion of individuals who are able to control HIV viral load very effectively without the assistance of anti retroviral therapy (ART). Long-term non-progressors have low and in many cases, undetectable plasma, viral loads, with high CD4 counts and robust immune systems. According to Van Vuren (2004:208) these individuals are a lucky proportion. Many such individuals have been infected for more than 20 years

AIDS Epidemic Update (2003: 3-5) emphasises that there are four stages of HIV infection. The first stage in known as primary HIV infection and last until the body's initial immune response develops a small measure of control over the virus. During this stage people develop non-specific symptoms such as nights sweats, fever, headaches and enlarged lymph glands. The second stage is called seroconversion – a period during which the body develops antibodies to ward off HIV. After seroconverson, an HIV positive person enters an asymptomatic stage during which time he or she will generally remain clinically healthy. It takes some time for HIV to make the body weak (Soul City Life Skills, 2001: 17). The final stage is regarded as AIDS. This occurs when the CD4 blood count drops below 200 and a person become vulnerable to serious opportunistic infection.

Stages of HIV infection according to Crewe and Orkin (1992) in Tabane (2004: 51-52), Evian (2000: 25) and Wilson et al. (2002: 57) can be displayed as shown in Table 5.

Table 5: Stages of HIV infection

APPROPRIATE TIME	SYMPTOM	TIME
12 weeks	Development of anti-bodies	- Sera-conversion - Symptomatic infection
12 weeks – 7 years	Less than 10% weight loss	HIV well-mined disease episodes
7-10 years	Chronic fatigue, fever and night sweats, serious forms of herpes, thrush, more than 10% weight loss, swelling of lymph glands,	HIV disease. Severe illness (Symptomatic)

APPROPRIATE TIME	SYMPTOM	TIME
	diarrhoea, deterioration of central nervous system (in some cassia)	
10-15 years	Opportunistic infection For example: Extra pulmonary TB	AIDS Patient is dying

Van Dyk (2001: 36) notes that although HIV infection cannot in practice be precisely demarcated into separate and distinct phases with easily identifiable boundaries, it can nevertheless be theoretically divided into five phases. Barrett-Grant et al. (2001: 22-23), Evian (2000: 27-32), Folks and Butera (1997: 36) as well as Van Vuren (2004: 208-210) also agree that there are five stages of the HIV/AIDS disease namely:

- Primary HIV infection (or acute sero-conversion illness)
- The asymptomatic phase or 'silent' phase
- The minor symptomatic phase (Early HIV symptomatic disease)
- The major symptomatic phase and opportunistic disease (The medium-stage HIV Symptomatic disease)
- The severe symptomatic phase (Late-Stage HIV symptomatic disease (AIDS)

2.9.1 Primary HIV infection

The acute phase of HIV infection (also called acute sero-conversional illness) occurs within a few weeks after infection with HIV. This is a time when people sero-convert on their blood test for HIV – in other words, change from being HIV negative to HIV positive. This usually coincides with the time when an HIV antibody test will usually convert from being negative to positive. The HIV antibody test usually becomes positive 4 – 6 weeks after infection (AIDS Epidemic Update, 2003: 3; Evian, 2000: 28; Van Dyk, 2001: 37; Van Vuren, 2004: 208).

According to Van Dyk (2001: 37) this stage usually occurs 4 to 8 weeks during which most people experience non-specific flu-like symptoms such as fever, skin rash, headache, tiredness, sore throat muscle and joint pains, some swelling of the lymph glands and occasionally oral ulcers. Approximately 30% to 60% of people infected with HIV will develop this glandular fever-like illness and the symptoms of this fever will last between one and two weeks. To others this acute reaction can go unnoticed. This clinical condition is referred to as the sero-conversion illness because the problem is non-specific. It often passes unnoticed by the patient (Van Vuren, 2004: 208; AIDS Epidemic Update, 2003: 3; Evian, 2000: 28; Van Dyk, 2001: 37; Barnett & Whiteside, 2002: 31).

Because of the rapid replication of the virus, the HIV viral load is usually very high during the acute phase. Although it is possible for HIV to be transmitted at any time during the course of the disease, HIV-infected people are considered most infectious during this stage because of the high viral load. Immediate and aggressive treatment with anti-retroviral therapy (ART) at this stage may be effective in reducing the viral load to undetectable levels, or even in eradicating the virus and may possibly offer the patient a better future. Early detection is especially important after needle prick injuries, rape and other known high-risk sexual encounters. Antiretroviral therapy (ARVT) should be given in the early weeks. Unfortunately, this early detection of HIV is often missed in most patients (Evian, 2000: 28; Van Dyk, 2001: 23, 37; Van Vuren, 2004: 209).

2.9.2 The asymptomatic or silent stage

After seroconversion, an HIV positive person enters an asymptomatic stage or silent phase. In this stage an infected person displays no symptoms. The person will generally remain clinically clean for years. This is a symptom-free phase and can last ten years or more. Persons with HIV remain in good health and feel very well during this period. The only way to determine if one has the virus is to have an HIV test. During this time, the only indication that a person is infected with HIV is that he/she can test positive on standard HIV tests. Nevertheless, HIV is not dormant but very active, it continues to replicate, causing progressive destruction of the immune system. Infected individuals are often not even aware that they are infected. It can take years of infection before debilitating symptoms becomes apparent in the individual. By the time the wave of HIV

infection makes itself felt in the form of illness, the torrent of the epidemic is about to overwhelm individual. The asymptomatic phase is a marker of the "silent phase where the virus slowly but surely spreads throughout the body (AIDS Epidemic Update, 2003: 3-5; Barnett & Whiteside, 2002: 16; Evian, 2000: 29; Kramer, 2003:6; Van Dyk, 2001: 37; Soul City Life Skills, 2001: 17; Van Vuren, 2004: 209).

According to Crewe and Orkin (1992) in Tabane (2004: 51) as well as Van Dyk (2001: 37) infected individuals are often not even aware that they are carrying the HI virus in this stage, and may therefore unwittingly infect new sex partners. This is one of the most terrifying features of the disease, which makes it so difficult to control. The person will be infected and show no symptoms and yet be infectious at the same time. She/he will be able to spread the virus during this phase. Although people carry on with their work in a normal way HIV is still very active and is continuing to destroy the immune system during this stage (Van Dyk, 2001: 209; Van Vuren, 2004: 209).

The asymptomatic phase is usually associated with a CD4 cell count of between 500 and 800 cell/mm^3 (Van Dyk, 2001: 37). She further asserts that while some people remain HIV positive for many years without any manifestation of clinical disease others may deteriorate rapidly, develop AIDS and die within months. In some cases the only symptom during this phase is persistent generalise lymphadenopathy or swollen glands.

In most Third Word countries, people live with HIV infection throughout the asymptomatic stage without knowing it. If a diagnosis is made, it is invariably at the late stage when the person present at a clinic or hospital. While an HIV diagnosis is not an automatic guarantee of a person practising safer sex or injecting habits, undiagnosed HIV infection increases the susceptibility of a society to the epidemic (South African AIDS Organisation, Update, 2003: 4).

2.9.3 The minor symptomatic phase of HIV disease

In the third phase of infection, minor and early symptoms of HIV disease usually begin to manifest. This stage occurs between 3 and 7 years after infection. The individual in this

stage is usually able to carry on with his or her normal activities, despite being symptomatic (Evian, 2000: 30; Van Vuren, 2004: 209).

According to Evian (2000: 30), Van Dyk (2001: 380) and Van Vuren (2004: 209) the following symptoms are usually an indication of the minor or early symptomatic stage of HIV disease:

- Mild to moderate swelling of the lymph nodes in the neck, armpits and groin (persistent generalised lymphadenopathy)
- Occasional fevers
- Herpes zoster or shingles
- Skin rashes, dermatitis, chronic itchy skin,
- Fungal nail infections
- Recurrent oral ulcerations
- Recurrent upper respiratory tract infections
- Weight loss up to 10% of the person's usual body weight
- Malaise, fatigue and lethargy

The minor symptomatic phase is usually associated with a CD4 cell count between 350 and 500 cell/mm^3 (Van Dyk, 2001: 38).

2.9.4 The major symptomatic phase of HIV infection

The major symptomatic stage is characterised by illness and extensive destruction of the immune system. During this phase, the viral load tends to increase progressively and the immune system is seriously weakened. The immune system becomes immune deficient and the person's vulnerability to infection is increased. Major symptoms and HIV related disease begin to appear as the immune system continues to deteriorate. This phase can last from a few months to several years. It takes place between 5 – 8 years following HIV infection (Evian, 2000: 30-31; Van Dyk, 2001: 38-39; Van Vuren, 2004: 209).

During this phase the lymph nodes and tissue become damaged and the body fails to keep up with replacing damaged cells. In time, most HIV infected people develop a variety of

indicators of ill health. These signs and symptoms are usually referred to as opportunistic disease. Today, these indicators are known as AIDS Related Complex (ARC). These signs and symptoms are usually due to overgrowth of some of the body's natural flora with fungal infection and reactivation of old infection such as Tuberculosis (TB). They are as due to uncontrolled multiplication of HIV itself (Evian, 2000: 30-31; Soul City – Know the Facts, 2002: 1; Van Dyk, 2001: 39; Van Vuren, 2004: 209).

Later as the immune deficiency progress, more frequent and severe opportunistic infections occur. During this stage the person is usually bedridden for up to 50% of the day during the last month. The major symptomatic phase is casually associated with a CD4 count of between 150 and 350 cells/ mm3 (Van Dyk, 2001: 39).

According to Evian (2000: 31), Van Dyk (2001: 39) and Van Vuren (2004: 209-210), the most common signs and symptoms of the advanced immune deficiency are as follows:

- Persistent and recurrent oral and vaginal candida infections (or thrush): candida or thrush in the mouth is a common sign of immune deficiency.
- Recurrent herpes zoster or shingles
- Bacterial skin infections and skin rashes
- Intermittent or constant unexplained fever that lasts for more than a month
- Persistent night sweats
- Persistent and intractable chronic diarrhoea that lasts for more than a month
- Significant and unexplained weight loss (more than 10% of the usual body weight)
- Generalised lymphadenopathy (or, in some cases, the shrinking of previously enlarged lymph nodes)
- Abdominal discomfort, headaches
- Oral hairy leucoplakia (thickened white patches on the side of the tongue)
- Persistent cough and reactivation of tuberculosis
- Opportunistic diseases of various kinds

While the associated infection are common in HIV negative persons, the critical difference is that those who are HIV positive experience these complaints as chronic infections, and they can persist for several weeks or months. The onset of oral/vaginal candidiasis (thrush) and recurrent herpes infection, such as herpes simplex (cold sores) or herpes

zoster (shingles) are commonly the first clinical signs of advanced immune deficiency. These signs act as a marker for the onset of AIDS (AIDS Epidemic Update, 2003: 4; Van Vuren, 2004: 210).

2.9.5 The severe symptomatic phase (AIDS-defining conditions)

The symptomatic phase, as described above, usually progresses over the next year or 18 months into the fully developed AIDS phase of the disease. The immune system during this stage is in a state of severe failure. The illness that present becomes more and more severe eventually leading to an AIDS diagnosis. In the final stage of AIDS, the symptoms of HIV disease become more acute. The body becomes progressively weaker with repeated infections and tumours. The person becomes infected by relatively rare and unusual organisms that do not respond to antibiotics and the immune system deteriorate exponentially. There is total inability to defend the system against infections. The person becomes seriously ill and more persistent and untreatable opportunistic conditions and cancers begin to manifest. It is at this stage that a person moves from being merely HIV positive to having full-blown AIDS. The person eventually die from one of the sickness that AIDS has given them (AIDS Epidemic Update, 2003: 5; Evian, 2000: 31; Kramer, 2003: 6; Soul City Life Skills, 2001: 17; Van Dyk, 2001: 40; Van Vuren, 2004: 210).

According to Van Dyk (2001: 40) and Van Vuren (2004: 210) AIDS patients usually have a viral load and a CD4 cell count of below 200 cell/mm^3. This allows the development of severe opportunistic infections and HIV-related organ damage. The presence of any serious opportunistic infection is a sign that the body is not coping immunologically. The people are usually bedridden for more than 50% of the day during the last month. Death due to severe life-threatening opportunistic infections and cancers occurs within +/-one year (Kramer 2003: 6; Van Vuren, 2004: 210). While people with AIDS usually die within two years, with the development of effective anti-retroviral therapy and the prevention and treatment of opportunistic infections, infected people can expect to live reasonable lives for a longer time (Barnett & Whiteside, 2002: 32; Van Dyk, 2001: 40).

According to South African AIDS Organisation Update (2003: 5) a person, therefore, does not die of AIDS, but rather succumbs to an infection, or collection of infections. AIDS is

a catchall for the many medical conditions that arise from a weakened immune system that can no longer fight infections. It is during this stage, that medical costs escalate and jobs are lost placing enormous strain on the finances of the individual and the state.

The following are symptoms, conditions or opportunistic infection of the severe symptomatic phase as identified by Van Dyk (2001: 40-41):

- Because of continuous diarrhoea, nausea and vomiting (which may last for weeks or even for months), an AIDS patient is usually thin and emaciated. Infectious diarrhoea is often caused by infections of the bowel.
- The patient is plagued by oral manifestations of HIV infection such as oral didiasis, oral hairy leukoplakia, herpes simplex (cold sores), varicella zoster and bacterial periodontol conditions. Thrush in the mouth may become so painful that the patient is no longer able to eat.
- Persistent, recurrent vaginal candidiasis (yeast infection or thrush) is often the first sign of HIV infection in women. An increased incidence and severity of cervical cancer has also been reported in women with HIV infection. Amenorrhoea in women of reproductive age, and severe pelvic infection with abscess formation can also be associated with HIV infection in women.
- Persistent generalised lymphadenopathy (PGL) may be said to be present when lymph nodes are larger than one centimetre in diameter, in two or more sites other than the groin area, for a period of at least three months.
- Severe and recurrent skin infections such as warts, ring worm and folliculitis (inflammation of the central nervous system) occur in some AIDS patients. These conditions usually cause blisters and ulcerations.
- Respiratory infections may cause the patient to present with a persistent cough, chest pain and fever.
- Pneumonia, especially pneumocystis carinii pneumonia (PCP), is often seen in patients with AIDS. PCP is a parasitic infection of the lungs caused by a protozoon. PCP is characterised by a continual dry, non-productive cough, laboured and sometimes painful breathing, weight loss and fever. The disease is less common in black Africans.

- A wasting of the body's tissues and marked weight loss and fever are often observable in patients with AIDS.
- Severe herpes zoster (or shingles) often occurs in people with depressed immune systems.
- The AIDS patient is usually fatigued and exhausted and this can promote multiple infections such as shingles, herpes, dermatitis or skin infections and ulcerative herpes simplex and persistent generalised lymphadenopathy.
- Peripheral neuropathy, which is characterised by pains, numbness or 'pins and needles' in the hands and feet, often occurs in AIDS patients.
- AIDS patients sometimes suffer from neurological abnormalities such as HIV encephalopathy which is characterised by symptoms such as memory loss, poor concentration, tremor, headache, confusion, loss of vision and seizures.
- AIDS patents may develop cryptococcal meningitis (a fungal infection in the central nervous system) which presents with fever, headache, malaise, nausea, vomiting, neck stiffness, mental status changes, and seizures. Toxoplasma encephalitis (a protozoal infection of the brain which causes damage to the brain itself) can occur.
- Cytomegalovirus retinitis, an inflammation of the retina of the eye, often occurs in AIDS patients. It may lead to blindness. The disease is caused by the cytomegalovirus (CMV), which is often excreted in the urine, saliva, semen, cervical secretions, faeces or breast milk of immune –depressed patients. CMV infections usually occur in the late stages of AIDS when the CD4 levels fall below 50 cell/mm^3.
- Kaposi's sarcoma, a rare form of skin cancer, is characterised by a painless reddish-brown or bluish-purple swelling on the skin and mucous membranes (such as in the mouth). Kaposi's sarcoma can also occur in the gastro-intestine tract and lungs. Kaposi's sarcoma react well to chemotherapy or to alpha-interferon, but it can develop into invasive open lesions and cause death if not promptly treated. Kaposi's sarcoma is less common in black Africans.
- Lymphoma or cancer of the lymph nodes may present with enlargement of the lymph nodes, the spleen or liver.
- Tuberculosis is a very serious opportunistic infection which affects people with AIDS. According to the Statistic South Africa study, tuberculosis accounted for the highest number of mortalities and officials admit that these deaths could be linked to HIV/AIDS. Tuberculosis recorded 22 021 and 50 872 fatalities in 1997 and 2003

respectively making it the leading cause of death (Venter & Brown, 2005: 2; Agence France Presse, 2005: 1; Sunday Times, 2005: 1).

- Other sexually transmitted (STD) diseases (such as discharge from the penis or from the female urethra or cervix caused by gonorrhoea and chlamydia). Abnormal vaginal discharge is usually caused by STDs known as trichomoniasis genital candidiasis and bacterial vaginosis.

Adding to the above symptoms, conditions or opportunistic infection Van Dyk (2001: 42-43) lists the following symptoms of HIV infection in children.

- Failure to thrive and weight loss
- Prolonged fever
- Recurrent oral thrush (candidiasis)
- Chronic diarrhoea and gastroenteritis
- Tuberculosis
- Recurrent bacterial infections (casing upper respiratory tract infections, otitis media or ear infections, pneumonia, urinary tract infections and meningitis)
- Lymphoid interstitial pneumonitis or LIP (an otherwise rare respiratory or lung disease found in HIV-infected children; it is characterised by a continuous coughing and mild wheezing)
- Anaemia, pallor, nose bleeds
- Persistent generalised lymphadenopathy
- Hepatomegaly (enlargement of the liver)
- Splednomegaly (enlargement of the spleen)
- Skin conditions such as herpes zoster, herpes simplex and seborrhoea dermatitis
- Enlargement of the parotid gland and parotitis (inflammation of the parotid gland)
- Delays in attaining developmental milestones or the loss of those already attained
- Neurological abnormalities such as seizures and reduced head growth
- Severe herpes simplex infection
- Complicated chickenpox or measles
- Any other AIDS defining condition such as pneumocystis carinii pneumonia, Kaposi's sarcoma, toxoplasmosis, cytomegalovirus, etc.

Symptoms that are common to many treatable conditions in children, such as diarrhoea, recurrent fever and dermatitis tend to be more persistent and severe in HIV infected children. HIV infected children also do not respond as well as non-infected children to treatment and are more likely to suffer life-threatening complications. Furthermore, the clinical course of HIV infection in children differs significantly from that of adults. The time lapse between infection and the onset of full-blown AIDS is usually much shorter in children than it is in adults. The progress of AIDS in children may be accelerated by poor nutrition and illness such as tuberculosis, malaria and measles (Child & Adolescent Health Development Fact sheet, 2005: 1; Van Dyk, 2001: 43).

According to Van Vuren (2004: 208) it is not yet clear whether every HIV infected person will progress to develop illness and AIDS. Approximately 80% of HIV infected people will have developed AIDS within 12 years of acquiring the infection. On average it takes about 8 years from HIV infection to the development of AIDS. It seems likely that most HIV infected people will eventually develop severe immune deficiency and symptomatic disease, even if this takes 15-20 years.

It is evident from the above discussion that HIV can spread silently for many years before the infection develops into symptomatic AIDS and becomes a cause of recurring illness and, finally, death. One can remain without HIV/AIDS symptoms while infected for a very long time. Since the early symptoms are so unremarkable, many may not know that they are infected. It is therefore important for people to be tested in order to know their status so that they are able to protect themselves and access treatment if they need it. Voluntary counseling and testing is increasingly seen as an important component of prevention and will be discussed in more detail in the next section.

2.10 VOLUNTARY COUNSELING AND TESTING (VCT)

According to Baggaley (2001: 2) voluntary counseling is a process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. Voluntary counseling is viewed as having a vital role to play within a comprehensive range of measures for HIV prevention and care. It has emerged as a major strategy for the prevention of HIV infection and AIDS especially in Africa. The idea is to

provide people with access to rapid testing in an environment where they will receive counselling. If they are negative then they have an incentive to stay that way. If infected, the message is positive living. Such an intervention only works in a supportive environment and ideally where people can access some form of care (Baggaley, 2001: 2; Barnett & Whiteside, 2002: 333; Van Dyk, 2001: 96).

There are different reasons why people want to be tested. Therefore, it is important for the counsellor to explore reasons why people came for testing. Reasons that clients who want to be tested often adduce include: their partner has requested it; they want to be tested prior to getting married, before starting a new relationship or planning to become pregnant; anxiety about lifestyle especially if concerned about having had multiple sex partners; they have had recent sexual encounters in which they did not use condoms; they have been raped or assaulted; they are manifesting symptoms that are giving them cause for concern; they come for insurance purposes and other come to reconfirm a positive HIV test. Some people seek testing services because of curiosity or because they have been referred by an STD or TB clinic due to persistent tuberculosis or sexually transmitted disease (Evian, 2000: 39; Tabane, 2004: 57; Van Dyk, 2001: 238-239).

Baggaley (2001: 4) lists the following as the potential benefits of VCT:

- Improved health status through good nutritional advice
- Earlier access to care and treatment/prevention for HIV-related illness
- Emotional support
- Better ability to cope with HIV-related anxiety
- Awareness of options for prevention of mother-to-child transmission feeding
- Motivation to initiate or maintain safer sexual and drug-related behaviour.

Apart from the above-mentioned benefits, many studies show that knowing one's HIV status is instrumental in affecting behaviour change and the adoption of safer sex practices (Mkaya-Mwamburi et al., 2000; Serima & Manyenna, 2000 in Van Dyk, 2001: 96). Van Dyk (2001: 97) therefore, suggests that if voluntary counseling and testing services exist in a community, community members should be encouraged to make use of such services.

According to SAFAIDS (2002) as quoted by Tabane (2004: 59) communities affected by HIV/AIDS benefit from VCT as it contributes in the following ways:

- It changes the image of HIV/AIDS form the illness, suffering and death to living positively with HIV.
- It generates optimism as large number of person's tests HIV negative.
- It reduces stigma and enhances the development of care and support services.
- It reduces transmission.
- It enables access to preventive prophylaxis and anti-retroviral therapy where available, and access to needed clinical services (antenatal clinics, TB clinics and primary care clinics).

Voluntary counseling and testing services are essential because they empower the uninfected to protect themselves form HIV and assists infected persons to protect other and live positively. The two most important components of voluntary counseling are HIV Counseling and HIV Testing. In this context it is therefore important to know more about them.

2.10.1 HIV Counseling

According to Van Dyk (2001: 238) the HIV test is different from all other tests. It has phenomenal emotional, psychological, practical and social implications for the client. HIV tests should therefore never be done without thorough counselling

Baggaley (2001: 2-3) defines HIV counseling as "a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The intention of counseling is not to solve people's problems or prescribe treatment, but to help clients to review their problems and choices they have for dealing with these problems. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour (Baggaley, 2001: 3; Van Dyk, 2001: 10).

The two main objectives of HIV counseling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing. This is done to help clients make decision about whether or not to be tested and to provide support and facilitate decision making following testing. People often come for HIV testing in states of considerable anxiety – for their health, their family's health, their relationship and their future employment. This makes the role of counseling all the more important. It can help provide confidence to be tested and to decide on possible future courses for the benefit of client and his/her loved-ones (Baggaley, 2001: 3; Wilson et al., 2002: 70).

HIV counseling is important as it prepares people for the results of the tests. In the absence of counseling many relationships have broken up due to one partner being HIV positive and some people have lost jobs or have been rejected by their friends and family after disclosing their health status. Feelings of depression, anger and guilt might be experienced which can lead to attempt of suicide after receiving the HIV test results. This implies that everyone who has an HIV test must be properly counselled before the test as well as after the test (Evian, 2000: 50; Van Dyk, 2001: 238-239).

Fear of stigmatisation and ostracism are very real factors when one has been diagnosed with HIV/AIDS. It is the fear of rejection and isolation that cause AIDS patients the greatest pain. Stigma may actively prevent people accessing care, gaining support, and preventing onward transmission. HIV counseling is important because it reduces stigma in communities by talking about HIV/AIDS and supporting those living with the disease. Support for people diagnosed with HIV infection and those close to them involves both emotional and practical support. The uncertainty regarding the onset of illness and other problems increase the stress experienced by the individual and the family and friends. With the consent of the client, counseling can be extended to spouses, and/or other sexual partners and other supportive family members or trusted friends where appropriate (Baggaley, 2001: 3; Tabane, 2004: 60; Van Dyk, 2001: 296).

Evian (2000: 39) postulates that HIV testing should be done in a proper and ethical manner. He emphasises that before HIV testing is done, pre-and post counseling must always be offered to the patients. It is important for the patient to understand the reason for HIV tests, the nature to the test, the meaning of an HIV test, the meaning of HIV positive and negative results, and the possible psychological implication of the results and

a follow up plan. Counseling should also be carried out in an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Furthermore, counseling must be flexible and focused on the individual client's specific needs and situation (Evian, 2000: 39; Baggaley, 2001: 3).

For many patients the only evidence of HIV infection is a positive HIV test. Wilson et al. (2002: 70) mention that a person who has tested HIV positive may never experience the quality of life again. HIV positive who have had positive and helpful experience at the time of testing deal with their situations more satisfactory and are better able to talk about their fears and feelings and to plan for their future.

According to Van Dyk (2001: 238) there are two counseling contexts where HIV counseling can take place namely:

- Pre-HIV-test counseling
- Post-HIV-test counseling

2.10.1.1 Pre-HIV-test counseling

The purpose of pre-test counseling is to provide individuals who are considering being tested with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implication of being diagnosed as either HIV positive or HIV negative. Furthermore, it is aimed at finding out why individuals want to be tested, the nature and extent of their previous and present high risk behaviour and the steps that need to be taken to prevent them from becoming infected or from transmitting HIV infection (Van Dyk, 2001: 239).

It is also important to determine exactly what the client believes and knows about HIV/AIDS. The counsellor needs to correct errors by providing accurate information about transmission and prevention.

Van Dyk (2001: 240-241) emphasises that it is important to explain the following points to the client before they take an HIV test:

- There is a difference between being sera-positive and having AIDS. The HIV antibody test is not a 'test for AIDS'. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.

- The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. On the contrary, it means that he or she has been infected with HIV and that he or she can pass the virus on to others.

- The meaning of a positive and negative test result.

- The meaning of the concept 'window period' stresses the need for further testing if the person practice's high-risk sexual behaviour and tests negative.

- The reliability of the testing procedures. A positive HIV antibody test result is always confirmed with a second test and reliability of test results is usually high. False-positive or false-negative results may however occasionally occur despite the general reliability of HIV tests.

- The testing procedure. Explain how blood is drawn for the test, where it is sent, when the results will be available and how the person will be informed of the outcome.

It is important for the counsellor to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome. Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result. Finally it is important that the client be assured (if he or she is HIV positive) that medical treatments are available which can help to keep them healthier for longer (Van Dyk, 2001: 242).

Pre-test counseling is extremely important since it can be used as a vehicle to educate people about HIV/AIDS and safer sex. It is also a good tool of preparing people for the HIV test. However, it is important to mention that the choice to be tested remain the client's prerogative. Advantages of testing can be explained to the client but he/she

should not be forced to be tested. The mere knowledge of people's HIV status is helpful but will not necessarily protect them or their loves ones from infection. People should be willing to change unsafe sexual practices as well.

2.10.1.2 Post-HIV-test-counseling

Post-HIV-test counseling is a follow-up of pre-HIV-test counselling. Counseling offered after testing depends much on the outcome of the test which may be a positive result or a negative one. The aim of counseling therefore is two-folded. For a negative test result, the aim of counseling is to encourage the clients to reduce the chances of future infection. They are advised about risk reduction and safer sex. The possibility that the client is in the 'window period' should also be pointed out. For a positive test result, the counsellor must explain to the client what such test result means. The counsellor must also undertake the task of helping the client to live a healthy and happy life after diagnosis (Soul City, 2004: 23; Van Dyk, 2001: 246-247).

People react in different ways after receiving HIV positive results. Fear of pain and death are often the most serious and immediate problems. Some people might experience profound feelings of grief about the losses they are anticipating. HIV-infected people often feel that they have lost everything that is most important and beautiful to them. They experience loss of control, loss of autonomy, loss of their ambitions sexual relationships etc. Guilt and self-reproach for having contracted HIV and for having also possibly infected others are frequently expressed by HIV infected individuals. Some of them go through a phase of denial. Anger, anxiety, low self esteem and depression are also often experienced. Inwardly directed anger manifests as self blame, self-destructive behaviour or even suicidal impulses or intention (Evian, 2000: 53; Van Dyk, 2001:256-259).

According to Van Dyk (2001: 249) talking to clients about the future is one of the important therapeutic interventions that the counsellor can use. If the client shows any suicidal tendencies, emergency hospitalisation should be arranged especially if there is no one to offer support. The counsellor must ensure that the person has support after he/she leaves the office. The counsellor also needs to convey hope by explaining to client that

anti-retroviral therapy may reduce the viral load in the blood. Furthermore, the counsellor should explain to the client that opportunistic infections can be successfully treated and prevented with medication. The clients need to be encouraged to visit their family doctor or health clinic for regular medical check-ups. HIV infected individuals may live a relatively healthy life for many years. It is therefore important to convey information about safer sex, infection control and health care in general. They should be encouraged to use safer sex practices (Evian, 2000: 53; Van Dyk, 2001:246-252).

Daigle et al (1999: 3) highlight that a person diagnosed with HIV live with the uncertainty of when or how the disease will manifest itself. It is the responsibility of the counsellor to make the family and loved ones recognise the many facets of this challenge and provide needed help and support.

According to Van Dyk (2001: 246) pre- and post-test counseling should preferably be done by the same person because the established relationship between the client and counsellor provides a sense of continuity for the client. The counsellor will also have a better idea of how to approach the post-test counseling because of what he/she experienced in the pre-test counselling.

An HIV-positive test result makes a dramatic and irreversible impact on a person's life. However a person can still live a healthy and happy life for many years after diagnosis. It is therefore important that changes have to be made by the infected person to live within the constraint that are imposed the presence of the virus.

To further understand voluntary counseling and testing the next section will deal with HIV testing.

2.10.2 HIV Testing

As already noted earlier, HIV infection is usually not noticed in the first few years after infection. Later signs and symptoms may suggest HIV infection or AIDS. However, these signs and symptoms are often not specific to HIV/AIDS alone. The HIV test is often

the first and only definite evidence of HIV infection (Evian, 2000: 36; Soul City Life Skills, 2001: 116).

According to Van Dyk (2001: 57) there are three main reasons why HIV antibody testing is carried out. It is carried out for purposes of screening donated blood, the epidemiological surveillance and mapping of HIV prevalence, and the diagnosis of HIV infection in individuals. People are encouraged to make use of voluntary counseling and testing services to find out their HIV status. It is hoped that if people know their HIV status, they will be motivated to adopt preventative measure to prevent future infection (Soul City Life Skills, 2001: 116; Soul City, 2004: 21; Van Dyk, 2001: 57).

Other benefits of HIV testing according to Van Dyk (2001: 241) are:

- Knowing the result may reduce the stress associated with uncertainty,
- One may begin to make rational plans for preparing oneself emotionally and spiritually to live with HIV,
- Symptoms can be confirmed, alleviated or treated,
- Prophylactic (preventative) treatment can be considered,
- Anti-retroviral treatment can be considered,
- Adjustments to one's lifestyle and sex life can protect oneself and one's sex partners from infection;
- One can make decisions about family planning and new sexual relationships,
- One can plan for future care and orphan care.

Baggaley (2001: 3), Tabane (2004: 58) and Van Dyk (2001: 241-242) note that although there are many benefits to knowing one's HIV status testing may have negative consequences or results in communities where HIV-infected people are stigmatised. That is why UNAIDS stipulates that testing should be voluntary, and should take place in collaboration with stigma reducing activities. No one should be coerced into being tested. The decision to undergo HIV testing should be entirely voluntary. Given the possibility of discrimination, ostracism and personal recrimination that an individual diagnosed with HIV may face, it is important that confidentiality be guaranteed. As such VCT services require continued comprehensive evaluation to help adapt the services in response to evolving knowledge client needs and technology (Baggaley, 2001: 3; Tabane, 2004: 58).

According to Van Dyk (2001: 243) the result of the test must be kept absolutely confidential. However, shared confidentiality is encouraged. Shared confidentiality implies that confidentiality is shared with others. These others might include family members, loved ones, care givers and trusted friends. This shared confidentiality is at the discretion of the person who has been tested. If individuals choose not to disclose their status, they must be reassured that no information will be communicated without their prior permission to anyone. Although the result of the HIV test should be kept confidential, other professions such as counsellors and health social service workers might also need to be aware of the person's HIV status in order to provide appropriate care (WHO, 2000: 5).

Evian (2000: 39) notes that an HIV test does not tell whether people have AIDS. It only determines whether a person has been infected with the virus. A negative test usually means a person has not been exposed or infected with the HI virus or the person may have been infected but the anti-bodies have not yet been formed (the person may be in the window period). Even though the test is negative after infection, the person is able to pass on the virus to others during this 'window period'. The positive test means that the person is infected with HIV and can spread the virus to others during sex, through his/her blood or during pregnancy, childbirth or breast-feeding. This test does not reveal when or for how long the person has been infected. The test also gives no indication of the stage of infection, nor of the time it may take to develop AIDS (Evian, 2000: 36-37; Soul City Life Skills, 2001: 116; Van Dyk, 2001: 60-61).

The diagnosis of HIV infection is based mainly on the laboratory testing of blood samples. There are various types of testing methods of testing HIV in the blood. Van Dyk (2002: 57) has identified two broad categories of tests namely: HIV anti-body tests, which react to antibodies which have formed in reaction to the virus, and tests which detect the actual virus (HIV) in the blood.

2.10.2.1 HIV antibody tests

The most common HIV test is the ELISA antibody test. This test is regarded as not expensive and it is easier to use than other screening methods. It is usually done on blood (serum). The ELISA test reveals only the presence of antibodies. It does not directly detect HIV. But because antibodies are produced only in response to infection – not to mere exposure – a positive in an ELISA test for HIV is a strong indication of HIV infection. If the testing is being done for data collection and a diagnosis is not going to be given to a patient, then the ELISA test is sufficient. If, however, the testing is being done to give a diagnosis and the test is positive, a second ELISA test is usually carried out. If this is positive, then a more sophisticated test, known as the Western Blot Tests, is usually performed (Evian, 2000: 42; Soul City, 2004: 22; Van Dyk, 2001: 58; Van Vuren, 2004: 216-217; Wilson, 2002: 38).

The Western Blot Test is the most common confirmatory test. It is a highly specific method of testing. It is designed to distinguish a false-positive ELISA result from a true positive result. The Western Blot Test also is done on the blood (serum). This test has a much lower false-positive rate, because it uses HIV proteins that are separated into distinct groups or bands. The other tests that can be used to confirm a positive ELISA test is the Rapid HIV antibody tests. These tests are especially used in remote or rural areas where resources are limited. Rapid test are accurate as ELISA, and many doctors believe that the use of rapid tests in conjunction with the ELISA is more reliable than the combination of the ELISA and Western Blot tests (Evian, 2000: 42 & 49; Van Dyk, 2001: 58-59; Van Vuren, 2004: 216-217; Ward, 1999 in Tabane, 2004: 63-64).

2.10.2.2 HI virus tests

According to Evian (2000: 40) and Van Dyk (2001: 60) the most common HI virus tests are HIV P24 antigen and the polymerise chain reaction (HIV PCR) tests. These tests detect the actual HI virus (or HIV antigens) in the blood and they yield a positive HIV test much sooner after infection than do the ELISA, Western Blot and Rapid HIV antibody tests. These tests produce results within 10 to 14 days after infection.

Evian (2000: 40) notes that the HIV P24 antigen test is often useful in certain clinical situations, but its disadvantage is that it often lacks sensitivity especially for newborn babies. In infants the tests are more reliable from approximately one moth after birth. A negative test in the first two weeks after infection may be a false negative hence it should be repeated. The HIV PCR test can be used for diagnostic as well as post diagnostic purposes. This can be a qualitative test (used to diagnose an individual as HIV positive or HIV negative) or a quantitative test (mainly used to establish the number of viral RNA particles in the blood). The qualitative PCR test is especially useful in cases where early diagnosis is required and quantitative PCR test is used for post diagnostically for treatment purposes. This test is usually a reliable indicator of the infected individual prognosis and it is used to measure an individual's response to antiretroviral therapy (Evian, 2000: 40; Soul City, 2004: 23; Van Dyk, 2001: 60).

The HI virus tests are sophisticated and unfortunately they are extremely expensive. They are therefore, not widely available especially in remotes areas of the country (Barret-Grant, et al., 2001 in Tabane, 2004: 20; Van Dyk, 2001: 60).

All the tests mentioned above have an accuracy of over 99%. However, people who are in the window period and have not yet developed antibodies will not test positive. This is the reason why a series of tests some months apart are recommended to people who think they have been exposed to HIV (Van Vuren, 2004: 217).

In a nutshell it can be said that HIV testing is indispensable for any person alive today because it is only through testing that a person can know his or her status thus know from then which precautionary measures to adopt, however there are important requirements which should be met to ensure that testing fulfils this quest.

2.10.3 Requirements for voluntary counseling and testing

Baggaley (2001: 4) identified the following four requirements as basic for voluntary counseling and testing:

- **Informed Consent:** All models of voluntary counseling must ensure that counseling is truly voluntary. People should have the right to opt out or refuse testing if they do not think that it is in their best interest. In some settings it is suggested that written consent is obtained before testing. Before consenting to HIV testing the client must understand the nature of the test. A client may never be misled or deceived into consenting to an HIV test (Baggaley, 2001: 4; Van Dyk, 2001: 244).

- **Confidentiality:** The counsellor should stress the confidentiality of test results. Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. Therefore, it is important that confidentiality should be guaranteed. The counsellor should assure clients that their right to confidentiality will be respected at all times. If individuals choose not to disclose their status, they must be reassured that no information will be communicated without their prior permission to anyone. However the clients should be encouraged to share their test results with their sexual partners and health care staff. Trust between the counsellor and client enhances adherence to care, and discussion of HIV prevention (Baggaley, 2001: 4; Van Dyk, 2001: 244).

- **Legislation to prevent discrimination:** Unless seropositive people can be assured that they will not be discriminated against following testing VCT should not be promoted and supported (Baggaley, 2001: 4).

- **Quality Control:** It is essential that the quality of both testing and counseling can be assured with appropriate monitoring and evaluation as a key and planned component of interventions (Baggaley, 2001: 4).

In this section it has been shown that voluntary counseling and testing is a beneficial intervention for people who test HIV positive or negative. Knowledge of HIV status can facilitate decisions about future relationships, pregnancies and lifestyle. It helps people to plan for their and their dependents' future. People who test HIV positive can receive appropriate medical care at an early stage of the disease. As the numbers of people becoming infected and living with HIV increases, so does the number of those needing treatment. At present there is no cure for HIV however, there are therapies and treatment

that can alter the course of the disease. Based on proper treatment HIV is becoming a long-term disease that people can live with. In the following section treatment of HIV/AIDS is looked at.

2.11 TREATMENT

Enormous resources have gone into the search for a cure and vaccine for HIV/AIDS. Neither has yet been developed. While a cure and a vaccine have eluded the scientist, considerable progress has been made in treating HIV as a chronic disease. The development of combination of drug therapies that suppress the viral load has greatly reduced the number of people progressing from HIV to AIDS. These various forms of treatment can greatly improve the quality of life of those infected with HIV. The early and effective treatment of opportunistic infections, the use of anti-retroviral therapy (ART) at appropriate stages of illness, improved nutrition and the administration of complementary medicines, can have a positive impact on the immune system (AIDS Epidemic Update, 2003: 8; Barnett & Whiteside, 2002: 42; Update on National HIV & AIDS Programme, 2003: 4).

2.11.1 Strengthening the immune system

People who are infected with HIV require treatment. According to Whiteside & Barnett (2002: 338) however, prior to treatment focus should be on 'positive living' where people are encouraged to eat healthy balanced diets, avoid stress, give up harmful substances such as drugs and alcohol and lead more balanced lives.

Update on National HIV and AIDS Programme (2003: 5) emphasises that the immune system can be strengthened and opportunistic infections averted by a whole number of interventions. Measures to alleviate poverty and improve nutrition are critically important to improving the quality of life to those infected with HIV or living with AIDS. Eating healthy food will not cure HIV, but it can help to keep the immune system strong. Soul City Life Skills (2001: 133) and Soul City (2004: 31) emphasise that people should eat lots of fresh fruit and vegetable, porridge, bread, chicken and fish. The South African government views its food security and poverty alleviation intervention as an intrinsic part

of its response to HIV/AIDS and TB. The importance of good nutrition for the health of people living with HIV/AIDS is stressed by the World Health Organisation. A number of measures aimed at enhancing nutrition were announced towards the end of 2002. These included measures to counter the impact of high food prices as well as enhancing the cultivation and use of more nutritional food (Update on National HIV & AIDS Programme, 2003: 5).

According to Godan and Klonda (1988) in Tabane (2004: 81-82) people can look after their immune systems through avoiding stress as much as possible. They need to get enough rest. They should also eat well and should avoid too much alcohol and tobacco. Smoking and drinking make the body weak. It is then easier for the virus to strong and for people to get AIDS quickly. People living with HIV are also encouraged to get daily exercise. People can go for a walk, play some sports or even going dancing. Finally they should also adopt safer sexual practices. This will prevent them from getting more HIV into their body because this is likely to hasten the progress of the disease. This will also prevent infection with other sexually transmitted diseases, which also appear to increase the risk of developing AIDS (Soul City Life Skills, 2001: 133; Soul City, 2004: 31).

2.11.2 Treating opportunistic infections

When people's immune systems begin to fail people infected with HIV contract opportunistic infections such as tuberculosis, diarrhoea and thrush. Most of these can be treated or in some cases prevented by the judicious use of drugs (Barnett& Whiteside, 2002: 338).

According to Update on National HIV and AIDS Programme (2003: 4) public health facilities have a responsibility to offer treatment of opportunistic infections. People living with HIV/AIDS need to get treatment for infections to save their immune systems from unnecessary work, for example tuberculosis (TB) and sexual transmitted diseases. Treatment for TB is free and available in the public health sector. However to prevent the onset of infection common to people infected with HIV there is a need to:

- Detect cases much earlier. Presently many TB patients report at an advanced stage of illness.
- Ensure completion of the course of treatment through a nationwide system of support
- Facilitate access to good nutrition during treatment (Update on National HIV & AIDS Programme, 2003: 4).

Success in this area depends on increase public awareness and collaboration among key social partners. Tabane (2004: 84) states that communication plays a vital role in promoting all STD/HIV/AIDS prevention and clinical care for opportunistic infections. Education can be addressed through educational programmes based on sound medical, social and psychological knowledge.

2.11.3 Anti-retroviral therapy (ARVT)

According to Barnett and Whiteside (2002: 338) as the immune system deteriorates, people infected with HIV, need to be provided with anti-retroviral therapy. These drugs medicines do not cure HIV and AIDS but they can help people live longer and more healthily (Soul City Life Skills, 2001: 133; Soul City, 2004: 37).

Antiretroviral therapy involves the application of medicines that stop a retrovirus HIV from damaging the individual immune system. As already mentioned in this chapter, unlike other viruses, retroviruses are constructed from genetic material called RNA hence are not easy to treat. Antiretroviral (ART) drugs interfere with the life cycle of the retrovirus and help the immune system to recover. Furthermore, these medicines reduce viral load so people are less infectious (if they practice unsafe sex) experience fewer opportunistic infections and require less treatment. Since 1996 in countries such as the United States of America, highly active antiretroviral therapy (HAART) has dramatically reduced death from AIDS and hospital admission for AIDS complications. People have been able to return to full functioning (Barnett & Whiteside, 2002: 339; Evian, 2000: 80).

Evian (2000: 79), Soul City (2004: 37) and Van Vuren (2004: 218) describe the purpose of anti-retroviral therapy as to achieve viral suppression and reduce the level of HIV RNA to as low a level as possible, for as long as possible. ART suppresses HIV, maintaining

the integrity of the immune system and postponing development of opportunistic infections. This is in turn will result in less immune damage and will reduce any continued decline in the health status to the patient. Antiretroviral treatment is needed to improve the quality of life and survival of HIV positive- people. This would delay the onset of full- blown AIDS for people already infected but having not developed AIDS. This will help them to lead healthier lifestyles (Evian, 2000: 79; Love life, 2003: 1; Van Vuren, 2004: 218; Whiteside & Barnett, 2002: 339).

According to Soul City – Know the Facts (2002: 1) there are three main reasons of using ARTs namely:

- To reduce the risk of women passing HIV to their newborn child. This involves a short course of medicine.
- To reduce the risks of people getting HIV so that they stay healthier and livelong. Antiretroviral therapy used to treat HIV/AIDS involves taking three or more different therapy or most commonly known as High Active Antiretroviral Therapy (HAART). The different drugs work together to tackle HIV in different ways. These medicines must be taken for life and requires high physician and patient compliance to be effective (Barnett & Whiteside, 2002: 339).

The AIDS Epidemic Update (2004: 5) notes that most people who need antiretroviral treatment in many countries now can access it. However, despite the improvements, coverage remains uneven and in several respects, highly unsatisfactory. UNAIDS and WHO specify that approximately 440 000 people in low-and middle income countries were receiving antiretroviral treatment as of June 2004. This means that nine out of every ten people who need antiretroviral treatment, the majority of them in sub-Saharan Africa are not receiving it. If this low level of coverage continues five to six million people will die of AIDS in the next two years. Treating and caring for the millions of Africans living with HIV/AIDS poses an inescapable challenge to the African continent and the world at large (AIDS Epidemic Update, 2004: 4-5; Report on the Global AIDS Epidemic, 2004: 1).

South Africa is one of the African countries that adopted a policy to ultimately make antiretroviral therapy available to improve the lives of the more than five million HIV positive- people. However, comparatively few people are currently benefiting from this

commitment. According to Sunday Times (2005: 2) the South African president Thabo Mbeki, mentioned in one of his speeches in 2004 that some 53 000 people would be receiving free anti-retroviral drugs (ARVs) from 113 state-accredited health centres by March 2005. However, that target has not been met and AIDS activists estimate that only 20 000 people are receiving free ARVs. It is therefore noted that these efforts are valuable but measured against the extent of need; they are plainly inadequate. At the moment, many people living with HIV/AIDS in South Africa find it hard to get access to this service and hence are dying in numbers. The financial, emotional and physical price of the treatment is great.

Evian (2000: 180), Daigle et al. (1999: 3) and Van Dyk (2001: 71) identified the following factors as associated with the provision of antiretroviral treatment:

- The cost of drugs. Because anti-retroviral therapy is expensive, it is beyond the reach of most people who are HIV positive.

- Side effects may occur. The side effects of the medications may be disconcerting or potentially toxic. Some patients may experience side effects such as nausea, vomiting, abdominal discomfort, diarrhoeal, skin rashes fatigue, headache, anaemia, liver toxicity, fever, peripheral neuropathy and kidney stones.

- The need to maintain treatment on an ongoing basis and adherence to therapy may be a problem. A patient who wants to take anti-retroviral therapy should be committed and well informed and should be in a position to adhere to a stitch medication regime. This means they should be able to take 2 to 3 tablets three times a day (taking some dosages with food and some on an empty stomach).

- There is the potential for HIV to develop resistance to the drugs. Current treatments are permanent and life-long. It is therefore, absolutely essential for the patient to adhere strictly to the therapy. Patients often stop treatment because of side effects and this may lead to the development of viral resistance to the drugs.

- Some drug regiments are complex. Drug therapy should be monitored on a regular basis by measuring the viral load. This monitoring enables one to know whether the viruses are being successfully suppressed.

Soul City – Know the Facts, (2002: 1-2) pinpoints that although HIV cannot be cured, through HAART it is becoming a manageable chronic disease similar to diabetes or high blood pressure. It is also stated that people who take HAART need careful monitoring and must take their medicines every day without fail. If the medicines are not taken properly, the virus can become resistant to the medicines. These medicines are considered to be able to block the replication of HIV; however it is uncertain whether replication is ever total suppressed. Research suggests that once ARVT is discontinued, viral replication is usually resumed and viral loads usually rise again (Evian, 2000: 81).

According to Wilson, et al. (2002: 154) although treatment in the form of medicine is an essential tool in the response to the morbidity and mortality caused by HIV/AIDS, people living with the virus still need to have access to care and support to cope successfully with HIV/AIDS. Care could include the medical, social educational and spiritual aspects. Examples include ongoing counselling; help with cooking and or cleaning; food parcels; material support; wound care; basic hygiene; supervision of drug taking and treatment of tuberculosis.

Because hospital care is expensive, Van Dyk (2001: 327-328) mentions that home based care is often the best way to look for someone with AIDS. It involves giving care to individuals in their own homes when their families, their extended families or those of their choice support them. The main goal of community home-based care programmes is to provide the organisational structures, resources and framework that will enable the family to look after its own sick members. The family and community are empowered to cope effectively with the physical, psychological and spiritual needs of those living with HIV/AIDS. The family is supported by a multidisciplinary team and complementary caregivers consisting of a medical practitioner, nursing supervisor, social worker, health educator, physiotherapist, occupational therapist, AIDS health promotion workers, volunteers, traditional healers, religious healers and religious leaders. Home-based care will only be as successful as the ability of the identified team to meet the needs of the

client in the home environment (Daigle, 1999: 4; Evian, 2000: 299; Frohlich, 1999 in Van Dyk, 2001: 327).

According to Daigle et al. (1999: 4) care in the home for the person with HIV or AIDS occurs on a continuum. It begins when a person is first diagnosed with HIV/AIDS, and it can continue through the course of the illness until death. During the time of death, if possible the family can involve other terminal care agencies such as hospice associations, cancer associations and AIDS organizations, to assist in managing a dying family member. Social workers, clinical psychologists, bereavement counsellors are often experienced in dealing with these issues and may be very helpful (Evian, 2000: 299).

Ultimately, AIDS treatment and care will only be affordable and sustainable if HIV prevention is effective and only then can the spread of AIDS be halted. Lovelife (2003: 2) emphasises that antiretroviral treatment is not a cure and an HIV+ person is still infectious and must always practice safe sex. According to UNAIDS business as usual spells disaster. A massive effort is needed to achieve a response on scale that matches that of the AIDS epidemic. Without invigorated HIV prevention strategies that deal boldly with the epidemic, the world is unlikely to gain the upper-hand over AIDS in the long run (AIDS Epidemic Update, 2004: 5).

This section has established that the diagnosis of the presence of HIV infection was once a sentence of death. Now with the advent of newer drug therapies and improved access to health care, some view AIDS as more of a chronic illness. It has been argued that the use of antiretroviral therapy can lead to a drop of a number of deaths. People are expected to live for more than ten years with the disease and a compromised immune system. However in the absence of treatment, infected individuals can expect to experience periods of illness that increase in frequency, severity and duration. South Africa is challenged by the prospect of a vast and growing burden of illness and death associated with AIDS. The financial price of treatment is great. The implications on human development are extensive. HIV/AIDS is among the greatest challenges to sustainable economic, social and civil society. In the following section focus will be on impact of HIV/AIDS on the South African society at large.

2.12 THE IMPACT OF AIDS IN SOUTH AFRICA

The rate at which AIDS is spreading in South Africa will have far reaching implications tearing at the fabric of social life in this country. It undermines all aspects and all sectors of the entire society. An increase in sickness and death will have implications on the population, economy, education, health, individual, household and welfare services.

2.12.1 The demographic impact of AIDS

According to Barnett and Whiteside (2002: 167) demography looks at populations and their dynamics. It is concerned with the numbers, growth rates and structure of populations. It measures and predicts size and growth rates, structure by gender and age and key indicators like birth, death and fertility rates, life expectancy and infant as well as child mortality.

The most direct demographic consequence of AIDS is an increase in mortality (Barnett& Whiteside, 2002: 168). An analysis of South Africa's death registration data shows a steep rise of mortality in the past six years. The official statistical SA agency released a new report on the causes of death on 18th February 2005 which indicates that South Africa's death rate jumped 57% between 1997 and 2003 with HIV/AIDS emerging as one of the main killers (Agence France, 2005: 1; Venter & Brown, 2005: 2; Sunday Times, 2005: 1).

Detailed demographic surveillance is providing further evidence of steep rises in mortality. One such survey, conducted in rural area of Kwazulu-Natal province, which has high HIV prevalence among pregnant women, has confirmed a sudden massive rise in adult mortality starting in the 1990s with AIDS constituting the leading cause of adult death (48%) by 2000. These AIDS mortality rates will almost certainly worsen in the coming years, since HIV prevalence levels in this particular province rose steeply in the late 1990s (Hosegood, Vanneste & Timaeus, 2004 in AIDS Epidemic Update, 2004: 8).

These AIDS mortality rate clearly indicates that the overall impact will be that South Africa's population will decline dramatically. A study released by the Pretoria based

University of South Africa has concluded that the pandemic is set to reduce the countries population by as much as 12 million. The study approximated that without HIV/AIDS South Africa's population would top 61 million in 2015, however, the effects of the disease would leave no higher than 49 million (International Hope HIV Updates: 2003: 1).

According to Barnett and Whiteside (2002: 174) mortality rates crucially affect life expectancy indices. The lower the death rates, the more people will survive through an entire age cohort, and thus the number of years lived will be greater. The higher the death rates, the fewer people will survive through an entire age cohort, and thus the number of years that a new born infant can expect to live will be lower. The above-mentioned study indicates that life expectancy in some of the worst hit provinces could reach as low in eight years. At present South Africa has a population of 45 million of which more than five million are estimated to be infected with HIV/AIDS (International Hope HIV Updates: 2003: 1).

Anthony Kinghorn and Malcolm Steinberg of HIV Management Services reported that within 3 years almost 250,000 South Africans will die of AIDS each year (AIDS Epidemic Update, 2003: 2). The projections indicate an increase of mortality in South Africa. AIDS has been identified as the major cause of deaths of adults aged 15-44. However, HIV/AIDS does not only affect adult mortality. Mother to child transmission means increased infant and more particularly child mortality. According to Barnett and Whiteside (2002: 173) between 13% and 45% of children born to infected mothers are infected. Many survive beyond their first birthdays, but sadly most do not reach their first birthdays. Thus the greatest impact is on child rather than infant mortality.

Barnett and Whiteside (2002: 169) conclude by emphasising that the demographic impact of HIV/AIDS is largely unstoppable. The population will grow more slowly and the overall structure of the society will change. The demographic effects that have been outlined are the origins of the economic and social consequence that will be explored next.

2.12.2 Impact on the economy

A healthy economy is essential for the well-being and self-sufficiency of any country. Report on the Global AIDS Epidemic (2004: 2), Whiteside and Sunter (2000: 6), Poku (2001: 193) and AIDS Epidemic Update (2003: 4) agree that the economy is likely to suffer the most as a result of HIV/AIDS. AIDS is likely to reduce the growth rate of the labour force as it primarily strikes the working-age population. AIDS is a real threat to the productivity of all commercial firms. Organizations survive by providing services or producing other kinds of output. Business organisations aim to make profit. According to Barnett and Whiteside (2002: 242-243) HIV/AIDS raises costs, reduces the productivity of individual workers and alters the firm's operating environment through:

- Increased absenteeism, the result of employee ill health or because staff, particularly women, take time off to care for sick members of their families or because funeral ceremonies are frequent and time-consuming;

- Falling productivity: workers whose physical or emotional health is failing will be less productive and unable to carry out more demanding jobs;

- Employees who retire on medical grounds or who die have to be replaced and their replacements may be less skilled and experienced;

- Recruitment and training of replacement workers incurs costs for an organisation;

- Employers may increase the size of the workforce and hence payroll cost to cover for absenteeism;

- As skilled workers become scarcer, wages rates may increase;

- The business environment may change with investors reluctant to commit funds if they think AIDS and its impact will compromise their investments and returns.

According to Kramer (2003: 21) and Van Vuren (2004: 214) South Africa is more dependent on skilled labour and is already battling with a skills shortage. AIDS will exacerbate this and raise remuneration and replacement for companies. If managers, engineers, technicians and all other skilled workers are frequently absent from their work because of AIDS-related illnesses, economic output is bound to be affected. Barnett and Whiteside (2002: 243-244) mention that it is not in the interests of an employer to retain workers who are unable to perform and who are chronically sick. Legal protections provide most employees with days of paid and unpaid sick leave. Once these are exhausted the person is dismissed. Therefore, employees may force themselves to come to work fearing that if they don't they will lose their jobs. But they will not be effective while they are there. Loss of skilled and professional staff could hamper business and government operations, and possibly slow economic growth (Barnett & Whiteside, 2002: 243; Kramer, 2003: 21).

The study of African enterprises found that HIV-related absenteeism accounted for 37% of increased labour costs and AIDS absenteeism accounted for a further 15% (Barnett & Whiteside, 2002: 244). In addition Kramer (2003: 21) notes that indirect cost of AIDS include 45% loss in turnover/profit, 10% sick/compassionate leave, 10% in new recruitment and training, 10% legal costs, 5% of motivation/productivity loss and 20% in management and labour meetings.

As already mentioned business organisations activities are profit driven. Barnett and Whiteside (2002: 247-248) mention that in certain circumstances, HIV/AIDS could reduce the absolute number of potential customers by altering the 'demographics' of a society. The demographics of HIV/AIDS reduce numbers of consumers in the 25-49 year age group. In 2001, Deutsche Bank looked at soft drinks manufacture Amalgamated Beverage Industries (ABI) and found that the epidemic will adversely affect demand for the company products and it was estimated that the shrinking 'young' population will reduce sales growth by 12.5% over the next ten years (Barnett & Whiteside, 2002: 249).

HIV/AIDS is a real threat to economic growth. Through its impact on the labour force, and the economic sector there is a high risk that development and growth will be negatively affected. This might result in some companies being forced to close down.

2.12.3 Impact on the health sector

People with HIV/AIDS have a range of health care needs. Most HIV-related conditions can be managed effectively at the primary care level. However, as the disease progresses demand changes. Care is needed for both acute, treatable illnesses and terminal conditions. The epidemic has created a need for robust, flexible health systems in many governments. Health budgets and systems are strained by extending prevention and care for sexually transmitted diseases, counseling and testing, prevention of mother-to-child transmission services and HIV treatment. In settings where anti-retroviral drugs are available new systems are required to manage complex therapies and ensure adherence to treatments (Barnett & Whiteside, 2002: 308; UNAIDS, 2002: 50).

Epidemic Update (2003: 4) notes that HIV/AIDS is currently a substantial part of health care spending in South Africa. The direct cost on micro level includes those of screening, diagnosis, treatment and providing information as the loss of productivity and increased mortality. Government expenditure on health services is growing, and may be expected to account for the major share of the country's annual national budget. Increased demand is from people who are not normally users of health care: young adults. (Barnett & Whiteside, 2002: 308; Van Vuren, 2004: 213; Whiteside & Sunter, 2000: 6).

An increase in illness also increases the burden of care. The scale of this additional demand is particularly problematic. Health care sectors have difficulty in meeting basic medical care needs. Already, there under-resourced health services are not able to cope with the increased burden of care. In some cases patients are being discharged to their homes, and there has been an increase in home-based care of AIDS victims. Concurrently the human resources that are expected to provide these services will also be depleted by the epidemic (Barnett & Whiteside, 2002: 308; Van Vuren, 2004: 213; Whiteside & Sunter, 2000: 6).

The effects of HIV/AIDS are enormous. The challenge of the health care sector is to manage the burden on without shifting unsustainable burden on to individuals, families and communities.

2.12.4 Impact on the educational sector

The school is the place where children can acquire new knowledge and life skills. Education is crucial in the life of any child. However, AIDS is a significant obstacle to children achieving universal access to primary education. Education faces both supply and demand side impacts (Barnett & Whiteside, 2002: 310; Van Vuren, 2004: 212).

Impact on demand: Demographic impact results in smaller numbers of children needing education. Fewer children are born and many HIV-infected infants do survive to school age. Enrolment may be further affected by household economic difficulties and the need for children's labour. The school population is expected to reduce dramatically as more and more children are taken out of schools so that they can work as carers in their families or shoulder the responsibility of managing the family as heads of the household (Van Vuren, 2004: 212).

According to Barnett and Whiteside (2002: 311) as well as the Report on the Global AIDS Epidemic (2004: 2) children, especially girls, from AIDS-affected families are already often withdrawn from schools to compensate for loss of income through a parent's sickness and related expenses, to care for sick relatives and look after the home. These families may also take their children out of school because they cannot afford school fees (UNAIDS, 2002: 52).

In addition Van Vuren (2004: 213) mentions that as the disease spreads and starts affecting adolescents and the younger age groups, fewer children will be admitted into schools. Teachers are likely to have to cope with poor performance on the part of the learners who are either infected with or affected by the disease. Poor performance will also affect the prospect of children who rely on scholarships to further their education.

Impact on supply: The education system is also affected when staff becomes infected and affected. According to Barnett and Whiteside (2002: 311) all teachers are at risk and there are indications that they may be at greater than average risk. Their status and income create opportunities for high-risk behaviour. Increase in HIV infection among teachers means that there is shortage of school-teachers. Absenteeism among teachers and

pupils has increased, and sick leave request has become more frequent. As the suffering and deaths brought about by the disease start making their impact in the classroom, morale will drop and schools will be confronted with the need to provide emotional support to both educators and learners (AIDS Epidemic Update, 2003: 2; Van Vuren, 2004: 213; UNAIDS, 2002: 52; UNICEF, 2003: 3).

Finally, this section will examine the impact of AIDS at the individual, household and welfare level. This is where the impact is felt first and worst. But it is also here, beyond the obvious clinical and medical consequences, that it is it hardest to measure.

2.12.5 Impact on the individual, households and the welfare sector

In the absence of treatment, infected individuals can expect to experience periods of illness that increase in frequency, severity and duration. A few individuals may through a combination of appropriate lifestyle, good nutrition and good luck, not fall ill. However for most, as CD4 cell counts decline, so does their state of health. Thus individuals who are infected always confront an impact on their health. The infected person invariably need a great deal of care, which can place an intolerable burden on the family, particularly since caring for a person living with AIDS may place the caregiver at risk of becoming infected. Furthermore, in most cases the infected persons also face an impact on the resources they have at their disposal. The disease may also exhaust the individual's financial resources. Individual resources may not be affected if one is fortunate enough to have an insured medical benefits or he/she lives in a society where care is provided free by the state and this is currently not the case in all poor countries (Barnett & Whiteside, 2002: 183; Van Vuren, 2004: 212).

The impact of HIV/AIDS on the South Africa's households can be severe. Generally, households are able to achieve food security when they can produce sufficient amounts of nutritious food, earn enough cash income to purchase food, and rely on social support networks for assistance. The HIV/AIDS epidemic is eroding each of these coping methods. It reduces households' capacities to produce and purchase food, depletes their assets and exhaust social safety nets. As greater numbers of youths, and adults succumb to the disease, there will be fewer economically active people to support and care for

children and elderly people (AIDS Epidemic Update, 2002: 31; Barnett & Whiteside, 2002: 187-189; Poku, 2001: 196; Van Vuren, 2004: 212).

Furthermore, AIDS put the family under pressure where people have to cope with a person suffering from AIDS. The infected person will require medical care and possibly special foods, thus increasing demands on household resources. Escalating medical costs have to be met, yet the family's income earning capacity is being depleted as members of the family have to forego work opportunities to stay at home and care for infected parents and/or siblings. (AIDS Epidemic Update, 2002: 31; Barnett & Whiteside, 2002: 187-189; Van Vuren, 2004: 212).

AIDS takes away the income and production capacity of family members that are sick, at the same time as creating extraordinary care needs and rising household expenditure on medical and other costs, such as funeral expenses. On average, AIDS care-related expenses can absorb one third of household's monthly income. Families may have to use their savings, sell assets such as land or livestock, borrow money or seek support form the extended family. They also have to reduce spending on housing and clothing. In South Africa and Zambia studies of AIDS-affected households – most of them already poor – found that their monthly income fell by 66%- 80% because of coping with AIDS related sickness (Report on the Global AIDS Epidemic, 2004: 2). The loss of income, additional care related expenses, the reduced ability of caregivers to work, mounting medical fees and funeral expenses collectively push affected households deeper into poverty (UNAIDS, 2002: 51).

According to the Report on the Global AIDS Epidemic (2004: 1) the epidemic impact is particularly hard on women and girls as the burden of care usually falls on them. Girls drop out of school to care for sick parent or for young siblings. Older women often take on the burden of caring for ailing adult children and later, when they die, adopt the parental role for the orphaned children. They are often also responsible for producing an income. These women may be isolated socially because of AIDS-related stigma and discrimination. Stigma also means that family support is not a certainty when women become HIV-positive. They are too often rejected, and may have their property seized when their husband dies (AIDS Epidemic Update, 2002: 31-32; Report on the Global AIDS Epidemic, 2004: 1).

According to South African AIDS Organization Update (2003: 2) welfare will face the challenge of dealing with those debilitated by AIDS and the increase of the elderly whose adult children die prematurely. Of particular concern is the impact on children.

The growing number of orphans is an extremely worrying development. Literally thousands of children are being left orphaned and homeless on a daily basis as the deadly HIV/AIDS sweeps across the globe. It is estimated that 20% to 40% of the children of HIV positive mothers will develop AIDS and probably die before the age of five (Whiteside & Sunter 2000: 71). However, 60 to 80 percent will not be infected but remain orphaned. It is estimated that by the year 2010, there will be over 40 million children left orphaned by this horrendous disease. Up to 95% of these children will be living in sub-Saharan Africa (Network for Good Report: 2003: 2). This is threatening since every child needs financial and emotional support and the care of their parents as they go through different stages of life. Without support, AIDS orphans and Street Children update (2003: 1) has warned that these children are in danger of slavery, diseases, or being forced into prostitution to survive. Since they have no money to survive and family support, these children end up on the street (Van Dyk, 2001: 334-335).

The majority of South Africans are already affected by this epidemic as it impacts on family members, friends and colleagues. The consequence of this is that many people end up deprived of basic social services.

The above section has provided a general overview of the impact of HIV/AIDS on South Africans. The epidemic is expanding much faster with its associated mortality rates and societal effects. The impact of AIDS on the population, health care services, education, economy, individual, household and welfare sector may lead to dramatic decline in the South African population, growing expenditure in the health care services, a loss of productivity, a burden on family life, more AIDS orphans and poor school performance. It has been argued that epidemic has very far-reaching consequences. HIV/AIDS is erasing decades of heath, economic and social progress, reducing life expectancy by year, deepening poverty, and contributing to as well as exacerbating food shortages. To meet these challenges, the worldwide response must outpace the epidemic itself. An effective

response demands committed, urgent, and sustained action by alliances of individuals, organizations and governments.

The following section looks at responses to the HIV/AIDS epidemic, where priorities have been and where they should have been.

2.13 PREVENTION STRATEGIES

Barnett and Whiteside (2002: 195) state that the greatest challenge for those who assist individuals to deal with the awful consequences of the AIDS epidemic is to develop interventions and methods of support. HIV/AIDS has succeeded in joining people around the world in common consciousness about its threats and implications. It is the only disease to have a dedicated United Nations Organisation – UNAIDS charged with the single aim of confronting it. Since there is no known cure for AIDS, prevention of HIV infection has remained critical (Barnett& Whiteside, 2002: 4; UNAIDS, 2005: 2; Van Dyk, 2001: 80).

According to Barnett and Whiteside (2002: 328) as well as Van Vuren (2004: 217-218) there are different range of interventions of preventing the spread of HIV/AIDS and most of these interventions have been biomedical and behavioural.

- **Biomedical**: The aim is to ensure that if someone has sex with someone who is infected, the risk is reduced. This includes the treatment of sexual transmitted diseases and the use of condoms. Sexual transmitted diseases compromise the sexual organs by creating lesion and ruptured membranes, making transmission of HIV into the bloodstream much easier. It is estimated that a person with a STD is three to five times more likely to be infected with HIV than a person without one. Sexual transmitted diseases management and control has been viewed as a key element of any HIV prevention programme. Biomedical intervention also involves provision of safe blood and blood products. Testing all donated blood and anti-selection – discouraging people in thigh-risk groups from donating. Mothers are also encouraged to take anti-retroviral therapy to cut down the risk of passing HIV on to their unborn babies. Medical researchers believe that the best hope for the epidemic is a vaccine. Such a

vaccine seems a long way off. However, many hope that one-day there would discover an HIV vaccine to prevent people from getting infected with HIV (AIDS Epidemic Update, 2003: 8; Wilson, et al., 2002: 62; Barnett & Whiteside, 2002: 328-330).

- **Knowledge, attitude and behaviour**: This set of intervention seeks to prevent people from being exposed to HIV. People have to make decisions to protect themselves. People are encouraged to stick to one partner and delay the first experience of sexual intercourse. People are also encouraged to take precautions when touching blood or blood fluids. Using of effective contraceptives such as condoms is also emphasised. Much has been written about this second set of intervention. However, it is increasingly recognised that knowledge is not enough. Most people are aware of HIV/AIDS. The problem is they do not see themselves as a risk (Barnett & Whiteside, 2002: 331; Wilson, et al., 2002: 62-64).

Many researchers agree that there has been a failure in dealing with HIV/AIDS so far. The above-mentioned responses have been inadequate and generally ineffective (Barnett & Whiteside, 2002: 4; UNAIDS, 2005: 2). Unfortunately, prevention has not worked in most of Africa. As already noted earlier South Africa's death rate jumped between 1997 and 2003 with HIV/AIDS emerging as one of the main cause of death. The release of the latest statistics on the causes of death come a week after President Thabo Mbeki declared in his state of the nation address that his government's plan to fight AIDS was "the best in the world" (Agence France, Presse, 2005: 1; Sunday Times, 2005: 1; Venter & Brown, 2005: 2).

UNAIDS (2005: 1) asserts that failure to control the spread of HIV/AIDS implies that new ways to fighting the epidemic must be found. The time of quick fixes and emergency responses is over. The argument is that policy makers and activists do not look beyond biomedical and behavioural interventions. They do not see the importance of factors that determine susceptibility to infection, that frame the behaviours that put people at risk. Responses must take account of determinants of the epidemic and address them. There is a need to balance the emergency nature of the crisis with the need for sustainable solutions. The principle of successful prevention is to ensure that people are not exposed

to the disease, or if they are, they are not susceptible to infection (UNAIDS, 2005: 1; Van Vuren, 2004: 217; Whiteside & Barnette, 2002: 333).

According to Whiteside and Barnett (2002: 333) in addition to the biomedical and behavioural interventions there is a need of 'upstream' intervention. The goal is to empower people to make decisions that reduce risks of infection, or to stick to existing behaviours that have the same effect. Currently prevention programmes are not reaching the people who need them, especially two highly vulnerable groups – women and young people (Report on the Global AIDS Epidemic, 2004: 1). Therefore, focussed efforts that protect these vulnerable groups are viewed as essential and will be discussed below:

- **Empowerment of women**

As highlighted earlier in this chapter the AIDS epidemic is affecting women and girls in increasing numbers. HIV infections are massively concentrated among women. These trends point to serious gaps in the AIDS response. Poverty, lack of education, poor access to health care and jobs, and social and cultural practices all contribute to women's lack of power and control over their decision-making. This powerlessness makes women especially vulnerable to HIV infection (AIDS Epidemic Update, 2004: 7; AIDS Epidemic Update, 2003: 14; Van Vuren, 2004: 211).

In most countries, most women do not know how to protect themselves against HIV infection. Social norms impose a dangerous ignorance on girls and young women, who often are expected to know little about sex and sexuality. That lack of knowledge magnifies their risk of HIV infection. Women and girls need more information about AIDS. A recent UNICEF survey found that up to 50% of young in high prevalence countries did not know the basic facts about AIDS (AIDS Epidemic Update, 2004:3-5). Yet the vulnerability of women and girls to HIV infection stems not simply from ignorance, but from their pervasive disempowerment. Most women become HIV infected through their partner's high-risk behaviour, over which they wield little if any control. In order to prevent the high infection rates of women, the root causes of their vulnerability, their legal, social and economic disadvantages must be addressed (AIDS Epidemic Update, 2004:3-5; Report on the Global AIDS Epidemic, 2004: 1).

In many places, HIV prevention efforts do not take into account the gender and other inequalities that shape people's behaviours and limit their choices. According to UNAIDS (2004: 1) for many women the "ABC" prevention approach (Abstinence, Being faithful and reducing number of sexual partners, and condom use) is insufficient. Many HIV strategies assume an idealized world in which everyone is equal and free to make empowered choices, and cannot to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality women and girls face a range of HIV related risk factors that men and boys do not encounter. These factors are embedded in the social relations and economic realities of their societies. Strategies to address gender inequalities are urgently needed. Specifically, more work is needed on right-based approaches to the epidemic; to empower women who are most vulnerable. Empowering of women must address harmful practices, which contribute to the spreading of AIDS (AIDS Epidemic Update, 2004:3-5; UNAIDS, 2004: 1).

According to AIDS Epidemic Update (2004: 50) the fact that the balance of power in many relationships is tilted in favour of men can have life-or-death implications. Women often lack the power to abstain from sex or to insist on condom use. A recent study among women attending antenatal-care clinics in Soweto, found that women were more likely to be HIV positive in relationships where men wield considerably more power and control that they do (Dunkie et al., 2004 in AIDS Epidemic Update, 2004: 4). Therefore, it is suggested that special attention must be paid to prevent infection within marriages. Women need greater power and skills to help decide the terms of sexual relationships and at the same time the HIV risk of their male partners must be reduced. Concrete action is necessary to prevent violence against women such as tougher laws on rape and sexual harassment; ensuring access to property and inheritance rights, basic education and employment positions; and providing capital to assist women to become entrepreneurs (Stephenson & Obasi 2004 in AIDS Epidemic Update, 2004: 5; Barnett & Whiteside, 2002: 333; UNAIDS, 2004: 17).

Van Dyk (2001: 94) mentions that women and young people can be empowered by being taught communication skills, negotiation skills, assertiveness, decision-making strategies, self-esteem, self-efficacy, life skills and the fundamental of competent sexual behaviour, problem solving and conflict resolution. Through these skills they can be empowered to

address their own health concerns and find solutions to solve their own problems. Empowered people are in a better position to implement effective HIV prevention programmes.

- **Behaviour change programmes especially for young people**

According to Van Vuren (2004: 211) 50% new infections are now accruing in young people aged between 10 and 24, with young women more prone to becoming infected than young men. The latest estimates are that 7000 young people are being infected with HIV every day (Van Vuren, 2004: 211). More than three quarters (77%) of young South Africans living with HIV are female (AIDS Epidemic Update: 2004: 7). UNAIDS and WHO stipulate that the future trajectory of the HIV/AIDS epidemic depends on whether the world can protect young people everywhere against the epidemic and its aftermath. Young people need to be treated as a priority in all HIV/AIDS related activities. Effective prevention among young people is essential (AIDS Epidemic Update, 2002: 5; AIDS Epidemic Update, 2004: 7).

UNAIDS (2005: 3) notes that one of the main driving forces of the epidemic in South Africa is sexual behaviour, and if it were to change the spread of the epidemic will diminish. Van Vuren (2004: 217) notes that as sex is the main mode of transmission, it is here that winning strategies are needed. Good sexual health is seen as paramount (Van Vuren, 2004: 217).

Protecting the rights of young girls is viewed as a key to lowering HIV prevalence among young people. In order for this to occur, it would require that the freedom of women become integrated into black culture, as gender oppression has always been a large problem (Report on the Global AIDS Epidemic, 2004:1; UNAIDS, 2005: 3).

Furthermore, young people need access to confidential health information and condoms (Report on the Global AIDS Epidemic, 2004: 1). To support the behaviour change needed for safer sexual practices, the South African government has expanded the provision of both male and female condoms. Various surveys – mainly by independent researchers and Human Science Research Council have confirmed increase use of condoms, easy access to

condoms and government clinics as the major source of free condoms (Update on the National HIV and AIDS Programme, 2003: 3).

- **Preventing mother to child transmission of HIV**

Supplying the mother with a short course of AZT and Nevirapine drugs prior to birth and the infant after birth, has been shown to reduce HIV transmission from mother to child as much as 30 percent. Furthermore, in the case of nevirapine the dosage regimen is much simpler and more cost effective; the mother requires a single dose of the drug whilst in labour and the baby a single teaspoon of the syrup at birth (AIDS Epidemic Update, 2003: 9).

The programme to prevent mother-to-child transmission of HIV by providing Nevirapine to mother and baby is in place in South Africa. Most provinces are now extending the provision of this service to more facilities (Update on the National HIV and AIDS Programme, 2003: 3; AIDS Epidemic Update, 2003: 9). However fear of discrimination still prevents many women from using this service. Negative attitude can result in people denied the treatment, care and support they need. They discourage people from being tested. According to the Update on National HIV and AIDS Programme (2003: 8) government is therefore intensifying its campaign against discrimination.

The prevention of mother-to-child transmission is viewed as involving more than simple provision of antiretroviral drugs. It also requires appropriate counseling and testing services as well as support from mother and infants, including counseling on infant feeding options. An HIV-infected woman should receive counselling, which includes information about risks and benefits of different infant feeding options and specific guidance in selecting the option most likely to be suitable for her situation. The final decision should be the woman's and she should be supported in her choice (Joint UNAIDS/WHO Press Release, 2000: 2).

The above discussions have again emphasised that HIV is a real threat to the survival of many. Vaccines can provide a form of protection against disease, but they are not yet available for HIV. The most effective intervention is the empowerment of the two

vulnerable groups – women and young people. Furthermore all people need to be encouraged to change their unsafe sexual practices.

2.14 CONCLUSION

This chapter has established that South Africa has entered the epidemic phase where the rapid spread of AIDS is experienced. HIV/AIDS has changed the lives of individuals, ruined their health, caused their deaths, and left survivors to mourn. It is changing not only individuals' lives but also the trajectories of the whole societies. This overview of HIV/AIDS demonstrates the complexity of the epidemic. Current efforts have failed to make a significant impact, with the result that the HIV/AIDS epidemic will continue to wreak havoc in communities where it takes hold. New efforts to prevent infection that are addressing the social context in which behaviour takes place will hopefully achieve much needed containment of the epidemic.

In this chapter it has been indicated that the disease has implications far beyond the individual bodies that it destroys. It has social and economic consequences. The most prominent issue is the number of children who will be orphaned by losing their parents to AIDS. Amongst the most threatened are children from 'infected' household who are affected both before and after the deaths of their parents. The consequences of not caring for affected children will be felt throughout society for generations. To avert this social disaster it calls for imaginative responses from both the public and private sectors. The following chapter will focus on issues surrounding AIDS orphans.

- CHAPTER 3 –

AIDS ORPHANHOOD AS A SOCIAL PROBLEM

3.1 INTRODUCTION

The HIV/AIDS epidemic has altered and will progressively alter the demographic structure of many societies. In chapter 2 it was shown how HIV/AIDS is cutting away the middle generation of society. Population pyramids are becoming indented. This chapter focuses on one of the most affected group, the orphans or vulnerable children created by the epidemic. Under normal circumstances the young are cared for by their parents and later provide support for those parents however, this has changed. So far, the AIDS epidemic has left behind an estimated 15 million children under the age of 15 orphaned worldwide and the worst lies ahead (Avert, 2005: 1; UNICEF, 2004: 1). Barnett and Whiteside (2002: 199) note that the bare statistics are troubling. They tell of a generation of children deprived of their childhood.

In times past it was usually war or neglect or famine or poverty that resulted in a child being orphaned. Now many children who are being orphaned are as a result of HIV/AIDS. 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. According to a Children on the Brink Report as mentioned by Tracey (2005: 1) by 2010, at least 44 million children will have lost one or both parents to AIDS. This report reveals the fact that AIDS has become a social nightmare creating international communities of orphans at an alarming rate. With the staggering death toll that HIV/AIDS takes, it is easy to overlook the challenges faced by the people the disease leaves behind. These orphans, the majority of whom are HIV-negative, are at enormous risk of growing up without adequate health care, food, education or emotional support (Avert 2004: 3; Deame, 2001: 2; Robbins, 2004: 1).

Estimates from the UNAIDS/WHO AIDS Epidemic Update (2004: 1) reflect that at the end of 2004, 37.2 million adults and 2.2 million children were living with HIV and deaths among those already infected is expected to increase for some years even if prevention programmes manage to cut the number of new infections to zero. Ruiz-

Casares (2001: 2) notes that for every adult who die as a result of AIDS, four or five children are left behind. According to UNAIDS, executive director Peter Piot, "more children have been orphaned by AIDS than people who developed AIDS" (Ruiz-Casares 2001: 2). With the HIV – positive population still expanding UNICEF (2003: 2) maintains that HIV/AIDS will cause unprecedented suffering among children for at least the next decade if not longer.

Although the number of AIDS orphans is rising in most parts of the world there is a major crisis brewing in Africa. Africa is the hardest hit by the disease – more than 12 million children under the age of 15 have been orphaned by the disease. Because of the ongoing epidemic, children in Africa are becoming orphans in overwhelming numbers (Africa's child, 2005: 1; Tracey, 2005: 1; UNAIDS, 2004: 1). This crisis is most acute in sub-Saharan Africa. Around 90% of AIDS orphans live in sub-Saharan Africa and the number is increasing daily. The number of AIDS orphans in the region is projected to double or triple by 2010 (Africa's child, 2005: 1; Avert, 2004: 1; Robbins, 2004: 1; Ruiz-Casares, 2001: 3; UNAIDS, 2004: 1).

However, the orphan crisis is not restricted to sub-Saharan Africa. This region is hardly alone in facing such wrenching ramifications of the AIDS pandemic. Other regions especially in the Caribbean and Asia are expected to experience large increases in the number of children orphaned by AIDS (Barnett & Whiteside, 2002: 198; UNAIDS 2002: 1;). At the end of 2001 there were an estimated 1.8 million orphans living in South and South-East Asia; 85, 000 in East Asia and the Pacific; 330, 000 in Latin America; 250,000 in the Caribbean and 65,000 in North Africa and Middle East (Avert: 2004, 1). Furthermore, with infection rates in highly populous countries such as China projected to skyrocket, so too are the number of AIDS orphans there (Laino: 2002, 3). India had 1.2 million AIDS orphans in 2001 and predicted to rise to 2 million in five years and 2.7 million in ten years (Boseley, 2002: 1).

But statistics do not capture the misery that HIV/AIDS can bring to children. The death of a parent pervades every aspect of a child's life from emotional well-being to physical security, mental development and overall health. According to Bartholet (2000: 13) it is not only the raw numbers that make this orphan crisis unlike any ever seen. Most of these children do not have AIDS but are in danger of slavery, dying of

childhood diseases or being forced into prostitution to survive. AIDS affects children long before their parents die. The toll taken by the disease begins during the period of illness, continues through death and bereavement and will likely to persist into adulthood if adequate support and protection are lacking. What is more, the stigmatisation and discrimination that people affected with HIV often live with is passed onto their children, making their fight for survival that much more precarious. The strain that these children endure, watching their parents die and then forced to forage for themselves could create a generation of horribly disaffected people (Avert, 2004: 3; Tracey, 2005: 1; UNAIDS, 2000: 2; UNICEF, 2004: 1; UNICEF, 2003: 1).

The onslaught of AIDS on people of reproductive age is increasing the numbers of orphans at such a rate that communities cannot rely on traditional means caring for these children. The children, who have often watched their parent die alone and in pain, are left in a world where AIDS has unravelled such traditional safety nets as the extended family and in household where not a single adult is able to earn a living. This is particularly true in many sub-Saharan African countries lacking adequate basic social services. The inability of communities to respond adequately and appropriately to the situation has resulted in social, psychological and economic deprivation for the children. The absence of parental protection and care, combined with many other factors, has contributed significantly to the increase in deaths of children. This is likely to continue for the long term if nothing is done (Avert, 2005: 1; Avert, 2004: 3; UNAIDS, 2000: 2).

This chapter seeks to address the issue of aids orphan-hood as a social problem. Specifically it speaks to four points. Firstly, given the nature of the problem it focuses on how big the problem is. Second, it addresses the social emotional implications of rising statistics and difficulties faced by AIDS orphans. Thirdly it focuses on the rights of AIDS orphans. Finally, the chapter seeks to understand the threat the HIV/AIDS epidemic poses on AIDS orphans' skill development and to propose a strategy for curtailing this threat. To consider these issues it is first necessary both to define the concepts orphan and AIDS orphan.

3.2 DEFINITION OF CONCEPTS ORPHAN AND AIDS ORPHAN

Throughout history a child who has been deprived of natural framework for love, food, shelter, physical protection, learning, guidance, and preparation for adult life, has been seen as the world's most unfortunate creature. Ruiz-Casares (2001:1) argues that differences in orphan definition have programme and policy implications. It is therefore imperative that researchers explicitly state their own understanding and usage of the term orphan.

Ruiz-Casares (2001: 2) points out that those local terms for orphans vary from poetic to prosaic and definitions vary by age and whether one or both parents have died. Webb (1997: 3) argues that standardised definitions of orphans are still needed. This is because there are such issues as orphans reverting to non-orphan status when the surviving parent (usually the father) remarries. Also orphans themselves are likely to marry at an earlier age. There are always orphans who grow out of the age bracket used in definitions, such as reaching the age 18, yet in reality they will just be as vulnerable as the next child is. In some African cultures, there is no definite age barrier of an orphan as long as one is not yet married. The other concern is that the orphan status of girls below the age of 18 who themselves, become parents is unclear.

Hope (1999: 94) defines an orphan as a child who is motherless or who has lost both parents. UNAIDS defines orphans as children below the age of 15 who have lost either their mother or both their mother and father (Whiteside & Sunter, 2000: 80). These definitions contain two important elements and distinctions: on one hand, there is a child who may have lost one or both parents: on the other, there is an emphasis on maternal orphan hood, as it leaves infants in particularly vulnerable situation.

Saoke and Mutemi (1994: 3) suggest that an orphan is a child, not older than 18 who has lost either or both parents. This is because their findings indicated that orphans who had lost their father have immediate felt needs as those who had lost their mothers. The argument is that in the Africa cultural sense, there is no definite age barrier of an orphan as long as one is not yet married. Therefore this suggests that the

definition of and orphan should include any unmarried person who is not self supporting.

Nyandiya-Bundy (1997: 9) classifies orphans into three different categories. Maternal orphans are children under the age of 18 whose mothers have died. Paternal orphans are children under the age of 18 whose fathers have died. Double orphans are children under the age of 18 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. Maternal and paternal orphans "graduate" into being double orphans since the death of a spouse usually followed by the other especially in AIDS cases (Nyandiya-Bundy, 1997: 13).

For the purpose of this study an orphan is defined as a child under the age of 18 who has had at least one parent die. A child whose mother has died is known as a maternal orphan; a child whose father has died is a paternal orphan. A child who has lost both parents is a double orphan.

Before 2002, UNAIDS defined AIDS orphans as children who before the age of 15 have lost their mother to AIDS. In 2002 UNAIDS changed their definition of AIDS orphans to children who before the age of 15 have lost either one or both parents to AIDS (Avert, 2003: 13). The definition was reviewed because if one parent is infected, it is likely the other will be infected too and will die soon. Furthermore, the exclusion of paternal orphans was seen as a great oversight, bearing in mind the large amount of absentee mothers for paternal orphans (Barnett & Whiteside, 2002: 200).

In the context of this study the term AIDS orphan refers to any child who before the age of 18 has lost parent/s due to AIDS.

The point is that definitions are important and there is no final way of deciding who is or is not an orphan, it is a social role and varies from place to place and culture to culture. Since the study is conducted in South Africa it is important to understand the African view of orphanhood and this will follow in the next section.

3.3 ORPHANHOOD: THE AFRICAN PERPECTIVE

Hope (1999: 94) argues that the definition of an orphan in many African societies is the loss of the mother, as women are the primary care givers. Children are not considered to be orphans if they lose their father. This is due to the primary role of nurturing played by the 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. Hunter and Williamson (1996: 2) further state that the death of a mother has dramatic psychosocial consequences as children loose love and nurturing, whereas the loss of a father may mean loss of economic support only. 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.

According to Avert (2004: 2) almost throughout sub-Saharan Africa, there have been traditional systems in place to take care of children who lose their parents for various reasons. Nyandiya-Bundy (1997: 6) states that there used to be no orphanhood in most traditional African societies. This is because paternal or maternal relatives customarily adopt orphans. A child in most African societies grows up being surrounded by “small and big fathers” and “small and big mothers”. The possibility that a child might exist for whom there were no parental substitute within the kin network was not entertained in African culture. This means the family in African culture remained the universally effective context for handing casualties connected with death within its ranks. Missionaries set up some orphanages and children’s homes in the colonial period, but they were not widely used nor usually perceived as relevant to the African social need (Kurewa, 1999: 41). Institutional care was viewed as unacceptable in most parts of Africa (Barnett & Whiteside, 2002: 207).

Avert (2004: 2) notes that the deep-rooted kinship systems that exist in Africa extended family networks of aunts and uncles, cousins and grandparents, are an age-

old social safety net for orphans, and it has long proved itself resilient even to major social chances. Throughout Africa, children orphaned have been absorbed into extended families. But the onslaught of HIV slowly but surely erodes this good traditional practice by simply overloading its caring capacity by the sheer number of orphaned children needing support or care. The capacity and resources are now stretched to breaking point, and those providing the necessary care, are in many cases already impoverished (Avert, 2004: 1-2; Robbins, 2004: 1; Barnett & Whiteside, 2002: 199; United Nations Children's Fund, 2003: 1).

HIV also undermines the caring capacity of families and communities by deepening poverty due to loss of labour, the high medical treatment and funerals (Avert, 2004: 2). According to UNICEF as quoted by Du-Venage (2002: 2) as well as Barnett and Whiteside (2002: 209) within the community there is reluctance to take in or help orphans because of the general economic climate and stigma associated with AIDS. Many people feel that they can barely feed, cloth and send their own children to school, let alone assume additional responsibility for orphans. Some fear that the orphans themselves may be infected with AIDS. They are rejected on the basis of the perceived immoral sexual habits of their parents coated with fear of contracting the disease. This has been brought about by what Overall and Zion (1993: 4) identify as the theory of "blaming the victim". This is whereby there is a tendency to identify other people as scapegoats who are then labelled as guilt and deserve the fate.

The HIV/AIDS epidemic confronts people with a new situation. Many people remain poor and will be further impoverished by the epidemic itself. The growth of the AIDS orphans' population is now a global phenomenon and is set to accelerate over the coming decades. The following section provides an overview of the extent of the situation.

3.4 THE EXTENT OF THE PROBLEM OF AIDS ORHANS

According to Avert (2004: 4) it is very difficult to estimate the number of children orphaned by AIDS each year, but whatever the figures, it is clear that there is an enormous problem. In the following paragraphs the extent of AIDS orphanhood is

reviewed worldwide, in Africa, in South Africa and in the North-West Province of South Africa.

3.4.1 World wide

The increase in AIDS orphaning is one of the major challenges facing many countries. According to North-West Population Trends and Development Report - HIV/AIDS Perspective (2004: 37) one of the worst consequences of AIDS is that large numbers of children are orphaned as a result of parents dying from AIDS. Some of these children are HIV-positive themselves – having been infected by their mothers either at birth or through breast milk.

Estimates show that by mid 1997 ten million children under the age of 15 had lost their mothers to AIDS worldwide. According to UNAIDS, by the end of 1999, 570 000 children were infected worldwide (Ruiz-Casares, 2003: 2). By the end of 2000, the HIV/AIDS crisis had created more than 13 million orphans worldwide (Deame, 2001: 1). At the end of 2001 the AIDS epidemic had left behind 13.2 million orphans worldwide (Barnett & Whiteside, 2002: 198; Laino, 2002: 3).

Presently it is estimated that there are 15 million children worldwide who have lost a parent or both parents to AIDS. More than 90 per cent of children orphaned by AIDS are in sub-Saharan Africa, and the numbers are increasing daily. In African countries that have already had long, severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope (Avert, 2004: 1-2).

For the moment, the rate of AIDS orphans continues to rise because there are still more newly infected individuals joining the pool of people living with HIV every year than there are people leaving it through death. According to Avert (2005b: 1) during 2004 some 4.9 million became infected with the human immunodeficiency virus and the year saw 3.1 million deaths from AIDS - a – high global total. The overwhelming majority of these people, some 95% of the global total, live in the developing world. This proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for

prevention and care fuel the spread. With infection rates projected to rise, so too are the number of AIDS orphans.

Deame (2001: 1) states that by 2010, the total orphan population in 34 African, Asian, and Latin American countries with severe HIV/AIDS epidemics is projected to reach 44 million. This is considered that it will create a child-care crisis never before seen in any war, famine, or other tragedy.

3.4.2 Africa

Children orphaned by AIDS are found in almost every country of the world. In some countries, there are only a few hundred or a few thousand. In Africa, there are millions. All have suffered the tragedy of losing one or both parents to AIDS (UNAIDS, 2001: 1). AIDS orphans in Africa are regarded as the largest and fastest growing category of children in difficult especially circumstances. These children have also been labelled "children in distress" or "children on the brink" (UNAIDS, 2003). They grow up in deprived and traumatic circumstances without the support and care of their immediate family. As the number of adults dying of AIDS rises over the next decade, an increasing number of orphans will grow up without parental care and love and will be deprived of their basic rights to shelter, food, health and education (UNAIDS, 2003).

As already mentioned the area in Africa south of the Sahara desert, sub-Saharan Africa is regarded as the region hard-hit by HIV/AIDS. The emergence and rapid spread of HIV/AIDS has been phenomenal by any standard and the region has one of the highest rates of infection in the world. The region has just over 10% of the world's population, but is home to over 60% of all people living with HIV. An estimated 3.1 million adults and children became infected with HIV during the year 2004 and AIDS killed approximately 2.3 million people in the same year (Avert, 2005: 1).

Presently AIDS is the leading killer in sub-Saharan Africa and therefore more than 90% if AIDS orphans live in sub-Saharan Africa (Avert, 2004: 1; Barnett & Whiteside, 2002: 198; Deame, 2001: 1; Hope 1999: 93). AIDS has already orphaned

more than 12 million African children. This numbers are projected to increase since millions more children currently live with sick and dying parents (Robbins, 2004: 1). By 2010, this number is expected to climb to more than 18 million (Laino, 2002: 3; UNAIDS, 2004: 1). It is further expected that in many African countries by 2010 orphans will make up 15% of all children under 15 year old (UNICEF, 2003: 2). Botswana, Namibia, Swaziland, Zimbabwe, Central African Republic and South Africa are expected to have the highest proportion of children orphaned as a result of parental deaths caused by AIDS. This is expected to create a child-care crisis never before seen in a war, famine or other tragedy (Deame, 2001: 2; UNICEF, 2004: 1).

According to UNAIDS (2000: 1) before the onset of AIDS about two percent of all children in developing countries were orphans. In 1998, wars in Africa killed 200 000 people whereas AIDS killed 2 million people on the continent (Ruiz-Casares, 2003:2). By 1997, the proportion of children with one or both parents dead as a result of AIDS in some parts of Africa had increased to 7% and in some cases reached an astounding 11% (Barnett & Whiteside, 2002: 198). By 1999, ten percent and more children were AIDS orphans in some African countries. At the end of 1999 the estimated numbers of orphans living in some of the worst affected countries were 211 000 in Burkina Faso, 90 000 in Ethiopia, 58 000 in Namibia, 97 000 in Nigeria, 371 000 in South Africa, 447 000 in Zambia and 623 000 in Zimbabwe (UNAIDS, 2000: 1). At the end of 2001 the total number of AIDS orphans in Africa was 11 million (UNICEF, 2003: 2).

At the end of 2003 there were, for example, an estimated 1.8 million orphans living in Nigeria, 650, 000 in Kenya and 980,000 in Zimbabwe. These numbers are expected to increase as the epidemic develops. According to a report issued by UNICEF (2003: 1) the staggering number of African children already orphaned due to AIDS is only the beginning of a crisis of gargantuan proportions, and the worst is yet to come. It has been estimated that the number of children orphaned by AIDS in Africa will rise dramatically in the next 10-20 years especially in southern Africa (Avert, 2004: 1).

Zambia is one of the countries that have hit the hardest by HIV/AIDS. According to Online News hour (2002: 1) “It is very hard to find a family in Zambia that hasn’t

been personally touched. It's very hard to find a child that hasn't seen or witnessed a death related to HIV/AIDS". The estimated number of children orphaned because of AIDS in Zambia at the end of 2003 was 630 000 and it has also been estimated that the number of orphans will rise to nearly one million by the year 2014 (Avert, 2004: 2; Saluseki, 2003: 1).

According to Barnett and Whiteside (2002: 208) the majority of orphans in Botswana are children whose parents have died from AIDS-related infections. UNAIDS have estimated that 120 000 children in Botswana, had lost their parents to AIDS by the end of 2003 (Avert, 2004: 6). Malawi has been struggling with high levels of HIV infection which is made worst by extreme poverty. The AIDS crises has had a crippling on the country's children and UNAIDS estimated that Malawi had 500 000 children orphaned by AIDS at the end of 2003 (Avert, 2004: 7). Zimbabwe has one of the worst AIDS epidemic in the world and it has so far left behind an estimated 980 000 orphans (Avert, 2004: 3). It is believed that the worst affected children are those in rural areas, where there have also been shortages of drugs, food and other resources. According to Boseley (2002: 1) Zimbabwe had an orphan rate of 17.6% with more than three-quarters due to AIDS. It is further estimated that by 2010, 21% of children will be orphans and 89% will be due to AIDS.

Already there are, for example one million orphans living in Nigeria and 890 000 in Kenya (Avert, 2003: 1). These numbers will increase as the epidemic develops. It has been estimated that the number of children orphaned by AIDS will rise dramatically in the next 10-20 years, especially in southern Africa. In Lesotho more than a quarter of all the children will be orphaned – four out of five from AIDS (Boseley, 2002: 1). Hall (2005: 3) notes that about four out of every ten adults in Swaziland are HIV-positive. In this country about 70 000 children are said to have lost their parents to AIDS.

According to McGreal (2001: 1) in countries afflicted by war, such as Sierra Leone, rape has fuelled the spread of the disease and the numbers of children left behind. In Rwanda, where close to one people died in genocide, nearly 250 000 children were already been orphaned by AIDS in 2001. Many of the children left behind are themselves HIV- positive, although few know it.

The above statistics reflect that a serious situation exists in Africa. The epidemic has vastly increased the numbers of orphans in Africa. AIDS is generating orphans so quickly that family structures can no longer cope. Caring for them within the extended family is desperately hard. Levels of care are variable, and some end up on the streets of the cities while others are drawn into soldiering (Barnett & Whiteside, 2002: 211; Robbins, 2004: 1). In either case these lives are hardly a preparation for the future as a member of a household or a community, least of all as a citizen. As these orphans grow into youth and adulthood, there are serious implications for the societies in which they will live their lives. These implications will be discussed later in this chapter.

3.4.3 South Africa

According to UNAIDS (2004: 2) some countries have yet to experience the full impact of parental deaths as a result of AIDS. Barnett and Whiteside (2002: 210) state that there will be a boom in South Africa's Aids orphan population during the next decade. South Africa currently has a high proportion of children who are not continuously cared for by either parent, and very high rates of care by aunts and by grandmothers (Avert, 2004: 1; UNICEF in Du-Venage, 2002: 1; Whiteside & Sunter, 2002: 2). Presently there are about 250 000 AIDS orphans in South Africa (Mesatywa, 2005: 1). This number is expected to rise to 1.5 million by 2010 (Avert, 2005: 1). In addition Medical Research Council Estimates showed that unless significant action is taken, by 2015, about 15% of all children under the age of 15 will be orphaned (Mesatywa, 2005: 1).

UNICEF as mentioned by Du-Venage (2002: 2) notes that in developing countries, the norm is about 2 percent of children to be classed as orphans however; in South Africa that figure is more than 17 percent. This is due to the history of displacement of people to implement the racially segregated society envisaged during the years of apartheid, combined with the migrant labour system. The epidemic inserts itself into this already fragile family environment, and one of its worst consequences is the creation of AIDS orphans.

Whiteside and Sunter (2000: 80) state that South Africa is witnessing the emergence of child headed households and the conversion of facilities designed for early childhood education into de facto residential homes. According to them it has been estimated that Kwazulu-Natal for instance will face nearly 500 000 AIDS orphans by the year 2010. Briefing the Media at parliament on Monday, 07/03/05 Mike Waters of the Democratic Alliance social development said there were an estimated 83 000 child-headed households in South Africa, run by children under the age of 18 (Mesatywa, 2005: 1).

According to Tshukudu as quoted by Irin News (2003:1) when the parents die of HIV/AIDS, in African culture it is the duty of the extended family to care for children left behind. 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).

Furthermore, UNICEF 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 (Du-Venage, 2002: 2; Barnett & Whiteside, 2002: 209). 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). Government officials concede that they are overwhelmed by the enormity of the problem. South Africa which has the highest number of people with HIV will have to cope with millions of children orphaned by AIDS by the end of the decade (Du-Venage, 2002: 2).

Since the study is conducted in the North-West Province of South Africa, a brief discussion of the situation of AIDS orphans in the province is reviewed in the next section.

3.4.4 North-West Province

According to North West Population Trends and Development Report – HIV/AIDS Perspective (2003: 37) about 15 728 children in the North-West Province were newly orphaned in 2002. A total of 10 745 of these new orphans were as a result of AIDS.

The projected number of orphans expected in the North-West by 2021 as estimated by Demographic Information Bureau according to a low and high impact scenario will be 515 378 000 and 764 328 000 respectively (North West Population Trends and Development Report – HIV/AIDS Perspective, 2003: 37). In both scenarios there is a drastic increase in the number of orphans by 2021. This means that whatever the magnitude of orphans due to AIDS, the real problem is already known and it will be much greater. Table 6 presents a projected orphan population in the North West 2001-2021 (North West Population Trends and Development Report HIV/AIDS Perspective, 2003: 37).

Table 6: Projected orphan population in the North-West Province 2001 – 2021

Impact	2001	2006	2011	2016	2021
Low	22.468	67.540	119. 310	341.359	515.378
High	28.766	86.464	150.467	436.568	764.328

Although statistics are high UNAIDS (1996: 1) notes that statistics do not capture the misery that HIV/AIDS can bring to children. There are children who face the trauma of watching their parents grow sick and die. Furthermore, there are children who themselves are abandoned or orphaned, often become in turn –street children. For many neither money nor time is available for normal schooling to continue. However, opting out for school may help with short term needs bit the long term, it entrenches the household's poverty and the children at greater risk of becoming infected with HIV. The result is a vicious circle linking poverty, food insecurity and HIV/AIDS. The following section is devoted to the specific issues around difficulties faced by AIDS orphans.

3.5 THE SOCIO-EMOTIONAL IMPLICATIONS OF THE RISING STATISTICS OF AIDS ORPHANS AND DIFFICULTIES FACED BY AIDS ORPHANS

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. HIV/AIDS may cause extreme poverty, lack of social networks, as well as lack of sufficient psychological and economical support. There is a concern that AIDS orphans might come to constitute a "lost generation" of young people who have been marginalized and excluded for much of their lives (Avert, 2004: 3). The fact that children orphaned by AIDS are more vulnerable than children orphaned in other ways will become clear in the detailed discussion of the following implications of this social problem.

3.5.1 Poverty

According to UNAIDS (1999: 2) the onset of AIDS, in many developing countries, marked the beginning of a transition from poverty to complete destitution. Factors such as loss of household incomes, the cost of treating HIV-related illnesses, and funeral expenses frequently leave orphaned children destitute. The reality is most bleak in the worst affected areas of sub-Saharan Africa, where over 50% of the population lives below the poverty line. Of the many vulnerable members of society, young people who have lost one or both parents are among the most exposed of all (Avert, 2003a: 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. In communities where adult deaths are high, food supplies often dwindle. Many face the constant difficulties of living with poverty and deprivation (Deame, 2001: 2; Doka, 1994: 36; Newsweek, 2000: 15; Robbins, 2004: 1; UNAIDS, 2004: 3; UNICEF/UNAIDS, 1999: 4; UNICEF, 2003: 2).

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. The World Bank study in Kagera, Tanzania showed that even in 'richer' households 50% of orphaned children were wasted and had a very low weight for their height (Barnett & Whiteside, 2002: 201).

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. The report offers an analysis of seven basic deprivations that children feel and that powerfully influence their futures. UNICEF concludes that more than half the children in the developing world are severely deprived of one or more of the following necessities essential to childhood:

- 640 million children do not have adequate shelter
- 500 million children have no access to sanitation
- 400 million children do not have access to safe water
- 300 million children lack access to information
- 270 million children have no access to health care services
- 140 million children have never been to school
- 90 million children are severely food-deprived

The State of the World's Children also makes clear that poverty is not exclusive to developing countries. In 11 of 15 industrialized nations, the proportion of children living in low-income households during the last decade has risen (UNICEF Report, 2004: 1).

Illness and loss of a parent may reduce the capacity of families to provide for the children most basic needs (Hope, 1999: 98). In rural areas this could be the inability to produce crops and in urban and rural areas to generate income. According to Irin News (2003: 1) in Malawi for instance the AIDS crises has led to many orphans having little food, few clothes, no bedding and no soap and as a whole community care. Lack of administrative capacity at the National level coupled with inadequate resources has made it difficult for the government to keep up with the growing

epidemic. The Malawian government for instance has acknowledged that its support has been grossly inadequate and the condition of orphans is made worse by extreme poverty and the erosion of extended families (Africa Recovery, 2001: 1). Poverty is a huge problem in Malawi and is estimated that 65% of the people live below the poverty line (Avert, 2003b: 8).

In 1995 Uganda had 1.2 million AIDS orphans. Based on the number of AIDS deaths and other factors there could have been 1.5 million AIDS orphans in 2000, but there were only 1.1 million. That is, Uganda was missing 400 000 AIDS orphans. According to UWESO's Ntambirweki as quoted by Newsweek (2000: 15) either the babies were born HIV positive, or died from neglect and poverty. These children may have been deprived of proper nutrition and care which results in poor physical condition and compromised immune system.

A study of the situation of AIDS orphans in relation to poverty in Tanzania sums up their circumstances (Conroy et al., 2001 in Barnett & Whiteside, 2002: 212). This survey looked at the lives of AIDS orphans and ordinary orphans and found that:

- Child-headed households are more frequently found among AIDS orphans than among others.
- AIDS orphans attended school less frequently than did other orphans.
- AIDS orphans are more likely to drop out school than others.
- Numbers of orphans are swamping household and community ability to cope.
- In a sample of 2, 786 AIDS orphans, there were 128 incidents of attempted suicide; in a sample of 2, 420 other orphans there were none.

Children whose parents have already died are disadvantaged in numerous and often devastating ways. Many of the orphans live where poverty, malnutrition, and lack of water, sanitation, and basic health and education services already make children's lives risky. In addition to the trauma of witnessing the sickness and death of their parents worsen their situation. They must grapple with the stigma and discrimination so often associated with AIDS, which often deprives them of basic social services. Many people are unable to take on the responsibilities of extra children because they

are already strained (Barnett & Whiteside, 2002: 212; Robbins, 2004: 1; UNAIDS, 2004: 3).

The unmeasured consequences for the AIDS orphan generation are of great concern. According to Avert (2004: 7) more action and money are needed for the care and provision of basic needs for AIDS orphans.

3.5.2 Pressure on the extended family

The second socio-emotional implication of the rising statistics of AIDS orphans is the pressure on the extended family. According to Avert (2004: 2) in most African societies, children did not belong to the nuclear family into which they had been born, but to the whole clan, which had the responsibility of ensuring that when orphaned, they were brought up and cared for. The deep-rooted kinship systems that exist in Africa extended – family networks of aunts and uncles, cousins and grandparents, are an age-old safety net for such children, and it has long proved itself resilient even to major social changes. After the death of a second parent, orphaned children would be shared out among relatives or kept together under the guardianship of grandparents, aunts and uncles. In this way the extended family system provided an effective safety net for the small number of orphans in society, especially in rural areas. Fostering and adoption by families without a blood tie was uncommon in Africa. Orphaned children remained in the extended family system at all times (Avert, 2004: 2; Deame, 2001: 2).

Before the AIDS epidemic in the 1970s, there were, effectively no orphans in Africa. 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. The extended family is no longer able to continue with its traditional care-giving role. It is unable to offer the mechanism for coping with the approaching crisis of mass orphanhood as AIDS has orphaned more children than anywhere else.

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; UNICEF, 2003: 1).

Fleshman (2001: 9) state that in Zambia, one of the countries hit the hardest by the HIV/AIDS epidemic, the traditional mechanisms for the care of vulnerable children, the extended family, has started to break down under the twin pressures of poverty and AIDS. Often the members of the extended family are elderly and find looking after and bringing them up a huge challenge. Avert (2004: 9) mentions that for many Zambian children the loss of parents brings hardship, an end to schooling and stigmatisation by other people.

In Botswana like all other African countries, traditionally the orphaned children have been cared by the extended family. However, this practice is rapidly unravelling as people are no longer willing to do this. It has been found in Botswana that the level of care the orphans receive is unacceptable and sometimes the family members use the orphans to benefit the government orphan packages (Avert, 2004: 7).

UNAIDS (1997: 14) notes that even before the AIDS epidemic, this traditional social security system was already being pushed to a breaking point. This may be due to a number of reasons. Firstly, migration from rural to urban areas has weakened the sense of mutual obligation between clan members. This has led to the emergence of individualism or nuclear family where people are considering themselves first. Secondly, population pressure on limited agricultural land has reduced the capacity of many households to provide food, clothing, shelter and education for the children of the deceased relatives. Lastly, AIDS deaths are highest among the age group of people who in the past would have been most likely to accept the orphans into their own homes.

According to Deame (2001: 2-3) without a traditional family support system, the problems for orphans mount quickly. In some countries, children in AIDS-affected households may be more likely to drop out of school because remaining family members cannot afford to pay fees or buy books, or child may be needed to care for other relatives, or to work. When families can no longer absorb more orphaned relatives, orphans may end up on the streets. Many suffer social isolation, and some are pressured by poverty into prostitution (Barnett & Whiteside, 2002: 207-212; Deame, 2001: 2; UNICEF/UNAIDS, 1999: 5; Van Dyk, 2001: 334-335).

Barnett and Whiteside (2002: 207) in conclusion state that it is necessary for communities and government to find ways to care for orphans within family and household systems that have been increasing stretched, using institutional care as a last resort.

3.5.3 Aging parents caring for AIDS orphans

According to Avert (2004: 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. Avert (2004: 2), UNAIDS (2004: 3), UNICEF (2003: 1) and Hope (1999: 96) as well as Barnett and Whiteside (2002: 218) highlight that increasingly, grandparents are raising the infected and uninfected offspring of their own children who have died of AIDS. 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. A study of 300 orphans in Zimbabwe found that nearly half of caregivers of orphans were grandparents and most were already generally poor (Ruiz-Casares, 2001: 3).

For instance in South Africa's Alexandra Township, "The Go-Go Grannies" are a group of grandmothers who help and encourage each other as they raise their orphaned grandchildren. They have lost their own children to AIDS and are now

finding it difficult to cope, both emotionally and physically. The Grannies are part of the Alexandra AIDS orphans Project, which runs support-group programmes for children and caregivers living with, and affected by, the epidemic. The project currently provides psychosocial, financial and material support to 30 grandmothers. This includes one-time building grants to ensure adequate shelter for their growing families, as well as seeds and fertilizers so the women can start their own gardens to bring in food and income for their families (UNAIDS, 2004: 4).

Lewis (2003: 1) and Avert (2004: 3-4) note that it has become a common situation that the grandmothers are the caregivers for orphans in most African States. Many of the elderly are caring for the ill children and grandchildren with inadequate knowledge and understanding of AIDS and this leads them to spend resources trying to find a cure. They may sell their few belongings and go in search of a cure so that by the time their child dies they are left with grandchildren without sufficient funds and hence worsen their situation.

In some cases HIV/AIDS causes urban to rural migration, the opposite of the regular patterns. As a result orphaned children born and brought up in urban areas are sent to grand parents in the rural villages. Therefore, elderly grandparents increasingly have to bear the burden of caring for large numbers of orphaned grandchildren with little or no support from the surviving members of the extended family or other sections of society. 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. They would normally count upon their sons to provide for their old age (Chachkes & Jennings, 1994: 84; Hope, 1999: 96; UNICEF, 2003: 1).

In a study that was carried out in Zimbabwe, it was found that many older people who care for their HIV- infected adults' children or orphaned grand children face the harsh realities of stigma attached to the disease. The study recommended that the older people should be recognised as carers and should be offered adequate support (Avert, 2004: 3; WHO, 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. These grandparents have to take on the responsibility of caring for their orphaned grandchildren. Barnett and Whiteside (2002: 218-219) as well as Black (1991: 34) identified problems associated with this. For example, grandparents typically lack the energy to work long and hard in the fields, so the range of food available to them and their dependents becomes smaller and household nutritional status falls. Without adequate material, economic and nutritional support the children are vulnerable to malnutrition and infectious diseases.

Looking after children may mean preparing regular meals, treating minor illnesses, and taking children to under five clinics, preventing household accidents and providing the children with stimulating environment and to discipline them. All the above responsibilities, but especially discipline are extremely difficult when large numbers of children live with one elderly grandparent. All this may prove to be very difficult to the elderly grandparent and the effects of such a situation are summed up by Barnett and Whiteside (2002: 219) as:

- High school drop rates
- Poor health
- Poor nutrition
- Lack of discipline.

3.5.4 Child-headed households

As AIDS creates generations of orphans it is redefining family structure and roles in many communities. AIDS disrupts social roles, rights and obligations. 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. For the orphaned child there is often a premature entrance to burdens of adulthood, all without the rights and privileges – or the strengths – associated with adult status (Barnett & Whiteside, 2002: 206).

According to Barnett and Whiteside (2002: 206) becoming an orphan of the epidemic is rarely a sudden switch in roles. It is slow and painful, and the slowness and pain have to do not only with the loss of a parent but also with the long-term care which that parent failing may require. 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.

Van Dyk (2001: 337) states that households headed by adolescents (sometimes as young as 12 years old) who care for their younger siblings are often seen in many communities. 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). In other cases, the young orphans must leave school as they struggle to make a living and take of care of themselves and at times their younger siblings. Most of these children are plunged into economic crises and insecurity by their parent's death and struggle without services or support systems in impoverished communities (Tracey, 2005: 1; Newsweek, 2000: 13; Avert, 2004: 3). A study conducted in Ethiopia for instance found that the majority of child domestic workers in the capital city Addis Ababa are orphans (UNICEF, 2003: 25).

The following studies indicate that many children are already raised by other children. A study in Zambia of child-headed households found that in some homes, children were headed by children as young as 11 years of age (Ruiz-Casares, 2003:1). In Swaziland, as many as one in 10 households are run by orphans (UNICEF, 2003: 2). Avert (2004: 10) states that child-headed household, once a rarity in Zambia, are now increasingly common. Further, reports of children-headed household in countries such as Uganda, illustrate a phenomenon to many is inconceivable – children caring and providing for children through the maintenance of domestic and family structures (Hope, 1999: 98). The emergence of orphan households headed by siblings is an indication that the extended family is under stress.

World Bank (1997) describes a family as a social institution whereby social norms are organised in order to preserve societal values. Marriage provides the basic family group referred to as nuclear family, which is a unit made up of mother, father and children. However, with the advent of AIDS the idea of a family as it has always

been known will definitely change. As already mentioned there have been a growing number of households headed by children in their early teens because relatives are either unwilling or unable to accept them into their own homes. In most cases the AIDS orphans have become "an unwanted community within a community" (Webb, 1997: 183). According to UNAIDS (1997: 15) most orphaned households are left in the hands of grandparents at the death of the parents. The death of a grandparent then may leave the situation where there in no one else in the extended family willing to care for the children, giving rise to orphan households headed by older siblings.

Growing under conditions of orphanhood and child-headed households raises serious concerns about the quality of life of these children and the prospect that they will themselves experience HIV infection at the time they are sexually active. Kalumba (1997: 4) has raised concerns over the situation at home where HIV-infected children are likely to face serious health care orphan's problems being taken care of by siblings without the supervision of grownups. Often the elder siblings who take charge are too young to provide care for their younger brothers and sisters.

According to Nyandiya-Bundy (1997: 10) the child headed household phenomenon exacts negative pressure on AIDS orphans. Children assume roles too young an age. They miss out on their childhood and they are too young for adult responsibilities. The executive director of UNAIDS Peter Piot in Boseley (2002: 1) notes 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. In many countries there is nothing that is in place to assist AIDS orphans to effectively deal with the trauma brought about by the extended illness and death of the parent(s) due to HIV/AIDS. They face the reality of family disruptions, and major problems with the loss of financial and emotional support and possible separation from siblings.

3.5.5 Children's social and emotional development

Nyandiya-Bunddy (1997: 15) and Barnett and Whiteside (2002: 206) state that in taking care of the dying parent, the roles of parent and child become reversed as the

young children take on the responsibility of supporting and caring for their parents and this has serious consequences for a child's development. 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. According to UNICEF (1998: 3) 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.

Black (1991: 10) argues that 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. If discipline is taken against them, it compounds secret grief and leads to further disturbed behaviour.

According to Mukoyogo and Williams (1991: 8) the quality of childcare also suffers as AIDS invades the family, for example, the mother is less able to prepare food for the children even if the food is available. Inevitably children also suffer from lack of guidance and affection which are vital for their social and emotional development. Fontes and Hillis (1998: 347) discovered that in Rio de Janeiro, the common trend is that children who are orphaned by HIV/AIDS are displaced and many are abandoned due to the death of the primary care giver. 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.

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 early marriage especially for girls, child prostitution to meet basic needs and drug and alcohol abuse. Webb (1997: 4) has come up with evidence from Uganda that indicates that sexual activity generally starts earlier in orphans than in non-orphans. Kalumba (1997: 6) notes that these children respond more to peer pressure to turn into delinquent behaviour for

survival. They are subject to less stringent socialisation pressures, which could lead to deviancy and vulnerability to HIV infection.

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. Barnett and Whiteside (2002: 212) as well as UNICEF (2003: 2-3) argue that AIDS orphanhood will lead to a rise in the number of children living on the streets, begging, scavenging and descending into a life of crime. These streets are themselves at high risk of HIV infection. They are vulnerable to sexual exploitation. According to Webb (1997: 181) the growing number of street children in urban Kenya can be attributed to the increase in AIDS, who are forced to live, due to either ostracizing and/or the lack of community support in their home areas. Therefore, it can be seen that the relaxation of family ties and lack of adult guidance, parental upbringing and sense of identify contributes to the failure of many orphans to develop personal, moral and self-protective behavioural code which are essential for personal growth.

3.5.6 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. However, resources may be lacking for children to continue or enrol in school or in formal training. 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. They will therefore work full time in the home to help sick parents. These children's earnings are needed to help support the rest of the family (Avert, 2004: 7; Hall, 2005: 1; Robbins, 2004: 1; UNICEF, 2003: 2; UNICEF, 2004: 1; Van Dyk, 2001: 153).

AIDS orphans are less likely to have proper schooling. 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. Hope (1999: 98), Tracey (2005: 1) and UNICEF (2004: 1) mention that orphans are

likely to be forced to leave school as they struggle to make a living and take care of themselves. Many may be required to find employment to compensate for the loss of their parents labour. For instance a study conducted in Kwa-Zulu Natal on the plight of AIDS orphans revealed that some children drop out of school temporarily so that they could work full time to raise money for school fees and uniform. Some were working only part-time during weekends and school holidays and others had dropped out of school permanently, but intended to return if their circumstances changed (Mturi & Nzimande, 2002: 3).

Another recent study conducted by the Khmer HIV/AIDS NGO Alliance and Family Health International in Cambodia found that about one in five children in AIDS-affected families reported that they had to start working in the previous six months to support their family. One in three had to provide care and take on major household work. Many had to leave school, forego necessities such as food and clothes, or be sent away from their home. All of the children surveyed had been exposed to high levels of stigma and psychosocial stress, with girls more vulnerable than boys (UNAIDS, 2004: 4).

Orphan learners may face enormous financial hardship and have great difficulty in paying for school fees, uniforms and books. For instance, Hall (2005: 1) notes that in Swaziland many orphans are dropping out of school because of lack of finances. At the heart of the problem lies the fact that schools fear taking on students who are unable to pay fees. Swaziland's Ministry of Education set aside just over three million dollars to subsidise the schooling of these children – an amount that later had to be raised to almost 6.4 million dollars (Hall, 2005: 2).

Research in Zimbabwe showed that 48% of the orphans of primary school age who were interviewed had dropped out of school usually when their parents became too sick to look after themselves or when their parents died. Not one orphan of secondary school age was still in school (Van Dyk, 2001: 154). Studies in Uganda suggest that after the death of one or both parents, the chance of orphans going to school is halved and those who still attend school spend less time there (Deame, 2001: 2). A study in Kenya found that 52% of the children orphaned by AIDS were not in compared to 2% of non orphans (Avert, 2004: 3). In another study of orphans in Kenya, 64% of boys

tended to cite economic reasons for leaving school while 69% of girls made mention of pregnancy and marriage (UNAIDS, 2000: 29).

According to Barnett and Whiteside (2002: 202) in Zambia there is evidence of a fall of numbers of children attending primary school. Nearly one out of three urban orphans and two out of three rural orphans don't attend school, which is significantly worse than attendance rates for non orphans (UNICEF/UNIAIDS, 1999: 17). Furthermore, Ruiz-Casares (2001: 1) mentions that in rural areas of Zambia, 64% of orphans are not enrolled in formal school compared with 48% of non-orphans. In Zambia's Copperbelt – an area badly affected by HIV/AIDS it found that 44% of the children of school-going age were not attending school, but with proportionately more orphans (53%) than non-orphans (42.4%) not attending (Barnett & Whiteside, 2002: 202). A similar pattern was apparent in a rural are in the eastern part of the country where only 38% of the orphaned school age children were attending school, compared with the provincial average of 51%. More data show that 32% of orphans of school going age were not enrolled and in rural areas the situation is more severe with 68% of rural orphans not enrolled (Barnett & Whiteside, 2002: 202; Webb, 1997: 189).

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).

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. Since virtually everywhere in Africa governments charge school fees, when the family cannot raise up the fees, the children suffer the consequences (Barnett & Whiteside, 2002: 204; Irin News, 2003: 1; Newsweek, 2000: 15; UNAIDS, 1997: 15). In Zambia, a study cited by the

UNAIDS report (2002: 1) found for instance that one third of urban children with parents enrol in school, but only one quarter of orphans do.

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. In a study in Nasaka district in Uganda, UNICEF/WHO (1994: 37) identified some of the common sources of psychological stress among AIDS orphans. One fact that came out was that children felt that school teachers are unsympathetic to their difficulties and are often too ready to punish them for being late or ill equipped without looking for explanation.

However, in Zambia, a scheme under the Zambia Open Community Schools has initiated programmes, which attempt to help children deal with their grief and their fear. Teachers are trained on child psychology and the skills needed to address the situation. After a loss of a parent or a family member, teachers encourage children to tell or write stories or draw pictures dealing with death. Eventually, this leads to children to open up and talk about their feeling related to loss (UNAIDS, 1997: 24).

HIV/AIDS has also a devastating impact on the education system holistically. Avenstrup (1999: 8) observes that AIDS is changing the whole education context. AIDS increases teacher deaths and it may be difficult to replace particularly in deprived, rural or otherwise remote communities. Teacher's illness is of particular importance. Classes remain untaught for extended periods and replacement is difficult while staff members are on sick leave. The standard of education that a child receives may be low (Barnett & Whiteside, 2002: 202).

UNICEF Report (2004: 1) also highlights that HIV/AIDS is not only killing parents but is destroying the protective network of adults in children's lives. Many teachers, health workers and other adults on whom children rely are also dying. And because of the time lag between HIV infection and death from AIDS, the crisis will worsen for at least the next decade. For instance UNAIDS (2000: 29-30) reported that the Central African Republic in 2002 was already experiencing a 33% shortage of primary school teachers. Now because of staff shortages in the Central African Republic, 107 schools

have closed and only 66 have been able to remain open. It is estimated that more than 71 000 children between the ages of 6 and 11 will deprived of a primary education by the year 2005 in the Central African Republic (Van Dyk, 2001: 153). Furthermore, it has been noted that in the Caprivi region in Namibia, HIV/AIDS is severely disrupting schooling. Over the last three years it is reported that the region lost 15 out of 90 life science teachers to AIDS. One teacher commented that "The teacher who is sick can not prepare or teach well. Teachers have to go for funerals every second day so they have no time to teach" (The Namibian, 1999: 1).

Schools are taking more and more orphans and in some schools (for example in Zambia) up to 35% of the school children are AIDS orphans. But the education system is threatened by teacher absenteeism and deaths. The provision of quality education is hampered by the fact that teachers, principals and education administrators are also dying of HIV/AIDS (UNICEF, 2003: 2).

Another major problem identified by Avenstrup (1999: 9) is that of the particular risk faced by schoolgirls. Since men retain the false belief that sex with girls will cure them of HIV/AIDS, many men invent cultural tradition in order to have sex with girls. The male teachers may in turn abuse the schoolgirls as a self-fulfilling prophesy, yet these are the people who are left to become the main role model for the children.

According to Avert (2004: 3), UNAIDS (2004: 4) and UNICEF (2003: 2) keeping orphans at school is crucial for the future. Staying in school offers orphaned children the best chance of escaping extreme poverty and its associated risks. It can provide education that can work as a safety net in the child's life. Schooling can also help to break the cycle of poverty. Offering children free basic education, giving them a safe and viable option for earning a living can mean that many orphans can have a bright future.

3.5.7 Health care

Orphanhood has serious implications for child health. Increasing AIDS related poverty causes a degradation of the family's immediate environment, multiplies

health risks, and reduces its ability to access health services. AIDS orphans are often at greater risk of illness, abuse and sexual exploitation. Furthermore, they may not receive health care they need, and sometimes this is because it is assumed they are infected with HIV and their illnesses are untreatable. Orphans are also generally thought to run a greater risk of being malnourished and stunted than children who have parents to look after them (Avert, 2004: 5; Hope, 1999: 98; Robbins, 2004: 1).

Mukoyogo and Williams (1993: 12) point out that AIDS diminishes the family's capacity to grow food and earn money to buy food even while both parents are alive. The death of a parent exacerbates the situation still further. As a result children consume less food and also eat less nutritious food. Barrett (1997: 5) has come up with evidence that indicates that orphanhood, particularly caused by the death of a mother, often entails the deterioration in the health of the child. This evidence shows that in many families in South Africa, a mother is the primary health care worker whose responsibility includes family health-care. Therefore AIDS orphans are often prone to malnutrition and infections and are less likely to receive health care than any other children. Lewis (2003: 1) also argues that these children are likely to suffer deep psychological wounds because many would have watched their parents die painful, lingering deaths.

Discrimination in accessing health care is a major form of social exclusion faced by AIDS orphans. The fact that is often unknown and ignored is that not all AIDS orphans are infected. UNAIDS (1997: 13) has come up with evidence that two thirds of children born to HIV-positive mothers do not contract the infection and grow up to be as healthy as any other child in the community. The evidence also suggest that children orphaned by AIDS may be at greater risk of dying of preventable diseases and infections because of the mistaken belief that when they become ill it must be due to AIDS and therefore there is no need to seek medical help.

Very little attention has been given to the health needs and developmental problems of children whose parents die of AIDS. Webb (1997: 189) points out that hospital initiated home-based care programmes, have generally failed to go beyond the medical attention of the AIDS patient to look at the health care needs of the affected

children. However, the counselling and support of affected children remains a priority since they also go through the trauma caused by the bereavement.

3.5.8 Emotional trauma and stigma associated with HIV/AIDS

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 illness and loss of a parent is very traumatic for a child and lack of consistent nurture can have serious developmental effects. Orphaned children are more likely to suffer damage to their cognitive and emotional development and to be subjected to the worst forms of child labour. The vulnerability of children orphaned by AIDS and that of their family starts well before the death of the parents. The emotional suffering of the children usually begins with their parents' distress and progressive illness. 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; Chachkes & Jennings, 1994: 80; Doka, 1994: 40; Hope, 1999: 98; UNICEF, 2003: 2; UNICEF, 2004: 1).

Eventually the children suffer the death of their parent(s) and the emotional trauma that results. According to UNICEF (2003: 2) and UNAIDS (2004: 3) depression and alienation become common. Any death, especially the death of a parent, raises questions for the child. Questions such as "Why did this happen?" Why did it happen to me?" and "Why did he/she or they have to die?" While any death raises profound question of meaning, AIDS related death may be particularly problematic. The children have to adjust to a new situation, with little or no support at all (UNICEF, 2003: 2).

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. They may personally experience the stigma of AIDS related illness, as they are teased by classmates or ostracised by peers and other parents (Avert, 2004: 5; Doka, 1994: 35).

According to UNAIDS (2004: 3) 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. When one parent is HIV-infected, the probability is high that the other parent is as well. Therefore, children often lose both parents in quick succession.

Barnett and Whiteside (2002: 206) note that successive orphaning is not unknown. An orphan's caregivers may also succumb to AIDS, with the result that children may suffer multiple bereavements. The child's suffering is often compounded by being separated from his or her siblings. 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). Many experience depression, anger, guilt and fear for their futures. This experience can lead to serious psychological problems such as post-traumatic stress syndrome, alcohol and drug abuse, aggression, and even suicide (UNAIDS, 2004: 3).

Avert (2004: 5) and Robbins (2004: 1) note that children grieving for dying or dead parents are stigmatised or ostracised by society through association with HIV/AIDS. Often children who have lost their parent to AIDS are assumed to be infected with HIV themselves. 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. Because of this stigma, and often-irrational fear surrounding AIDS these children may be denied access to schooling and heath care (Avert, 2004: 6; Barnett & Whiteside, 2002: 202). This further stigmatises the children and reduces their opportunities in the future. Peter Piot, the executive director of UNAIDS made this sad statement "if your father died in war, you are a hero. If he died of AIDS you are an outcast (Ruiz-Casares, 2001: 2).

Grodney (1994: 137-138) identified the following as common socio-emotional reactions amongst children who lost parents (s) to AIDS:

- Anger: Children who are old enough to understand the ways in which HIV is transmitted may be extraordinary disappointed in and angry with the parent for engaging in the behaviour.

- Fear of death: The death of their parents may cause children to begin to view their world as unpredictable. They can respond with a heightened sense of vulnerability, often marked by fears of recurrent tragedy.

- Guilt: Many children are guilt-ridden and feel they have caused their mother to get sick.

- Loss and abandonment: Children experience a great deal of anxiety about who will care for them if their parent(s) die.

- Depression: Depression is regarded as the most common reaction to the announcement of a parent's HIV infection, AIDS and death. The features of this are withdrawal from family and social activities, isolation, moodiness, below-or above-average appetite, sleep disturbances, and inability to concentrate.

- Suicidal ideation and gestures: Children have also been known to have suicidal ideation after the death of a parent. This ideation is clearly and identification with the parent who has died from AIDS.

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.

3.5.9 Children's exploitation and HIV infection

As highlighted earlier some children live on their own at a young age as result of their parents dying from AIDS. According to Avert (2004: 5) orphans enduring the grave social isolation that often accompanies AIDS when it strikes a family and they are at

far greater risk than most of their peers of eventually becoming infected with HIV. Often emotionally vulnerable and financially desperate, orphans are more likely to be sexually abused and forced into exploitative situations, such as prostitution, as means of survival. Girls are also in greater risk of becoming infected at a younger age than boys, because they are biologically, socially and economically more vulnerable (Avert, 2004: 5; Robbins, 2004: 1).

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. A survey of 1600 children in four poor areas of Zambian Capital Lusaka for instance showed that more than 25% of children aged 10 had already had sex. In South Africa, 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.

Child sexual abuse has become a subject of worldwide concern. In Africa, newspapers and other forms of mass media frequently report about the increasing cases of child sexual abuse. According to Hope (1999: 41) there are many theories that explain why men abuse children. Firstly, there is the prevention theory, which is based on the assumption that all sexually active are likely to be HIV/AIDS infected. If an individual is uninfected and wishes to engage in safe sexual activity this can only be done with a partner who is uninfected and in this case children less than 12 years. Secondly there is the cleansing theory, which suggests that by engaging in sexual relations with children HIV/AIDS can be passed from the infected individual to his or partner (Hope, 1999: 41). However, regardless the underlying motive for childhood sexual abuse, these children are at increased risk of exposure to HIV/AIDS.

In Uganda, focus groups discussions revealed that girls orphaned by AIDS were especially vulnerable to sexual abuse in domestic housework (UNICEF, 2003: 2). Girls carry a larger burden of domestic responsibility than boys and are more likely to be kept out of school. In Zambia, a study conducted by the International Labour Organisation in several districts, shows that the majority of children in prostitution are orphans (UNICEF 2003: 1-2).

Without the protective environment of their homes, orphaned children face increased risk of violence, exploitation and abuse. They may be ill-treated by their guardians, and dispossessed of their inheritance and property. Those living with foster families are more likely to be malnourished, underweight, or short for their age in comparison to non-orphans. In worst-case scenarios, orphaned children may be abducted and enrolled as child soldiers or driven to hard labour, sex work, or life on the streets (Barnett & Whiteside, 2002: 212; Robbins, 2004: 1; UNAIDS, 2004: 4).

3.5.10 Loss of family security and identity

According to Ruiz-Casares (2001: 1) as well as Siegel and Freund (1994: 54) not only do children carry the emotional burden of watching a loved one suffer and die, but they also experience the trauma of the family unit collapsing. A family illness and death necessitate changes in responsibilities, routines, living conditions, and even place of residence. Such extensive environmental change can deprive children of the feelings of security and comfort they derive from familiar routines and settings. According to Doka (1994: 36) these children, given their environment, may experience developmental or behavioural problems. They may find it difficult to trust or to bond with adults.

Children deserve a childhood filled with comfort, security and hope. Unlike most diseases, HIV/AIDS generally kills not just one, but both parents. Once AIDS has claimed the mother or father, children are far more likely to loose the remaining parent. When parents fall sick and die a child's identity falls apart. One of the concerns revealed by several focus group discussions and interviews held with orphaned children and community members from a rural area near Mutare in Zimbabwe, is feeling different from other children because many lack family support and hence suffer more frequently from malnutrition, illness and abuse (Ruiz-Casares, 2003: 1).

Doka (1994: 36) notes that AIDS orphans may have to struggle with issues of multiple losses. Many of these may have lost both parents through AIDS, abandonment, and inability of others to care for them. As already noted they may have experienced the loss of other family members. They may have been separated

from their siblings, friends, neighbours, and classmates. 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 (Doka, 1994: 36; Siegel & Freund, 1994: 55).

Consequently, even if such disruptions are unavoidable caregivers are encouraged to try to maintain as much stability and consistency in the child's environment as possible. Even maintaining such simple routines as having meals at a certain time or going through an established bedtime ritual can reassure the children that all has not changed. 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. Many believe that orphans should be cared for in family units through extended family networks, foster families and adoption. At the very least, siblings should not be separated (Avert, 2004: 5; Siegel & Freund, 1994: 54).

3.5.11 A bleak future and life of crime

A generation of orphans threatens to undermine economic development, for children without parents can seldom afford education. School is a place where children can acquire knowledge and skills to prepare for the future. According to Dr Peter Piot of UNAIDS many AIDS orphans end up roaming the streets and prime targets for gangs (Bartholet, 2000:13). Growing up without parents, and badly supervised by relatives, this growing pool of orphans will be at greater than average risk to engage in criminal activity. These children are often much more likely to being swallowed by crime as it is viewed as a means of survival especially in the streets (Barnett & Whiteside, 2002: 210). According to Lewis (2003: 1) the children live traumatised and unstable lives, robbed not just of their parents but their child hood and future.

According to Barnett and Whiteside (2002: 212) in extreme cases, which are all too common orphans turn to the street where physical needs and financial desperation make them more vulnerable to crime, sexual exploitation and substance abuse. This

places a significant number at risk of contracting HIV through virtually inescapable income-generating prostitution.

This section has established that as the number of adults dying rises over the next decade, an increasing number of orphans will grow up without parental care and love and will be deprived of their basic rights to shelter, food, health and education. According to UNICEF (2003: 2) many of the most severely affected countries in sub-Saharan Africa have no national policies to address the needs of orphaned children, including children orphaned and made vulnerable by HIV/AIDS. The ongoing failure to respond to the orphan crisis will have grave implications not just for the children themselves but for their communities and nations. The following paragraphs specifically review legal implications and ethical aspects of the socio-emotional problems faced by these orphans.

3.6 THE RIGHTS OF AIDS ORPHANS

According to Barnett and Whiteside (2002: 211) orphanhood threatens many aspects of children's lives. Hunter and Williams (2000: 215-216, 236-237) state that the hardships faced by AIDS orphans have been documented for more than a decade, and many African governments are trying to develop and implement solutions. Some countries have created new laws and policies to protect children and to help children defend their inheritance and rights to property while others have not. The 2003 report on progress in meeting the 2001 UN Declaration of Commitment on HIV/AIDS goals notes that 39% of countries with 'generalized epidemics' have no national policies to provide orphaned and vulnerable children with essential support. Some 14% of these countries are developing policies, but 25% have no plans to do so (UNAIDS, 2004:5).

According to The State of the World's Children 2005, "Childhood Under Threat," as mentioned by UNICEF (2004: 1) more than 1 billion children are denied a healthy and protected upbringing as promised by 1989's Convention on the Rights of the Child, the world's most widely adopted human rights treaty. The report stresses that the failure of governments to live up to the Convention's standards causes permanent damage to children and in turn blocks progress toward human rights and economic advancement. "Too many governments are making informed, deliberate choices that

actually hurt childhood," said UNICEF Executive Director Carol Bellamy in launching the report at the London School of Economics (UNICEF, 2004:1).

UNAIDS (1997: 14) states that the relation between HIV/AIDS, impoverishment and denial of human rights is apparent in the impact of the epidemic on children who have been orphaned by AIDS. Ennew and Milne (1989: 12) argue that children have not always been on the human rights agenda as a separate group. For years they were regarded as a residual category of persons, lacking full human rights. Furthermore, they have observed that in many countries children are not given the opportunity to vote, do not contribute to election campaigns, and do not make policy decisions. The development and implementation of social policy for children rests with adults. Therefore, children cannot choose, but have to accept the choices made for them by adults. Social rights emerge from needs and provide framework for social policy development, therefore, as problems faced by AIDS orphans become visible, social policies emerge.

The South African Constitution (Act 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The Bill of rights within the constitution sets out a number of rights, which protect children. However, the most comprehensive document containing the rights of the child is the United Nations Convention on the Rights of the Child (UN CRC, 1990), which was adopted by the United Nations General Assembly in November 1989 and entered into force in September 1990. The above-mentioned document sets out a wide range of political, civil, cultural, economic and social rights of children. It is based upon four broad principles that are essential in all matters affecting the child. These principles are; protection, participation, survival and development, and non-discrimination. Every child has a right to education, to the highest attainable standard of health, to seek, receive and impart information and ideas of all kinds, to special protection and assistance if deprived of his or her family environment, to non discrimination and privacy, to express opinion and freedom from drug trafficking, prostitution, sexual exploitation and sexual abuse (UN CRC, 1990).

This United Nations Convention on the Rights of the Child Document (UN CRC, 1990) in principle provides a protective framework for children. It accords them the following rights which are to be protected by signatory governments.

- To be cared for by his or her parents (Article 7)
- To preserve identity, nationality, name and family relations (Article 8)
- To maintain regular contact with parents if separated (Article 9)
- To freedom of expression (Article 13)
- To freedom of association (Article 15)
- To be brought up by parents or guardians whose basic concern is his or her best interests (Article 18)
- To protection from physical or mental ill-treatment, neglect or exploitation (Article 19)
- To conditions of living necessary for his or development (Article 27)
- To education (Article 32)
- To rest, leisure, play and recreation (Article 31)
- To protection from economic exploitation and performing any work that interferes with his or her education or is harmful to his or her mental, spiritual or social development (Article 32)
- To be protected from all forms of sexual exploitation and sexual abuse (Article 34)
- To be protected from abduction, sale or trafficking (Article 35)
- To be protected from torture or other cruel, inhuman or degrading treatment or punishment (Article 37)

Barnett and Whiteside (2002: 212) state that in normal circumstances many of these rights are violated; HIV/AIDS increases the number of children at risk.

When AIDS invades homes, family possessions such as livestock, furniture and even land may be sold off to obtain cash for treatment of the parents. In extreme cases money is borrowed from relatives and friends. Van Dyk (2001: 334) 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. Speaking at a launch of regional orphan care initiative, Land and Housing Minister Margaret Nash of Botswana was reported as saying that relatives often tried to take over deceased parents' homes as well as their cars and bank accounts (Irin News, 2003: 1).

Further, Avert (2004: 6), Barnett and Whiteside (2002: 206) as well as Robbins (2004: 1) highlight that once parents die, children particularly in case of girls, may be denied their inheritance and property. 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. In South Africa for example it has been noted that banks are left with unpaid debts because mortgage holders have died from AIDS (Du-Venege, 2002: 1). Loss of income or inability to repair and maintain the home can result in shelter being lost or becoming inadequate and the children left without a home. It has been argued that in theory the law is usually on the side of the orphan but in practice the enforcement of the law is very difficult unless the child receives legal assistance (Du- Venage, 2002: 1-2).

A study in Zambia reported that 46 percent of families affected by AIDS had been forced to move to poor premises with fewer facilities (Hope, 1999: 98). After the death of parents the children may find themselves living with various caregivers. Some children are taken in by relatives, others by the neighbours or found a bed in one of the few orphanages. For the rest there are only the streets of cities, where children lacking adult supervision and a stable environment, survive by begging and petty crime (Avert 2003a: 10; Doka, 1994: 36).

Van Dyk (2001: 335) mentions that some relatives take in orphans in order to entitle them to land claims or foster grants and become "self appointed trustees" ending up expropriating the children's land, or money or manipulating land boundaries in their own favour. In such cases they may reject male orphans for fear that they will rightfully claim back their land. According to Irin News (2003: 1) in Botswana for instance there are a lot of cases reported of property grabbing where the family members divide it among themselves and leave the children with nothing. Because

these children no longer have access to education and because they lack work skills and family support of any kind they often end up living on the streets (Van Dyk, 2001: 334-335).

In Africa, orphaned children have relatively few legal or customary rights to property or to decision making about their future, unless the parent has made specific provision for them in the will. UNICEF (1998: iii) has come up with evidence that in a research in Namibia, the vast majority of the dying parents had not a will providing for the transfer of their property or responsibility for their children.

Some forms of exploitation are open for example, in case where the orphaned child is accepted into an extended family as a domestic servant. Ennew and Milne (1998: 53) came up with evidence that in Jamaica orphan girls are taken in as domestic servants by relatives. The conditions under which live are generally far poorer that those of their "new" family. Some were discovered to be sleeping under kitchen tables and they usually dine on scraps of leftover food. The hours of work were exceptionally long and many were on call 24 hours a day. The study concluded that these children are living in virtual slavery. Salazar and Glasinovich (1998: 12) agree with this by producing evidence that in Guatemala orphans working as domestic servants have psychological problems due to discrimination, isolation and disdain. It was disclosed that these children cannot leave the house and are not paid adequately. Even though there were difficulties in reaching these children for survey, evidence pointed out that there was physical, mental and sexual abuse.

Many children are not aware of their legal rights and to pursue these rights in courts needs money, skills and self-confidence that these children lack. UNAIDS (1997: 15) has noted that grandparents also find it difficult, without necessary legal information and support, to defend the inheritance rights of their grandchildren against the claims of the children's greedy relatives.

UNAIDS (1997: 6) states that AIDS orphans are vulnerable to infection through sexual abuse, coercion and commercial exploitation which stems from failure to respect their rights. The majority of them do not have the rights to information, education and services. Taylor-Brown et al (1998: 140) have come up with evidence

that these children mistrust and fear the legal system or other government intervention. This is because, while legal rights are by definition enforceable, the AIDS orphans have been afforded few or no rights.

According to Avert (2004: 5) there is much that can be done to ensure the legal and human rights of AIDS orphans. Many communities are now writing wills to protect the inheritance rights of children and to prevent land and property grabbing (an adult attempting to rob orphans of their property once the children have no parents). The State of the World's Children argues that bridging the gap between the ideal childhood and the reality experienced by half the world's children is a matter of choice (UNICEF, 2004: 1). The quality of a child's life depends on decisions made every day in households, communities and in the halls of government. The report further emphasizes that people must make choices wisely, and with children's best interests in mind. If people fail to secure childhood, the nations will fail to reach larger, global goals for human rights and economic development. As children go, so goes the nation (UNICEF, 2004: 1).

Because of the preceding premise describing challenges and shortcomings of AIDS orphans the question of skills development becomes indispensable. As a matter of fact there is a demise of skills which culminates in far reaching results as detailed below.

3.7 IMPACT OF AIDS ON SKILLS DEVELOPMENT

As already mentioned in this chapter every year tens of thousand of children lose their parents to AIDS reflecting a lost generation of children with no hope and no future. AIDS orphans frequently suffer many losses including parent(s), sibling(s), school, home, neighbourhood, friends and social supports. Until now, most orphan-support interventions have been piecemeal and have not matched the scale of the problem (UNAIDS, 2004: 5).

According to Mike Waters of the Democratic Alliance, South African National Government Policy for the care orphans of the AIDS epidemic is terrible. The process of rolling out antiretroviral drugs which would keep many parents alive for

longer, is excruciatingly slow hence many children are left orphaned as their parents succumb to AIDS. He said further, there was a shortage of more than 6 500 social workers, representing a 72% vacancy rate at the Department of Social Development (Mesatywa, 2005: 1). This leads to a lack of support for AIDS orphans and this lack of support makes it difficult for children to have normal development.

A parent's death deprives the child the learning and values they need to become socially knowledgeable and economically productive adults. Recent research suggests that this breakdown in intergenerational knowledge may play a part in a country's economic decline. 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 (Avert, 2004: 7; Bell et al., 2003 in UNAIDS, 2004: 3; UNAIDS, 2004: 3).

Another significant issue is that traditional skills may not be passed by parents because of premature death. Education can empower the children and give them the skills and hope for the future. Otherwise, if insufficient action is taken, there is a danger of a huge generation of uneducated youths and adults. 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).

According to Grodney (1994: 133) the needs of adolescents who are surviving parental death from AIDS have not received sufficient programmatic attention. Although these children may seem invisible, the multiple traumas they have faced and their vulnerability make it imperative that programmes be developed that attend to their needs. He further notes that programmes to empower these children are generally limited hence these young orphans usually grow up in communities blighted by drug use, poverty, and violence. Absence of basic knowledge and life skills contribute to the vulnerability and exploitation of orphans.

Anderson and Okoro (2000: 2) note that the only solution will be to purposefully employ a continuous positive preventive approach in order to stabilise or change the life-styles of the youth. These programmes must have the potential to provide self-

empowerment to these children. They should offer them necessary assistance that will enable them to survive and take part in their future (Grodney, 1994: 133).

Avert (2004: 3) states that empowering affected children means regarding them as active members rather than just victims. Many AIDS orphans already function as heads of households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of HIV/AIDS in their families and communities. Hunter and Williamson (2000: 2) state that programs to help AIDS orphans must be able to be implemented quickly, given the speed with which the orphan problem is growing, be sustainable for several decades, and be able to adapt to the epidemic's growing and changing impacts.

Life skills are widely recognised as an effective method of intervening. They promote abilities that contribute to positive health behaviour, positive interpersonal relationships and physical as well as mental well-being. The promotion of mental and physical well-being contributes to people's motivation to look after themselves and others, hence the prevention of health and behaviour problems. Particular emphasis is placed on behaviour change via values-oriented education accurate information and intervention that foster self-respect. This support will ensure that children grow up safely without experiencing exploitation and themselves falling prey to HIV (WHO, 1997: 17; Anderson & Okoro, 2000: 6-7). Consequently the focus of this study is directed towards the development and empirical testing of a life skills programme for AIDS orphans.

3.8 CONCLUSION

The AIDS orphan crises worldwide and specifically in South Africa is a daunting challenge for the country. It is very difficult to estimate the number of children orphaned by AIDS each year, but whatever the figures, it is clear that there is an enormous problem. Millions of children worldwide have already lost at least one parent to the epidemic, and millions more will do so in the years to come. Some thousands of people will die of AIDS today and some thousands will die tomorrow, and the next day. For the children the tragedy is only beginning.

This chapter has established that most of the children orphaned by AIDS come from socio-economically disadvantaged families. Parental death may be one in a series of significant stressors that they have had to confront. Others may be poverty, crowded living conditions, poor education and health care. These children may face discrimination and rejection with their extended families and communities. Thus these children constitute a very vulnerable population. With the relentless toll of AIDS reducing the ability of families and communities to support and care for children countries are now facing troubling scenarios: grandmothers struggling to care for orphans, households headed by children, many of them primary-school age, who are caring for younger siblings, and worse, children with nowhere at all to turn.

The extraordinary challenge and difficulties that these children (mostly adolescents) experience expose them to risky habits detrimental to their health. The AIDS epidemic threatens the viability, perhaps the very existence, of this generation. A healthy productive generation of adolescents today will ensure that South Africa has the healthy generation of adults needed in the 21st century. Specifically the next chapter serves to understand adolescence as a stage to help in understanding the nature of adolescence and the developmental processes which are involved. Once this understanding is developed, focus can be on developing a program which is specifically designed to parallel the adolescent developmental process.

- CHAPTER 4 -

ADOLESCENCE AS A LIFE PHASE WITH SPECIFIC EMPHASIS ON EARLY-ADOLESCENCE

4.1 INTRODUCTION

According to Gallahue and Ozmun (2002: 346) the term adolescence is difficult to define. Not only is it a period of rapid physical change, but it is also a period of social and psychological transition from childhood to adulthood. Sdorow and Rickabaugh (2002: 115) describe adolescence as the transition period between childhood and adulthood. It is a stage between the closing of childhood and the beginning of adulthood (Amanat & Beck, 1994: 2; Geldard & Geldard, 1999). The Social Work Dictionary (1999: 9) describes adolescence as: "The life cycle period between childhood and adulthood, beginning at puberty and ending with young adulthood." The term adolescence derives from the Latin adolescentia, which refers to the process of growing or growing up to adulthood (Hoge, 1999: 2; Louw, 1992: 377; Louw, van Ede & Louw, 1998: 384). According to Gallahue and Ozmun (2002: 346) adolescence is a period of preparing for life. The young person moves from being part of a family group to being part of a peer group and to standing alone as an adult. Therefore, while childhood is certainly important in shaping future growth, adolescence provides opportunities for fresh starts, for new directions that are not predictable from the events of childhood. It is an exciting, but sometimes difficult period in the life of most young people (Gladding, 1997: 105; Mabey & Sorensen, 1995 in Geldard & Geldard, 1999: 2).

According to WHO (2004: 1) one in every five people in the world is an adolescent. Out of 1.2 billion adolescents worldwide, about 85% live in developing countries and the remainder live in the industrialized world. Adolescents are generally thought to be healthy. By the second decade of life, they have survived the diseases of early childhood, and the health problems associated with ageing are still many years away. Death seems

so far removed as to be almost unthinkable. Yet many adolescents do die prematurely. Every year an estimated 1.7 million adolescents lose their lives- mostly through accidents, suicide, violence, pregnancy-related complications HIV/AIDS and other illnesses (WHO, 2004: 1).

Since the study is about AIDS orphans in their early-teenage years this chapter aims at examining adolescence, with specific emphasis on early adolescence, the time when individuals are still defined by their relationships within the family and ends as they cross the threshold to adulthood. In order to help adolescents effectively it is important to understand the nature of adolescence and the developmental processes that are involved. In this context the goal of this chapter is to present an understanding of adolescence. Understanding the experiences of adolescence leads us to a better knowledge of growth and development. Adolescence is a difficult period in a young person's life. A detailed description of the unique needs and problems of adolescents is beyond the scope of this study. Therefore, the focus in this chapter will be on the following:

- Adolescence as a developmental stage;
- Early adolescence;
- Adolescents risky taking behaviors;
- Pre-disposing factors that expose adolescents to risky behaviors;

4.2. ADOLESCENCE DESCRIBED

The age at which adolescence begins varies from 11 to 13 and the age at which it ends varies from 17 to 21 (Louw, van Ede & Louw, 1998: 384). According to Gillis (1999: 70) it is easier to determine when adolescence get under way than to decide when an individual is no longer an adolescent. The termination of adolescence cannot be defined in measured terms. Rather, it is considered to have come to an end upon culmination of those developmental processes, which lead to physical, sexual, social, cognitive and emotional maturity. The first transition is tied to specific bodily changes, while the second is marked by social and emotional changes. During adolescent years, young

people go through great emotional, cognitive and social transformations (Geldard & Geldard, 1999: 2).

Adolescence is considered to be one of the most highly elaborate dramas of life. The teen years are a time of tremendous growth and experience, and adolescents have more diverse experiences than do younger individuals. It is a time of unevenness and paradoxes marked by extensive personal changes. The beginning of adolescence is said to correspond to the onset of puberty when primary and secondary sexual developments make their first appearance. Hence, some adolescence may have a particularly difficult time of coping with the changes that occur. During this lengthy period of maturation, they may experience intense feelings of despair, anxiety, hopelessness, preoccupations, anger, impatience and oppression. Adolescent years can be extremely lonely ones, and it is not usual for an adolescent to feel that they are alone in their conflicts and self-doubts. Thus, all adolescents are assumed to experience emotional turmoil, conflicts with parents and risk-taking behaviors (Amanat & Beck, 1994: 11; Corey, 2004: 7; Corey & Corey, 2002: 306; Dworetzky, 1990: 529; Gladding, 1997: 105; Hoge, 1999: 2).

Adolescence is described as a time when self-concept may alter considerably. According to Louw, van Ede and Louw (1998: 425) the beginning of adolescence inevitably entails the adolescent losing the stable self-concept he had during childhood. Herewith adolescents struggle to find self-identity, and this struggle is often accompanied by erratic behavior. They experience to a greater or lesser extent, a sense of confusion, which could result in increasing tension and self-consciousness. Bezuidenhout and Dietrich (2004: 63) note that out of these changes emerges a pattern of thought and volition that defines self. At this point of development the pursuit of independence and an identity is prominent. During these years, the dependence-independence struggle becomes central. Although teenagers yearn for independence form their parents, they also long for their security (Corey & Corey, 2002: 307).

According to Corey and Corey (2002: 306) “one of the most important needs of this period is to experience successes that will lead to a sense of individuality and

connectedness, which in turn lead to self-confidence and self-respect regarding their uniqueness and their sameness." Adolescents need opportunities to explore and understand the wide range of their feelings and to learn how to communicate with significant others in such a way that they can make their wants, feelings, thoughts and beliefs known. They need to be trusted and given the freedom to make some significant decisions (Corey & Corey, 2002: 307).

Adolescence is also described as a time when key decisions are made that can affect the course of one's life. To make these choices wisely, they must have information both about their abilities and interests. These abilities could help them to resolve issues concerning their own value system. Furthermore, adolescence is known as a time of questioning, challenging, exploring, and critically examining the actions of peers and adults. These specific characteristics of adolescents' cognitive development play an important role in the formation of their identities. These pursuits are viewed as essential if the adolescent is to make a successful transition from childhood to adulthood (Corey, 2004: 7; Corey & Corey, 2002: 307; Gallahue & Ozmun, 2002: 347; Louw, van Ede & Louw, 1998: 430).

In order to grow towards adulthood adolescents have to accomplish certain developmental tasks or challenges (Gillis, 1999: 71; Louw, van Ede & Louw, 1998: 388). The successful completion of these tasks will enable them to function optimally in adulthood. Gillis (1999: 71-72) and Gladding (1997: 106) identified the tasks as follows:

- Adjusting to changing bodily growth,
- Mastering new, complex ways of thinking,
- Dealing with awakening sexuality, and the powerful drives which accompany it,
- Achieving a satisfactory sexual identity,
- Learning to relate to peers and to society in a mature way,
- Attaining emotional independence from parents, family and other adults,
- Accepting adult responsibilities, and socially acceptable values and behavior.

An important developmental task of the adolescents is to satisfy their sexual needs in a socially acceptable way so that it contributes positively to the development of their identity (Louw, 1992: 390; Louw, van Ede & Louw, 1998: 400). Their newly developed sexuality must also be integrated with their interpersonal relationships. These relationships that begin during adolescence offer the adolescent an opportunity to achieve a certain amount of sexual satisfaction and also the opportunity to develop his identity as a sexual being.

Gallahue and Ozmun (2002: 346) indicate that adolescence behavior is essentially exploratory and this exploratory behavior should not be viewed as unimportant for it helps adolescents to find their places in society. However, adolescence is characterized by exploration and experimentation, processes that may have lifelong consequences. Exploratory behavior carries high risks as a result; adolescence is often seen as a turbulent time full of heartaches and problems (Bezuidenhout & Dietrich, 2004: 63-69).

Adolescents often experience stressors associated with pubertal changes, demands for and engagement in sexual activity, and fears of early unwanted pregnancy. Sexual conflicts are also part of the adolescent period. Adolescents not only need to establish a meaningful guide for their sexual behavior but also must wrestle with the problem of their gender-role identification. Teenagers may have real difficulty clarifying what it means to be a man or a woman and what kind of a man or woman they want to become (Corey & Corey, 2002: 307).

Teenagers as a group are greatly misunderstood and stereotyped. Often adolescence is considered merely as an awkward phase of development characterized by rebellion and confusion, when the personality patterns of childhood are destroyed and reassembled. However, Corey and Corey (2002: 307) note that adolescence is a time for continually testing limits. During adolescence the young experiment with aspects of life and take on new challenges (Bezuidenhout & Dietrich, 2004: 63). They use this processes to define and shape their identities and their knowledge of the world. This period is characterized by an urge to break away from control or dependent ties that restrict freedom. Although

adolescents are often frightened of the freedom they do experience they tend to mask their fears with rebellion and cover up their dependency by exaggerating their newly felt autonomy. These defense mechanisms play an important role in a way early adolescents react to situation and interact with others. The rebellion of adolescents can be understood as an attempt to determine the course of their own lives and to assert that they are who and what they want to be rather than what others expect of them. Inappropriate behavior may often be a consequence of the internal struggles. Adolescents clearly have a difficult time dealing with the heightened intensity of their emotions and reactions (Corey & Corey, 2002: 307; Geldard & Geldard, 1999: 8-9).

In the following section the stages of adolescence are discussed. The stages in the life of an adolescent do not generally flow neatly and predictably in the order described below. In actuality there is considerable overlap between stages.

4.3 THE ADOLESCENT STAGES

According to Bezuidenhout and Dietrich (2004: 65) as well as Collins (1998: 167) the adolescent stage is divided into three overlapping stages, that is: child adolescence, mid adolescence, and adult adolescence. Gillis (1999: 70) refers to the three stages as puberty, middle adolescence, and late adolescence. According to Louw, van Ede and Louw (1998: 385) many authors are inclined to describe adolescence in terms of the following three phases:

- Early adolescence, between approximately 11 to 14 years
- Middle adolescence, between approximately 14 to 18 years
- Late adolescence, between approximately 18 to 21 years

The early, middle and later stages are differentiated by differences in cognitive, emotional and social thinking. During early adolescence the individual is learning to cope with the demands of rapid growth. Early adolescents normally ask the question, "What is happening to me?" In mid adolescence, adolescents experiment with

developmental changes in a number of different areas. In mid adolescence the statement "I'm almost grown-up, but I still need answers to a great many questions" occupies the adolescent's mind. This period has fewer physical changes but the adolescent must adapt to his or her new identity as a person with an adult body. In late adolescence, the adolescent is forming a meaningful and stable personal identity, and taking mature decisions with regard to one's future. During this stage, the adolescent is occupied with the question. "Who am I as a person, and where am I going in life?" As a group, late adolescents continuously reach out for growth and change and become the pioneers of each generation. By late adolescence many young people are psychologically ready for an active sexual life which includes intercourse (Bezuidenhout & Dietrich, 2004: 65; Collins, 1998: 167-168; Gillis, 1999: 72-75; Gladding, 1997: 107; Geldard & Geldard, 1999: 4).

Since the focus of this research is on early adolescence in the following section this stage is described fully.

4.4 EARLY ADOLESCENCE

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 (Simons, 1994: 260). Biological factors have a more obvious influence during early adolescence than during other stages of life. Early adolescence is dominated by a sharp acceleration in the physical rate of growth of the maturing body known as puberty (Gillis, 1999: 72). These changes are the only characteristics of adolescence that can be said, with certainty, to be universal.

During early adolescence the body changes from that of a child into that of an adult and this period is known as puberty. Puberty is known as a period during which sexual maturation takes place. Puberty refers to the biological events which surround the menstruation in girls and the first ejaculation in boys. The onset of puberty is generally

termed pubescence. The pubertal phase generally occurs between the ages of 11 and 15. It is characterized by rapid physical changes. 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 (Gallahue & Ozmun, 2002: 296; Geldard & Geldard, 1999: 3; Simons, 1994: 256; Louw, 1992: 383; Louw, van Ede & Louw, 1998: 388).

Simons (1994: 258) indicates that puberty is more than a physical event. It is viewed as not point in time, but rather a process. The fact that it is a process indicates that puberty is fairly gradual, usually lasting from 2 to 4 years. Louw (1992: 385) is of the opinion that this stage lasts for about two years and ends at point, which an individual is sexually mature and able to reproduce. During this process most early adolescents are in the junior high school or the first year of high school. They are undergoing the bodily changes of pubescence and mental changes of cognitive maturity (Specht & Craig, 1987: 149).

Puberty begins when the ovaries and related organs, such as the uterus in girls and the prostate gland and seminal vesicles in boys, begin to enlarge. According to Louw, van Ede and Louw (1998: 388) the rapid sexual maturation is initiated by gonadotrophin (sex hormones), which stimulates the gonads (testes in males and ovaries in females). The onset of puberty is usually attributed to the action of male and female sex hormones during adolescence. Males produce male hormones known as androgens and females produce female hormones estrogens (Louw, van Ede & Louw, 1998: 388-389). When the level of these hormones is sufficiently high, puberty comes to an end.

Furthermore, during pubescence primary and secondary sex characteristics begin to appear. Changes in the reproductive system (sex organs mature, changes in the endocrine system) are the primary sex characteristics. Other changes, from hair distribution to voice range, are changes in secondary sex characteristics. The first visible signs of the commencement of puberty are the development of breasts in girls and the appearance of public hair in boys (Louw, 1992: 385; Louw, van Ede & Louw, 1998: 389).

Table 7 gives the developmental sequence of the primary and secondary sexual characteristics for boys and girls during puberty.

Table 7: Developmental sequence of the primary and secondary sexual characteristics

FEMINE	MASCULINE
Enlargement of breasts	Enlargement of testes, scrotum and seminal vesicles
Appearance of straight pigmented armpit hair	Appearance of straight pigmented public hair
Rapid physical growth	Growth of penis
Appearance of curly public hair	Voice breaks
Enlargement and development of vagina, and clitoris and uterus	Growth of beard
Menstruation (initially at irregular intervals; ovulation unstable)	Growth of curly public hair and armpit hair
Localized fatty deposits	First ejaculation (sperm count low; infertile)
Sebaceous glands more active	Spermatogenesis (formation of spermatozoa)
Increasing maturity of reproductive organs	Seminal emissions

Adapted form Louw (1992: 385)

Hoge (1999: 18) notes that the sequence of development in the sexual maturation of boys and girls normally results in complete sexual maturity around the age of 13 for girls and 15 for boys. According to Gallahue and Ozmun (2002: 299) the onset of the preadolescent growth spurt and puberty marks the transition from childhood to reproductive maturity. The physical changes and appearance of secondary sex

characteristics are frequently a cause for heightened interest in one's body and a dramatically increased level of self-consciousness. The development of secondary sex characteristics is a focus of much adolescent concern because they are much visible than reproductive organs.

In early adolescence, young people tend to form close relationships with friends of the same sex because they feel secure with them. During this time, some will become involved in sexual experimentation. However, for others the sexual feelings of early adolescence are managed through fantasy and masturbation. If young adolescents appear preoccupied with matters of sex, it is because a whole host of dramatic and rapid changes are occurring before their eyes. The young adolescent frequently feels like a spectator in his or her growth process. Each day seems to bring about changes that are whispered about, giggled over, and closely scrutinized. Therefore it is important that adults be sensitive to these physical changes and the impact that have on the social and emotional development (Gallahue & Ozmun, 2002: 299; Geldard & Geldard, 1999: 3).

The other noticeable event during early adolescence is the adolescent growth spurt. The growth spurt (i.e. the accelerated increase in height and mass) occurs during early adolescence. The average age for the onset of accelerated growth in boys is between 12 and 13, and in girls between 10 and 11. This spurt terminates sometime in adolescence and is generally followed by minimal changes in stature until growth is completed in late adolescence. During the 2 or 3 years of the adolescent growth spurt, gains of 2 to 4 inches in height and 10 to 14 pounds are not uncommon. The adolescent growth spurt is associated with the typical differences in height and skeletal structure that characterize men and women (Hoge, 1999: 18; Louw, 1992: 385; Louw, van Ede & Louw, 1998: 389).

According to Gladding (1997: 106) in addition to physical changes an early adolescent also experiences the normal problems that exist in the family, school and community. These might include pressure from peers, demands by the school for excellence, conflicting attitude of parents and other problems with establishing self-identity.

In summary Gillis (1999: 72) describes early adolescents as follows: They are the center of their own world, and tend to view everything almost exclusively through their very restricted, personal frame reference; parents are no longer automatically considered all-knowing; the peer group begins to increase in importance and influence, and there is pressing need for social acceptance by the group; their sex drive continues to increase hence there may be experimentation with what appear to be sexually appropriate or inappropriate sex roles. These characteristics will be discussed in detail in the following sections.

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 behavioral 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.

According to Louw, van Ede and Louw (1998: 384) since the age boundaries of adolescence vary it is important to demarcate the adolescent developmental stage on the basis of specific physical, cognitive, psychological developmental and socio-cultural characteristics. In the following section adolescent development will be discussed based on the specified characteristics.

4.5 ADOLESCENCE AS A DEVELOPMENTAL STAGE

Gallahue and Ozmun (2002: 354) state that the process of development is continual and multifaceted. As already mentioned tremendous changes are occurring during adolescence. It is a time of physical, cognitive, social and emotional changes. However, most apparent are the physical developmental changes.

4.5.1 Physical development

As already discussed earlier, adolescence is characterized by a period of rapid physical change known as puberty (Geldard & Geldard, 1999: 3; Louw, van Ede & Louw, 1998: 388; Sdorow & Rickabaugh, 2002: 115). The end product of the process called puberty is adult sexual dimorphism. Stevens-Long and Cobb (1983: 85) define sexual dimorphism as the physical distinctions between males and females. Focus here is on the differences between female and male development. Morphological changes occur in the ovaries and uterus of females, in the testes of males and in the genital tract of both sexes. These events signal the beginning of a process of profound physical change.

Females' development: According to Gallahue and Ozmun (2002: 300) the following are the signs of female journey to sexuality. Breast growth marks the first visible sign of the female journey to sexual maturity. Breast development begins around the age of 11 and is completed around age 15. Public hair is usually the second sign of progress toward sexual maturity. On the average, hair growth begins between 11 and 12 years of age. Furthermore, hairs may grow around the nipples of the breast, becoming coarser and more profuse with age. Changes in female genitalia are usually the third step in progress toward reproductive maturity. Some development of the external genitals is also common. The external sex organs (i.e., the vulva, mons, labia and clitoris) increase in size and become sensitive to stimulation. The internal sex organs of the female also undergo considerable change. The uterus and ovaries increase in weight. The vagina increases in size and the ovaries although structurally complete at birth, continue to moderately gain weight throughout adolescence. According to Geldard and Geldard (1999: 3) these changes trigger an increase in sexual arousal, desire and urge to have sex.

The highlight of puberty in females is marked by a clearly distinguishable event, menarche. Menarche is the most dramatic sign of sexual maturation for girls as is the beginning of menstruation, the monthly sloughing of the lining of the unfertilized womb. Furthermore, it is indicated that girls who have been prepared for menstruation usually accept it with a feeling of pride and enhanced status. However, for some especially those

who have not been prepared experience shock and repulsion and do not see it as a sign of womanhood but a negative experience (Louw, 1998: 389; Louw, van Ede & Louw, 391).

Other developments are the accumulation of body fat (which means a young girl increases in body weight), rapid height growth, hips becoming broader and softer in shape, slight deepening or lowering of the voice, and changes in the texture of the skin (Amanat & Beck, 1994: 5; Louw, van Ede & Louw, 1998: 390).

Males' development: Puberty begins in males with growth of testes. Increased testicular growth begins around 11.5 years of age and may range from ages 10 to 14. As the male reproductive gland, the testes produce sperm and male sex hormones. As the level of sexual hormones increases rapid growth may begin. Public hair growth begins as early as age 10 or as late as 15. Penis growth begins a year after the first onset of testicular and public hair growth. The scrotum first becomes larger, followed by the lengthening and then thickening of the penis (Gallahue & Ozmun, 2002: 301; Louw, van Ede & Louw, 1998: 392).

Louw, van Ede and Louw (1998: 392) note that the most symbolic sign of sexual maturation in boys is the first seminal emission (the discharge of seminal fluid). In adolescent boys an erection may sometimes occur spontaneously or it may occur as a response to a large number of psychosexual stimuli, such as erotic pictures, sounds, smells, words or even athletic activity. Adolescent boys may experience anxiety about increased frequency of erection or increased feelings of urgency at puberty. Ejaculation is often experienced for the first time during sleep and is most often accompanied by erotic dreams (Louw, 1992: 390; Louw, van Ede & Louw, 1998: 398).

Other noticeable secondary sex characteristics are axillary's hair, facial hair and deepening of the voice, beard growth, trace facial lip hair, appearance of other bodily hair and the broadening of the shoulders (Louw, van Ede & Louw, 1998: 392; Amanat & Beck, 1994: 5). These changes are all associated with progress towards reproductive maturity.

Changes in the length of the vocal cords are changes that are more noticeable in boys than in girls. Many boys complain about voice changes more often than any other aspect of puberty, with the important exception of penis growth. Furthermore, acne is related to androgen production, and because boys produce more androgen, they complain more often of profuse sweating and skin eruptions (Louw, van Ede & Louw, 1998: 392-399).

Obvious sex differences between males and females may have far reaching effects. All differences seem to have their advantages and disadvantages. Therefore Louw, van Ede and Louw (1998: 392) note that an important developmental task during this stage is the acceptance of changed physical appearance. There may be issues for the adolescent who may feel embarrassed, self-conscious, and awkward about his /her body.

The biological changes of adolescence result in emotional, social and cognitive changes. In the following section focus will be on emotional changes.

4.5.2 Psychological development

During adolescence, the rise in sexual hormones may influence the person's emotional state. Young people during adolescence stage mature physically and mentally, but they struggle with psychological issues related to their growth and development. Adolescents must cope with crises in identity; dramatic body changes; their desire for independence; career decisions and self-doubt. Research on early adolescence has been especially fruitful on such topics as how the timing of puberty affects the psychological development, the description of generational changes, and the influence of appearance or body image on the growth of personality (Geldard & Geldard, 1999: 4; Gladding, 1997: 105; Stevens-Long & Cobb, 1983: 96).

Louw, van Ede and Louw (1998: 394) note that adolescents in industrialized countries such as South Africa are very aware of their body shape and appearance. As already mentioned one of the developmental tasks during adolescence is the acceptance of a changed physical appearance. However this acceptance is not always easy for

adolescents. The biological changes during puberty present an important psychological challenge to adolescents and their implications will become clear in the following detailed discussion of the psychological challenges.

4.5.2.1 Body image and appearance during early adolescence

Body image is a person's mental representation of his or her physical body and includes the sensations, feelings and attitudes that a person has toward his or her body (Simons, 1994: 256). According to Olivier (2004: 137) females are frequently victims because of their preoccupation with slenderness. Most young teenagers are more concerned about their physical appearance than about any other aspect of themselves and many are dissatisfied of what they see in the mirror. Young adolescents focus primarily on their bodies and physical appearance because puberty has changed their appearance and bodily processes so much that they are forced to become body-oriented. Their self-image receives renewed scrutiny at this time.

According to Simons (1994: 258) pubertal change is most stressful when an early adolescent feels different from peers and when the changes are not seen as desirable. Whether a person sees himself or herself as thin or fat, tall or short, beautiful, average or unattractive reflects on part what he or she sees in the mirror is how others react to that person. Both sexes worry about their weight, their complexion, and their facial features. However, girls tend to be unhappier about their looks than boys of the same age. Most early-maturing boys have enhanced body image and improved moods; however, most early-maturing girls have decreased feelings of attractiveness. This makes it difficult for them to control and modulate their behavior responses which at times may be inappropriately extreme. The sex difference due to early-adolescent results in males feeling more positive about their body changes than females (Geldard & Geldard, 1999: 8; Simons, 1994: 258).

Given the pace of change in adolescence, sometimes body images are realistic helpful reflections, but sometimes are distorted as early adolescent boys often complain of awkwardness and feeling out of proportion whereas girls are more concerned about their

skin and with their figures, especially their weight. According to Stevens-Long and Cobb (1983: 139) because adolescents often believe that others are as concerned about them as they are, negative self-evaluations are likely to result in feelings of shame, a public oriented emotion. Geldard and Geldard (1999: 8) state that shame is a major disruptive emotion of early adolescence. Adolescents frequently experience feelings of ridicule, humiliation and embarrassment, and feel disgusted and ashamed of themselves. This is both stressful and anxiety provoking for them.

Self-consciousness dramatically increases in early adolescence and then gradually declines from middle adolescence through late adolescence (Simons, 1994: 261). Early adolescents may feel like they are on a display and that everyone is preoccupied with observing and critiquing them. Late adolescents are not as self-conscious and concerned with others' reactions and opinions. They no longer perceive themselves as unique.

4.5.2.2 Body image, self-concept and self-esteem

According to Hoge (1999: 24) self-concept refers to the image people hold of themselves and self esteem refers to the extent to which individuals place a positive or negative value on the way in which they perceive themselves. In other words self-esteem is the evaluative component of the self-concept. From a very early age children begin to form an image or picture of themselves and this is largely based on the way in which they are treated by significant people in their life. These people through their responses give them information about themselves and about their behaviors. As a consequence, they will develop both positive and negative attitudes toward themselves. People who have a positive self-esteem evaluate themselves as being worthwhile and capable (Baron & Byrne, 2003: 171; Collins, 1998: 314; Geldard & Geldard, 2004: 209; Gillis, 1999: 79; Van Niekerk, Van Eeden & Botha, 2001: 73).

Self-focusing is more pronounced during adolescence. According to Collins (1998: 314) the development of good self-image and positive self-esteem is considered important for adolescents. Between the ages of 10 and 14 young people are more self-conscious.

Adolescent's body image is to a great extent, linked to their self-esteem and their experience of how other people perceive them. Adolescents are acutely aware of the physical changes they experience. In order to form an idea of their identity they have to integrate these changes into their existing identity to form a unified whole (Corey & Corey, 2002: 308; Louw, van Ede & Louw, 1998: 393).

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. The most serious feature of children suffering from low self-concept is their fear of 'not being good enough' to perform completely. 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 (Baron & Byrne, 2003: 174; Geldard & Geldard, 2002: 116; Gillis, 1999: 80; Louw, 1992: 387; Stevens-Long & Cobb, 1983: 187).

During early adolescence when the growth spurt, pubertal changes, cognitive and social changes occur, adolescents are inclined to experience a temporary decline in their self esteem. Furthermore, negative life events have negative effects on self-esteem. For example, when problems arise in school or within the family or among friends, self-esteem decreases. Children with poor self-esteem are especially vulnerable to criticism and praise in the classroom. However as they adjust to their physical, cognitive and social changes, their feelings of self-worth are restored again. The value and judgment they place on their self-concept, that is, the level of their self-esteem, will inevitably have a major influence on their adaptive functioning (Baron & Byrne, 2003: 174; Geldard & Geldard, 2002: 209; Gillis, 1999: 81; Louw, van Ede & Louw, 1998: 433).

Louw, van Ede and Louw (1998: 434) mention that adolescents are often described as being more emotionally unstable than young children. The views that adolescents develop about themselves begin to determine their emotional responses. They are also

described as often having emotional outbursts and that they are inclined towards intense mood swings. When adolescents feel threatened, they close up and defend their beliefs. For example, if adolescents value their independence, they can easily find themselves in a heated argument with someone who has told them they may not do something. Arguing is a way in which adolescents can be sure that they are deciding things for themselves. Some adolescents with low self-esteem strive for social approval by behaving in ways, which are over-compliant, or by pretending to be self-confident when they are not. They are struggling to feel good about themselves (Collins, 1998: 169).

According to Louw (1998: 388) because of the profound physical changes, adolescence is a critical period in the development of the self-concept. The adolescent can only construct concepts of self within the context of relations with others, yet is also seeking to establish separateness through boundaries. Thus the adolescent development of self-concept is based on a balance of formation of personal identity and integration with society. Unless this balance is achieved there are likely to be personal crisis for the individual (Geldard & Geldard, 1999: 8).

While adults of teenagers dismiss adolescents' feelings about their looks, such feelings can have long lasting repercussions. The adolescents' body image is linked to their self-esteem and is also determined by their experience of how other people perceive them. The way adolescents view themselves is important for their self-concept and self-esteem. Unfortunately most of the children's negative feelings about themselves are formed from adult's evaluations. Negative feelings about themselves can affect their motivation to live and work as well as interpersonal relationships and future successes. Once formed, a poor or negative self-concept is difficult to reverse (Louw, 1992: 387; Thompson & Rudolph, 2000: 534).

Overcoming inferiority and helping young people build good self-esteem have emerged as significant for adolescents. Therefore attempts to change poor self-esteem should be directed towards bringing about more positive self-evaluations. Group work is generally

considered the most effective way of enhancing their self-esteem. Children can realistically and positively evaluate themselves through the process of group interaction. Specific area of skill development can easily be targeted through exercises and activities (Baron & Byrne, 2003: 175; Collins, 1998: 314; Geldard & Geldard, 2002: 210).

4.5.2.3 Internalized patterns of thought

Some authors suggest that adolescents engage in risky behaviors to demonstrate a mature status. They often become preoccupied with themselves and their thoughts, frequently fail to distinguish their own concerns from those of the people around them. They seem to have exaggerated feelings of self-consciousness. Because adolescents perceive themselves as special and unique, they think that they are invulnerable and indestructible. This attitude is linked and related to high-risk behavior such as drug use, heavily drinking, engaging in sex despite the fact that they see their friends overdose, or getting pregnant. They may not be trying to destroy themselves; they may believe that they are special and that what is happening to their friends will not happen to them (Bezuidenhout & Dietrich, 2004: 66; Louw, van Ede & Louw, 1998: 419).

4.5.2.4 Adolescents' identity development

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. Simons (1994: 291) defines identity as the sense of knowing yourself. The development of an identity seems to be a universal requirement for adolescence. It includes congruence between a person's view of himself and how others view him. It involves a sense of continuity between ones' past, current identity and future life plans (Hoge, 1999: 24; Louw, van Ede & Louw, 1998: 425).

Identity development is a lifelong process. Although identity development begins during infancy and continues till the end of the life cycle, the greatest degree of identity development occurs during adolescence. The process of identity development starts in

infancy until late adulthood. The process is accentuated in early adolescence because of the biological changes and new societal demands that bring the self to new awareness. Thus adolescence is known as a period of searching for an identity and clarifying a system of values that will influence the course of one's life (Corey & Corey, 2002: 306; Geldard & Geldard, 1999: 8-9; Gillis, 1999: 72-73; Louw, van Ede & Louw, 1998: 425; Zastrow, 2000: 65).

The adolescent has the task of forming personal identity which is unique and individual. The adolescent moves into a separate space of relative independence from family relationships, the weakening of ties to objects which were previously important to the young person when a child, and the increased capacity to assume a functional role as a member of society. To develop success identity, a person must experience both love and worth. Worth comes through accomplishing tasks and achieving success in the accomplishment of those tasks. A failure identity is likely to develop when a child has received inadequate love or been made to feel worthless. Failure to achieve a satisfying personal identity is almost certain to have negative implications. People with a failure identity are likely to be depressed, lonely, anxious and reluctant to face everyday challenges. Escape through drugs or alcohol, withdrawal, criminal behavior and the development of emotional problems are common (Zastrow, 2000: 65; Geldard & Geldard, 1999: 8).

The goal of adolescence is establishing personal identity and having this chosen identity confirmed by others. Teenagers display a development tendency for fluctuation in their self-esteem. They feel more needy, inadequate, and insensitive if not supported. At times when they receive adequate approval, praise and attention, they feel superior and exhibit a smart-alecky self-confidence. On the other hand, when they are humiliated, shamed or exposed to narcissistic injury, their self-esteem decreases rapidly and they feel depressed, inferior and full of shame (Amanat & Beck, 1994: 7).

According to Louw, van Ede and Louw (1998: 426) and Zastrow (2000: 64) the process of identity development implies that adolescents need to define who they are, what is

important to them, and what directions they have to take in life. During adolescence, teenagers develop a unique, integrated, and continuous identity, and use this growth in identity to develop a new role within their families and peer groups (Louw, 1992: 441). The adolescent is increasingly able to reevaluate parental rules and values to make independent choices about behavior. They begin to take a more active role in deciding things for themselves and in living with the consequences of their decisions and actions. Stevens-Long and Cobb (1983: 149) note that the process of achieving an identity involves some risk. There is a risk in making commitment to a course if action is based on one' own decisions. Not all early adolescents are willing to take these risks, and for some the process will continue into adulthood.

4.5.2.5 Adolescents' identity crises

Simons (1994: 291) notes that progress towards one's identity is achieved through identity crises. According to Louw, van Ede and Louw (1998: 428) the identity developmental crisis occurs early in adolescence and is resolved between 15 and 18 years. Identity crisis is viewed as useful since it can lead to complementary blending of an individual's energy or, unfortunately, to prolonged identity confusion, in which individuals regress or stay in unsatisfactory stand. In early adolescence, individuals are struggling to form a sense of personal identity.

One of the great paradoxes of adolescence is the conflict between a young person's yearning to find an individual identity, to assert a unique self different form anyone else in the world, and an overwhelming desire to be exactly like his or her friends. They do not wish to be perceived as being dependent, passive or weak. Peer group is a powerful influence in the adolescent's life, and acceptance by peers is a central concern. Many adolescents have conflicting loyalties between their families and their peer group. As individuals become increasingly independent of their families in early adolescence, they come to depend more on friendship. With this process of separation from parental figures and becoming independent persons, they relinquish many of the attachments of the past in order to achieve new bonds with their peers (Amanat & Beck, 1994: 9; Hoge,

1999: 29). However, many theorists argue that children experience the strength and freedom to step away from their parents and explore the world for themselves only when they can carry some of the parents' strengths along with them. Adolescents must sort through their feelings, needs, beliefs and attitudes and discover those, which are really theirs. Their emerging identities must reflect continuity with their past as well as a projection of themselves into the future (Stevens-Long & Cobb, 1983: 143).

"Identity confusion occurs when adolescents are indecisive about themselves and their roles. They cannot integrate the various roles, and when they are confronted by contradictory value systems they have neither the ability nor the self-confidence to make decisions" (Louw, van Ede & Louw, 1998: 427). They turn to have anxiety and hostility towards roles and values.

People arrive at their identities both by taking on new ways of being and by excluding others. Thus for adolescents, peers' perception becomes particularly important during this stage and parents perception less influential (Gillis, 1999: 73). They conform not only to the social behavior of their peers but also their norms concerning physical appearance and skills. Anything that obviously sent an adolescent apart from the crowd is apt to be unsettling.

4.5.2.6 Adolescents' sexuality

According to Simons (1994: 273) although sexuality has been part of the growing child, it takes a more urgent and enhanced role during adolescence. Because of the extensive physical development during puberty, adolescents become increasingly aware of their sexuality. Physical sexual growth increases the need for sexual interaction. Their newly developed sexuality also begins to form a part of their interpersonal relationships. Overall, adolescents' sexual attitudes become more permissive. Unfortunately, because adolescents are inexperienced they are likely to engage in sexual activity without fully understanding the social, psychological and physical consequences of this behavior. Adolescents who initiate sexual intercourse are likely to have poor health later on in life,

lower educational attainment, and are less economically productive than their peers (Amanat & Beck, 1994: 13; Bezuidenhout & Dietrich, 2004: 79; Geldard & Geldard, 1999: 39; Louw, van Ede & Louw, 1998: 400).

In early adolescence biological changes and new social pressures to become independent coincide with sexual freedom. Louw, van Ede and Louw (1998: 400) mention that the important developmental task of adolescents therefore, is to satisfy their sexual needs in a socially acceptable way so that it contributes to the development of their identity. Specht and Craig (1987: 161) describe early adolescent as a trial period where young people can form basic attitudes about sex roles and sexual behavior without feeling pressured to become too deeply involved.

During this phase, adolescents also discover their sexual orientation. Sexual attraction is usually focused on the opposite sex and heterosexual relationships which, provides adolescents with the opportunity for sexual gratification. They may become too attached and obsessed with opposite sex relationships. However it is noted that in early adolescence, masturbation and homosexuality are common sexual behaviors. Teenagers, in experimenting with sexuality, may have some homosexual experiences. Early male sexual impulses are most often expressed through masturbation. Although children masturbate from infancy, there is sharp increase in the frequency and prevalence of masturbation in early adolescence. Masturbation is described as a practice that teaches the adolescent to accept sexual longings and excitement more readily (Amanat & Beck, 1994: 8; Bezuidenhout & Dietrich, 2004: 76; Geldard & Geldard, 1999: 39; Gillis, 1999: 98; Thompson & Rudolph, 2000: 76; Louw, van Ede & Louw, 1998: 400; Zastrow, 2000: 245).

Stevens-Long and Cobb (1983: 111-112) note that although overall, relatively few adolescents report homosexual experience, many adolescents not only do not oppose homosexuality but in fact support it for any young people who have these reactions. They see laws against homosexual behaviors as labeling people. Most homosexual people become aware of their homosexual feelings in early adolescence. According to the

above-mentioned authors, the average age of such awareness is 13.8 for girls and 12.8 for boys.

According to Louw, van Ede and Louw (1998: 403) there is widespread evidence that adolescents are more sexually active and are becoming sexually active at a younger age than previously. Reasons that South African adolescents give for indulging in early sexual activity are: seeking physical pleasure, trying to prove that they are normal, to prove their love for someone, and getting carried away by passion and peer group pressure (Buga et al., 1996 in Louw, van Ede & Louw, 1998: 405). Research conducted among Xhosa-speaking adolescents in the rural areas of the Transkei indicated that 90.1% of the boys and 76% of the girls in the research groups were sexually active (Buga et al in Louw, van Ede & Louw, 1998: 405).

Louw, van Ede and Louw (1998: 413) state that a number of studies done on sexuality to South African adolescents have proposed the following guidelines to help adolescents cope with their sexuality:

- A holistic approach to sexuality education should be adopted. School-based programmes should include sexuality education, health education and life skills training. These life skills should include communication skills, conflict resolution skills, tolerance and negotiation skills.

- Sexuality education should start from preschool upward to dispel misinformation and lack of knowledge. This sexuality education should focus on loving relationships, power relationships between men and women, and respect for one's body and another's body, and not only on the physical aspect of sexual activity.

- Adolescents should receive instruction regarding the different sexual value orientations. This can provide some guidance in their confusion about norms and values and help them make responsible choices.

- Because of the tremendous influence of the peer group, peer-guided programmes could be used to instruct peers regarding the risks involved in making irresponsible choices. Many researchers believe that adolescents should be encouraged to delay sexual activity. Peers could also be utilized to guide such discussions.

4.5.2.7 Parental attitudes towards adolescence sexuality

According to Bezuidenhout and Dietrich (2004: 78) parents' attitudes toward sex influence adolescent adjustment. Parents are regarded as the primary socialization agents through modeling, identification and the establishment of mores for their children. It is noted that parents who hold traditional attitudes to sex and communicate those to their adolescents will influence their sexual behavior. Adolescents want to receive information from their parents about sex but often do not. In turning to adults for guidance there is inevitably a degree of embarrassment in discussing topics or behavior which are perhaps considered socially taboo or which are viewed in some way as being undesirable (Gillis, 1999: 97).

Mogotsi (1996: 78) noted that this situation exists because many parents are unable or unwilling to meet this need. They often feel confused, embarrassed, or emotionally inhibited to do so because their own parents rarely gave them information regarding physiological changes or sexual behavior. Furthermore, middle-aged parents have no models for teaching about sex, and what information they do have may be inaccurate. Sex as a subject is considered a taboo in most black cultures.

According to Baumrind (1990) and Lamborn et al. (1991) in Louw, van Ede and Louw (1998: 447) the social behavior of adolescents is influenced positively by parents who lay down certain rules for behavior. Simons (1994: 276) notes that the majority of researchers believe that parents should be actively involved in their children's sex education. Parent-child communication about sex influences the onset of the first sexual intercourse. Parents who discuss sexuality with their children help them to make better

behavioral choices and to avoid pregnancy. Further, today with prevalence of STD's and AIDS discussing sex with them may even save lives.

Therefore, Mogotsi (1996: 89) suggests that programmes are needed to ensure that accurate information is effectively communicated. These programmes might also provide a formal setting, which participants feel less emotionally inhibited by any cultural taboos.

4.5.3 Cognitive development

Along with physical changes, adolescents develop broadened cognitive capacities. In contrast to the physical changes that are conspicuous and occur universally, cognitive changes are less conspicuous and more variant (Geldard & Geldard, 1999: 4; Louw, van Ede & Louw, 1998: 412). Hoge (1999: 19) defines cognition as the mental processes used by humans to acquire knowledge and solve problems. The most important of these changes for adolescents has to do with the period of formal operational thought. Their thinking is concerned with the here and now. Individuals are assumed to reach this stage sometime during early adolescence. Its most significant feature is that the individual now acquires the ability to process information in purely abstract terms, discovers how to think about relationship issues, learns how to think creatively, critically and to reason logically (Geldard & Geldard, 1999: 4; Gillis, 1999: 73; Hoge, 1999: 19; Louw, van Ede & Louw 1998: 412).

Between the ages of 11 and 14 adolescents develop efficient convergent problem solving and the ability to do abstract thinking. They tend to be more concrete in their thinking. At about age 11 there is a critical shift in children's thinking from the use of elementary logic with reference to concrete objects and events to the use of more sophisticated logical thinking about abstract ideas. They become passionately interested in abstract concepts and notions and are therefore able to discern what is real from what is ideal. Generally adolescents' thinking becomes different from children. At their early teens, adolescents solve problems. At the highest level of thinking, individuals are able to

differentiate between theory and evidence, and they can coordinate the two. Practically every aspect of adolescents' thinking undergoes subtle change (Corey & Corey, 2002: 308; Geldard & Geldard, 1999: 4-5; Louw, van Ede & Louw, 1998: 416; Simons, 1994: 258).

Dworetetzky (1990: 511) notes that in most individuals, the ability to reason and to think becomes fully developed during adolescence. By the time children reach adolescence their cognitive development is advanced. They can understand metaphor, appreciate multiple meanings, and formulate counter-factual statements. They can imagine things that have never existed, set goals for the future, follow a philosophical discussion. They are able to think beyond the present, as the empirical world to be viewed as only one of an infinite number of possibilities. Above all, they can appreciate the fact that they can do all of these things (Simons, 1994: 259-260).

According to Papadou and Papadatos (1991: 24) adolescents are capable of prepositional and hypo-deductive thinking. These abilities are needed because at this stage the young person is developing a new identity, new roles, and new relationships. During this period of transition, previously held perceptions and understanding are reexamined, analyzed and changed. According to Specht and Craig (1987: 154) adolescents' new cognitive skills allow them to analyze a problem in their heads and determine all the possible solutions to it before they start to work on it. They also tend to anticipate the reactions of those around them and assume that their own self-assessment is matched by the approval of others.

Falvell (1977) in Geldard and Geldard (1999: 5) suggested a number of ways in which adolescent thinking progress beyond that of childhood. Included among these were the ability to:

- Imagining possible and impossible events,
- Thinking of a number outcomes from a single choice,
- Thinking of the ramifications of combination of propositions,

- Understanding information and to act on that understanding,
- Solving problems involving hypothesis and deduction,
- Problem solving in a wider variety of situations and with greater skill than in childhood.

Adolescence is described as a time for existential confrontations: Who am I? Who do I want to be? Where am I going? What is life? Adolescents scrutinize themselves, their changing body image, new feelings, new abilities, and new needs. Adolescents are more acutely aware of themselves. Furthermore, adolescence is a time of intense questioning. Parental authority is challenged, and parents find themselves compared to newly formulated ideals. The new intellectual changes that occur in adolescence have a profound effect on almost every aspect of life (Papadou and Papadatos, 1991: 24; Stevens-Long & Cobb, 1983: 120).

Childhood beliefs and existing values are subjected to close scrutiny, and there is a probing interest in the nature of God and of good and evil. Standards for behavior are constantly questioned and evaluated against more general life principles. At certain times, this awareness takes the form of painful self-consciousness; at other times, it produces feelings of self-importance and power. At times the intellectual changes of adolescents affect their behavior in ways that are less than easy to live with. However, these cognitive skills play a major role as they risk and learn to understand and value the sequences of their behavior (Bezuidenhout & Dietrich, 2004: 63; Louw, van Ede & Louw, 1998: 459).

4.5.4 Social development

According to Geldard and Geldard (1999: 90) a major challenge for adolescents is concerned with their need to find their place in society and to gain a sense of fitting in that place. This is a process of socialization involving an adolescent's integration with society. Gallahue and Ozmun (2002: 354) state that socialization is a lifelong process that is particularly important during adolescence. It refers to the modification of one's

behavior to conform to the expectations of a group. According to Sage (1986: 344) socialization is defined as the process by which persons learn the skills, attitudes, values and behaviors that enable them to participate as members of the society in which they live. A major characteristic of socialization is the transference of the beliefs, attitudes and values of a culture to its citizens. To become productive members of society, children must be socialized into the culture. Furthermore, socialization enhances the sense of personal identity and the development of personal identity assists the adolescent in dealing with society's expectations and standards (Gallahue & Ozmun, 2002: 350; Geldard & Geldard, 1999: 9; Zastrow, 2000: 203).

According Gallahue and Ozmun (2002: 352-354) many factors influence the process of socialization, including people, institutions, and activities. Each of these is briefly discussed in the following paragraphs.

- **People**

An Adolescent can only construct a personal identity in the context of relationships with others. Family members, peers, friends and significant others play critical roles in the social development of the adolescent. The family remains the dominant agent of socialization from childhood well into adolescence. It is a setting in which people learn how to deal with other people. It is the primary provider of the emotional, intellectual and physical environment in which a child lives. The family is responsible, among other things, for fostering a sense of autonomy, love and trust in the adolescent. It also has tremendous influence in introducing children to physical activity and sports. The family is regarded as the most important vehicle for promoting values in adolescence, enabling them to be successful at school and to have confidence in peer relationships. The socioeconomic status of the family, parental attitudes, encouragement, and personal participation have also been found to be important factors in adolescence development (Baron & Byrne, 2003: 300; Geldard & Geldard, 1999: 11-12; Gallahue & Ozmun, 2002: 352; Gutierrez, Parsons & Cox, 1998: 146; Zastrow, 2000: 6).

As adolescence approaches and childhood wanes, the dominance of the family is frequently diminished by a rise in the influence of the peer group. Building strong ties to a peer group is regarded as a first giant step toward autonomy for the adolescent. Gallahue and Ozmun (2002: 352) state that special friends and significant adults outside the family frequently play important roles in the process of adolescent socialization. The influence of these individuals sometimes even overshadows that of the family and the peer group. The respected friend or the revered coach affects the social maturation of the adolescent. According to the Carnegie "Council Report on Adolescent Development (1995) peer counseling and modeling behaviors of respected mentors offer promise as effective techniques for inspiring behaviors changes in adolescents.

- **Institutions**

Adolescents come into contact with a variety of societal institutions that affect how they are socialized. Society's expectations pose a challenge for adolescents and are valuable in helping them to progress along the path to adulthood. The school is probably the primary agent if for other reason than that is occupies the greatest portion of the day for the longest period. The primary influence of the school is in the acquisition of academic skills and knowledge, but its influence extends far beyond academic matters. School activities help adolescents to develop the skills necessary for healthy lives. This is an environment in which social attitude and social problem-solving skills are developed (Gallahue & Ozmun, 2002: 353; Geldard & Geldard, 1999: 10; Zastrow, 2000: 203).

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According to Hoge (1999: 30) because the school plays such a critical role in development, it is also the context in which many problems of development originate or, at any rate, express themselves. Adolescents might find the pressures of school stressful. Academic underachievement, delinquency, social rejection, and negative self-concept are all problems that may be associated with the school environment. The school also represents a useful venue for introducing interventions designed to address these problems. However school programs not relevant for adolescents' needs and interests, or that fail to promote learning enjoyment, are doomed to failure. If the school fails to offer

consistent direction and positive goals adolescents drift towards undesirable behaviors, tend to become confused and experience a generally diffused sense of self (Geldard & Geldard, 1999: 10).

- **Activities**

The activities that adolescents engage in are important in cultural socializations. Skills of daily living, recreational activities and competitive sport experiences play a major role in the socialization process.

According Gallahue and Ozmun (2002: 354) ensuring optimal development of adolescents should be a priority commitment of all socializing agents. No one group can be responsible for the successful integration of adolescents into society. All must work in concert to affect a maximum positive transition into adulthood. The following five recommendations have been adapted from the 1995 report of the Carnegie Council on Adolescent Development.

- Re-engage families with their adolescent children. Parents need to remain actively involved in their adolescent's education.

- Create developmentally appropriate schools for adolescents. Health education programmes that are developmentally appropriate need to be an integral part of the educational programme.

- Develop health promotion strategies for young adolescents. To reverse the dramatic increase in behavior-related conditions such as sexually transmitted disease, teen pregnancy, and teen suicide, proactive steps must be taken to instill in adolescents the knowledge, skills, and values that promote positive mental and physical health.

- Strengthen communities with adolescents. The community as a socializing agent must provide safe, attractive, positive growth-promoting settings during the out-of-

school hours. Youth organizations must expand their reach in offering more activities that teach adolescents about life, responsibility, and respect.

Overall adolescence is a difficult period in a young person's life. The difficulties faced by adolescents may be both stressful and rewarding. For most adolescents there is frustration and stress in being dependent on their parents and their school/community authorities and dealing with their environments. Vulnerable youth may be exposed to high-risk behavior as a way of escape. Reaching adulthood successfully and unscathed will be influenced by environmental stresses and hazards discussed in the following section.

4.6 ADOLESCENTS RISK-TAKING BEHAVIOURS

According to Bezuidenhout and Dietrich (2004: 63) adolescence is a time of risk taking. Risk taking behavior holds on the possibility of chance of negative consequence or loss. Adolescent behavior is often characterized by exploration. At times such exploration is unacceptable and even dangerous. "Adolescents are at moderate to high risk when engaging in one or more self-destructive behaviors that include unsafe sex, teenage pregnancy and childbearing, drug and alcohol use, under-achievement, failure and dropping out of school, delinquent or criminal behaviors, suicide, practicing satanism, violence, unsafe driving, fighting using foul language and running away form home" (Bezuidenhout & Dietrich, 2004: 66).

South Africa is experiencing a high rate of pathologies, which are threatening the lives of individuals especially the youth. These pathologies among others include: HIV/AIDS, substance abuse, child sexual abuse, juvenile delinquency, satanism, teenage pregnancy etc. (Anderson & Okoro, 2000: 7). Brack (2000: 12) adds by stating that many South African youths are not fully prepared for life and how to cope and as result, many of them end up being vulnerable or victims of life itself hence their social functioning becomes impaired.

According to Gallahue and Ozmun (2002: 346) it is naïve to assume that the period of adolescence will be as smooth and placid as childhood. Clearly, the choices made have powerful implication and lifelong consequences.

4.6.1 Indiscriminate sex and Sexual Transmitted diseases (STDs)

As already mentioned adolescence is a time of sexual exploration and experimentation; of sexual fantasies and realities; and of incorporating sexuality into one's identity. During early adolescence sexual interest and experimentation develop (Bezuidenhout & Dietrich, 2004: 75; Santrock, 2001: 183).

According to Dworetzky (1990: 546) attitudes toward adolescent sexuality and dating have become more permissive. Many teenagers are engaging in high-risk sexual behaviors such as unprotected sex, sex with multiple partners and the consumption of drugs or alcohol before sex. Clearly, there are significant risks in sexual behavior. Due to these unsafe sexual practices, these young people are exposed to many dangers or become more vulnerable to various pathologies. One of the most unfortunate results of an increase in sexual activity among adolescents is the resultant increase in sexually transmitted diseases. All diseases can be contracted by general poor health, lack of hygiene, and low resistance, but all genital infections labeled STDs can be contracted by sexual contact with an already infected person. The best known of these diseases are syphilis, gonorrhea, cancroids, herpes, chlamydia and HIV/AIDS (Baron & Byrne, 2003: 329; Geldard & Geldard, 1999: 39; Simons, 1994: 269; Tsatsi, 2001: 64; WHO, 2004: 1).

Lachman (2000) in Tsatsi (2001: 65) noted that each year approximately three million cases of sexually transmitted diseases occur among teenagers and approximately one million become pregnant. Furthermore, Drum's (200) as mentioned by Tsatsi (2001: 65) shocking findings showed that roughly 20% of South African teenagers were HIV positive and experts warn that the figure is bound to rise unless youngsters are given proper sex education. According to (WHO, 2004: 1) an estimated 10.3 million young people worldwide are living with HIV/AIDS and half of new infection - over 7000 daily -

are occurring among young people. The reasons for the high rates of venereal diseases among young people are many: increased sexual activity, substance abuse, refusal to use a condom, complacent attitude that STDs can be cured easily; adolescent beliefs that make the youth think they and their lovers are immune to the diseases that affect other people and the willingness to take risks because people want sexual intercourse more than they fear diseases. Many others do not know how to protect themselves (Bezuidenhout & Dietrich, 2004: 76-80; WHO, 2004: 1).

Various studies found that boys and girls become sexually active from the age of 14 years (Anderson, 1994; Mogotsi, 1996; The Girl Child Survey, 1998). Some teenagers end up being involved in prostitution and most of them lacking the facts and knowledge about sex. Mogotsi (1996: 86) further found that most children received their sex information from peers and exclaimed that the "most threatening finding is the minimal role played by parents". When she asked the school children about their attitude with regard to premarital sex, 60.2% said that it was completely acceptable; 23.1% were uncertain and only 16.7% were against premarital sex. This scenario leads to a high level of ignorance and misinformation for girls and boys regarding their sexuality. Consequently, their sexual education may be incomplete as much of their information originates from peers. Therefore they are likely to be unaware, for example of the subtle forms that venereal diseases can take whereas many will not seek medical attention unless they have more recognizable and more serious symptoms of the disease.

Mogotsi (1996: 87) concludes that her findings support the concept that health sex education should be introduced at an early stage of a child's life. Sapire (1994: 47) supports this statement by saying that although it is tempting to start sexual education late in a child's life, adolescents start experimenting with sex at an early stage. According to Gladding (1997: 109) adolescents could be helped to avoid contracting HIV/AIDS and other sexually transmitted by employing both an informational and skills-based intervention system. Adolescents could be offered opportunities for interpersonal skill building through simulating potentially hazard situations.

4.6.2 Drug abuse

Pharmacologically, a drug is any substance that chemically alters the function or structure of a living organism (Zastrow, 2000: 270). For the purposes of this study, a definition based on context is more appropriate. According to Zastrow (2000: 270) in a social problems approach, "a drug is any habit-forming substance that directly affects the brain and nervous system. It is a chemical that affects moods, perceptions, body functions, or consciousness and that has the potential of misuse because it may be harmful to the user." According to Bezuidenhout and Dietrich (2004, 67) different drugs are freely available on the South African black market. The news media, both television and newspapers, report on arrests of persons who traffic in drugs.

Zastrow (2000: 307) mentions the following as the most commonly used drugs: depressants (alcohol, barbiturates, tranquilizers), stimulants (cocaine, crack, caffeine butyl nitrate), narcotics (opium, heroin, morphine), hallucinogens (peyote, psilocybin), tobacco, marijuana, and anabolic steroids. Alcohol is by far the most widely abused drug in our society. The attitudes are formed or reinforced by the treatment of drinking on television. Furthermore, South African society has become more permissive in the sense that beverages containing alcohol are readily available and in abundance. There is a great deal of drinking without any negative consequences. Moreover, beer and wine are advertised extensively on television, and there is evidence that the more people see such advertisements, the more they are likely to drink (Bezuidenhout & Dietrich, 2004: 69; Brewis, 2001 in Brandt, 2002: 122; Lauer, 1998: 105).

Drug abuse is the regular or excessive use of a drug when, as defined by a group, the consequences endanger relationships with other people, are detrimental to the user's health, or jeopardize society itself (Zastrow, 2000: 270). Sue (1997: 251) describes substance abuse as a maladaptive pattern of recurrent of substances that extends to distress and continues despite social, occupational, psychological or safety problems. Drug abuse has become one of the most pervasive problems facing the community especially young people.

By far, the greatest teen drug of dependence and perhaps the most difficult social problem of adolescent chemical dependency is alcohol. The highest illicit use of alcohol is found among the youth. Adolescent alcoholism is a major problem encountered by physicians, psychologists, social workers, counselors, teachers and other professional dealing with teenagers. Adolescents who are moderate to heavy drinkers have more positive and more liberal attitudes about the use of alcohol. In South Africa alcoholic beverages are available at homes, restaurants, hotels, shebeens, bottle stores and shack shops, to name but a few. This makes it difficult to enforce the statute that states an individual has to be 18 years or older to buy alcohol (Amanat & Beck, 1994: 279; Anderson & Okoro, 2000: 8-9; Dollar & Dollar, 2002: 356; Gillis, 1999: 107; Lauer, 1998: 105).

Drugs and especially legal drugs have become an increasingly common part of the youth everyday life style and hence has become a major concern. It is a well-known fact that some teenagers use drugs when they get together. It is not uncommon to read research articles that give evidence of drug use in schools by learners. Furthermore, there have also been reports of drugs being sold on school property. Some adolescents take alcohol to school in their juice bottles. Legal drugs can harm or kill just as effectively as the illicit ones. Being legal does not mean that a drug is harmless (Amanat & Beck, 1994: 274; Bezuidenhout & Dietrich, 2004: 67; Gillis, 1999: 107; Lauer, 1998: 95; Louw, 1992: 187; Van Rensburg, 2002: 14).

Potgieter, Roos and Du Preez (2001: 325) state that alcohol consumption is on the increase among adolescents. Available statistics of drug abuse, which are totally inadequate and only touches the tip of the iceberg reveal that locally 2 out of every 3 children, are currently using drugs. (Fourie, 2001 in Brandt, 2002: 122). A substantial proportion of adolescents and children have been found drinking. A study conducted in 1995 among adolescents indicates that between 40% and 83% of high school pupils report having taken alcohol at some time during their lives (Morojole, 1997 in Potgieter, Roos & Du Preez, 2001: 325). Furthermore, a school survey undertaken by UNISA

reported that about one in four Grade 7, 10 and 11 learners get drunk occasionally during the course of a typical month (Pary, Pluddemann, Bhana, Matthysen, Potgieter & Gerber, 2000 in Brandt, 2002: 122). It is therefore impossible to determine the full extent of the drug problem in South Africa.

Bezuidenhout and Dietrich (2004: 68-70) and Gillis (1999: 108) have identified the following as reasons why adolescents use drugs. Some of the reasons are: a desire for acceptance by the peer group, curiosity as adolescents want to explore adult ways of behaving, copycat behavior i.e. adolescents copying the behavior of their parents, inadequate methods of coping with stress or tension by creating an artificial sense of well being through drugs, readily availability of drugs and the media portraying alcohol use in an appealing and social way.

Youthful drug-taking patterns generally follow those of the adult society. Children naturally imitate the behavior of others. Children of parents who drink alcohol will very probably also use alcohol. Some adolescents learn from their parents that drinking is a sophisticated activity. Just as adults take drugs to alleviate unhappiness, depression, anxiety, problems and day-to-day pressures, so do the youths. Most young people are said to have their first drink before they get to high school. They drink and smoke because it seems as a grown-up thing to do. The above-mentioned authors also state that adolescents start to use hard drugs like marijuana because they are curious, and they want to do what their friends are doing, and they want to hurtle into adulthood (Bezuidenhout & Dietrich, 2004: 68).

Norman (1986) as quoted by Anderson and Okoro (2000: 8) exclaimed that nearly every organ in the human body could be damaged by excessive and prolonged consumption of drugs. These include amongst others brain damage, heart diseases, high blood pressure and strokes, cancer of the throat, mouth and lungs diabetes, pancreatitis and cirrhosis of the liver. Furthermore, the use of addictive substances over a long period of time may impair the memory and problem-solving abilities of the individual. This will have consequences for scholastic and other academic achievements. Scholars who are

identified as substance abusers or addict could be asked to leave their school voluntary or could be expelled. The social costs of drugs include property crime and violence (generally committed to support the habit), motor accidents, economic losses, health problems, disrespect for the law, family disruption, spouse and child abuse, neglect, financial crises for users and adverse psychological effects on individuals. Teenage drinking is also closely linked to delinquent behavior (Amanat & Beck, 1994: 281; Bezuidenhout, 2004: 128; Dollar & Dollar, 2002: 356; Zastrow, 2000: 307).

Specht and Craig (1987: 170) noted that there is a need of services for troubled youths and their families. Some families can tolerate and successfully help a teenager who gets into all sort of trouble; however, others lack the resources to handle the situation. Of prime importance is the need for the adolescents to develop greater understanding of substance abuse. By increasing their knowledge base and learning what substance is, how it develops, its effects on the body and how to break out of an addiction, adolescents stand a better chance of keeping themselves out of harm (Dollar & Dollar, 2002: 377). According to Tsatsi (2001: 90) life skills are essential for young people who are perceived to be at risk of starting to experiment with drugs. The aim is to prevent the initiation of drug use. Gladding (1997: 109) states that these programmes work best when they are started early in adolescents' lives.

4.6.3 Teenage Pregnancy

According to Bezuidenhout (2004: 33) teenage pregnancies have reached epidemic proportions in Africa. It is estimated that approximately one million teenagers fall pregnant each year – about 30 000 of them before reaching the age of 15 years. South Africa is noted as experiencing a skyrocketing rate of teenage pregnancies coupled with increasing rate of HIV/AIDS infection among the youths. Although statistics of teenage pregnancies are not available in South Africa researchers have published figures that range from 13-25% (Bezuidenhout, 2004: 33). As in other developing countries, teenage pregnancies resulting in illegitimate births in South Africa have increased.

Teenage pregnancy is perceived as an "epidemic of adolescent child and child having children. It includes a pregnant person under the age of 18 who does not enjoy adult or legal status (Potgieter, Roos & Du Preez, 2001: 316). The pregnancy is most often not planned and constitutes a crisis. The highest risk groups are early-adolescents and those from socially and economically disadvantaged backgrounds. Furthermore, it is noted that teenage pregnancy in South Africa is more common amongst black teenagers than white teenagers. Reasons to this could be family disorganization within black families; rapid urbanization and westernization, which have eroded, many of the traditional norms and values of black families; and the poor socio-economic situations (Bernstein & Gray, 1997: 113; Bezuidenhout, 2004: 37-38; 2001: 16).

In a research undertaken by Preston-Whyte and Louw in Bernstein and Gray (1997: 113-114) the following were identified as the general factors that contribute to the high rate of teenage pregnancy among black teenagers in urban areas:

- Lack of supervision when both parents are working or in female-headed households where the mother is at work for long hours.

- Children becoming involved in helping their mothers make money in the informal sector. Girls would thus come into contact with adult men who had money available for drink or food, and would flatter the girls and "give them a good time".

- Poor or inadequate recreational facilities.

- Late entry to school and high failure rates which mean that many scholars are nearer 20 years old and many over 20 when they leave school.

- Sexual experimentation and involvement beginning at an early age.

- Peer group pressure against the maintenance of virginity for both sexes.

- Absence of formal sex education at school and reluctance among parents to raise the subject with their children.

Teenage pregnancy is viewed as detrimental to the teenager as it limits his/her future career prospects and therefore contributes to a lower socio-economic status for her and the newborn child. The implications of teenage parenthood are enormous for the young parents and the society at large as they are usually emotionally and socially immature and dependent. The major problem is that so many teenage mothers are poor. Hence the majority of pregnant teens never finish high school; as a result, they often become unemployed relying on social security grants. A teenage mother's socio-economic status, her education, health and family development are affected (Anderson & Okoro, 2000: 17; Bezuidenhout, 2004: 39-40; Gladding, 1997: 112; Louw, van Ede & Louw, 1998: 410; Potgieter, Roos & Du Preez, 2001: 317).

Teenage parenting is filled with many socio-emotional issues. Tsatsi (2001: 73) describes a teenager who becomes pregnant as having 90% of her life script written for her. Mdaka, Mbatha and Sejaramane in Tsatsi (2001: 73) outlined the following as the consequences of teenage pregnancy: disruption of schooling; loss of opportunity e.g. career; dangers associated with maternal health; and abandonment, foster care or adoption of the child. McWhirter et al. (1993: 143-144) further note that teenage girls who keep their babies are likely to suffer consequences such as standard housing, poor nutrition, ill health, unemployment, lack of education and financial dependency. A further problem that teenage mothers endure is the responsibility of raising the child alone. According to McWhirter et al (1993: 145) "many teenage fathers never acknowledge parenthood." The consequences of teenage pregnancy could cause a syndrome of failure, i.e. "failure to fulfill the functions of adolescence, failure to remain in school, failure to limit family size, failure to establish a vocation and become self supporting and failure to have children who reach their potential in life" (Blum & Godhagen, 1981 in Louw, van Ede & Louw, 1998: 410; Potgieter, Roos & Du Preez, 2001: 318).

Papalia and Olds (2002: 355) note that because pregnancy in adolescence can be so devastating to parents and the baby, it is up to the educators and government officials to do everything within their power to help teenagers avoid becoming children who bear children. The process of working with teenage parents is usually accomplished through collaborative efforts. In conclusion Tsatsi (2001: 63-64) notes that to minimize the prevalence of teenage pregnancy sex education should be part of a holistic life skills education programme. The implementation of these efforts might break this dysfunctional cycle. The following are guidelines based on findings from research studies and recommendations by those who work with adolescents (Papalia & Olds 2002: 355).

- Parents should discuss sex with children from an early age, instilling healthy, positive attitudes, and being "ask able," so that their children will feel free to go to them with questions. Such children are likely to delay sexual activity to an appropriate time.

- Schools, churches, and the mass media should offer realistic sex education, including information about the risks and consequences of adolescent pregnancy, the different kinds of contraception, and the places where teenager can obtain family services.

- Peer counseling programmes should be instituted to encourage sexually active teenage girls to use contraceptives, since research has indicated that they are more responsive to girls chose to their own age than they are to nurse counselors.

- Community programmes encouraging teenagers to delay sexual activity should be instituted. Such programmes can help young people stand up against peer pressure urging them to be more sexually active than they want to be, can give adolescents ways to "no" gracefully, and can offer guidance in problem solving.

4.6.4 Adolescent violence

Violence is the use of great physical force or intimidation, which at time is unlawfully exercised. The result of violence is outrage or injury. By acting in a violent manner, an individual disrespects and violates the rights of the victim. Adolescents are constantly exposed to violence in popular literature, television shows, video games and cult hero movies. In addition with the breakdown of many communities norms regarding conduct, many adolescents act aggressively and engage in destructive behaviors toward other people. Young people might even use a weapon such as knife or gun when having conflicts with others (Bezuidenhout & Dietrich, 2004: 72; Gladding, 1997: 110; Zastrow, 2000: 211).

Hickson (1992) and Mlazi (1994) in Van Niekerk and Prins (2001: 11) state that South African children are exposed to high levels of violence, with far reaching consequences for their lives. Magwaza, Killian, Petersen and Pillay (1993) as mentioned by Van Niekerk and Prins (2001: 11) found that 84% of children included in their study on intra-community violence appeared to be preoccupied with violence. This type of violence is frequently accompanied by the following, which all impact on most aspects of children's lives:

- The death or injury of family and friends,
- The loss of homes and belongings,
- The destruction of schools,
- The disruption of social services, and
- Increased levels of malnutrition (National Children's Rights Committee, 1994).

According to Gladding (1997: 110) young adolescents most prone to engage in violent behaviors include those with low self-esteem, asocial behavior, family abuse, resistance to counseling and depressive or suicidal behavior. These young people have little respect for social norms and hence they sometimes engage in violent behavior either to protect themselves or to harm someone else. Adolescents who have developed an impersonal

and insensitive attitude towards human life can and resort to violence and killing to settle their disagreements. Where adolescents have become members of a gang, they also learn to participate in violent activities, as violence is characteristic of most gang-cultures (Bezuidenhout & Dietrich, 2004: 72; Gladding, 1997: 110).

In conclusion causes of adolescent violence include among others lack of family structure - adolescent grow with no order around them; television violence that promotes youth violence; learnt behavior – aggression is a learnt behavior; child abuse – the majority of juveniles who kill others come from disorganized families; rock lyrics – there's strong relationship between antisocial and preference for rock music wiry destructive themes; greed or poverty; drug use and youth gangs (Bezuidenhout & Dietrich, 2004: 72-74). Anderson and Okoro (2000: 39) advocate an accelerated approach promoting the development of young people in the second decade of life. Central to this approach is that young people need to acquire life skills to safe guard them against harm. According to Gladding (1997: 110) these skills will empower young people to act in socially responsible and non-violent ways when faced with conflict or provoked.

4.6.5 Crime and Juvenile Delinquency

A crime is simply an act committed or omitted in violation of a law (Zastrow, 2000: 311). According to Bezuidenhout and Tshiwula (2004: 87) as well as Van Niekerk and Prins (2001: 11) crime is one of the most serious problems facing the nation. Further, it is noted that South Africa has a high rate of crime. A review of available statistics for 2003 shows a gradual increase in crimes such as attempted murders, robbery, rape accidents and a sharp increase in the number of indecent assaults (Bezuidenhout, 2004: 167).

A juvenile delinquent refers to a person under the age of 18 who has been arrested and found guilty of an offence punishable by law (Bezuidenhout, 2004: 176). The offence may be the kind of behavior that would be a crime no matter who did it, like robbery, rape or murder. Young people appear to commit far more than their share of crime, including the crimes that are classified as most serious such as rape, murder, robbery,

arson, burglary, aggravated assaults, auto theft, and larceny. Other adolescents come under the jurisdiction of the juvenile justice system for statuses offences such as truancy or refusing to accept parental supervision. Juvenile delinquency can therefore be understood to be an umbrella term that covers both juvenile crime and other antisocial actions (Bezuidenhout & Tshiwula, 2004: 87; Zastrow, 2000: 313).

According to Bezuidenhout and Tshiwula (2004: 87) juvenile delinquency is a universal phenomenon. Criminal behavior among adolescents is on the increase. In some countries, juvenile offence currently accounts for 60% to 70% of all recorded crimes in both the most and least developed countries including South Africa (Cilliers & Du Preez, 1991 in Bezuidenhout & Tshiwula, 2004: 87).

There are a number of explanations as to why adolescents participate in delinquent behavior. Lauer (1998: 155) notes that various family factors have been associated with delinquency. In essence, there is less delinquency among those youths whose parents value, love and accept them as well as spend time with them. In contrast, rates of delinquency are higher among those youth whose parents define them in negative terms.

Bezuidenhout and Tshiwula (2004: 92) hold that most people stay out of trouble because they are bonded to society's norms through their affiliations with their family. This bond is significant because it has the power to shape pro-social behavior. The children adhere to the society's norms because they do not want to fail their parents. However, the picture of the family of young offenders that emerges from many different studies is one of parents who are harsh, rejecting, or indifferent, and rarely affectionate; who neglect or beat their children, are erratic in their discipline, and rarely exercise consistent firm guidance. Poor relationships mean that the parents' moral and emotional authority over the children is weakened. That tends to weaken the children's bonds to the social order and increases the likelihood of delinquency (Lauer, 1998: 156).

According to Bezuidenhout and Tshiwula (2004: 92) delinquents sometimes become victims of indifference or actual hostility from their parents hence become less attached

to their parents. In addition, such parents are themselves unhappy, insecure, inadequate at coping with life, and unable to offer their children qualities to admire and copy. They are often so burdened with their own emotional and social problems that they have little time, energy, or sensitivity for their children. Adolescents may engage in antisocial, deviant behavior to increase their self-esteem.

Burchard and Burchard (1987) in Bezuidenhout and Tshiwula (2004: 90) identified the following factors as associated with juvenile delinquency:

- Being male rather than female, especially in a society that glorifies violence, power and winning, and makes cultural heroes out of the "cool and lawless",
- Living in a slum,
- Experiencing harsh, rejecting and inconsistent parental discipline, coupled with inadequate supervisions,
- Growing up in a home where there is martial discord and a lack of family affection and cohesions,
- Being rejected or abandoned by parents and, for males, perhaps particularly by fathers,
- Having a difficult temperament and exhibiting hyperactive, aggressive and other externalizing problem behavior as a child,
- Experiencing repeated failure in school,
- Being disadvantage and unemployed with little stake in mainstream society,
- Having a negative self-concept, and
- Associating with delinquent peers

The above factors clearly indicate that adolescents from poor families do not have the same probability of becoming successful adults, as do children of the middle class. Adolescents from poor families often lack the social or academic skills, even when they are able to achieve these, overt or covert discrimination may still block their way. Such circumstances may increase their drive and therefore the potential for lawlessness and

violence as a means of coping with failure. Similarly, troubled family relationships are more likely to result in adult criminal behavior (Lauer 1998: 156).

Lauer (1998: 161) mentions that there is a desperate need to curb juvenile delinquency alternative to the present system. However, studies of juvenile correctional treatment show that virtually nothing works (Whitehead & Lab, 1989 in Lauer 1998: 161). Diversion programmes take into account the fact that offenders are extremely unlikely to be rehabilitated in the existing correctional system. In conclusion Lauer (1998: 163) notes that it is important to ensure that the youth of the community have meaningful activities and opportunities. Programmes that stress self-improvement and responsibility would bring positive benefits. It is important, then to try to prevent crime among juveniles through community programmes targeting their behaviors.

4.6.6 Diet and eating disorders

Nutrition is of special importance in adolescence. Van Niekerk and Prins (2001: 78) mention that diet has a direct bearing on the state on one's health, moods and ability to perform. Because of the tremendous physical growth that occurs, nutritional requirements are increased during adolescence. Emotional needs and social pressures also feature in adolescent's eating habits. Adolescents can have enormous appetites hence gain weight. Dollar and Dollar (2002: 377) state that in a society that glorifies thinness, an enormous amount of pressure is put on adolescents to obtain the perfect body.

According to Oliver (2004: 137) eating disorders affect many adolescents and females are frequently victims. For example, about 95% of all anorexia nervosa cases are females. The most vulnerable age group is 12-30 usually with onset during puberty and reaching it peak during late adolescence. Teenagers are vulnerable probably because they become occupied with analyzing their bodies as they are undergoing revolutionary changes. As adolescents, especially girls, put on weight this leads to a lifelong struggle to get down to levels that are most desirable for both health and beauty. Being fat leads to more body

self-consciousness and fewer social activities. Careful scrutiny in mirrors reveals many imperfections that teenagers want to overcome (Oliver, 2004: 137; Simons, 1994: 264; Zastrow, 2000: 162).

Many girls entering adolescence find it hard to appreciate the attractiveness of their new curves. According to Oliver (2004: 137) teenagers who are self-critical about their physical aspects, thinking abilities fashion tastes may decide that improving their bodies is the area to tackle first. Individuals either driven by a deep-seated need to conform to societal pressure are known to suffer from eating disorders (Dollar & Dollar, 2002: 377).

The three primary disorders are anorexia nervosa, bulimia nervosa and compulsive overeating. However, in recent years, the different kinds of eating problems likely to affect adolescent girls are anorexia nervosa and bulimia. Both reflect the society's stringent standards of female beauty, exalting the ideal of slenderness above all else. Both also reflect individual pathologies trying to meet those standards through bizarre patterns of eating. These eating problems are regarded as strategies adopted by youngsters to escape from an unbearable situation of being over weight. These teenagers subject themselves to intense dieting, either to counteract overweight or to achieve idealized body proportions. Others embark upon rigorous regiments of physical fitness and strength training such as weight lifting, athletics, and exercise (Dollar & Dollar, 2002: 377; Oliver, 2004: 136; Zastrow, 2000: 162).

Anorexia nervosa is a disorder characterized by the relentless pursuit of thinness through voluntary starvation. Anorexia nervosa is described as an eating disorder in which individuals diet and exercise until their body is significantly below normal, which leads to serious, life threatening health risks. Anorexics do experience hunger pangs, but deny and suppress them with a strong will and self-discipline. Although anorexics look very thin and unhealthy to others, they usually have a disturbed body image and view themselves as overweight. They also erroneously believe that having a perfect body (defined by society as a thin body) will ensure happiness and successes. Anorexia

nervosa has an extremely high death rate (Dollar & Dollar, 2002: 378; Oliver, 2004: 136; Simons, 1994: 266; Zastrow, 2000: 162).

Another eating disorder that teenagers may acquire is bulimia nervosa, which is characterized by obsession and craving for food accompanied by binge eating followed by purging (Dollar & Dollar, 2002: 378; Oliver, 2004: 136). With bulimia an individual may binge-eat from 1,000 to 10, 000 calories and then use fasting, self-induced vomiting, laxatives and diuretics to purge themselves of feelings of being bloated, nauseous, and physically sick. Bulimics typically binge on high calorie junk food, such as sweets and fried foods. The most common way of purging that bulimics use is vomiting. Vomiting may be introduced initially by putting the fingers down the throat. Some bulimics use cotton swabs or drink copious amounts of fluids. With practice, many bulimics gain control of their esophageal muscles so they can induce vomiting at will. This is also accompanied by compulsive exercise, such as swimming running and working out with barbells and weights. Bulimia, although it is much common than anorexia, went unrecognized for a long time because the binging and purging cycle is almost always done in secret. Furthermore, many bulimia sufferers do not have an abnormally low body weight unlike those suffering from anorexia nervosa (Dollar & Dollar, 2002: 379; Oliver, 2004: 136; Zastrow, 2000: 162).

Anorexics and bulimics have some similarities. For example for the most part, they were good children, eager to obtain the love an approval of others. Both tend to lack self-esteem, feel ineffective, and have a distorted body image that cause them to view themselves as fatter than others perceive them. Anorexics and bulimics differ in that anorexics also are very thin, whereas bulimics are not as underweight and may even be overweight. Furthermore, bulimics' health may be gravely affected by binging and purging, but their lives are not necessarily in imminent danger as is often the case with anorexics (Zastrow, 2000: 162).

Eating disorders are the result of distorted self-perception. Often the individual compares himself or herself to an impossible and faulty standard of beauty or fitness. Adolescents

want thin bodies because these represent fashionable sliminess. They forget that everyone's genetic makeup is unique. Their insecure status increases their need for conformity, and they are extremely intolerant of deviations in body types such as obesity. They begin their journey of dieting, binging and purging as a way to cope with painful emotions. They also see this as a way to be in control of their life. However these acts cause damage not only to their physical health, but also to their self-esteem. Professional help is recommended because professionals are aware of life-threatening risks of these disorders (Dollar & Dollar, 2002: 381; Simons, 1999: 266; Zastrow, 2000: 162).

4.6.7 Adolescents and death

Death is a universal and inevitable process that must be faced by people of all ages. Sadly experiencing death is part of the lives of some adolescents. In recent years, the specter of HIV/AIDS has added a new pattern of deaths. It is now common for children and adolescents to lose members of their immediate family such as parents or siblings. According to AIDS Epidemic Update (2004: 2) there were about 3.1 million AIDS deaths worldwide in 2004. About 2.6 million people who died were adults. From these statistics it is clear that parents die in great numbers living their children. Coping with death is difficult for most adolescents because both death and adolescence are transitional phases (Papadatou & Papadatos, 1991: 43). 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 adolescents face a need to find meaning and purpose both in their lives and the deaths.

Grief arises because someone of value has been lost and the griever is faced with the emptiness and difficult task of re-adjusting. For most adolescents the grief over the loss of a close family member is difficult. Their reactions depend greatly on their understanding of death, their relationship with the deceased, and the existing family support systems. Adolescents who suffered the loss of a parent by death report intense shock, disbelief and a sense of loss usually accompanied by profound feelings of aloneness and despair. These experiences are found to be more intense than those of

adults. Bereaved children often feel "diminished, ashamed, and lonely". Peers are less able to identify with the bereaved child because bereavement is not part of their own experiences. Lack of empathy, in turn, makes it more difficult for them to give comfort and support to the bereaved peers. This perceived loss of peer status compounds their primary loss (Collins, 1998: 346; Geldard & Geldard, 1999: 23; Gillis, 1999: 163; Papadatou & Papadatos, 1991:29).

Collins (1998: 351) mentions that bereavement can be bad for one's health. Grief can put a lot of stress on the griever at a time when he/she is least able to resist the onslaught of illness. Furthermore, bereavement has also a negative impact on school performance. Papadatou and Papadatos, (1991:29-30) note that bereaved children and adolescence have difficulty concentrating on their work, loose motivation to learn, lack energy and as a result their school performance suffers. In addition they may become disruptive and act out in class. When teachers are unaware of the underlying cause of this school behavior, they may discipline and punish them when what they need is understanding, patience and support.

According to Geldard and Geldard (1999: 23) it is becoming increasingly recognized as important for adolescents to work through the grieving process so that their developmental process is not impeded by their grief. Papadatou and Papadatos (1991: 46) state that helping adolescents to cope effectively with death and bereavement begins in societies with principles of good communication and with accurate information about these subjects. The most widely available sources of help are family members, friends and pastors. However, there is a need of programs of education that help children to cope. Furthermore self-help groups, especially where there is a bond of shared experiences, can be a particularly valuable resource (Collins, 1998: 355; Papadatou & Papadatos 1991: 46).

4.6.8 Depression and suicide

According to Dollar and Dollar (2002: 367) depression and suicide are epidemics that touch the lives of thousands of people every year. Although a majority of people

consider suicide to be highly undesirable, a considerable minority at one time or another during their lives welcome or seek suicide. According to WHO (2004: 1) suicide is a huge public health problem, causing almost half of all violent deaths and resulting in almost one million fatalities worldwide every year. Estimates suggest fatalities could rise to 1.5 million by 2020. According to Potgieter, Roos and Du Preez (2001: 320) no official statistics have been available in South Africa since 1993. A survey conducted in 1992 reflected 1 039 suicides (Statistics SA, 2001 in Potgieter, Roos & Du Preez, 2001: 320).

Many individuals experience some level of suicidal ideation at some point during adolescence thus is considered a common problem among adolescents. Every year between 600, 000 to one million teenagers attempt suicide worldwide. Estimates indicate, for every successful suicide in the general population, 6 to 10 attempts are made. For adolescents, the figure is as high as 50 attempts for every life taken (Amanat & Beck, 1994: 213; De Leo, Schmidtke & Diekstra, 1998: 11; Santrock, 2001: 191).

Marcus (1996) and Cole and Siegel (1990) in Van Niekerk and Prins (2001: 320) define suicide as an act initiated and performed by a person in the knowledge or expectation of its fatal outcome – the act of killing oneself on purpose. This implies that suicide is the act of taking one's own life voluntary and intentionally. Suicidal behavior has a large number of complex underlying causes, including poverty, arguments, breakdown in relationships, family history of suicide as well as alcohol and drug abuse. A common factor among suicidal youth is depression. Highly stressful circumstances, such as loss in relation to family, parental separation, death, illness or poor progression at school, can trigger youth suicide attempts. Furthermore, family quarrels, lack of affection and emotional support as well as the pressure from adults are related to adolescent depression, which ultimately leads to suicide attempts. Adolescents who choose suicide as their option for coping obviously are seriously emotionally disturbed (Amanat & Beck, 1994: 200; Dollar & Dollar, 2002: 367-368; Gillis, 1999: 161; Gladding, 1997: 109; Geldard & Geldard, 1999: 49; Santrock, 2001: 191; WHO, 2004: 1).

According to Cunningham (2004: 109) negative parental attitudes towards the child increase the number of suicides among adolescents. Parents who are ambivalent in their demands upon their children often create uncertainty in their children. These adolescents may develop depressed feelings or be emotionally withdrawn to turn towards suicide as a means of coping with their situation. Adolescents suffering the loss of a friend who has committed suicide appear to be more likely to experience major depression occurring as a complication of the bereavement process. These adolescents may also develop an increased risk of suicide themselves after someone they loved has committed suicide. Guilt plays a greater role in bereavement when death has been by suicide as compared to natural causes. Many depressed teenagers do not admit to sadness or guilt, rather they withdraw from human contact. For them time passes slowly and life becomes meaningless or dreary (Amanat & Beck, 1994: 210; Geldard & Geldard, 1999: 23).

In addition Pillay in Cunningham (2004: 109) indicates that the cause for para-suicide among adolescents is associated with problems with their parents. Such problems include a lack of emotional involvement, intimacy and affection between parents and child, the reluctance of parents to allow their children their independence and low level of trust between parents and adolescent. 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 (Amanat & Beck, 1994: 200).

There are various reasons why adolescents ponder thoughts about suicide. However, most experts agree that the majority of depressive reaction can be traced to some traumatic event. For example, the grief reaction of a bereaved person can be intense enough to threaten life. Furthermore unfavorable social and economic circumstances such as poverty similarly may produce increased risk in adolescents. Suicide is considered as a cure for their obvious worthlessness (Cunningham, 2004: 112; Gladding, 1997: 109). Therefore, suicide attempts are often a kind of last-resort problem solving

aimed at changing someone else's behavior rather than true reflections of a wish to die young.

Depression is characterized by significantly impaired mood with loss of interest or pleasure in activities that are normally enjoyable. Depressed people feel extremely sad, grief-stricken and also report anxiety or apprehension and feelings of hopelessness. Their unpleasant thoughts include negative reactions to the self, ranging from disappointment and criticism to deep self-loathing. Pessimism about one's own future and the state of the world in general is characteristic. Depressed people may also become obsessed with ideas of disease and death. Sleep disturbances, difficulty in concentrating, tension, hostility, low tolerance for stress, and strong guilt feeling are all indicators of depression. In a very severe depression, an individual may begin to lose contact with reality, to prefer isolation; experience delusions and hallucinations cease conversing in a normal way. However, it is important to mention that depression in young people is not always identifiable as such, often manifesting itself in disguised forms such as restlessness, boredom, listlessness, pervading feelings of worthlessness, or even belligerency. Therefore suicide becomes a major concern when dealing with depressed young people (Dollar & Dollar, 2002: 368; Geldard & Geldard, 1999: 47; Gillis, 1999: 162; Stevens-Long & Cobb, 1983: 432).

While successful suicide ends in death, unsuccessful suicide may affect adolescents' mental and physical abilities and his or her psychosocial functioning. The adolescents may permanently scar their body, with lasting psychological effects, especially if they are asked about the reason for the scarring. Some injuries may be so severe that the individual may have to spend his or lifetime suffering the consequences (Cunningham, 2004: 109: 112).

According to Amanat and Beck, (1994: 215) and Gillis (1999: 161) any suicide attempt should be considered in terms of an urgent plea for help. Deep down the youngster does not want to end his life. Most teenagers desire to ask for help when they are suicidal but are fearful, ashamed, lonely, and often think others might consider them as crazy or

cowards. Stevens-Long and Cobb (1983: 439-40) note that if concerned, sympathetic, genuine efforts are made to deal with the problems in the family, another suicide attempt is unlikely. It is important to note that suicide is preventable. However, the above-mentioned authors mention that suicide prevention is still sadly neglected today by many governments and public health authorities. Suicide reduction requires a multi approach including improved management of depression and education. Intervention programmes tailored to the needs and circumstances of potential suicide victims are essential. The programmes dealing with suicide potential should be as broad-based, stressing the seriousness of such a self-destructive act. Discussion of death, dying and suicide in-group settings would seem to be proactive and a likely preventative step. If people understand that suicide is often a cry for help, then they may be able to consciously seek other more direct, less risky alternatives (De Leo, Schmidtke & Diekstra, 1998: 1; Gladding, 1997: 109; Stevens-Long & Cobb, 1983: 439-40; WHO, 2004: 1).

Having discussed risk behaviors that adolescents engage in, there is a general awareness that not all risk taking behavior is harmful. According to Bezuidenhout and Dietrich (2004: 63) some view risk-taking behavior during adolescence as a normative, healthy developmental behavior. Experimenting with new behaviors and feelings can encourage more complex thinking, increase confidence and help to develop their ability to assess and undertake risks in the future (Ponton, 1998 in Bezuidenhout & Dietrich, 2004: 63). Additional to this, there is an awareness that the majority of adolescents do not participate in unhealthy risks and that adolescents need to take risks in order to develop into, no-risk taking adults.

In this section a number of risky behaviors associated with adolescents' development have been considered. Risk taking behaviors such as substance usage can have life threatening consequences for the adolescent. Ways that people can employ to help prevent potential problems have been explored. Adolescents can be assisted in meeting the challenges they face through preventive means such as life skills initiatives. Through preventative means adolescents can be helped in dealing with the potential problems such as HIV/AIDS and other sexually transmitted diseases; substance abuse; teenage

pregnancy; sexual abuse, violence; suicide and depression. Following is a discussion of factors that expose young people to the above-discussed behaviors.

4.7 PREDISPOSING FACTORS THAT EXPOSE ADOLESCENTS TO RISKY BEHAVIOURS

While adolescents experience the developmental changes, they are also influenced by situational factors that shape their current behavior and future course of development. According to Bezuidenhout and Dietrich (2004: 66) there are numerous reasons why adolescents participate in risk behaviors that are self-destructive in nature. Various risk-taking behaviors are caused by social environmental factors. These factors include: poverty, disturbed family life, peer pressure, parent-child conflict, sexual abuse and lack of recreational faculties. These factors influence adolescents decision-making on daily basis hence have critical impact on adolescent development. Below is a brief discussion of the above-identified factors:

4.7.1 Poverty

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). Duncan (1997) in Van Niekerk and Prins (2001: 14-15) comes to the conclusion that since the first democratic elections in 1994, the quality of life for the large majority of black South Africans has not improved significantly. While he agrees that the economy shows signs of growth and the inflation rate is down, he argues the South Africa has the highest gap between the rich and the poor in society. Zastrow (2000: 137) state that in 2000 about 20% of children under the age of 18 were living in poverty and nearly 40% were children under 16. Van Niekerk and Prins (2001: 14) note that these children are not exposed to situations that would promote the development of the coping skills required to the meet the demands of an increasingly complex society.

According to Zastrow (2000: 157) an agreed definition of poverty does not exist. The usual definitions are based on a lack of money with annual income almost commonly used to gauge who is poor. Poverty does not mean simply that poor people are living less well than those of average income. It means that poor people are often hungry. Many are malnourished. Poverty may means not having running water, living in substandard housing. It means not having sufficient heat in the winter. It means great susceptibility to emotional disturbances, alcoholism and victimization by criminal as well as a short life expectancy. It also means lack of opportunity to advance oneself socially economically or educationally. The pain of poverty involves not only financial hardships but also the psychological implications that being "poverty stricken" have for a person (Zastrow, 2000: 128). Therefore in this study poverty refers to a condition in which people live below acceptable minimum standard of living and find themselves socially, economically and psychologically excluded from the mainstream of society.

As is the case with many social phenomena in society, it is difficult to determine a single causative factor for poverty. The causes of poverty are numerous. Poverty is viewed as the result of collective effective factors such as unemployment; low income; low standard of education and training; poor physical health, large families; absence of the breadwinner as a result of divorce, desertion or death of a spouse; substance abuse; retirement; war and other forms of violence (Bezuidenhout, 2004: 184-185; Zastrow, 2000: 138). This list is not exhaustive. However, it shows that there are many causes of poverty.

According to Walker and Walker (2000: 50) poverty is not confined to any particular group or place, but it is not a random experience. Certain groups of people are particularly vulnerable because of their economic or family status. Children and young people are amongst the largest segments of the poor population. Their poverty status is a consequence of the low income or lack of income of their parents(s) (Bezuidenhout, 2004: 182).

Compared to children of the non-poor, children of the poor are more likely to fail in school even when they are intelligent. Schools in poor areas are of lower quality and have fewer resources. As a result, the poor achieve less academically and are more likely to drop out of schools. They are more likely to be arrested, indicated, and imprisoned and they are given longer sentences for the same offences committed by the non-poor. They are more likely to experience hostility and distrust rather than neighbourliness with those around them. They are less likely to participate in meaningful groups and associations. Thus it can be said that vulnerability to poverty is closely associated to family status (Lauer, 1998: 219; Walker & Walker, 2000: 54; Zastrow, 2000: 128).

While many adolescents aspire to good jobs and adequate incomes, with all the security that these imply, the reality is that many are trapped in a cycle of poverty. This lack of options and desirable alternatives for the future lead some adolescents to increased sexual activity as a way of achieving immediate, if short-lived pleasure. Thus living in poverty is associated with early sexual activity (Bezuidenhout & Dietrich, 2004:78).

Some studies have shown that the socio-economic conditions that a teenager is exposed to, have an influence on his/her sexual behaviour (Anderson, 1994; Mogotsi, 1996). A study conducted by the National Research Council revealed that a large number of teenagers of all classes and races are sexually active, however most poor teenagers may be initiated into sex at a slightly younger age than the non-poor (Tsatsi, 2001: 69). Furthermore it was found in poor neighbourhoods, teenagers experience less control over many aspects of their lives than the non-poor (Tsatsi, 2001: 69). Similar findings from a national survey of young boys suggested that lack of economic resources and job opportunities at that neighbourhood level was associated with sexual activity (Kiy, Sonestein & Plek, 1994 as cited in Smith, 1997: 355).

According to Hambright as cited in McWhirter et al (1993: 140-141) girls with greater career and life options were significantly less likely to engage in sexual intercourse and are more likely to use contraceptives when they do engage in sexual activities. A study conducted by Jesser as cited in Smith (1997: 336) done with a predominantly white high

school sample found that higher expectations for academic achievement was associated with later sexual initiation. Due to poverty some teenagers are forced to resort to one of the oldest methods of earning money in order to survive i.e. prostitution. According to Lachman, (2000) in Tsatsi (2001: 39) because of lack of life skills, these children live on the streets and may simultaneously be infected with HIV/AIDS.

Children raised in poor families are likely to live in poverty in their adult years. The pain of poverty involves not only financial hardships but also other aspects of life. 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 (Bezuidenhout & Dietrich, 2004: 79; Zastrow, 2000: 140-142).

4.7.2 Disturbed family life

The second factor that exposes adolescents to risky behavior is a disturbed family life. Families are regarded as the primary agents of socialization. A disorganized family implies a breakdown of interpersonal communication. A disorganised family cannot fulfil this function adequately. Many children at risk of neglect come from dysfunctional families where there are problems of alcohol/drug abuse, violence or financial problems. It is the younger children, in particular, who may be deprived of important primary socialization development (Bezuidenhout, 2004: 9; Geldard & Geldard, 1999: 18; Zastrow, 2000: 233).

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Family disorganization includes the weakening maladaption or dissolution of ties that bind the members of the family as a group. This implies that the reciprocal relationship that should exist between the members of the family to create a smooth functioning social

group has been damaged. Factors such as violence, unemployment, imprisonment, natural catastrophes, diseases, desertion of a marital partner and death of one or more members of the family may lead to disorganization. Such an environment may provide the young person with feelings of insecurity during a period in life when much is changing. At a time when the adolescent is trying to establish independence it can be very disturbing for the family to be faced with these challenges (Bezuidenhout 2004: 3; Geldard & Geldard, 1999: 27; Potgieter, Roos & Du Preez, 2001: 328).

According to Bezuidenhout and Dietrich (2004: 66) the home environment of South African adolescents has gradually changed increasing adolescents' potential exposure to unhealthy behavior. Among a number of reasons for this change is poverty, influx of mothers into the labour market, the rise in single-parent families and a high unemployment rate that forces breadwinners to seek employment elsewhere, away from the family. According to the above-mentioned authors, all these factors create opportunities for adolescents to spend more time unsupervised or with theirs peers. This in turn increases the incidence of risk-taking behaviors.

Family disorganization may prompt members to engage in deviant acts, such as truancy, prostitution, drug abuse, suicide attempts and child battering (Bezuidenhout, 2004: 10). Such acts are often symptomatic of the disorganized state of the family. People who come from disturbed families tend to have various difficulties. According to Lauer (1998: 470) sexual variance, drug and alcohol abuse, and juvenile delinquency have been associated with a disturbed family life. Other kinds of difficulties include antisocial behaviors such as aggression and bullying, insecurity, over conformity to one's peers, a tendency to withdraw from relationships; difficulties in relations to others; problems with one's personal identity; and other various problems. Family members may also experience fear, anxiety and feelings of guilt about their situation (Lauer, 1998: 471).

Some parents engage in behaviors which are unacceptable to society with consequent damage to their children. Unfortunately when parents engage in anti-social and maladaptive behavior they increase the possibility of their children doing the same. Both

criminal behavior and alcoholism in parents especially particularly fathers, is related to adolescent anti-social behavior. Divorce, severe parental conflict, and abuse all are associated with higher rates of conduct disorder among children. Children may experience emotional problems and may run away from home in search of stability and security. Adolescents from divorced families tend to have higher rates of drug use and premarital sexual activity, poorer academic performance, and higher rates of dropout from school (Bezuidenhout, 2004: 10; Geldard & Geldard, 1999: 17).

Zastrow (2000: 313) identified family disorganization, especially the rapid increase in the number of female-headed families as one of the factors that contribute to high rates of crime among young people. Single parents and their adolescents are under potentially significant amounts of stress due to a combination of factors. According to Zastrow (2000: 205) divorced people have a shorter life expectancy. Suicide rates are higher for divorced men than for married man. In such families children lack male role models with legitimate jobs, leaving open the possibility that children will be influenced by others in the community, including individuals who engage in criminal activities. Children may have to adjust to lower standards of living, losing a mother full-time work. Children in situations such as those described need to be assisted and empowered to develop protective behaviors that can be used in times of crisis (Geldard & Geldard, 2002: 226-227; Geldard & Geldard, 1999: 27).

4.7.3 Parent-Adolescent conflict

As an infant becomes a child and then an adolescent, parenting can constitute more of a challenge. While attachment to parents remains strong during adolescence, the connectedness is not always smooth. Most parents do not know what is normal and realistic with regard to the expectations which they might have of their adolescent children. As their children grow through adolescence many parents become worried and at times distressed, by behaviors which are normal for adolescents. This leads to conflict between parents and their children (Geldard & Geldard, 1999: 11).

Early adolescence is a time when conflict with parents escalates beyond childhood levels. Teenagers beginning with puberty at age 12-13 become somewhat oppositional, secretive, and fight with family members over trivial issues. Adults are particularly distrustful of the influence of friends during adolescence. Intense interest in sexuality sometimes makes adolescents appear somewhat "wild eyed" to their parents. Both boys and girls have increased conflict with their mothers and feel less close to their fathers. Girls' level of conflict with their fathers increases notably (Santrock, 2001:471; Simons, 1994: 258; Amanat & Beck, 1994: 9). 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.

Also a natural part of the adolescent's growing up is gaining independence from his or her family (Bezuidenhout & Dietrich, 2004: 66). Because the adolescent is dependent on parents while seeking an independent identity tension emerges between parents and their children during this stage. Some adolescents have problems communicating their feelings, frustrations and needs and often use anger or other unacceptable behavior to cover up their feelings of hurt or frustrations. They would rather become violent, use drugs and alcohol, engage in sexual intercourse or drop out of school rather than admit that they hurt emotionally. Parents on the other hand might be shocked by adolescents' preferences in dress, music and vocabulary. Their own perception of adolescence is of children who mirror their parents, but adolescents' values oscillate between those of their parents and those of their peers (Santrock, 2001: 117; Stark, 1995 in Bezuidenhout & Dietrich, 2004: 66).

Adolescence is considered the stage in which parents or adults and their adolescent counterparts are meant never to understand each other. The parent-child relationship must always be seen as an interaction between two changing systems. Adolescents are coping with new demands, asking for new freedom, taking on new responsibilities, and learning to accept a changing physical self. Their parents on the other hand are often middle-aged. Middle-aged parents are in crisis too, going through their own identity crises, dealing not only with changes in their family system and the development of their

child but also with personal biological, occupational, and ideological changes. These changes sometimes raise parents' fears of waning sexuality and physical attractiveness at the same moment that adolescent children are blossoming (Bezuidenhout & Dietrich, 2004, 63).

According to Bezuidenhout and Dietrich (2004: 2004: 63) parents and adults assume that all risk taking is dangerous or harmful to the life of the adolescent. Furthermore, many of these parents hold fairly negative expectations about adolescence in general because they themselves grew up in a very different world that they perceived as less threatening. They worry about drugs; sexual promiscuity and the rejection of materialism that they believe characterize the young. Parents become distressed because their adolescent children do not want to discuss personal issues with them. Therefore, communication becomes strained by feelings of guilt and frustration, especially when an adolescent child is already likely to be critical and faultfinding. Honest sharing between a child who feels ambivalent and defensive and a parent who feels rejected or guilty is unlikely and may not even be helpful. When parents and adults hold such views, this may sometimes create behavioral patterns that severely disrupt the relationship between them (Bezuidenhout & Dietrich, 2004: 63; Geldard & Geldard, 1999: 12).

However, even when there are tensions in family life, the family remains one of the most important influences in an adolescent life. Thus an important challenge for adolescents is to maintain positive relationship with their parents (Geldard & Geldard, 1999: 11-12).

4.7.4 Peer pressure

At every age, people are influenced by their friends. Beginning at childhood, people establish friendships with peers who share common interests. However, there can be no doubt that peers play an increasingly important role in an adolescent's development. During adolescence parental influence is expected to reduce and the influence of peers to increase. The youth's self-identity, his or her social, academic, political attitudes,

relationships with parents and behavior are all profoundly affected by relations with peers (Gillis, 1999, 73; Geldard & Geldard, 1999: 33; Hoge, 1999: 29).

In the adolescent years peers become more important in forming adolescents' beliefs and regulating their behavior. As adolescents are striving for independence from their parents they have a need for acceptance. Because of this need to be accepted by their peers they are highly susceptible to peer pressure. The strong desire of many young people to be like their admired peers and part of a group can lead them to engage in anti-social behavior, that they perceive as characteristic of a particular group. Adolescent with high self-esteem and self-confidence are better able to resist negative peer pressure because they are more easily able to form and maintain friendships and to be accepted by others (Bezuidenhout & Dietrich, 2004: 78; Corey & Corey, 2002: 307; Geldard & Geldard, 2002: 226; Geldard & Geldard, 1999: 34).

Peer pressure plays an important role in many aspects of an adolescent life, including sexual decisions. According to Geldard and Geldard (2002: 226) most children want to be accepted by their peers and are therefore highly susceptible to pressure. This is particularly true for pre-adolescent and early adolescent children. Tsatsi (2001: 70) notes that teenagers sometimes feel isolated and want to feel that they belong to a particular group or want to be accepted by a certain group of people. In order to achieve this they must "blend" in with the members of these groups, and they therefore often engage in activities that they would not normally engage in.

Hoge (1999: 30) notes that the most extreme expression of peer group influence may be found in the effects of gang membership. All aspects of members' attitudinal and belief structures and their behavior are dictated by the peer group context. A major problem for gang members is the possibility of abuse. Gang members generally, but especially females can become victimized by other gang members and be subjected to physical, sexual and psychological abuse. Clearly adolescents in peer groups or gangs will generally be subjected to strong social pressures to conform to group behaviors. Where

these behaviors are self-destructive or anti-social there are likely to be negative consequence for the young person (Geldard & Geldard, 1999: 36; Gillis, 1999: 73).

In sum, a central part of the adolescent experience is peer group pressure, a force that pulls at the person to conform to the standard of friends. Because of the exaggerated need for approval, there is a danger that they will sell themselves out and increasingly look to others to tell them who and what they should be. This can lead to a range of behaviors that cause problems such as dependence on drugs. According to Geldard and Geldard (2002: 227) protective behavior education must include information about how to resist inappropriate peer pressure and learn skills as well as strategies to deal with peer pressure. Through education young people can become more self-reliant and less pressured by their peers.

4.7.5 Child sexual abuse

Childhood is a time of innocence, discovery, spontaneity, security and happiness. Unfortunately for some children including adolescents, unscrupulous adult abusers abruptly change the beauty of being a child. 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. 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).

Bezuidenhout (2004: 4) defines child sexual abuse as "the involvement of dependent, developmentally immature children and adolescent in sexual activities that they do not truly comprehend, and to which they are unable to give informed consent." It is the exploitation of a child for sexual gratification of an adult. Sexual abuse involves misuse of power and control, making it hard for children to protect themselves because they do not have adult strength. Sexual abuse includes sexual intercourse (genital or anal) but also oral-genital contact, fondling and behaviors such as exposing oneself to a child and

photographing or viewing a child for the molester's erotic pleasure. Experts believe that this type of child abuse is the most unreported due to the "code of silence" that often exists in these cases (Bezuidenhout, 2004: 4; Collins, 2004: 1; Dollar & Dollar, 2002: 386; Geldard & Geldard, 2002: 226; Gillis, 1999: 148).

Danya and Stephen (1988) in Anderson and Okoro (2000: 14) note that child sexual abuse normally occurs within families and that most of the abusers are known to the child victims, often being relatives and even adult friends. Children are abused by someone they know and trust. Children become vulnerable because of lack of knowledge and experience to make a properly informed decision about the subject. Furthermore, children do not have the freedom to give or refuse their consent in a truly independent manner (American Academy of child & adolescent psychiatry, 2004: 1; Anderson & Okoro, 2000: 14; Bezuidenhout, 2004: 49; Geldard & Geldard, 1999: 21; Gillis, 1999: 145; Zastrow, 2000: 255).

Sexual abuse within the family circle is known as incest whereas the act occurring outside the family (e.g. a neighbor, caretaker or stranger being the perpetrator) is termed child sexual molestation (Zastrow, 2000: 255; American Academy of child & adolescent psychiatry, 2004: 1). According to Bezuidenhout (2004: 49) the sexual abuse of sons by their fathers is considered a rare phenomenon. However, there is a high incidence of abuse between stepfathers and stepdaughters. Often a daughter will be manipulated into wrongly believing that the abuse is all her fault. In addition she may be threatened that if she talks to anyone about the abuse she will be seen as a bad person and may be arrested and jailed. Unfortunately, the outcome of such a situation is often for the adolescent to withdraw socially or run away from the family (American Academy of Child & Adolescent Psychiatry, 2004: 1; Zastrow, 2000: 255).

According to Zastrow (2000: 254) over 90% of child molesters are males and in most cases the offender is an acquaintance, friend, or relative. Force is rarely used. The abuser generally gains sexual access to the child by manipulation and enticement rather than by use of a threat of force or harm. The perpetrators may threaten to harm children

physically if they attempt to resist or if they disclose abuse. When sexual abuse occurs there is a high risk of physical harm hence children live in fear. Sexual abuse has devastating effects also on the intellectual, social and psychological development of children and recovery can be long and difficult. The scars are deep and can last for a lifetime. A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal distorted view of sex. Victims are at high risk for becoming abusers themselves or prostitutes (American Academy of Child & Adolescent Psychiatry, 2004: 1; Dollar & Dollar, 2002: 387; Geldard & Geldard, 2002: 226; Zastrow, 2000: 254).

Bezuidenhout (2004: 53) mentions that children who are sexually abused find it difficult to cope with their schoolwork. The parent child relationship may also be adversely affected. Children may experience feelings of depersonalization, and may regard themselves as sexual objects. The child may be accused of lying or be blamed for seducing the father or mother's lover when reporting the incident. A child may become withdrawn and mistrustful of adults and can become suicidal (American Academy of Child & Adolescent Psychiatry, 2004: 1).

Hunt and Baird (1990) in Bezuidenhout (2004: 53) found that when children do not experience adequate trust, love and stability, they are unable to predict event that may occur in the social environment. Therefore to address child sexual abuse a well preventive programme should be directed towards children and the youth when they are still in their most formative years (Anderson & Okoro, 2000: 17). Children need to be taught simple rules to deal with unfamiliar approaches, not to obey adults if their request or actions such as "bad touches seem to threaten their self esteem; and to differentiate between good and bad secretes with an adult they trust. Geldard and Geldard (2002: 226) suggest that counselors need to educate children with regard to appropriate sexual boundaries, and to help them to develop strategies for protecting these boundaries. They also need to empower children so that they are able to report instances of inappropriate behavior.

In conclusion Dr Darleen Edwards in Sunday Times (24 October, 1999) emphasized that children should be taught specific life skills to safeguard them against sexual molesters. Amongst others she suggested the following skills: "I am special; everyone deserves to be safe and happy; my body is special; I have the right to privacy; 'good' and 'bad' touches; how to keep my body safe; how to say 'no' and how to find help and report incidents".

4.7.6 Lack of recreational facilities

According to Bezuidenhout and Dietrich (2004, 67) the physical environment in which adolescents find themselves may, together with its social context, also trigger risk-taking behaviors. For example, adolescents who grow up in a physical environment with few or no facilities for recreation, may resort to other forms of recreation should those be available to them. Such recreation may expose them to risk-taking behaviors associated with negative consequences for the adolescent and his or her family.

Furthermore, the physical- social environment may also provide access to various adolescent groups such as gangs that do not adhere to society's norms and values. According to Bezuidenhout and Dietrich (2004, 67) such groups provide opportunities for peer association and participation in various antisocial behaviors. Participating in gang activities increases risk-taking behavior, especially when in return the adolescent receives continuing membership status, increased social standing among peers and financial rewards.

According to Bezuidenhout and Dietrich (2004, 67) the list for adolescent risk-taking behavior is never ending. To the above, they add lack of appropriate adult guidance, lack of understanding especially from those close to them. Their inability to resolve personal problems can cause unmanageable stress in their lives, lack of adequate decision-making training, and a general lack of understanding of the fare-reaching consequences that certain-risk-taking behavior may have on their current and future quality of live.

4.8 CONCLUSION

Early adolescence is the time in life when people first take notice of themselves and become aware that they are caught up in a process of change. Early in adolescence the individual develops new social skills with peers, tries socially defined sex roles, incorporates physical changes into a concept of self, and reduces his or her emotional dependence on parents. For most people adolescence is a difficult period characterized by paradoxes: they are typically self-centered and preoccupied with their own world, yet they are expected to cope with societal demands; they are not given complete autonomy, yet they are often expected to act as though they were mature adults; they rebel against control, yet they want direction and structure; although they push and test limits imposed on them, they see some limits as an sign of caring. With all these polarities it is easy to understand that adolescence is typically a turbulent period. Life skills programmes are viewed as very useful in helping teenagers deal with these feelings and make constructive choices for a satisfying life.

Due to the devastating effects of pathologies on the lives of the youth, all young people especially AIDS orphans need to be prepared at all levels i.e. physically, emotionally, spiritually and socially. Often this involves learning different ways of relating to others so that they can make friends, get their needs met, be appropriate assertive, identify and within sensible boundaries, and cooperate with others. Life skills groups provide support systems that can offer counsel and encourage adolescents to develop adaptive skills. Therefore in the next chapter an in depth review of life skills with specific emphasis on early adolescents will be done.

- CHAPTER 5 -

A REVIEW OF LIFE-SKILLS WITH SPECIFIC EMPHASIS ON EARLY-ADOLESCENTS

5.1 INTRODUCTION

The society is riddled with many social and health problems as a result of HIV/AIDS. As mentioned in the previous chapters the number of AIDS orphans is on the increase. With no one to take care of them they are at risk of being victims of sexual abuse, infection with HIV, substance abuse, murder and violence, which are, rive in many communities (Anderson & Okoro, 2000:2). Apart from the specific deviant act itself, these pathologies present devastating consequences such as broken lives and even death, misery, trauma and financial losses. Without elaborating on the afore-mentioned circumstances, the researcher will suffice with a statement made on 4 May 1999 by the previous Minister of Health in South Africa, Dr Zuma (quoted from Sunday Times 24 October 1999).

She expressed her shock with amongst others the rapid increase of the HIV especially amongst teenagers. She further mentioned that this trend must be expected as permissiveness towards sex, liquor and substance usages as well as the other social unacceptable practices have become the order to the day. She further exclaimed that our life-style, influenced to a great extent by television, the media and peer pressure, has made it possible for young people to live and behave in a certain manner. In other words a great number of people, especially the youth, have accepted a life-style without realizing the devastating effects thereof. She further mentioned that even children in their formative years are left unguided and vulnerable to bad influences and exploitation

According to Anderson and Okoro (2000: 1) programmes to combat these problems have until now proved to be unsuccessful. Possible reasons for the failure of such programmes

and other efforts such as action groups to effectively curb or prevent these problems are amongst others the following:

- The tendency to mainly concentrate on curative and rehabilitative measures instead of primary preventive efforts;

- Concentration on short-term programmes hoping for miracle results. Long-term continuous programmes are considered tedious and too expensive;

- Confusion between the authorities and community of who should take the initiative and responsibility in dealing with these problems; and

- Problem areas are compartmentalized and dealt with separately. What is not realized is that social and health pathologies are the consequences of specific life styles, which demand a more holistic approach.

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. Preventative work with children should concentrate on teaching of life skills (Anderson & Okoro, 2000: 1- 2; Brack, 2000: 3-4; Gladding, 1997: 101; Potgieter, 2004: 217).

The point of departure when dealing with social and health problems should be based on efforts to internalize an accepted life style or to change the life-styles of people. The life style of people is influenced to a great deal by factors such as culture, values and socialization processes therefore whatever the nature of the problem, the solution, will be to purposefully employ a continuous positive preventive approach in order to stabilize or

change the life styles of people. Life skills help people to acquire necessary tools to take charge and effectively manage their lives (Anderson & Okoro, 2000: 1- 2; Brack & Hill, 2000: 3-4; Nelson-Jones, 1993: 10; Potgieter, 2004: 217; Stewart et al, 1996: 167).

A survey conducted by Brack and Hill (2000: 3-4) at schools in North West Province revealed that many young people lack informed knowledge concerning the potential dangers of existing pathologies. For instance children start experimenting with sex at an early stage without realizing the possible consequences of their actions; furthermore, young people in varying degrees, show uncertainty with regard to important life skills such as responsible decision-making. This is reflected for instance where the majority of learners expressed their acceptance of pre-marital sex. Finally the researchers concluded by stating that young people need life skills to help them to identify deviations and efficiently deal with it. It is therefore vital to equip adolescents with life skills that will stand them in good stead for the rest of their life (Brack & Hill, 2000: 3-4; Potgieter, 2004: 217).

According to Brack and Hill (2000: 1) the life skills concept which emphasizes the wonder of the human body and the enormous potential of every human being, is a positive preventive approach to problems such as substance abuse, AIDS, child sexual abuse, crime and violence. The aim is to instill in young people a deep respect for the complexity and beauty of the human body and for life itself, so that they will consider it unthinkable to abuse their bodies in whatever way. Furthermore, life skills are conveyed to children to value their own individuality and respect the dignity and rights of other people. The focus of life skills helping is not just the present. Helpers can assist clients to learn self-helping skills to prevent and manage future problems (Nelson-Jones, 1993: x; Nelson-Jones, 1995: 352).

Since the study is about AIDS orphans in their early-teenage years this chapter focuses on life-skills that are needed to stabilize or change their life-styles. It is divided in the following sections:

- The concept life skills.
- Historical development of life skills.
- Theoretical perspectives regarding life skills.
- Life skills theory.
- Importance of life skills to adolescents.
- Classification of life skills
- Effective life skills
- Areas of knowledge in adolescent life skills development.
- Life skills education.
- Life skills programme
- Life skills in the context of a helping approach.

According to Hoelson and Van Schalkwyk (2001: 245) the popularity of life skills and their applications in diverse situations over the past three decades have led to many different definitions of life skills. They further mention that there are as many definitions of life skills as there are life skill practitioners. To develop a common understanding of what life skills mean to people and then to formulate a working definition of life skills, the concept life skills is reviewed in the next section.

5.2 THE CONCEPT LIFE SKILLS

While many experts discuss the importance of life skills, many still question what exactly represent such skills. As shall be shown, there is no single answer, but there are a variety of overlapping definitions, which highlight the most significant forms of life skills.

In practice, the term life skills is also used in several other ways, including to refer to livelihood skills, such as how to set up a business; to refer to practical self-care skills such as how to plan and prepare healthy meals or how to brush one's teeth, etc; to refer to skills used to deal with specific risk situations, such as saying "no" in the face of peer pressure etc. (WHO, 1994: 1).

The concept life skills involves personally responsible choices. These skills enable people to maximize their own choices, to enhance their personal well-being and to improve their quality of life. When people are being personally responsible they are in the process of making choices that maximize their happiness and fulfillment. Personal responsibility is a positive concept wherein people are responsible for their well-being and for making their own choices within the givens of their existence. Life skills therefore, are the component skills through which people assume – rather than avoid – personal responsibility for their lives. These skills enable people to make positive contribution which can lead to improvement of their lives (Nelson-Jones, 1993:10-11; Nelson-Jones, 1995: 355-356; Potgieter, 2004: 217; Anderson & Okoro, 2000: 19)

Elias (1990) as mentioned by WHO (1994: 1) notes that life skills are skills to carry out effective interpersonal relationships and to make choices and resolve conflict without resorting to actions that will harm oneself or others. Adding to this WHO (1994: 1) further defines life skills as skills that enable individuals to deal effectively with the demands and challenges of everyday life. This generic type of skills includes decision-making, problem-solving, self-awareness and communication skills. TACADE (1990: 2) views life skills as personal and social skills required by young people to function confidently and competently with themselves, with other people and with the wider community.

Peck and Hong (1988:99) cited in Tsatsi (2001: 44) state that life skills are skills, which enable people to care for themselves in a supportive environment, and are concerned with independence in self-care, understanding the environment and living with others. Skills also enable people to make decisions concerning life situations. From a practical point of view Peck and Hong (1988: 107) as mentioned by Tsatsi (2001: 44) outlined the following life skills. Firstly personal skills, which refer to those skills that are necessary to establish and maintain a network of appropriate and meaningful relationships, interests and support systems e.g. developing friendships, leisure interests, environmental and road safety, communication, social life, sexual relationships and marriage. Personal skills are also of great importance for especially young people to fully understand the influence of

peer pressure. Secondly, home management skills, which include theoretical and technical knowledge necessary to live safely, comfortable and healthy. Skills such as budgeting, nutrition and hygiene may serve as examples. Thirdly, self-reliance skills, which include those skills, which are necessary for the individual to be able to organize his/her own life and to maintain and utilize the resources, they need.

The effective acquisition and application of life skills influence the way people feel about themselves and others, and equally influence the way people are perceived by others. According to WHO (1997: 3-4) life skills contribute to peoples' perceptions of self-efficacy, self-confidence and self-esteem. Life skills therefore, play an important role in the promotion of individuals' mental well-being. The promotion of mental well-being contributes to people motivation to look after themselves and others, the prevention of mental disorders, and the prevention of health behavior problems. Life skills open doors and enable people to help themselves (Potgieter, 2004: 217).

Life skills are also framed as "abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life" (WHO, 1997: 1-2). Described in this way, skills that can be said to be life skills are innumerable and the nature and definition of life skills are likely to differ across cultures and settings. However, analysis of the life skills field suggests that there is a core set of skills that are at the heart to skills-based initiatives for the promotion of the health and well-being of children and adolescents (Brack & Hill, 2000: 9-10).

In the context of this study life skills are self-helping skills that enable people to help themselves. As such they are aimed at empowering people. People who possess life skills are more adequate to fulfill their potential and meet their needs. 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. For this study life skills include acquisition of self-reliance skills such as decision-making, problem solving, critical thinking, self-awareness, assertiveness

training, communication conflict resolution etc. A detailed discussion of these skills will follow later in this chapter.

A final topic of interest in conceptualizing the concept life skills is the place of belonging in defining life skills. Both the WHO (1994) and American School Counseling Associations (ASCA, 1994) as mentioned by Anderson and Okoro (2000: 13) imply that all life skills no matter at what level or dimension, must include the ability to facilitate a sense of belonging. Belonging plays a key role in the growth and development of self esteem, social skills and initiative while creating a sense of belonging does not mean being a "buddy" and always getting along, it does mean that a person is always welcomed into a group as long as they do not try to harm or disrupt the group. It also means that assertive communication and truth exist. It includes a sense of safety, both physical and emotional (Brack and Hill, 2000: 24; Anderson & Okoro, 2000: 12-13).

The need for belonging is also emphasized by Alfred Adler (1870-1937) as cited by Brack and Hill (2000: 24) who concluded that, as part of human nature there is a strong innate potential for kinship and belonging to the human race. 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 is a genetic need or genetic potential and it simply exists in everyone at birth. As noted above, an innate or genetic potential is a potential capability, which is likely to be developed if a person is given the right opportunities. Without the right opportunities this need can be distorted or destroyed (Baron & Byrne, 2003: 268; Brack & Hill, 2000: 24).

According to Brack and Hill (2000: 25) what is important to note here is that belonging, the ability to pursue meaningful relationships and contribute to society, is not automatic, it needs to be consciously developed and when it is developed, it is intrinsically rewarding. However, people have to actually learn ways of trusting others, giving and accepting care and being sincere. Adler (1870-1937) as cited by the above-mentioned authors, states that learning these skills is intrinsically rewarding because the skills fulfill a genetic potential. Furthermore, because this need is rooted in a strong genetic potential

the fulfillment of the need for belonging is also a prerequisite for emotional well-being. When the need for belonging is not met, a person may easily become aloof, manipulative and self-centered. When the feeling of belonging and interpersonal connectedness develops, a sense of social interest, co-operation and equality emerges. Belonging is met by obtaining results, which provides closer relationships with others, and competence is met by obtaining results, which are useful in many ways.

Basically belonging consists of forming a bond with other individuals. Belonging is a social component of normal human development. 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.

Following on defining the concept life skills the next section examines the history and development of life skills programmes.

5.3 HISTORICAL DEVELOPMENT OF LIFE SKILLS

According to Hoelson and Van Schalkwyk (2001: 246) life skills originate from Winthrop Adkins, a student of Donald Super, who developed the Adkins Life Skills Programme: Employability Skills Series during the 1960s. The programme began as an anti-poverty training initiative based on Super's tasks of vocational development. Initially its focus was on equipping educationally disadvantaged adults and youth with skills for choosing, finding, planning and getting a job. Later it expanded to include skills required for the challenges of normal life span development, such as skills relevant to marriage, parenthood and other personal developmental skills (Hoelson & Van Schalkwyk, 2001: 246).

Nelson-Jones (1990) as mentioned by Hoelson and Van Schalkwyk (2001: 246) offers five reasons for the progress of life skills programmes over the past three decades:

- An emphasis on development rather than remediation or rehabilitation.

- The preventive nature of programmes aimed at the personal and social developmental needs of all learners.
- The widespread incidence of problems in living.
- A more active and perceived cost-effective orientation that could increase facilitator accountability.
- The rapid growth of cognitive-behavioural approaches to intervention.

Hoelson and Van Schalkwyk (2001: 246) state that local need for life skills is associated with the gradual erosion of traditional systems of cultural education. This has been brought about by urbanization, acculturation to a western-oriented lifestyle and intra-group changes in rituals, customs and authority structures. To equip people adequately to meet the challenges of modern societies life skills programmes are viewed as significant. The aim of life skills programmes is self-helping, whereby clients maintain and develop skills, not just to cope with present problems but also to prevent and handle future problems (Nelson-Jones, 1995: 352).

Now that the historical development of life skills programmes has been reviewed, it is appropriate to examine theoretical perspectives to life skills. A theoretical review of all theoretical approaches is beyond the scope of this study. Hence the core propositions from those theories that most influenced the researcher's approach to life skills are briefly reviewed. The aim is to give good overview underlying life skills so that the connection between theory and practice can be seen.

5.4 THEORETICAL PERSPECTIVES

Theories and models help people to understand how a particular phenomenon is developed or formed and how it affects other phenomenons that are linked to it. Helpers need a guiding theory to help them make sense of the complex helping process. The main value of a theory is to give direction in helping. In this section ecological perspective, empowerment approach and experiential/observational learning theory are

looked at in order to get a better understanding of how life skills enhance human capabilities i.e. physically, socially and psychologically.

5.4.1 Ecological Perspective

The ecological perspective stresses the goodness of fitting between the person and his environment. It focuses more on promoting people's adaptive capacities and enhancing the mutuality between people and the environment. This perspective views individual human beings as living in constant reciprocity with their environment. This means that both people and their environment influence and shape one another. Therefore it views human development and functioning as the result of the interaction between the individual and his environment (Compton & Galaway, 1994: 4; Potgieter, 2004: 10).

Rooth (1995: 10) provides an explanation of human-environment relationships in relation to life skills. She emphasizes the importance of life skills in human environment relationships. In this regard the ecological perspective provides an understanding of the possibility of human environment interactions and relations being improved by the cross – fertilization between life skills and environmental interactions. It is emphasized that human beings are organic outgrowths of physical and social environments and not detached or independent entities (Rooth, 1995: 5). This implies that no person is an island on himself but is constantly influenced by the physical and social environments. The environment moulds and shape people's behavior.

According to Leff (1978) cited in Rooth (1995: 6) an understanding of ecological processes and continuing awareness of how these processes operate in one's life and surroundings are of great importance. She further mentioned that to separate life skills intervention from environmental contextuality is to do a disservice both to both people and the environment. In other words human beings are not separate and independent from their environment. In explaining life skills in terms of the ecological perspective, emphasis is placed on the following concepts: clarity, locus of control and participants feelings of being in charge of their environments (Rooth, 1995: 6).

The concept of clarity, stresses that an environment that is involved and that makes sense will foster the achievement of clarity just as the absence of this factor will incline the balance towards confusion and chaos (Rooth, 1995: 6). In other words an environment that is conducive for people to learn, participate and make decisions will enable them to be clear of what they want and need and in turn will be responsive to their needs.

The concept of locus of control involves how a person will respond to a specific situation (Rooth, 1995: 6). A high internal locus of control causes people to adopt proactive strategies. According to Baron and Byrne (2003: 414) these people believe that they can choose to behave in ways that maximize good outcomes and minimize bad ones. Bandura (1995: 21) indicates that self efficacy, which is marked by internality of locus of control is related to positive self concept, being less anxious, having less psychosomatic symptoms and coping better with stress. Bandura (1995: 218) further, mentions that an affirmative sense of self-efficacy contributes towards psychological well-being and performance accomplishments. This implies that life skills education is intrinsically concerned with encouraging internality of locus control, efficacy and proactivity for greater community and environmental benefits. From this it can be deduced that life skills in the context of the human environment paradigm, is concerned with enhancing people's locus of control so that they could develop strategies and skills of how to deal with environmental pressure.

According to Rooth (1995: 7) locus of control, self-efficacy and self-concept are constructs that cannot be removed from the environment in which they are adhered to. Life skills accretion is closely connected to environmental situated-ness. In conclusion Nelson-Jones (1993: 41) indicates that life skills enhancement are usually maintained both by what people do to themselves and by what the environment keeps doing to them.

The following sub-section endeavor to throw more light on the concept and process of empowerment by looking at the following:

- The concept empowerment.
- The relationship between life skills and empowerment.
- Assumptions.

5.4.2 Empowerment approach

According to Potgieter (2004: 216) "empowerment is a process of increasing personal, interpersonal and collective power which allows individuals families, groups and communities to maximize their quality of life." Carl (2002: 4) views the term empowerment as a process that envisions growth and development. According to Gore (1989: 3) the concept empowerment means to give authority and to enable. It enables people to gain the capacity to interact with their environment in ways that enhance their need gratification, well-being and satisfaction. People are helped to obtain a sense of personal power and self-worth by reinforcing positive feelings about their identity. Empowerment is therefore seen not as external intervention whereby something is "done to people" but rather as a process in which people are involved, that generates growth and enablement (Carl, 2002: 4; Gore, 1989: 3; Hoelson & Van Schalkwyk, 2001: 250, Ledbetter, 2002: 200; Potgieter, 2004: 216; Toseland & Rivas, 2005: 145). In this description of empowerment, the emphasis in on power being taken and its use is determined the goals of the possessor.

Life skills education is deeply rooted in the empowerment approach. Its aim is to empower people towards growth and development. According to Hepworth and Larsen, (1993: 495) empowerment is closely linked to competence, self-esteem, support systems and belief that individual actions can lead to improvement in one's life situation. Empowerment assumes that people have options available to them and that they can unlock the necessary resources to ensure maximum control over their own lives. Empowerment is basically a self-activity, which encompasses the development and stimulation of another person's capabilities. It enhances the ability of individuals to develop the power to act on their own behalf in society. Life skills helping aims to empower people with skills to cope better with their immediate and future problems. It

seeks to develop clients' self-helping skills so that they can become their own helpers (Gutierrez, Parsons & Cox, 1998: 4; Nelson-Jones, 1993: 4; Pinderhughes, 1995: 136).

Lagana (1989) in Carl (2002: 5) defines empowerment as the process of providing people with the opportunity and necessary resources to enable to believe and feel that they understand their world and have the power to change it; for example greater autonomy and independence in decision-making. Empowerment therefore deals with change, in that it focuses on the development of the individual as well as collective potential (Carl, 2002: 5). Empowered persons feel that they can actively take part and can make a contribution and that they can make a real difference.

According to DuBois and Miley (1996: 25) the following are the assumptions which empowerment approach rests upon:

- Empowerment requires a climate which focuses on strengths and assets of people;
- Client systems are competent and have the capacity to act in their own interest, given the opportunities and access to resources;
- Competence rests on acquired life skills – the ability to make sound decisions and solve problems;
- Empowerment supposes a relationship between equals who work together as partners;
- Empowerment requires resources and the ability to utilize these effectively;
- Empowerment is a dynamic, synergistic, evolutionary process;
- Environmental deficiencies tend to foster powerlessness, helplessness and low self-esteem;
- Empowerment does not result in power struggles. Increasing the power on one system does not mean decreasing the power of another;
- It does not ignore expertise in the helper but utilizes it as an important resource.

Grafft (1993) in Carl (2002: 13) suggests various steps that may be followed to promote and stimulate empowerment process:

- Building up confidence;
- The promotion of social interaction;
- The maintenance and promotion of good personal relationships;
- The maintenance of good communication;
- Carrying out effective conflict resolution;
- Drawing and following up clear objectives;
- The maintenance of health working relationships.

Empowerment requires client systems to believe in their own capacity to affect change. It shifts the attention away from viewing as the targets of charity and helping efforts. The acquisition of life skills provides the stepping-stones for the client systems to move form powerlessness to empowerment. Empowerment is characterized by treating people equitably with commitment, skills and often a touch of inspiration. This requires attaining programmes that are specifically designed to enhance people's capabilities. A life skills programme should form part of the basic resources and facilities, which social agencies offer to the community (Gutierrez, Parsons & Cox, 1998: 133; Hoelson & Van Schalkwyk, 2001: 250; Potgieter, 2004: 217).

From the a above it is clear that empowerment is that process of development and growth through which a person goes which enables him/her to take independent decisions and to act autonomously with a view to making a contribution towards the development of his particular environment. This process is coupled with the development of applicable skills, attitudes and knowledge within a positive climate.

In the next subsection experiential learning in life skills is discussed.

5.4.3 Experiential Learning theory

According to Johnson and Johnson (2003: 50) people learn from their experiences. Rooth (1995: 13) explains experiential learning as being more of expanding on observational learning from experiences. She states that experiential learning is the

process of holistic learning from experiences. Beginning with a real experience is the key feature. Experiential learning involves doing the actual task and then discussing the experience and learning is derived.

Rooth (1995: 13) further explains that this theory is rooted in an epistemological perspective of emancipatory education, which permeates modes of implementation and has manifold implications for its use and practice. Research indicates that young people may learn more from life skills when their experiences are acknowledged and used in the learning process. The existing experiences should be incorporated whereas opportunities to practice life skills in the confines of a safe environment should be created.

According to Burnard (1989: 12-15) experiential learning has the following characteristics:

- The accent of the learning is on action. Problems are encountered through discussion, argument and action, and the learner is no longer passive, but involved in a dialogue with equally active teachers.

- Learners are expected and encouraged to reflect on their experience, although experience alone is not enough to ensure that learning takes place. New experiences must be integrated with past experiences through the process of reflection, which is an introspective act in which the learner can indulge individually or as a member of a group.

- The facilitator of the learning process uses a phenomenological approach, restricts himself or herself to the use of description and summaries of what the learner has said, and to enable learner to invest in their own learning. It is the learner who ascribes meaning to the process and the facilitator's ideas that are foisted on the learner.

- Learning is a subjective, life long, human process that involves the whole person and not just an outcome or content. The learner creates a view of the world in his or her own terms, and needs to develop the ability to ask critical question about the "facts" that are presented to him or her.

- Human experience is valued as a source of learning.

Reflection as an important ingredient of experiential learning is explained as a facet having a potential for enhancing learning. It refers to the ability to think about what has been experienced and learned, to become aware of feelings, the realization and insights as well as an idea of knowledge acquisition and future work required for skill enhancement (Rooth, 1995: 14). It enables participants to consolidate and internalize learning and promotes skills development and extension. Therefore from this theory of learning, one can deduce that young people may acquire knowledge on various life skills such as problem solving, decision-making, effective communication and assertiveness, through the process of experiential learning.

Through considering their experiences by using '"reflection" as a facet of experiential learning i.e. to mirror back their feelings and experiences that originally put them at risk of being the victims or being vulnerable to social pathologies, they can learn from such experiences and make better choices. For example, a teenager who has been influenced by peer pressure to abuse drugs may learn from his experiences of how peers can sometimes be destructive in one's life and as a result may learn or practice assertiveness in order not to repeat their past mistakes (Rooth, 1995: 14).

According to Johnson and Johnson (2003: 51) experiential learning is emphasized because people believe in knowledge they have discovered themselves than in knowledge presented by others. An approach to learning life skills based on inquiry and discovery increases the students' motivation to learn and their commitment to implement their conclusion in the future. Experiential learning offers the opportunity for experiencing success by allowing people to decide what aspect of their experiences they wish to focus

on and what skills they wish to develop. To learn to be a more effective decision maker, for example, the learner must develop a concept of what decision making is and decision making behaviors that will lead to effective decision making (Johnson & Johnson, 2003: 56).

The discussion above makes it evident that life skills are dynamic and important. They enable people to care for themselves in a supportive environment and are concerned with independence in self-care, understanding the environment and living with others. The following discussion will therefore give a description of life skills theory.

5.5 LIFE SKILLS THEORY

Life skills theory is an integrative approach for assisting clients to develop self-helping skills. It is an approach that integrates many of the insights and strengths of the above-mentioned approaches. It is integrative because it combines and reworks ideas form other approaches into a coherent theoretical whole. According to Nelson-Jones (1995: 349-350) life skills counseling owes much to others' work for example, the emphasis on the importance of supportive helping ships and on sensitively attending to clients shows the influence of Carl Roger's person-centered approach; the emphasis on thinking skills is derived form the writings of Albert Ellis; the emphasis on action skills represents the influence of the behaviorists; and the emphasis on personal responsibility choice and courage has origins in the work of Viktor Frankl, William Glasser and Gerald Egan.

Life skills theory focuses on the acquisition of life skills. These skills assist people to become more balanced, independent and able to solve problems creatively in their lives (Hoelson & Van Schalkwyk, 2001: 249). The theory and practice of life skills counseling is expressed in skills language. Skills language consistently uses the concept of skills to describe and analyze how people think and act. In each skill area people can possess skills strengths and skills deficits. Processes by which people acquire life skills strengths and deficits include supportive relationships, learning from example and consequences, instruction and self-instruction, information and opportunity and experiences. Processes

by which people maintain life skills deficits include insufficient use of skills language, thinking skill deficits and unchanged environmental circumstances (Nelson-Jones, 1995: 349-350 & Potgieter, 2004: 217). These processes will be discussed later in this chapter.

According to Nelson-Jones (1995: 349-350) life skills theory has dual goals: developing the skills to cope with specific problems now and in future, and developing skilled persons. The skilled person possesses significant life skills strength to cope in all areas of his/her life. The approach assumes that theory is as much for clients' benefit as for that of their helpers. Where possible, helpers transmit life skills theory to their clients. The ultimate goal of life skills theory is self-helping, whereby clients maintain and develop skills, not just to cope with present problems but also to prevent and handle future problems (Nelson-Jones, 1995: 352).

According to Johnson and Johnson (2003: 53) people are not born with skills, nor do they magically appear when they are needed. Life skills are learned just as any other skill is learned. All skills are learned according to the same way, according to the following steps:

- Understand why the skill is important and how it will be of value to you. To want to learn a skill, you must see a need for it. You need to know that you will be better off with the skill than without it.

- Understand what the skill is, what are the component behaviors you have to engage in to perform the skill, and when it should be used. To learn a skill, you must have a clear idea of what the skill is and you must know how to perform it.

- Find situations in which you can practice the skill over and over again while a "coach" watches and tells you how well you are performing it.

- Assess how well the skill is being implemented. The key to assessing how well you engage in the skills is to realize that you can never fail. Rather, your behavior

approximates what you ideally wish and, through practice and experiential learning, the approximations get closer and closer to the ideal.

- Keep practicing until the skill feels real and it become an automatic habit pattern.

- Load your practice toward success. Set up practice unit that you can easily master. It always helps to feel like a success as you practice a skill.

- Get friends to encourage you to use the skill. Your friends can help you learn by giving you encouragement to do so. The more encouragement you receive, the easier it will be for you to practice the skill.

- Help others learn the skills. It is only when people develop others that they permanently succeed. Nothing is completely learned until it is taught to someone else. By helping others learn skills, you enhance your own expertise. (Johnson & Johnson, 2003: 54-55).

The essential element of any skill is the ability to make and implement sequences to achieve objectives. Good choices in skills are areas of skills strengths and poor choices are skills deficits. The object of life skills theory is to help clients, in one or more skills areas, move more in the direction of skills strength rather than skills deficits. For instance, if clients are to be good at asserting themselves or managing stress, they have to make and implement effective choices in the life skills areas (Nelson-Jones, 1995: 355).

In the following section, focus is on why life skills are particularly relevant and important to adolescents' lives. In the context of this study discussion of the importance of life skills suggests ways in which life skills can be tailored to the needs of AIDS orphans.

5.6 THE IMPORTANCE OF LIFE SKILLS TO ADOLESCENTS

Nelson-Jones (1993: 10) notes that people require a repertoire of life skills and these skills should be appropriate both to their developmental tasks and to any special problems, challenges and transitions they may face.

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. The adolescent years can be extremely lonely ones, and it is not unusual for an adolescent to feel that no one is there to help. 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 contribute to low self-esteem, loneliness and strained marital relations. These conditions also handicap the development of satisfying interpersonal relationships and influence the infectiveness of role performance (Corey, 2004: 7; Geldard & Geldard, 1999: 15; Hepworth & Larsen, 1993: 454; Potgieter, 2004: 217).

Life skills can provide children with the opportunity to express their feelings. Life skills are especially suited for adolescents because they give them a place to express conflicting feelings. Adolescence is a time when key decisions are made that can affect the course of one's life. Receiving assistance at this stage, they stand a better chance of coping effectively with the developmental tasks they must face later in life (Anderson & Okoro, 2000: 1; Corey, 2004: 7; Geldard & Geldard, 1999: 13).

According to Brack and Hill (2000: 2) life skills are vital because they help prepare children for their puberty and adolescent stage. Life skills also help children to become defensible from being the victims of various pathologies. In addition Herbert (1988: 182) notes 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 such as assertiveness and effective communication.

The Department of Welfare (White Paper – Social Welfare) as quoted by Brack and Hill (2000: 3) views the importance of life skills in a broader context. Life skills were viewed as critical component of a comprehensive solution. The well-being of children depends on the ability of families to function effectively. Because children are vulnerable they need to grow in a nurturing and secure family that can ensure their survival, development, protection and participation in family and social life. Not only do families give their members a sense of belonging, they are also responsible for imparting values and life skills. Families create security; they set limits on behavior; and together with the spiritual foundation they provide, instill notion of discipline. All these factors are essential for the health development of the family and of any society (Brack & Hill, 2000: 3-4).

However, as already indicated in the previous chapters, the tragedy is that many of South African families are already in crisis. Brack and Hill (2000: 4) note that unfortunately, the Department of Welfare does not have unlimited resources. In view of fiscal constraints, it is not possible for the welfare function to grow in real terms in the medium term. Real growth will be accommodated by restructuring the welfare function.

Not only has the Department of Welfare recognized the importance of life skills, but also the Department of Education has taken a more interest in promoting life skills. According to Hoelson and Van Schalkwyk (2001: 253) in South African schools, life skills education and training are generally offered as part of the Guidance curriculum as set out in the Department of Education Interim Core Syllabus for the Guidance (1995). Guidance which is supposed to be an integral part of the school curriculum is defined as essentially a preventative group programme that is appropriate to the need of learners in a democratic society (Hoelson & Van Schalkwyk, 2001: 253). The Guidance programme

aims to assist systematically the learner's person academic and career development. However, according to the above-mentioned authors over a number of years this idea seems to have remained unattainable for the majority of South African schools.

Clearly, government structures are cognizant of the needs for Life Skills Education, and are trying to formulate polices and programmes, which can address these concerns, yet such programmes must be cost effective, efficient, and productive.

Life skills programmes are viewed as important to AIDS orphans. These children in most cases live without basic human rights and dignity (Van Dyk, 2001: 335). Furthermore, these children have gone through a traumatic experience of watching their parents succumb to the disease. As already mentioned, in the earlier chapters their loss is exacerbated by prejudice and social exclusion. Although the teaching of generic life skills has been incorporated in the education system of this country there are many children such as school-drop outs, orphans and street children who can not be reached by the formal educational system (Van Dyk, 2001: 9). The ability of life skills to assist AIDS orphans to cope is seen as critical.

According to Nelson-Jones (1995: 365) people require thorough knowledge to develop life skills. In the next section critical areas of knowledge that informs adolescents about life and that may also help them to gain more control over their behaviors are discussed.

5.7 AREAS OF KNOWLEDGE IN ADOLESCENTS' LIFE SKILLS DEVELOPMENT

Most people need assistance at some point in their lives to deal with troublesome issues that stifle their personal growth and limit their potential. Geldard and Geldard (1999: 183) note that adolescents are on a journey of self-discovery and are mostly hungry to learn about themselves and their relationships with others. Gaining such knowledge helps them to develop identity and make sense of the world around them. The following

areas of knowledge are pivotal in enhancing the process of adolescents' development and by implication the mastering of life skills.

5.7.1 Knowledge of the human body

It is imperative that young people know and understand the composition and functioning of the body and how to maintain a healthy lifestyle. Attention here is given to matters such as sufficient rest, a healthy balanced diet, the importance of exercise and mental stimulation. Young people should also be informed about how and why the body functioning is affected by substances that upset its delicate equilibrium. The approach should be to demonstrate and explain the physical, mental and emotional effects of any abuse such as drugs or indiscriminate sexual act on the human body. Furthermore participants need to be made aware of their needs and how they should meet these needs within the framework of an accepted value system (Anderson & Okoro, 2000: 22).

5.7.2 Healthy life style

The focus here is to maintain a healthy life style. Attention should be given to those matters, which are important to maintain and develop a healthy body. Matters such as nutrition, rest, constructive leisure time activities and safe living in general should be included into this section. In this regard teenagers need basic knowledge and insight of substances and circumstances, which can and will harm the normal functioning of the body and retard development. The more important destructive factors that are identified as those that need special attention are amongst others substance abuse, illness and disease with emphasis on HIV/AIDS, child abuse and neglect emphasizing child sexual abuse, stress management and finally satanism (Anderson & Okoro 2000: 23).

5.7.3 Time management and setting lifestyle goals

Time management implies planning the best utilization of time, including cutting down on time wasting, devoting more time to the really important tasks and completing more

tasks in the time available. Failure to manage time can leave people so short of time that they have a "last minute rush" to get a really important job done. Inevitably, something gets overlooked, causing another crisis, which in turn takes yet more time and money to rectify. In order to manage time effectively, thereby being more productive, proactive and successful implies setting goals or objectives as part of planning (Swart, 2000: 25-26).

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. In addition, they have an unknown future which threatens to present them with unexpected challenges. Because they are moving through unknown territory in their lives, they often have problems in finding an overall direction, which makes sense for them. If they lack an overall sense direction, and do not have clear lifestyle goals, they may become excessively troubled by the uncertainty of their lives. To be successful young people must have a good sense of both short and long-term goal as well as direct their effort in a meaningful way toward appropriate goals (Doyle, 1992: 32; Geldard & Geldard, 1999: 176).

The essence of a goal is that it is an ideal. It is a desired end toward which people are working, a state of affairs that people value. It specifies ways in which individuals will interact with each other. Lifestyle goals provide a general sense of direction within which other less global decisions can be made. They also help to provide motivation to succeed. Goals breathe life into people hopes and dreams. To be useful goals have to be specific, understandable, clear and challenging enough. Defining goals clearly helps people to focus on what they are attempting to achieve. However, for goals to be achieved people must work hard enough and have necessary support (Geldard & Geldard, 1999: 176; Johnson & Johnson, 2003: 76-78; Swart, 2000: 26; Toseland & Rivas, 2005: 207).

According to Toseland and Rivas (2005: 268-269) steps in helping people to achieve their goals include: maintaining people's awareness of the goals they have identified and agreed to work on, and by facilitating the development of specific plans to achieve those goals. The plan should specify what to be done, when, where, how often and under what conditions. A person should be clear about his/her roles, responsibilities and expected contribution. However, to be successful the plan should be realistic.

5.7.4 Assertiveness

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. People who are withdrawn and passive need to be encouraged to recognize their rights as people as well as accept the right of others (Thompson & Rudolph, 2000: 228).

Assertiveness has often been misunderstood and misidentified with concepts as "aggression". Yet in fact assertiveness is the anti-thesis of aggression, which is a common problem with at risk youth. Assertive behavior relates to standing up for one's rights, whilst not being insensitive or indifferent to the thoughts and feelings of others. Aggressive behavior, on the other hand, is viewed in terms of meeting one's own needs at the expense of others, and is almost always accompanied by disrespect in some way. The aggressive person is one who demands his or her rights at the cost of another. Only the assertive person seeks to assert his or her right in conjunction with another. Simply stated assertive behavior is expressing oneself without hurting or stepping on others. Assertiveness is therefore about interacting with another in a manner where both individuals can negotiate to have his or her rights met (Anderson & Okoro, 2000: 24; Couch, Felstehausen & Hallman, 1997: 5; Geldard & Geldard, 1999: 173; Gillis, 1994: 41; Hill & O' Brien, 1999: 273; Hoelson & Van Schalkwyk, 2001: 265; Zastrow, 2000: 477-478). Assertiveness as a skill will be discussed later in this chapter.

5.7.5 Interests, values and ideals

According to Anderson and Okoro (2000: 24) the focus of this area of knowledge is to establish and develop sound/accepted value orientation towards life situations. The objectives are to define what is meant by a value and to relate general behavior and lifestyle to underlying values. Teenagers need to know themselves and know what their values are in relation to the more important life issues. The specific objectives are to encourage exploration of individual values and to encourage personal growth and, if necessary, change. Within this category emotional maturity, growth and development should also be attended to (Anderson & Okoro, 2000: 24).

5.7.6 Self-esteem

Van Niekerk, Van Eeden and Botha (2001: 73) state that it is rare for individuals to hold neutral attitudes towards themselves. According to Baron and Byrne (2003: 171) the most important attitude a person develops is the attitude about self. This evaluation of oneself is known as self-esteem. Couch, Felstehausen and Hallman (1997: 5) describe esteem as a feeling that one is important, valued and respected. Self-esteem is a general term used to describe the personal assessment of value or worth people place on themselves. It also refers to the extent to which people have accepted themselves for who they are and what they are not. The child's ability to enter into and sustain meaningful relationships is dependent on their self-esteem. This value can be expressed either positively, for example: "I am a capable person" or negatively as in "I am a looser. Of great importance for a young person is to know himself and to realize that he/she is a unique human being (Anderson & Okoro, 2000: 23-24; Geldard & Geldard, 2002: 27; Gillis, 1994: 79; Stewart et al, 1996: 182; Van Niekerk, Van Eeden & Botha, 2001: 73).

Having high self-esteem means that an individual likes himself or herself (Baron & Byrne, 2003: 171). According to Geldard and Geldard (2002: 27-28) children with high self-esteem tend to have the following characteristics:

- They have a greater capacity to be creative.
- They are more likely to assume active roles in social groups.
- They are less likely to be burdened by self-doubt, fear and ambivalence.
- They are more likely to move more directly and realistically towards personal goals.
- They find it easier to accept differences between their own levels of competence and that of others is areas such as peer relationships and physical pursuits. They are able to accept these differences and still feel positive about themselves.

Children with poor self-esteem feel helpless and inferior, incapable of improving their situation. They strive for social approval by behaving in ways which are over-compliant, or by pretending to be self-confident when they are not. They are struggling to feel good about themselves. The most notable feature of young people suffering from low self-concept and poor self-esteem is their fear of not being good enough to perform competently. This influences almost every aspect of their behavior, and being motivated to avoid failure rather than seek successes. 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 (Geldard & Geldard, 2002: 210; Gillis, 1994: 80; Thompson & Rudolph, 2000: 153).

According to Thompson and Rudolph (2000: 152-153) self esteem is a by-product of achievements and relationships and can be increased by helping people improve their self-concept. Interventions to directly enhance self-esteem usually involve the use of praise and performance feedback. However, although useful Geldard and Geldard (2002: 210) are of the opinion that direct intervention is not always the most effective way to bring about improvement in self-esteem. For most children working in groups provides the best opportunity for self-esteem improvement. These young people can realistically and positively evaluate themselves through the process of group interaction. Specific areas of skill development can easily be targeted through exercises and activities.

Gillis (1994: 80) suggested the following strategies in helping young people enhance their self-concept:

- Establish a caring, personal relationship, and create an environment of acceptance and optimism. Young people need to feel that they are considered sufficiently worthwhile to merit special attention, genuine respect and appreciation.

- Use every opportunity to accentuate the positive. The objective is to boost the person's morale by focusing on existing strengths, rather than to work on improving present inadequacies.

- Provide numerous opportunities for success, setting goals which are relatively easily attainable. At the end of the day discuss, and possibly record, details of all successes attained.

- Reward any attempt of positive achievement with generous approval. However, young people because are suffering from low self-esteem and are so uncertain of themselves, it is essential they perceive the approval as genuine appreciation for attaining their objectives, rather than simply encouragement or reassurance.

- Encourage them to change negative self-thinking attitudes such as 'I can't' or 'I'm not capable' to 'I can' and 'I am capable'.

- Use modelling, role-play and assertiveness training to reinforce feelings of confidence in their ability to achieve.

- Teach problem-solving skills.

- As helping others is morale-building they need to be encouraged to assist others even if they are of a younger age group in some activity.

- Avoid criticism. People with poor self-esteem are especially vulnerable to criticism.

Thompson and Rudolph (2000: 153) further note that people with low esteem need to be encouraged to view themselves as special and unique and because they are special they have a responsibility to help and not hurt themselves. This statement is discussed to teach the concept of unconditional valuing of people simply because they are people. By helping the persons to see themselves differently, they are likely to accept responsibility of developing and leaning to improve those characteristics of themselves which they perceive as negative. According to Thompson and Rudolph (2000: 155) the process of integrating self-concept with life skill development is most effective if it becomes the focus and foundation of education.

5.7.7 Sexuality

Sexuality is the most difficult and sensitive topic to be conveyed to children. Anderson and Okoro (2000: 25) mention that sexual maturation and reproduction are areas, which prove to be extremely difficult, and in many instances, sensitive to teach. Adults usually feel embarrassed or uncomfortable talking about sex and sexuality to young ones. Although there are those who can easily talk about these important issues because of the relationship that they have with their children, they do not go into in depth with this topic. Scatter (1987) as mentioned by Tsatsi (2001: 77) defines sex education as "the full training of boys and girls to enable them to meet and solve the problems that arise in connection with the instinct of procreation". It includes the necessary instruction in the facts of life, but goes far beyond that. Good sex education includes, the teaching of religious and moral principles, safeguarding the physical and emotional well-being of individuals. In addition Geldard and Geldard (2002: 226) emphasize that children need to be taught and empowered about appropriate sexual boundaries as well as to report instances of inappropriate behavior.

According to Tsatsi (2001: 77) the fact that there is an increase in pathologies such as HIV/AIDS, substance abuse, teenage pregnancy etc. is an indication that many young people have not received proper life skills during the socialization process. Most parents do not spend quality time with their children or they do not involve themselves in their

children's activities. Children end up engaging in unpleasant acts behind their parent's backs. A great amount of thought is necessary to decide what and to which level of learners' information on sexuality should be departed. Because of the prevalence of HIV/AIDS the general opinion is that sex education should start as early as possible in a child's life.

However, the general objective of this section as highlighted by Anderson and Okoro (2000: 25) is to provide information that will enable young people to understand sexuality and to gain control over their sexual functioning. Attention should be given to sexual maturation and reproduction, attitudes and feelings, love, sex, marriage and parenthood. The primary goal of most sex education curricula remains to prevent or reduce sex related problems with the underlying assumption that knowledge alone can change behavior. In conclusion Tsatsi (2001: 78) emphasizes that sex education as part of life skills education can serve as a powerful tool to overcome ignorance and provide correct information on sexuality. Sexuality is a major and positive dimension in human development. It is important that adolescents come to terms with their sexuality in ways which are positive (Geldard & Geldard, 1999: 40).

5.7.8 Decision-making

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 a client system. Healthy personal functioning depends to a large extent on the ability of people to make good decisions. Decisions also have an important influence of the quality of life of human beings. Included in the process of decision making is these amongst others individualism and the capability of taking independent decisions; taking responsible decisions; peer pressure in decision-taking; goal setting; productive and creative problem-solving abilities (Anderson & Okoro, 2000: 26; Johnson & Johnson, 2003: 275; Potgieter, 2004: 218).

As adolescents are moving from a stage of being dependent on their parents and family to being independent, they are required to make many decisions for themselves. For many adults, making decisions can be difficult. However, when compared with adults, making decisions is even more difficult for most adolescents (Geldard & Geldard, 1999: 177). This is because they do not have a body of experience from past decisions on which to base their current judgments. Additionally, they often do not have information about the options available to them or the likely consequence of these options. Sometimes, even though cognitively they will understand the consequences of particular actions because they have not personally experienced such consequences they may underestimate their importance or severity. Alternatively, they may exaggerate their importance and be afraid to choose alternatives because they believe that the associated consequences will be too severe for them. Therefore, adolescents need skills to make decisions that will foster growth and independence (Doyle, 1992: 80-81; Geldard & Geldard 1999: 177; Potgieter, 2004: 218).

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. Furthermore, it helps them to deal constructively with decisions about their lives. These children become autonomous and are able to resist negative influences around them (Doyle, 1992: 79-80; Couch, Felstehausen & Patsy, 1997: 25; Tsatsi, 2001: 39). In addition Brack (2000: 49) states that of specific importance is to show learners how they can calm down and reorganize themselves when they are under stress such as negative pressure; to help themselves to develop an understanding of the social situation, feeling and perspectives of other people; to help themselves to elaborate and clarify personally meaningful and pro-social goals and to help them to plan strategies to reach their goals. In helping adolescents to make decisions, decision-making skills are vital and these will be discussed in detail later in this chapter.

5.7.9 Stress

Stress is known as one of the killer diseases of modern life. Long-term, unrelieved stress has been shown to lead to major illness, apathy and fatigue. Swart (2000: 383) defines stress "as strain a person experiences from the pressure of outside forces and which results in physical, psychological and/or behavioral responses to adjust to these pressures." It is normal for people to encounter challenging situations or taxing and potentially stressful conditions.

As adolescents progress on their journey of self-discovery, they continually have to adjust to new experiences, encounters and situations. This is both stressful and anxiety provoking for them. Any change in life, whether perceived as positive or negative may also cause stress. Adolescents often experience stressors associated with pubertal changes, demands for and engagement is sexual activity, and fears of early unwanted pregnancy. The other cause of stress is pressure. Family and family conflicts are among the most prevalent of the adolescent stressors. Adolescents are 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 on drugs or alcohol in order to cope with the pressure. Young people need assistance to deal with stress and to enable them to make decisions to protect themselves in the future (Amanat & Beck, 1994: 260; Bezuidenhout, 2004: 68; Corey & Corey, 2002: 307; Doyle, 1992: 21; Geldard & Geldard, 1999: 8, 202).

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 are various strategies of coping with stress and this will be discussed later in this chapter.

5.7.10 Peace education and conflict resolution

Peace education and conflict resolution are imperative in skills learning in order for people to realize the value and importance of democratic co-operation and tolerance. Furthermore, peace education and conflict resolution also concentrate on the creation of appropriate attitude and actions to counteract the effects of violence. An effective application of these strategies prevents further violence and allows a room for negotiations to be initiated. Good communication is an essential part of resolving any conflict (Anderson & Okoro, 2000: 26; Anstey, 2002: 283-284; Couch, Felstehausen & Patsy, 1997: 149). Conflict resolution as a skill will be discussed later in this chapter.

5.7.11 Environmental awareness and care

The focus of this area of knowledge is to teach and encourage young people to fully utilize and protect as well take an active interest in their natural surroundings. The specific objectives according to Anderson and Okoro (2000: 26) are to teach young people to manage the natural resources wisely; to actively oppose pollution; to guard and save the water supply; to care for the earth and all living things; and ways and means to cycle waste products.

From the above discussion of learning areas, we learn that there are effective life skills required by adolescents. For the purpose of getting a general overview of life skills the next section focuses on classification of life skills as presented by Brack and Hill (2000: 11-12). This will be followed by a review of life skills related to adolescent development.

5.8 CLASSIFICATION OF LIFE SKILLS

The American School Counseling Associations (ASCA) as mentioned by Brack and Hill (2000: 11-12) classifies life skills into three major groups:

a. Learning to belong as a life long learner (academic life skills);
b. Learning to belong as a life long worker (career life skills); and
c. Learning to be safe and to survive (personal/social life skills)

By closely combining the WHO and the ASCA documents, Brack and Hill (2000: 11-12) came up with a holistic means of teaching people to approach life's challenges. An integration of WHO and ASCA life skills is shown in figure 1:

Life Skills

LEARN TO LEARN	LEARN TO WORK	LEARN TO LIVE
Academic life skills	Career life skills	Personal/social life skills
Decision-making	Decision making	Decision-making
Problem solving	Problem solving	Problem solving
		Creative thinking
Critical thinking	Critical thinking	Critical thinking
Effective communication	Effective communication	Effective communication
	Interpersonal Relationship	Interpersonal Relationship
Self-awareness	Self awareness	Self awareness
Coping with emotions	Coping with emotions	Coping with emotions
Coping with stress	Coping with stress	Coping with stress

Figure 1: Classification of life skills
(Adapted from Brack & Hill, 2000: 11-12).

Furthermore, ASCA in Brack and Hill (2000: 17-18) outlined the targets goals for each domain as follows:

A. **Learning to Learn** Target goals

- Participants will acquire the attitudes, knowledge, and skills that contribute to effective learning in school and across the life span;
- Participants will complete school with the academic preparation essential to choose from a wide range of substantial postsecondary options, including college;
- Participants will understand the relationship of academics to the world of work, and to life at home and in the community.

B. **Learning to Work** Target goals

- Participants will acquire the skills to investigate the world of work in relation to knowledge of self and to make informed career decisions;
- Participants will employ strategies to achieve future career success and satisfaction;
- Participants will understand the relationship among personal qualities, education and training and world of work.

C. **Learning to Live** Target goals

- Participants will acquire the attitudes, knowledge, and interpersonal skills to help them understand and respect self and others;
- Participants will make decisions, set goals, and take necessary action to achieve goals.
- Participants will understand safety and survival skills.

Adapted from Brack and Hill "2000: 17-18).

Following is a discussion of life skills considered that are essential and vital in adolescents' development. Each life skill contains knowledge concerning what are the correct choices to make.

5.9 EFFECTIVE LIFE SKILLS

According to Johnson and Johnson (2003: 534) people experience problems because they lack skills or are unable to utilize them effectively. However, people can learn skills to live more effectively and attain their potential (Hill & O'Brien, 1999: 6). Often, these skills can alleviate the powerlessness that individuals feel when they are unable to communicate their emotions directly and can assist them in engaging more fully in their lives. WHO (1997: 2) mentions that the life skills are often taken for granted, however, there is a growing recognition that with changes in many culture and lifestyles, many young people are not sufficiently equipped with life skills to help them deal with the increasing demands and stresses they experience. According to Corey and Corey (2002: 300), Hill and O'Brien (1999: 6) as well as Stewart, De Kock, Smit, Sproat and Storrie (1996: 167) life skills such as skills in communication, decision-making, problem-solving etc. help people to acquire necessary tools to take charge of and effectively manage their lives.

In the context of this study the focus will be on the following life skills namely: communication skills, interpersonal relationship skills, assertiveness skills, problem solving skills, decision-making skills, conflict resolution skills, critical thinking skills, creative thinking skills, self-awareness, empathy, coping with emotions and coping with stress.

5.9.1 Communication

According to Hoelson and Van Schalkwyk (2001: 261) communication is a cluster of skills that forms the foundation of all other life skills. Without effective communication skills, the development of life skills and life itself is unsustainable. Every system depends upon communication for its survival (Cleary, 2004: 7).

Communication is the basis for all human interaction. Effective communication is essential for good relationships. Although it is impossible not to communicate, since all behavior is communication, basic communication skills are often not so easily acquired. Communication is effective when the idea or message, as it was initiated and intended by the sender, corresponds closely with the message as it is perceived and responded to by the sender. Children frequently suffer emotional problems because they have poor communication skills and are unable to express their feelings or talk about their needs and worries. Young people who have poor communication skills are unlikely to have the ability to stand up for themselves and to assert their rights. In situations involving peers or adults, this lack of communication skills can result in feelings of helplessness and powerlessness. Learning to communicate effectively helps adolescents to build positive relationships with others and it also increases their self-esteem (Cleary, 2004: 7; Couch, Felstehausen & Patsy, 1997: 95; Geldard & Geldard, 2002: 228; Johnson & Johnson, 2003: 137; Potgieter, 2004: 228).

Communication is the process of creating meaning between two or more people through the expression and interpretation of messages. It occurs when people send a message to one or more receivers with the conscious intent of affecting the receivers' behavior. Basically the communication process comprises the transmitter of a message, the message itself and the receiver thereof. The communication process occurs when only all these elements are present. Good communication occurs when two or more people focus their attention on the same issue at the same time and understand the meaning of the expressed comments. This type of communication generates understanding, spreads information and is the means for achieving problem solving (Anstey, 2002: 179; Cleary, 2004: 2; Doyle, 1992: 31; Hoelson & Van Schalkwyk, 2001: 260).

There are basic sending and receiving skills that people need to master to communicate effectively. Sending skills include taking clear ownership for one's message, making messages complete and specific, ensuring that one's verbal and nonverbal messages are congruent, building in redundancy, obtaining feedback on how the message was received, adapting the message to the receivers' frame of reference, describing one's feelings and

describing others' behavior with evaluation. Receiving skills include paraphrasing accurately and evaluating the content to the message and the senders' feelings, describing one's perception of the sender's feelings and negotiating meaning of the message until receiver and sender agree. Effective communication requires effective speaking and effective listening. Furthermore, effective communication exists when the receiver interprets the sender's message in the same way that sender intended it. It is the responsibility of helpers to train clients in how to send and receive communication (Anstey, 2002: 180; Doyle, 1992: 31; Johnson & Johnson, 2003: 172 & 138; Nelson-Jones, 1995: 344).

Communication is much more than just the exchange of words. It is a process by which people convey meanings to each other by using symbols. All behavior conveys some message and is, therefore, a form of communication. Communication involves the exchange of ideas and perspectives, values, beliefs, needs, assumptions, cultural, spiritual and family backgrounds, a well as past and present thoughts, feelings and behavior of both speaker and audience. Furthermore, communication involves expressing thoughts in ways that are appropriate to peoples' cultures and situations (Anstey, 2002: 179; Brack & Hill, 2000:10; Johnson & Johnson, 2003: 137; Long 1996: 78; Potgieter, 2004: 79; Toseland & Rivas, 2005: 65).

Communication is characterized by a complex combination of verbal signals and nonverbal signals. Verbal communication is communication using words whereas non-verbal communication is communication without words. People often communicate by a willingness to listen more by what they do than what they say. Non-verbal communication is an important part of all messages, involving all senses, and is also the foundation on which human relationships are built. This form of communication comes in the tone of one's voice, the speed at which ones speaks, the pauses, shouting, whispering and other vocal expressions. It also includes facial expressions, hand gestures, foot movements and body position. People who are good communicators are able to express opinions and desires, but also needs and fears. Their faces are truly their windows on the world and their expressions the most important things they are wearing.

Non-verbal behavior is relatively irrepressible, difficult to control so that even when people try to conceal their inner feelings from others, these often leak out in many ways through nonverbal cues. The non-verbal aspect of a message thus always carries more weight than the verbal component (Anstey, 2002: 179-180; Baron & Byrne, 2003: 39; Clearly, 2004: 24; France, 1996: 32; Long, 1996: 172; Myrick, 1997: 131; Potgieter, 2004: 83).

Communication skills have been shown by researchers to be effective in developing helping relationships and assisting people in improving their lives. These skills can be improved through training and practice. The ability to communicate is vital since it facilitates the change processes (Hill & O'Brien, 1999: 4; Potgieter, 2004: 78).

5.9.2 Interpersonal relationship skills

According to Hoelson and Van Scalkwyk (2001: 263) interpersonal skills involve a cluster of skills necessary for establishing, maintaining and ending relationships, and are closely interconnected with communication skills. They are regarded as one of the major keys to decreasing self-defeating behavior and increasing self-enhancing behavior (Brack & Hill, 2000: 10).

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. Interpersonal skills help people to relate in positive ways with the people they interact with. The most important characteristic of interpersonal communication is that the participants continually provide feedback or response to each other's messages. Conversing with a family member or discussing a movie with friends are examples of interpersonal communication. This may mean being able to make and keep friendly relationships, which can be of great importance to a persons' mental and social well-being. It may also mean keeping good relations with family members, which are an important sorcery of social support. A person is able to end relationships constructively if well trained. In this training, helpers identify and train clients in how to

interact socially and affectionately. Clients are taught the importance of showing concern, positive reinforcement as well as give and take (Brack & Hill, 2000: 10; Johnson & Johnson, 2003: 534; Nelson-Jones, 1995: 344; Potgieter, 2004: 228; Steinberg, 2003: 21).

According to Doyle (1992: 179) communication support is an important relationship skill. The attitude and effective use of attending and clarifying responses demonstrate support by showing a real interest in someone. This skill involves actively providing positive feedback; communicating feelings of security; reassurance; and reaffirming the one's sense of self. Supportive and reassuring responses stress faith and believe in others; believe the other person's ability to resolve issues; have an understanding of the frailty of human condition; and respect the dignity and worth of every individual.

5.9.3 Assertiveness skills

Steinberg (2003: 90) notes that sometimes problems are created in relationships with friends, family or work colleagues because people lack the communication skills needed to express emotions, needs, and opinions assertively. People may choose to bury them or unleash them uncontrollably. 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 (Gillis, 1999: 41). Verderber (1990) in Steinberg (2003:90) defines assertiveness as "verbalizing your position on an issue for purposes of achieving a specific goal." The specific goal is for the person to express himself in such a way that he hurt neither himself nor others. Assertiveness involves the ability to express feelings and opinions openly and honestly without offending others. Assertiveness training aims at teaching clients to stand up for their rights (Anderson & Okoro, 2000: 24; Couch, Felstehausen & Hallman, 1997: 5; Geldard & Geldard, 1999: 173; Hill & O' Brien, 1999: 273, Zastrow, 2000: 477).

Assertive individuals are those who act in their own best interests without too much anxiety and without infringing on the rights of others. Assertive people are aware of their

rights; communicate their opinions, needs, and feelings in appropriate ways; and make reasonable demands on others. Being assertive involves listening to the other person, validating what the other person has said, believing in your right to present a point of view and being prepared to express a point of view. Unassertive individuals on the other hand allow themselves to be treated as persons of little or no consequence (Doyle, 1992: 139; Geldard & Geldard, 1999: 173).

Steinberg (2003: 92) notes that training people to improve assertive behavior is not easy however, it is certainly worth. Assertion training is concerned with the building of self-confidence and esteem, and the ability to translate this into improving communications and relationships. Doyle (1992: 139-140) also emphasizes that learning to be assertive is hard work and has suggested the following steps in helping people to be assertive:

- Help the client to recognize that his or her inhibitions are causing a great deal of tension and unpleasantness. The client must be able to overcome these inhibitions.

- Obtain all detailed descriptions of all the situations that are related to unassertive behavior, identify specific instances of unassertiveness and causes.

- Help the client arrange a hierarchy, from the situations where the clients has a higher probability of being assertive to those where the client is unassertive.

- Teach the client the distinction between assertiveness and aggression.

- Develop a plan to teach the client more assertive behavior.

- Implement the plan. The helper needs to be systematic and provide positive feedback and reinforcement.

- Encourage the client to evaluate his or her own behavior and any changes that have taken place. Plan to follow up with the client.

In addition Nelson-Jones (1995: 344) identifies four specific assertive response patterns or abilities that helpers can train client as: saying 'no'; asking for favors and making requests; expressing positive and negative feelings; and initiating, continuing and terminating conversations. Assertiveness training is designed to help people realize, feel and act on the assumption that they have the right to be themselves and express their feelings freely. Once assertiveness skills have been acquired it should significantly increase the learners' self-esteem and self-efficacy and decrease loneliness, social awkwardness and social phobia (Couch, Felstehausen & Hallman, 1997: 5; Zastrow, 2000: 477-478).

5.9.4 Problem-solving skills

A problem is any unsatisfactory or undesirable condition that needs to be corrected. All people experience problems. Some need immediate action; others need careful thought and time before they can be resolved. Without adequate information, people tend to go for quick solutions that aggravate the condition since it addressed the symptoms rather the real issue. Some people may attempt to rationalize their problems away or to ignore them in the hope that they will disappear. Many of the conditions that people encounter are the result of inadequate problem solving capacities. It is therefore of utmost importance that people should be taught problem solving skills (Hepworth & Larsen, 1993: 446; Myrick, 1997: 161; Potgieter, 2004: 220-222; Swart, 2000: 356).

It is natural for young people to turn to adults at times, for guidance when faced with challenges. Gillis (1999: 47) notes that whilst the opinions given may be instrumental in helping them to resolve a specific issue, the young person's long-term interests may be better served if the opportunity is used to a systematic approach to problem solving. The art of problem solving need not be the exclusive domain of counselors. Young people can be trained in problem-solving skills as part of their growing process and be assisted in applying those skills in their personal lives (Anderson & Okoro, 2000: 9; Brack & Hill, 2000: 11; Myrick, 1997: 161).

Problem-solving skills enable people to deal constructively with problems in their lives. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strain. Problem solving is described as a step-by-step method of dealing with problems by following a formal reasoning process. In this process, problems are identified and a series of decisions are made to improve the situation. The counselor provides the necessary guidelines during the learning process. The youngster experiences his problems clearer and is expected to play the decisive role in resolving them. Furthermore, it is noted that an essential pre-requisite in helping is the youngster's total commitment and involvement in the process is that the person must acknowledge that there is problem and should be genuinely motivated to resolve it (Brack & Hill, 2000: 9; Gillis, 1999: 47; Swart, 2000: 356).

A review of processional literature suggests that problem solving involves the following several steps:

- Identifying the problem and establishing goals. Counseling skills are used identify and clarify the problem and determine goals.
- Generating alternative solutions. The youngster is encouraged to brainstorm every possible means of achieving the goals.
- Choosing the best alternative.
- Developing a plan.
- Implementation; The youngster acting upon the plan.
- Follow up to evaluate how the solution(s) worked.

(Anstey, 2002: 135; France, 1996: 60; Gillis, 1999: 47-48; Hepworth & Larsen, 1993: 446; Myrick, 1997: 161-163; Potgieter, 2004: 222-224; Swart, 2000: 360-362; Zastrow, 2000: 48-49).

According to Myrick (1997: 161) problem-solving can be a difficult task as the presenting problem may not be the real problem. The presenting problem may only be a symptom or a manifestation of the source of the problem. Later, other related problems or

behaviors may emerge during the process of problem solving. Therefore problem solving can be tedious work. It is not easy to know where to begin. However, by training and by job description a helper is considered a resource to be drawn upon. The young person is coached through a thinking process, where it is possible to put the problem in perspective and to arrive at some action which can be taken. The process of solving the problem rests with the individual. Mastering the process requires persistence and determination and the willingness to repeat and practice until mastery is achieved. Part of the learning process should include preparing the client system for possible failure (Potgieter, 2004: 223-224; Myrick, 1997: 161).

According to Potgieter (2004: 224) knowledge of the problem-solving skill 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.

5.9.5 Decision-making skills

Decision-making is an extension of the problem-solving process. According to Gillis (1999: 48) the procedure is similar; expect that it provides a structural basis for making choices, rather than for finding solutions. The ability to make good decisions helps to prevent problem conditions. Making good decisions involves choosing between two or more options. The need for effective decision-making is an ongoing process throughout the life span of an individual and it is also something that everyone must do every day. If this skill is not sufficiently acquired during the normal developmental process, special efforts should be made to rectify the situation (Doyle, 1992: 79-80; Potgieter, 2004: 219; Swart, 2000: 356).

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. Helpers

need to help them to use their own resources for arriving at decisions. They need to be encouraged to make the best possible choices taking account of their personal values and the objectives they wish to achieve (Janis & Mann, 1982 as quoted by Geldard & Geldard, 1999: 178).

Values and attitudes play a vital role in the process of decision-making (Tsatsi, 2001: 39). The presence of values removes the association that there are right or wrong answers or outcomes. Learning decision-making skills increases the possibility of an individual attaining what he or she values. Young people are made aware that every decision made has consequences, and they must accept the responsibility for the consequences of the decisions made. Being made aware that they should at times be capable of taking their own decisions affecting their own lives will boost their self confidence and assure them that they have the right to exert some control over their lives.

The decision-making process involves a systematically working through a series of steps. In helping adolescents to make decisions it can be useful for a helper to identify for them the following stages of decision making: define the problem, examine the possible choices and the consequences of each choice, select the best choice, act on your decision and evaluate your decision. The role of the helper is not one of making decisions for the client systems, but to give them the skills to deal with the present concern, and also to deal effectively with future problems (Couch, Felstehausen & Patsy 1997: 27; Doyle, 1992: 80; Geldard & Geldard, 1999: 178; Potgieter, 2004: 220; Swart, 2000: 358-362).

Basically the main trust of all helping interventions is to assist client to make better choices. The helper needs to help clients develop rational decision-making skills. A critical aspect of effective decision-making is the ability to view the decisions from various points of view. Poor decisions are often made because people do not think of proper alternatives or do a poor job of evaluation. For most important decisions, all of the above mentioned stages would be required. If any of them are missed out, then it may be that decisions will be reached that cannot be maintained. Learning the decision-making process helps individuals anticipate problems, minimize the probability of acting

impulsively, and lessens the anxiety and tension often associated with crises and indecisiveness. Therefore, mastering decision making skills enables young people achieve a sense of control over their lives by making sound and responsible choices (Doyle, 1992: 83; Johnson & Johnson, 2003: 299; Nelson-Jones, 1994: 274; Potgieter, 2004: 224).

5.9.6 Conflict-resolution skills

According to Potgieter (2004: 233) conflict is part of life of all systems. It is both natural and inevitable in interpersonal relationships. The closer the ties between people, and the more frequent their contact, the greater the chances of getting irritable and annoyed with one another. Conflict is defined as a struggle between two or more people over values and claims to scarce status, power and resources in which the aims of the opponents are to neutralize, injure or eliminate reviles (Anstey, 2002: 5). Conflict exists in a relationship when parties believe that their aspirations cannot be achieved simultaneously, or perceives a divergence in their values, needs and interests. Members of a system cannot come to an agreement about the events, rules, goals, behaviors, task performances or the decision making that affect their lives together. Therefore, they employ their power in an effort to defeat change each other to protect or further their interests in the interaction. However, because there is conflict, it does not necessarily mean that the relationship is doomed. Positively managed conflict can produce remarkably positive results (Anstey, 2002: 6; Clearly, 2004: 51; Potgieter, 2004: 233; Swart; 2000: 367).

Conflict can be constructive or destructive. Constructive conflict is productive in the sense that it triggers creativity, innovation and stimulates trusts and understanding. It brings problems, differences of opinion and competing needs out into the open. This conflict has the potential to energize the problem-solving capacities of people, to stimulate constructive forms of interaction and to promote growth. Destructive conflict involves efforts to destroy each other and includes behaviors such as belittling, degrading, verbal abuse or physical violence. The consequence of this type of conflict is

often negative with the different parties involved in attacks and effort to destroy each other. It is not the presence of conflicts, but the way in which they are managed, that determines whether they are destructive or constructive (Anstey, 1993: 17; Anstey, 2002; 10; Cleary, 2004: 51-52; Corey & Corey, 2002: 179-180; Johnson & Johnson, 2003: 382; Swart, 2000: 368).

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, faulty communication, 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. These strategies are said to be counterproductive. Avoiding conflict rarely leads to satisfying and meaningful dialogue. When conflicts are avoided, true feelings and opinions are not expressed. When unresolved problems from the past are brought up, negative feelings escalate; fueling anger and despair, which often detract from the motivation and possibility of resolution. Before conflict can be dealt with and constructively worked through, it must first be recognized (Anstey, 2002: 13; Baron & Byrne, 2003: 496; Corey, 2004: 98; Cumming & Davies, 1994: 16; Potgieter, 2004: 233-234; Swart, 2000: 369-371; Toseland & Rivas, 2001: 340).

According to Potgieter (2004: 236-237) the following strategies can be used to manage conflict:

- Mutual respect. Understanding and respect for each other's point of view is a basic requirement during conflict resolution.

- Ability to pinpoint "the issue". People should develop the ability to identify an issue behind an event or a complaint.

- Focusing on facts in the present. This requires the ability to distinguish between facts and emotions and to concentrate on what is relevant in the situation.

- Conflict resolution needs the co-operation of both parties.

- Strive for a collaborative two-winner approach. Losing creates bitterness and triggers feelings of revenge. A two-winner approach requires the ability to understand the viewpoint of the other.

- Address the issue in small steps. Arguments and conflicts are less likely to become overheated if issues are addressed once at a time.

- Mastering the ability to make request. Many conflicts are the result of the inability of parties to openly express their needs in clear and direct requests.

When conflicts are managed constructively, they have many desirable outcomes. People discover that their relationships are strong enough to withstand an honest level of challenge. Constructive conflict can help people understand each other and can keep the relationship clear of irritations and resentments. Conflict management skills are vital in sustaining healthy relationships (Johnson & Johnson, 2003: 380-382).

5.9.7 Critical thinking skills

According to Nelson-Jones (1994: 248) thinking skills can help people to think before they act. Critical thinking skills are described as the ability to analyze information and experiences in an objective manner (Brack & Hill, 2000: 10). Critical thinking can contribute to health by helping people to recognize and assess the factors that influence attitudes and behavior, such as values, peer pressure, and media. 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 (Gladding, 1997: 10-108; Gillis, 1994: 72-75; Geldard & Geldard, 1999: 6). People with critical thinking skills are able to recognize and define problems, gather information, form tentative conclusions and evaluate these to make decisions. Of particular importance is to teach adolescents to improve their capacity for critical thinking. Following is a brief description of thinking skills areas as outlined by Nelson-Jones (1995: 361-362).

- Owning responsibility for choosing. People should be aware that they are the author of existence and can choose how to think, act and feel.

- Using coping self-talk. Instead of taking to themselves negatively before, during and after specific situation, people can make self-statements that can calm them down and coach them in how to cope.

- Choosing realistic personal rules.

- Choosing to perceive accurately. Being able to distinguish between fact and inference and make inferences as accurate as possible.

- Explaining cause accurately. Develop the skills of explaining the causes of events accurately.

- Predict realistically. Be realistic about the risks and rewards for future actions. Assess threats and dangers accurately.

- Setting realistic goals. Short and long term goals should reflect values, be realistic, specific and have a time frame.

- Using visualizing skills. People think in pictorial images as well as in words.

- Realistic decision-making. Confront rather than avoid decisions.

- Prevent and managing problems. Anticipate and confront problems. Assess the thinking and action you require to deal with issues.

According to Brack and Hill (2000: 9-10) the implementation of thinking skills should be followed by creative thinking skills.

5.9.8 Creative thinking skills

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). The ability to be spontaneously creative, approaching situation with fresh ideas is important to adolescents. According to Brack and Hill (2000: 9-10) creative thinking contributes to both decision-making and problem-solving by enabling people to explore the available alternatives and various consequences of their actions or non-actions. It helps people to look beyond their direct experience, and even if no problem is identified, or no decision is to be made. Creative thinking helps people to respond adaptively and with flexibility to the situations of their daily lives.

5.9.9 Self-awareness skills

Stewart et al (1996: 169) mention that many people lack proper self-knowledge. They do not know where they are in their lives, what their long-term goals are or how they intend achieving goals based on their potential abilities. 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).

Self-awareness includes peoples' recognition of themselves, their character, identity, cultural perspectives, goals, motivations, needs, values, feelings, strengths and weaknesses as well as desires and dislikes. Developing self-awareness helps people to recognize when they are stressed or feel under pressure. Furthermore, it is viewed as a prerequisite for effective communication and interpersonal relations, as well as for developing empathy for others. The more one is in touch with one's own feelings, attitudes and behavior, the greater the chance the level of communication. 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 (Brack & Hill, 2000: 10; Corey & Corey, 2002: 32; Doyle, 1992: 113).

Self-awareness also implies knowledge of past experiences. According to Stewart et al (1996: 170) before people can properly know themselves as they are today, they need to look at their past. The way people see themselves today is certainly the result of past experiences and influences. However, these influences should be viewed as external events and cannot be seen as a focus point. A person's strengths rest on an internal foundation and people should focus on them to enhance their potential. The past should be viewed as a learning experience. By looking at the past events, enables people to focus on their weakness and recognize strengths in themselves. The main important point is that people should reinforce (build) those strengths that make them feel good about life. Whenever people feel despondent about themselves, they should recall their strengths hence their ego will be boosted (Stewart et al, 1996: 170).

According to Stewart et al (1996: 173) self-awareness also implies that people should consider their personal expectations about their future actions. Human potential is regarded as limitless. Therefore, it is important that people should become aware of their unlimited potential and the future opportunities open to them.

5.9.10 Empathy

Corey and Corey (2002: 135) define empathy as the ability to tune in to what others are subjectively experiencing and to see their world through their eyes. It is the ability to imagine what life is like for another person, even in a situation that you may not be familiar with. Empathy helps in understanding and accepting others who may be very different, which can improve social interactions. By understanding the feelings of others such as the need for love and acceptance, hurt of past experiences, loneliness, joy and enthusiasms people make, it becomes possible for others to open up. When people experience this understanding without critical judgment, they are most likely to reveal their real concerns. However, understanding others perspectives alone is not sufficient, one must be able to express verbally a sense of understanding and attempt to do something to relieve ones pain. Thus empathy means not only "I feel your pain," but also, "I understand your pain" (Baron & Byrne, 2003: 408; Clearly, 2004: 82; Corey, 2004: 110; Corey & Corey, 2002: 135).

Empathy is an avenue of demonstrating support. The core of the skill of empathy lies in being able to openly grasp another's experiencing and at the same time to maintain one's separateness. It requires the capacity to feel an emotion deeply but to remain separate enough not to get sucked into or overwhelmed by such emotion (Brack & Hill, 2000: 10; Corey & Corey, 2002: 135, 36; Hackney & Cormier, 1994: 14-15; Potgieter, 2004: 103).

Empathy can also help to encourage nurturing behaviors toward people in need of care and assistance, or tolerance, as is the case with people living with HIV/AIDS, or people with mental disorder, who may be stigmatized and ostracized by the very people they depend upon for support. Empathy is associated with other positive characteristics such as a sense of well-being, achievement motivation, sociability and a positive emotional state. To be effective and empathic, stepping into the shoes of the other must lead to understanding. Workshops and skills development are regarded as important means of enhancing knowledge of making use of empathic understanding (Baron and Byrne, 2003: 412; Brack & Hill, 2000: 10; Potgieter, 2004: 103).

5.9.11 Coping with emotions

Emotions are part of human nature. According to Baron and Byrne (2003: 541) coping refers to the way in which people deal with threats and with their emotional consequences. Of special interest is the effect of emotions on health. Coping with emotions involves recognizing your emotions and others emotions, being aware of how emotions influence behavior, and being able to respond to emotions appropriately. Intense emotions, like anger or sorrow can have negative effects on a persons' health if a person does not react appropriately (Brack & Hill, 2000: 10).

5.9.12 Coping with stress/Stress management

Coping with stress is about recognizing the sources of stress, recognizing how these affect a person, and acting in ways that help to reduce levels of stress. This may mean that people have to take action to reduce the sources of stress, for example by making changes to their physical environment or lifestyles. The active efforts taken to solve or ameliorate stressful conditions people experience and lower their anxiety are what is called coping strategies. Basically there are two responses to stress shared by adolescents: fight or flight. However, the best way to reduce stress is to know as much as possible about the conditions that cause stress. Knowledge provides a sense of control, rather than ignorance and the unpredictability (Amanat & Beck, 1994: 258; Baron & Byrne, 2003: 542; Doyle, 1992: 22; WHO, 1997: 2).

Stress can be managed effectively by individuals. Some of the ways that are used to cope with stress are proactive or constructive whereas others are more reactive and nonconstructive. Nonconstructive coping skills include being aggressive, defensive, self-blaming, and being withdrawn. Although these tactics can relief stress they ultimately have serious negative physical and emotional repercussions (Doyle, 1992: 22). Proactive or constructive coping strategies involve taking direct and effective steps to handle a

given issue, problem, or demand of life. According to Doyle (1992: 22-23) constructive strategies involve efforts to:

- Appraise the situation in realistic ways. This involves making an accurate and realistic evaluation of the situations and circumstances that cause the stressful events. Having a clear perception of a problem and the circumstances that caused it is an important coping process.

- Use appropriate problem-solving skills. Learning how to solve, modify, or circumvent the problems faced in life is a major coping process.

- Deal effectively with one's emotional reactions to stress. It is often important to reduce the emotional reactions caused by stress. This can be accomplished by learning how to release emotions in mature and socially acceptable ways.

- Maintain one's body in good physical condition. Keeping the body in reasonably good physical condition enable people to deal more effectively with the demands on them by any stressful condition. Learning to eat nutritional foods and engaging in reasonable amount of exercise are activities that can help prevent and ameliorate the problems of stress.

Baron and Byrne (2003: 548) note that the physical and psychological comfort provided by other people also is beneficial in times of stress, and it is effective regardless of the kind of strategies that are used. When people feel stressed, it helps to have family and friends who can provide an outlet for blowing steam; they give support to one lacking self-confidence, and they can be confided in about personal problems. The presence of social support helps toward healing and enables one to recover more quickly. Support groups are considered helpful especially when the problem is stigmatizing, for example AIDS and alcoholism. Employing these positive coping strategies does not automatically ensure a successful outcome in any particular situation. However since the coping process is an ongoing one that is repeated over and over again, the use of these

constructive copings skills generally leads to positive outcomes (Swart, 2000: 399; Doyle, 1992: 22; Baron & Byrne, 2003: 548).

Instilling life skills is based on an educational theoretical framework. Life skills education most often implies running structured groups of limited duration to train participants in one or more specific life kills (Nelson-Jones, 1995: 356; Nelson-Jones, 1993:227). In the next section life skills education is looked at.

5.10 LIFE SKILLS EDUCATION

According to Anderson and Okoro (2000: 18) the most effective way in dealing with social and health problems is to direct primary prevention programs at young people where internalisation of healthy life-styles and a sound socially acceptable value system is still possible. This process is known as empowering children through appropriate education. Appropriate education again refers to a positive approach in which the target group is provided with knowledge and life skills to purposefully assist them to more effectively cope with daily life situations. To combat or minimize the problems people need to maintain a healthy balance between preventive, controlling and treatment measures with prevention as the predominant role. Skidmore (1994: 332) mentions that prevention is the process of action taken to minimize anti-social behavior or to see to it that it does not arise at all.

According to WHO (1994: 1) life skills are competencies and abilities for adaptive and positive behavior, that enable individuals to deal effectively with challenges of everyday life. The teaching of skills is therefore practical and intended to equip the learner with new or improved abilities. The methods to teach life skills are based on experiential learning (learning through active participation) rather than didactic teaching. Life skills acquisition requires opportunities for practice and application of skills being taught. Life skills are taught in many different health promotion and prevention education programmes. According to WHO (1994: 2) life skills education is relevant to many areas of public health concern and programmes can be designed to address the major

behaviour-related health problems for children and adolescents. Life skills education is seen as a comprehensive approach to health education and health promotion among the youth. The above-mentioned author further, outlines the areas of public concern that makes life skills education essential and these are listed below:

- Drug abuse
- Adolescent pregnancy
- AIDS
- Child abuse
- Depression
- Conflict and Crime
- Suicide

The teaching of life skills marks recognition of the need to address the socio-emotional factors that influence young peoples' behaviour. These include the effects of self-esteem, self-image, social support networks and stress. Craig et al (1996: 6) believe that life skills can be learnt modified and improved as the person develops and adjust to life's challenges.

In life skills education, children are actively involved in a dynamic teaching and learning process. Life skills education involves the learning of new skills. Methods used to facilitate the learning of skills include; skill practice, group discussion, panels, debates, brainstorming, role-playing, small group work and games. Through these and other innovative teaching techniques children can acquire skills to deal assertively with peer pressure, the use of drugs or to have unprotected sex and learn how to manage and cope with a wide range of other specific problems. Life skills education has been proved to be effective in the developed world in such areas as the prevention of substance abuse, adolescent pregnancy and prevention of bullying. There are also life skills programmes to prevent HIV/AIDS, for peace education, and for the promotion of self-confidence and self-esteem. A number of developing countries like South Africa have adopted life skills education in the national educational curricula (The Department of Education Interim

Core Syllabus for Guidance, 1995) and others have shown keen interest (WHO, 1997: 1; WHO, 1994: 2; Brack & Hill, 2000 13).

According to Gladding (1997: 101) timing as well as content is crucial when working with children. Learning should occur when the children are ready and able to learn. A life skills lesson may start with a teacher exploring with the students what their ideas or knowledge is about a particular situation in which a life skill can be used. The role of the teacher is not only to teach, but also to act as a facilitator in a dynamic and learning process. The children are given opportunities to discuss the issues raised in more detail in small groups. They may then engage in short role-play scenarios, or take part in activities that allow them to practice the skills in different situations. The actual practice of skills is very important component of life skills educations. Finally homework will be assigned to encourage the children to further discuss and practise the skills with their families. Promoting communication skills is crucial in the education role of the helper (Gladding, 1997: 101; WHO, 1997: 4).

Life skills lessons are effective when combined with health information or other programmes, which influence the health and development of young people. The method used in the teaching skills builds upon what is known of how young people learn from their own experiences and the people around them, from observing how others behave and what consequences arise from behaviour (Anderson & Okoro, 2000; WHO, 1997: 16).

Life skills education is a growing area. According to WHO (1994:2-3) as well as Brack & Hill (2000: 97) the growing popularity of life skills approaches reflects a move towards more positive and holistic approaches to preventive education. WHO (1997: 7) mentions that life skills are important for children and adolescents as it promotes their mental well-being and cooperative learning. It promotes the learning of abilities that contribute to positive health behaviour and positive interpersonal relationship. Nelson-Jones (1993: 227) outlines the following as reasons for the growth of life skill education:

- It has a developmental emphasis. The target of life skills training in the ideal world would be to train everyone in the skills required to meet each task at every stage of their life span. Such training has developmental rather than a remedial or rehabilitation emphasis.

- It has a preventive emphasis. Efforts are devoted to the personal and social education of people in such a way that their developmental needs are anticipated.

- Problems of living are widespread. People need various life skills to assist them to cope with their problems.

There are several objectives of life skills education. In the following section, these objectives are discussed in detail.

5.10.1 Objectives of life skills education

Many life skills programmes address multiple prevention and health promotion objectives. Anderson and Okoro (2000: 27) suggest the following as objectives of life skills education.

- To educate young people on how the human body works and in particular to educate them on the effect that diseases (especially HIV/AIDS), substances (drugs) and other abusing factors have on the working of the human body;

- To equip young people with the skills necessary to understand and overcome pressures which can lead them to abuse the working of their bodies;

- To equip young people with the skills to understand and overcome pressures which limit the uniqueness and potential of human beings;

- To educate young people on the relationship between human beings, animals, the environment ant the universe; and

- To equip young people with the outlook, life skills and philosophy necessary to promote a feeling of harmony within themselves, with others, the environment and the universe.

In addition, the Journal of Social Psychology (1993: 528) identified the following life skills areas, which will support the restrainment of social, and health problems:

- To reinforce knowledge of human sexuality, reproduction, sexual transmitted diseases and HIV/AIDS;

- Equip people with basic skills such as assertiveness, negotiation, problem solving and decision making;

- Learn to identify and develop core values like honesty, respect, caring, tolerance, loyalty and commitment;

- Help to promote attitudes and behavior changes that will prevent infection; and

- Encourage young people to become involved in addressing and /or preventing problems in the community as such as substance abuse, violence and crime.

Next is the discussion of three methods of delivering life skills education. Each method focuses on the basic principles that can be applied when working with adolescents.

5.10.2 Methods used in life skills education

As already noted, in life skills education children are actively involved in a dynamic teaching and learning process. The methods used to facilitate this active involvement include working in small groups, brainstorming, and role-play.

5.10.2.1 Group work

According to Thompson and Rudolph (2000: 416) and Myrick (1997: 187) people are born into groups, live and work in groups, become dysfunctioning in groups, and can be helped in groups. Toseland and Rivas (2005: 12) define group work as a goal-directed activity with small treatment groups and task groups aimed at meeting socio-emotional needs and accomplishing tasks. Groups are uniquely suited to help persons grow and change in constructive ways (Johnson & Johnson, 2003: 517). That groups often exert powerful effects upon their members is obvious and will be a basic theme in this section.

A small group is a collection of between 3-12 individuals who are involved in face-to-face interaction to achieve a common goal. The term small group implies the ability of members to identify themselves as members to engage in interaction and exchange thoughts and feelings among themselves through verbal and non-verbal communication process. The group generates a sense of community, belonging, caring, understanding, acceptance, assistance and support to members, which foster the members' willingness to explore problems. Groups provide an arena for safe practice. A good working environment is one that promotes interaction in the group. Members achieve a sense of belonging, and through cohesion that develops they learn ways of caring and of challenging their situations. In this supportive environment, members can experiment with alternative behaviors. Ultimately, it is up to the members themselves to decide what changes they want to make (Clearly, 2004: 37; Corey, 2004: 6; Gladding, 1997: 172-174; Jacobs, Masson & Harvill, 1998: 4; Johnson & Johnson, 2003: 524; Myrick, 1997: 221; Steinberg, 2003: 99; Ward, 2002: 152-153).

According to Thompson and Rudolph (2000: 417) group interventions may be informational, developmental, and preventive in nature in that they can help children to function more effectively at each level of development or cope with specific problems that may affect their growth development. Their goal may be to assist members to communicate better, learn assertion skills, improve relationship skills, develop leadership skills, communicate with parents, say no to drugs or gangs or adjust to a new home life. Jacobs, Masson and Harvil (1998: 347) state that adolescence is a difficult period in a young person's life. Therefore, voluntary growth, discussion, education and counseling groups can be quite valuable at this stage. Groups can help with identity problems, sexual concerns alcohol abuse and problems with parents, friends and school.

Gladding (1997: 172) describes life skill development groups as classified under educational groups. The primary function of these groups is the prevention of personal or societal disorders through the conveying of information and or the examining of values. Group participants may be taught for instance how to deal with a potential threat (e.g., HIV/AIDS), a developmental life event (e.g. growing older), or an immediate life crisis (e.g., the death of a loved one). A group leader working with adolescents should like and respect teenagers, want to learn more about their immediate world, and understand the kinds of struggles they go through while trying to grow up (Jacobs, Masson & Harvil: 1998: 347).

Group work provides an opportunity for members to identify and discuss acceptable and unacceptable social behaviors. It provides an opportunity for members to receive feedback. Groups allow adolescents more especially to openly question their values and to modify those that need to be changed. In the group, adolescents learn to communicate with their peers, they benefit from the modeling provided by the leader. In such groups, adolescents can safely experiment with reality, test their limits, express themselves, and be heard. These personal and interpersonal skills are achieved though the processes of increased self-awareness and self-disclosure to others (Corey, 2004: 7; Corey & Corey, 2002: 308; Geldard & Geldard, 2002: 215; Gladding, 1997: 111; Nelson-Jones, 1994: 274).

Another unique value of group work for adolescents is that it offers a chance for them to be instrumental in one another's growth. Because of the opportunities for interaction available in the group situation, the participants can express their concerns and be heard, and they can help one another on the road toward self-understanding and self-acceptance. Most important, a group gives adolescents a chance to express themselves and help one another in the struggle of self understanding and to interact with their peers (Corey, 2004: 7; Corey & Corey, 2002: 308).

According to Gladding (1997: 111) working in groups can be helpful to adolescents in making a successful transition form childhood to adulthood especially in regard to handling stressful situations. Membership in a supportive group strengthens one's identity as a person who is growing and changing. Working in groups appeals to many young people, especially as they learn how they often share common interests and concerns. These groups can provide support, facilitate new learning, help ease internal and external pressures, and offer hope and models for change. Such groups are conducted in community as well as schools setting and traditionally have an adult leader. They focus on common concerns such as identity, sexuality, parents, peers relationships, career goals, and educational problems. Young people who join these groups do so out of a sense of need and strive to gain knowledge and experiences to help them better handle their concerns (Gladding, 1997: 111; Johnson & Johnson, 2003: 525; Myrick, 1997: 187).

According to Jacobs, Masson and Harvil (1998: 348) sessions with adolescents should last between 40-90 minutes. The size of any kind of growth, support, educational and counseling group should be no more than eight members with six being ideal. Life skills group is best conducted in relatively small group. It allows the trainer to focus on the skills of individual members. Where there are two trainers, the overall size of the group can be considerably larger. Depending on the groups' purpose, the leader may want to lead all males, all females, or mix of both. The value of the coed group is that there is a lot of learning about the opposite sex during the adolescent years, and the group can be a

very good place to do so. The disadvantage to mixed groups is that members may be inhibited when the opposite sex is present. Life skills group often takes place in fixed length groups lasting six to ten sessions. The clients for life skills training groups frequently select themselves for membership. Sometimes people may be assigned to attend life skills training groups (Jacobs, Masson & Harvil, 1998: 348-349; Nelson-Jones, 1993: 233).

From this discussion group work can be viewed as a vehicle for helping people make changes in their attitudes, beliefs about themselves and others, feelings and behaviors. Therefore young people are more comfortable and willing to participate in groups to explore their ideas attitudes, feelings and behaviors especially as related to personal development. In the following section role-play as an activity used in groups is discussed.

5.10.2.2 Role-playing

According to Hoelson and Van Schalkwyk (2001: 264) role-play is a technique by which people take on different role to illustrate a situation or idea. It is an enactment of a social role in an imagined social situation. It is used to help people learn new ways of responding to specific life situations. It is viewed as a powerful tool for assessment, simulation, understanding, decision-making or behaviors change. Role playing techniques increase members' awareness and understanding of their interpersonal skills and produce behavior changes by providing members with corrective feedback. By role-playing, participants can learn how to express themselves more effectively, test reality, and practice new behaviors. Responses can be improved through feedback, rehearsal and coaching. Role-play can help children learn about cause and effect and experience the consequences of their behavior in a relatively safe setting. Once the children have chosen appropriate skills for use in a particular situation, they can help one another to devise a plan of action. Thus they are able to think about ways in which to implement the learnt social skill into the various settings of their own unique and individual environment

(Corey & Corey, 2002: 315, Hill & O' Brien, 1999: 273, Geldard & Geldard, 2002: 215; Thompson & Rudolph, 2000: 226; Toseland & Rivas, 2005: 297& 120).

When counseling adolescents, role-play is an excellent way of keeping the energy following. It keeps the interest level high and it gives a here-and-now flavor to the work being done (Geldard & Geldard, 1999: 137). Corey and Corey (2002: 315) note that role playing fosters creative problem solving, encourages spontaneity, usually intensifies feelings, and gets people to identify with others. During role-play many adolescents become actively involved in a very dynamic process. They can play parts of their lives in a highly charged and physical way, which for many young people is easier than sitting down and talking through issues. However, Geldard and Geldard (1999: 137) as well as Corey and Corey (2002: 316) state that engaging in role-playing does not suit all adolescents. Some are too self-conscious to allow themselves to play a role creatively. It is therefore essential for helpers to check out whether an adolescent is willing or not to use role-play. Sometimes adolescents will be willing to try out role playing if it is made clear to them that they may withdraw if they find that role is not comfortable or useful for them. When using role-play it is important for the young person to feel in control of the process and also to feel supported in what she does (Geldard & Geldard, 1999: 137).

According to Geldard and Geldard (1999: 137) role-play can be used for the following purposes:

- To gain an understanding of roles and relationships,
- To get in touch with feelings,
- To explore parts of the self,
- To make choices,
- To externalize beliefs or feelings and,
- To practice and experiment with new behaviors.

Role-play can be useful in helping adolescents explore their relationships with others and gain a better understanding of the issues involved in these relationships, both from their

own point and the perspectives of others. During role-play adolescent can act out, both verbally and non-verbally, ways in which they behave in their relationship with others (Corey & Corey, 2002: 315; Geldard & Geldard, 1999: 137). Therefore, Geldard and Geldard (1999: 137) suggest that when a young person is involved in role play it is important for the helper continually to observe his verbal and non-verbal behavior in order to detect underlying emotional feelings. When the group leader notices behaviors that suggest underlying emotions, which are not being openly acknowledged it can be useful to feed back the observed information to the young person. In addition role-play can be used to help adolescents recognize the difference between roles which thy believe are functional and productive and roles which are dysfunctional and unproductive. They then have the opportunity to expand their repertoires of roles by learning to play new roles which have not been used previously (Geldard & Geldard, 1999: 137-138).

From the role-play experience, it is likely that the adolescent will gain an understanding of new own issues, feelings and thoughts, and will also gain some level of understanding of the others persons' perspectives.

5.10.2.3 Brainstorming

One of the biggest benefits for people to work in groups is that they can brainstorm together. Hoelson and Van Schalkwyk (2001: 246) note that brainstorming is a frequently used method in life skills education. Often groups suffer when members do not produce a wide variety of ideas that be contrasted with each other. Brainstorming is a technique whereby people are asked in small groups to generate as many possible solutions as they can, someone recording these as they are suggested. It helps with problem solving. Problem solving depends on developing divergent views that conflict with each other. Brainstorming generates ideas for a wide base because it encourages all group members to participate fully. Through collaboration, more ideas can be produced than can be generated by either person alone. The purpose of brainstorming can be described as to increase the number of ideas generated by members (Anstey, 2002: 142; Johnson &

Johnson, 2003: 373; Hill & O' Brien, 1999: 311; Hoelson & Van Schalkwyk (2001: 246; Toseland & Rivas, 2005: 352).

According to Papier and Geshenfeld (1993) in Toseland and Rivas (2001:64) and Johnson and Johnson (2003: 373) the other benefits of brainstorming include the following:

- Dependence on a single authority is reduced,
- Opening sharing of ideas is encouraged,
- Members of highly competitive group can feel safe,
- A maximum output of ideas occur in a short period of time,
- Ideas are generated internally,
- It is enjoyable and self-stimulating and,
- It encourages divergent thinking.

The rationale for using brainstorming is the belief that many ideas are never born or are quickly stifled due to domineering members, stereotypes of each other other's expertise and intelligence, interpersonal conflict and silence, or fear to ridicule or evaluation. Brainstorming is preferred because participants are asked to spontaneously produce as many, and as uninhibited, ideas as they possibly can and to withhold criticism in order to optimize creativity. During brainstorming, total effort is directed toward creative thinking rather than to analytical or evaluative thinking. Evaluation is viewed as hampering creativity (Anstey, 2002: 142; Clearly, 2004: 49; Johnson & Johnson, 2003: 373-374; Toseland & Rivas, 2005: 352).

Brainstorming can be conducted in any size of the group, although large groups may inhibit idea generation and reduce member's ability to participate in the allotted time. Because brainstorming encourages the generation of creative and unique ideas, a heterogeneous membership representing many points of view facilitates the process. Groups that use brainstorming produce more ideas of higher quality than groups that do not use this approach (Toseland & Rivas, 2005: 353).

In the section above life skills education was explored. According to Hoelson and Van Scalkwyk (2001: 255) life skills education occurs through intervention programme known as life skills programme. In the following section the researcher briefly reviews life skills programme.

5.11 LIFE SKILLS PROGRAMME

Brack (2000: 5) defines life skills programme as activities aimed at empowering people to internalise a repertoire of life skills according to their developmental tasks and specific problems of living. According to WHO (1997: 1-2) life skills programmes are educational programmes designed to promote positive health behaviour by enabling individuals to deal effectively with the demands and challenges of every day life. The teaching of life skills is therefore practical and intended to equip the learner with new improved abilities. Effective life skills programme require that the participants collaborate in their effort to become empowered and to learn skills necessary to function optimally (Hoelson & Van Schalkwyk, 2001: 255).

Hoelson and Van Schalkwyk (2001: 255) state that life skills programmes aim at assisting people to become more balanced, independent and able to solve problems creatively in their daily lives. Life skills programmes are usually approached through a dynamic and active learning process. As life skills programmes are aimed at development of practical competence and behaviour, didactic teaching should be avoided and experiential learning encouraged (Ham, 1992 in Hoelson & Van Schalkwyk, 2001: 256).

According to Hoelson and Van Schalkwyk (2001: 257) facilitating skill learning process requires time. Permanent changes in attitudes and development of new skills do not take place in a brief period of learning, but require sufficient opportunities for practice. WHO (1994: 4) states that only when the intervention is maintained for a longer term, spanning

several years, to create longer-term improvements can we expect to have a significant and lasting impact on the participants.

Hoelson and Van Schalkwyk (2001: 255) note that learners can be encouraged to engage in the following activities in any life skill programme:

- **Introduction:** Participants each receive a nametag and are encouraged to introduce themselves to the group stating their name, age, affiliation, and some unique identifying aspect about themselves. The identifying aspect could be a favourite activity, an animal or object in nature they identify with or a key role they perceive for themselves.

- **Group rules:** Participants take turns listing rules of behaviour they would like to see implemented in the group and briefly explaining the consequences of the rule for the group process.

- **Group picture:** On a large piece of paper using markers, each member participates in making a picture of the group. Participants need to decide on a theme and assign each other roles for completing the picture. This process introduces the participants to the idea of negotiation and it promotes bonding.

While the above-mentioned factors contribute to the effectiveness of life skills programmes, they are not the only contributors to the success of life skills programmes. So that effective learning of life skills can take place there are certain requirements that have to be met. In the following section these requirements are discussed.

5.12 REQUIREMENTS FOR LEARNING LIFE SKILLS

According to Potgieter (2004: 217) the acquisition of life skills requires a structured process of learning. Before we can focus on the process of life skill helping, we will first examine some of the basic requirements of learning life skills. These factors influence

how people initially learn life skills strengths and weaknesses. In the context of this study the focus will be on the following requirements namely a supportive relationship; learning from example; instruction and self-instruction; information and opportunity as well as learning from consequences.

5.12.1 A supportive relationship

People require a supportive relationship when they engage in the process of learning, when people are attempting constructive changes and when they are venturing into frightening territory. This is based on the notion that people of all ages are the happiest and most effective when they feel that standing behind them is a person who will come to their aid should difficulties arise. This is particularly true when it comes to life skills development, for it is the relationship that enables people to risk trial-and error methods of learning and provides them with the security that is needed for the process. Reassuring or supporting behavior is intended to encourage and tell people that we believe in them. Making changes can be difficult, hence people feel supported when knowing that someone is on their side (Corey & Corey, 2002: 37; Hill & O' Brien, 1999: 315; Myrick, 1997: 140; Nelson-Jones, 1993: 13-16; Potgieter, 2004: 217).

Nelson-Jones (1993: 13-16) lists the following as advantages of making use of supportive relationship when working with children:

- Supportive relationship provides children with the security to engage in exploratory behavior and risk-trial-and-error learning. This enables them to collect information about themselves and their environments;

- Supportive relationships help children listen better to themselves. By feeling prized and accurately understood, children can get more in touch with their wants, wishes and personal meanings;

- Children may feel freer to manifest emerging life skills without risk of ridicule;

- Instruction in specific skills is frequently best conducted in the context of supportive relationships in which the anxiety attached to learning is diminished;

- The presence or absence of supportive relationship can either affirm or disconfirm children's sense of worth. They may either be helped to become confident to face life's challenges or they may become inhibited, withdrawn, and afraid to take risks. Alternatively, they may mask their insecurity by excessive attention seeking.

Learning is regarded as most effective within a supportive helping relationship. People need to hear supporting statements to make them more disposed to take constructive action in issues that affect them. Children, who learn in a supportive relationship where they are understood and prized, feel confident to engage in exploratory behavior. They are better able to take the risks involved in learning new skills. However it should be noted that too much support might send the message that people are unable to support themselves (Corey & Corey, 2002; 37; Nelson-Jones, 1993: 19; Nelson-Jones, 1995: 352; Scissons, 1993: 124).

5.12.2 Learning from example

Potgieter (2004: 217) notes that experience is one of the best teachers, especially in the case of life skills development. People learn from the examples set by others and from the behaviors they demonstrate around them. Learning from example is a major way in which people acquire life skills strengths and weaknesses (Nelson-Jones, 1994: 147; Nelson-Jones, 1995: 363).

According to Burnard, (1989: 1) as well as Johnson and Johnson (2003: 50-55) people cannot learn to be interpersonally competent by reading books on the subject, nor by listening to lectures on the topic. People learn though living and doing. Nelson-Jones (1994: 14) further mentions that people may absorb from example deficient skills for thinking, feeling and action and then possess the added barrier of remaining unaware that

this has happened. If parents and others use ineffective thinking skills, for example blaming and over-generalizing, children may be quick to do likewise.

According to Potgieter (2004: 217) experiential learning is a process that relies on personal experiences and people's reflection on such experiences. It starts with a concrete experience that provides learners with opportunities for meaningful discovery and expects them to sort things out for themselves by restructuring their perceptions of the event.

5.12.3 Instruction and self-instruction

According to Nelson-Jones (1994: 20) while helpers can encourage clients to do their own work, clients often require instruction as well. Instruction is regarded as major transmitter of life skills. Much life skills instruction takes place informally in the home. Parents frequently tell children how to relate, how to study, how to look after their health and so on. Relatives and peers can also be other providers of instruction outside the home. Nevertheless life skills programmes are considered important in instilling life skills to children. Much informal life skills instruction takes place in the school settings in such areas as career education, drug education etc. In addition a range of life skills programmes may be offered in colleges targeting areas such as relationships skills, stress management and effective thinking. Most often participation in such programmes is voluntary (Nelson-Jones, 1993: 20 & 364-365).

Instruction within life skills takes place as people rework and practice the original concepts and skills. According to Nelson-Jones (1994: 20) good helpers should always be on the lookout for ways of presenting material so clearly that clients learn to instruct themselves. In addition helpers can also make use of books, training manuals, self-help cassettes and videos as instructional sources.

5.12.4 Information and opportunity

Information is regarded as an important source of power. People need adequate and reliable information to develop life skills. Intentionally or unintentionally, adults often relate to their children on the basis of lies, omission of truth. Furthermore, necessary information may not be readily available for children outside their home. This lack of information hinders children from making right choices. For instance keeping children in ignorance about basic facts of sexuality and death impedes self-awareness and emotional responsiveness (Anstey, 2002: 26; Nelson-Jones, 1995: 365; Nelson-Jones, 1994: 15-16; Potgieter, 2004: 217).

In addition people need opportunities to test out and develop life skills. These opportunities need to be in line with their maturation and state of readiness. Lack of information and opportunities give rise to struggles and contribute to levels of mistrust in relations. Over and above it reduces the capacity of people to understand each other (Anstey, 2002: 26; Nelson-Jones, 1995: 365 & Nelson-Jones, 1994: 15-16; Potgieter, 2004: 217).

3.12.5 Learning from consequences

Learning from observing role models is frequently intermingled with learning from rewarding or unrewarding consequences. People acquire skills with learning from rewarding or unrewarding consequences. Rewarding consequences can be either primary or secondary. Primary rewarding consequences are ones that people find independent of their learning: for example, food and shelter. Secondary rewards include rewards such as approval or money. Secondary rewarding consequences are viewed as playing a big part in helping or hindering people from acquiring skills. Providing positive rewards such as praise or approval increases the probability of skill development. If they are offered appropriately children can develop necessary skills needed to improve their well-being. However, sometimes children are rewarded for exhibiting skills deficits rather than strengths (Nelson-Jones, 1993: 14; Nelson-Jones, 1995: 365).

The following section looks at ways in which social work practitioners can contribute to life skills education. Focus specifically is on the role of social workers.

5.13 THE ROLE OF SOCIAL WORKERS IN LIFE SKILL EDUCATION

Social workers are called to work with individuals, families, groups, organizations and communities to address concerns that limit their social functioning. The focus of social work is on the improvement of the social functioning of people in interaction with their environment (Zastrow, 2000: 48). The social work profession exists because there will always be people who are vulnerable, less fortunate, helpless, exploited and often unable to help themselves. With the rise of HIV/AIDS there are almost overwhelming signs of poverty, despondency, crime, abuse of children, abuse of substances like alcohol and drugs. In such a context, social work as a profession aims the change the conditions through appropriate action. It is the function of social work to identify needs and problems that affect the social functioning of people and to facilitate actions that might resolve or minimize this (Potgieter, 2004: 4-5 & 28-30; Zastrow, 2000: 48-49).

As already mentioned earlier the object of life skills education is to help people increase the probability of making good rather than poor choices in the targeted skills. This requires exposure to training programmes that are specifically designed to make people self sufficient and self reliant rather than being recipients of services. Social workers encourage client systems to believe in their own capacity affect change. Life skill development programmes serve as basic resources and facilities that social welfare agencies offer to the community. Social workers assume the responsibility of linking people to these programmes and stimulate the development of new resources where necessary to supplement the empowerment efforts of clients. What the social worker gives is not power, but the climate, relationship, resources and procedures to develop life skills which the client then utilize in order to take control of their lives (Compton & Galaway, 1994: 20-21; Potgieter, 2004: 216-217 & 29-30).

The acquisition of life skills requires a structured process of learning (Potgieter, 2004: 217). Such learning normally takes place as part of the process of socialization. Due to a number of reasons, many people find themselves in situations for which the lack preparation appropriate coping mechanisms. The social worker sees these people as having potential and believes in their ability to grow and develop. Education is often the most appropriate strategy when assisting people enhance their quality of life. Appropriate knowledge and skills are often all that is needed to affect change. Within an educational framework social workers can use a variety of training intervention-assisting clients with specific problems.

As noted eelier, deficiencies in life skills contribute to low self-esteem, loneliness and parent-child problems. The social worker enable client to gain the capacity to interact with their environment in ways that enhance their need gratification, well-being and satisfaction (Hepworth & Larsen 1993: 495; Potgieter, 2004: 216). The social worker believes that client systems have many competencies, skills and knowledge available within themselves and accepts that they can achieve even more if they focus on their strengthens rather than on their weakness or problems. The focus of the helper is not so much on problems, or on what is lacking or wrong, but rather on growth and the potential of people to develop through the utilization of available strengths (Potgieter, 2004: 9 & 216). The social work profession seeks to tap this inherent wisdom through the use of a helping relationship.

According to Potgieter (2004: 217) social workers should create a climate that is conducive to the development of life skills. The social worker should provide a supportive atmosphere by creating a positive environment in which trust and respect communicated and modelled. Supportive and accepting climates induce listening, understanding and trust; and promote willingness to cooperate and provide mutual assistance. When clients feel safe they feel trusting and free to be open and share their thoughts and feelings. This climate is generated by the social worker's capacity to be honest, and sincere (Anstey, 2002: 183; Hackney & Cormier, 1994: 29).

Life skills education has its roots on empowerment approach. Empowerment practice on the other hand draws from social work. It incorporates the basic values of the social work profession. The social workers professional commitment to client self-determination and self-actualization plays a significant role in life skills. Furthermore, clients and workers must effectively engage in the creation of and environment compatible with human needs; that is congruent with the practice of social work. The goal of social work practice asserts that social workers are obliged to help groups at risk increase their personal, interpersonal and socioeconomic strength by improving their life circumstances (Gutierrez, Parsons & Cox, 1998: 5-6; Zastrow, 2000: 59).

According to Nelson-Jones (1993: 227) life skills training most often implies running structured groups of limited duration to train participants in one or more specific skills. Overall, social workers are in a strong position to teach life skills because of their skills training and knowledge. Social work practitioners use skills to help meet the needs of their clients. A social worker is a multiskilled professional. Their group work knowledge enables them to lead groups with skill. The primary social work roles assumed in empowerment practice are teacher/trainer, resource consultant and awareness raiser. The social worker applies these group leadership skills to clients, to empower them to stand for themselves (Gutierrez, Parsons & Cox, 1998: 13; Zastrow, 2000: 67).

Life skills' helping is a growing area. In the next section life skill helping will be discussed with specific emphasis on the so-called DASIE model as an intervention model to enhance life skills.

5.14 LIFE SKILLS IN THE CONTEXT OF A HELPING APPROACH

Hill and O'Brien (1999: 3) note that most people need assistance at some point in their lives to deal with troublesome issues that hinder their personal growth and limit their potential. Helping can be defined as a process of assisting people in exploring feelings,

and gaining insight, and making positive changes in their lives (Hill & O'Brien, 1999: 4). It is viewed as an effective means for people to discover direction for their lives, and receive feedback that can facilitate change.

Many children experience pain, rage, and frustration because from an early age their needs have been thwarted or blocked. This is particularly true for persons who grew up in families where there was a great deal of conflict, stress, and/or impaired boundaries (Hackney & Cormier, 1994: 2; Geldard & Geldard, 2002: 21).

According to Nelson-Jones (1994: 2) life skills helping is a people-centered approach for assisting client and others to develop self-helping skills. It is a people-centered approach, meaning that all people may benefit at some stage of their lives from contact with skilled helpers. Life skill helping involves helpers in making choices that assist clients to develop life skills. The goal of life skill helping emphasizes helping people to help themselves by acquiring skills for living. Hill and O'Brien (1999: 6) mention that these skills might include learning how to communicate with others, practicing ways to resolve conflicts, identifying decision making strategies or changing unhealthy habits (e.g. having unprotected anonymous sex.)

Nelson-Jones (1994: x) further states that life skills helping approach seeks to develop clients' self-helping skills so that they become their own best helpers. The approach is based on the following assumptions:

- To live effectively clients need to learn and then maintain good life skills;

- Though external factors contribute, clients sustain problems because of weakness in one or more life skills. It is assumed that all people have acquired and sustain life skills strengths and weaknesses. Life skills helpers collaborate with clients to detect the life skills weaknesses that sustain difficulties and then, within supportive relationships, educate them in relevant self-helping skills;

- After helping, clients often repeat problematic behaviors when faced with the same or similar problems to those that brought them to helping. Helpers have insufficiently assisted them to learn and maintain relevant life skills;

- The aim of helping is to provide clients with self-helping skills for managing not only current but future problems. People-centeredness involves showing clients how to become their own best helpers (Nelson-Jones, 1994, x).

Life skills' helping is a process. This implies that clients and helpers collaborate in such activities as clarifying problems, redefining problems in skills terms, setting goals, choosing interventions, setting session agendas and evaluating progress. Client participation in decision-making is emphasized. Helpers need both good training and good helping relationship skills to be effective. Such helpers are likely to be helping service professionals and para-professionals such as counselors, psychologists, social workers, probation officers, nurses and personnel officers among others. At all times helpers must attempt to be psychologically present in interviews as genuine and caring people (Nelson-Jones, 1994: 6-7; Potgieter, 2004: 216-217).

The practice of life skills helping is structured around DASIE, a systematic five state model for helping clients both to manage problems and to alter problematic life skills (Nelson-Jones, 1994: 32). The model provides a framework or set of guidelines for helper choices. Nelson-Jones (1994: 32) and Nelson-Jones (1995: 370) note that the use of the acronym is deliberate; it is intended to assist beginning helping service trainees to remember the five stages when faced with the anxiety of working with clients for the first time. The stages of the model are as follows:

D **Develop** the relationship, identify and clarify problems(s)

A **Assess** the problems(s) and redefine in skill terms

S **State** working goals and plan interventions

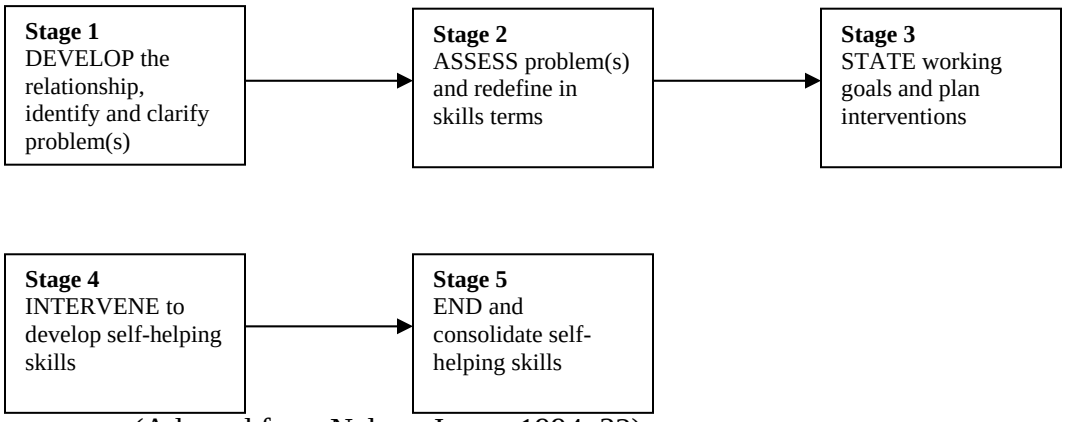
I **Intervene** to develop self-helping skills

E **End** and consolidate self-helping skills.

According to Nelson-Jones (1994: 30) the five-stage model lends itself to both individual and group training interventions. The focus in life skills helping is on developing skills for life and not just for the immediate present. Life skills helpers assist clients to alter underlying patterns of problematic skills and develop skills for use across a range of settings for the present and in the future. Effective helpers focus both on the relationship and also on the task of helping clients develop life skills. Helping relationships are tools to support clients as they learn self-support.

Life skills' helping is not the mechanistic application of a set of techniques but helpers work within the context of person-to person relationships to develop clients' self-helping skills. The personhood of both helpers and clients is central to the approach. The life skills helping model requires helpers to develop a range of specific interventions related to clients' problems and problematic skills (Nelson-Jones 1994, 57).

In figure 2 the DASIE – five stage life skills helping model is graphically displayed.



(Adapted from Nelson-Jones, 1994: 32)

Figure 2: DASIE: The five-stage life skills helping model

According to Nelson-Jones (1994: 52) the stages tend to overlap and there may be reversion to earlier stages, as more information or new problems arise during the intervention stage. There are basically two assumptions that underlie the DASIE model:

- Much helping is relatively short term i.e. three to ten sessions. Often very brief helping contacts take place because clients have immediate agendas that require attention.
- The model tends to be focused on one or two major problems or problematic skills areas

Based on Nelson-Jones (1994: 52-78) and Nelson-Jones (1995: 370-378) below is a discussion of each stage of DASIE:

- **Stage 1: Develop the relationship, identify and clarify problem(s)**

In stage one, helpers develop supportive relationship with clients and work with them to identify and clarify problems. Life skills helping as a process places heavy emphasis on building supportive working relationships with clients. Such relationships go beyond helpers showing empathy, non-possessive warmth and genuiness to the more active fostering of client self-support. Helpers support clients emotionally and technically. Emotionally, they support clients as they tell their stories, gain insight into their patterns of skills strengths and weaknesses and strive to manage problems and develop skills strengths. Technically, helpers support clients in analyzing their skills strengths and weaknesses, setting realistic goals planning for change and in implementing interventions.

In this stage, the primary emphasis is on providing emotional support as clients tell their stories and share their frames of reference. In subsequent stages, whilst still offering emotional support, helpers support clients by offering specific expertise or act as psychological educators.

- **Stage 2: Assess problems(s) and redefine in skills terms**

In stage two, helpers and clients collaborate to build definitional bridges between describing and actively working on problems and problematic skills. In stage one,

problems have been described, amplified and clarified largely in everyday language. Therefore in stage two, helpers' build upon information collected in stage one to explore hypotheses about how clients think and act that sustains difficulties. Helpers add to and ago beyond clients' present perceptions to look for "handles" on how to work for change. They collaborate with clients in breaking their problems into their component skills weaknesses. This stage ends with redefinitions of problems in skills terms.

While doing this it is important that helpers support clients in making sense of their stories. Clients are provided with space to explore and experience their thoughts, feelings and personal meanings. Helpers are mirrors that allow clients to see their reflections and then, when ready, to further in self-understanding. Helpers need to develop good skills in redefining problems in skills terms and in communicating these working definitions to clients.

- **Stage 3: State working goals and plan interventions**

In the previous stages the counselor and the clients moved from descriptive definitions of problems to skills redefinitions of problems. Stage three builds on the redefinitions in skills terms to focus on the question "What is the way to manage problems and develop requisite skills?" In stage three, helpers translate skills redefinitions into working goals and plan interventions to attain goals. Stage three consists of two phases: stating goals and planning interventions.

The helper is there, to help the clients to set working goals. If necessary, the helper needs to restate and check clients' overall goals. Working goals need to be stated clearly, realistically, succinctly and where appropriate with a time frame. How helpers think influences how well they set working goals.

Having stated goals, helpers need to determine how best to help clients attain them. Interventions are actions on the part of helpers designed to help clients attain goals. There is no single best way to plan interventions, since clients' problems and underlying

problematic skills vary so much. It is important therefore for helpers to try to involve clients as much as possible. Then, at different stages of helping, the helper can negotiate with clients what goals and interventions are important.

- **Stage 4: Intervene to develop self-helping skills**

In stage four, within the context of supportive relationships helpers intervene to develop clients' self-helping skills. The intervention stage has two objectives: to help clients manage their presenting problems better; and to assist clients in working on their problematic skills patterns and developing skills strengths. Helpers assist clients in assuming responsibility for managing problems and altering problematic skills. Good helping relationship skills are important during this stage. Clients feel more supported if they think that helpers understand what they go through both in having problems and in trying to cope with them.

Individual sessions in the intervention stage may be viewed in four phases: preparatory, initial, working and ending. The preparatory phase entails helpers thinking in advance on how best to assist clients. The initial phase consists of meeting, greeting and seating then giving permission to talk. The working phase focuses on specific interventions designed to help clients' manage problems and develop life skills. The ending phase focuses on summarizing the major session learning, negotiating homework, strengthening commitment to between-session work, and rehearsing and practicing skills outside helping.

To be effective in their practice helpers should keep abreast of relevant theoretical and, research literature on how to best to intervene for specific problems and skills weaknesses. Furthermore, helpers require a repertoire of thinking skills and action skills interventions about which they are knowledgeable, and which they are skilled. It is insufficient to know what interventions to offer without also being skilled in how to offer them.

- **Stage 5: End and consolidate self-helping skills**

In stage five, the helping contact ends with further attention to consolidating clients' self-helping skills. Ideally, ending is based on both parties perceiving that clients have made appreciable gains in their ability to manage their problems, and that they have consolidated their gains into self-helping skills for use afterwards. The topic of ending should be brought well in advance before the final session. This allows both parties o work through the various task and relationship issues connected with encoding the contact. A useful option is to fade contact with some clients by seeing them progressively less often. Certain clients may appreciate the opportunity for booster sessions. Booster sessions provide both clients and helpers with the chance to review progress and consolidate self-helping skills. Scheduling follow-up telephone call can perform some of these functions too.

5.15 CONCLUSION

The central premise of this chapter is that life skills are an important means of addressing the many social crises worldwide. This is particularly true in South African context in which our historical legacy of restricted opportunities and challenges brought about by poverty and HIV/AIDS. These circumstances require creative opportunities that will be to individuals and communities advantage. The development of life skills programmes is viewed as crucial in assisting people to become more balanced, independent and able to solve problems creatively. Life skills education programme encompasses a wide range of skills necessary for effective living i.e. the enhancement of an individual's physical, emotional and psychological well-being. They are geared at empowering individuals towards dealing effectively with daily demands and challenges.

The need to equip people effectively and efficiently with the required life skills cannot be overemphasized. Life skills, facilitated in the context of a life skills programme may equip people to cope better with their needs and ever-changing life challenges. In the next chapter the newly developed life skills programme for AIDS orphans is presented.

It explores the nature and the purpose of the programme; programme content as well as specific activities aimed at the development of practical competence and behaviour.

- CHAPTER 6 -

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

The newly developed life skills programme is named:

AIDS orphans life skills programme

6.1 INTRODUCTION

South Africa has one of the most severe HIV/AIDS epidemics in the world. Children and young people are especially vulnerable to HIV infection for a host of social and economic reasons including poverty, sexual exploitation, violence and lack of access to information and prevention services. HIV/AIDS will continue to affect the lives of several generations of children. The impact will mark their communities for decades as the numbers of impoverished children rise, their insecurity worsens, education and work opportunities decline, nurturing and support systems erode, and mortality rises. Of particular concern is the impact of HIV/AIDS on AIDS orphans. So far, the AIDS epidemic has left behind an estimated 15 million children under the age of 15 orphaned worldwide and the worst lies ahead (Avert, 2005: 1; UNICEF, 2004: 1).

Presently there are about 250 000 AIDS orphans in South Africa alone (Mesatywa, 2005: 1). This number is expected to rise to 1.5 million by 2010 (Avert, 2005: 1; UNAIDS, 2004: 1).

As already highlighted in the previous chapters, statistics do not capture the misery that HIV/AIDS can bring to children. AIDS orphans, the majority of whom are HIV-negative, are at enormous risk of growing up without adequate health care, food, education or emotional support (Robbins, 2004: 1; Avert 2004: 3; Deame, 2001: 2). The death of a parent pervades every aspect of a child's life from emotional well-being to physical security, mental development and overall health. According to Bartholet (2000: 13) it is not only the raw numbers that make this orphan crisis unlike any ever seen. Most of these children do not have AIDS but are in danger of slavery, dying of childhood diseases or being forced into prostitution to survive. The strain that these children endure, watching their parents die and then forced to forage for themselves could create a generation of horribly disaffected people (Avert, 2004: 3; Tracey, 2005: 1; UNAIDS, 2000: 2; UNICEF, 2003: 1; UNICEF, 2004: 1). WHO (2004: 1) states that large-scale and long-term efforts are needed to cope with these harsh new realities.

The context has brought about an increasing need and urgency for life skills programmes. According to Hoelson and Van Schalkwyk (2001: 246) local need for life skills programmes is associated with the gradual erosion of traditional systems of societies and the families. To equip the youth to adequately cope with challenges of modern societies life skills programmes can make a significant contribution. Within this context, the researcher endeavoured to craft a life skills programme specifically for early adolescents AIDS orphans to help them develop necessary skills that will improve their capacity to cope with problems they encounter. The researcher developed the programme based on the broad aim of the study which is:

To develop and empirically test the effectiveness of a life skills programme for early adolescent AIDS orphans.

The study was conducted in two phases, namely qualitative phase and the quantitative phase. The qualitative phase was conducted in order to explore the socio-emotional needs, problems of and life skills needed by AIDS orphans. Accordingly study objectives for the first phase 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 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; and

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

Based on an in-depth literature review and the information collected in the first phase of this study the programme was specifically developed for early adolescent AIDS orphans namely AIDS orphans life skills programme. In order to test the effectiveness of the developed life skills programme the researcher conducted the second phase of the study. Accordingly the objectives of the second phase included:

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

b) To suggest practical recommendations for further utilisation of the newly developed life skills programme for 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.

Now that the origin AIDS orphan life skills programme has been dealt with, the next step is to examine what the programme entails.

6.2 AIDS ORPHANS LIFE SKILLS PROGRAMME

AIDS orphans life skills programme is a comprehensive educational programme, which promotes abilities for adaptive and positive behaviour that enable early adolescent AIDS orphans to deal effectively with the demands and challenges of everyday life. It includes all those skills that enable people to maximise their choices, to enhance their personal well-being and to improve their quality of life. Life skills enable the individuals to translate knowledge, attitudes and values into actual abilities i.e. "what to do and how to do it." 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.

The life style of people is influenced to a great deal by factors such as culture, values and socialization processes. Therefore whatever the nature of the problem, the solution, will be to purposefully employ a continuous positive preventive approach in order to stabilize or change the life styles of people. The programme creates opportunities for participants to practice life skills so they can make healthy and informed choices. AIDS orphans life skills programme help young people to acquire necessary tools to take charge and effectively manage their lives.

Life skills can be developed for children of all ages however, these skills should be appropriate both to people's developmental tasks and to any special problems, challenges and transitions they may face. According to WHO (1997: 2) early adolescent years seem ideal to instil skills as a positive response since young people of this age group seem to be most vulnerable to behaviour-related health problems. The programme has been developed especially for AIDS orphans in their early adolescent years (11 – 14 years). 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 for example:

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

Furthermore, participants get opportunities to develop healthy values and practice important skills. In this programme a wide range of activities are included. These activities will encourage the participants to learn new knowledge and develop a range of skills at the same time. Some of the activities require participants to remember the right information, while others encourage them to think for themselves or write about their feelings.

The programme does not aim at telling people how to live their lives, but it focuses on giving early adolescent AIDS orphans accurate information and opportunities to develop skills and positive values. This will help them to make responsible and healthy choices for their lives.

The programme is primarily designed for social workers involved in the field of HIV/AIDS. Social workers are called to work with individuals, families, groups, organizations and communities to address concerns that limit their social functioning. The focus of social work is on the improvement of the social functioning of people in

interaction with their environment (Zastrow, 2000: 48). The social worker sees these people as having potential and believes in their ability to grow and develop. Education is often the most appropriate strategy when assisting people enhance their quality of life. Appropriate knowledge and skills are often all that is needed to affect change. Within an educational framework social workers can use a variety of training intervention-assisting clients with specific problems.

According to Nelson-Jones (1993: 227) life skills training most often implies running structured groups of limited duration to train participants in one or more specific skills. Overall, social workers are in a strong position to teach life skills because of their skills training and knowledge. Social work practitioners use skills to help meet the needs of their clients. A social worker is a multiskilled professional. Their group work knowledge enables them to lead groups with skill. The primary social work roles assumed in empowerment practice are teacher/trainer, resource consultant and awareness raiser. The social worker applies these group leadership skills to clients, to empower them to stand for themselves (Gutierrez, Parsons & Cox, 1998: 13; Zastrow, 2000: 67).

Life skills education has its roots on empowerment approach. Empowerment practice on the other hand draws from social work. It incorporates the basic values of the social work profession. The social workers professional commitment to client self-determination and self-actualization plays a significant role in life skills. Furthermore, clients and workers must effectively engage in the creation of and environment compatible with human needs; that is congruent with the practice of social work. The goal of social work practice asserts that social workers are obliged to help groups at risk increase their personal, interpersonal and socioeconomic strength by improving their life circumstances (Gutierrez, Parsons & Cox, 1998: 5-6; Zastrow, 2000: 59).

A comprehensive discussion of the relevance of social work in life skills is beyond the scope of this chapter (See chapter 5, for a detailed discussion of the role of social workers in life skills education). In the next section the rationale for the development of the programme is briefly reviewed.

6.3 THE RATIONALE FOR THE DEVELOPMENT OF AIDS ORPHANS LIFE SKILLS PROGRAMME

The underlying rationale for the development of this programme is that 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. As mentioned in the previous chapters, 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 strengthening of these skills will help these young people to develop effective skills for use across a range of settings, both now and in the future (Anderson & Okoro, 2000: 1- 2; Brack & Hill, 2000: 3-4; Gladding, 1997: 101; Potgieter, 2004: 217).

According to Grodney (1994: 133) the needs of adolescents who are surviving parental death from AIDS have not received sufficient programmatic attention. Programmes to empower these children are generally limited hence these young orphans usually grow up in communities blighted by drug use, poverty, and violence. Anderson and Okoro (2000: 2) note that the only solution will be to purposefully employ a continuous positive preventive approach in order to stabilise or change the life-styles of the youth. Although these children may seem invisible, the multiple traumas they have faced and their vulnerability make it imperative that programmes be developed that attend to their needs.

AIDS orphans life skills programme aims to offer early adolescent AIDS orphans necessary assistance that will enable them to survive and take part in their future. It has the potential to provide self-empowerment. According to Hopson and Scally (1981) in Hoelson and Van Schalkwyk (2001: 251) becoming self-empowered requires personal awareness, knowledge of own goals and acquisition of relevant life skills.

Next is the discussion of methods of delivering AIDS orphans life skills education. Each method focuses on the basic principles that can be applied when working with adolescents.

6.4 METHODS USED IN AIDS ORPHANS LIFE SKILLS PROGRAMME

In the AIDS orphans life skills programme, early adolescent AIDS orphans are actively involved in a dynamic teaching and learning process. The methods used to facilitate this active involvement include working in small groups, brainstorming, and role-play. These methods to teach life skills are based on experiential learning (learning through active participation) rather than didactic teaching. The teaching of skills is both theoretical and practical. It is intended to equip the learner with new or improved abilities. It is based on the principle that people learn best when they are actively involved in their lessons. According to WHO (1994: 2) life skills acquisition requires opportunities for practice and application of skills being taught. AIDS orphans life skills programme therefore employs activities at the end of every session. These activities provide systematic opportunities for participants to learn practices and demonstrate a range of knowledge, skills, values and attitudes. The activities to be used are viewed as relevant to topics to be discussed. The aim is that the participants will immediately identify with the activities employed and recognise their own life experiences reflected in the activities.

According to Potgieter (2004: 217) the development of life skills programme should take note of requirements for learning life skills. In the following section the requirements for learning life skills are discussed.

6.5 REQUIREMENTS FOR LEARNING LIFE SKILLS IN AIDS ORPHANS LIFE SKILLS PROGRAMME

As already mentioned in the previous chapter the acquisition of life skills requires a structured process of learning and there are certain requirements that have to be met. In

the context of this AIDS Orphan Life Skills Programme the following requirements namely a supportive relationship; learning from example; instruction and self-instruction; information and opportunity as well as learning from consequences have to be adhered to.

- **A supportive relationship:** Early adolescent AIDS orphans require a supportive relationship when they engage in the process of learning. This is based on the notion that people of all ages are the happiest and most effective when they feel that standing behind them is a person who will come to their aid should difficulties arise. This is particularly true when it comes to AIDS orphans life skills development, for it is the relationship that enables people to risk trial-and error methods of learning and provides them with the security that is needed for the process. According to Potgieter (2004: 217) reassuring or supporting behavior is intended to encourage and tell others that that we believe in them. Making changes can be difficult, hence people feel supported when knowing that someone is on their side

- **Learning from example:** Potgieter (2004: 217) notes that experience is one of the best teachers, especially in the case of life skills development. People learn though living and doing. They learn from the examples set by others and from the behaviors they demonstrate around them. Learning from example is a major way in which early adolescent AIDS orphans will acquire life skills strengths and weaknesses in AIDS orphans life skills programme.

- **Instruction and self-instruction:** According to Nelson-Jones (1994: 20) while helpers can encourage clients to do their own work, clients often require instruction as well. AIDS orphans life skills programme is considered important in instilling life skills to early adolescent AIDS orphans. Instruction within life skills takes place as early adolescent AIDS orphans rework and practice the original concepts and skills.

- **Information and opportunity:** Information is regarded as an important source of power. People need adequate and reliable information to develop life skills. In addition people need opportunities to test out and develop life skills. These opportunities need to be in line with their maturation and state of readiness. Lack of information and opportunities give rise to struggles and contribute to levels of mistrust in relations. AIDS orphans life skills programme intends to keep participants informed and to be actively involved in the programme.

- **Learning from consequences:** People acquire skills with learning from rewarding or unrewarding consequences. Providing positive rewards such as praise or approval increases the probability of skill development. According to Nelson-Jones (1993: 14) and Nelson-Jones (1995: 365) if they are offered appropriately children can develop necessary skills needed to improve their well-being. AIDS orphans life skills programme places much emphasis on acquiring skills through provision of positive rewards.

In the following section the content of AIDS orphans life skills programme is presented. The context of the programme, existing of ten sessions, is based on an in-depth literature review as well as interviews conducted with AIDS orphans, caregivers and social workers. The results of the interviews are presented in Chapter 7.

6.6 THE CONTENT OF AIDS ORPHANS LIFE SKILLS PROGRAMME

AIDS orphans life skills programmes consists of two interrelated dimensions namely, academic and practical. The academic dimension includes knowledge regarding specific life skills. The practical focuses on direct acquisition of life skills. As already highlighted, in this programme a wide range of activities are included. These activities will encourage the participants to learn new knowledge and develop a range of skills at the same time.

AIDS orphans life skills programme for early adolescents AIDS orphans consists of ten sessions. For the sake of easy comparison Table 8 gives a summary of each session according to topic and goal.

Table 8: AIDS orphans life skills programme – Programme sessions according to topic and goal

Session	Topic	Goal
Session 1	A good sense of identity and self esteem	Improvement of self-concept
Session 2	Communication skills. 'Basic verbal and non-verbal communication skills".	The capacity to develop healthy relationships through acquiring communication skills.
Session 3	Assertiveness skills. "Assertive communication in the face of peer pressure".	The capacity to develop healthy relationships through acquiring assertiveness skills.
Session 4	Self awareness "Learning about me as a special person".	Personal growth through knowledge and understanding of self
Session 5	Coping and stress management	Development of abilities to

Session	Topic	Goal
	skills. "Identifying sources of stress and methods for coping in stressful situations".	cope with emotions and manage stress.
Sessions 6	Decision making skills. "Learning basic steps for decision making".	Development of abilities to make informed and responsible decisions
Session 7	Problem solving skills. "Basic steps for problem solving".	Development of abilities to solve problems.
Session 8	Conflict management skills "Conflict resolution".	Development of abilities to manage conflict.
Session 9	Independent, critical and creative thinking skills "Learning the basic processes in critical and creative thinking	Development of capacities to think critically and creatively.
Session 10	Maintaining a healthy life style	Development and maintenance of a healthy life style.

Instilling life skills is based on an educational theoretical framework. Life skills education most often implies running structured groups of limited duration to train participants in one or more specific skills (Nelson-Jones, 1995: 356; Nelson-Jones, 1993:227). As highlighted in Table 8 AIDS orphans life skills programme comprises of ten sessions which aims at personal and social skills development in targeted areas (See Appendix 8 for a detailed discussion of the AIDS orphans life skills programme).

Following is a brief description of each session.

6.6.1 Description of sessions and activities to be used in each session of the AIDS orphans life skills programme

6.6.1.1 Session one: 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 development of an identity seems to be a universal requirement for adolescence. It includes congruence between a personal view of himself and how others view him. It involves a sense of continuity between ones' past, current identity and future life plans. The process of identity development implies that adolescents need to define who they are, what is important to them, and what directions they have to take in life. Of great importance for a young person is to know himself and to realize that he/she is a unique human being (Anderson & Okoro, 2000: 23-24; Geldard & Geldard, 2002: 27; Gillis, 1994: 79; Stewart et al, 1996: 182).

Having high self-esteem means that an individual likes himself or herself (Baron & Byrne, 2003: 171). These children have a greater capacity to be creative and are more likely to assume active roles in social groups. They are less likely to be burdened by self-doubt, fear and ambivalence. They are also more likely to move more directly and realistically towards personal goals (Geldard &Geldard, 2002: 27-28). Children with poor self-esteem feel helpless and inferior, incapable of improving their situation. They

strive for social approval by behaving in ways which are over-compliant, or by pretending to be self-confident when they are not. They are struggling to feel good about themselves therefore they 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 (Geldard & Geldard, 2002: 210; Gillis, 1994: 80; Thompson & Rudolph, 2000: 153).

The development of self-esteem is viewed as critical for AIDS orphans. According to UNAIDS (2004: 4) and Robbins (2004: 1) without the protective environment of their homes, orphaned children face increased risk of violence, exploitation and abuse. They may be ill-treated by their guardians, and dispossessed of their inheritance and property. Such extensive environmental change can deprive children of the feelings of security and comfort they derive from familiar routines and settings. Doka (1994: 36) notes that these children, given their environment, may experience developmental or behavioural problems such as poor self-esteem. They may find it difficult to trust or to bond with adults. The development of self-esteem will help early adolescent AIDS orphans to see themselves differently i.e. to view themselves as special and unique. According to Hoelson and Van Niekerk, Van Eeden and Botha (2001: 73) when people value themselves highly, they will have necessary confidence to accomplish goals. AIDS orphans will maintain high levels of self-esteem as they nurture positive attitude in respect to themselves.

Aspects to be covered in this session include: self-concept, self-esteem and identity development. The adolescent has the task of forming personal identity which is unique and individual. To develop success identity, a person must experience both love and worth. Worth comes through accomplishing tasks and achieving success in the accomplishment of those tasks.

The activity to be used in this session is as follows:

- **Activity 1**

Having a positive self-image is important for building confidence. The activity is based on a good sense of identity and self esteem. The theme of the activity is the "uniqueness of me"

- The facilitator will ask the children to write their names on a large sheet, and to say what it means and how they feel about themselves and their names.
- In pairs, the children discuss their characteristics e.g. physical characteristics, skills, achievements, and also things they would like to be able to do.
- The group is then asked to mention how does the image make them feel about themselves.
- Finally the children are asked whether they enjoyed the activity, and what they have learnt about themselves. They are asked to finish the statement: "Something I discovered about myself which makes me feel good is….."
- The children are then told the importance of having a good sense of identity, self-concept and self-esteem.

6.6.1.2 Session two: Communication skills

Every system depends upon communication for its survival. Communication is the basis for all human interaction. Effective communication is essential for good relationships. Although it is impossible not to communicate, since all behavior is communication, basic communication skills are often not so easily acquired. Young people who have poor communication skills are unlikely to have the ability to stand up for themselves and to assert their rights. In situations involving peers or adults, this lack of communication skills can result in feelings of helplessness and powerlessness (Cleary, 2004: 7; Geldard & Geldard, 2002: 228; Johnson & Johnson, 2003: 137; Potgieter, 2004: 228).

This session is based on the assumption that learning to communicate effectively helps early adolescents AIDS orphans to build positive relationships with others and it also boosts their self-esteem. According to Hoelson and Van Schalkwyk (2001: 260) people are not born with the ability to communicate effectively. The nature of their early childhood and current environment has a major influence on their ability to express feelings thoughts and other aspects of themselves. Avert (2004: 7), UNAIDS (2004: 3) as well as Van Dyk (2001: 334-335) note that parents' deaths deprive AIDS orphans the learning and values they need to become socially knowledgeable and productive adults. Many suffer social isolation. They must grapple with the stigma and discrimination so often associated with AIDS, causing a low level of communication proficiency and lack of confidence in expressing themselves. Self-confidence and communication are interdependent to such an extent that difficulties or problems in the one area will affect the other (Hoelson & Van Schalkwyk, 2001: 253). It therefore of paramount importance that AIDS orphans be equipped with a wider range and depth of communication skills if they are to live effectively and creatively.

Aspects to be covered in this session include; communication as a process; verbal and non-verbal communication; levels of communication; basic sending and receiving skills. Communication skills have been shown by researchers to be effective in developing helping relationships and assisting people in improving their lives. These skills generate understanding, spread information and are the means for achieving problem solving. These skills can be improved through training and practice (Anstey, 2002: 179; Cleary, 2004: 2; Hill & O'Brien, 1999: 4; Potgieter, 2004: 78).

The activity to be utilised in this session is presented below:

- **Activity 2**

Strong relationships involve good communication skills. The focus of the activity is building good relationship through communication skills.

- As an introduction, the group engages in an activity in which one group member whispers a message to another, and this is then whispered from person to person until it has gone around the whole class. At the end, the group compare the final message to the original, to see if it has changed.
- The group is then asked to define communication, and under what conditions effective communication is said to have taken place.
- The facilitator then tells the group that communication can be verbal and non verbal.
- Three members are given cards with the words "anger", "nervous" and "happy". Each member uses non-verbal behaviour to communicate the emotion on the card. The rest of the group takes turns to guess the emotion that is being expressed.
- The group is then asked to give example s of misunderstanding in communication that they have experienced, and to think about how it might have been avoided.

6.6.1.3 Session three: Assertiveness skills

Steinberg (2003: 90) notes that sometimes problems are created in relationships with friends, family or work colleagues because people lack the communication skills needed to express emotions, needs, and opinions assertively. People may choose to bury them or unleash them uncontrollably. Assertiveness skills are utilized to assist individuals who are unduly hesitant about expressing their wants or feelings, or in standing up for their personal rights. Verderber (1990) in Steinberg (2003:90) defines assertiveness as "verbalizing your position on an issue for purposes of achieving a specific goal." The specific goal is for the person to express himself in such a way that he hurt neither himself nor others. Assertiveness training aims at teaching clients to stand up for their rights (Anderson & Okoro, 2000: 24, Zastrow, 2000: 477).

According to UNICEF (1998: iii) in Africa, orphaned children have relatively few legal or customary rights to property or to decision making about their future, unless the parent has made specific provision for them in the will. Van Dyk (2001: 334) 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. UNAIDS (1997: 15) state that many AIDS orphans are not aware of their rights and to pursue these rights needs skills and self-confidence that these children lack.

Assertiveness training in AIDS orphans life skills programme is designed to help participants realize, feel and act on the assumption that they have the right to be themselves and express their feelings freely. Once assertiveness skills have been acquired it should significantly increase the learners' self-esteem and self-efficacy and decrease loneliness, social awkwardness and social phobia.

Aspects to be covered in this session include the following: understanding the differences between assertiveness, non-assertiveness and aggression; building self-confidence and esteem; ways of asserting oneself.

The activity for session three is as follows:

- **Activity 3**

The focus of the activity is assertiveness training.

- It is not easy to know what to say when someone is putting pressure on you. Below are two situations where assertiveness and non-assertiveness behaviours are demonstrated:
- A situation is role-played in front of the group who are asked to look for verbal and non-verbal cues for lack of assertiveness. A friend trying to get another friend (friend 1) to smoke drugs. The friend does not want too, but doesn't know how to say no afraid of loosing friendship. He ends up agreeing and being arrested for illegal possession of drugs.

- In another situation a boyfriend pressurises a girlfriend to have sex. Although the girl is aware that if she says no she might loose the boyfriend she finally says 'no'.
- The group is asked to discuss about the two responses
- They then compare the reactions.
- The group is given the opportunity to think of other situations in which they want to say 'no' to something. They then work out what they would say.

6.6.1.4 Session Four: Self-awareness

Self-awareness includes peoples' recognition of themselves, their character, identity, cultural perspectives, goals, motivations, needs, values, feelings, strengths and weaknesses as well as desires and dislikes. Developing self-awareness helps people to recognize when they are stressed or feel under pressure. Furthermore, it is viewed as a prerequisite for effective communication and interpersonal relations, as well as for developing empathy for others. 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 (Brack & Hill, 2000: 10; Corey & Corey, 2002: 32; Doyle, 1992: 113).

According to Stewart et al (1996: 170) self-awareness also implies knowledge of past experiences. Before people can properly know themselves as they are today, they need to look at their past. The way people see themselves today is certainly the result of past experiences and influences. The past should be viewed as a learning experience. By looking at the past events, enables people to focus on their weakness and recognize strengths in themselves. The main important point is that people should reinforce (build) those strengths that make them feel good about life. Whenever people feel despondent about themselves, they should recall their strengths hence their ego will be boosted (Stewart et al, 1996: 170).

Knowledge of self allows AIDS orphans to deal more successfully with the life demands. According to Van Niekerk, Van Eeden and Botha (2001: 72) adolescents who are aware

of their strengths and weaknesses (including abilities, aptitudes, values and personality traits) are better able to arrive at realistic and informed career choices than their uniformed counterparts. In similar vein, the better they know themselves, the better able they are to develop a philosophy of life, define moral values and in the process pursue a healthy life style. The greater levels of self-awareness, the better able people are to make informed choices.

Topics to be discussed here include: Knowledge of self, strengths and limitations; knowledge of past and personal experiences; as well as personal expectations. The activity to be used is presented below:

- **Activity 4**

Being a teenager means that the body is changing so are the feelings. Learning to understand self can help teenagers cope better with life. This activity is based on self-awareness

- The members of the group are asked to imagine to be looking for friends. To do that they must advertise in a local newspaper. In the advert they are supposed to mention the kind of person they are. The only guide is that they should be honest with themselves.
- Afterwards they are given the opportunity to share their advert with the whole group.
- The group is then asked whether they have enjoyed the activity, and what they have learnt about themselves.
- Finally the facilitator explains the importance of self-awareness.

6.6.1.5 Session five: Coping with stress and emotions

The focus of this session is on coping with stress and emotions. Coping with emotions involves recognizing your emotions and others emotions, being aware of how emotions

influence behavior, and being able to respond to emotions appropriately. Intense emotions, like anger or sorrow can have negative effects on a persons' health if a person does not react appropriately (Brack & Hill, 2000: 10).

There is no one response to AIDS orphans who often observe one or both of their parents succumb to AIDS. The death of a parent is certainly a profound psychological and social crisis for a child, especially when the parent dies from AIDS. These children exhibit emotional and behavioural disturbances. 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. They may personally experience the stigma of AIDS related illness, as they are teased by classmates or ostracised by peers and other parents. 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. The child's suffering is often compounded by being separated from his or her siblings (Avert, 2004: 5; Doka, 1994: 35; UNICEF, 2003: 2; UNICEF, 2004: 1).

In addition the illness and loss of a parent is very traumatic for a child and lack of consistent nurture can have serious developmental effects. Orphaned children are more likely to suffer damage to their emotional development. The emotional suffering of the children usually begins with their parents' distress and progressive illness. 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; Doka, 1994: 40; Chachkes & Jennings, 1994: 80; Hope, 1999: 98; UNICEF, 2003: 2; UNICEF, 2004: 1).

Eventually the children suffer the death of their parent(s) and the emotional trauma that results. This experience can lead to serious psychological problems such as post-traumatic stress syndrome, aggression, alcohol and drug abuse. Many experience anger; guilt; loss and abandonment, fear of death and fear for their futures (UNAIDS, 2004: 3). According to UNICEF (2003: 2) and UNAIDS (2004: 3) depression and alienation become common. Children have also been known to have suicidal ideation after the

death of a parent. This ideation is clearly and identification with the parent who has died from AIDS. The children have to adjust to a new situation, with little or no support at all (UNICEF, 2003: 2).

According to Doka (1994: 38) it is critical that the child have support. Coping and stress-management skills are important since they provide a platform for discussing feelings of sadness, disillusionment, dissatisfaction, alienation, anger, guilt and disbelief. Coping with stress is about recognizing the sources of stress, recognizing how these affect a person, and acting in ways that help to reduce levels of stress (Amanat & Beck, 1994: 258; Baron & Byrne, 2003: 542; WHO, 1997: 2).

Discussions in AIDS orphans life skill programme include the following aspects: Importance of identifying sources of stress, ways of reducing sources of stress (proactive or constructive coping strategies) and ways to solve or ameliorate stressful conditions The session is based on the assumption that knowledge provides a sense of control, rather than ignorance and the unpredictability.

The activity that will be used in this session is as follows:

- **Activity 5**

Coping with feelings and stress is a challenge that all people face. There are many ways of coping with difficult feelings and stress. Some are constructive whereas others are destructive. The activity is based on ways of coping with stress and the theme is "Thinking Positive".

- Participants are asked to think about a stressful situation they were once in, and which they would like to cope with better if that situation came up again. They are asked to imagine the situation with eyes closed, and to remain calm.
- They are then asked to think of a time when they did well in that kind of a situation and how good they felt to have coped.

- Finally they are asked to think how they might improve on the way they handled the situation in the future and rehearse this in their mind, before slowly opening their eyes.
- The participants are then introduced to the value of saying positive things to themselves during a stressful situation
- They are encouraged to cope by talking to themselves through a situation by keeping calm and positive, focusing on what is going well, and to praise themselves after the situation for the things they did well however big or small.

6.6.1.6 Session Six: Decision-making skills

According to Geldard and Geldard (1999: 178), Potgieter (2004: 220) as well as Swart (2000: 358-362) the decision-making process involves a systematically working through a series of steps. The focus of this session is helping participants make good decisions by giving them the skills to deal with the present concern, and also to deal effectively with future problems. Stages of decision making include: define the problem, examine the possible choices and the consequences of each choice, select the best choice, act on your decision and evaluate your decision. Young people are made aware that every decision made has consequences, and they must accept the responsibility for the consequences of the decisions made (Tsatsi, 2001: 39). Basically the main trust of all helping interventions is to assist client to make better choices by developing rational decision-making skills.

The need for effective decision-making is an ongoing process throughout the life span of an individual and it is also something that everyone must do every day. The ability to make good decisions helps to prevent problem conditions. Mastering decision making skills enables young people achieve a sense of control over their lives by making sound and responsible choices (Doyle, 1992: 83; Johnson & Johnson, 2003: 299; Nelson-Jones, 1994: 274; Potgieter, 2004: 224).

This session is based on the assumption that learning the decision-making process helps early adolescent AIDS orphans anticipate problems, minimize the probability of acting impulsively, and lessens the anxiety and tension often associated with crises and indecisiveness. As highlighted in the previous chapters some children live on their own at a young age as result of their parents dying from AIDS. 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 such as engaging in criminal activity, sexual exploitation, and eventually becoming infected with HIV. Failure to make sound choices results in stress and coping problems for the child.

In helping early adolescent AIDS orphans to make decisions, decision-making skills are vital. 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. Furthermore, it helps them to deal constructively with decisions about their lives. These children become autonomous and are able to resist negative influences around them (Doyle, 1992: 79-80; Couch, Felstehausen & Patsy, 1997: 25; Tsatsi, 2001: 39).

Following is a presentation of the activity that will be used in this session.

- **Activity 6**

Big changes are taking place during adolescence. All teenagers are faced with the challenge of making decisions about the future. Learning decision-making skills can help them make good decisions that will define their future. This activity is based on making decisions step by step and theme is “Choosing right”.

- The participants are asked to explore advantages and disadvantages of different ways of making decisions such as by impulse; procrastinating, by not deciding; by letting others make decision for them; by evaluating all choices then deciding.

- The facilitator then tells the group that the last way – evaluating different aspects of the situation is the best process.
- The decision making process is then presented.
- The group then is allowed to go through the model for example decision-making dilemma in small groups. Then the participants compare how the different groups handled the same dilemma.
- The group is then given the opportunity to evaluate the whole process.

6.6.1.7 Session Seven: Problem-solving skills

A problem is any unsatisfactory or undesirable condition that needs to be corrected. All people experience problems. Problem-solving skills enable people to deal constructively with problems in their lives. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strain. Problem solving is described as a step-by-step method of dealing with problems by following a formal reasoning process. In this process, problems are identified and a series of decisions are made to improve the situation (Hepworth & Larsen, 1993: 446; Potgieter, 2004: 220-222; Swart, 2000: 356).

This session is based on the assumption that without adequate information, people tend to go for quick solutions that address the symptoms rather the real issue. According to Webb (1996: 4) 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 early marriage especially for girls, child prostitution to meet basic needs and drug as well as alcohol abuse. Kalumba (1997: 6) notes that these children respond more to peer pressure to turn into delinquent behaviour for survival. It is therefore of utmost importance early adolescent AIDS should be taught problem solving skills. 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.

The focus of the session is on the problem-solving process which includes the following: Identifying the problem and establishing goals; generating alternative solutions; choosing the best alternative; developing a plan; implementation; and follow up to evaluate how the solution(s) worked. Mastering the process requires persistence and determination and the willingness to repeat and practice until mastery is achieved.

The activity to be used in this session is highlighted below:

- **Activity 7**

No matter how good a relationship is, it will run into difficulties from time to time. The lesson is based on problem solving with activities designed to help participants work through each step. The theme of the activity is – 'solving problems fair'

- Participants are asked to work in a group of two**.**
- They are then asked to choose any problem they know of that needs to be solved.
- They are advised to use ideas from the problem solving process discussed in the session to solve the problem.

6.6.1.8 Session Eight: Conflict-Management skills

Conflict is part of life of all systems. It is both natural and inevitable in interpersonal relationships. The closer the ties between people, and the more frequent their contact, the greater the chances of getting irritable and annoyed with one another. Conflict exists in a relationship when parties believe that their aspirations cannot be achieved simultaneously, or perceives a divergence in their values, needs and interests. Members of a system cannot come to an agreement about the events, rules, goals, behaviors, task performances or the decision making that affect their lives together. Therefore, they employ their power in an effort to defeat change each other to protect or further their

interests in the interaction. However, because there is conflict, it does not necessarily mean that the relationship is doomed; if positively managed conflict can produce remarkably positive results (Anstey, 2002: 6; Clearly, 2004: 51; Potgieter, 2004: 233).

From the above it becomes clear that no one is immune to conflict. When people cannot reach some sort of reconciliatory arrangement on how to deal with a particular situation further tension and conflict may result into violence. Violence may include destructive behaviour such as the use of great physical force or intimidation, which at times is unlawfully exercised (Bezuidenhout & Dietrich, 2004: 72). Therefore the importance of conflict-management skills cannot be overemphasized. This is true for AIDS orphans who are likely to engage in antisocial activities because of peer pressure.

This session covers the following aspects: sources of conflict; constructive and destructive conflict and strategies of managing conflict. The activity to be used in this session is described below:

- **Activity 8**

Everybody argues sometimes, and in a good relationship both partners try to solve their conflicts peacefully. The activity is based on conflict management.

- The group is asked to think about important ways of solving a conflict. It can be with a friend, family member or neighbour.
- They then discuss advantages of making use of such means.
- The group is asked to rate how satisfied they are with the different ways of resolving a conflict
- Conclude the activity by writing out a summary statement about the importance of resolving conflict.

6.6.1.9 Session Nine: Critical and creative thinking skills

The focus of this session is both on critical thinking and creative thinking. According to Brack and Hill (2000: 10) critical thinking skills are abilities to analyze information and experiences in an objective manner. Thinking skills can help people to think before they act (Nelson-Jones, 1994: 248). Creative thinking on the other hand involves divergent thinking, flexibility, originality, the consideration of remote possibilities and the ability to consider a variety of solutions to the same problem. The ability to be spontaneously creative, approaching situation with fresh ideas is important to adolescents. Creative thinking helps them to respond adaptively and with flexibility to the situations of their daily lives (Brack & Hill, 2000: 9-10; Geldard & Geldard, 1999: 6).

This session is based on the notion that early adolescent AIDS orphans need to develop the ability to think logically and to use their capacity for logical thinking to make judgments and decisions for themselves. Knowledge and application of critical and creative thinking skills will empower AIDS orphans towards growth and development. To make these skills a permanent part of the learner's lifestyle requires that these skills be incorporated into problem-solving, decision-making and interpersonal skills (Hoelson & Van Schalkwyk, 2001: 254).

Aspects that are covered in this session include: the importance of owning responsibility for choosing; using coping self-talk; choosing realistic personal rules; explaining cause accurately; predict realistically; assessing threats and dangers accurately; setting realistic goals; using visualizing skills; realistic decision-making; preventing and managing problems.

- **Activity**

The theme of the activity is "Do your own think"

- The facilitator provides examples which contrast critical thinking.
- The facilitator then introduces the critical thinking steps.
- The facilitator then uses one of the examples given earlier to go through the critical thinking steps.
- Then the participants work in pairs to show their use of critical thinking steps.
- Thereafter the facilitator asks the participants to consider why it is so important to understand and use critical thinking in making decisions and to think about areas in their livers when these skills can be applied.

6.6.1.10 Session Ten: Maintaining a healthy life style

The focus here is to maintain a healthy life style. Attention is given to those matters, which are important to maintain and develop a healthy body such as nutrition, rest, constructive leisure time activities and safe living in general. In this regard teenagers need basic knowledge and insight of substances and circumstances, which can and will harm the normal functioning of the body and retard development. The more important destructive factors that are identified as those that need special attention are amongst others substance abuse, child abuse, illness and disease with emphasis on HIV/AIDS.

The extraordinary challenge and difficulties that these AIDS orphans (mostly adolescents) experience expose them to risky habits detrimental to their health. The AIDS epidemic threatens the viability, perhaps the very existence, of this generation. Maintaining a healthy life style is important for all people, but particularly for young people. A healthy productive generation of adolescents today will ensure that South Africa has the healthy generation of adults needed in the 21st century.

- **Activity 10**

  Many people are destroyed because of lack of knowledge. When you don't know, it is easy to get fooled with wrong information or to make choices that you regret later. The activity is based on healthy living and the theme is "Thinking wisely".

- The group is asked to think about behaviour that reflects healthy living. As a group they then decide ten rules of healthy living.
- The group is encouraged to stick to rules of healthy living and are encouraged that although it is not easy to change the way we behave, practice make perfect and now it is a good time to start.

In the following section preparation for a life skill lesson is discussed:

6.7 PLANNING FOR A LIFE SKILL LESSON

Planning include identifying the target, developing a code of conduct for life skills lessons, preparing activities, the researcher's role and thinking about how learning will be assessed.

6.7.1 Defining the target group

As highlighted in the first chapter (Chapter 1, page 42) the target group is:

- 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.

6.7.2 A code of conduct for the life skills class

It is important that there are agreed upon rules of behaviour. Everyone needs to feel respected and comfortable to participate in the group. Before the programme starts, the facilitator and participants will draw up a code of conduct or a set of rules for behaviour

within the group. The facilitator will then write the rules on the board or as a poster to put up on the walls. There should be rules for both the facilitator and the participants.

6.7.3 Activities

It is important to introduce or to end the life skill course by using activities. The activities are a good way to break the ice and get to know the participants better and they provide opportunities for participants to learn, practice and demonstrate a range of knowledge and skills.

Hoelson and Van Schalkwyk (2001: 255) note that learners can be encouraged to engage in the following activities in any life skill programme:

- **Introduction:** Participants each receive a nametag and are encouraged to introduce themselves to the group stating their name, age, affiliation, and some unique identifying aspect about themselves. The identifying aspect could be a favourite activity, an animal or object in nature they identify with or a key role they perceive for themselves.

- **Group rules:** Participants take turns listing rules of behaviour they would like to see implemented in the group and briefly explaining the consequences of the rule for the group process.

- **Group picture:** On a large piece of paper using markers, each member participates in making a picture of the group. Participants need to decide on a theme and assign each other roles for completing the picture. This process introduces the participants to the idea of negotiation and it promotes bonding.

6.7.4 The researcher's role

Schilling (1977) as mentioned by De Vos (2002: 396) sees an intervention as an action undertaken by a social worker or other helping agent, usually in concert with a client or other affected party, to enhance or maintain the functioning an well-being of an individual, family, group, community or population. The researcher's roles are therefore identified as a contributing partner, knowledge creator and disseminator in this study.

6.7.5 Assessment

An important point about this programme is that a facilitator needs to think about what they want participants to achieve. The facilitators will assess participants through questioning at the end of the programme.

The researcher will utilise a self-constructed group administered questionnaire to collect quantitative data before and after implementation of the life skills programme (pretest and posttest).

6.8 MINIMUM CRITERIA FOR IMPLEMENTING AIDS ORPHANS LIFE SKILLS PROGRAMME

The criterion to be used is as follows:

- The teaching of life skills requires a learning environment in which the facilitator can organise active and experiential learning activities.
- The life skills teaching should have continuity and sequence over time, i.e. life skills lessons should, to some extent, relate to and build upon previous lessons.
- The facilitator should be sensitive to the capabilities and understanding of those taking part in life skills programme, and be able o adapt life skills lessons accordingly.

- The life skills activities should ideally, be led by a facilitator.

6.9 CONCLUSION

In brief, the reviewed chapter suggests the planning and design of a comprehensive AIDS orphans life skills programme, for early-adolescent AIDS orphans (11 – 14 years old) in North-West Province. The underlying rationale of the programme is based on the notion that 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. AIDS orphans life skills programme empowers children to make good rather than bad choices in life.

In Chapter 6 the empirical findings and research results with regard to (a) the qualitative data (interviews with AIDS orphans, social workers and caregivers on the socio-emotional needs of AIDS orphans) and (b) quantitative data (the implementation and evaluation of the developed life skills programme) will be given.

- 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.

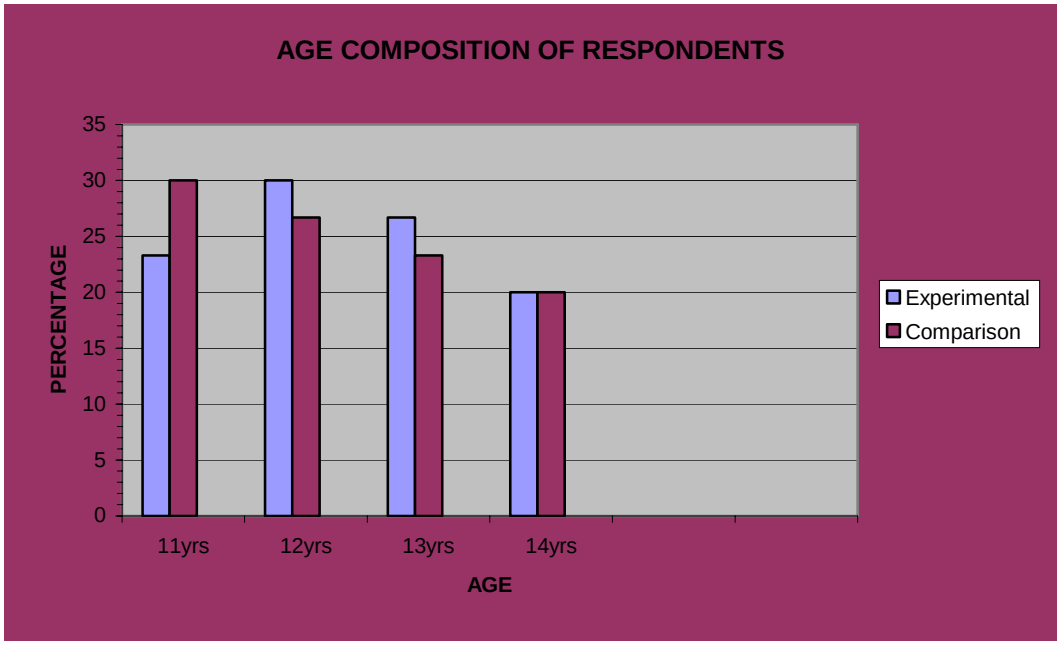


Figure 2: A column chart of the age of respondents participating in the study

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.

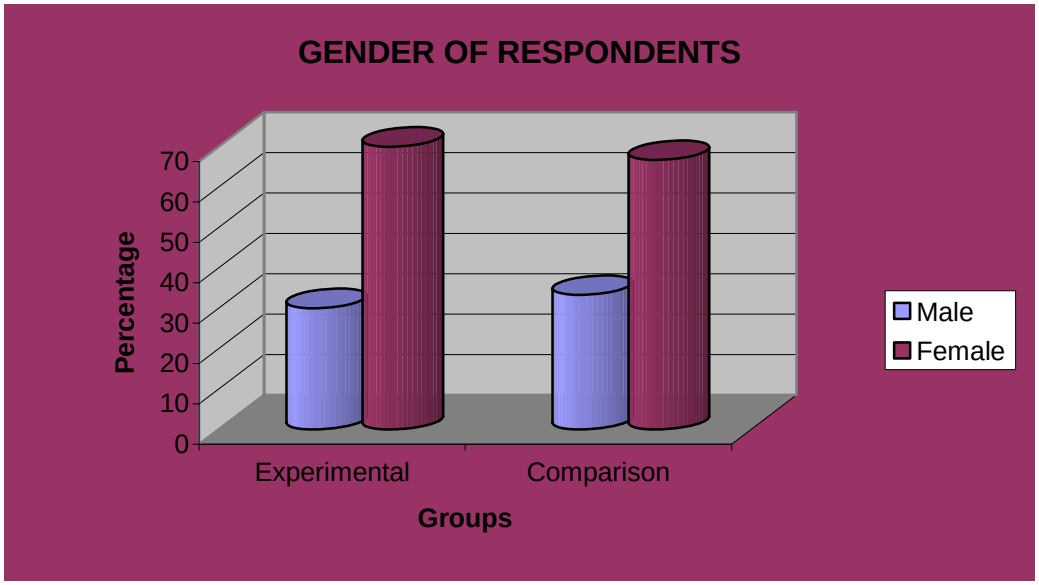


Figure 3: A cylinder chart of the gender of respondents participating in the study

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.

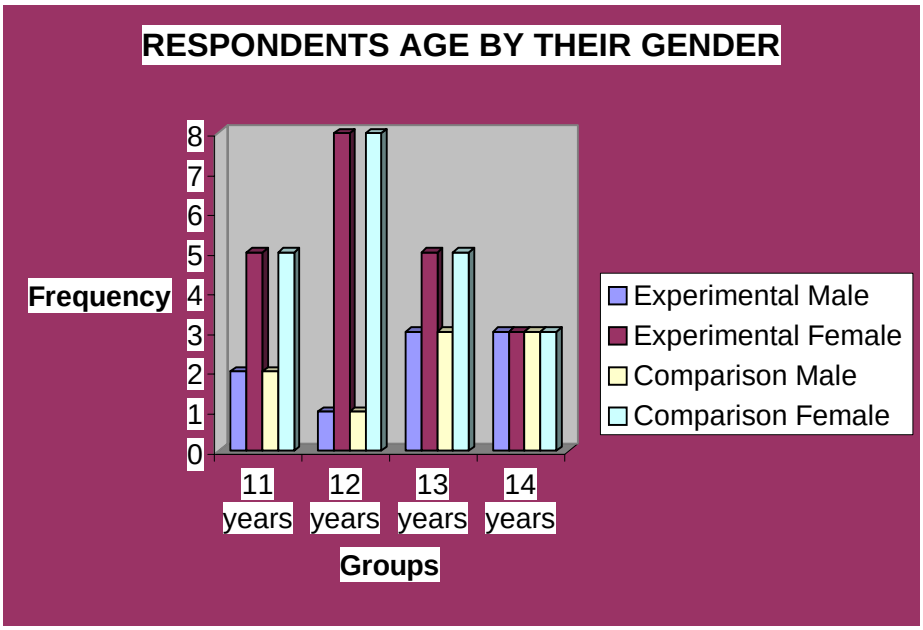


Figure 4: A column chart of respondents' age by their gender

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.

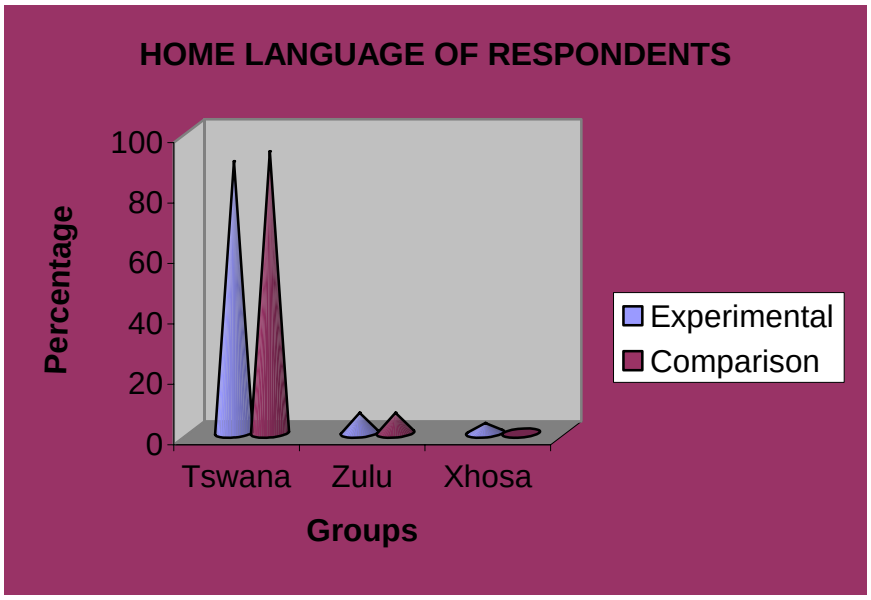


Figure 5: A cone chart of respondents' home language

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.

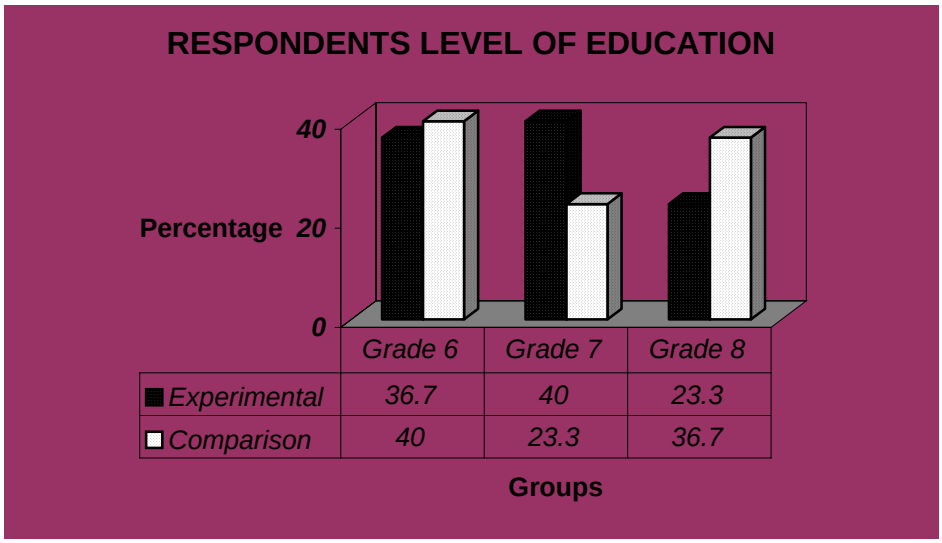


Figure 6: A column chart of respondents' level of education

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.

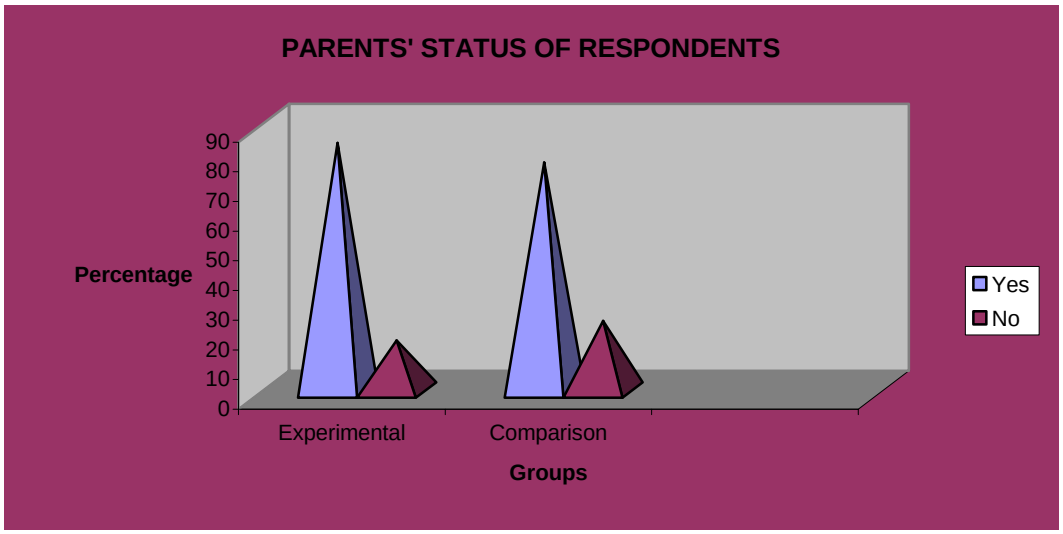


Figure 7: A paradigm chart of respondents' parental status

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.

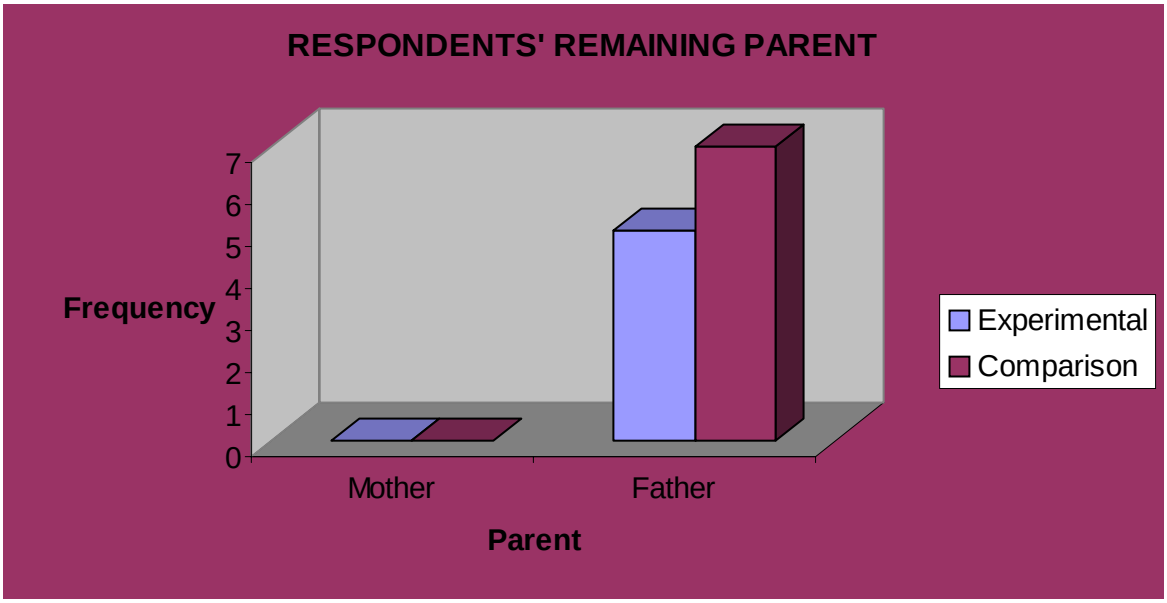


Figure 8: A column chart of respondents' remaining parent

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.

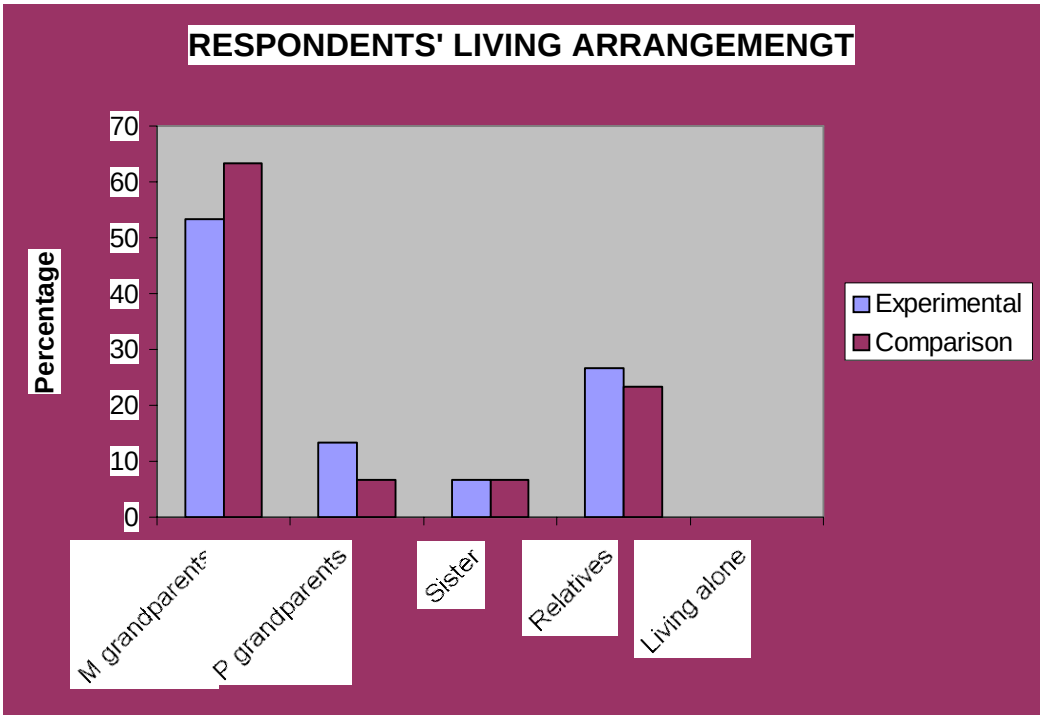


Figure 9: A column chart of respondents' living arrangement

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.

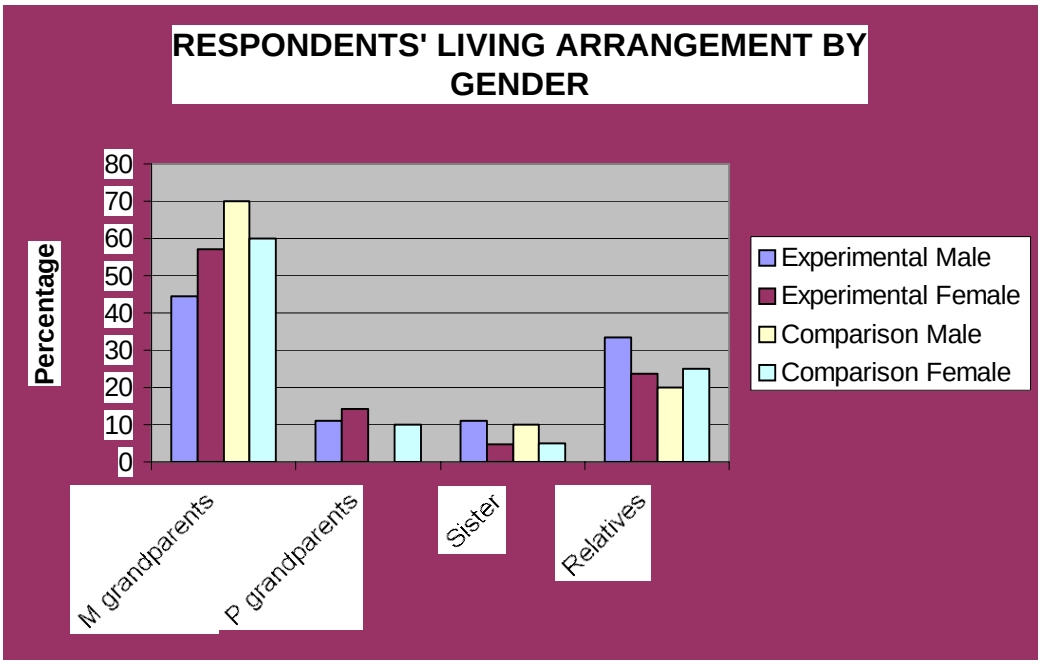


Figure 10: A column chart of respondents living arrangement by gender

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.

- CHAPTER 8 -

GENERAL SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

The HIV/AIDS epidemic raging across Africa is a tragedy of epic proportion, one that is altering the countries demographic future. It is reducing life expectancy, raising mortality, lowering fertility and leaving millions of orphans in its wake. The year 2004 ended with 37.2 million adults and 2.2 million children living with HIV. During 2004, some 4.9 million people became infected with HIV and the year also saw 3.1 million deaths from AIDS – a high global total since AIDS was discovered (AIDS Epidemic Update, 2004: 1; Avert, 2005: 1).

The rate of AIDS infection in South Africa is one of the fastest growing in the world. It is estimated that 1 500 new infections occur in South Africa every day. South Africa has the highest HIV/AIDS caseload in the world, with 5.3 million people or one in five adults, living with HIV (AIDS Epidemic Update, 2004: 5; Agence France Presse, 2005: 1; Sunday Times, 2005: 1). In addition the South African Medical Research Council stated in January 2005 that there is a steep rise in AIDS deaths in South Africa, but a large number still goes unreported because they are attributed to AIDS-related conditions, without the disease mentioned as the cause of death (Agence France Presse, 2005: 1). According to the recent report released by Statistics South Africa, South Africa's death rate jumped 57 percent between 1997 and 2003 with HIV/AIDS emerging as one of the main killers in the 15 to 49-age bracket. (Agence France Presse, 2005: 1; Sunday Times, 2005: 1; Venter & Brown, 2005: 2). As infected people are generally at the peak of their reproductive lives South Africa faces a holocaust that threatens to undermine the social, economic and political reconstruction of the nation.

So far, the AIDS epidemic has left behind an estimated 15 million children under the age of 15 orphaned worldwide and the worst lies ahead (Avert, 2005: 1; UNICEF, 2004: 1). The impact of HIV/AIDS on children is seen most dramatically in the wave of AIDS orphans. According to a Children on the Brink Report as mentioned by Tracey (2005: 1) by 2010, at least 44 million children will have lost one or both parents to AIDS. This report reveals the fact that AIDS has become a social nightmare creating international communities of orphans at an alarming rate.

South Africa currently has a high proportion of children who are not continuously cared for by either parent, and very high rates of care by aunts and by grandmothers (Avert, 2004: 1; UNICEF in Du-Venage, 2002: 1; Whiteside & Sunter, 2002: 2). Presently there are about 250 000 AIDS orphans in South Africa (Mesatywa, 2005: 1). This number is expected to rise to 1.5 million (UNAIDS, 2004: 1). Barnett and Whiteside (2002: 199) note that the bare statistics are troubling. They tell of a generation of children deprived of their childhood.

With the staggering death toll that HIV/AIDS takes, it is easy to overlook the challenges faced by the people the disease leaves behind. These orphans, the majority of whom are HIV-negative, are at enormous risk of growing up without adequate health care, food, education or emotional support (Avert 2004: 3; Deame, 2001: 2; Robbins, 2004: 1). The extraordinary challenge and difficulties that AIDS orphans (mostly adolescents) experience expose them to risky habits detrimental to their health. The AIDS epidemic threatens the viability, perhaps the very existence, of this generation. A healthy productive generation of adolescents today will ensure that South Africa has a healthy generation of adults needed in the 21st century.

Due to the devastating effects of pathologies on the lives of the youth, all young people especially AIDS orphans need to be prepared at all levels i.e. physically, emotionally, spiritually and socially. Often this involves learning different ways of relating to others so that they can make friends, get their needs met, be appropriately assertive, identify and within sensible boundaries cooperate with others. Life skills programmes provide support systems that can offer counsel and encourage adolescents to develop adaptive skills (Anderson & Okoro, 2000: 2; Hoelson & Van Schalkwyk, 2001: 246).

Therefore, the broad aim of this study was thus to develop and empirically test the effectiveness of a life-skills programme for early adolescent AIDS orphans.

The 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 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.

The following research questions were thus formulated for the first part of the study (qualitative).

- 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?

Accordingly a hypothesis was worded (quantitative):

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.

The study inevitably brought certain insights that are now discussed in the form of a general summary, conclusions and recommendations. The latter is presented according to the next discussion points, i.e.:

- Literature study

  - General introduction.
  - HIV/AIDS as a social phenomenon.
  - AIDS orphanhood as a social problem.
  - Adolescence as a life phase with specific emphasis on early adolescence.
  - A review of life skills with specific emphasis on early adolescents.
  - A life skills programme for early adolescents AIDS orphans.

- Empirical research findings:

  - Qualitative findings based on in-depth literature about the phenomenon HIV/AIDS and AIDS orphans, the specific characteristics, needs and problems of early adolescents as well as life skills for early adolescents.

  - Qualitative findings based on semi-structured interviews with social workers, caregivers and AIDS orphans.

  - Quantitative findings based on the evaluation of a life skills programme for early adolescent AIDS orphans (AIDS orphans life skills programme).

8.2 LITERATURE STUDY

8.2.1 General introduction to the study

8.2.1.1 Summary

The first chapter is an introductory chapter. It starts with general introduction and orientation to the research report. Focus is also placed on formulation of the problem, the rationale for the choice of topic, goal and objectives, research questions as well as a hypothesis formulated. The core of this chapter is explanation of the methodology employed for the research project to be undertaken.

The chapter gives a description of the research approach, the type of the research, research design, research procedure and strategy followed. Aspects concerning the pilot study are also explained and a description of the research population, sample and sampling methods is given. Ethical aspects and limitations of the study are briefly outlined and key concepts are defined. The chapter ends by highlighting the topics of the subsequent chapters in the thesis.

8.2.1.2 Conclusions

From the literature in this chapter the researcher concludes that:

- HIV/AIDS seem to be a universal problem throughout the world especially in sub-Saharan Africa. AIDS in Africa has orphaned more children than anywhere else in the world.

- South Africa has one of the most severe HIV epidemics in the world. The recorded cumulative number of HIV infections to date exceeds 43 million, of which 5.3 million are South Africans. That means more than 10% of the global population living with HIV is in South Africa.

- The majority of people living with HIV and AIDS are economic active people. Around half of the people who acquire HIV become infected before they turn 25 and typically die before the 35th birthday. It is estimated that 1 in 5 people of this age group are living with HIV.

- HIV/AIDS kills people in the prime of their lives. The fact that young adults die in their productive years means that families are deprived of their major source of economic support.

- When breadwinners lose their jobs or die prematurely of AIDS, many elderly people use their pensions to care for their children who are ill and/or grandchildren who are orphaned.

- Factors driving the epidemic in South Africa include: poverty, stigma, violence against women and children as well the low economic status of women.

- The increasing number of AIDS orphans is a concern to the South African government. Orphans experience a loss of parental love, care and support when their parents die. This may result in socio-emotional problems that perpetuate poverty.

- There seem to be no specific intervention programme for the promotion of life skills for early adolescent AIDS orphans.

- There is an urgent need to develop an intervention programme that aims at the promotion of life skills for early adolescent AIDS orphans.

Based on the methodology of the study the researcher concludes:

- The type of research i.e. intervention research, selected for this study was suitable as the study was in essence a problem-solving process seeking an effective intervention for the promotion of life skills for early adolescent AIDS orphans.

- The combined quantitative-qualitative research approach was effective as it enabled the researcher to focus on the process and the aim of the study. The process resulted in the development and evaluation of AIDS orphans life skills programme.

- The researcher utilised and moved from the phenomenological design that is organized around 2 research questions to a comparison group pretest-posttest design that is focused on more definite, hypothesis testing.

- Phenomenological design is viewed as 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.

- Choice of quantitative research design: A comparison group pretest-posttest design was used to gather quantitative data and realise the aim of the study. A longitudinal approach to the study, however, is seen as the ideal and could lend itself to fundamental findings in social work practice.

- The main limitation of the study is that the findings are inconclusive and cannot be generalised to the larger population given the fact that a purposive sample of only 60 respondents participated in the study.

- This study can make a valuable contribution to social work profession as it represents a groundbreaking investigation regarding dealing with socio-emotional needs and problems experienced by AIDS orphans.

8.2.1.3 Recommendations

The researcher recommends that:

- Research in the field of HIV/AIDS prevention strategies should increase in South Africa. Researchers should however focus on the impact of HIV/AIDS on specific groups of people.

- Dealing with HIV/AIDS requires a partnership between all South Africans. No prevention programme can be successful without support, commitment of all people. To succeed collaboration between government, private and community sectors is highly recommended.

- To ensure quality of care for AIDS orphans interventive programmes such as life skills programmes should be promoted and strengthened. Life skills programmes both empower and equip people with life skills that enhance their coping capacities. Successful programmes should impart knowledge, life skills as well as create social consensus on safer behaviour.

8.2.2 HIV/AIDS as social phenomenon

8.2.2.1 Summary

This chapter is dedicated to literature study focusing on HIV/AIDS. The chapter opens with the description of the relationship between HIV and AIDS. Chapter 2 offers definitions of HIV and AIDS and surveys the historical background to the contemporary HIV/AIDS. It further explains the unique characteristics of the HI virus and how it affects the immune system. Literature concerning HIV/AIDS in general, global and in particular the South African situation was discussed. Important issues such as the nature of the disease, the impact, the current status of the epidemic as well as the future of the epidemic were looked at. Statistics describing the relationship between HIV/AIDS and AIDS orphans were also described. Furthermore socio-economic factors that are fuelling the epidemic in South Africa were reviewed.

The researcher also examined how the virus is transmitted and provided an overview of HIV progression to AIDS. The chapter catalogued and described the symptoms of HIV infection; AIDS and AIDS related illness in adults as well as children. The

importance of recognising the symptoms and early diagnosis of HIV is emphasised. Methods of testing for HIV were discussed in some detail in this chapter. Furthermore, the importance of voluntary counselling was highlighted. Treatment of HIV/AIDS and the management of HIV infection were also described. Finally ending with a summary of issues touched on in the chapter.

8.2.2.2 Conclusions

Chapter two confirms the following:

- HIV causes AIDS and that the number of people living and dying with HIV/AIDS is shocking. At the end of 2004 there were 37.2 million adults and 2.2 million children living with HIV. During 2004, some 4.9 million people became infected with HIV and the year also saw 3.1 million deaths from AIDS – a high global total since AIDS was discovered.

- HIV is primarily transmitted through sexual intercourse, when HIV infected blood is passed directly into the body of another person, or when a mother infects her baby during pregnancy, childbirth or as a result of breastfeeding. The major mode of HIV transmission in South Africa is through sexual intercourse.

- HIV/AIDS is referred to as a social disease. The links between socio-economic and HIV/AIDS are increasingly recognised and understood.

- The way in which HIV progresses to AIDS is a gradual process that moves through various clinical stages that occur over a long period of time usually 5 – 12 years. The final stage is regarded as AIDS and it occurs when the CD4 blood count drops below 200 and a person become vulnerable to serious opportunistic infections.

- Preventing and treating opportunistic infections quickly and effectively improves one's quality of life and delays the onset of AIDS.

- There is still no known cure for HIV/AIDS but the provision of antiretroviral medicines prolongs and improves the quality of life for many South Africans living with HIV.

- Scaling up access to highly active antiretroviral therapy (HAART) allows the immune system of many people to regain strength and combat opportunistic infections, making HIV/AIDS a more manageable health condition.

- Currently, antiretroviral medicines are the only form of treatment that has been scientifically proven to repair one's immune system ones the CD4 count has fallen below a certain level.

- Availability of accessible and affordable antiretroviral medicines is a problem that should be addressed by the South African government.

- The most effective way to reduce the number of people living with HIV is to prevent HIV infection in women of childbearing age, young people and adults in general.

- Maintaining a healthy and nutritional diet is important for all people, but particularly for people living with HIV. A poor diet impairs the functioning of the immune system, and hastens the progress of HIV infection to AIDS.

- The HIV/AIDS pandemic can only be countered if it is fought on all fronts, that is, if all sectors (government, community and private sector) become actively involved in caring for the sick and orphaned people.

8.2.2.3 Recommendations

The researcher recommends that:

- Wide-scale communication and social mobilization efforts are needed to broaden HIV/AIDS awareness within communities. Reducing the stigma and discrimination often associated with HIV/AIDS is a fundamental element.

- Research into a vaccine aimed at preventing HIV and AIDS be strengthened. However, the discovery of this vaccine remains a long way off.

- Antiretroviral medicines service points to be expanded to every municipality in South Africa, both urban and rural so that a service point will be available for all people. This will be an important development, as it will prolong the lives of many people living with HIV enabling them to provide care for their families.

8.2.3 AIDS orphanhood as a social problem

8.2.3.1 Summary

Chapter three explored literature regarding AIDS orphans in general, global and South Africa in particular. The chapter provided a description of the basic concepts i.e. orphan and AIDS orphan. This was followed by a discussion of orphanhood based on the African perspective. Accordingly the extent of the problem of AIDS orphans was reviewed. Grounding, description and explanation of the needs of AIDS orphans were then presented to give a clear picture of challenges faced by these children. Problems of orphan-hood such as legal and ethical issues, socio-emotional issues, educational issues, financial issues and child-headed households were reviewed. The importance of the involvement of major role players i.e. government, family and community in the care and support of AIDS orphans was discussed. The chapter concludes with a short summary of the most important issues covered.

8.2.3.2 Conclusions

This chapter concludes that HIV/AIDS affects AIDS orphans in diverse and numerous ways:

- In 2004 already 15 million children worldwide were orphaned by AIDS and the number risks being doubled by 2010 if the response to the epidemic is not scaled up.

- The epidemic has forced vast numbers of children into precarious circumstances, putting them at high risk of becoming infected with HIV. AIDS orphans are especially vulnerable to HIV infection for a host of social and economic reasons including poverty, sexual exploitation and violence, and lack of access to HIV information and prevention services.

- The extended family (which would have traditionally provided support for orphans) is greatly overextended in communities most affected by AIDS; it can now no longer take care of its orphaned children. The consequence of this is that children are often socially isolated and deprived of basic social services.

- Many children are struggling to survive on their own in child-headed households, frequently carrying the burden of caring for family members living with HIV/AIDS. They do not know how to protect themselves and have no access to needed facilities.

- Children in households with a HIV-positive member suffer the trauma of caring for ill family members. Seeing their parents or caregivers become ill and die can lead to psychosocial stress, which is aggravated by the stigma so often associated with HIV/AIDS.

- Increasing numbers of AIDS orphans are withdrawn from schools to care for ill parents or their siblings, thus losing opportunities for acquiring necessary life skills needed for them to create sound and healthy households and living environments.

- AIDS orphans especially early adolescents are also particularly vulnerable to HIV infection because they often do not have available to them the basic healthy environment – food, shelter, education and health services – through which they can protect themselves from HIV and other infectious diseases.

- HIV/AIDS will continue to affect the lives of several generations of children. The impact will mark their communities for decades as the numbers of impoverished children rise, their insecurity worsens, education and work opportunities decline, nurturing and support systems erode, and mortality rises.

- All children especially AIDS orphans need love, care and support. As with adults it is important that they live healthy lives. Without adult guidance, life skills and means of sustaining their livelihood, these children become easy victims of exploitative and unhealthy child labour.

- There is a general consensus that help for AIDS orphans should be targeted at supporting families and improving their capacity to cope rather than setting up institutions for the children.

8.2.3.3 Recommendations

The researcher suggests that:

- AIDS orphans need a safe and supportive environment. This requires sensitive attitudes, policies and legislation at family, community and national levels. To build sturdy family and community systems capable of providing prevention and care will require support from all role players such as government, private and community sectors.

- Every attempt should be made to trace relatives of AIDS orphans. Relatives who cannot afford to look after orphaned children should be helped financially so that they can care for these children.

- Wide-scale communication and social mobilization efforts are needed to broaden HIV/AIDS awareness within communities who are in the frontlines for providing prevention, care and support for children. Reducing the stigma and discrimination associated with HIV/AIDS is a fundamental element.

- Support for AIDS orphans HIV counselling and support of the children, their parents and siblings, can considerably improve their quality of life, relieve suffering and assist in the practical management of illness.

- Policy makers must recognize that the rights of children and young people, especially girls, must be protected and promoted; and that young people are critical resources for making HIV programmes meaningful to their peers.

- Large-scale, long-term efforts are needed to cope with the above-mentioned harsh new realities. Life skills programmes are viewed as crucial in improving the quality of life of AIDS orphans.

- Social workers should take a lead in empowering AIDS orphans with life skills.

8.2.4 Adolescence as a life phase with specific emphasis on early adolescence

8.2.4.1 Summary

The literature study in Chapter 4 covered the discussion of adolescent period in detail with specific emphasis on early adolescence. The researcher opened the discussion by defining the term adolescence. She then described the nature of adolescence and the developmental processes that are involved. The researcher discussed the physical,

psychological, cognitive and social developments during adolescence. Focus was on changes that take place during this stage and the importance as well as effects of the changes.

Furthermore, the chapter highlighted the characteristics of the stage taking various developmental tasks into account. Adolescents' risk behaviour was reviewed. This was done to help understand the factors that motivate adolescents' risk-taking behaviours. Focus was also on problems and challenges experienced by early adolescents. The chapter ends with a brief summary of key points.

8.2.4.2 Conclusions

The reviewed literature points to the following:

- Adolescence is a biological and psychosocial path to adulthood. However, adolescents need to complete a number of developmental tasks to successfully enter into adulthood. These developmental tasks include a gradual shift to independence from parents, development of an own identity, an adjustment to sexual maturation as well as establishing cooperative relationships with significant others.

- Within a developmental picture, successful adolescents are able to achieve a separate identity, independence from their parents and prepare themselves for appropriate relations to achieve the adult development task of job, marriage and family.

- Adolescence as a stage of human development is divided into three phases i.e. early adolescence, mid-adolescence and adult adolescence. The phases are characterised by both physical and psychological changes. While some adolescents find it relatively easy to cope with the effects of such changes, early adolescents find it difficult to define and constructively deal with them.

- Adolescence behaviour is often characterised by exploration. At times such exploration is unacceptable and even dangerous. Adolescents are at high risk when engaging in more self-destructive behaviours that include unsafe sex, teenage pregnancy, substance abuse, suicide and delinquent or criminal behaviours.

- External factors have a tremendous impact on how adolescents think and behave; the values and behaviours of their peers are increasingly important while parents and other family members continue to be influential.

- The home environment of South African adolescents has gradually changed increasing adolescents potential exposure to unhealthy behaviour. Among a number of reasons for this are the influx of mother into the labour market, the rise in single-parent families and a high unemployment rate. All of this creates opportunities for adolescents to spend more time unsupervised or with their peers. This increases the incidence of risky-taking and harmful behaviours.

- The consequences of early adolescents risky behaviour are multifaceted and intensifies progressively underlining the need for comprehensive and integrated measures against them.

8.2.4.3 Recommendations

- Adolescents are experiencing an urgent need to improve their situations. The researcher recommends that programmes that enhance the quality of early adolescents' lives should be promoted.

- Life skills programmes should be age specific and developmentally appropriate.

- The programme should include life skills that promote healthy living. The skills include problem solving, decision-making, critical thinking,

communication, interpersonal skills, empathy, and methods to cope with emotions.

- Life skills can enable adolescents to develop sound and positive view of life. They can improve substantially the emotional, social, cognitive and physical development of early adolescents.

- Target for prevention intervention with early adolescents could be family relationships, peer relationships, the school as well as the community environment. Each of these domains can be a setting for deterring the initiation of adolescents' risky behaviours through adoption of life skills and prosocial attitudes as well as behaviour that encourages the development of health behaviour.

8.2.5 A review of life-skills with specific emphasis on early adolescents

8.2.5.1 Summary

Chapter five provides a review of life skills with specific emphasis on early adolescents. The chapter commenced with the definition of the concept life skills. The researcher then described the concept life skills in detail, followed by presentation of various theoretical perspectives regarding life skills. This was done to get a better understanding of how life skills enhance human capabilities i.e. physically, socially and psychologically. The importance of life skills to early adolescents was also outlined.

The researcher also covered specific issues regarding life skills such as classification of life skills, life skills theory, life skills education, life skills programmes, and life skills in the context of a helping approach. Areas of knowledge in adolescents' life skills development are identified in this chapter. The chapter ends with a short summary.

8.2.5.2 Conclusions

The reviewed literature indicates that:

- The most effective way in dealing with social and emotional problems is to direct primary prevention programmes at young people where internalisation of healthy life styles and a sound socially acceptable value system is still possible.

- Life skills are self-helping skills that enable young people to help themselves. They are aimed at empowering people by reinforcing positive feelings about their identity hence obtain a sense of personal power and self-worth.

- Life skills enable people to maximise their own choices, to enhance their personal well-being and to improve their quality of life. They enable adolescents to make positive contribution and deal effectively with demands and challenges of everyday life.

- Life skills are especially suited for adolescents because adolescence is a time when key decisions are made that can affect the course of one's life.

- The learning of life skills should occur at a young age before negative patterns of behaviour have been established. Early adolescent years seem ideal to instil life skills as a positive response since young people of this age group seem to be most vulnerable to behaviour-related social and health problems.

- This learning is regarded as most effective within a supportive helping relationship.

- The effective acquisition and application of life skills influences the way people feel about themselves and others, and equally influence the way people are perceived by others. Life skills contribute to peoples' perceptions of self-efficacy, self-confidence and self-esteem.

- The teaching of life skills is both theoretical and practical intended to equip the learner with new or improved abilities. The methods used to facilitate active involvement include working in small groups, brainstorming and role-play.

- The teaching of life skills has largely focused on school populations. Although the teaching of life skills has been incorporated in the education system of this country, there are many children such as school-drop outs, orphans and street children who cannot be reached by the formal educational system.

- There are currently no life skills programmes specifically designed for AIDS orphans in South Africa.

- Deficiencies in life skills contribute to the vulnerability and exploitation of AIDS orphans.

- Social workers are in a strong position to teach life skills because of their skills, training and knowledge. A social worker is a multiskilled professional who sees people as having the potential and believes in their ability to grow and develop.

8.2.5.3 Recommendations

- Health and social problems are on the increase in South Africa. Measures to combat these social problems have proved unsuccessful. The only solution is to purposefully employ a more holistic approach which promotes abilities for adaptive and positive behaviour.

- The researcher recommends that a life skills programme for early adolescent AIDS be promoted in order to stabilise and change their life styles.

- Special emphasis should be given to life skills, which promote healthy living among early adolescent AIDS orphans. Ten skills that have been identified include: self esteem and identity; communication skills; assertiveness skills; self-awareness; coping with emotions; decision-making skills; problem solving skills; conflict management skills; critical and creative thinking skills as well as a healthy life style.

8.2.6 A life skills programme for early adolescent AIDS orphans

8.2.6.1 Summary

Chapter six is mainly set out in terms of a presentation of a developed life skills programme for early adolescent AIDS orphans in North-West Province (AIDS orphans' life skills programme). The chapter starts with explanation of the programme based on the goal and objectives of the study. This is followed by a detailed description of the programme with specific emphasis on life skills to be employed. The researcher further highlights the planning and minimum criteria for implementing AIDS orphans life skills programme. The researcher concludes with a short summary of the most important issues dealt with in the chapter.

8.2.6.2 Conclusions

It has become clear that:

- The ability of AIDS orphans life skills programme in order to assists AIDS orphans to cope is seen as critical.

- AIDS orphans life skills programme seeks to mobilize and strengthen life skills promotion and education activities. The initiative is designed to

improve the lives of AIDS orphans by strengthening their capacities through life skills.

- AIDS orphans life skills programme can provide a platform for provision of life skills for early adolescent AIDS orphans and can provide a supportive environment for the teaching of life skills.

8.2.6.3 Recommendations

- Training should be provided to social workers that are interested in the implementation of the programme (AIDS orphans life skills programme).

- AIDS orphans life skills programme should be introduced to all welfare organizations in South Africa.

- Future research might include development life skills programme targeting other identifiable subgroups.

Following is a discussion of empirical research findings.

8.3 EMPERICAL RESEARCH FINDINGS

8.3.1 Qualitative findings based on needs, problems of and life skills needed by early adolescent AIDS orphans

8.3.1.1 Summary

The qualitative findings based on needs, problems of and life skills needed by early adolescent AIDS orphans were described in Chapter 7 of this research report. The researcher used semi-structured interviews with a schedule to collect qualitative data in order to examine and answer the research questions that 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 researcher interviewed 10 social workers, 10 caregivers and 20 AIDS orphans. The total number of respondents who participated in the first phase of the research project was 40.

8.3.1.2 Conclusions (demographic information)

Three groups of people participated (i.e. social workers, caregivers and AIDS orphans) participated in the first phase of the study (the qualitative phase). Conclusions with regard to the demographic details of the three groups of respondents are presented below:

- **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. The social workers (100%) were all employees of the Department of Social Services, Arts, Sports and Culture (North-West Province).

- Age: 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.

- Gender: All of the respondents (100%) were females.

- Qualifications: All of the respondents were qualified social workers with graduate (60%) and postgraduate (40%) degrees in social work.

- Position at work: 50% of the respondents were social workers, 40% senior social workers and the remaining 10% chief social workers.

- Years of social work experience: All the respondents (100%) had more than five years experience in the Social Work field.

- Years of experience with AIDS orphans: 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.

- Geographical area: All of the respondents (100%) resided in the North-West Province in particular Mafikeng and Rustenburg.

- **Demographic information of caregivers**

The study population consisted of 10 caregivers in two major cities of the North-West Province namely Rustenburg and Mafikeng.

- Age: The majority of the respondents (70%) were of the age group 46-60 followed by those of the age group 20-45 (20%) and respondents (10%) of the age group 61-75 years.

- Gender: All of the respondents (100%) were females and the majority of respondents (80%) were grandmothers and the remaining 20% were AIDS orphans' sisters.

- Marital Status: Most of the respondents (50%) were married followed by widows (30%) and those who were never married (20%).

- Language spoken: All the respondents (100%) were Setswana speaking.

- Years of care giving: The majority of respondents' years of care giving was more than five years (60%).

- Own children under your care: All of the respondents (100%) were parents with either own children or grandchildren to bring up.

- AIDS orphans under your care: All respondents (100%) had more than one child under their care whose parents have already died.

- Assistance received: Most of the respondents (60%) did not receive any form assistance. Only few (40%) were receiving assistance from government in the form of social grants. Teachers were considered helpful in helping families with applying for birth certificates and identifying children in need by many respondents (70%). 30% of respondents indicated that some members of their family assist them financially in taking care of the children.

- Geographical area**:** All of the respondents were residents of the North-West Province in particular Mafikeng (50%)and Rusternburg (50%).

- **Demographic information of AIDS orphans**

The study population consisted of 20 AIDS orphans from Ledig one of the villages in Rustenburg (North-West Province).

- Age: All of the respondents (100%) who participated in the research fell within the age group 11-14.

- Gender: There was equal representation of gender. 50% of respondents were females and the other 50% were males.

- Highest educational standard passed: The majority of respondents (60%) were in grades 3-4 followed by those in grades 5-6 (40%).

- Language spoken: All of the respondents (100%) were Setswana speaking and could clearly communicate in Setswana.

- Parent(s): The majority of respondents (85%) lost both parents to AIDS**.** 15% of respondents indicated that their fathers were still alive.

- Guardian(s): 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%).

- Siblings: The majority of respondents (90%) stated that they had two and more brother(s) or sister(s).

- Period of orphanhood: The period of being orphans differed. The majority (75%) have been orphans for about three years with few (25%) having been orphans for more than three years

In the following section conclusions regarding the social needs, problems of and life skills needed by AIDS orphans are presented as identified by all the participants (i.e. social workers, care givers and AIDS orphans. The total number of respondents was 40.

8.3.1.3 Conclusions (socio-emotional needs, problems of and life skills needed by AIDS orphans)

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

The social needs and problems of AIDS orphans are presented according to six key elements namely educational, relationship, upbringing, health-care, subsistence/finances and housing/security.

Educational

- Unpaid school fees (n-38): Because many of AIDS orphans come form impoverished families, they often cannot afford to pay for their school fees.

- Poor school performance and high failure rate (n-29): The emotional difficulties suffered by AIDS orphans combined with social stigma tend to block their ability to learn at school (n-18). They often have little ability or motivation that contribute to their educational development (n-24).

- Insufficient time to study (n-23): Children do not have sufficient time to rest and study at home because of heightened home chores. 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).

- Lack of supervision (n-36): AIDS orphans do not receive constant supervision and assistance with their schoolwork

- High rate of absenteeism and school drop rate (n-31). 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.

- Shortage of school uniform, books and food (n-40). These lead to the children being demotivated.

- AIDS orphans need family support, love and acceptance and constant supervision. They need to be assisted with their schoolwork (n-40).

- AIDS orphans need financial support especially in the form of bursaries and educational sponsorships to ensure that they remain at school when their families are experiencing financial difficulties (n-28).

Relationships

- AIDS orphans experience lack of support from both the family and community (n-32).

- Children grieving for dying or dead parents are stigmatised or ostracised by society through association with HIV/AIDS (n-18). They often experience rejection, lack of appreciation, affirmation and encouragement (n-23). They may personally experience the stigma of AIDS related illness, as they are teased by classmates or ostracised by peers and other parents.

- They are rejected on the basis of the perceived immoral sexual habits of their parents coated with fear of contracting the disease (n-2).

- AIDS orphans have interpersonal problems (n-29). They experience interpersonal problems such as conflict with peers, cousins and teachers. Their communication is characterised by lack of openness.

- Poor choice of friends is blamed for AIDS orphans misbehaviour and lack of respect (n-24).

- Foster parent-teen relationships are often characterised by 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 (n-10).

- Many children orphaned by AIDS 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 in relationships (n-10).

- AIDS orphans need to be loved unconditionally, supported, accepted, and respected (n-40).

Upbringing

- Poverty was identified as a serious problem that AIDS orphans are confronted with (n-40). 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.

- AIDS orphans are often stigmatized (n-18). Relatives are not prepared to be foster parents due to the stigma attached to HIV/AIDS (n-23). 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.

- Lack of proper care (n-38): Most of the AIDS orphans are raised by their grandparents. Because some of the grandparents are too old, they find it difficult to supervise the children and give proper care. Grandparents cannot assist the children with their schoolwork.

- There is an increase of child-headed households in many communities (n-25). These orphans were also viewed as exposed to household accidents, sexual abuse and molestation.

- AIDS orphans are often deprived of their childhood (n-36). Roles are reversed because most of the time AIDS orphans take care of grandparents and other siblings. They occupy adult roles and that affect their school performance as they are deprived of time to study at home.

- Vulnerability to the life of crime is a risk that most AIDS orphans are faced with (n-27). 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 such as sexual molestation and even HIV/AIDS.

- AIDS orphans need financial assistance, responsible caregivers and family as well as community responsive to their needs (n-40). AIDS orphans are disadvantaged since they suffer from lack of guidance and affection, which are vital for their social and emotional development.

- AIDS orphans need equal and same treatment of all children in the household (n-8).

Health care

- With regard to health care AIDS orphans do not experience serious problems. Clinics are available for medical examinations (n-40). However it was indicated that some children experienced ill health after the death of their parents (i.e. headaches and lack of sleep).

- Like all other children AIDS orphans need healthy food. They should daily be provided with balanced meals (n-40).

- It is critical that AIDS orphans have support. They need to be provided with government supported medical aids, which will cater for their health and medical needs (n-5).

- Parental care. AIDS orphans need someone to take them to clinics when they get sick (n-40).

Subsistence/Finances

- Illness and loss of parents reduce the capacity of families to provide for the children's most basic needs (n-40). Resources available in AIDS-affected households decrease because of the deaths of productive members and the increased demand for household expenditure – medicine and food.

- AIDS orphans experience socio-economical problems such as financial problems (n-40), being street kids (n-10) and run the risk of being infected with HIV (n-40).

- Children experience problems such as insufficient provision of food due to their impoverished status (n-40). Without adequate material, economic and

nutritional support the children are vulnerable to malnutrition and infectious diseases. Children in these households are usually less well nourished and have a greater chance of being of being infected with HIV themselves (n-16).

- Most families are not receiving social grants (n-34). The reasons include unavailability of birth certificates and the slow process of issuing the grants. Most of the foster parents are still waiting for the grants to be approved. Social grants need to be approved in a short period of time.

- Social grants were viewed as not enough (n-40).

- There are caregivers who misuse the social grants by giving their own needs priority without adequate regard for the needs of their children (n-24). Some even spend the money on alcohol (n-7). They are not committed in proper upbringing of the children but the money. They volunteer to look after the children just to benefit from the government orphan packages (n-21).

- Proper measures need to be taken to ensure that money is used for the benefit of the children (n-28). Thorough assessment should be done before appointment of a foster parent. Children need to be brought up by responsible guardians who will manage their finances with wisdom (n-27).

Housing/Security

- The majority of AIDS 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. Homes are not equipped with all the resources the children need (n-40).

- AIDS-affected households tend to experience overcrowding. Therefore some children are forced to sleep on the floor (n-40).

- 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. 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 (n-27).

- Children experience emotional problems and run away from home in search of stability and security (n-9). AIDS orphans need to be supervised and mentored by adults who will enforce discipline (n-40).

- AIDS orphans are at risk of being sexually abused (n-22). Sexual victimization of children contributes to the risk of suicidal attempts and delinquency, which may later develop into more serious criminal activity.

- A home, which is safe and secured (n-40). Child-headed households should be discouraged (n-37). Relatives should be encouraged to foster the children. In cases where there is no one take care of the children; AIDS orphans need to be placed at shelters or foster homes (n-8).

- The need for healthy guardian-child relationships as well as conducive home environments were viewed as of prime importance (n-40). If these needs are gratified, these children will grow up in an environment which affords them identity, self-respect and a sense of living.

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

The emotional needs and problems are discussed based on five key elements namely personality, emotions, mental-health, support systems and loss of parents and identity.

Personality

- AIDS orphans suffer from inferiority complex, depression, passivity (n-24), and bitterness (n-25). Rebellion and aggression are commonly expressed as a way of expressing bitterness (n-20).

- AIDS orphans have a tendency to isolate themselves (n-25). 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. 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.

- The self-esteem and confidence of AIDS orphans were viewed as often severely threatened (n-40). Rejection by significant others such as loved ones, friends and family usually cause one to lose confidence and thus experience reduced feelings of self-worth.

- Some children are viewed as stubborn and being withdrawn (n-31). They need to be encouraged to recognize their rights as people as well as accept the right of others.

Emotions

- Participants (n-40) alluded that AIDS orphans experience various emotions such as sadness, loneliness, rejection, blame especially towards God. They mostly blame God for failing to prevent their parents' death.

- Children experience feelings of hurt and pain (n-40). They miss their parents very much. However, some feel betrayed by their parents especially because of not disclosing the cause of their illness.

- AIDS orphans experience depression, grief, anger, guilt, frustration (n-31) and fear for their futures (n-40); hence they need the support and understanding of significant others (n-40).

- 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 (n-33).

- When parents die, these children often act out their feelings of anger resentment in anti-social behaviour towards their guardians, teachers and friends (n-30). 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 (n-24).

- AIDS orphans have emotional needs such as acceptance, love, respect and appreciation. 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 (n-40).

- Children should be prepared before the parent's death. Honesty is important. Children need to be told the truth regarding the cause of their parents' illness (n-17).

- Emotional healing. AIDS orphans need to be helped to deal with unresolved feelings of hurt, pain and bitterness that make them susceptible to illness. Spiritual counseling. Spiritual counseling is necessary especially if the children are blaming God (n-22).

Mental health

- Stress is viewed as a major emotional problem amongst AIDS orphans (n-24). Most of the children become stressed as a result of being unable to cope with problems they encounter.

- Some children experienced serious depression (n-18) and some even attempted to commit suicide (n-3).

- Each child should have a supportive adult whose main function is to maintain the child's emotional comfort (n-40).

- Therapeutic counseling. Counseling is a necessity because of the emotional trauma AIDS orphans experience (n-32).

Support systems

- AIDS orphans need support of both family and community members (n-40). Family members should be encouraged to take care of orphans. It is not the responsibility of the aged alone. Like all other children, AIDS orphans need to be accepted, loved and cared for (n-40).

- Children should be part of support groups, where they will encourage and support one another (n-7).

- AIDS orphans have need for counseling (n-34). 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 were viewed as best equipped to occupy that role (n-28).

Loss of identity

- Many AIDS orphans struggle with issues of multiple losses (n-37). Having lost both parents through AIDS, they also experience abandonment, and inability of others to care for them. They often live on their own or have to be relocated to unfamiliar places as well as being separated from their siblings, friends, neighbours, and classmates. This result in the children feeling left out and rejected.

- Change of residence and relocation were indicated as a noticeable problem (n-36). Change of residence to unfamiliar places was seen as having a negative effect on the children' development. It is characterized by change of family religion, culture, values and in some cases, even a surname.

- Children encounter adjustment problems since they have to change schools, friends and even neighborhoods (n-26). They end up with a failure identity.

Life skills needed by AIDS orphans

Life skills identified included:

- Coping and stress-management: 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 (n-20).

- Self-awareness, assertiveness training, communication and conflict management skills. These skills were seen as pivotal because many children were viewed as incapacitated to function independently (n-13).

- Self-esteem and confidence. AIDS orphans need to be equipped with skills that will boost their self-esteem and confidence. A young person with high self-esteem and good social skills who is clear about her/his values and has access to relevant information is likely to make positive decisions about health. Children with poor self-esteem feel helpless and inferior, incapable of improving their situation (n-20).

- Decision-making, critical and creative thinking skills: These 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 (n-14).

- Sex education: The need for AIDS orphans to be taught about sex education was seen as important. The knowledge they have about sex was viewed as superficial. They need detailed information (n-16).

- Budgeting and financial management skills: Aids orphans need to be taught about the importance of social grants (n-10).

- Home management skills: Children need to be taught basic skills of cleaning baking and gardening (n-6).

In conclusion it is important to mention that responses with regard to life skills are based on social workers and caregivers. AIDS orphans could not answer questions pertaining to life skills indicating that they did know the skills that they needed. The absence of basic knowledge and life skills contribute to the vulnerability and exploitation of AIDS orphans. 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.

8.3.1.4 Recommendations

- AIDS orphans should be encouraged to be involved in life skills programmes focusing on skills development so that they can empower themselves and be independent. This intervention is pro-active rather than reactive.

- AIDS orphans life skills programmes need to be sensitive to the socio-emotional needs of AIDS orphans – a sensitivity that is often missing in other life skills programmes.

- Everyone has a role to play. Families and community involvement in the care of AIDS orphans should be encouraged. This will break down the fear ignorance, prejudice and negative attitudes toward AIDS orphans.

- Government should play an active role in ensuring that the socio-emotional needs of AIDS orphans are met by monitoring the use of social grants by foster-parents.

- Future research might include investigation into the use of social grants by foster parents. A potential fruitful area is to look upstream at what can be done to ensure that social grants benefit all AIDS orphans.

- Relocation of AIDS orphans after their parents' death should be minimized and done with care. Changes should be only done if there is no other alternative.

- If possible child-headed households should be discouraged. Every reasonable attempt should be made to trace relatives. If these children cannot be accommodated anywhere social workers should visit the home bi-weekly to check on their socio-emotional well-being.

- Therapeutic counseling should be made available to all AIDS orphans who need it.

- Social workers need an in-depth understanding of particular problems experienced by AIDS orphans and should be sensitized as how such problems may influence the child. Furthermore, social workers should be aware of possible intervention strategies that may be employed to assist AIDS orphans.

8.3.2 Quantitative findings based on the evaluation of a life skills programme for early adolescents AIDS orphans (AIDS orphans life skills programme).

8.3.2.1 Summary

The empirical findings and research results with regard to quantitative data (i.e. the implementation and evaluation of the developed life skills programme) were given in chapter seven of this research. Evaluation was done by means of a quasi-experimental comparison group pretest-posttest design. 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. The

empirical data was collected to include two measurements, once before and once after the intervention (AIDS orphans Life Skills Programme).

8.3.2.2 Conclusions

Demographic information

- Age: All the respondents (100%) were early adolescents. Their age group ranged from11 to 14 years. There was 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%).

- Gender: Males and females were represented in the sample. 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 31.6 (n=19) were males.

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

- Home language: The majority of respondents (92%) were Setswana speaking.

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

- Parent status: The majority of respondents (80%)have lost both their parents due to HIV/AIDS. Only 20% of respondents have one parent still alive.

- Remaining parent: All of the respondents who mentioned that they still have one parent remaining indicated that the parent who is still alive is the father.

- Living arrangement: Most of the respondents (58.3%) lived with their maternal grandparents. 25% of respondents lived with their relatives whilst (10%) lived with their paternal grandparents. Only a small portion (6.7%) lived with their brother or sister.

- Siblings under respondents' care: There was no respondent who lived alone. The respondents were either living with their grandparents, sister/brother or relatives.

Life skills

Conclusions are presented based on life skills namely a sense of identity and self-esteem, communication, assertiveness, self-awareness, coping and stress-management, decision-making, problem-solving conflict-management, critical and creative thinking skills as well as a health life style.

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

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

- **Self-awareness**: The Student Paired t test statistic was 1.44 with a P-value of 0.1832. That compared favourably with the 0.05 level of significance, as a P-value is smaller and 0.05 indicates a statistical difference. The researcher thus concluded that there is a statistical difference in the experimental groups' self-awareness with a 95% chance that the results were due to AIDS orphan life skills programme.

- **Coping and stress-management skills**: The Student Paired t test statistic was 0.93 with a P-value of 0.3651. Compared with the 0.05 level of significance the researcher concluded that there was 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**: The Student Paired t test statistic was 0.93 with a P-value of 0.37878. That compared favourably with the 0.05 level of significance. The researcher therefore concluded that there was a statistical significant difference in the experimental group's decision-making skills, with a 95% chance that the results were due to a positive influence of AIDS life skills programme and not to chance.

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

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

- **Critical and creative thinking skills**: The Student's Paired t test statistic was 0.39 with a P-value of 0.70718. Compared with the 0.05 level of significance,

the researcher concluded that there was not a statistical significant difference in the experimental critical and creative thinking skills.

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

In conclusion the researcher concluded that there was a statistical significant difference in nine out of the ten key elements of AIDS orphans life skills programme with a chance that the results were due to AIDS Orphans Life Skills Programme and not to chance. It can thus be mentioned that the programme was successful in that it promoted life skills amongst early adolescent AIDS orphans. The following hypothesis **"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"** was therefore confirmed. Even though critical and creative thinking skills were not confirmed the researcher concluded that a noticeable positive movement in the development of these skills did occur. The programme (AIDS Orphans Life Skills Programme) was 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.

8.3.2.3 Recommendations

- Permanent changes in attitudes and the development of new skills do not take place in a brief period of learning, but require sufficient opportunities for practice. The WHO (1994: 4) emphasises that only when the intervention is maintained for a longer term, spanning several years, to create longer term of improvement in behaviour and longer-term impact on behaviour preparedness, can we expect to have a significant and lasting impact on social behaviour. It

therefore goes without saying that AIDS Orphans Life Skills Programme should be conducted over a long period of time.

- Intervention outcomes must be evaluated more thoroughly, with careful follow-up for several years. Outcome studies should focus on positive behaviour changes that are noticeable after implementation of AIDS Orphans Life Skills Programme.

- Favourable outcomes are more likely to result when life skills learning occur within a broad socio-cultural setting. A thorough evaluation of the socio-cultural setting of participants is required before any intervention. This includes addressing and challenging traditional sex roles, division of labour within the family and the position of children and women in society.

- It has become evident that the most effective intervention involves recognising the family as a system in which all members are affected regardless of whether only one person or all persons are involved. With this approach the whole family becomes the focus of intervention. Parenting skills workshops are therefore recommended to empower foster-care parents in proper childcare giving.

- Attempts of group learning in our multicultural and heterogeneous society require that facilitators remain sensitive to individual and group differences. Accepting the differences between learners as well as similarities is of primary importance for effective group learning.

- The need for practical life skills such as housekeeping, cooking, and budgeting cannot be overlooked. It is therefore recommended practical life skills should be incorporated in the programme.

- In conclusion the study has confirmed a point made by Mays and Cochran (1993) in Potgieter, Roos and Du Preez (2001: 335) that intervention programmes that focus on specific groups are effective. Therefore it is

suggested that further comparative studies should be done with different ethnic groupings.

8.4 AIM AND OBJECTIVES OF THE STUDY

Aim of the study: To develop and empirically test the effectiveness of a life skills programme for early adolescent AIDS orphans.

Table 46 focuses on how the above aim of the study and resulting objectives of the study were accomplished.

Table 46: Accomplishment of the study objectives

Nr.	Objective	Objective Achievement
1.	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 for early adolescents.	This aim was achieved as reflected in the discussion presented in Chapters 2 – 6.
2.	To explore and identify the nature and prevalence of socio-emotional needs and problems of early adolescent AIDS orphans.	This objective was met. Findings in chapter 7 revealed the socio-emotional needs and problems of early adolescent AIDS orphans.
3.	To explore and identify the life skills which AIDS orphans, in their early adolescent phase need to improve their coping capabilities.	This aim was realised through a presentation of life skills needed by early adolescent AIDS orphans in chapter 7 of this report
4.	To develop a life-skills programme for early adolescent AIDS orphans.	This objective was accomplished through the planning and design of a life

No.	Objective	Objective Achievement
		skills programme for early adolescent AIDS orphans (AIDS orphans life skills programme) as explained and presented in chapter 6.
5.	To empirically test the effectiveness of the developed life skills programme for early adolescent AIDS orphans.	The objective was attained. Chapter 7 gives a detailed discussion on the quantitative findings of the implementation and evaluation of a life skills programme for early adolescent AIDS orphans (AIDS orphans life skills programme).
6.	To suggest practical recommendations for further utilisation of the newly developed life skills programme for early adolescent AIDS orphans.	This aim was accomplished through presentation of practical recommendation for further utilisation AIDS orphans life skill programme in the same chapter (Chapter 8).

8.5 CLOSING STATEMENT

There is no question that South Africa has a severe HIV epidemic. There is no easy answer or quick fix that can remedy the situation. Responses to HIV/AIDS need to incorporate planning for the future of children who are orphaned. The consequences of not caring for the affected children will be felt throughout society for many generations to come. However, South Africa is a country that has experienced a number of miracles over the past few years. The battle against the HIV/AIDS will only be won by the contributions of community members. Some contributions will be more effective, than others, but every little bit will count.

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Appendix 1: Written letter of approval from the Department of Education

Department of Education
Lefapha la Thuto
Departement van Onderwys

OFFICE OF THE DEPUTY DIRECTOR GENERAL

Enquiries: [illegible]
Telephone: 0181 [illegible]
Fax: [illegible]

To: Mrs N.M. Motepe
Lecturer: Department of School Work
North West University

From: Mr M.A. Sookraroo
Deputy Director General

Date: 30 March 2006

REQUEST TO CONDUCT RESEARCH: A LIFESKILLS PROGRAMME FOR AIDS ORPHANS

Your request to conduct research on the above topic is granted subject to the following:

- That in the course of your research you will adhere to all ethical code and to uphold the rights of the individual learners. This is absolutely critical given the sensitivities around AIDS issues.
- Liaison with the principals of affected schools and other relevant role players to ensure that the education of learners is not compromised. This would include the need to secure the necessary authorisation of all participants.
- The North West Education Department will appreciate it greatly if your findings are made available to us as well.

We take this opportunity to wish you well in this worthy project. We look forward to your valuable contribution to our collective efforts to manage the AIDS pandemic effectively.

Yours sincerely

Mr M.A. Sookraroo
Deputy Director General
Department of Education

cc Mr A.M Kwinda
Superintendent General

MAS/lm

Appendix 3: A SEMI STRUCTURED INTERVIEW (SETSWANA)

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Researcher: MAUREEN MOTEPE

Address: P. O. BOX 5620
MMABATHO
5435

Tel : 018 3892350

Madume motsaya-karolo

Leina la me ke Maureen Motepe. Ke moithuti kwa Unibesiting ya Petoria. Ke mo bogareng ga dithuto tsame. Ke dira dipatlisiso ka "Life skills programme for early adolescent AIDS orphans". Jaaka karolo ya dithuto tsa me, ke tshwanetse ke go botsisa (interview) batho ba ba nang le kitso ka diknutsana la lobaka la AIDS. Maikaelelo magolo ka seo, ke go batla go itse mathata, ditlhokego le katiso e bana ba e tlhokang. Mobatlisese o tla dirisa lonaneo la dipotso go dira tiro botlhofo. Le kopiwa gore lo sale morago.

Ka tswee tswee o a kopiwa gore o tsaye karolo mo dipatlisisong tse. Dipotsiso di tlaya metsotso e masome a mararo fela.

Ke lebogela tirisano mmogo le wena.

SEMI STRUCTURED INTERVIEW SCHEDULE (Setswana)

Batsaya karolo: **Dikhutsana ka lobaka la AIDS (AIDS Orphans)**

Demographic information

1. Dijara	11 – 12 years	☐
	13 – 14 years	☐
2. Bong	Mosetsana	☐
	Mosimane	☐
3. Mophato wa bofelo o o falotseng	Mophato 3 – 4	☐
	Mophato 5 –6	☐
4. Tulo ya logae	Lekeisheneng	☐
	Motseng	☐
5. Puo ya ko gae		☐
6. Motsadi	Mme	☐
	Rre	☐
	Ope	☐
7. Ke mang yo a go tlhokemetseng ko gae?	Mme/Rre	☐
	Leloko	☐
	Mongwe	☐
8. Ke lobaka lo lokae o le khutsana?	1 – 3 years	☐
	4 – 5 years	☐

Semi structured interview schedule (Setswana) ☐

Batsaya karole: Batlhokomedi ba bana

Demographic information

1. Dijara
   - 20 – 45 years ☐
   - 46 – 60 years ☐
   - 61 –75 years ☐
   - Dijara dingwe ☐
2. Bong
   - Mme ☐
   - Rre ☐
3. Lenyalo
   - K nyetse/nyetsewe ☐
   - Ke motlholagadi ☐
   - Re arogane ☐
4. Puo ☐
5. Dijara tsa tlhokemelo ya bana
   - 1 – 5 years ☐
   - 6 – 10 years ☐
6. Bana ba gago ba tsalo ☐
7. Bana ba o ba tlhokemelang (AIDS orphans) ☐
8. Ana o a thusiwa mo matsapeng a gogo? Eng ☐ ☐

Nya

9. Fa karabo e le eng, o thuswa ke mang? Puso ☐

Baagisane ☐

Maloko ☐

Batho bangwe ☐

10 Mokgwa wa thuso Ditshelete/Madi ☐

Ya batho ☐

Ka dithoto ☐

11 Tulo ya logae ☐

☐

INTERVIEW SCHEDULE (Dikhutsana ka lobaka la AIDS/Batlhokomedi ba bana)

Ba tsaya karolo ba tla araba dipotso tse di latelang:

SOCIAL NEEDS AND PROBLEMS

Ke mathata afe mo loagong a bana ba dikhutsana ka lobaka la AIDS ba itemogelang ona?

- Dikamanong
- Kgolong
- Dithutong
- Tsa bophelo
- Ditsheleteng
- Tlhokomelo le bodulo

EMOTIONAL NEEDS AND PROBLEMS

Ke ditlhoke dife tsa maikutlo tse bana ba dikhutsana ka lobaka la AIDS ba ditlhokang?

- Maikutlong
- Tlhaloganyong
- Semelong
- Bathusi
- Go tlhoka batsadi le go ikitse

LIFE SKILLS

Ke dithutiso (life skills) dife tse bana ba dikhutsana ka lobaka la AIDS ba ditlhokang?

Appendix 4: A SELF-CONSTRUCTED GROUP QUESTIONNAIRE FOR AIDS ORPHANS (SETSWANA)

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Researcher: MAUREEN MOTEPE

Address: P. O. BOX 5620
MMABATHO
5435

Tel : 018 3892350

Madume motsaya-karolo

Leina la me ke Maureen Motepe. Ke moithuti kwa Unibesiting ya Petoria. Ke mo bogareng ga dithuto tsame. Ke dira dipatlisiso ka "Life skills programme for early adolescent AIDS orphans". Jaaka karolo ya dithuto tsa me, ke kopa thuso ya gago gore o arabe dipotso tsa lonaneo la dipotso (questionnaire). Maikaelelo a me ke go bona fa porogerama ya AIDS orphans life skills programme e dira phaphang mo matshelong a a batho. O kopiwa gore o arabe dipotso pele le morago ga go tsaya karole mo porageramenng.

Ka tswee tswee o a kopiwa gore o tsaye karolo mo dipatlisisong tse. Dipotsiso di tlaya metsotso e masome a mararo fela.

Ke lebogela tirisano mmogo le wena.

TSWANA

Research Title: A Life skills programme for early adolescent Aids orphans

Dipotsiso Patlisiso

Nomoro ya Batsaakarolo | | |

1. Kitso ya demogerafi

Ke kopa o arabe karolo e ya dipotso ka go baya sefapano (X) mo bokosong e e fa thoko.

1.1 Dijara

1	Dijara dile 11	
2	Dijara dile 12	
3	Dijara dile 13	
4	Dijara dile 14	

1.2 Bong

1	Mosimanyana	
2	Mosetsanyana	

1.3 Lotso

1	Montsho	
2	Wa mmala	
3	Montia	
4	Mosweu	

1.4 Puo ya fa lapeng

1	Setswana	
2	Sepedi	
3	Sesotho	
4	Zulu	

5	Xhosa	
6	Tsonga	
7	Puo engwe (…...…….)	

1.5 Mophato kwa sekolong

1	Mophato 4	
2	Mophato 5	
3	Mophato 6	
4	Mophato mongwe (……)	

1.6 Ana batsadi ba gago ba ba sentse ba le mo botshelong na?
Fa karabo ya gago e le nya, ke mang yo o se tlholeng a le mo botshelong?

1	Ee	
2	Nyaa	

1.7 Fa karabo ya gago ele nya, ke mang yo o sentseng a tshela?

1	Mme	
2	Ntate	

1.8 Ke mang yo a nnang le wena ko gae? (Tlhogo ya lelapa)

1	Mme	
2	Ntate	
3	Nko le ntatemogogolo (kwa bomme)	
4	Nko le ntatemogogolo (kwa borre)	
5	Ausi/Abuti	
6	Baleloko	
7	Ditsala/Baagisane	
8	Ke tshela ke le monosi	
9	Ditikwatikweng	
10	Tulo engwe (……)	

1.9 Fa o tshela ole monosi, ke bana ba geno ba ba kae ba o ba tlhokomelang?

1	1-2	
2	3-4	
4	Mongwe	

2. Life skills

Araba karolo e e latelang ya dipotso ka go bala dikgang tse di latelang, morago e be o tshwaye mo lebokosong la se o dumelanang le sona.

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.1	Ke itumelela go nna nna.			
2.2	Go tlwaelegile gore batho ba dira diphoso, ka jaalo le nna nka dira diphoso gonne ke motho.			
2.3	Ke tlhaba ke ditlhong/kgale fa batho ba ntebelela gonne ke tshwenyega ditebego tsa me.			
2.4	Gantsi ke a dumela fa batho ba itumelela dilo tse ke didirang.			
2.5	Ke tlhoka gore batho ba tlhompe gore ke nne ke itumetse.			
2.6	Ke mosha yo a inyatsang.			
2.7	Ke tshwenyega ka bokamoso jwame.			
2.8	Ke opa ke tlhogo kgotsa mala fa ke tshwenyegile kgotsa ke tenegile.			
2.9	Fa dilo di sa tsamaye sentle ke ipona molato ka metlha.			
2.10	Ke nyema mooka fa ke kopana le dikgwetlho tse dintshwa.			
2.11	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.			
2.12	Ke itira o kare ke siame le fa ke sa siame ka nnete.			
2.13	Fa ke tlhakana tlhogo ke tlala pelo ebe ke lwa.			

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.14	Ke a tswhenyega fa batho ba sa nkutlwisese fa ke bua.			
2.15	Fa ke utlwile botlhoko kgotsa ke tshwenyegile ke leka go bua le mongwe ka se se ntshwentseng.			
2.16	Ka dinako tse dingwe batho ba mpona diphoso, empa go siame gonne ga gona ope yo a senang diphoso.			
2.17	Ke a itlhompa jalo ga ke dumelele batho go ntirisa dilo tse ke sa dibatleng.			
2.18	Ke a tshoga fa ke tshwanetse go ema mo matshwititshwiting a batho ebe ke farologano le bona.			
2.19	Fa re tlotla ke a didimala ga ke ntshe ditshwaelo tsame gone ke tshoga gore di ilo go tsibogela jwang.			
2.20	Ke tshaba go ikemela ka nosi.			
2.21	Ke ikemeseditse go emelela se ke se dumelang.			
2.22	Ke kgona go eme kgatlhanong le ditsala tsame fa ke sa dumelane le tsona.			
2.23	Ke itumelela go bolelela batho gore ke naganang ka bona.			
2.24	Ditsala tsa me di nagana gore ke moeteledipele.			
2.25	Ka nako tsothle ke aga ke ikutlwa ke ratiwa ebile ke amogela ke ditsala tsame.			

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.26	Gantsi ke abelana le ditsala tsame maikutlo ame.			
2.27	Ke tswanetse go thabisa ditsala tsame gona le gore ke dire se ke batlang go se dira.			
2.28	Ke itumelela go dira botsalano le batho ba bangwe.			
2.29	Ke dumela mo go nna ka metlha.			
2.30	Gantsi ke rarabolola mathata ka go naganisisa dilo sentle pele ke tsaya tshwetso.			
2.31	Gantsi ke dira dilo ka lepotlapotla ke sa nagana.			
2.32	Ke kgona go itseela ditswhetso ka bonna.			
2.33	Fa ke sena go tsaya tshwetso e ke dumelang mo go yona gantsi ke a e diragatsa.			
2.34	Ee yame ke ee le nyaa yame ke nyaa.			
2.35	Go thata gore ke ipeela maparego mo se ke batlang go sedira le se ke sa batleng go se dira.			
2.36	Fa ke tshwanetse go tsaya tshwetso, go thata gore ke fetse le monagano wame.			
2.37	Fa ke dira phoso, ke tsaya maikarabelo ebe ke ithute go tswa mo diphosong tse ke di direleng.			

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.38	Ka dinako dingwe batho ga bana tlhompo; Ke kgona go emelelana le seo gonne ke a tlhaloganya.			
2.39	Go go ntsi, nna ga ke sa kgona go feta fa.			
2.40	Moya wame o ko tlase ka dinako tse dintsi. Ke iphitlhela ke lela ke hutsafetse.			
2.41	Ke utlwa botlhoko le ditlhabi tse di tseneletseng fa ditsala tsame di sa nkamogele.			
2.42	Go dira le go tshola dikamano le batho go botlhokwa mo go nna.			
2.43	Ke dira le batho botlhe sentle.			
2.44	Ke tlhompa dikakanyo tsa batho ba botlhe le fa di sa tshwane le tsame.			
2.45	Ke a utlwelela fa batho ba bua le nna.			
2.46	Fa ke bua le batho bangwe, ke ba lebelela mo matlhong go bontsha kgatlego yame le tsepamo e feletseng.			
2.47	Ke leka go tlhaloganya le go tsibogela maikutlo a batho ba bangwe ka tsela e e bontshang gore ke a ba kgathelela.			
2.48	Ga nke ke ke atlega mo sengwe le sengwe. Ke nagana gore ke a palelwa mo botshelong.			
2.49	Ke motho yo a sa itumelang.			
2.50	Batho bangwe ba botoka go nkgaisa.			

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.51	Go thata gore ke gopole dilo tse di fitileng.			
2.52	Ke motho yo o sa rategeng.			
2.53	Gantsi ke motho yo a imametseng.			
2.54	Ke jewa ke bodutu.			
2.55	Ke ikemeseditse go tswelela pele mo bophelong.			
2.56	Ke motho yo o senang thuso.			
2.57	Gantsi ke lebelela gore batho ba lebegang jang fa se fatlhegong fa ke bua le bona.			
2.58	Go botoka go dira gona le go bua fela.			
2.59	Ke letla batho ba bangwe go dumela se ba batlang go se dumela.			
2.60	Ga kena mosola.			
2.61	Ke itumelela go tla ka dikakanyo tse dintsha.			
2.62	Ke tshaba dikgwetlo tse dintsha.			
2.63	Fa ke fiwa kakanyo ke a e dira.			
2.64	Go naganela kwa pele go botlhokwa go nna.			
2.65	Go siame gore mathata a rarabololwe ka kagiso.			
2.66	Fa ke sa tlhola sentle kgotsa ke entse le letsatsi le le sa ntumedisang ebile dilo tsame di sa tsamaya sentle, ke iphodisa ka go ikotlolola mmele.			

No	Kgang	Ke a dumela	Ga ke dumele	Ga ke itse
2.67	Ke robala sentle.			
2.68	Go siame gore batsha ba gane thobalano.			
2.69	Ke a itlhokomela gonne ke batla go tshela sebaka.			
2.70	Go tsuba ga gowa siamela mmele.			
2.71	Go tshega go siameletse pelo.			
2.72	Ga ke je dijo tse dinang le dikotla ka nako tsotlhe.			
2.73	Thobalano e e bolokesegileng kefa batho ka dinako tsotlhe ba dirasa condomo pele ga thobalano.			
2.74	Go nwa bojwala ke selo se se itumediseng.			
2.75	Nkaya go dira diteko tsa HIV fanka tlhakalana dikobo le mongwe ke sa itshereletsa.			

Dikarolwana tsa mela go tswa mo Sectioning ya Bobedi, ya Dipotsiso tse di iketseditswng go ya ka puisana Life skills development

1. A good sense of identity and self esteem: Improvement of self-concept

1.1	Ke itumelela go nna nna.	Potso 2.1
1.2	Go tlwaelegile gore batho ba dira diphoso, ka jaalo le nna nka dira diphoso gonne ke motho.	Potso 2.2
1.3	Ke tlhaba ke ditlhong/kgale fa batho ba ntebelela gonne ke tshwenyega ditebego tsa me.	Potso 2.3
1.4	Gantsi ke a dumela fa batho ba itumelela dilo tse ke didirang.	Potso 2.4
1.5	Ke tlhoka gore batho ba tlhompe gore ke nne ke itumetse.	Potso 2.5
1.6	Ke mosha yo a inyatsang.	Potso 2.6
1.7	Fa dilo di sa tsamaye sentle ke ipona molato ka metlha.	Potso 2.9
1.8	Ke itira o kare ke siame le fa ke sa siame ka nnete.	Potso 2.12
1.9	Ka dinako tse dingwe batho ba mpona diphoso, empa go siame gonne ga gona ope yo a senang diphoso.	Potso 2.16
1.10	Ke a tshoga fa ke tshwanetse go ema mo matshwititshwiting a batho ebe ke farologano le bona.	Potso 2.18
1.11	Fa re tlotla ke a didimala, ga ke ntshe ditshwaelo tsame gone ke tshoga gore di ilo go tsibogela jwang.	Potso 2.19
1.12	Ke tshaba go ikemela ka nosi.	Potso 2.20
1.13	Ke ikemeseditse go emelela se ke se dumelang.	Potso 2.21

1.14	Ke kgona go eme kgatlhanong le ditsala tsame fa ke sa dumelane le tsona.	Potso 2.22
1.15	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.23
1.16	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.24
1.17	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.25
1.18	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
1.19	Ke tswanetse go thabisa ditsala tsame gona le gore ke dire se ke batlang go se dira.	Potso 2.27
1.20	Ke dumela mo go nna ka metlha.	Potso 2.29
1.21	Ee yame ke ee le nyaa yame ke nyaa.	Potso 2.34
1.22	Ka dinako dingwe batho ga bana tlhompo; Ke kgona go emelelana le seo gonne ke a tlhaloganya.	Potso 2.38
1.23	Ga nke ke ke atlega mo sengwe le sengwe. Ke nagana gore ke a palelwa mo botshelong.	Potso 2.48
1.24	Batho bangwe ba botoka go nkgaisa.	Potso 2.50
1.25	Ke motho yo o sa rategeng.	Potso 2.52
1.26	Ke ikemeseditse go tswelela pele mo bophelong.	Potso 2.55
1.27	Ke motho yo a senang mosola.	Potso 2.56

2 **Communication skills**: Development of healthy relationships.

2.1	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.	Potso 2.11
2.2	Ke itira o kare ke siame le fa ke sa siame ka nnete.	Potso 2.12

2.3	Ke a tswhenyega fa batho ba sa nkutlwisese fa ke bua.	Potso 2.14
2.4	Fa ke utlwile botlhoko kgotsa ke tshwenyegile ke leka go bua le mongwe ka se se ntshwentseng.	Potso 2.15
2.5	Fa re tlotla ke a didimala ga ke ntshe ditshwaelo tsame gone ke tshoga gore di ilo go tsibogela jwang.	Potso 2.19
2.6	Ke ikemeseditse go emelela se ke se dumelang.	Potso 2.21
2.7	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.23
2.8	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
2.9	Ke itumelela go dira botsalano le batho ba bangwe.	Potso 2.28
2.10	Ee yame ke ee le nyaa yame ke nyaa.	Potso 2.34
2.11	Go dira le go tshola dikamano le batho go botlhokwa mo go nna.	Potso 2.42
2.12	Ke dira le batho botlhe sentle.	Potso 2.43
2.13	Ke tlhompa dikakanyo tsa batho ba botlhe le fa di sa tshwane le tsame.	Potso 2.44
2.14	Ke a utlwelela fa batho ba bua le nna.	Potso 2.45
2.15	Fa ke bua le batho bangwe, ke ba lebelela mo matlhong go bontsha kgatlego yame le tsepamo e feletseng.	Potso 2.46
2.16	Ke leka go tlhaloganya le go tsibogela maikutlo a batho ba bangwe ka tsela e e bontshang gore ke a ba kgathelela.	Potso 2. 47
2.17	Gantsi ke lebelela gore batho ba lebegang jang fa se fatlhegong fa ke bua le bona.	Potso 2. 57
2.18	Go botoka go dira gona le go bua fela.	Potso 2.58

3 **Assertiveness training skills**: Development of abilities to make right choices in the face of peer pressure.

3.1	Ke tlhaba ke ditlhong/kgale fa batho ba ntebelela gonne ke tshwenyega ditebego tsa me.	Potso 2.3
3.2	Ke tlhoka gore batho ba tlhompe gore ke nne ke itumetse.	Potso 2.5
3.3	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.	Potso 2.11
3.4	Ke itira o kare ke siame le fa ke sa siame ka nnete.	Potso 2.12
3.5	Ke a itlhompa jalo ga ke dumelele batho go ntirisa dilo tse ke sa dibatleng.	Potso 2.17
3.6	Ke a tshoga fa ke tshwanetse go ema mo matshwititshwiting a batho ebe ke farologano le bona.	Potso 2.18
3.7	Ke ikemeseditse go emelela se ke se dumelang.	Potso 2.21
3.8	Ke kgona go eme kgatlhanong le ditsala tsame fa ke sa dumelane le tsona.	Potso 2.22
3.9	Ditsala tsa me di nagana gore ke moeteledipele.	Potso 2.24
3.10	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
3.11	Ke tswanetse go thabisa ditsala tsame gona le gore ke dire se ke batlang go se dira.	Potso 2.27
3.12	Ke dumela mo go nna ka metlha.	Potso 2.29
3.13	Ee yame ke ee le nyaa yame ke nyaa.	Potso 2.34
3.14	Go thata gore ke ipeela maparego mo se ke batlang go sedira le se ke sa batleng go se dira.	
3.15	Ke ikemeseditse go tswelela pele mo bophelong.	Potso 2.55

4 **Self awareness**: Personal growth through knowledge and understanding of self

4.1	Ke mosha yo a inyatsang.	Potso 2.6
4.2	Ke motho yo a sa itumelang.	Potso 2.49
4.3	Ke motho yo o sa rategeng.	Potso 2.52
4.4	Gantsi ke motho yo a imametseng.	Potso 2.53
4.5	Ke jewa ke bodutu.	Potso 2.54
4.6	Ke ikemeseditse go tswelela pele mo bophelong.	Potso 2.55
4.7	Ke motho yo o senang thuso.	Potso 2.56
4.8	Ke letla batho ba bangwe go dumela se ba batlang go se dumela.	Potso 2.59
4.9	Ga kena mosola.	Potso 2.60
4.10	Ke tshaba dikgwetlo tse dintsha.	Potso 2.62

5 **Coping and stress management skills:** Development of abilities to cope with emotions and managing stress.

5.1	Go tlwaelegile gore batho ba dira diphoso, ka jaalo le nna nka dira diphoso gone ke motho.	Potso 2.2
5.2	Ke mosha yo a inyatsang.	Potso 2.6
5.3	Ke tshwenyega ka bokamoso jwame.	Potso 2.7
5.4	Ke opa ke tlhogo kgotsa mala fa ke tshwenyegile kgotsa ke tenegile.	Potso 2.8
5.5	Fa dilo di sa tsamaye sentle ke ipona molato ka metlha.	Potso 2.9

5.6	Ke nyema mooka fa ke kopana le dikgwetlho tse dintshwa.	Potso 2.10
5.7	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.	Potso 2.11
5.8	Ke itira o kare ke siame le fa ke sa siame ka nnete.	Potso 2.12
5.9	Fa ke tlhakana tlhogo ke tlala pelo ebe ke lwa.	Potso 2.13
5.10	Ke a tswhenyega fa batho ba sa nkutlwisese fa ke bua.	Potso 2.14
5.11	Fa ke utlwile botlhoko kgotsa ke tshwenyegile ke leka go bua le mongwe ka se se ntshwentseng.	Potso 2.15
5.12	Ka dinako tse dingwe batho ba mpona diphoso, empa go siame gonne ga gona ope yo a senang diphoso.	Potso 2.16
5.13	Ke a tshoga fa ke tshwanetse go ema mo matshwititshwiting a batho ebe ke farologano le bona.	Potso 2.18
5.14	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.23
5.15	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
5.16	Ka dinako dingwe batho ga bana tlhompo; Ke kgona go emelelana le seo gonne ke a tlhaloganya.	Potso 2.38
5.17	Go go ntsi, nna ga ke sa kgona go feta fa.	Potso 2.39
5.18	Moya wame o ko tlase ka dinako tse dintsi. Ke iphitlhela ke lela ke hutsafetse.	Potso 2.40
5.19	Ke utlwa botlhoko le ditlhabi tse di tseneletseng fa ditsala tsame di sa nkamogele.	Potso 2.41

6 **Decision making skills:** Development of abilities to make informed and responsible decisions

6.1	Gantsi ke rarabolola mathata ka go naganisisa dilo sentle pele ke tsaya tshwetso.	Potso 2.30
6.2	Gantsi ke dira dilo ka lepotlapotla ke sa nagana.	Potso 2.31
6.3	Ke kgona go itseela ditswhetso ka bonna.	Potso 2.32
6.4	Fa ke sena go tsaya tshwetso e ke dumelang mo go yona gantsi ke a e diragatsa.	Potso 2.33
6.5	Ee yame ke ee le nyaa yame ke nyaa.	Potso 2.34
6.6	Go thata gore ke ipeela maparego mo se ke batlang go sedira le se ke sa batleng go se dira.	Potso 2.35
6.7	Fa ke tshwanetse go tsaya tshwetso, go thata gore ke fetse le monagano wame.	Potso 2.36
6.8	Fa ke dira phoso, ke tsaya maikarabelo ebe ke ithute go tswa mo diphosong tse ke di direleng.	Potso 2.37
6.9	Ke a utlwelela fa batho ba bua le nna.	Potso 2.45
6.10	Go naganela kwa pele go botlhokwa go nna.	Potso 2.64

7 **Problem solving skills:** Development of abilities to solve problems.

7.1	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.	Potso 2.11
7.2	Ke itira o kare ke siame le fa ke sa siame ka nnete.	Potso 2.12
7.3	Fa ke tlhakana tlhogo ke tlala pelo ebe ke lwa.	Potso 2.13
7.4	Ka dinako tse dingwe batho ba mpona diphoso, empa go siame gonne ga gona ope yo a senang diphoso.	Potso 2.16

7.5	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
7.6	Gantsi ke rarabolola mathata ka go naganisisa dilo sentle pele ke tsaya tshwetso.	Potso 2.30
7.7	Gantsi ke dira dilo ka lepotlapotla ke sa nagana.	Potso 2.31
7.8	Ke kgona go itseela ditswhetso ka bonna.	Potso 2.32
7.9	Fa ke sena go tsaya tshwetso e ke dumelang mo go yona gantsi ke a e diragatsa.	Potso 2.33
7.10	Ee yame ke ee le nyaa yame ke nyaa.	Potso 2.34
7.11	Go thata gore ke ipeela maparego mo se ke batlang go sedira le se ke sa batleng go se dira.	Potso 2.35
7.12	Fa ke tshwanetse go tsaya tshwetso, go thata gore ke fetse le monagano wame.	Potso 2.36
7.13	Fa ke dira phoso, ke tsaya maikarabelo ebe ke ithute go tswa mo diphosong tse ke di direleng.	Potso 2.37
7.14	Ke tlhompa dikakanyo tsa batho ba botlhe le fa di sa tshwane le tsame.	Potso 2.44
7.15	Ke a utlwelela fa batho ba bua le nna.	Potso 2.45
7.16	Go siame gore mathata a rarabololwe ka kagiso.	Potso 2.65

8. Conflict management skills: Development of abilities to manage conflict.

8.1	Go tlwaelegile gore batho ba dira diphoso, ka jaalo le nna nka dira diphoso gone ke motho.	Potso 2.2
8.2	Fa mongwe a nkgalefisa ke a didimala. Ga ke emelane leena.	Potso 2.11
8.3	Ke itira o kare ke siame le fa ke sa siama ka nnete.	Potso 2.12
8.4	Fa ke tlhakana tlhogo ke tlala pelo ebe ke lwa.	Potso 2.13

8.5	Fa ke utlwile botlhoko kgotsa ke tshwenyegile ke leka go bua le mongwe ka se se ntshwentseng.	Potso 2.15
8.6	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.23
8.7	Gantsi ke abelana le ditsala tsame maikutlo ame.	Potso 2.26
8.9	Gantsi ke rarabolola mathata ka go naganisisa dilo sentle pele ke tsaya tshwetso.	Potso 2.30
8.10	Gantsi ke dira dilo ka lepotlapotla ke sa nagana.	Potso 2.31
8.11	Go thata gore ke ipeela maparego mo se ke batlang go sedira le se ke sa batleng go se dira.	Potso 2.35
8.12	Fa ke tshwanetse go tsaya tshwetso, go thata gore ke fetse le monagano wame.	Potso 2.36
8.13	Fa ke dira phoso, ke tsaya maikarabelo ebe ke ithute go tswa mo diphosong tse ke di direleng.	Potso 2.37
8.14	Ka dinako dingwe batho ga bana tlhompo; Ke kgona go emelelana le seo gonne ke a tlhaloganya.	Potso 2.38
8.15	Ke tlhompa dikakanyo tsa batho ba botlhe le fa di sa tshwane le tsame.	Potso 2.44
8.16	Ke a utlwelela fa batho ba bua le nna.	Potso 2.45
8.17	Go siame gore mathata a rarabololwe ka kagiso.	Potso 2.65

9. Critical thinking and creative thinking skills: Development of capacities to think critically and creatively.

9.1	Ke itumelela go bolelela batho gore ke naganang ka bona.	Potso 2.23
9.2	Gantsi ke rarabolola mathata ka go naganisisa dilo sentle pele ke tsaya tshwetso.	Potso 2.30
9.3	Gantsi ke dira dilo ka lepotlapotla ke sa nagana.	Potso 2.31

9.4	Fa ke tshwanetse go tsaya tshwetso, go thata gore ke fetse le monagano wame.	Potso 2.36
9.5	Ga nke ke ke atlega mo sengwe le sengwe. Ke nagana gore ke a palelwa mo botshelong.	Potso 2.48
9.6	Go thata gore ke gopole dilo tse di fitileng.	Potso 2.51
9.7	Ke itumelela go tla ka dikakanyo tse dintsha.	Potso 2.61
9.8	Ke tshaba dikgwetlo tse dintsha.	Potso 2.62
9.9	Fa ke fiwa kakanyo ke a e dira.	Potso 2.63

10. Maintaining a healthy life style: Development and maintenance of a healthy life style.

10.1	Fa ke sa tlhola sentle kgotsa ke entse le letsatsi le le sa ntumedisang ebile dilo tsame di sa tsamaya sentle, ke iphodisa ka go ikotlolola mmele.	Potso 2.66
10.2	Ke robala sentle.	Potso 2.67
10.3	Go siame gore batsha ba gane thobalane.	Potso 2.68
10.4	Ke a itlhokomela gonne ke batla go tshela sebaka.	Potso 2.69
10.5	Go tsuba ga gowa siamela mmele.	Potso 2.70
10.6	Go tshega go siameletse pelo	Potso 2.71
10.7	Ga ke je dijo tse dinang le dikotla ka nako tsotlhe.	Potso 2.72
10.8	Thobalano e e bolokesegileng kefa batho ka dinako tsotlhe ba dirasa condomo pele ga thobalano.	Potso 2.73
10.9	Go nwa bojwala ke selo se se itumediseng.	Potso 2.74
10.10	Nkaya go dira diteko tsa HIV fanka tlhakalana dikobo le mongwe ke sa itshereletsa.	Potso 2.75

Appendix 5: SEMI STRUCTURED INTERVIEW WITH A SCHEDULE

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Researcher: MAUREEN MOTEPE

Address: P. O. BOX 5620
MMABATHO
5435

Tel : 018 3892350

Dear participant

My name is Maureen Motepe. I am a student at the University of Pretoria, busy with a study on a life skills programme for early adolescent AIDS orphans. As part of the study I need to conduct interviews with major role players and that includes you. My objective with this interview includes identifying socio-economic needs, problems of and life skills needed by early adolescent AIDS orphans. During the interview the researcher will make use of a schedule, as a guideline to ensure systematic data.

You are therefore kindly invited to be a participant in this study. The interview will take approximately 30 minutes of your time. You are also kindly requested to read and sign the informed consent provided to you.

Thank you for your cooperation.

RESEARCH TOPIC: A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Respondents: Social Workers

Demographic information

1. Age
   - 20 – 30 years ☐
   - 31 – 40 years ☐
   - 41 – 50 years ☐
   - 51 – 60 years ☐
2. Gender
   - Female ☐
   - Male ☐
3. Qualifications
   - Graduate Degree ☐
   - Post-graduate ☐
   - Other ☐
4. Position at work ☐
5. Years of social work experience
   - 2 – 5 years ☐
   - 6 – 10 years ☐
   - 10 – 30 years ☐
6. Experience with AIDS orphans
   - 1 – 5 years ☐
   - 6 – 10 years ☐
   - 10- 15 years ☐
7. Geographical Area ☐

INTERVIEW SCHEDULE (Social Workers)

The respondents will focus on the following themes as part of the semi structured interview.

SOCIAL NEEDS AND PROBLEMS

What problems do AIDS orphans experience regarding:

- Relationships
- Upbringing
- Education
- Health-care
- Subsistence
- Security

What are the social needs of AIDS orphans?

EMOTIONAL NEEDS AND PROBLEMS

What problems do AIDS orphans experience regarding:

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

What are the emotional needs of AIDS orphans?

LIFE SKILLS

Which life skills do AIDS orphans need to enhance their personal well-being regarding socio-emotional needs?

RESEARCH TOPIC: A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS ☐

Respondents: AIDS Orphans

Demographic information

1. Age	11 – 12 years	☐
	13 – 14 years	☐
2. Gender	Female	☐
	Male	☐
3. Highest educational standard passed	Grade 3 – 4	☐
	Grade 5 –6	☐
4. Residential area	Urban	☐
	Rural	☐
5. Language spoken		☐
6. Parent(s)	Mother	☐
	Father	☐
	None	☐
7. Who is your guardian?	Mother/father	☐
	Relative	☐
	Other	☐
8. How long have you been an orphan?	1 – 3 years	☐
	4 – 5 years	☐

INTERVIEW SCHEDULE (AIDS orphans)

The respondents will focus on the following themes as part of the semi structured interview.

SOCIAL NEEDS AND PROBLEMS

What problems do you experience regarding:

- Relationships
- Upbringing
- Education
- Health-care
- Subsistence
- Housing

What are your social needs?

EMOTIONAL NEEDS AND PROBLEMS

What problems do you experience regarding:

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

What are your emotional needs?

LIFE SKILLS

Which life skills do you need to enhance your personal well-being regarding socio-emotional needs?

RESEARCH TOPIC: A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Respondents: Caregivers

Demographic information

1.	Age	20 – 45 years	☐
		46 – 60 years	☐
		61 –75 years	☐
		Other	☐
2.	Gender	Female	☐
		Male	☐
3.	Marital Status	Married	☐
		Widow	☐
		Divorced	☐
4.	Language spoken		☐
5.	Years of care giving	1 – 5 years	☐
		6 – 10 years	☐
6.	Own children under your care		☐
7.	AIDS orphans under your care		☐
8.	Do you receive assistance?	Yes	☐
		No	☐
9.	If yes, from whom?	Government	☐

Community ☐

Relatives ☐

Other ☐

10. Type of assistance

Financial Support ☐

Human Support ☐

Material Support ☐

11. Geographical Area ☐

☐

INTERVIEW SCHEDULE (Caregivers)

The respondents will focus on the following themes as part of the semi structured interview.

SOCIAL NEEDS AND PROBLEMS

What problems do AIDS orphans experience regarding:

- Relationship
- Upbringing
- Education
- Health-care
- Housing
- Security

What are the social needs of AIDS orphans?

EMOTIONAL NEEDS AND PROBLEMS

What problems do AIDS orphans experience regarding:

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

What are the emotional needs of AIDS orphans?

LIFE SKILLS

Which life skills do AIDS orphans need to enhance their personal well-being regarding socio-emotional needs?

Appendix 6: A SELF-CONSTRUCTED GROUP QUESTIONNAIRE

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

Researcher: MAUREEN MOTEPE

Address: P. O. BOX 5620
MMABATHO
5435

Tel : 018 3892350

Dear participant

My name is Maureen Motepe. I am a student at the University of Pretoria, busy with a study on a life skills programme for early adolescent AIDS orphans. As part of the study I need your assistance in filling this questionnaire. My objective with this questionnaire includes testing the effectiveness of the newly developed AIDS orphans life skills programme. You are expected to fill the questionnaire before and/or after participation in the programme.

You are therefore kindly invited to be a participant in this study. The questionnaire will take approximately 45 minutes of your time. You are also kindly requested to read and sign the informed consent provided to you.

Thank you for your cooperation.

ENGLISH

Research Title: A Life skills programme for early adolescent Aids orphans

Research Questionnaire

Respondent No | | |

1. Demographic information

Please answer this part of the questionnaire by marking all the answers that apply to you with a cross (X) in the provided box.

1.1 Age

1	11 years old	
2	12 years old	
3	13 years old	
4	14 years old	

1.2 Gender

1	Male	
2	Female	

1.3 Race

1	Black	
2	Coloured	
3	Indian	
4	White	

1.4 Home language

1	Tswana	
2	Sepedi	
3	Sesotho	
4	Zulu	
5	Xhosa	
6	Tsonga	
7	Other (Specify…….)	

1.5 Level of education

1	Grade 4	
2	Grade 5	
3	Grade 6	
4	Other (Specify……)	

1.6 Are both your parents still living?
If no, who has passed away?

1	Yes	
2	No	

1.7 If no, who is still alive?

1	Mother	
2	Father	

1.8 Who do you live with? (Only head of the house)

1	Mother	
2	Father	
3	Maternal Grandparent(s)	
4	Paternal Grandparent(s)	
5	Brother/Sister	
6	Relatives	
7	Friends/Neighbors	
8	Living alone	
9	At an institution	
10	Other (Specify……)	

1.9 If living alone, how many siblings are under your care?

1	1-2	
2	3-4	
4	Other (Specify……)	

2. Life skills

Answer the following part of the questionnaire by carefully reading the next statements and making a mark in the box which best describes your answer.

No	Statement	Agree	Disagree	Uncertain
2.1	I am OK being myself.			
2.2	Everybody makes mistakes; that's normal, so I am normal.			
2.3	I feel embarrassed when others look at me because I worry about my body image.			
2.4	I usually believe people when they compliment me.			
2.5	I need other people's respect to feel good about myself.			
2.6	I am an insecure teenager.			
2.7	I worry about my future a lot.			
2.8	I get headaches and stomach pains when I am worried or upset.			
2.9	When things go wrong I usually blame myself.			
2.10	I am easily discouraged by new challenges.			
2.11	When someone makes me angry I keep quiet. I don't confront the problem.			
2.12	I usually pretend to be okay even when I am not.			
2.13	When frustration builds up I lose my temper and I fight.			

No	Statement	Agree	Disagree	Uncertain
2.14	I feel upset when people do not understand what I say.			
2.15	When I am sad or worried I try to talk to someone about it.			
2.16	People sometimes criticize me, but that's OK because nobody is perfect.			
2.17	I respect myself and I do not allow people to try to push me around.			
2.18	It is scary to stand up in a crowd and be different.			
2.19	Sometimes I keep quiet in conversation because I am afraid of how others will react.			
2.20	I am scared of being on my own.			
2.21	I am willing to defend that, which I believe in.			
2.22	If I differ with my peers I am able to go against them.			
2.23	I enjoy telling people what I think of them.			
2.24	My friends think I am a leader.			
2.25	I often feel loved and accepted by my friends.			
2.26	I often share with my friends about how I feel.			
2.27	I ought to please my friends rather than do what I want.			

No	Statement	Agree	Disagree	Uncertain
2.28	I enjoy socialising with others.			
2.29	I always believe in myself.			
2.30	I usually solve problems by carefully thinking things through before making any decision.			
2.31	I usually do things at a spur of the moment.			
2.32	I can make my own decisions about what to do.			
2.33	Once I have made a decision I believe in, I usually stick to it.			
2.34	My yes is always yes and my no is always no.			
2.35	I find it difficult to set limits on what I will and will not do.			
2.36	When I have to make a decision I find it difficult to make up my mind.			
2.37	When I make a mistake, I take responsibility and learn from what went wrong.			
2.38	Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.			
2.39	It's all too much I just can't cope anymore.			
2.40	I am depressed much of the time and find myself crying and moping around.			

No	Statement	Agree	Disagree	Uncertain
2.41	I become hurt and experience extreme pain when I feel unappreciated by my friends.			
2.42	Making and keeping relationship with people is very important to me.			
2.43	I work well with other people.			
2.44	I respect other people's views even if they are different from mine.			
2.45	I listen carefully to what other people have to say.			
2.46	When I talk to others, I look into their eyes to show my interest and full attention.			
2.47	I try to understand and react to other people's feelings in a caring and responsible way.			
2.48	I never succeed in anything and I think I am a failure in life.			
2.49	I am a very unhappy person.			
2.50	Other people are better than me.			
2.51	I find it difficult in remembering things.			
2.52	I am unlovable.			
2.53	I am usually a calm person.			
2.54	I am lonely.			
2. 55	I am motivated to succeed in life.			
2.56	I am a helpless person.			

No	Statement	Agree	Disagree	Uncertain
2.57	I usually observe people's facial expression when I'm talking to them.			
2.58	Actions speak louder than words.			
2.59	I am tolerant of others beliefs.			
2.60	I feel no good at anytime .			
2.61	I enjoy generating new ideas.			
2.62	I am fearful of new challenges.			
2.63	When I get an idea I run with it.			
2.64	Planning is very important to me.			
2.65	It is good for problems to be solved peacefully.			
2.66	When I've had a bad day or things are going wrong I relieve tension by doing some exercise.			
2.67	I sleep properly.			
2.68	It is good for young people to say no to sex.			
2.69	I look after myself so that I live longer.			
2.70	Smoking is not healthy for the body.			
2.71	Laughing is good for the soul.			
2.72	I do not always eat healthy food.			
2.73	Safe sex means always using a condom when having sex.			

No	Statement	Agree	Disagree	Uncertain
2.74	Drinking alcohol is an exciting thing to do.			
2.75	I would go for an HIV test if I had had an unsafe sex.			

Categorizitaion of statements, from Section 2 of the Self Constructed Research Questionnaire, according to the topics of Life skills development

1. A good sense of identity and self esteem: Improvement of self-concept

1.1	I am OK being myself.	Question 2.1
1.2	Everybody makes mistakes; that's normal, so I am normal.	Question 2.2
1.3	I feel embarrassed when others look at me because I worry about my body image.	Question 2.3
1.4	I usually believe people when they compliment me.	Question 2.4
1.5	I need other people's respect to feel good about myself.	Question 2.5
1.6	I am an insecure teenager.	Question 2.6
1.7	When things go wrong I usually blame myself.	Question 2.9
1.8	I usually pretend to be okay even when I am not.	Question 2.12
1.9	People sometimes criticize me, but that's OK because nobody is perfect.	Question 2.16
1.10	It is scary to stand up in a crowd and be different.	Question 2.18
1.11	Sometimes I keep quiet in conversation because I am afraid of how others will react.	Question 2.19

1.12	I am scared of being on my own.	Question 2.20
1.13	I am willing to defend that, which I believe in.	Question 2.21
1.14	If I differ with my peers I am able to go against them.	Question 2.22
1.15	I enjoy telling people what I think.	Question 2.23
1.16	My friends think I am a leader.	Question 2.24
1.17	I often feel loved and accepted by my friends.	Question 2.25
1.18	I often share with my friends about how I feel.	Question 2.26
1.19	I ought to please my friends rather than do what I want.	Question 2.27
1.20	I always believe in myself.	Question 2.29
1.21	My yes is always yes and my no is always no.	Question 2.34
1.22	Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.	Question 2.38
1.23	I never succeed in anything and I think I am a failure in life.	Question 2.48
1.24	Other people are better than me.	Question 2.50
1.25	I am unlovable.	Question 2.52
1.26	I am motivated to succeed in life.	Question 2.55
1.27	I am a helpless person.	Question 2.56

2. Communication skills: Development of healthy relationships.

2.1	When someone makes me angry I keep quiet. I don't confront the problem.	Question 2.11

2.2	I usually pretend to be okay even when I am not.	Question 2.12
2.3	I feel upset when people do not understand what I say.	Question 2.14
2.4	When I am sad or worried I try to talk to someone about it.	Question 2.15
2.5	Sometimes I keep quiet in conversation because I am afraid of how others will react.	Question 2.19
2.6	I am willing to defend that, which I believe in.	Question 2.21
2.7	I enjoy telling people what I think of them.	Question 2.23
2.8	I often share with my friends about how I feel.	Question 2.26
2.9	I enjoy socialising with others.	Question 2.28
2.10	My yes is always yes and my no is always no.	Question 2.34
2.11	Making and keeping relationship with people is very important to me.	Question 2.42
2.12	I work well with other people.	Question 2.43
2.13	I respect other people's views even if they are different from mine.	Question 2.44
2.14	I listen carefully to what other people have to say.	Question 2.45
2.15	When I talk to others, I look into their eyes to show my interest and full attention.	Question 2.46
2.16	I try to understand and react to other people's feelings in a caring and responsible way.	Question 2. 47
2.17	I usually observe people's facial expression when I'm talking with them.	Question 2.57
2.18	Actions speak louder than words.	Question 2.58

3. **Assertiveness training skills**: Development of abilities to make right choices in the face of peer pressure.

3.1	I feel embarrassed when others look at me because I worry about my body image.	Question 2.3
3.2	I need other people's respect to feel good about myself.	Question 2.5
3.3	When someone makes me angry I keep quiet. I don't confront the problem.	Question 2.11
3.4	I usually pretend to be okay even when I am not.	Question 2.12
3.5	I respect myself and I do not allow people to try to push me around.	Question 2.17
3.6	It is scary to stand up in a crowd and be different.	Question 2.18
3.7	I am willing to defend that, which I believe in.	Question 2.21
3.8	If I differ with my peers I am able to go against them.	Question 2.22
3.9	My friends think I am a leader.	Question 2.24
3.10	I often share with my friends about how I feel.	Question 2.26
3.11	I ought to please my friends rather than do what I want.	Question 2.27
3.12	I always believe in myself.	Question 2.29
3.13	My yes is always yes and my no is always no.	Question 2.34
3.14	I find it difficult to set limits on what I will and will not do.	Question 2.35
3.15	I am motivated to succeed in life.	Question 2.55

4. **Self awareness**: Personal growth through knowledge and understanding of self

4.1	I am an insecure teenager.	Question 2. 6
4.2	I am a very unhappy person.	Question 2.49
4.3	I am unlovable.	Question 2.52
4.4	I am usually a calm person.	Question 2.53
4.5	I am lonely.	Question 2.54
4.6	I am motivated to succeed in life.	Question 2.55
4.7	I am a helpless person.	Question 2.56
4.8	I am tolerant of others beliefs.	Question 2.59
4.9	I feel no good at anytime .	Question 2.60
4.10	I am fearful of new challenges.	Question 2.62

5. **Coping and stress management skills:** Development of abilities to cope with emotions and managing stress.

5.1	Everybody makes mistakes; that's normal, so I am normal.	Question 2.2
5.2	I am an insecure teenager.	Question 2.6
5.3	I worry about my future a lot.	Question 2.7
5.4	I get headaches and stomach pains when I am worried or upset.	Question 2.8
5.5	When things go wrong I usually blame myself.	Question 2.9
5.6	I am easily discouraged by new challenges.	Question 2.10

5.7	When someone makes me angry I keep quiet. I don't confront the problem.	Question 2.11
5.8	I usually pretend to be okay even when I am not.	Question 2.12
5.9	When frustration builds up I lose my temper and I fight.	Question 2.13
5.10	I feel upset when people do not understand what I say.	Question 2.14
5.11	When I am sad or worried I try to talk to someone about it.	Question 2.15
5.12	People sometimes criticize me, but that's OK because nobody is perfect.	Question 2.16
5.13	It is scary to stand up in a crowd and be different.	Question 2.18
5.14	I enjoy telling people what I think of them.	Question 2.23
5.15	I often share with my friends about how I feel.	Question 2.26
5.16	Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.	Question 2.38
5.17	It's all too much I just can't cope anymore.	Question 2.39
5.18	I am depressed much of the time and find myself crying and moping around.	Question 2.40
5.19	I become hurt and experience extreme pain when I feel unappreciated by my friends.	Question 2.41

6. **Decision making skills:** Development of abilities to make informed and responsible decisions

6.1	I usually solve problems by carefully thinking things through before making any decision.	Question 2.30
6.2	I usually do things at a spur of the moment.	Question 2.31

6.3	I can make my own decisions about what to do.	Question 2.32
6.4	Once I have made a decision I believe in, I usually stick to it.	Question 2.33
6.5	My yes is always yes and my no is always no.	Question 2.34
6.6	I find it difficult to set limits on what I will and will not do.	Question 2.35
6.7	When I have to make a decision I find it difficult to make up my mind.	Question 2.36
6.8	When I make a mistake, I take responsibility and learn from what went wrong.	Question 2.37
6.9	I listen carefully to what other people have to say.	Question 2.45
6.10	Planning is very important to me.	Question 2.64

7. Problem solving skills: Development of abilities to solve problems.

7.1	When someone makes me angry I keep quiet. I don't confront the problem.	Question 2.11
7.2	I usually pretend to be okay even when I am not.	Question 2.12
7.3	When frustration builds up I lose my temper and I fight.	Question 2.13
7.4	People sometimes criticize me, but that's OK because nobody is perfect.	Question 2.16
7.5	I often share with my friends about how I feel.	Question 2.26
7.6	I usually solve problems by carefully thinking things through before making any decision.	Question 2.30
7.7	I usually do things at a spur of the moment.	Question 2.31
7.8	I can make my own decisions about what to do.	Question 2.32

7.9	Once I have made a decision I believe in, I usually stick to it.	Question 2.33
7.10	My yes is always yes and my no is always no	Question 2.34
7.11	I find it difficult to set limits on what I will and will not do.	Question 2.35
7.12	When I have to make a decision I find it difficult to make up my mind.	Question 2.36
7.13	When I make a mistake, I take responsibility and learn from what went wrong.	Question 2.37
7.14	I respect other people's views even if they are different from mine.	Question 2.44
7.15	I listen carefully to what other people have to say.	Question 2.45
7.16	It is good for problems to be solved peacefully.	Question 2.65

8. Conflict management skills: Development of abilities to manage conflict.

8.1	Everybody makes mistakes; that's normal, so I am normal.	Question 2.2
8.2	When someone makes me angry I keep quiet. I don't confront the problem.	Question 2.11
8.3	I usually pretend to be okay even when I am not.	Question 2.12
8.4	When frustration builds up I lose my temper and I fight.	Question 2.13
8.5	When I am sad or worried I try to talk to someone about it.	Question 2.15
8.6	I enjoy telling people what I think of them.	Question 2.23
8.7	I often share with my friends about how I feel.	Question 2.26

8.9	I usually solve problems by carefully thinking things through before making any decision.	Question 2.30
8.10	I usually do things at a spur of the moment.	Question 2.31
8.11	I find it difficult to set limits on what I will and will not do.	Question 2.35
8.12	When I have to make a decision I find it difficult to make up my mind.	Question 2.36
8.13	When I make a mistake, I take responsibility and learn from what went wrong.	Question 2.37
8.14	Sometimes people are disrespectful towards me, I can cope with that because I know that I am OK.	Question 2.38
8.15	I respect other people's views even if they are different from mine.	Question 2.44
8.16	I listen carefully to what other people have to say.	Question 2.45
8.17	It is good for problems to be solved peacefully.	Question 2.65

9. **Critical thinking and creative thinking skills**: Development of capacities to think critically and creatively.

9.1	I enjoy telling people what I think of them.	Question 2.23
9.2	I usually solve problems by carefully thinking things through before making any decision.	Question 2.30
9.3	I usually do things at a spur of the moment.	Question 2.31
9.4	When I have to make a decision I find it difficult to make up my mind.	Question 2.36
9.5	I never succeed in anything and I think I am a failure in life.	Question 2.48
9.6	I find it difficult in remembering things.	Question 2.51

9.7	I enjoy generating new ideas.	Question 2.61
9.8	I am fearful of new challenges.	Question 2.62
9.9	When I get an idea I run with it.	Question 2.63

10. **Maintaining a healthy life style**: Development and maintenance of a healthy life style.

10.1	When I've had a bad day or things are going wrong I relieve tension by doing some exercise.	Question 2.66
10.2	I sleep properly.	Question 2.67
10.3	It is good for young people to say no to sex.	Question 2.68
10.4	I look after myself so that I live longer.	Question 2.69
10.5	Smoking is not healthy for the body.	Question 2.70
10.6	Laughing is good for the soul.	Question 2.71
10.7	I do not always eat healthy food.	Question 2.72
10.8	Safe sex means always using a condom when having sex.	Question 2.73
10.9	Drinking alcohol is an exciting thing to do.	Question 2.74
10.10	I would go for an HIV test if I had had an unsafe sex.	Question 2.75

Appendix 7: Informed Consent Letter

Principal Investigator: Maureen Motepe
Department of Social Work
University of Pretoria

Informed Consent

1. Title of Study: A life skills programme for early adolescent AIDS orphans.

2. Purpose of the study: The broad aim of this study is to develop and empirically test a life-skills programme for early adolescent AIDS orphans.

3. I will be interviewed about socio-emotional needs and problems I'm experiencing. I will also be asked to be part of a group where we will be taught and informed about life skills needed by early adolescent AIDS orphans. Thereafter, I will be asked to complete a group administered questionnaire related to what I gained from the group and the changes I have experienced since participating in the project.

4. Risks and Discomforts: The risk and discomfort associated with this project is that I may experience feelings of pain, hurt, anger, frustration, uncertainty etc. as I relate my needs and problems during the interview. A social worker will be present during the interview to support and offer me the necessary help me when I'm overwhelmed by such feelings.

5. Benefits: The main benefit of participating in this study is that I will learn more about life skills needed by early adolescent AIDS orphans and thereby enhancing my personal-well being. Furthermore, the study will surely help researchers gain a better understanding of needs and problems experienced by early adolescent AIDS orphans.

6. Participant's Rights: I may withdraw from participating in the study at any time.

7. Financial Compensation: I don't expect to get any financial reward from the researcher. I understand and accept that the researcher will have contact with me at my school or residential welfare agency.

8. Confidentiality: I have been assured that everything I say will be kept strictly confidential except in cases where the researcher shares information with the authorized supervisor. Furthermore, I have been assured that my responses will be anonymous since I will not be requested to mention my name. Anonymity is assured by the use of a number system for comparison of the pretest and posttest results.

9. If I have any question or concerns, I can call 012- 4202394 at the University of Pretoria during office hours.

I understand my rights as a research subject and I voluntary consent to participation in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

---------- ----------

Subject's signature Date

Signature of the Investigator

Appendix 8: AIDS Orphans Life Skills Programme

A LIFE SKILLS PROGRAMME FOR EARLY ADOLESCENT AIDS ORPHANS

The following life skills development programme is named:

AIDS orphans life skills programme

AIDS orphans life skills programme is a comprehensive educational programme, which promotes abilities for adaptive and positive behaviour that enable early adolescent AIDS orphans to deal effectively with the demands and challenges of everyday life. It includes all those skills that enable people to maximise their choices, to enhance their personal well-being and to improve their quality of life. Life skills enable the individuals to translate knowledge, attitudes and values into actual abilities i.e. "what to do and how to do it." 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.

AIDS orphans life skills programme creates opportunities for participants to practice life skills so they can make healthy and informed choices. AIDS orphans life skills programme help young people to acquire necessary tools to take charge and effectively manage their lives. According to Hoelson and Van Schalkwyk (2001: 246) the local need for life skills programmes is associated with the gradual erosion of traditional systems of societies and the families. To equip the youth to adequately cope with challenges of modern societies life skills programmes can make a significant contribution.

The programme deals with key topics that early adolescent AIDS orphans need to know about for example:

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

In the AIDS orphans life skills programme, early adolescent AIDS orphans are actively involved in a dynamic teaching and learning process. The methods used to facilitate this active involvement include working in small groups, brainstorming, and role-play. These methods to teach life skills are based on experiential learning (learning through active participation) rather than didactic teaching. The teaching of skills is both theoretical and practical. It is intended to equip the learner with new or improved abilities. It is based on the principle that people learn best when they are actively involved in their lessons. AIDS orphans life skills programme therefore employs activities at the end of every session. The aim is that the participants will immediately identify with the activities employed and recognise their own life experiences reflected in the activities. These activities encourage the participants to learn new knowledge and develop a range of skills at the same time. Some of the activities require participants to remember the right information, while others encourage them to think for themselves or write about their feelings.

The programme does not aim at telling people how to live their lives, but it focuses on giving early adolescent AIDS orphans accurate information and opportunities to develop

skills and positive values. This will help them to make responsible and healthy choices for their lives.

The programme is primarily designed for social workers involved in the field of HIV/AIDS. Social workers are called to work with individuals, families, groups, organizations and communities to address concerns that limit their social functioning. The focus of social work is on the improvement of the social functioning of people in interaction with their environment. The social worker sees these people as having potential and believes in their ability to grow and develop (Zastrow, 2000: 48).

THE CONTENT OF AIDS ORPHANS LIFE SKILLS PROGRAMME

AIDS Orphans Life Skills Programme for early adolescents AIDS orphans consists of ten sessions. The content of this programme is thus set out in terms of the next consecutive sessions.

SESSION 1

A SENSE OF IDENTIY AND SELF-ESTEEM

Goal

-Improvement of self-concept and self-esteem-

Session one: A good sense of identity and self-esteem

OUTCOMES

After completing this session you should:

- Demonstrate understanding of the concept self-concept, self-esteem and self-identity.

1.1 Introduction

The development of self-esteem is viewed as critical for AIDS orphans. According to UNAIDS (2004: 4) and Robbins (2004: 1) without the protective environment of their homes, orphaned children face increased risk of violence, exploitation and abuse. They may be ill-treated by their guardians, and dispossessed of their inheritance and property. Such extensive environmental change can deprive children of the feelings of security and comfort they derive from familiar routines and settings. Doka (1994: 36) notes that these children, given their environment, may experience developmental or behavioural problems such as poor self-esteem. They may find it difficult to trust or to bond with adults. The development of self-esteem will help early adolescent AIDS orphans to see themselves differently i.e. to view themselves as special and unique. When people value themselves highly, they will have necessary confidence to accomplish goals. AIDS orphans will maintain high levels of self-esteem as they nurture positive attitude in respect to themselves.

Aspects to be covered in this session include the development of:

- Self-concept;
- Self-esteem and
- Identity.

Table 1 provides the planned course for session 1

Table2: Developing a sense of identity and self-esteem

Time	Topics and Activities
5 minutes	Introduction
10 minutes	Description of self-concept, self-esteem and a sense of identity
5 minutes	Advantages of a high self-esteem
5 minutes	Disadvantages of a poor-self-esteem
20minutes	Strategies of building self-esteem and confidence
15 minutes	Activity: "The uniqueness of me"

1.2 Description of self-concept, self-esteem and a sense of identity

- Definitions and general overview of the concepts: self-concept, self-esteem and a sense of identity.

1.3 Advantages of having a high self-esteem

- Greater capacity to be creative.
- Assume active roles in social groups.
- Less likely to be burdened by self-doubt, fear and ambivalence.
- More likely to move more directly and realistically towards personal goals.
- Find it easier to accept differences between their own levels of competence and that of others is areas such as peer relationships and physical pursuits.

1.4 Disadvantages of poor self-esteem

- People feel helpless and inferior.
- Incapable of improving their situation.
- Strive for social approval by behaving in ways which are over-compliant.
- Pretending to be self-confident when they are not
- Struggling to feel good about themselves
- Fear of not being good enough
- Easily discouraged in whatever they do.

1.5 Strategies of building self-esteem and confidence

- Establish a caring personal relationship, and create an environment of acceptance.
- Use every opportunity to accentuate the positive.
- Provide numerous opportunities for success.
- Reward any attempt of positive achievement with generous approval.
- Encourage them to change negative self-thinking attitudes such as 'I can't' or 'I'm not capable' to 'I can' and 'I am capable'.
- Use modelling, role-play and assertiveness training to reinforce feelings of confidence in their ability to achieve.
- Teach problem-solving skills.
- Avoid criticism. People with poor self-esteem are especially vulnerable to criticism.

1.6 Session's Activity

Activity : "The uniqueness of me"

Having a positive self-image is important for building confidence. The activity is based on a good sense of identity and self esteem. The theme of the activity is the "uniqueness of me"

- The facilitator will ask the children to write their names on a large sheet, and to say what it means and how they feel about themselves and their names.
- In pairs, the children discuss their characteristics e.g. physical characteristics, skills, achievements, and also things they would like to be able to do.
- The group is then asked to mention how does the image make them feel about themselves.
- Finally the children are asked whether they enjoyed the activity, and what they have learnt about themselves. They are asked to finish the statement: "Something I discovered about myself which makes me feel good is….."
- The children are then told the importance of having a good sense of identity, self-concept and self-esteem.

SESSION 2

COMMUNICATION SKILLS

Goal

-The capacity to develop healthy relationships through acquiring communication skills-

Session two: Communication skills

OUTCOMES

After completing this session participants should be able to:

- Give an overview of communication as a process.
- Illustrate effective ways of communicating with others.
- Utilise different communication skills.

2.1 Introduction

Every system depends upon communication for its survival. Communication is the basis for all human interaction. Effective communication is essential for good relationships. Although it is impossible not to communicate, since all behavior is communication, basic communication skills are often not so easily acquired. Young people who have poor communication skills are unlikely to have the ability to stand up for themselves and to assert their rights. In situations involving peers or adults, this lack of communication skills can result in feelings of helplessness and powerlessness (Cleary, 2004: 7; Geldard & Geldard, 2002: 228; Johnson & Johnson, 2003: 137; Potgieter, 2004: 228).

This session is based on the assumption that learning to communicate effectively helps early adolescents AIDS orphans to build positive relationships with others and it also boosts their self-esteem. According to Hoelson and Van Schalkwyk (2001: 260) people are not born with the ability to communicate effectively. The nature of their early childhood and current environment has a major influence on their ability to express feelings thoughts and other aspects of themselves. Avert (2004: 7), UNAIDS (2004: 3) as well as Van Dyk (2001: 334-335) note that the parent's death deprives an AIDS orphan the learning and values they need to become socially knowledgeable and productive adults. Many suffer social isolation. They must grapple with the stigma and discrimination so often associated with AIDS, causing a low level of communication proficiency and lack of confidence in expressing themselves. Self-confidence and communication are interdependent to such an extent that difficulties or problems in the one area will affect the other (Hoelson & Van Schalkwyk, 2001: 253). It is therefore of

paramount importance that AIDS orphans be equipped with a wider range and depth of communication skills if they are to live effectively and creatively.

Aspects to be covered in this session include:

- Communication as a process;
- Verbal and non verbal communication;
- Levels of communication;
- Guidelines that can be helpful in communicating
- Basic sending and receiving skills.

Table 2 provides the planned course for session 2

Table2: Developing communication skills

Time	Topics & Activities
5 minutes	Introduction
10 minutes	Communication as a process
10 minutes	Verbal and Non-verbal communication
10 minutes	Guidelines that are helpful in communication
10 minutes	Basic sending and receiving skills
15 minutes	Activity: Building good relationships

2.2 Communication as a process

- Basic process of communication

2.3 Verbal and non-verbal communication

Communication is characterized by a complex combination of verbal signals and nonverbal signals. **Verbal communication** is communication-using words whereas **non-verbal communication** is communication without words.

Non-verbal communication

Non-verbal communication is an important part of all messages, involving all senses, and is also the foundation on which human relationships are built. Focus is on the following non-verbal cues:

- The tone of one's voice.
- The speed at which one speaks.
- The pauses, shouting, whispering and other vocal expressions.
- Facial expressions.
- Hand gestures
- Foot movements
- Body position.

2.4 Guidelines that can be helpful in communication

- Avoid distractions.
- Begin sentences with positives instead of negatives.
- Convey your communications calmly, clearly, concretely and completely. Be brief and to the point. Long-winded or verbose communications only confuse people.
- Demonstrate good communication.
- Establish eye contact.
- Provide feedback.
- Keep language simple.
- Stick with what you say.

2.5 Basic sending and receiving skills

There are basic sending and receiving skills that people need to master to communicate effectively.

Sending skills

- Taking clear ownership for one's message.
- Making messages complete and specific.
- Ensuring that one's verbal and nonverbal messages are congruent.

- Building in redundancy.
- Obtaining feedback on how the message was received.
- Adapting the message to the receivers' frame of reference.
- Describing one's feelings and describing others' behavior with evaluation.

Receiving skills

- Paraphrasing accurately.
- Evaluating the content to the message and the senders' feelings.
- Describing one's perception of the sender's feelings.
- Negotiating meaning of the message until receiver and sender agree.

2.6 Session activity

- **Activity: Building good relationships**

Strong relationships involve good communication skills. The focus of the activity is building good relationship through communication skills.

- As an introduction, the group engage in an activity in which one group member whispers a message to another, and this is then whispered from person to person until it has gone around the whole class. At the end, the group compare the final message to the original, to see if it has changed.
- The group is then asked to define communication, and under what conditions effective communication is said to have taken place.
- The facilitator then tells the group that communication can be verbal and non verbal.
- Three members are given cards with the words "anger", "nervous" and "happy". Each member uses non-verbal behaviour to communicate the emotion on the card. The rest of the group takes turns to guess the emotion that is being expressed.
- The group is then asked to give example s of misunderstanding in communication that they have experienced, and to think about how it might have been avoided.

SESSION 3

ASSERTIVENESS SKILLS

Goal

-The capacity to develop healthy relationships through acquiring assertiveness skills-

Session three: Assertiveness skills

OUTCOMES

After completing this session participants should be able to:

- Differentiate between assertive, non-assertive and aggressive behaviour.
- Illustrate ways of interacting with others: non-assertion, aggression, and assertion.
- Stand up for their rights**.**

3.1 Introduction

Steinberg (2003: 90) notes that sometimes problems are created in relationships with friends, family or work colleagues because people lack the communication skills needed to express emotions, needs, and opinions assertively. People may choose to bury them or unleash them uncontrollably. Assertiveness skills are utilized to assist individuals who are unduly hesitant about expressing their wants or feelings, or in standing up for their personal rights. Verderber (1990) in Steinberg (2003:90) defines assertiveness as "verbalizing your position on an issue for purposes of achieving a specific goal." The specific goal is for the person to express himself in such a way that he hurt neither himself nor others. Assertiveness training aims at teaching clients to stand up for their rights (Anderson & Okoro, 2000: 24; Zastrow, 2000: 477).

According to UNICEF (1998: iii) in Africa, orphaned children have relatively few legal or customary rights to property or to decision making about their future, unless the parent has made specific provision for them in the will. Van Dyk (2001: 334) 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. UNAIDS (1997: 15) state that many AIDS orphans

are not aware of their rights and to pursue these rights needs skills and self-confidence that these children lack.

Assertiveness training in AIDS orphans life skills programme is designed to help participants realize, feel and act on the assumption that they have the right to be themselves and express their feelings freely. Once assertiveness skills have been acquired it should significantly increase the learners' self-esteem and self-efficacy and decrease loneliness, social awkwardness and social phobia. Aspects to be covered in this session include the following: Understanding the differences between assertiveness, non-assertiveness and aggression; specific communicative assertiveness behaviours; ways of asserting oneself.

Table 3 provides the planned course for session 3.

Table3: Developing assertiveness skills

Time	Topics and Activities
5 minutes	Introduction
10 minutes	Activity: Behaviors associated with assertiveness
20 minutes	Definition of concepts: assertiveness, non-assertiveness and aggression.
10 minutes	Specific communicative assertiveness behaviours
15 minutes	Activity: Assertiveness training

3.2 Definitions and general overview of the concepts

- Assertive behaviour.
- Non-assertive behaviour.
- Aggressive behaviour.

3.3 Specific communicative assertive behaviours

- Being able to express disagreements (saying no)
- Making requests
- Expressing, positive and negative feelings
- Being able to initiate, maintain and terminate interactions or discussions.

3.4 Session activities

Activity: Behaviour associated with assertiveness

As an introduction to assertiveness, participants can be asked to note the behaviours associated with assertive, non-assertive and aggressive behaviour. Then in small groups they can discuss the advantages and disadvantages of behaving in such ways.

Activity: Assertiveness training

The focus of the activity is assertiveness training.

- It is not easy to know what to say when someone is putting pressure on you. Below are two situations where assertiveness and non-assertiveness behaviours are demonstrated:
- A situation is role-played in front of the group who are asked to look for verbal and non-verbal cues for lack of assertiveness. A friend trying to get another friend (friend 1) to smoke drugs. The friend does not want too, but doesn't know how to say no afraid of loosing friendship. He ends up agreeing and being arrested for illegal possession of drugs.
- In another situation a boyfriend pressurises a girlfriend to have sex. Although the girl is aware that if she says no she might loose the boyfriend she finally says 'no'.
- The group is asked to discuss about the two responses
- They then compare the reactions.
- The group is given the opportunity to think of other situations in which they want to say 'no' to something. They then work out what they would say.

SESSION 4

SELF AWARENESS

Goal

-Personal growth through knowledge and understanding of self-

Session Four: Self awareness

OUTCOMES

After completing this session participants should:

- Demonstrate understanding of self
- Be able to identify personal strengths and limitations
- Develop strategies of dealing with limitations

4.1 Introduction

Self-awareness includes peoples' recognition of themselves, their character, identity, cultural perspectives, goals, motivations, needs, values, feelings, strengths and weaknesses as well as desires and dislikes. Developing self-awareness helps people to recognize when they are stressed or feel under pressure. Furthermore, it is viewed as a prerequisite for effective communication and interpersonal relations, as well as for developing empathy for others. 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 (Brack & Hill, 2000: 10; Corey & Corey, 2002: 32; Doyle, 1992: 113). Topics to be discussed here includes:

- The value of knowing yourself.
- Knowledge of past and personal experiences.
- Personal expectations.

Table 4 provides the planned course for session 4.

Table4: Developing communication skills

Time	Topics and Activity
5 minutes	Introduction
15 minutes	The value of knowing yourself
15 minutes	Knowledge of past and personal experiences
10 minutes	Expectations
15 minutes	Activity: Learning to understand self

4.1 The value of self-knowledge

- Allow people to deal more successfully with the life demands.
- Enable people to arrive at realistic and informed career choices than their uniformed counterparts.
- Enable people to develop a philosophy of life, define moral values and in the process pursue a healthy life style.
- Enable people to make informed choices.

4.2 Knowledge of past and personal experiences

- Learning from personal experiences
- Learning from others' experiences

4.3 Expectations

- Expectations about self
- Expectations about others

4.4. Session's activity

- **Activity: learning to understand self**

Being a teenager means that the body is changing so are the feelings. Learning to understand self can help teenagers cope better with life. This activity is based on self-awareness

- The members of the group are asked to imagine to be looking for friends. To do that they must advertise in a local newspaper. In the advert they are supposed to mention the kind of person they are. The only guide is that they should be honest with themselves.
- Afterwards they are given the opportunity to share their advert with the whole group.
- The group is then asked whether they have enjoyed the activity, and what they have learnt about themselves.
- Finally the facilitator explains the importance of self-awareness.

SESSION 5

COPING AND STRESS-MANAGEMENT SKILLS

Goal

-Development of abilities to cope with emotions and manage stress-

Session 5: Coping with stress and emotions

OUTCOMES

After completing this session participants should be able to:

- Identify different sources of stress
- Describe how people respond to a stressful situation
- Describe ways of coping with stress

5.1 Introduction

The focus of this session is on coping with stress and emotions. Coping with emotions involves recognizing your emotions and others emotions, being aware of how emotions influence behavior, and being able to respond to emotions appropriately. Intense emotions, like anger or sorrow can have negative effects on a persons' health if a person does not react appropriately (Brack & Hill, 2000: 10).

The death of a parent is certainly a profound psychological and social crisis for a child, especially when the parent dies from AIDS. These children exhibit emotional and behavioural disturbances. 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 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 experience can lead to serious psychological problems such as post-traumatic stress syndrome, aggression, alcohol and drug abuse. Many experience anger; guilt; loss and abandonment, fear of death and fear for their futures (UNAIDS, 2004: 3).

Coping and stress-management skills are important since they provide a platform for discussing feelings of sadness, disillusionment, dissatisfaction, alienation, anger, guilt and disbelief. Coping with stress is about recognizing the sources of stress, recognizing

how these affect a person, and acting in ways that help to reduce levels of stress (WHO, 1997: 2; Baron & Byrne, 2003: 542; Amanat & Beck, 1994: 258).

Discussions in AIDS orphans life skill programme include the following aspects:

- Coping with emotions
- Identifying sources of stress
- Ways of reducing sources of stress

- Table 5 provides a planned course for session 5.

Table 5: Developing stress management skills

Time	Topics and Activities
5 minutes	Introduction
10 minutes	Coping with emotions
10 minutes	Sources of stress
	Ways of reducing sources of stress
15 minutes	Activity: "Thinking positive"

5.1 Coping with emotions

- Pain, hurt and sadness
- Loneliness
- Anger and bitterness
- Fear
- Grief
- Rejection

5.2 Sources of stress

The are various sources of stress. Focus will be on sources identified by participants.

5.3 **Ways of reducing stress**

- Constructive ways
- Destructive ways

5.4 Session's activity

- **Activity 5 "**Thinking Positive".

Coping with feelings and stress is a challenge that all people face. There are many ways of coping with difficult feelings and stress. Some are constructive whereas others are destructive. The activity is based on ways of coping with stress and the theme is "Thinking Positive".

- Participants are asked to think about a stressful situation they were once in, and which they would like to cope with better if that situation came up again. They are asked to imagine the situation with eyes closed, and to remain calm.
- They are then asked to think of a time when they did well in that kind of a situation and how good they felt to have coped.
- Finally they are asked to think how they might improve on the way they handled the situation in the future and rehearse this in their mind, before slowly opening their eyes.
- The participants are then introduced to the value of saying positive things to themselves during a stressful situation
- They are encouraged to cope by talking to themselves through a situation by keeping calm and positive, focusing on what is going well, and to praise themselves after the situation for the things they did well however big or small.

SESSION 6

DECISION-MAKING SKILLS

Goal

-Development of abilities to make informed and responsible decisions-

Session 6: Decision making skills

OUTCOMES

After completing this session participants should be able to:

- Give an overview of the decision-making process.
- Identify pitfalls to decision-making.
- Demonstrate ability to take decisions

6.1 Introduction

According to Geldard and Geldard (1999: 178), Pogieter (2004: 220) as well as Swart (2000: 358-362) the decision making process involves a systematically working through a series of steps. The focus of this session is helping participants make good decisions by giving them the skills to deal with the present concern, and also to deal effectively with future problems. Young people are made aware that every decision made has consequences, and they must accept the responsibility for the consequences of the decisions made. Basically the main trust of all helping interventions is to assist client to make better choices by developing rational decision-making skills.

This session is based on the assumption that learning the decision-making process helps early adolescent AIDS orphans anticipate problems, minimize the probability of acting impulsively, and lessens the anxiety and tension often associated with crises and indecisiveness. Failure to make sound choices results in stress and coping problems for the child.

Table 6 gives outlines the planned course for session 6.

Table 6: Developing decision making skills

Time	Topics and Activity
5 minutes	Introduction
30 minutes	The decision making process
10 minutes	Pitfalls to decision making
15 minutes	Activity: "Choosing right"

6.1 The decision making process

Focus is on the following steps:

- Define the problem.
- Examine the possible choices and the consequences of each choice.
- Select the best choice.
- Act on your decision.
- Evaluate your decision.

6.2 Pitfalls to decision-making

- Decide on one thing and do another.
- Decide on a choice and then do nothing about it.
- Decide but act half-heartedly.
- Procrastinate, delay a choice, rationalize or blame someone else.
- Ignore analysis of the situations.
- Make a choice without any investigation or analysis.
- Panic and decide harshly on a solution which promises immediate relief but addresses only a symptom of the condition.

6.3 Session's Activity

- **Activity: "Choosing right"**

Big changes are taking place during adolescence. All teenagers are faced with the challenge of making decisions about the future. Learning decision-making skills can help them make good decisions that will define their future. This activity is based on making decisions step by step and theme is "Choosing right".

- The participants are asked to explore advantages and disadvantages of different ways of making decisions such as by impulse; procrastinating, by not deciding; by letting others make decision for them; by evaluating all choices then deciding.
- The facilitator then tells the group that the last way – evaluating different aspects of the situation is the best process.
- The decision making process is then presented.
- The group then is allowed to go through the model for example decision making dilemma in small groups. Then the participants compare how the different groups handled the same dilemma.
- The group is then given the opportunity to evaluate the whole process.

SESSION 7

PROBLEM-SOLVING SKILLS

Goal

-Development of abilities to solve problems-

Session Seven: Problem solving skills

OUTCOMES

After completing this session participants should be able to:

- Demonstrate ability to solve problems.
- Know the problem-solving process.
- Identify benefits of problem management.

7.1 Introduction

A problem is any unsatisfactory or undesirable condition that needs to be corrected. All people experience problems. Problem solving skills enable people to deal constructively with problems in their lives. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strain. Problem solving is described as a step-by-step method of dealing with problems by following a formal reasoning process (Hepwoth & Larsen, 1993: 446; Potgieter, 2004: 220-222; Swart, 2000: 356).

This session is based on the assumption that without adequate information, people tend to go for quick solutions that address the symptoms rather the real issue. It is therefore of utmost importance early adolescent AIDS should be taught problem solving skills. According to Potgieter (2004: 224) knowledge of the problem solving skill 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. The focus of the session is on the problem solving process. Mastering the process requires persistence and determination and the willingness to repeat and practice until mastery is achieved.

Table 7 gives the planned course of session 7.

Table 7: Developing problem solving skills

Time	Topics and Activities
5 minutes	Introduction
20 minutes	The problem-solving process
10 minutes	Features of good and bad problem solving
10 minutes	Benefits of mastering problem-solving skills
15 minutes	Activity: 'solving problems fair'

7.2 The problem-solving process

- Identifying the problem and establishing goals.
- Generating alternative solutions.
- Choosing the best alternative.
- Developing a plan.
- Implementation; The youngster acting upon the plan.
- Follow up to evaluate how the solution(s) worked.

7.3 Features of good and bad problem-solving

Good problem definitions

- Mutual agreement between parties.
- Outline each party's role in the problem.
- Include a simple and specific description of the problem.
- Include a description of each party's feelings about the problem.
- Include something positive.

Bad problem definitions

- State only one party's view.
- Are accusatory and blaming.
- Tend to be general and vague.
- Simply list each person's gripes.
- Focus only on the negative.

7.4 Benefits of mastering problem-solving skills

- Reduces tensions and anxiety
- Reduces stress that often accompanies the problem
- Promotes working together of members of the system.
- Development of mutual respect.
- Prevent interpersonal conflicts.

7.5 Session activity

- **Activity: 'solving problems fair'**

No matter how good a relationship is, it will run into difficulties from time to time. The lesson is based on problem solving with activities designed to help participants work through each step. The theme of the activity is – 'solving problems fair'

- Participants are asked to work in groups of two**.**
- They are then asked to choose any problem they know of that needs to be solved.
- They are advised to use ideas from the problem solving process discussed in the session to solve the problem.

SESSION 8

CONFLICT-MANAGEMENT SKILLS

Goal

-Development of abilities to manage conflict-

Session Eight: Conflict Management

OUTCOMES

After completing this session participants should be able to:

- Understand the differences between constructive and destructive conflict.
- Identify various sources of conflict
- Understand the importance of conflict management skills

8.1 Introduction

Conflict is part of life of all systems. It is both natural and inevitable in interpersonal relationships. The closer the ties between people, and the more frequent their contact, the greater the chances of getting irritable and annoyed with one another. Conflict exists in a relationship when parties believe that their aspirations cannot be achieved simultaneously, or perceives a divergence in their values needs and interests. When people cannot reach some sort of reconciliatory arrangement on how to deal with a particular situation further tension and conflict may result into violence. Violence may include destructive behaviour such as the use of great physical force or intimidation, which at times is unlawfully exercised (Bezuidenhout & Dietrich, 2004: 72). Therefore the importance of conflict-management skills cannot be overemphasized. This is true for AIDS orphans who are likely to engage in antisocial actives because of peer pressure.

This session covers the following aspects:

- Types of conflict
- Sources of conflict
- Strategies of managing conflict.

Table 8 gives the planned course of session 8.

Table 8: Developing conflict management skills

Time	Topics and Activity
5 minutes	**I**ntroduction
10 minutes	Types of conflict
10 minutes	Sources of conflict
10 minutes	Productive strategies of conflict management
10 minutes	Counterproductive strategies of conflict management
15 minutes	Activity: Conflict management

8.2 Types of conflict

Constructive conflict:

- Is productive in the sense that it triggers creativity and innovation.
- It stimulates trusts and understanding.
- It stimulates constructive forms of interaction.
- It promotes growth.
- It brings problems, differences of opinion and competing needs out into the open.
- Has the potential to energize the problem-solving capacities of people.

Destructive conflict

It involves efforts to destroy each other and includes behaviors such as belittling, degrading, verbal abuse or physical violence. The consequence of this type of conflict is often negative with the different parties involved in attacks and effort to destroy each other.

8.3 Sources of conflict

The sources of conflict are multiple and complex and they include:

- Styles of decision-making and problem solving techniques.
- Faulty communication.
- Struggle for power.
- Personality clashes.

- Competition for limited resources.
- Poor task performance.
- Changes in roles.
- Status and leadership.
- Changing norms and expectations etc.

8.4 Strategies of managing conflict

- Mutual respect.
- Ability to pinpoint "the issue".
- Focusing on facts in the present.
- Conflict resolution needs the co-operation of both parties.
- Strive for a collaborative two-winner approach.
- Address the issue in small steps.
- Mastering the ability to make request.

8.5 Counterproductive strategies of dealing with conflict

- Avoiding conflict
- Ignoring conflict
- Minimizing conflict

8.6 Session's activity

- **Activity: Conflict management**

Everybody argues sometimes, and in a good relationship both partners try to solve their conflicts peacefully. The activity is based on conflict management.

- The group is asked to think about important ways of solving a conflict. It can be with a friend, family member or neighbour.
- They then discuss advantages of making use of such means.

- The group is asked to rate how satisfied they are with the different ways of resolving a conflict
- Conclude the activity by writing out a summary statement about the importance of resolving conflict.

SESSION 9

CRITICAL AND CREATIVE THINKING SKILLS

Goal

-Development of capacities to think critically and creatively-

Session Nine: Critical and creative thinking skills

OUTCOMES

After completing this session participants should be able to:

- Identify and solve problems by using critical and thinking skills.

9.1 Introduction

The focus of this session is both on critical thinking and creative thinking. Thinking skills can help people to think before they act (Nelson-Jones, 1994: 248). Creative thinking on the other hand involves divergent thinking, flexibility, originality, the consideration of remote possibilities and the ability to consider a variety of solutions to the same problem. The ability to be spontaneously creative, approaching situation with fresh ideas is important to adolescents. Creative thinking helps them to respond adaptively and with flexibility to the situations of their daily lives.

This session is based on the notion that early adolescent AIDS orphans need to develop the ability to think logically and to use their capacity for logical thinking to make judgments and decisions for themselves. Knowledge and application of critical and creative thinking skills will empower AIDS orphans towards growth and development.

Aspects that are covered in this session include:

- Critical thinking skills
- Creative thinking skills

Table 9 gives the planned course of session 9.

Table 9: Developing conflict management skills

Time	Topics and Activity
5 minutes	Introduction
20 minutes	Critical thinking skills
20 minutes	Creative thinking skills
15 minutes	Activity: "Do your own think"

9.1 Critical thinking skills

Critical thinking skills covered in this session include:

- Owning responsibility for choosing.
- Using coping self-talk.
- Choosing realistic personal rules.
- Choosing to perceive accurately.
- Explaining cause accurately.
- Predict realistically.
- Setting realistic goals.
- Using visualizing skills.
- Realistic decision-making.
- Confront rather than avoid decisions.
- Prevent and managing problems. .

9.2 Creative thinking skills

Creative thinking helps people to respond adaptively and with flexibility to the situations of their daily lives. Focus is on:

- Divergent thinking,
- Flexibility,
- Originality,

- The consideration of remote possibilities and the ability to consider a variety of solution to the same problem

9.3 Session's activity

- **Activity : "Do your own think"**

The theme of the activity is "Do your own think"

- The facilitator provides examples which contrast critical thinking.
- The facilitator then introduces the critical thinking steps.
- The facilitator then uses one of the examples given earlier to go through the critical thinking steps.
- Then the participants work in pairs to show their use of critical thinking steps.
- Thereafter the facilitator asks the participants to consider why it is so important to understand and use critical thinking in making decisions and to think about areas in their livers when these skills can be applied.

SESSION 10

MAINTAINING A HEALTHY LIFE STYLE

Goal

-Development and maintenance of a healthy life style-

Session Ten: Maintaining a healthy life style

OUTCOMES

After completing this session participants should:

- Demonstrate an understanding of healthy living.
- Understand HIV/AIDS in the social and health context.

10.1 Introduction

The focus here is to maintain a healthy life style. Attention is given to those matters, which are important to maintain and develop a healthy body such as nutrition, rest, constructive leisure time activities and safe living in general. In this regard teenagers need basic knowledge and insight of substances and circumstances, which can and will harm the normal functioning of the body and retard development. The more important destructive factors that are identified as those that need special attention are amongst others substance abuse, child abuse, illness and disease with emphasis on HIV/AIDS.

The extraordinary challenge and difficulties that these AIDS orphans (mostly adolescents) experience expose them to risky habits detrimental to their health. The AIDS epidemic threatens the viability, perhaps the very existence, of this generation. Maintaining a healthy life style is important for all people, but particularly for young people. A healthy productive generation of adolescents today will ensure that South Africa has the healthy generation of adults needed in the 21st century.

Table 10 gives a planned course for session 10

Table 10: Developing a healthy life style

Time	Topic and Activity
5 minutes	Introduction
10 minutes	Guidelines that contribute to a healthy lifestyle
10 minutes	Nutrition
10 minutes	Sexuality and HIV/AIDS
10 minutes	Substance abuse
15 minutes	Activity: "Thinking wisely"

10.1 Guidelines that contribute to a healthy lifestyle

- Eating nutritionally and in moderation.
- Keeping fit (Partake in moderate exercises three to four times a week).
- Maintain moderate weight
- Avoidance of alcohol consumption.
- Get enough sleep (7 to 8 hours a night).
- Avoidance of smoking
- Avoidance of addictive drugs.

10.2 Nutrition

- Follow a diet low in fat.
- Eat plenty of vegetables, fruits and grain products.
- Use sugar and salt in moderation.

10.3 Sexuality and HIV/AIDS

- Different attitudes to sex
- Differentiating between HIV/AIDS
- Stages of HIV infection
- Prevention of HIV/AIDS

10.4 Substance abuse

- Types of drugs
- Disadvantages of drug use

10.4 Session's activity

- **Activity 10: "Thinking wisely"**

Many people are destroyed because of lack of knowledge. When you don't know, it easy to get fooled with wrong information or to make choices that you regret later. The activity is based on healthy living and the theme is "thinking wisely".

- The group is asked to think about behaviour that reflects healthy living. As a group they then decide ten rules of healthy living.
- The group is encouraged to stick to rules of healthy living and are encouraged that although it is not easy to change the way we behave, practice make perfect and now it is a good time to start.

11. EVALUATING YOUR PROGRESS

You have now completed the ten sessions, and it is time to evaluate your progress.

Activity: Assessing your progress

1. Have you found it difficult to make progress? Yes NO
   If yes what areas? ……..
   ……

2. Have you skipped activities or had trouble participating? Yes No
   If yes which activities?……..
   ……

3. Does it seem impossible for you to make progress? Yes No

   If yes what areas……..

   . …….

SCORING

If you answered yes to Questions 1, 2 and 3 you are advised to review the sessions most relevant to the areas of difficulty.

If you answered no to questions 1,2, 3 it is important that you maintain your progress. ..

MAINTAINING PROGRESS

Like a plant that needs regularly watering, you need continual nurturing. Minor care taking now and then can save you some major work later. Continue applying the skills you have already learned in your daily life.

