UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Health promotion for families with adolescents orphaned by HIV/AIDS in rural Hammanskraal

MMAPHEKO DORICCAH PEU

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE

Philosophiae Doctor

in

Nursing Science

In the

FACULTY OF HEALTH SCIENCES

At the

UNIVERSITY OF PRETORIA

JANUARY 2008

Promoter: Prof NC van Wyk
Co-promoter: Dr ADH Botha

DECLARATION

Student No. 9726444

I declare that the thesis

Health promotion for families with adolescents orphaned by HIV/AIDS in rural Hammanskraal

is my original work and that it has not been submitted before for any degree or examination at any other institution. All the sources that have been used or quoted have been acknowledged by means of complete references in the text and bibliography.

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MMAPHEKO DORICCAH PEU **DATE**

DEDICATION

This study is dedicated to the following people who helped me to face my studies courageously:

- My late dad, Kgosi Nkwate Reuben Pilane, and my late mom, Mpolokeng Milia Pilane, who used to encourage me to finish my studies by saying "***THUTO KE BOSWA GA GONA YO A KA GO TSEELANG YONA***".

- My beloved and unique husband, Tsie Ephraim Peu, who supported me throughout my studies.

- My daughters, Salome, Ephenia and Lesedi, and my son, Agang, who kept asking about the submission date.

- My brothers, Tshimane, Nthepe and Gaseitsiwe; their wives, Mmanakedi, the late Morwesi, and Tiny; my sisters, Nchibidu Pilane, Mmaphiri Kgwathe, and her husband, Shorty Kgwathe; and my late sisters, Mpi Ruth Tau and Sebolelo Martha Komane.

- My late father-in-law, Mmatshwene Nicholus Peu; my mother-in-law, Mongotsana Eva Peu; my brother-in-law, Jacob Peu, his wife, Tiny Peu, and their son, Nicho Peu.

- Community healthcare providers and the Hammanskraal community.

- Hammanskraal orphans, and all the orphans in this country and in the rest of the world.

- Moretele-Sunrise Hospice staff for their continued support.

ACKNOWLEDGEMENTS

I would like to thank the Almighty God for giving me the opportunity, endurance and courage to complete this study and to fulfil its requirements.

I would also like to extend my sincere gratitude to the following people who contributed toward the success of this study:

- My husband, Tsie Ephraim Peu, who is always caring and supportive.
- My supervisor, Prof NC van Wyk, who assisted and encouraged me to proceed with the study. Although I found this road hard to travel, she supported me all the way.
- My co-supervisor, Dr ADH Botha, who also supported and encouraged me to complete my studies.
- Library staff, Magriet, Mike, Monicca, Richard, and others, who provided professional assistance in searching books and articles for this study.
- Ms MA Ntswane-Lebang, the co-coder who despite a busy schedule assisted me with the coding of data. She has proven her dedication and knowledge.
- My friends and colleagues: Dr Mavis Mulaudzi who used to say *"kondelela*" or "finish your study"; Mrs Salamina Phiri who used to say "*Ngwana wa kwa gae o tlo fetsa*" or "keep on studying"; her husband, Prof Phiri, who said a prayer for me; and Annette Ntswane-Lebang who always said "*Fetsa Ma Peu o tshwane le ba bangwe".*
- Mrs EA du Rand, who passionately provided me with relevant sources for my study and proofread it. She always said: "*Keep on studying, you will finish!"*
- Dr S Meyer, who assisted me when I needed computer skills for drafting the conceptual framework.
- My study companion, Carin Maree, with whom I shared the difficulties of studying as adults.
- The Moretele-Sunrise Hospice staff, who proudly assisted and encouraged me.

- All Department of Nursing Science lecturers at the University of Pretoria, who contributed to my degree.
- The District Manager, Mr Dodo Baloyi, who really supported me when I asked permission to conduct the study.
- The National Acting Director: Health promotion, Mr Kgweti Mahlako, who showed his dedication and supported me during the preparations for the guidelines development workshop.
- Ms Mareli Modiba, the Health Department representative, who demonstrated her skills and knowledge regarding health promotion guideline development on a national and international level.
- Ms Rose Modise, who always reminded me of the Almighty God, our Redeemer.
- Maureen Venter, who supported me spiritually, socially and physically.
- Mrs H Liebenberg and Ms M Werner, for editing the thesis.
- The University of Pretoria's Faculty of Health Sciences, DENOSA and NAVKOM, for supporting me financially during the study.

ABSTRACT

Health promotion for families with adolescents orphaned by HIV/AIDS in rural Hammanskraal

STUDENT: MMAPHEKO DORICCAH PEU
DEGREE: PhD
University of Pretoria
PROMOTER: Prof NC van Wyk
CO-PROMOTER: Dr ADH Botha

Health promotion is regarded as the cornerstone of good health. The aim of this research was to develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal. The objectives were to explore and describe the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal, and to develop and validate health promotion guidelines for such families. The research was conducted within a qualitative paradigm that was both exploratory and descriptive. In Phase 1 of the research, a qualitative, exploratory, descriptive and contextual research design was followed to investigate the health promotion needs phenomenon identified above. The study population for Phase 1 was made up of families with adolescents orphaned by HIV/Aids. Participants in this research, which were purposely selected, included substitute parents of all ages and adolescents between the ages 10 and 17. Data were collected by means of group interviews and field notes, and qualitative data analysis methods were used. Themes, categories and subcategories were identified and verified by means of a literature control. Thirteen themes summarising the needs of participant families as they relate to health promotion were identified from data obtained during several rounds of data collection. These themes served as the foundation for the development of health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

The development and validation of health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal comprised Phase 2 of the research. The research findings were discussed in the context and framework of relevant literature, *Maslow's Hierarchy of Needs* theory and a revised *Multilevel Approaches toward Community Health (MATCH)* model. Identified themes within the frameworks of the theory and model were utilised together with the empirical part of the study as the foundation for the development of the guidelines. Preliminary guidelines were refined by a panel of twelve stakeholders that were purposely selected because of their involvement in HIV/Aids programmes. The set of nine guidelines was validated by experts in the fields of guideline validation and HIV/Aids care. The guidelines were submitted to the National Director: Unit of Health Promotion at the South African Department of Health for confirmation that the guidelines were in line with national health promotion policies. However, the study context was rural Hammanskraal and it can therefore not be taken for granted that the results are applicable to other contexts. Recommendations are testing the guidelines in a clinical setting, preparing them for piloting before implementation and, after implementation, reviewing and updating the guidelines to ensure their credibility and sustainability.

Key terms: Health promotion, health promotion guidelines, adolescents orphaned by HIV/Aids, validation of guidelines.

OPSOMMING

Gesondheidsbevordering van gesinne met adolessente wat wees gelaat is weens MIV/VIGS in landelike Hammanskraal

STUDENT: MMAPHEKO DORICCAH PEU
GRAAD: PhD
Universiteit van Pretoria
PROMOTOR: Prof NC van Wyk
MEDEPROMOTOR: Dr ADH Botha

Gesondheidsbevordering word beskou as die hoeksteen van goeie gesondheid. Die doel van hierdie navorsing was om gesondheidsbevorderingsriglyne te ontwikkel en geldig te verklaar vir gesinne met adolessente wat wees gelaat is weens MIV/Vigs in landelike Hammanskraal. Die doelwitte was om die gesondheidsbevorderingsbehoeftes van gesinne met adolessente wat wees gelaat is weens MIV/Vigs in landelike Hammanskraal te verken en te beskryf, en om gesondheidsbevorderings-riglyne vir sodanige gesinne te ontwikkel en geldig te verklaar. Die navorsing is gedoen binne 'n kwalitatiewe paradigma wat beide verkennend en beskrywend is. 'n Kwalitatiewe, verkennende, beskrywende en kontekstuele navorsingsontwerp is in Fase 1 van die navorsing gevolg om die fenomeen gesondheidsbevorderingsbehoeftes wat hierbo omskryf is, te ondersoek. Die studiebevolking vir Fase 1 het bestaan uit gesinne met adolessente was wees gelaat is weens MIV/Vigs. Deelnemers aan die navorsing, wat doelbewus gekies is, het substituutouers van alle ouderdomme en adolessente tussen die ouderdomme 10 en 17 ingesluit. Data is deur middel van groepsonderhoude en aantekeninge tydens veldwerk ingesamel, en kwalitatiewe data-ontledingsmetodes is gebruik. Temas, kategorieë en subkategorieë is omskryf en deur middel van 'n literatuurkontrole geverifieer. Dertien temas, wat die behoeftes van die deelnemende gesinne opsom soos dit met gesondheidsbevordering verband hou, is geëien uit data wat verkry is tydens verskeie rondtes data-insameling. Hierdie temas lê die ontwikkeling

van gesondheidsbevorderingsriglyne vir gesinne met adolessente wat wees gelaat is weens MIV/Vigs in landelike Hammanskraal, ten grondslag.

Die ontwikkeling en geldigverklaring van gesondheidsbevorderingsriglyne vir gesinne met adolessente wat wees gelaat is weens MIV/Vigs in landelike Hammanskraal, beslaan Fase 2 van die navorsing. Die navorsingsbevindinge is bespreek binne die konteks en raamwerk van tersaaklike literatuur, *Maslow se teorie oor die hierargie van behoeftes* en die model *Meervlakkige Benaderings tot Gemeenskapsgesondheid* wat aangepas is. Temas wat geëien is binne die raamwerke van die teorie en model, het saam met die empiriese deel van die studie die grondslag gelê vir die ontwikkeling van die riglyne. Voorlopige riglyne is verfyn deur 'n paneel van twaalf belanghebbendes wat doelbewus gekies is weens hulle betrokkenheid by MIV/Vigs-programme. Die stel nege riglyne is deur kundiges op die terreine van riglyngeldigverklaring en MIV/Vigs-sorg geldig verklaar. Die riglyne is voorgelê aan die Nasionale Direkteur: Eenheid vir Gesondheidsbevordering by die Suid-Afrikaanse Departement van Gesondheid vir bevestiging dat die riglyne met nasionale gesondheidsbevorderingsbeleide ooreenkom. Die studiekonteks is egter landelike Hammanskraal en die resultate is dus nie vanselfsprekend op ander kontekste van toepassing nie. Aanbevelings is toetsing van die riglyne in 'n kliniese opset, die voorbereiding daarvan vir 'n loodstoets vóór implementering en, ná implementering, die hersiening en opdatering van die riglyne om die geloofwaardigheid en volhoubaarheid daarvan te verseker.

Sleutelterme: Gesondheidsbevordering, gesondheidsbevorderingsriglyne, adolessente wees gelaat weens MIV/Vigs, geldigverklaring van riglyne.

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
CIE	Conduct Impact Evaluation
COE	Conduct Outcome Evaluation
CPE	Conduct Process Evaluation
DPSA	Department of Public Service and Administration
EGC	Eastern Gauteng Council
HGS	Health Goal Selection
HIV	Human immunodeficiency virus
MATCH	Multilevel Approaches Toward Community Health
MTCT	Mother-to-child transmission
NGO	Non-governmental organisation
RDP	Reconstruction and Development Programme
SANC	South African Nursing Council
STD	Sexually transmitted disease
TB	Tuberculosis
TUT	Tshwane University of Technology
TV	Television
UK	United Kingdom
WHO	World Health Organization

CHAPTER 1

BACKGROUND TO THE STUDY AND PROBLEM STATEMENT

1.1 INTRODUCTION

Health promotion is a subsection of the primary healthcare approach, which calls upon communities and governments to make resources, partnerships, skills, time, energy and funds optimally available for the promotion of health care in South Africa. The South African government has invited all stakeholders, including governmental and non-governmental organisations (NGOs), as well as the community, to participate in rendering health promotion services in order to reduce and control the effects of infections/diseases such as the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/Aids) (Department of Health, 2001b:1). It is important that health promotion services should also be rendered in areas where children are affected by the HIV/Aids epidemic. In order to reduce the effects of the HIV/Aids epidemic on communities, it is vital that children who have lost their parents due to HIV/Aids be active participants in health promotion programmes. The involvement of orphaned children in health promotion programmes will help to cultivate an awareness of the contribution that an individual can make to improving his/her circumstances and health.

The relationship between Aids and poverty is powerful but has many nuances (UNAIDS, 2006:84). Many families in developing countries, and particularly in countries hit by HIV/Aids, have been and are still living in poverty (UNAIDS, 2006:84). When Aids was first diagnosed in 1981, the world, under the auspices of the World Health Organization (WHO) was slow to recognise the gravity of the new health crisis that would ultimately raise the level of poverty worldwide (UNAIDS, 2006:2). Aids tends to affect the poor more heavily than other economic groups because, as exemplified by the Botswana situation, every income earner is likely to have an additional dependant over the next ten years

(UNAIDS, 2006:85). HIV/Aids economically drains households belonging to the poor, leaving adolescents, orphaned by the disease, living in poverty.

Poverty can also be regarded as a contributory factor to HIV/Aids because poor families often adopt behaviours that expose them to HIV infection (Cohen, 2005). Many poor families are headed by women who engage in commercial sexual transactions. Often these engagements can be regarded as survival strategies or as a way of providing for dependants (Cohen, 2005).

In response to the HIV/Aids epidemic, certain strategies have been developed and implemented nationally and/or internationally. Because Aids is not only regarded as a disease but also seen as an economic concern (WHO, 2003:32), the Global Health Sector Strategy for HIV/Aids has been introduced to help combat the impact of the HIV/Aids pandemic (WHO, 2003:3). The South African National Department of Health introduced strategic priorities for its national health system (Department of Health, 2004:8). These strategic priorities focus on access and equity, as well as the efficiency, quality and sustainability of health promotion and poverty relief programmes for families suffering from the impact of HIV/Aids.

Poverty is a socio-economic burden and affects vulnerable groups such as children orphaned by the HIV/Aids epidemic. The epidemic may destroy families and leave children orphaned and without care or support. Therefore, there is a need to explore and describe the health-related needs of children orphaned by HIV/Aids in order to develop guidelines that will assist in promoting their health.

Children orphaned by HIV/Aids should be considered as equally important as other children in South Africa. According to the Constitution of the Republic of South Africa, 1996 (sections 27 and 28), all children deserve good, basic and sufficient nutrition, education, health care and treatment, social security, and leisure and recreation, irrespective of their status (South Africa, 1996b). De Haan, Dennill and Vasuthevan (2005:212-15) mention that good nutrition involves carbohydrates, meat products, fruit and vegetables. The health status of

orphaned children could be improved if these food products were sufficiently and regularly provided to them.

Among children orphaned by HIV/Aids, the older ones have the right to education and training which would help them to earn an income (Ramsden, 2002:14). The South African National Department of Health confirms that learners should be provided with a good education, and stresses that education should be accessible and of the highest quality, with participatory approaches (Department of Health, 2003:5). The Department adds that children should be supported financially in several ways, such as the Child Support Grant for those living with poverty (Department of Health, 2003:6). Because HIV/Aids in impoverished communities is making a bad situation worse, increasing poverty and breaking down family life, every South African needs to play a part in helping these children become educated and trained (Ramsden, 2002:1).

Both the Department of Health (2001b:10) and Ramsden (2002:14) emphasise that children orphaned by HIV/Aids should receive health care, including reproductive health care and treatment when illness or injury occurs. With reference to health care and treatment, these orphans should be provided with information that will guide them to improve their health status and consult with healthcare centres when illness occurs. According to the Constitution of the Republic of South Africa, 1996, the state must take reasonable measures, within its available resources, to achieve the realisation of these children's rights (South Africa, 1996b).

Leisure and recreation play an important role in the social development of an orphaned adolescent. A safe and supportive environment for the youth can be created through sports and by providing recreational facilities (Department of Health, 2001b:40). If orphaned adolescents could be actively involved in sports and recreation, the consequences of HIV/Aids, such as stress-related conditions, could be alleviated or eliminated.

Despite the involvement of both governmental organisations and NGOs in HIV/Aids awareness and health promotion programmes, the disease still places

an enormous psychological strain on victims and their families. When the primary income earner of the family becomes ill, HIV/Aids affected families face the additional economic burden of health care, and in the case of death, funeral costs.

During an interview at the Moretele Sunrise Hospice in Hammanskraal near Pretoria, its director, Mpho Sebanyoni-Matlhasedi, indicated that approximately 224 orphans were residing in the area at the time (Sebanyoni-Matlhasedi, 2003). The Moretele Sunrise Hospice is situated in the Hammanskraal area 50 km north of Pretoria in North West Province. It caters for patients with chronic diseases, mainly HIV/Aids. During a follow-up visit 16 months later, the director of the hospice indicated that the number of orphans in the Hammanskraal area had increased more than threefold to approximately 770 (Sebanyoni-Matlhasedi, 2004). The escalating number of HIV/Aids orphans in the Hammanskraal area is indicative of the necessity of a study of this nature in the area.

1.2 BACKGROUND TO THE PROBLEM

In 2005, an estimated 38,6 million people worldwide were living with HIV/Aids, 4,1 million became newly infected with HIV and 2,8 million lost their lives due to Aids (UNAIDS, 2006:8). In sub-Saharan Africa alone, an estimated 15,2 million children, including adolescents under the age of 17, were orphaned by HIV/Aids in 2005 (UNAIDS, 2006:509). The above statistics support the increase in the number of children orphaned by HIV/Aids in South Africa. The statistics also suggest that orphans in sub-Saharan Africa, which includes South Africa, may be suffering as a result of hunger and stress-related problems. This emphasises the importance of health promotion among adolescents adversely affected by HIV/Aids.

HIV/Aids with its consequences remains a problem in sub-Saharan Africa. Since the emergence of Aids as a major health emergency, the epidemic has had a serious and devastating effect on human development (UNAIDS, 2006:80). The effects of Aids include poverty and inequality, negative impacts on households, the weight of stigma and discrimination and negative impacts on women

(UNAIDS, 2006:80). Children orphaned by HIV/Aids have to face discrimination and stigmatisation, a situation that calls for intervention. These children, because of their orphan status, lack basic resources for survival. Often their rights are violated and they are suspected of being infected by HIV (UNAIDS, 2006:86). As HIV/Aids deeply affects all age groups in Africa, including adolescents, all stakeholders should regard health promotion as a priority. Through health promotion, orphaned adolescents should be prepared for their future and survival within their communities. According to UNAIDS, their Millennium Development Goals relate to poverty reduction, achievement of universal primary education, promotion of gender equality, reduction of child mortality and improvement of the health of mothers (UNAIDS, 2006:80).

Southern Africa remains the “global epicentre” of the Aids epidemic (UNAIDS, 2006:15). In Southern Africa, one in three people is infected with HIV (UNAIDS, 2006:15). Statistical data such as this cannot be ignored, because the implication is that HIV/Aids is adversely affecting the population. It could even have a long-lasting impact on the development of the population, as it is affecting, amongst other things, life expectancy (measured at birth), knowledge (measured by adult literacy and school enrolment) and standard of living (UNAIDS, 2006:82). The effects of Aids on human development are far-reaching and include a shorter lifespan and a drastic increase in the number of orphaned children. Often the burden of care of these orphans will remain with elderly caregivers, many of whom are poor and dependent on state pensions (UNAIDS, 2006:94).

South Africa’s Aids epidemic is one of the worst, and escalating, and statistics show no sign of a decrease in Aids cases (UNAIDS, 2006:17). The health status of the South African population affects both their economic and social status, thus limiting human and financial resources as well as role models. Worldwide, millions of children have been orphaned by Aids and are subject to the multiple effects of Aids on families and communities. As these effects result in rising mortality, the challenge for society is to provide health promotion services to HIV/Aids orphans (UNAIDS, 2006:183) and to help them survive. In South Africa alone, in 2005, the estimated number of orphans under 18 who had lost one or

both parents due to HIV/Aids was 685 354, and this figure has risen to over one million in 2006 (Health System Trust, 2006).

Much must still be done with regard to the impact of Aids in South Africa. Many orphans are left unattended. Some of these orphans are frustrated and lack basic resources for survival. Statistics show that the number of HIV/Aids orphans is escalating rapidly. This study is an attempt to assist in reducing the impact of HIV/Aids in South Africa.

In South Africa's HIV/Aids/STD Strategic Plan concerning HIV/Aids and sexually transmitted diseases (STDs), it was revealed that, of all the people living with HIV in the world, six out of ten men, eight out of ten women and nine out of ten children live in sub-Saharan Africa (Department of Health, 2000:6,7). According to the South African Department of Health (2000:6,7), these figures provide sufficient motivation for making HIV/Aids both a regional and national priority.

Surveys conducted on women attending antenatal clinics provided good estimates of HIV prevalence and trends over the past ten years (Department of Health, 2000:6,7). The incidence of HIV in women attending antenatal clinics has increased by 15,3 per cent (Department of Health, 2000:6,7). Statistics also revealed that one in every three pregnant women attending these clinics was HIV positive, and showed a gradual escalation in the number of women infected by the virus (UNAIDS, 2006:17).

In South Africa the rural provinces are most affected. In comparison with the other provinces, KwaZulu-Natal has the highest HIV prevalence (32,5%) among pregnant women (Department of Health, 2000:6,7). Mother-to-child transmission (MTCT) of HIV infection can be prevented by appropriate treatment. However, while their infants survive, the mothers do not, and children are left in the care of other family members, often the elderly.

The researcher wished to respond to the epidemic by producing a study that could serve as a resource on health promotion for adolescents orphaned by HIV/Aids. Besides the initiatives of government and NGOs on health promotion

(Department of Health, 2000:10), individuals have to come up with new strategies on health promotion to assist the government to reduce the negative impact of HIV/Aids. The promotion of health amongst children who have lost one or both parents through HIV/Aids is a priority. The lack of resources regarding health promotion of children orphaned by HIV/Aids (including financial and material resources) prompted the researcher to conduct this research in order to add to existing resources on the subject.

In response to the rising HIV/Aids epidemic and limited healthcare resources in South Africa, the South African government has consulted with and involved the youth of this country in the intervention and promotion of healthy lifestyles for adolescents (Department of Health, 2001b:3). Adolescents are not just an important sector of population, they are the most important because they may prevent and respond to specific health problems affecting the youth (Department of Health, 2001b:3). This government initiative suggests that if adolescents are involved in health promotion strategies, optimum health will be attained and life expectancy increased. Therefore, health promotion programmes for the youth should be holistic, adolescent-centred and sensitive to their culture, religion and personal value systems (Department of Health, 2001a:4,5). Health promotion should be seen as an empowerment strategy that will allow capacity building and promote the autonomy and functional independence of adolescents and their families (Department of Health, 2001a:4).

Families that consist of or include HIV/Aids orphaned adolescents are faced with health promotion challenges. Therefore, guidelines and strategies need to be formulated to assist families in promoting the health of the family with special emphasis on that of the orphaned adolescent.

1.3 PROBLEM STATEMENT

In South Africa, there is a lack of healthcare resources, limited information on health promotion amongst adolescents orphaned by HIV/Aids and poor access to health promotion services. According to the South African government, because the statistics regarding adolescents orphaned by HIV/Aids are alarming, health

promotion is a priority. The impact of the disease is such that these children are often left without basic resources for survival. The circumstances under which many of these families live are not conducive to survival. They are vulnerable to illnesses and abuse. Some of these adolescents risk their health by being involved in commercial sexual transactions (Cohen, 2005). Families with orphaned adolescents experience hunger as a result of shortage of basic needs, leading to chaotic life situations.

The high prevalence of HIV/Aids in South Africa, the escalating costs of health care and the lack of resources for health promotion necessitate this study (Department of Health, 2004:13; Department of Health, 2001b:2). Health promotion interventions in rural communities are limited and need attention. Initiatives such as health promotion interventions in rural communities will enable families with adolescents who have lost their parents due to HIV/Aids, to promote the health of their own members.

When adolescents lose their parents, they lose their role models. Substitute parents, often family members, do not automatically perform the duty of supporting these adolescents in developing health promotion skills and becoming responsible adults. Special emphasis in supporting adolescents who have been orphaned by HIV/Aids is necessary.

Adolescents orphaned by HIV/Aids are facing stigma and discrimination. This has tremendous impact on the health and future of these adolescents. Interventions against stigma have not yet been evaluated in any systematic way (UNAIDS, 2006:197). If the stigmatisation of and discrimination against HIV/Aids orphans are not attended to, their survival and future will be threatened. It is important to attend to these children as they are faced with the multifaceted impact of HIV/Aids.

Furthermore, there are no formal, written guidelines for the health promotion and support of families with adolescents who have recently been orphaned by HIV/Aids in rural Hammanskraal.

The following research question is therefore applicable:

What guidelines should nurses follow in order to promote the health of families with adolescents orphaned by HIV/Aids?

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

1.4 SIGNIFICANCE OF THE RESEARCH

The results of this study will contribute toward the improvement of the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal. Guidelines developed from the study findings should enable the rendering of adequate and/or improved health promotion to orphans, families and communities affected by HIV/Aids, and assist the government in making policies on health care based on empirical data. In this study, capacity building among families will be enhanced by their participation in health promotion activities.

1.5 PURPOSE

The purpose of this study is to develop and validate guidelines for the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

1.6 OBJECTIVES

The specific objectives that form the basis of this study are:

- To describe the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal; and
- To develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

1.7 DEFINITIONS OF KEY CONCEPTS

1.7.1 Adolescents recently orphaned by HIV/Aids

For the purpose of this study, the term 'adolescents recently orphaned by HIV/Aids' refers to any adolescent who has recently lost their last surviving parent due to HIV/Aids and who is between the ages of 10 and 17 years. The HIV/Aids status of these orphans is unknown and not part of the current research focus.

1.7.2 Family

In this study, family refers to a group of people consisting of adults and children related by blood. This group of people can include children, adolescents, adult siblings, grandmothers and grandfathers, uncles and aunts, as well as nieces and nephews.

1.7.3 Guidelines

Gates (1995:35) defines guidelines as "systematically developed statements to assist practitioners' decisions about appropriate health care for specific circumstances". According to the guideline developer's handbook, *Sign 50* (2004), guidelines are regimes provided to assist in the provision of health care.

1.7.4 Health promotion

O'Donnel (1987) in Edelman and Mandle (2002:16) defines health promotion as the science and art of helping people change their lifestyles in order to move toward a state of optimal health. Edelman and Mandle further emphasize that health promotion not only includes exercise and nutrition information, but also involves proactive decision-making at all levels of society. Health promotion focuses on maintaining and improving the general health of individuals, families and communities. Lundy and Janes (2001:289) define health promotion as organised actions or efforts that enhance, support or promote the well-being or health of individuals, families, groups, communities or societies.

1.8 OVERVIEW OF THE RESEARCH METHODOLOGY

1.8.1 Introduction

A brief overview of the methodology follows, as the methodology is dealt with in detail in Chapter 2. The purpose of the research was to develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in order to enhance the quality of life of families and adolescents in rural Hammanskraal. The study was conducted in two phases, namely Phase 1: The empirical part of the research, and Phase 2: The development and validation of health promotion guidelines.

1.8.2 Phase I: Exploration and description of the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal

In phase one, a qualitative, exploratory, descriptive and contextual research design was followed to investigate the health promotion needs phenomenon described above in an in-depth and holistic way through the collection of rich narrative materials using flexible strategies (Polit, Beck & Hungler, 2001:469). The health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal were explored in their context and then described. The empirical data were later used to develop health promotion guidelines for families with adolescents orphaned by HIV/Aids.

The study population for Phase 1 was made up of families with adolescents orphaned by HIV/Aids, who live in rural villages in Hammanskraal. The researcher included only adolescent orphans between the ages of 10 and 17 years, who had lost their last surviving parent not long before the research was conducted. Purposive sampling was used in order to select study participants from the population. For the purposes of this study, the researcher requested a knowledgeable social worker to handpick study participants. This method was

used to select families to be included in the study. All participants were included irrespective of their HIV status.

Data were collected by means of group interviews, and this process continued until data saturation was achieved. Field notes in the form of observational, theoretical and methodological notes were included. An audiotape recorder was also used during the interviews to capture all the data. Various communication skills such as paraphrasing, probing and reflecting were employed (see Chapter 2 for more clarity).

Qualitative data analysis methods were used. Tesch's analysis process, which entails a series of steps (see Chapter 2 for more details), was followed (Creswell, 2003:192). Two coders were used and completed their analysis of the transcribed interviews before comparing it with the others'. Themes, categories and subcategories were identified through the clustering of descriptive phrases derived from the data. The description of themes and categories was presented in tables as adjuncts to the discussions (see Chapter 3, Table 3.1 and 3.2). The data were interpreted, and verified by means of a literature control.

1.8.3 Phase 2: The development and validation of health promotion guidelines for adolescents orphaned by HIV/Aids in rural Hammanskraal

In this study, guidelines are regarded as regimes, policies and regulations that govern health professionals' provision of care to clients (for more clarity, refer to Chapter 2 and 5). Guidelines are recommendations that assist nurses and other stakeholders to promote the health of the community (Appleton & Cowley, 1997:1008; Good & Moore, 1996:75; Mead, 2000:113; Shekelle, Woolf, Eccles, Grimshaw, 1999:593).

The development and validation of health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal comprise Phase 2 of the research. The development and validation of the guidelines (see Chapter 4, 5

and 6) were based on the modified methodology for the development of guidelines adopted from the Royal College of Nursing Institute 2000 (Thompson & Dowding, 2002). The development process was based on the empirical data that were collected and then theoretically confirmed by means of a literature control in Phase 1. The researcher discussed the research findings in the context and framework of the relevant literature, *Maslow's Hierarchy of Needs* theory and the revised *Multilevel Approaches toward Community Health (MATCH)* model. The model and theory were individually consulted, analysed and theoretically supported. Identified themes within the frameworks of the theory and model were utilised together with the empirical part of the study as the foundation for the development of guidelines (see Chapter 2 and 4 for more details).

The scope and objectives of the guidelines were determined and clarified in Chapter 2 and 5. Guideline statements were logically formulated and drafted by the researcher. Stakeholders who were directly or indirectly involved in the fields of health promotion and HIV/Aids assisted the researcher in the development of the guidelines. A detailed discussion of this phase was conducted in Chapter 2 and 5.

The guidelines development process took into consideration attributes associated with guidelines of high quality (see Chapter 2, Table 2.4 and Chapter 5, Table 5.1).

Twelve stakeholders (see Table 5.2) were formally requested to participate in the preliminary guidelines development. The panel of twelve were made up of community nurses, a member of LoveLife, a teacher, a church minister, a social worker, hospice managers, academics, local government council representatives, a district health representative and a National Department of Health representative. The researcher, promoter and co-promoter were also involved in the guidelines development workshop. The participants were purposely selected based on their knowledge of and experience in health promotion, especially in the HIV/Aids context. The panel was informed beforehand about their responsibilities and roles (Shekelle *et al.*, 1999:593).

The people on the panel were provided with a set of preliminary guidelines and instructed on how to comment on it. The group was given one week to study the preliminary guidelines and to prepare their comments and recommendations for change. Before the workshop commenced, the researcher clarified the rules of the workshop and what was expected from the participants. Discussion of the guidelines and recommendations in order to reach consensus was vital. Each guideline was discussed in detail. After the workshop, the revised set of guidelines was delivered to all the participants for confirmation. The revised set of guidelines was thereafter submitted to the South African Department of Health's National Director: Unit of Health Promotion to assess whether the guidelines were in line with the National Health Promotion Policy. Adjustments were made in accordance with comments and suggestions, and the guidelines prepared for validation by a panel of nurse experts (see Chapter 6).

Validation of the guidelines was ensured through the involvement of nurse experts who were skilled researchers (with experience in the development and validation of guidelines). The purpose of validation was to provide a systematic framework for assessing and determining the attributes of quality of the guidelines (Agree Collaboration, 2003:2). The expert respondents critically validated the guidelines and rated them according to criteria provided to them (see Chapter 6 for more detail).

Before validation of the guidelines commenced, the researcher re-consulted relevant literature and re-extracted guiding attributes that could be used when validating the guidelines (see Table 2.4 and Chapter 5 for detailed information on validation). Extensive literature reviews suggest that the validity of guidelines depends on the expert knowledge of the participants, how evidence is identified and synthesised, and how recommendations are developed (UNAIDS, 1999:5).

Guidelines should be reviewed and updated regularly and the date for upgrading should be specified (Shekelle *et al.*, 1999:596). Therefore, the researcher intends to update the guidelines every three to five years once they have been implemented (see Chapter 5).

1.9 ETHICAL CONSIDERATIONS

Permission to conduct the research in the North West Province was granted by the relevant authority (see Annexure A). The Ethics Committee of the Faculty of Health Sciences, University of Pretoria, evaluated and approved the proposal (see Annexure C). After the research was thoroughly explained to him/her, each family representative who was approached to participate in the research was requested to sign a consent form, thus ensuring informed consent. The participants were assured that they could withdraw from the study at any time. The permission applied to all phases of this study.

Principles of research ethics were always applied. The following principles served as a guide in this study: beneficence, respect for human dignity, justice, informed consent, respect for vulnerable subjects, and protection of human rights.

1.9.1 Respect for human dignity, justice and beneficence

All participants were respected and treated with dignity. They were given the opportunity to make informed voluntary decisions. Freedom of decision-making was granted to all participants. The participants were treated fairly and their privacy always maintained. The participants were also guaranteed confidentiality of the information they provided. The researcher tried by all means to avoid any harm to the participants. The participants were assured that the information would not be used against them in any way (Polit *et al.*, 2001:73-89).

1.9.2 Informed decision-making

Two information leaflets were used to inform the participants of the research. The Moretele Sunrise Hospice representative made use of the first information leaflet (see Annexure D) in order to inform the families about the research and enable them to make an informed decision on whether they would like to take part. The researcher conducted information sessions with representatives of Moretele Sunrise Hospice on how to present the planned research to the families who met the criteria for inclusion in the study. The Moretele Sunrise Hospice was used to

gain access to the research participants. The participants were informed of the research during regular home visits conducted by the representatives of the hospice. The families were visited individually to ensure confidentiality.

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

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

1.9.3 Protection of vulnerable subjects

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

1.10 SUMMARY

In this chapter, the background to the problem, problem statement and overview of methodology on health promotion for families with adolescents orphaned by HIV/Aids were discussed. Concepts were described and defined. Chapter 2 contains a comprehensive discussion of the methodology of this research.

1.11 ORGANISATION OF THE STUDY

The chapter organisation is summarised below.

CHAPTER 1: Background to the study and problem statement

CHAPTER 2: Context and methodology of the study

CHAPTER 3: Discussions of research findings and literature control

CHAPTER 4: Discussion of empirical part of the research with reference to an applicable theory *(Maslow's Hierarchy of Needs)* and model for health promotion *(Multilevel Approaches Toward Community Health)*

CHAPTER 5: Development of the guidelines for the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal

CHAPTER 6: Review of the findings, validation and description of the guidelines with applicable recommendations, limitations, implications and conclusions

CHAPTER 2

THE CONTEXT AND METHODOLOGY OF THE STUDY

2.1 INTRODUCTION

The research is aimed at developing and describing health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal in order to enhance their quality of life.

2.2 THE CONTEXT OF THE STUDY

Hammanskraal is a rural area situated north of Pretoria. The area is made up of both semi-urban and rural villages. A semi-urban village can be defined as a group of houses situated in a rural area (Pearsall, 2002:1599). Lundy and Janes (2001:62) indicate that the definition of rural area is based on a geographic, demographic, sociological and economic perspective. The simplest definition is that a rural area is a country area. Hammanskraal is approximately 50 km away from the central area of Pretoria. It is one of the previously disadvantaged areas that were marginalised and neglected before South Africa became a democratic country in 1994 (Phaphamang Tourism Forum, 2003). Pearsall (2002:954) defines neglect as a failure to give proper care or attention. Neglect can also be defined as unfavourable circumstances or conditions where the people are socially and economically deprived. Hammanskraal's neglect was as a result of the apartheid policy of the government of the time. The area is divided by a provincial boundary. Part of it falls under the provincial government of the Gauteng Province while the largest part is in the North West Province.

2.2.1 Historical background

Hammanskraal was a farm owned by a Mr Rens. It shared borders with the very poor villages of Marokolong and Ramotse in the north, the City of Tshwane in the

south, the Stinkwater village in the west and the Kekana village in the east. Today, these villages form part of the Hammanskraal area. These villages have grown into large residential areas despite widespread poverty. With the assistance of the present government and through the implementation of the Reconstruction and Development Programme (RDP), houses for the poor have been erected (Van Rensburg, 2004:112). However, at the time of the research, the participants of this study were still waiting for houses. Many of them were living in tin shacks that they had constructed themselves.

According to Mahlangu (2004), the Hammanskraal administration that fell under the Bophuthatswana Bantustan[1] and the Pretoria local authority ran the local government before the emergence of the new order in 1994.

2.2.2 Local authority

After the new dispensation in 1994, the Eastern Gauteng Council (EGC) of the Gauteng Province became responsible for the administration of the local government of Hammanskraal. The EGC was responsible for 11 town councils and nine rural municipalities including Hammanskraal (Mahlangu, 2004). It provided water, electricity and waste removal to these areas. Currently, the section of Hammanskraal that falls in the Gauteng Province is administered by the City of Tshwane Metropolitan Municipality.

The City of Tshwane Metropolitan Municipality was established in 2000 and is responsible for 14 local authorities including Hammanskraal Local Authority. Services rendered include the development of housing and infrastructure, ensuring safety and security and enhancing social and economic development, as well as natural resource development and institutional development (Hammanskraal Local Government Councillors, 2005).

This section of Hammanskraal is serviced by the Tshwane North Sub-structure of the Tshwane Metropolitan Municipality, which provides Hammanskraal with

[1] A black homeland set up in terms of the policy of separate development (Branford & Branford 1991:22).

electricity, water and housing services. According to Mahlangu (2004), the municipality is responsible for the northern parts of Pretoria, as well as the areas north of Pretoria including Mandela Village, Mokonyama and Haakdoringboom. Not all the people in the Hammanskraal area have water and electricity. Some still collect water from a distant source, while others live in houses with electricity and clean tap water.

The part of Hammanskraal that lies in the North West Province is under the authority of the local governance of the Temba Transitional Representative Council. Various changes have occurred in both Hammanskraal and Temba. The two most obvious changes are the construction of tarred roads and telecommunication systems.

2.2.3 Development and infrastructure

According to Mahlangu (2004), Hammanskraal has various schools, both primary and secondary, as well as a tertiary education institution called Orbit Technikon. Orbit Technikon in Temba is one of the satellites of the Tshwane University of Technology (TUT). Its main focus is on skills development. These schools and institution are owned by the government, but are not well equipped (Mahlangu, 2004). At some of the schools, parents contribute to the school's budget by paying additional fees, which enables the school to buy equipment that the government does not supply. The fees vary from R300,00 per year per child in the eastern part of Hammanskraal to R2 000,00 per year per child in the Klipdrift area. Children from poor families cannot attend these schools, as their parents cannot afford to pay the fees, and must attend governmental schools where additional fees are not required.

There is only one school in Hammanskraal that is privately owned. The tuition fees at the Prestige College range from R600,00 to R1 000,00 per month per child depending on the subjects that the child chooses.

Various churches have congregations in Hammanskraal. These churches cater for more than the religious needs of the community, and often manage the social services and feeding schemes operating in the area.

There are 78 rural and semi-rural villages scattered over a 50 km area in Hammanskraal. Some of these villages are as far as 100 km away from Pretoria. Although services and infrastructure, such as shops and public parks, exist in Hammanskraal, many people prefer to go to Pretoria for shopping and business. The majority of the people in Hammanskraal work in Pretoria or Johannesburg, and the surrounding areas, and are, for example, employed in the Babelegi industrial area, domestic houses or the Carousel Hotel, which is 20 km north of Hammanskraal. Others are employed in government institutions, such as schools, hospitals, clinics and traffic departments.

Housing in Hammanskraal consists of a mixture of brick houses with two to 15 rooms, tin houses with two to five rooms, mud houses, wooden houses, tents and RDP houses built by the government. Some houses are arranged in blocks, while others are not arranged in any organised fashion; some were built on stands that are owned, while others were built on rented stands. There are also farms where mealies, corn, and other indigenous vegetables and fruit are grown.

The roads leading to these villages consist mostly of gravel roads, with only a few tarred roads. Figure 2.1 on page 22 shows the area in which the research was conducted.

In Hammanskraal, recreational activities for the youth are scarce. LoveLife, a governmental organisation, has established a centre to educate the youth on health issues, such as the prevention of HIV/Aids. This centre provides the youth with entertainment in the form of music and reading, and is usually well attended.

The Hammanskraal community makes use of several transport systems to travel to and from Pretoria. The majority of the people in the area use buses and taxis, while those that can afford it, purchase and commute in their own vehicles. A limited number of people make use of bicycles as means of transport.

FIGURE 2.1 AREA IN WHICH THE RESEARCH WAS CONDUCTED

2.2.4 Communication system

The communication system in Hammanskraal is made up of telephones and a postal service. Some members of the community have private telephones in their homes while others use public telephones. Cellphones are primarily used by the younger generations.

2.2.5 Healthcare institutions and services

Hammanskraal has a variety of private and public healthcare institutions and centres. As the majority of the population is poor, public healthcare centres, clinics and hospitals are used. Healthcare providers vary from Western trained doctors, nurses and health professionals to traditional or indigenous healthcare providers. Indigenous healthcare centres are available to patients that prefer traditional care and treatment. Hammanskraal has only one district hospital, the Jubilee District Hospital, which is supported by a network of public mobile and fixed clinics.

2.2.6 Moretele Sunrise Hospice

According to Sebanyoni-Matlhasedi (2004), the Moretele Sunrise Hospice in Hammanskraal is a non-governmental healthcare institution. It is managed as a non-profit organisation and is situated in the Temba area. It renders home-based care to patients with acute and chronic conditions. Its main aim however is to care for terminally ill patients, such as Aids patients in the final stage of the disease. The mission of this organisation is twofold, namely to render a non-profit service by being compassionate carers and to encourage the community to become well informed and self-reliant.

The staff at Moretele Sunrise Hospice strives to:

- Provide a support system to the community, especially to families with orphans,

- Participate in awareness campaigns concerning HIV/Aids and related conditions,
- Provide palliative care,
- Provide counselling services,
- Render home-based care,
- Supply a daycare service to HIV/Aids orphans, and
- Manage a bereavement programme for the family of the deceased.

According to Sebanyoni-Matlhasedi (2004), the hospice has established 15 satellite care centres in Hammanskraal, and has conducted 500 awareness campaigns since its inception. Approximately 1 400 home visits are made per month, 200 patients taken care of per day and 50 new referrals received per month.

2.2.7 Geography and climate

Hammanskraal is situated on a plateau dissected by streams and a river, the Pienaars River. The Pienaars River runs from Pretoria and through the east of Hammanskraal. The summers are very hot and the winters cold. Farming is difficult in the area as a result of the hot climate and water scarcity. Many people in the Hammanskraal community are subsistence farmers, producing mainly mealies and indigenous vegetables, such as tomatoes, onions and green vegetables, for their own use. Many keep chickens and pigs on their stands, but also only for own consumption and not for commercial farming purposes.

2.2.8 Demography

According to Moraka (2004), the population of Hammanskraal is estimated at 350 995. These people utilise the abovementioned infrastructure for their daily needs and survival.

2.2.9 Cultural groups

The area of Hammanskraal in which the interviews were conducted is inhabited by various ethnic groups, namely the Tswana, Ndebele, Tsonga, Northern Sotho, Southern Sotho, Zulu, Xhosa and Venda. The majority are Setswana speaking, followed by isiNdebele, Xitsonga and Sesotho speaking groups. There are also Sesotho sa Leboa, isiZulu, isiXhosa and Tshivenda speaking groups. Setswana is the language spoken most commonly in the area, while the Tswana, Ndebele, Tsonga and Northern Sotho are the most common ethnic groups. The most common cultural practices were those of the Tswana, Ndebele, Northern Sotho and Tsonga. Other ethnic groups are currently relocating to the area.

The ethnic groups in the area live together under the leadership of Chief Kekana. Kekana's chieftainship is derived from the Ndebele in the north east of Limpopo Province. This history was passed from generation to generation but never recorded.

2.2.10 Profile for HIV/Aids and tuberculosis

The high incidence of HIV/Aids and tuberculosis remains the main obstacle to development in Hammanskraal. However, tuberculosis is curable and treatment is available at the district hospital and clinics. HIV/Aids infects and affects both the young and the old. It is thus necessary to focus not only on HIV/Aids patients, but also on the impact of the disease on the lives of the patients' families. No statistics on the incidence of HIV/Aids in the Hammanskraal area are available, as it is not a notifiable condition in South Africa.

2.2.11 Housing of participants

Like the majority of people in Hammanskraal, the participants of this study lived in tin houses consisting of two to three very small rooms. One of the participant families consisted of eight members living in a three-roomed tin house with very poor ventilation. Another family lived in a house in which one room served as kitchen, sitting room, storage room and bedroom. Only one of the eight families

who participated in the study lived in a brick house. On the first visit, the participants' houses were not very clean, but on subsequent visits they were properly cleaned. One family member commented: "We need to clean this house because we knew that you are coming".

Furniture was a scarce commodity for these families. They used old drums and soft-drink crates as chairs. The families did not have beds and some family members, including adults and the elderly, slept on the floor. The houses also lacked tables or electric appliances, such as stoves and kettles, despite being provided with electrical power.

The external environment was clean and no environmental hazards were found. However, the majority of the houses did not have fences. As a result, the families could not grow vegetables in their yards.

2.2.12 Cooperative and collaborative processes in Hammanskraal

Health science students in the departments of Nursing Science, Medicine, Physiotherapy, Occupational Therapy, Human Nutrition and Radiography at the University of Pretoria are allocated to the hospital and clinics in the Hammanskraal area for their clinical training. The students and their lecturers, in cooperation with the hospital and clinic staff, provide healthcare services to the people of Hammanskraal.

The University of Pretoria's Centre for HIV/Aids provides counselling services to the victims of HIV/Aids and their family members. The centre is involved in several awareness programmes.

2.3 REASONS FOR SELECTING HAMMANSKRAAL FOR THE STUDY

The researcher resides in the Hammanskraal area and thus understands the nature and pattern of the lives of the people in the community. She has served the community for the past twenty years through primary healthcare services and community development projects. She understands the various cultures of the

people. Her experiences within the community led her to become interested in the needs of the poor and more specifically the needs of children orphaned by HIV/Aids and the people that care for them. The intention of this study is to better the lives of these children by providing policy makers with guidelines for the health promotion of these families.

2.4 METHODOLOGY OF THE RESEARCH

The study was conducted in two phases (see Figure 2.2):

- *Phase 1* consists of the empirical part of the research with the emphasis on the exploration and description of the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal.
- In *Phase 2*, the development and validation of health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal are addressed.

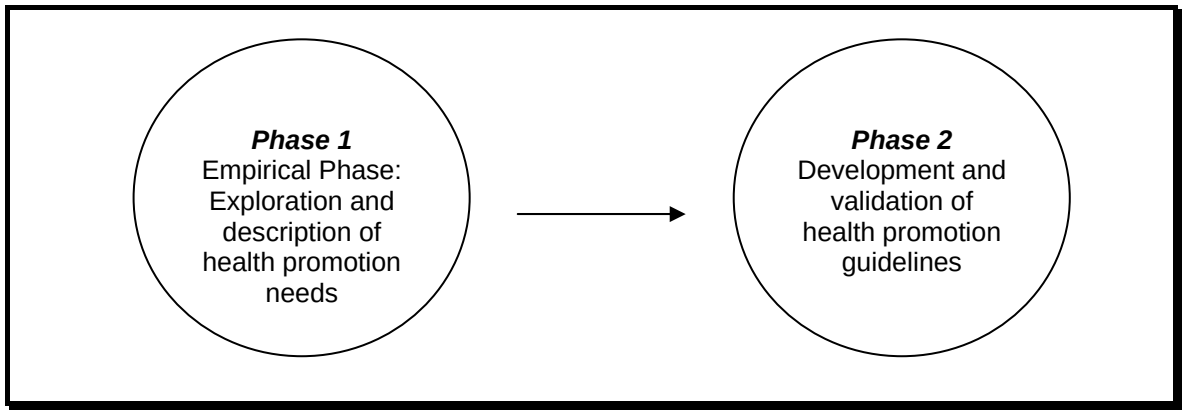


FIGURE 2.2: THE PHASES OF THE RESEARCH PROCESS FOLLOWED

2.5 PHASE 1

In Phase 1 of the study, a qualitative paradigm was adopted. Qualitative research explores a topic when the variables and theory base are unknown or the available theory is inaccurate and inappropriate (Creswell, 2003:75). Therefore, in this study, the uniqueness of the phenomenon was explored and described. An exploratory, descriptive and contextual method was used to explore the needs

and problems related to the health promotion of families with adolescents orphaned by HIV/Aids.

- **Exploratory design**

An exploratory design investigates and explores the dimension of a phenomenon under study as well as other related features (Polit *et al.* 2001:19). Babbie and Mouton (2007:79) add that an exploratory design is appropriate when examining a new interest or when the subject of the study is relatively new. The researcher explored a given situation and later identified the health promotion needs of families with adolescents orphaned by HIV/Aids. The nature of the problem determined the manner, range and depth of the exploratory study (De Vos, 2002:213). In this study, the researcher explored the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal. The health promotion needs were explored until data were saturated, in other words until no new themes, categories and subcategories could be identified.

- **Descriptive design**

Descriptive studies refer to the description of a phenomenon. The dimensions, variations, situations, events and the importance of the phenomenon are described (Babbie & Mouton, 2007:80). A descriptive study may be used to identify problems in the current situation and practices or to determine plans for improving healthcare practices in different situations (Lobiondo-Wood & Haber, 2006:240-41). It aims at discovering new facts about situations, people, activities or events through the collection of information, scrutiny of the portrayal of the views of people and categorisation of the results (Streubert-Speziale & Carpenter, 2007:86). In this study, the researcher explored and described the phenomenon of the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

- **Contextual design**

In contextual design, the researcher has a preference for understanding events, actions and processes in their concrete and natural context (Babbie & Mouton, 2007:272). The study was conducted in the context of the participants at Hammanskraal. Hammanskraal is a rural area situated north of Pretoria. The area is made up of both semi-urban and rural villages. A semi-urban village can be defined as a group of houses situated in a rural area (Pearsall, 2002:1599).

2.5.1 Population

According to Burns and Grove (2003:43) and Polit *et al.* (2001:233), a study population includes elements such as individuals, objects or substances that meet certain criteria for inclusion in a particular study. It reflects the entire aggregate of cases that meet a designated set of criteria. The study population in Phase 1 was made up of families with adolescents orphaned by HIV/Aids who lived in Hammanskraal villages and who, at the time of the study, were directly linked to the hospice for support. These participants were selected from 260 families with orphans in Hammanskraal to take part in the interviews. According to the social worker who selected the participants, by the end of 2006, there were 1 200 orphans from 260 families in Hammanskraal (Ledingwana, 2007). The participants who were involved in this research were grandmothers, a grandfather, related adults such as siblings, as well as orphaned adolescents aged between 10 and 17. The families who were chosen to participate in the research were poor and could not survive on their own.

An information session with the social worker and the director of the Moretele Sunrise Hospice was conducted in December 2003. In this session, the criteria of how the study population should be selected were addressed. The purpose and nature of the research were also discussed. The reason for selecting specifically adolescent orphans was an important issue. The ages of the children ranged from 10 to 17 years. Participants in this age group were included because they were vulnerable and had to be supported by an adult substitute parent to attain optimum good health. All families with adolescents orphaned by HIV/Aids, who

were living in the surrounding villages and associated with the hospice, were included in the study population.

The researcher decided to include only adolescent orphans, between the ages of 10 and 17 years, who had lost their last surviving parent not long before the study commenced. In Hammanskraal, the cultural period of mourning extends from six months to one year following the death of an adult.

The reason for including all the adolescent's family members was to explore various experiences related to health and health promotion in rural communities. The participants' experiences, as told during the interviews, assisted the researcher in identifying the needs on which the guidelines for the health promotion of families with adolescents orphaned by HIV/Aids were based.

2.5.2 Sample

Purposive sampling was used to choose the study population for participation. This method of sampling is based on the belief that a researcher's knowledge about the population can be used to handpick cases to be included in the sample (Burns & Grove, 2003:43; Polit *et al.*, 2001:234). In this study, the social worker selected participants, ensuring confidentiality regarding their circumstances. The circumstances and vulnerability of the families determined their selection. Another criterion was that the families should have members caring for adolescents orphaned by HIV/Aids. The records of these families were kept at the Moretele Sunrise Hospice because they were involved in the hospice support programme. Although the hospice support programme included the provision of food, the food provided was insufficient. However, families could survive while arrangements for government support were made.

The social worker, who received information regarding the sample criteria, selected the families from different villages in Hammanskraal. The selection was thus based on the ages of the adolescents and the absence of both parents due to Aids-related deaths. The families had to consist of at least one adult and one or more adolescents (aged between 10 and 17) under the care of the adult (see

Table 2.1). Participants were included irrespective of their HIV status. Because of ethical considerations and in order to select families that met the criteria set for the study, a social worker from the Moretele Sunrise Hospice had to be involved in the selection. Another reason for using the social worker to select the participants was that the researcher had no access to the hospice's records of the participants. The compilation of the sample is set out in Table 2.1.

TABLE 2.1: NUMBER OF PARTICIPANTS IN THE STUDY

District of Hammanskraal			
VILLAGE	**FAMILY**	**NUMBER OF PARTICIPANTS**	
		ADULTS	**ADOLESCENTS**
Village 1	FA	1	2
Village 2	FB	1	3
Village 3	FC	2	3
Village 4	FD	1	2
Village 5	FE	1	2
Village 6	FF	1	2
Village 7	FG	1	2
Village 8	FH	1	2
8 Villages	**8 Families**	**9 Adults**	**18 Adolescents**

The phenomenon 'health promotion' was the main focus of the study. The inclusion of participants from eight different villages in Hammanskraal (see Table 2.1) contributed to the saturation of data obtained. The health promotion needs of adolescents orphaned by HIV/Aids were explored and described. The number of visits per family varied and was determined by the saturation of data. The minimum number of visits per family was three and the maximum six.

Profile of individual families

The profile of the individual families is set out in Table 2.2 on page 32. The composition of each family (including the age of each individual), their employment status and living conditions are tabulated. A short description of each family follows.

TABLE 2.2: PROFILE OF THE PARTICIPANT FAMILIES

Family	Composition and age	Employment	Environment
FA	• Adult, 24 yrs old (sister) • Adolescent, 10 yrs old • Adolescent, 15 yrs old	Unemployed	Two-roomed shack
FB	• Grandmother, 65 yrs old • Adolescent, 15 yrs old • Adolescent, 13 yrs old • Adolescent, 11 yrs old	Pensioner	Two-roomed shack
FC	• Adult, 26 yrs old (sister) • Adult, 24 yrs old (sister) • Adolescent, 15 yrs old • Adolescent, 12 yrs old • Adolescent, 10 yrs old	Employed Unemployed	Three-roomed shack
FD	• Grandfather, 70 yrs old • Adolescent, 15 yrs old • Adolescent 10 yrs old	Pensioner	Unfinished brick house
FE	• Adult, 22 yrs old (sister) • Adolescent, 16 yrs old • Adolescent, 14 yrs old	Unemployed	One-roomed shack
FF	• Grandmother, 75 yrs old • Adolescent, 17 yrs old • Adolescent, 14 yrs old	Pensioner	Three-roomed shack
FG	• Grandmother, (age unknown) • Adolescent ,15 yrs old • Adolescent, 11 yrs old	Pensioner	Two-roomed shack
FH	• Adult, 25 yrs old (sister) • Adolescent, 16 yrs old • Adolescent, 12 yrs old	Employed	Two-roomed shack

The ***FA family*** consisted of a 24-year-old woman and her two adolescent siblings, a 15-year-old girl and a 10-year-old boy for whom she was caring. The responsibility of looking after her brother and sister urged her to develop herself and she began attending school, but dropped out when she fell pregnant. While attending school, she was supported financially by the hospice. At the time of the study, she was not employed. The family lived in a two-roomed tin house. The

young woman did her best to look after her family. The father of the baby did not contribute to the household or live with the family. The hospice supported the family by giving them food parcels.

In the ***FB family***, there was a very communicative 65-year-old grandmother. She found it difficult to give the adolescents opportunity to talk and the researcher had to ask her repeatedly to allow the younger members of the family to take part in the conversations. She not only intimidated the adolescents, but also continually asked the researcher for money and support. The adolescents were a 15-year-old girl, a 13-year-old boy and an 11-year-old boy. The grandmother had her own children, 22 and 25 years old respectively. Both were employed but, although they lived with the family in the two-roomed tin house, it was unclear whether they contributed to the household. The grandmother looked depressed as a result of the family's situation and the researcher referred her to the nearest clinic for assessment. At one stage after the second interview, the grandmother shouted at the 15-year-old girl, accusing her of sleeping around and warning her that she would die like her mother. The family received food parcels from the hospice.

The ***FC family*** consisted of five brothers and sisters of whom two were adults. The 26-year-old sister acted as parent to the rest of the family. The 24-year-old sister received psychiatric treatment, but was able to care for the adolescents while the eldest was at work. The adolescents were a 15-year-old girl, a 12-year-old girl and a 10-year-old boy. They lived in a three-roomed tin house with poor ventilation and no furniture. During the interviews, all the participants sat on the floor. The house had no security fence and the doors could not be locked. The family received food parcels from the hospice but indicated that these were insufficient.

The ***FD family*** consisted of a grandfather and two grandchildren. His wife passed away three years ago and his daughter, the adolescents' mother, passed away two years ago. The family lived in an unfinished brick house. The grandfather was a pensioner and had six children of his own. His children did not permanently live with the family and it was unclear whether they supported the family financially.

The ***FE family*** lived in a one-roomed tin house. The only adult in the family was a 22-year-old woman who was pregnant at the time of the interviews. She was the adolescents' sister. The adolescents were a 16-year-old girl and a 14-year-old boy. At the time of the second interview, the sister had delivered a stillborn baby and was admitted to hospital for two weeks for further disease management. The house in which they lived was poorly ventilated and their furniture consisted of one bed, which was used as table, sleeping area and storage for clothing. They were living in this house for the past four years. The family received food parcels from the hospice although they usually found these insufficient.

The ***FF family*** resided in a three-roomed tin house. The family consisted of a grandmother of 75 years, a 17-year-old boy and a 14-year-old girl who received psychiatric treatment. The grandmother was very communicative and complained that the adolescents called her a witch because of her age. One of the grandmother's daughters visited the family frequently in order to assist. The grandmother had already been staying with the children for six years. Before that they stayed in the same house with their mother. The family received food parcels from the hospice.

At the time of the interviews, the ***FG family*** resided in a two-roomed tin house. A grandmother was looking after a 15-year-old girl and an 11-year-old boy. The grandmother was mourning for her husband who died a year after the death of the adolescents' mother. They also received food parcels from the hospice.

The ***FH family*** resided in a two-roomed tin house with poor ventilation. The sister who acted as parent was 25 years old. She had a two-year-old toddler. Her brothers were 12 and 16 years old. They formed a family five years ago after the death of the boys' father. The sister was employed at the time of the interviews and the family survived with the little support they received from the hospice.

Group interviews were conducted with each family in order to obtain data that could be analysed to determine the health promotion needs of families with adolescents orphaned by HIV/Aids.

2.5.3 Data collection

a) Method: Group interviews

A descriptive, exploratory and contextual study using qualitative methodology was adopted. In this study, group interviews were conducted with the families caring for adolescents orphaned by HIV/Aids. In group interviews, the researcher attempts to understand the world from the participants' point of view (De Vos, 2002:292). Therefore, in this study, the main focus of the group interviews was on understanding health promotion needs of families with adolescents orphaned by HIV/Aids in their contextual environment. Kruger (1994:16) mentions that people assembled in a series of groups possess certain characteristics that provide data of a qualitative nature, in a focused discussion. The researcher observed this throughout the study. The families were interviewed at their homes a year or more after the death of the parent in order to allow mourning.

The families were interviewed and followed up regularly to ensure prolonged engagement and saturation of data. Saturation, according to Streubert-Speziale and Carpenter (2007:31)**,** is the repetition of discovered information and confirmation of previously collected data. Health promotion needs were repeatedly highlighted during the visits. The number of visits per family differed from family to family. The majority of families were visited three to four times and a few were visited six times.

Before the researcher conducted the initial interviews with the families, an information session was held with each family in order to explain the concept of health promotion and what was expected of them. One session per family was sufficient for this. During the information session, the participants were given an opportunity to ask questions and all misunderstandings were clarified.

Group interviews rely on the systemic questioning of several individuals in a setting (Denzin & Lincoln, 2003:70). In this study, the homes of participants were used as natural settings for group interviews. The question *"What do you need in order to promote your own health?"* was used to allow the participants to explore

and describe their health promotion needs. The interviews were conducted in such a way that all the members of the families were encouraged to take part. The group interviews were thus active processes in which the families explored and described their health promotion needs. Each family was interviewed at a given time either in the morning or afternoon. They were interviewed separately to ensure confidentiality.

Sensitive information and the participants' privacy were always respected (Rossouw, 2003:146-7). The group interviews were conducted in three phases, namely: the preparatory phase, the interview phase and the post-interview phase. A pilot study was also conducted before the study.

b) Pilot study

A pilot study, which was not included in the final group interviews, was conducted with one family. The family consisted of three members, one grandmother and two adolescents. The question *"What do you need in order to promote your own health?"* was asked in the initial interview discussion. A few communication barriers, such as low voices and little confidence from the adolescents, occurred during the group interview discussion. The pilot study served as a guide to the researcher in facilitating the discussions and encouraging the adolescents to speak up in the final group interviews. During the pilot study, the concept of health promotion needs was misunderstood. As a result, in the rest of the study, the researcher conducted information sessions with the families in order to thoroughly explain the concept (see 2.5.3(a) above).

c) Preparation phase

During the preparation phase, the researcher visited the area to confirm the addresses of the families and to get an overview of the circumstances under which the participants lived. The Moretele Sunrise Hospice was used as a means to contact the families. On the first visit, the researcher was accompanied by the social worker from the hospice. During the visit, the researcher introduced herself to the participants and a rapport was established with the families. The

researcher explained the process of the research to the participants, as well as the steps taken to ensure that the research was ethically sound. Guarantees of confidentiality and anonymity were given and the participants were informed that the visits would continue until there was no new data (saturation). Appointment dates were arranged and telephone numbers of neighbours and relatives recorded in case the times needed to be adjusted. The participants agreed that a tape recorder could be used and that transcripts of the interviews would be used for research purposes. The researcher ensured that the tape recorder was in working condition.

d) Interview phase and process

The interviews were conducted in the homes of the participants. This contributed to the participants' feelings of freedom to explore and describe their health promotion needs. The researcher also created a favourable and non-threatening environment for the interviews by warmly thanking the participants for their willingness to participate in the research (Rossouw, 2003:146-7). The participants were interviewed in Setswana, as it is their home language. Each family group was interviewed separately.

In some instances, the researcher organised something for the family to eat before the interviews, as they appeared to be hungry. The researcher realised the importance of providing food so that the family was able to participate fully in the research process. A tape recorder was used during the interviews in order to capture all the data available. Various communication skills, such as paraphrasing, probing and reflecting, were employed during the interviews.

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

Probing was used to draw more information from the participants during the interviews. This involved repetition of the original question and long pauses,

which were intended to communicate with the participants (Babbie & Mouton, 2007:253). The question *"What do you need in order to promote your own health?"* was frequently asked. During the research process, various methods, such as asking *"Anything else?"*, were also used to get as much information from the participants as possible. These neutral probing methods were used in order to avoid affecting the nature of the responses (Babbie & Mouton, 2007:253-4).

The researcher used ***reflection*** in order to remind the participants of what had been said previously and in order to link this with current discussions. During subsequent visits, the researcher encouraged the participants to reflect on their health promotion needs, as well as their feelings and experiences (Burns & Grove, 2003:495).

The researcher focused on the question *"What do you need in order to promote your own health?"* in order to facilitate the participants' description of their health promotion needs. The interviewer was able to be flexible, objective, empathic, persuasive and a good listener in order to eliminate the participants' fear (Denzin & Lincoln, 2003:70-4). Three to six interviews were conducted per family, depending on the degree of the saturation of data (see Table 2.3). Each interview took forty-five to sixty minutes, depending on how the family explored and described their health promotion needs. The interviews were arranged for every six weeks. The reasons for this were:

- The researcher wanted to build a rapport and trust with the participants in order to facilitate further data collection,
- Six weeks is insufficient time to forget what had previously been said, yet enough time to come up with more data, and
- The period assisted the researcher not to lose focus.

After data were collected, it was transcribed and analysed. A comprehensive report on the findings of the research was written. After the initial interviews, appointments with the participants were made for two months' time in order to ensure member checking and the validity of data. The reason for the appointment was explained to the participants. The researcher visited individual families, and

explained and clarified the results. The participants confirmed that no incorrect data had been collected or added. The conclusions formulated from the data were discussed to ensure the validity of the findings.

Later, the researcher and her supervisors realised that some valuable information on how the participants coped with a particular problem was missing and a second round of interviews was decided upon. Four of the families were included in the second round of data collection. The families who had been visited four to six times during the first round of interviews were selected as they were under more challenging circumstances. The researcher arranged appointments and interviewed them regarding their unique coping skills. The participants were informed that although they had described and explored their health promotion needs fully, there was a need to further explore how they coped with their circumstances. The second round interviews were conducted in the same environment as the first, two months after the first round of interviews. Field notes were the only method of data collection used during the second round.

The researcher's observations on verbal and non-verbal cues, as well as her personal experiences, were also recorded (Rossouw, 2003:147). Non-verbal cues included pauses, crying, laughing, raised voices and dancing. Pauses were most often noticed in interviews with families with problems such as lack of food or other forms of assistance. Raised voices were characteristic of families with grandmothers caring for adolescent orphans. After each interview, these cues were indicated in the transcript of the interviews.

The researcher had various experiences during the data collection. These ranged from the personal to the environmental and psychological. The researcher struggled to find the houses of the participants due to the disorganisation of houses in the village and a lack of individual addresses. The researcher also found it difficult to witness the lack of basic resources in the homes of the families. The families had inadequate food to supply the members of the family. The families were supported by the Moretele Sunrise Hospice but this was not adequate. In families where the grandmother or grandfather was a pensioner, the family members had to rely on this money for survival. Because these families

were vulnerable and lacked the basics for survival, the researcher organised something for them to eat in that particular period in order to allow the participants to take part during the interviews. This small assistance on the part of the researcher encouraged families to participate fully during the research process. The researcher had to inform the hospice social worker that these families required more support.

In one family, two adolescent boys demonstrated disrespect to their grandmother. The adolescents regarded themselves as men after completing their traditional initiation school. These children shouted and disrespected their grandmother. The grandmother asked the researcher to intervene and resolve the existing conflict. The researcher had no choice but to provide temporary assistance to the family in order to contribute to its survival. This was time-consuming to the researcher because instead of commencing with the interviews, the researcher had to assist in resolving the conflict. During the next visit, the grandmother expressed her appreciation for the intervention. This made it clear that health promotion needs included more than physical needs. The researcher included what she has learned from the session in the data collected.

Despite these experiences, satisfactory discussions were held with the participants regarding their health promotion needs. Several interviews with families with adolescents orphaned by HIV/Aids were conducted. The interview visits per family ranged from three to six.

e) Post-interview phase

At the end of the interviews, the families were thanked for their cooperation, contribution and willingness to participate in the study. Other social visits were made with participants in order to keep in contact with them.

The researcher personally conducted the research, therefore it is possible that some points could have been missed while taking notes. Therefore, the use of the tape recorder was imperative. Field notes that the researcher took during the interviews contributed to the richness of the data.

Field notes were made in the form of personal notes during the interviews with the families. These notes included both empirical observations and interpretations, and contained an objective description of events, times, places, activities and non-verbal cues. The field notes were compiled during interactions and discussions with the family. Resources such as food, water and electricity, plumbing and housing were noted. The lack of facilities was also noted and addressed in the recommendations of the study.

Through prolonged engagement, the researcher tried to capture how families with adolescents orphaned by HIV/Aids participated in health promoting activities. The adolescents' needs and relationships with various members of the family, as well as their social environment, were noted. The notes were included as data in the analysis process.

The following are examples of circumstances noted (also see Annexure G):

- The families fetched water from a source far from where they lived,
- The families fed themselves with non-nutritious food,
- The houses were mostly shacks made from tin,
- Most houses were not furnished,
- The plumbing was poorly constructed,
- The cleanliness of the families was very poor,
- The children had to travel long distances to their schools,
- There were no entertainment systems in the houses,
- The grandmothers looked depressed and in want of assistance,
- The children preferred to visit neighbours and attend parties,
- The village lacked tarred roads,
- In families with grandmothers looking after grandchildren, interpersonal conflict was often observed,
- Time was not considered important in daily activities,
- The families had to travel long distances to the shops, and
- There seemed to be a vacuum created by the passing away of the children's parents.

The researcher also noted her own emotions. It was difficult for her to observe families surviving without basic resources except the little help they received from the hospice. During one interview, a woman of 24 years became overwhelmed and the family had to be comforted. The interview was postponed to a later stage.

During a visit to another family, the children pretended their parents were still alive. Those who played the roles of the children screamed with joy when their 'father' and 'mother' came home from work and pretended to help carry groceries into the house. These experiences contributed to the richness of data.

2.5.4 Data analysis

Data analysis is an ongoing process, which involves continual reflection about the data, analytical questioning and the writing of notes throughout the study (Creswell, 2003:190). In this study, reflection was used to enhance the credibility of the findings.

Three coders, consisting of the researcher and two experienced qualitative researchers who have been involved in various research report evaluations, coded the transcribed and translated data. The role of the researcher was to ensure that the codes were formulated within the context of the data collected. The two other coders were chosen to take part in the analysis, as they had not been involved in the data collection and were therefore less biased. The researcher and one co-coder could speak, read and write Setswana and English. The analysis of the data was done in English. The three sets of coded data were compared, discussed and adjustments were made.

The data analysis began after the first round of data collection and guided the decision to collect further data (Burns & Grove, 2003:378). The purpose of the data analysis was to preserve the uniqueness of each participant's experiences while permitting an understanding of the phenomenon under investigation. The study followed Creswell's (2003:191-3) modified steps for data analysis. Data were first organised, then translated and prepared for analysis. The transcriber listened to the tapes and created a transcript of the interviews. The transcript was

then translated into English. The coders analysed the data using the English transcripts. According to Rossman and Rallis (1998) in Creswell (2003:192), coding is the process of organising the data into 'chunks'. Text data were segmented into themes, categories and subcategories and labelled with terms based on the language of the participants. The coders then had consensus meetings in order to agree on the analysed data.

Tesch's analysis process, which entails a series of steps, was followed (Creswell, 2003:192). The first interview with the first family was chosen and analysed. The coders got a sense of the whole transcript by reading it repeatedly. All ideas were highlighted. Thoughts and ideas about the content of the interview were written down. Each coder completed their analysis of the transcribed interviews before comparing it with the others'. Themes, categories and subcategories were identified through the clustering of descriptive phrases derived from the data. After a comparison, a final decision on the description of each theme was made. The data belonging to each theme were assembled. Data were re-coded when necessary to ensure credibility (Creswell, 2003:192). Themes and categories were described and presented in tables as adjuncts to the discussions. The categories and subcategories as meaningful compartments were then interpreted. Chapter 3 deals with the themes, categories and subcategories identified.

2.6 TRUSTWORTHINESS OF THE STUDY

Trustworthiness refers to how well a researcher can convince his/her audience that the findings are correct and worth taking into account (Lincoln & Guba, 1985:290).

Guba's model for trustworthiness (Lincoln & Guba, 1985:290) was utilised in order to ensure validity and reliability within this study. The strategies of confirmability, credibility, transferability and dependability were implemented (see Table 2.3 on page 44).

TABLE 2.3: STRATEGIES TO ENSURE TRUSTWORTHINESS

STRATEGY	CRITERIA	TECHNIQUE
Confirmability	Confirmability audit	• The researcher has years of experience in the community environment • The use of raw data and quotations for analysing and describing the needs of the adolescents and their families • Recorded observations • The use of different translators
Credibility	Prolonged engagement	• The researcher spent three to six months with participants, thus the minimum spent with participants was three months throughout the study • Field notes were kept • The researcher spent 20 years as healthcare provider in the area where the research was conducted
	Triangulation	• The participation of different families in data collection • Information was gathered through interviews, field notes, observations and literature reviews
	Member checking	• Findings were constantly checked with participants for correctness • Coders used consensus to decide on the theme classifications
	Persistent observations	• Persistent observations regarding health promotion activities • Several visits were made to collect data from participants
	Peer examination	• Independent coders coded and verified data
	Researcher‘s authority	• The researcher’s research skills contributed • Study leaders’ authority in supervision
STRATEGY	**CRITERIA**	**TECHNIQUE (continued)**
Transferability	Dense description	• Various interviews were conducted • Use of multiple data sources

	Selected sample	• The researcher provided the context of the Hammanskraal settings to indicate the extent of the study's transferability • The use of purposive sampling to ensure a selected sample that would provide a true reflection of the phenomenon under study
Dependability	Code-recode procedure	• Consensus was reached amongst coders • The use of a pilot study to identify possible problems during data collection • Field notes were taken and non-verbal cues recorded

Adapted from Lehana and Van Rhyn (2003:30-1), Lincoln and Guba (1985:290), and Richter and Peu (2004:31-40).

2.6.1 Confirmability

Confirmability is the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher (Babbie & Mouton, 2007:278). As an experienced primary healthcare provider, the researcher personally conducted the research in order to ensure the confirmability of the study. Having raw data available on tape and transcriptions to verify the identified themes also ensured confirmability. Consistent use of the method of bracketing prior to data collection assisted in ensuring the pure description of the data. The researcher tried to avoid all pre-conceived ideas concerning health promotion needs (Lobiondo-Wood & Haber, 2006:155). The data collected were validated by means of member checking as well as a literature control. Two experienced translators were used to confirm the data collected. The first translator transcribed the tapes in the participants' home language and the second translator translated the data into English. The correctness of the transcripts and translated versions was confirmed by the researcher during data analysis.

2.6.2 Credibility

Credibility refers to the truth and compatibility of the study. The credibility of the findings was ensured through prolonged engagement, persistent observations, triangulation, peer examination and the researcher's authority (Babbie & Mouton, 2007:277; Krefting, 1991:221; Lobiondo-Wood & Haber, 2006:168). The researcher had 20 years of experience in service delivery in the area in which the research was conducted. She also spent three to six months with the participants while collecting the data. This prolonged period of engagement added to the credibility of the study. It also enabled the researchers to check perspectives and allowed participants to become familiar with the researcher.

The researcher used various methods to ensure triangulation. The participation of different families in data collection, and the gathering of information through different methods, such as interviews, field notes, observations and literature reviews, ensured triangulation in research.

The inclusion of different participants and the confirmation of findings with participants (member checking) contributed to the credibility of the findings (Streubert-Speziale & Carpenter, 2007:49). Field notes provided truth about points asserted by participants (Steubert-Speziale & Carpenter, 2007:43). Persistent observation in the interview context also ensured the credibility of the data.

Peer examination and the researcher's authority are criteria that ensured credibility. Independent coders coded and verified data. The researcher's research skills and her study leader's authority in supervision ensured credibility of the study.

2.6.3 Transferability

Babbie and Mouton (2007:277) define transferability as the extent to which the findings can be applied in other contexts or to other participants. Dense description of the background to the study was given. The use of multiple data

sources such as notes, various interviews and the provision of the context of the Hammanskraal setting indicate the extent of the study's transferability. The use of purposive sampling to select participants increased the transferability of the study. Group interviews and field notes contributed to the transferability of the findings (De Vos, 2002:352).

2.6.4 Dependability

Dependability is an alternative to reliability and entails the researcher accounting for the changing conditions in the phenomenon chosen for the study (De Vos, 2002:352). According to Babbie and Mouton (2007:278), in order to ensure dependability, evidence that the study is reliable must be provided, in other words, that if the research were repeated with the same/similar respondents in the same context, its findings would be the same. In this study, the researcher ensured dependability through consensus meetings with participants and coders. Field notes were taken and all non-verbal cues observed recorded.

2.7 PHASE 2: DEVELOPMENT AND VALIDATION OF THE GUIDELINES FOR HEALTH PROMOTION OF FAMILIES WITH ADOLESCENTS ORPHANED BY HIV/AIDS IN RURAL HAMMANSKRAAL

2.7.1 Development of guidelines

According to Gates (1995:35), guidelines are defined as statements that are logically developed to contribute toward practitioners' decisions about appropriate health care under specific and appropriate circumstances. In this study, guidelines are regarded as regimes, policies and regulations that govern nurses to provide care to the clients. Well-developed guidelines have the potential to enhance the appropriateness of practice, improve the quality of care, family outcomes and cost-effectiveness, and identify areas for further research.

Guidelines are recommendations that are systematically developed and, in this study, the purpose is to assist nurses and other stakeholders to promote the health of the community (Appleton & Cowley, 1997:1008; Good & Moore, 1996:75; Mead, 2000:113; Shekelle *et al.*, 1999:593). Guidelines in health care are aimed at maintaining and improving quality care as well as providing nurses with direction (Appleton & Cowley, 1997:1009; Pinkney-Atkinson, 1995:2; Strohschein, Schaffer & Lia-Hoagberg, 1999:85). These recommendations were initially formulated as preliminary guidelines in this study and at a later stage evaluated to become final guidelines (Good & Moore, 1996:75).

2.7.2 Methodology of guidelines development

The development and validation of health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal formed part of Phase 2 of the research. The development of the guidelines (see Chapter 4 and 5) was based on the modified methodology for the development of guidelines adopted from the Royal College of Nursing Institute (2000) (in Thompson & Dowding, 2002).

The development process was based on the empirical data collected and theoretically confirmed in Phase 1. The scope and objectives of the guidelines were determined and clarified (see Chapter 5 and 6). Guideline statements were logically formulated, drafted and prepared for further development by stakeholders. A detailed additional discussion concerning Phase 2 was conducted in Chapter 5.

The guidelines development methodology of Thompson and Dowding (2002) was followed. The researcher described and presented the methodology of guidelines development unchanged in Chapter 5. However, the methodology was adjusted and refined. The researcher clearly indicated which changes were made, why these changes were made, and how the process changed (for more details, see Chapter 5).

2.7.3 Guiding attributes to be followed when developing and validating guidelines

During guideline development, the set of attributes for quality should be taken into consideration. In this study, the guiding attributes were observed during the processes of guideline development and validation. The attributes displayed in Table 2.4 below formed the basis of the development and validation of the preliminary guidelines (Agree Collaboration, 2003; Helvie, 1998:428; Pinkney-Atkinson, 1995:12). The guidelines should meet the attributes (see Table 2.4 below) because, if these were not observed, the development process may result in imperfect recommendations (Thompson & Dowding, 2002:157). The attributes presented in Table 4.2 were modified to suit this study.

TABLE 2.4: GUIDING ATTRIBUTES TO BE FOLLOWED IN GUIDELINE DEVELOPMENT

ATTRIBUTES	CLARIFICATION
Clarity and presentation	The guideline is easily understandable, specific, unambiguous and clearly presented. The intention of the guideline and who will be involved are indicated. Various approaches to the phenomenon under study (in this case, health promotion of families with adolescents orphaned by HIV/Aids) are indicated.
Effectiveness	Quality health promotion is based on clinical effectiveness - the extent to which the health status of families with adolescents orphaned by HIV/Aids can be expected to be enhanced by various health promotion interventions.
Validity	The guideline is based on the analysed data, best available and correctly interpreted evidence, an applicable model and theory.
Relevance	The guideline is relevant in terms of the need for planning, implementing and sustaining health promotion programmes and activities for orphaned adolescents.

ATTRIBUTES	CLARIFICATION (continued)
Comprehensiveness	The guideline ensures a comprehensive approach to the health promotion of adolescents orphaned by HIV/Aids. This approach includes, amongst others, physical, social, emotional, spiritual and psychological aspects. Emphasis is on self-care and wellness.
Applicability	The target users of the guideline are clearly defined. The application thereof relies on adequate dissemination, implementation and evaluation strategies.
Acceptability	The guideline is both realistic and ambitious, and in line with the policies of the Department of Health (Youth and Adolescent Health Promotion and School Health Policies).

Sources: Agree Collaboration, 2003; Pinkney-Atkinson, 1995:12; Thompson & Dowding, 2002:157

2.7.4 Guidelines development group

Guidelines can be produced locally and internationally, and are developed by a group of stakeholders. Thompson and Dowding (2002:152) mention that the composition of a guideline development group is an essential component of the eventual validity and acceptability of the resultant guideline (Duff *et al.*, 1996a in Thompson & Dowding, 2002:152). In addition, Shekelle *et al*. (1999:596) emphasise that guideline development requires sufficient resources in terms of people with a wide range of skills, including participants in the fields of finance, research and leadership. Various participants with diverse characteristics were involved in the development of guidelines for the health promotion of adolescents orphaned by HIV/Aids (see Table 5.2 in Chapter 5).

Participants comprising a panel of stakeholders were formally requested to participate in preliminary guideline development. The letter requesting their participation informed these stakeholders of the research topic, problem

statement, significance of the study, research objectives as well as the methodology of the study (see Annexure H).

Twelve members (see Table 5.2) participated in the guideline development process. The group of stakeholders consisted of community nurses, a member of LoveLife, a teacher, church minister, social worker, hospice managers, academics, local council representatives, a district health representative and a representative of the South African Department of Health. The researcher, promoter and co-promoter were also involved in the guideline development workshop.

The participants were purposely selected based on their knowledge of and experience in the health promotion and HIV/Aids context. The panel was informed of their responsibilities and roles regarding the development of guidelines that could assist nurses in encouraging families with adolescents orphaned by HIV/Aids to take part in their health promotion. The preliminary guidelines developed by the researcher were made available to the stakeholders. They were given one week to familiarise themselves with the guidelines in order to enhance active participation in the workshop held to refine the guidelines.

The group involved in the workshop discussed each guideline in detail. Decisions on the wording of each guideline were made by consensus. Following the workshop, the researcher compiled the guidelines in accordance with suggestions made by the panel. The guidelines were then given to the same stakeholders for further adjustment and confirmation. The researcher delivered sets of guidelines to the members of the panel with the request that they should study the guidelines once again and either confirm that they agree with each guideline or suggest changes supported by motivations on why the changes were necessary. Again the researcher worked through the inputs from the panel and with the guidance of the supervisors made some changes to the set of guidelines. A change was only made when the majority of the panel members suggested it and it was in line with the needs of adolescents identified in the empirical part of the study. The guidelines were later submitted to the Department of Health's National Director: Unit of Health Promotion to assess if the guidelines were in line

with the National Health Promotion Policy. Efforts from the office of director were directed toward critical analysis of developed guidelines. Adjustments were made in line with comments and suggestions. The guidelines were prepared for validation by the participants (see Chapter 6).

2.7.5 Validation of the guidelines

The purpose of the validation of the guidelines was to ensure guidelines of high quality (Agree Collaboration, 2003:2). The validation panel was purposely selected. The respondents who were involved in the validation of the guidelines were nurse experts with experience in the development and validation of guidelines. The guidelines were made available to these experts for external review in order to ensure the validity thereof. The guidelines were scrutinised and refined; some amended. This process increased the likelihood that clients would benefit from the implementation of the guidelines (Agree Collaboration, 2003:62).

2.7.6 Validation group

Eleven knowledgeable and skilled nurses were requested to validate the guidelines, and rate them according to a set of criteria provided to them. The nurse experts were requested in writing to participate. They were informed about the research topic, problem statement, significance of the study, the study objectives and the methodology applied.

2.7.7 Measures to ensure the validity of the guidelines

To ensure that the guidelines were valid and science-based, they were developed from evidence-based information and explicit connection of recommendations with evidence was ensured (Thompson & Dowding, 2002:158). The multi-professional and collaborative approach was utilised to enhance the credibility of the process followed to develop and validate the guidelines. Therefore, the participants involved in the development process were recognised

stakeholders and directly or indirectly involved in health promotion in the HIV/Aids context.

The validity of the guidelines was ensured through consultation of various literature reviews and the use of different groups in the development and validation of the guidelines. Extensive literature reviews suggest that the validity of guidelines depends on the expert knowledge of the participants, how evidence is identified and synthesised, and how recommendations are developed (UNAIDS, 1999:5). Guidelines with greater scientific validity are those that are developed from evidence-based information and also ensuring explicit connection of recommendations with evidence (Thompson & Dowding, 2002:158). These authors further emphasise that using a multi-professional, collaborative approach can enhance the credibility of guidelines. A multi-professional group of stakeholders participated in the development of the guidelines while expert nurses validated the guidelines.

2.7.8 Reviewing and updating guidelines

Guidelines should be externally reviewed to ensure content validity, clarity and applicability (Shekelle *et al*., 1999:596). The guidelines in this study were validated by nurse experts with experience in guideline development. Guidelines should be updated regularly and the date for upgrading specified (Shekelle *et al*., 1999:596). Therefore, the researcher intends updating the guidelines every three to five years once they have been implemented.

2.8 SUMMARY

The exploratory, descriptive and contextual method used in this study assisted the researcher and participants to explore and describe the concept of health promotion. The various health promotion needs of families caring for adolescents orphaned by HIV/Aids were explored and described.

In this chapter, the suitability of a descriptive, exploratory and contextual method for this study was addressed. Each step was practically applied. The

methodology of Phase 2 was also discussed in this chapter. Chapter 3 addresses the findings of the research and the literature control on the health needs of families with adolescents orphaned by HIV/Aids.

CHAPTER 3

DISCUSSIONS OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

The findings deduced from the analysis of the participants' interview transcripts, as well as the researcher's observational and personal notes, regarding the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal are discussed in this chapter. A copy of the transcripts is included as Annexure G.

Group interviews were used as data collection instrument. The researcher personally conducted the data collection by interviewing individual families with adolescents orphaned by HIV/Aids in rural Hammanskraal. Observational notes are descriptions of events experienced through watching and listening, while the personal notes reflect the reactions and experiences of the researcher (De Vos, 2002:33; Morse & Field, 2002:94). A tape recorder was used during the interviews which were then transcribed verbatim.

The data analysis was done by means of the steps identified by Tesch (1990) as quoted by Creswell (2003:192). Themes, categories and subcategories were identified from the transcribed interviews, the observational notes and personal notes.

Categories are meaningful compartments on which the analysis is based. They form the bridge between the raw data and the underlying theoretical and conceptual fields.

Categories must comply with the following primary conditions:

- Reflective of the objective of the research.

- Must include all the information and must be comprehensive.
- Mutually exclusive at all the times.
- Categories must be of equal status. This means that no category can be regarded as more important than another.
- Independency should be observed.

  (Rossouw 2003:166-7.)

Subcategories are subsections of categories. Themes are ideas, concepts, behaviours, interactions, incidents, terminology or phrases used to give meanings to words (Taylor-Powell & Renner 2003:2). The literature control serves to verify themes, categories and subcategories that are identified.

The themes that emerged enabled the researcher to develop preliminary guidelines for the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

3.2 ANALYSES AND DISCUSSIONS

Thirteen themes were identified from data obtained during the first round of data collection. These themes, summarising the needs of participant families as they relate to health promotion, are displayed in Table 3.1 on page 57.

These themes were based on the subcategories and categories that emerged from the data analyses. Table 3.2 on page 58 gives an overview and summary of all themes, categories and subcategories that were identified during the data analyses.

NOTE: n=8 (in table 3.1; page 57) refers to eight participant families, representing a total of twenty-seven (27) respondents.

TABLE 3.1: THEMES REPRESENTING HEALTH PROMOTION RELATED NEEDS

NUMBER OF THEME	THEMES REPRESENTING HEALTH PROMOTION RELATED NEEDS	NUMBER OF FAMILIES (n=8) WITH IDENTIFIED NEED
1	Physical needs	8
2	Safety/security needs	8
3	Love and belonging needs	4
4	Emotional needs	7
5	Need for family structure	2
6	Health needs	7
7	Esteem needs	5
8	Educational needs	8
9	Spiritual needs	4
10	Need to become a whole person	8
11	Support needs	8
12	Social needs	8
13	Needs related to technology	5

The researcher realised that, although the needs and problems of the participant families appeared to be overwhelming, they existed against a background of hope and survival. Therefore, the researcher conducted follow-up interviews with the participant families in order to determine how these families managed to cope and to explore the topic further. As all subcategories within the identified categories and themes were addressed during the second round of interviews, the applicable results are discussed in a separate paragraph under each subcategory.

Table 3.2 on page 58-59 contains a summary of the themes, categories and subcategories of health promotion related needs of families with adolescents orphaned by HIV/Aids.

TABLE 3.2: SUMMARY OF THEMES, CATEGORIES AND SUBCATEGORIES

NO.	THEMES	CATEGORIES	SUBCATEGORIES
1.	Physical needs (3.2.1)	• Basic needs (3.2.1.1)	• Food and nutrition (3.2.1.1.a) • Water, sanitation and elimination (3.2.1.1.b) • Housing (3.2.1.1.c) • Sleep and rest (3.2.1.1.d) • Stimulation and activity (3.2.1.1.e)
		• Unmet basic needs (3.2.1.2)	• Lack of resources (3.2.1.2.a)
2.	Safety/security needs (3.2.2)	• Physical and personal security (3.2.2.1)	• Fence surrounding house (3.2.2.1.a) • Own stand (3.2.2.1.b) • Employment with sufficient income (3.2.2.1.c) • Clothes (3.2.2.1.d)
		• Financial security (3.2.2.2)	• Money for healthcare and clothing purposes (3.2.2.2.a) • Money for educational purposes (3.2.2.2.b)
3.	Love and belonging needs (3.2.3)	• Internal environment (3.2.3.1)	• To be loved by family members (3.2.3.1.a)
		• External environment (3.2.3.2)	• To be loved by non-family members (3.2.3.2.a)
4.	Emotional needs (3.2.4)	• Conflict (3.2.4.1)	• Fights (3.2.4.1.a) • House chores (3.2.4.1.b) • Disrespect toward grandmothers (3.2.4.1.c)
		• Recreational facilities (3.2.4.2)	• Boredom (3.2.4.2.a) • Teen pregnancies (3.2.4.2.b)
		• Concerns (3.2.4.3)	• Worry about not be given a decent funeral (3.2.4.3.a) • Stigma attached to being an orphan (3.2.4.3.b)
5.	Family structure (3.2.5)	• Internal family structure (3.2.5.1)	• Need for parental care (3.2.5.1.a)
		• External family structure (3.2.5.2)	• Need an elderly person (3.2.5.2.a)

NO.	THEMES (continued)	CATEGORIES	SUBCATEGORIES
6.	Healthcare needs (3.2.6)	• Clinics (3.2.6.1) • Personnel (3.2.6.2) • General health problems and intervention needs (3.2.6.3) • Illnesses (3.2.6.4)	• Utilisation of clinics (3.2.6.1.a) • Doctors and nurses (3.2.6.2.a) • Treatment (3.2.6.3.a) • Counselling (3.2.6.3.b) • Better hygiene (3.2.6.3.c) • Epilepsy (3.2.6.4.a) • Arthritis (3.2.6.4.b) • Epistaxis (3.2.6.4.c) • Asthma (3.2.6.4.d)
7.	Esteem needs (3.2.7)	• Self and others (3.2.7.1)	• Need for respect, recognition and dignity (3.2.7.1.a)
8.	Educational needs (3.2.8)	• Facilities (3.2.8.1) • Constraints (3.2.8.2)	• Need for school materials (3.2.8.1.a) • Long distance to school (3.2.8.2.a) • Lack of libraries and facilities for career guidance (3.2.8.2.b)
9.	Spiritual needs (3.2.9)	• Church services and other related needs (3.2.9.1)	• Prayer, attending church ceremonies and religion (3.2.9.1.a)
10.	The need to be a whole person (3.2.10)	• Fit into the family and society (3.2.10.1)	• Emotions because of limited choices (3.2.10.1.a)
11.	Support needs (3.2.11)	• Internal support (3.2.11.1) • External support (3.2.11.2)	• Family members 3.2.11.1.a) • Community (3.2.11.2.a) • Government (3.2.11.2.b)
12.	Social needs (3.2.12)	• Social needs related to interaction with others (3.2.12.1) • Social needs that professionals can help with (3.2.12.2)	• Recreational activities (3.2.12.1.a) • Social service (3.2.12.2.a)
13.	Needs related to technology (3.2.13)	• Telecommunication (3.2.13.1) • Other appliances (3.2.13.2)	• Computers, telephones (3.2.13.1.a) • Microwave and kettle (3.2.13.2.a)

3.2.1 Theme 1: Physical needs

The first theme that emerged relates to physical needs. Two categories, namely basic needs and unmet basic needs, were identified during the data analysis. Table 3.2.1 reflects the categories and subcategories within the theme physical needs.

TABLE 3.2.1: THEME 1: PHYSICAL NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
1.	Physical needs (3.2.1)	• Basic needs (3.2.1.1)	• Food and nutrition (3.2.1.1.a) • Water, sanitation and elimination (3.2.1.1.b) • Housing (3.2.1.1.c) • Sleep and rest (3.2.1.1.d) • Stimulation and activity (3.2.1.1.e)
		• Unmet basic needs (3.2.1.2)	• Lack of resources (3.2.1.2. a)

Physical needs are regarded as basic needs for all people irrespective of age, status or cultural background. Meeting basic needs is imperative to ensure the survival of the individual.

3.2.1.1 Category: Basic needs

Basic needs: Data

Within the first theme physical needs, the category basic needs emerged. The focus in this category was on the following subcategories: food and nutrition; water, sanitation and elimination; housing; sleep and rest; and stimulation and activity. Each will be discussed as a subcategory of the category basic needs.

- **Food and nutrition**

The participants expressed their needs regarding food and nutrition as follows:

> *"We are suffering with hunger. We need food to see this life."*
>
> *"We will never survive without food."*
>
> *"We need food because they [sic] give energy. We will then not be hungry."*
>
> *"We always go to school without lunch box or food."*
>
> *"We need food so that we do not feel hungry."*
>
> *"….and if they (food) are finished we have to request food from our neighbours."*
>
> **"***If you have various food stuff such as soya mince, balanced diet with vegetables, macaroni, milk and meat …".*
>
> *"It is to eat various food and fresh vegetables."*
>
> "*Our grandmother arranges, if there are no food, credits with informal shops to take basic foods such as mealie-meal (maize meal), five roses (tea), sugar and beans to survive. She pays with pension money every month. The Anglican Church congregation also donates food parcels to our family to survive".*

When the topic (subcategory) of food and nutrition was further explored during the follow-up interviews, the researcher wanted to determine what it meant for the participants to eat healthily or well. The researcher also wanted to determine the circumstances which enabled the participants to cope and survive. Data gathered from the first round of interviews were confirmed. It was clear that the participants believed that different kinds of food, such as pasta, vegetables and soya beans, constituted a balanced diet.

- **Water, sanitation and elimination**

The families expressed their needs regarding water, sanitation and elimination in the following ways:

> *"We need water for daily activities in home."*
>
> *"We need water. We usually fetch water from our neighbours, and sometimes we buy water at 50 cents for 25 litres."*
>
> *"We only have time to fetch water from our neighbours after they have completed fetching water."*
>
> *"We need basic needs such as good sanitation. The toilet has no door."*
>
> *"The toilet is too far from the house and it does not have a door. It is scary but you walk alone. People pass next to the toilet on the next 'door road' [sic] (through road or alleyway), that is why is scary. During darkness we use candles as a torch to walk to the toilet."*
>
> *"Washing baths are not there."*
>
> *"We need water pump in the house."*
>
> *"We fetch the water 1-3 km from home."*
>
> *"We use small bath for bathing."*
>
> *"We walk a distance of approximately 200 m from the house (for toilets)."*

When the topic (subcategory) of water, sanitation and elimination was further explored during the follow-up interviews, the researcher wanted to determine how the participants survived with little or no water, as well as poor sanitation and elimination facilities. The participants' response revealed that some were forced to travel from 200 m and up to 3 km away from their homes at Kekana Village to

fetch water. They also expressed fear at having to walk alone to the available toilet facilities, especially at night, as other people often passed by them, and they had only candles to light the way.

- **Housing**

In addition to food, water and sanitation, housing was emphasised as a basic need. Several expressions referred to housing. These were:

> *"We also need a house as this one is old and is not safe, especially when there is a storm."*
>
> *"We need a house that belongs to us."*
>
> *"We need our own yard."*
>
> *"We have no stand."*
>
> *"We have hired a stand."*
>
> *"The most problematic thing is a home – from December we have to see what to do."*
>
> *"We need a house that is suitable for our family."*
>
> *"The house that can accommodate all of us"*
>
> *"We need a house because we live in a shanty house and is not safe; planks are old and falling. During windy weather it will fall."*
>
> *"We need a brick house because people laugh at us."*

When housing as a basic need was further explored during the follow-up interviews, the researcher wanted to understand how these families coped or survived, as housing was a scarce commodity.

One family had difficulty obtaining a living stand and expressed uncertainty about whether they could stay in the area. Eventually, following some advice, they went to the tribal authority to request a stand. Chief Kekana, in return, provided them with a free stand. Housing also involves the aspect of privacy, as was emphasised by one family member who mentioned the desire to study in a quiet room, free of disturbances. It was mentioned that privacy was needed to ensure the safety of belongings and school materials, and that, when the whole family sleeps in one room, items tended to get lost.

- **Sleep and rest**

The participants explained that poor sleeping conditions led to discomfort and lack of sleep. Their problems surrounding this basic need were expressed as follows:

> *"We need blankets and mattresses - the mattresses we use are too old and the springs are pointing out."*
>
> *"We have insufficient blankets for these orphans."*
>
> *"We sleep on a mattress that is put on the floor."*
>
> *"It is not comfortable because you experience backache due to the hard surface."*

During the second round of interviews, the researcher wanted to further explore the issue of lack of sleep and rest. The participants indicated that they survived but still had problems such as discomfort and backache due to uncomfortable sleeping conditions.

- **Stimulation and activity**

The issues of activity and stimulation are interlinked.

On these issues, the participants expressed the following needs:

> *"Usually we use traditional exercises and games but they are not enough. We use various traditional games."*
>
> *"I want to train to be fit."*
>
> *"We want to exercise to be able to gain weight."*
>
> *"We need some toys to play with."*
>
> *"We play with sand and bricks."*
>
> *"Toys help with various plays."*

When the topic (subcategory) of stimulation and activity was further explored during the second round of interviews, the researcher wanted to determine the different ways in which the participant families met this specific basic need. The participants said that they had learned to create their own games, such as playing with blocks, running, singing, playing soccer and beating drums, and had realised that activity and stimulation increased creativity.

Basic needs: Literature control

New studies, reported daily, show the relationship between the composition of diets and the occurrence and prevention of diseases. Researchers suggest that dietary practices may be the single most important choice for determining health and longevity (Phipps, Sands & Marek, 2003:47, 60, 62). Allender and Spradley (2005:635) add that adequate nutrition must begin at birth and extend to young children and women. They further indicated that special supplemental food programmes need to be integrated to support these groups. Nutrition and weight control programmes as sets of health-focused promotion services are their main focus.

De Haan *et al.* (2005:210) indicate that correct and quality food is essential for health and life itself. A diet must be maintained for intellectual, as well as for physical health. It should provide adolescents with relevant nutritional needs. Healthcare professionals and non-healthcare professionals must be aware of the nutritional needs of adolescents in order to improve their quality of life.

In support of the above statements, Murray and Zentner (2001:534) add that due to accelerated physical and emotional development, growing children's bodies need enough and appropriate nutrition. Food, as part of nutrition, fulfils the following functions:

- It provides the body with heat and energy.
- It repairs tissues.
- It regulates body processes.
- It maintains health and protects the body against infection.

It was emphasised in the United Nations Convention on the Rights of the Child (Ramsden, 2002:14) that all children have a right to have basic needs, such as provision of food, fulfilled.

President Thabo Mbeki, in his address to communities in KwaZulu-Natal, emphasised the need for clean running water (South African Government Information, 2003a:1-5). This will also reduce local health problems, such as cholera and Bilharziasis. The provision of clean water would also contribute to health promotion among the participant families.

The Department of Health (2001b:10) in South Africa states that everyone has the right to have access to water. It is a fact that no human being can survive without clean water to drink. Water is a basic need, a *sine qua non* of life, without which people cannot survive.

Dennill, King and Swanepoel (2002:3) confirm that one of the components of primary health care is that there must be adequate supply of water and basic sanitation. This component is only practical if the community is informed about

access to clean water, the sources of clean water, the implications of clean and polluted water on health, water related hazards and water related diseases. Impure water will be used if clean water is not available and this will later affect people's health status, leading to disease or death.

De Haan *et al.* (2005:167,258) state that adequate housing is necessary for all people, meaning:

- The site must be suitable,
- The house must be well planned and constructed,
- The house must have facilities for cooking, washing, bathing, and storing food, and
- The house must have a piped water supply, adequate sanitation, and a satisfactory method of disposing garbage.

Lack of sleep will result in stress which may affect one's health and sleeping pattern. Sleep patterns vary greatly among individuals. The normal number of hours of sleep required by adolescents is eight hours per night (Edelman & Mandle, 2002:627-8).

Elimination is a digestive process that occurs after digestion and absorption, when waste products are evacuated from the body (Smeltzer & Bare, 2004:941). The gastro-intestinal system matures during the adolescent years, *i.e.* from the age 10 to 20 (Murray & Zentner, 2001:533). The elimination patterns of an adolescent are established and relate to food and fluid intake (Murray & Zentner, 2001:533). Elimination and privacy should be considered important during the adolescent years. Adolescents should be provided with adequate facilities, such as toilets, and their privacy be respected.

Regular physical activity and exercise enhance both physical and psychological health (Edelman & Mandle, 2002:320). Murray and Zentner (2001:538-9) suggest that exercise and rest must be balanced because they are related. They argued that once the body is tired, it should be allowed to rest, in order to maintain its balance.

3.2.1.2 Category: Unmet basic needs

Unmet basic needs: Data

Unmet basic needs emerged as the second category within the theme physical needs during the data analysis. Unmet basic needs can be described as the challenges experienced by families with adolescents orphaned by HIV/Aids in rural Hammanskraal when they lack necessary resources. It could be that resources are available but that these families for some reason do not have access to resources.

- **Lack of resources for basic needs**

The respondents in the study emphasised the lack of resources or facilities that serves as a barrier to their survival. This was revealed in expressions such as:

"We have inability to pay for what is needed."

"We do not have money to pay school fees and for pocket money."

"The blankets that we have are not enough."

"If you do not have anything you are not allowed at school."

"We do not have enough clothing."

"We want clothing to look similar with other children."

"There is no place for cooking."

"We need money to buy paraffin."

"I need washing soaps and washing cakes so that we become clean."

"We need lounge suit to sit properly at home. We need chairs to give visitors."

When the topic (subcategory) of unmet basic needs was further explored during the follow-up interviews, the researcher wanted to determine how families survived and coped in these circumstances. The participants admitted that they had to buy basic food such as mealie-meal (maize meal), tea, sugar and beans on credit to survive. One family mentioned that they received donations such as food parcels from a local church.

- ***Unmet basic needs: Literature control***

Availability of and accessibility to all basic needs are priorities to prevent poverty. The following definition of poverty is relevant:

"*Poverty is defined as a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security, and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political, and social rights*" (ICN, 2004:5).

In this study, many elements of poverty were observed. Edelman and Mandle (2002:607) confirm that unmet basic needs are associated with unemployment, inadequate housing, poor sanitation, poor nutrition, low educational levels, and limited access to health and social services. The lack of resources to fulfil basic needs is an obstacle for families with orphans.

Siaens, Subbarao and Wodon (2003:2) add that there is evidence to suggest that on average, orphans in Africa live in poorer households compared with non-orphans. The majority of these orphans, according to African tradition, are placed either in extended families or in fostering households. Many of these families live without support, in poverty.

3.2.2 Theme 2: Safety/security needs

The theme safety or security needs emerged from data obtained during the interviews. Within this theme, two categories, namely physical and personal

security, and financial security, emerged. Table 3.2.2 displays the categories and subcategories within the theme safety/security needs.

TABLE 3.2.2: THEME 2: SAFETY/SECURITY NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
2.	Safety/security needs (3.2.2)	• Physical and personal security (3.2.2.1)	• Fence surrounding house (3.2.2.1.a) • Own stand (3.2.2.1.b) • Employment with sufficient income (3.2.2.1.c) • Clothes (3.2.2.1.d)
		• Financial security (3.2.2.2)	• Money for healthcare and clothing purposes (3.2.2.2.a) • Money for educational purposes (3.2.2.2.b)

Participants regarded safety or security needs as an important aspect of human survival.

3.2.2.1 Category: Physical and personal security

Physical and personal security: Data

The first category that emerged from safety/security needs was the need for physical and personal security. The participants believed that a healthy family needs to reside in a physically secure environment. Their physical and personal security was also threatened by temporary living arrangements and insufficient income to provide for basic necessities. Subcategories within this category are a fence surrounding house, own stand, and employment with sufficient income. With respect to each subcategory, self-explanatory quotations are listed.

- **Fence surrounding house**

"There is no security and the place is not safe, because there is no fence."

"Crime is high, people are fighting next to our fence and later trespass our yard."

- **Own stand**

"We do not have our own stand for a while, and we are afraid that any time they can come and chase us away."

"The stand that we are living in, is not ours; the owner is selling it for R3 000,00 and I am afraid we have no place to stay."

- **Employment with sufficient income**

"One member is working and the pay is insufficient."

"We make some means to survive - we are selling things."

"We need tracksuits to be warm."

"We do not have blankets."

"During winter it is too cold."

"We need raincoat and umbrella. If it is raining, we are unable to go to the school."

When the topic of physical and personal security was further explored during the follow-up interviews, the researcher wanted to determine what was meant by safety and security and how these families coped within an insecure environment. Living on a stand that did not belong to them made families feel insecure. The participants also mentioned that a safe place meant having burglar doors, windows, and fencing.[2] The participants further indicated that they considered sufficient income as an income of R550,00 per week.

[2] In 2006, all the participant families received a sponsor from a hospice and their yards are now fenced.

Physical and personal security: Literature control

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

Employment is a process of being able to do work and earning enough money to cater for your family's needs. In the African tradition, it is the responsibility and obligation of all adults within a family to provide for the children in that family (Bozalek, 1999:1; Social Protection Sector, 2004:1). Unemployment often results in a vicious circle of family disorganisation, poverty, crime, disease and death, and always contributes to physical and personal insecurity. De Haan *et al.* (2005:19) refer to the Employment Equity Act, 1998 (Act No. 55 of 1998), which promotes the constitutional right to fair employment practices to ensure job opportunities for all people in South Africa.

South Africa is a country with high statistics of unemployment. In 2001, the overall unemployment rate in urban areas was 29,5%. In rural areas, the unemployment rate was 30,2% (Van Rensburg, 2004:206). This shows that unemployment is rife in both urban and rural areas, with rural areas slightly more affected than urban areas.

Unemployed young men and women were identified by the Department of Health (2001b:17), in the National Health Policy, as a target group whose situation has to be addressed. It was emphasised that the health needs of this group need to be recognised.

3.2.2.2 Category: Financial security

Financial security: Data

Within the category financial security, two subcategories, namely money for healthcare and clothing purposes, and money for educational purposes, emerged. The participants emphasised the need for money in order to maintain and promote their health, as well as for educational purposes. Relevant quotations are listed under each subcategory.

- **Money for healthcare and clothing purposes**

  "We do not have finance to buy."

  "We want money to go to the clinic."

- **Money for educational purposes**

  "*At school we are behind with the school fundraising money."*

  "We do not have money to pay school fund and for pocket money."

  "We need money to further my educational studies."

When financial security was further explored during the second round of interviews, the researcher wanted to determine to what extent the participants understood the issue of money and how they coped without money. Because of very limited finances, the participants found it difficult to cope. They had to pay school fees and buy household necessities. For these purposes, and to pay for an educational excursion and to buy school materials, the participants had to borrow money from their extended families. Only the most basic necessities are bought in order to survive.

- ***Financial security: Literature control***

The data analysis revealed that the participants realised that sufficient money could mean an improvement in their standard of living. In support of how the participants have expressed themselves, the government advocates a better life for all through a variety of strategies. A social security net is envisaged to ensure that social grants reach all beneficiaries. The age limit for child support grants has been extended to include children up to fourteen years old, increasing the number of children that will benefit from the grants to about 3,2 billion by 2006 (South African Government Information, 2004:1-2). This increase in the age limit will help the young adolescent orphans to improve their circumstances with the support of the government.

When parents die, their children suffer. A recent survey of their clients by MetLife found that 40 per cent of the workers between the ages of 21 and 30 years had not begun to save for their retirement and other circumstances. Many young adults do not know how to even begin doing so (Irvine, 2005:1). This indicates that, although money is a scarce commodity, people fail to plan for their own children's care should they die.

3.2.3 Theme 3: Love and belonging needs

Love and belonging needs also emerged during the data analysis. The theme love and belonging needs was categorised into an internal environment and an external environment that related to the circumstances of the participants. To be loved by family members (internal environment) and to be loved by non-family members (external environment) were identified as subcategories.

Table 3.2.3 on page 75 displays the categories and subcategories within the theme love and belonging needs as they relate to the promotion of health.

TABLE 3.2.3: THEME 3: LOVE AND BELONGING NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
3.	Love and belonging needs (3.2.3)	• Internal environment (3.2.3.1) • External environment (3.2.3.2)	• To be loved by family members (3.2.3.1.a) • To be loved by non-family members (3.2.3.2.a)

People need love in order to feel as if they belong to a particular unit or family. Adolescents orphaned by HIV/Aids emphasised the need to be loved and to belong to a family, and these orphans as well as their extended families stressed the need to be acceptable to and be accepted by society.

3.2.3.1 Category: Internal environment

Internal environment: Data

HIV/Aids orphans who participated in this study indicated the need to be loved by their family members. Family members such as uncles, aunts and grandmothers play an important role in creating feelings of love and belonging. Loving and love stimulate self-worth and self-actualisation, which are principles of a healthy person.

- **To be loved by family members**

Adolescents orphaned by HIV/Aids expressed their feelings as follows:

> *"Our family members do not want to stay with us."*
>
> *"The family members want me to stay away from friends, because friends may influence us."*
>
> *"We want to be listened to by our (substitute) parents."*

When the topic of internal environment was further explored during the second round of interviews, the researcher wanted to understand the views of the participants on the subject. The participant orphans emphasised that the love of a concerned person was similar to parental love. The participants further emphasised that they needed to be guided within their homes on how to rear children themselves.

Internal environment: Literature control

Graca Machelle in the year 2003, in a speech, said that the rights of orphaned children should not be postponed (Kalideen, 2003). She further indicated that it was the responsibility of all to start acting in a caring and responsible manner (Kalideen, 2003). Similar ideas and opinions are maintained in the statement issued by the Pennsylvania Conference on Interchurch Cooperation (1990:1). It says that a family is constituted to provide an opportunity for the expression of love and support in a stable relationship benefiting all its members.

3.2.3.2 Category: External environment

External environment: Data

The participants indicated their desire to be loved, not only by their families, but also by their peers and neighbours. They were of the opinion that this love from an external environment would motivate people to provide for them during difficult times, and ensure not only food during hunger, but also attention and visits.

- **To be loved by non-family members**

The participants expressed that:

> *"We also need good attention from our school mates and attention from other people and our parents (their surrogates)."*

The above statement reveals that families with children orphaned by HIV/Aids need to be accepted by society and fit into society. During the follow-up interviews, the researcher wanted to further explore the involvement of non-family members with the participants. The participants mentioned the help that they received from the Moretele-Sunrise Hospice and from next-door neighbours when they could not afford groceries. Even though they had no means, the participants survived and coped through the care and love of their neighbours.

- ***External environment: Literature control***

From the interviews conducted, it has become clear that being an adolescent orphan does not mean one has lost one's humanity. The need to love and to be loved still exists. An adolescent orphan is a complete being with feelings and with the need for a sense of belonging. They also need to feel loved by family members to promote their self-worth or self-esteem. If these needs are not taken into account, individuals become unfriendly, feel restless, unloved and even rejected and abandoned (Marker, 2003:1; Motivation, 2004).

3.2.4 Theme 4: Emotional needs

Emotional needs as theme emerged and was further categorised into conflict, recreational facilities, and fear.

TABLE 3.2.4: THEME 4: EMOTIONAL NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
4.	Emotional needs (3.2.4)	• Conflict (3.2.4.1)	• Fights (3.2.4.1.a) • House chores (3.2.4.1.b) • Disrespect toward grandmothers (3.2.4.1.c)
		• Recreational facilities (3.2.4.2)	• Boredom (3.2.4.2.a) • Teen pregnancies (3.2.4.2.b)
		• Concerns (3.2.4.3)	• Worry about not be given a decent funeral (3.2.4.3.a) • Stigma attached to orphans (3.2.4.3.b)

3.2.4.1 Category: Conflict

Conflict: Data

Conflict in the form of fights due to house chores and disrespect for grandmothers was a major concern among the participants. Relevant expressions are listed below.

- **Fights**

> *"We need an elderly person who can advise us or even to stop us when we are fighting."*
>
> *"These children are fighting and we are unable to handle the situation."*
>
> *"We experience the problems of fighting amongst these children."*
>
> *"They do ku-kur-ku-kur-ku-kur-kur in the house."* (The children were physically fighting and bumping into the furniture.)
>
> *"They even shout at each other in the street in front of people."*

When the topic of conflict was further explored during the follow-up interviews, the researcher wanted to determine the causes or factors influencing the fights and the way in which all participants cope when the children fight. The participants confirmed that they fight frequently because they do not respect each other and they are used to fighting. However, someone always calms the situation.

- **House chores**

The following quotes are relevant:

> *"We fight frequently."*
> (This was said referring to the context of house chores.)

"We fight over washing dishes – mmm - aish – and – aish – for family affairs." (These words are used when the situation is regarded as serious and solutions are sought.)

- **Disrespect toward grandmothers**

This situation is explained by the following quotes:

"These orphans do not respect their grandmother. They do not respect me."

"I do all the work alone."

"We have a problem with eighteen years young girl. She is taking alcohol and staying with a boyfriend. She absents herself from school. These cause lots of problems to me."

When the topic of disrespect for grandmothers (as parents) was further explored during the second round of interviews, the researcher tried to determine the reason for this behaviour and how the grandmothers coped with it. One participant said that the children insulted her and called her a witch-grandmother. The children also shouted at her in the streets and said that she was mentally not well. The grandmother mentioned that she consulted with the extended family (including an uncle and aunt) to try and modify the behaviours of the adolescents and to cope with the stress caused by their disrespect.

Conflict: Literature control

Murray and Zentner (2001:506,507) mention that in guidance and discipline, the parents need to instill confidence in the child. The child's privacy has to be respected. Consistency in guidance and discipline is important to help the child feel in control of him/herself. A well-disciplined child obeys the rules, norms and tradition of the family, thus contributing to health promotion.

Gerdes (1988:461) mentions that, in traditional South African culture, elderly people enjoyed a high status and thus respect in the family. However, industrialisation and urbanisation changed this. Murray and Zentner (2001:747-48) emphasise that children previously appeared most positive in their perception of elderly persons and further indicated that the elderly were perceived as powerful and admired.

3.2.4.2 Category: Recreational facilities

Recreational facilities: Data

The second category that emerged from the theme emotional need was a need for recreational facilities and this was further subcategorised into boredom and teenage pregnancies.

- **Boredom**

According to the expressions of the participants, boredom had the following results:

> *"I always think too much; I remember my mother. I think where she has rested."*
> (This was said in a context where boredom surfaced.)

> *"I have problems with the learners at school. They put chalk dust on my chair when I sit down, and when I complain they say I am naughty. I have been worrying them."*
> (The respondent wanted to indicate that she was bored at school, because the other learners did not play with her - they rather made fun of her.)

Boredom was further explored during the follow-up interviews. The participants added that they did not have recreational facilities like television and friends with whom to play.

- **Teenage pregnancies**

The following quotes are relevant:

> *"We are fine except the young daughter who is sometimes staying away from home. She is staying with a boyfriend."*
>
> *"She will be pregnant."*

When the topic of teenage pregnancy was further explored during the second round of interviews, the researcher was informed of the participants' belief that your guidance, way of life and how you were raised are important. The participants discussed their concern that young girls will sleep with their boyfriends and become pregnant. The participants stated that adolescents have to take responsibility for themselves and their behaviour.

Recreational facilities: Literature control

Uys and Middleton (2004:28) mention that the basic biophysical needs that are part of the patterns of fulfilling in every person include patterns of activity or exercise. Various factors cause a teenager girl to sleep with her boyfriend and fall pregnant. One of the major factors is a plea for attention and help, either from parents, the boy involved, or others (Stanhope & Lancaster, 2000:688-9). The above statement indicates that, because her parents are no longer alive, and these families are poor, the girl resorts to a boyfriend as her security. She lacks a role model and responsibility for herself and her behaviour. Being an orphan may, in some cases, lead to a teenage pregnancy with adverse long-term consequences for the adolescent.

The number of teenage pregnancies in Africa is high. According to a UNAIDS report, 70% of the people in Namibia are under 30 years of age, and one in every five pregnancies or 20% occur in the age group of 13-19 (IRIN NEWS.ORGANISATION, [S.a.]).

Neglected teenagers, and teenagers who fail to act responsibly, have a high risk of falling pregnant. In this study, the participants were concerned about the possibility that the female adolescents may fall pregnant, as it would make their circumstances worse. Being sexually active also increases their risk of acquiring sexually transmitted infections (STIs), including HIV.

3.2.4.3 Category: Concerns

Concerns: Data

The third category that emerged from the theme of emotional needs was concerns. This category was further subcategorised into worry that that they would not be given a decent funeral and the stigma attached to being an orphan.

- **Worry about not be given a decent funeral**

The following quotations are relevant:

> *"We need (burial) society – mmm – to prepare for any death in family."*
>
> *"We need finance to pay the society."*
>
> *"We need funeral society with funeral plans, if one member dies we are able to bury her/him because we are going to die."*
>
> *"We cannot live forever."*
>
> *"All of us, we are going to die."*
>
> *"Funeral society is important because they help if we do not have money."*
>
> *"The (burial society's) plans help with coffins, chairs and tents."*
>
> *"We need funeral plans because there is death that we cannot escape."*

"Death is there for life."

When the topic of the desire for a decent funeral was further explored during the second round of interviews, the researcher found that a funeral policy in these families is regarded as important, because a decent funeral shows respect to the deceased. Although all the participants are poor, they want to be able to contribute to a funeral policy as it will assist them to cover funeral costs when the situation arises.

- **Stigma**

The participant HIV/Aids orphans emphasised the fact that they were orphans. The following expressions are relevant:

"We want to be like other children."

"What will people say about our condition as orphans in our home?"

When the topic of the stigma attached to being an orphan was further explored during the follow-up interviews, the participants added that being an orphan carries the stigma of poverty and a low standard of life. According to them, society is quick to pass judgments on orphans.

Concerns: Literature control

The effects of the death of a loved one are described by Mengel (2003:31) as emotional numbness, inner sorrow, and longing, which result in a refusal to accept changes that are associated with death. Experiencing the death of a loved one also influences the way in which people will react to death in future. In this study, the death of their parents made the adolescents very aware of how necessary it is to prepare for death and the associated costs.

When a parent falls sick or dies, the lives of their children fall apart. They lose not only a parent and the guidance that he or she could provide, but also the financial

security that parents offer their children. In poor families, the financial burden that the death of a parent causes is worse. In many cases, the parents do not have financial insurance and the children are left without any money. These children are often stigmatised or ostracised by their communities and easily become victims of violence and exploitation (Children orphaned by AIDS, [S.a.]:2-6).

3.2.5 Theme 5: Family structure

Family structure was mentioned as an important aspect for the survival of the family. The theme family structure emerged during the data analysis and was further categorised into internal and external structures.

TABLE 3.2.5: THEME 5: FAMILY STRUCTURE

NO.	THEME	CATEGORIES	SUBCATEGORIES
5.	Family structure (3.2.5)	• Internal family structure (3.2.5.1) • External family structure (3.2.5.2)	• Need for parental care (3.2.5.1.a) • Need an elderly person (3.2.5.2.a)

3.2.5.1 Category: Internal family structure

- ***Internal structure: Data***

The first category that emerged was internal family structure. The internal family structure focused on one theme only, namely the need for parental care.

- **Need for parental care**

The need for parental care emerged during the data analysis. The participants in this study simply mentioned:

> *"A complete family is necessary."*

> *"There is a need for parental care."*

When the topic of the need for parental care was further explored during the second round of interviews, the participants emphasised again that one can survive if one has parental love. It was further added that only parents (as opposed to older children) can look after children properly.

Internal family structure: Literature control

A family is a unit with different sub-units. Each sub-unit contributes toward the survival of the whole family as a unit. Interference with one of the sub-units will affect the functions of other sub-units. In a nuclear family, parents have various functions, such as:

- Socialisation functions,
- Functions on affective level,
- Reproduction functions,
- Healthcare functions,
- Economic functions, and
- Educational functions.

These functions are fulfilled amongst members of families as complete or incomplete tasks. In the families that participated in the study, these functions are not completely fulfilled, which results in their need for support in order to survive. Although these families regard themselves as incomplete, Van der Walt, Tjallinks, Paton and Brink (1990:23) emphasise that in existentialist terms, an individual and thus every member of the family is continually coming into being or evolving toward something, indicating that the individual constantly experiences changes and that having to live under difficult circumstances does not mean that the individual cannot fulfil some aspects related to the family unit.

3.2.5.2 Category: External family structure

External family structure: Data

Only one subcategory, namely the need for an elderly person such as an uncle, aunt, grandparent, or neighbour, was identified within the category external family structure.

- **Need for elderly person**

The participants confirmed the need for an elderly person to take care of them:

> *"We also need an elderly person who can advise us or even stop us when we fight … Like me and Kedibone we fight."*
>
> *"I think if we can find a kind person who can share our problems."*
>
> *"These orphans do not respect their grandmother."*
> (The implication was that they needed somebody they would accept as a mother.)
>
> *"I want to assist mam Motaung. I want to buy her a car because she is the one who maintains us at school."*
> (This referred to an elderly person who helped to keep the children in the school, because she was paying school fees.)
>
> *"We also need some school uniform, because at school they need school uniform."*
> (This was said in a context where it became clear that they needed an elderly person to buy these for them.)
>
> *"I do all the work alone."*
> (This was said by a grandmother, with the implication that the involvement of another older person was needed in order to assist in caring for these orphans.)

During the follow-up interviews, the researcher wanted to verify if there was a real need for the involvement of an elderly person like an uncle, aunt or elderly neighbour to ensure the survival of the participant families. The participants confirmed that an elderly person would help solve their problems and that an elderly person can act as a substitute for the parent that they have lost. The participants further added that neighbours in the community help a lot because they give them what they do not have during difficult times.

- ***External family structure: Literature control***

A variety of family structures, such as the traditional, extended or multigenerational, as well as the nuclear type, constitutes the normal African family. Whenever a child loses both parents, traditionally the child is given to or adopted by one of the close relatives (Andrews & Boyle, 2003:170; UNAIDS, 2006:94). This is done in order to avoid orphanage, as orphanages are stigmatised. It is believed that nature does not leave any thing, in this case, children, in a vacuum (meaning without relationships). Andrews and Boyle (2003:170) also mention that elderly individuals can fulfil multiple care-giving roles, such as caring for orphans. The impact of HIV/Aids in Hammanskraal, as well as in other rural areas in South Africa, is that the elderly have to care for orphans. It should be noted that from an African perspective, elderly community members are preferred to take care of orphans, because they have the ability to transfer traditional norms to the adolescent, thus ensuring that the cultural traditions and norms are passed on to the next generation (UNAIDS, 2006:94).

3.2.6 Theme 6: Healthcare needs

Healthcare needs emerged as theme during the data analysis. It was further categorised into clinics, personnel, interventions, and illnesses. Health care, as a need, was emphasised by the participants in the study.

Table 3.2.6 on page 88 displays the categories and subcategories identified within the theme healthcare needs.

TABLE 3.2.6: THEME 6: HEALTHCARE NEEDS

NO.	THEMES	CATEGORIES	SUBCATEGORIES
6.	Healthcare needs (3.2.6)	• Clinics (3.2.6.1)	• Utilisation of clinics (3.2.6.1.a)
		• Personnel (3.2.6.2)	• Doctors and nurses (3.2.6.2.a)
		• General health problems and intervention needs (3.2.6.3)	• Treatment (3.2.6.3.a) • Counselling (3.2.6.3.b) • Better hygiene (3.2.6.3.c)
		• Illnesses (3.2.6.4)	• Epilepsy (3.2.6.4.a) • Arthritis (3.2.6.4.b) • Epistaxis (3.2.6.4.c) • Asthma (3.2.6.4.d)

3.2.6.1 Category: Clinics

Clinics: Data

The utilisation of clinics was identified as a subcategory of the category clinics.

- **Utilisation of clinics**

The participants expressed the following:

> *"We need health care such as clinics."*
>
> *"Clinics to be accessible care needed in promoting the health of these families."*
>
> *"Due to bad roads it is difficult to access clinics."*
>
> *"We need special doctor to check our young brother … who has nose bleeding … continuously."* (It was mentioned that children were checked at school.)
> *"Children are checked at school … for their health; the nurses do this - to attend the school kids regularly".*

When utilisation of the clinic was further explored during the follow-up interviews, the participants confirmed that they walk a distance to the clinic and that the untarred road is muddy in the rainy season. They make use of clinics when they are sick only and no health promotion or illness prevention services are made use of.

Clinics: Literature control

Dennill *et al.* (2002:6), in a strategy for the implementation of primary health care, emphasise that health services should be accessible, affordable, available, effective, efficient and be supplied equal to all in the community. Geographically, the community should have a clinic within 5 to 10 km and transport to and from the clinic should be available. Dennill *et al.* further emphasise that special attention should be given to disadvantaged regions of the country, especially rural areas.

Tarred roads are still a scarce commodity in rural areas, especially in Hammanskraal. The rural development renewal programmes announced in 2004 would with time improve the condition of the roads in rural areas (President Thabo Mbeki's State of the Nation Address on 21 May 2004) and thus also in Hammanskraal (South African Government Information, 2004).

3.2.6.2 Category: Personnel

Personnel: Data

Personnel emerged as category within the theme healthcare needs. Only one subcategory, namely doctors and nurses, is identified.

- **Doctors and nurses**

The following quotes are relevant:

"We need doctor or medical aid because one of our family member [sic] is sick".

" – at the clinic they do not give us the correct medicine."

"We want medical aid to secure our health condition."
(The implication was that medical aid to secure health was not always available).

"We need to attend check-ups for healthy life, but unfortunately doctors are not available in the clinics."

During the second round of interviews, the researcher wanted to determine why there was a need for doctors and nurses and how they contributed to the participant families' survival. The participants said that doctors help people by treating diseases such as tuberculosis (TB) and Aids. They further emphasised that, when there is no doctor, nurses assist the patients and dispense medicine for the treatment of diseases. Nurses were considered helpful.

- ***Personnel: Literature control***

The provision of health care has to be based on the principles of *Batho Pele* (Sesotho for 'people first'). This initiative by the Department of Public Service and Administration (DPSA) intends to improve the quality of public services in South Africa, including public healthcare delivery. According to the *Batho Pele* principles, the members of the community should be consulted, and treated with courtesy. Healthcare providers, including nurses, should render a client friendly service to all people of South Africa, and high standards of services are guaranteed by the Minister of Health (DPSA, 1997).

3.2.6.3 Category: General health problems and intervention needs

- ***General health problems and intervention needs: Data***

The category general health problems and intervention needs emerged during the data analysis. The following subcategories were identified: treatment; counselling; and better hygiene.

- **Treatment**

Effective treatment in promoting health was expressed as:

> *"We need good health to live longer."*
>
> *"I need medical aid card so that if I become ill I should go to the clinic."*
>
> *"I need medical service to help us. Maybe if one member is sick, we are able to take her where there is a help."*

When the topic of treatment was further explored during the follow-up interviews, the participants said that good medical treatment would prolong their lives. It was also implied that the participants would not misuse the availability of treatment by seeking treatment when healthy. However, it is firmly believed that treatment keeps one healthy.

- **Counselling**

The participants indicated that:

> *"I need to be counselled once or twice a week."*
>
> *"I have stress due to overload of responsibilities."*
>
> *"I do not cope. I share these problems with neighbours."*

This topic was further explored during the follow-up interviews in order to determine why the participants felt they needed counselling. One participant said that she needed counselling twice a week, because she experienced various problems every day, such as the socialisation of the children she looks after. She wanted to understand what they do at school and be counselled on how to take care of them.

- **Better hygiene**

Better hygiene emerged as subcategory within the category general health problems and intervention needs. The following quotations pertain to this topic:

> *"There are cockroaches and rats."*
>
> *"There is a need to be free from rats and cockroaches."*
>
> *"We need washing soaps and bathing soaps."*
>
> *"We need a storage trunk for our mealie-meal (maize meal) to prevent the dust from contaminating it."*
>
> *"When we sweep the floor in the house, it is easy for a dust to enter into a bag of mealie-meal if it is standing there."*
>
> *"Dust causes germs in our body."*
>
> *"Germs cause disease."*
>
> *"The house that we use is not safe."*
>
> *"The one we are living in has hairy worms and mice."*

The concept of better hygiene was further explored during the second round of interviews, because the researcher wanted to determine how participants relate this concept to health promotion. The participants understood the inter-relatedness of hygiene and health, because they said the house should be cleaned daily and that it was important to ensure that the food and water they consume were clean. The participants reiterated their problems of mice eating their food and emphasised the importance of a clean environment.

- ***General health problems and intervention needs: Literature control***

Good treatment could be ensured through appropriate primary health care, the implementation of the *Batho Pele* principles, the use of guidelines for good clinical practice, implementation of applicable legislation and adhering to treatment protocols (DPSA, 1997). The *Batho Pele Principles Guide* is used by all South African governmental institutions for rendering client friendly services.

Ramsden (2002:14) emphasises that children have the right to health care, and treatment when ill or hurt. It is not a privilege to have treatment but a right that must be fulfilled. Lack of effective treatment will negatively influence the health of a client. It is thus necessary to make sure that effective treatment be provided to all the members of the community to enhance quality of health. The current South African legal policy framework supports the right of access to healthcare services, including reproductive health care (Department of Health, 2001b:10; South Africa, 1996b).

The Patients' Rights Charter states that patients have choices of health services that are in line with prescribed service delivery guidelines (DPSA, 2000).

Counselling should be implemented in order to assist the clients to understand themselves and their situation, and to make informed decisions. Counsellors include teachers, health workers and religious leaders (Department of Health, 2001b:29). Counselling helps people to develop cooperative problem-solving skills and to share responsibilities, thereby increasing their self-confidence and well-being (Glass & Myers, 2001:104-15).

Poor environmental hygiene may result in diseases such as malaria, TB and typhoid fever. The first step in promoting health is to create a healthy and safe environment. Proper health education regarding environmental and personal hygiene should be provided to vulnerable people. The public should be made aware of legislation that protects the environment.

3.2.6.4 Category: Illnesses

Illnesses: Data

Various illnesses were mentioned as barriers to health promotion. These are subcategorised as:

- Epilepsy,
- Arthritis,
- Epistaxis, and
- Asthma.

- **Epilepsy**

Relevant quotes are:

> *"There is one child with epilepsy."*

> *"She (an epileptic) is receiving treatment from the clinic."*

When the topic of epilepsy was further explored during the follow-up interviews, the researcher wanted to determine the effect of epilepsy on the participants and how they coped with the condition. They described it as a disease that causes one to collapse or faint ("seebana"/fainting) and indicated that they get medicine from the clinic for this condition.

- **Arthritis**

The participants explained that:

> *"If you have arthritis, you cannot work properly."*

> *"It disturbs a person when doing things for yourself."*

During the follow-up interviews, the researcher wanted to further explore arthritis as a general health problem. The participants said, about arthritis, that it is a "disease of bones" and that it affects "old people".

- **Epistaxis (nose bleeding)**

The participants mentioned that:

> *"My brother suffers from nose bleeding/ epistaxis ("mokola") and at the clinic they do not tell us exactly what it is."*
>
> *"They only give him some medicines that do not cure him."*
>
> *"We need special doctor to check our young brother - who has nose bleeding – continuously."*

During the follow-up interviews, the participants elaborated on this topic by saying that nose bleeding/epistaxis is a heavy bleeding and that treatment can be found through the clinic or a traditional healer. They coped because they received medicine.

- **Asthma**

Asthma was referred to as follows:

> *"I have a brother with asthma."*
>
> *"I heard that there is flu that is caused by sun."*
> (It was their way of describing asthma.)
>
> *"We need bed because we sleep on the floor and this causes flu."*

During the second round of interviews, the researcher wanted to determine if the participants know what asthma is, and how they cope with it. The participants

explained that asthma is a disease of the chest and that a person with asthma coughs with difficulty. They believed that the solution was to wear warm clothing.

Illnesses: Literature control

Communicable, as well as non-communicable diseases (mentioned above), have a negative impact on the general health and functioning of the family. Diseases adversely affect the already malfunctioning family (*e.g.* families where elder siblings act as substitiute parents for adolescents), as they further disturb the new, adapted roles of family members (UNAIDS, 2006:94).

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

3.2.7 Theme 7: Esteem needs

The need for esteem and self-worth was identified. When it was explored, it became clear that the respondents experienced problems regarding self-worth and esteem. The identified category and subcategory within the theme esteem needs are set out in Table 3.2.7 below.

TABLE 3.2.7: THEME 7: ESTEEM NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
7.	Esteem needs (3.2.7)	• Self and others (3.2.7.1)	• Need for respect, recognition and dignity (3.2.7.1.a)

3.2.7.1 Category: Self and others

Self and others: Data

The need for respect, recognition and dignity with reference to self and others emerged during the data analysis.

- **The need for respect, recognition and dignity**

The following comments are relevant:

"I want to be something when I grow old."

"I want to take my driver's license in December."

"We need to be regarded as normal like other children and we need freedom."

"We want clothing to look the same than other children."

"We need clothing to look like other children."

"I think if we can find a kind person we can share our problems."

"The one who is approachable and sharp."

"We need good attention from our school mates and attention from other peoples."

"I want the house because we do not have the space. The house is too small - we cannot wash."

"I want to sleep alone."

When the topic of respect, recognition and dignity with reference to self and others was further explored during the follow-up interviews, no new information came to light. However, the above comments indicate the need for self-worth, self-esteem, self-actualisation, privacy, recognition and conformity to the standard of the group.

Self and others: Literature control

Adolescents need to maintain their dignity and receive respect, personal freedom and recognition. The above is only possible if an adolescent is positively influenced during an identity formation stage (Murray & Zentner, 2001:547-8). An adolescent, like every other person, is unique, and needs respect and privacy. Parents or guardians should respect their children's need for privacy by, for example, knocking on their door before entering (Month of Young Adolescents, 2005:1). Surveys show that adolescents want to converse with their parents, but they do not always know how to start the conversation. Respecting adolescents' need for privacy will enhance communication between adolescents and parents and will encourage them to consult their parents rather than their peers.

Carpenito-Moyet (2003:3,4) in Maslow's revised theory, supports self-respect, recognition, honour, glory, status, independence, freedom, appreciation and dignity as needs in the healthy life of an adolescent. Firstly, adolescents need to respect themselves so that they can be honoured and recognised in what they are doing. Adolescents should be afforded the same status as those living in the same areas as them. Usually adolescents prefer to be independent but still under the guidance of a parent. Since these adolescents are socialised by people who are not their biological parents, the need for independence is increased. Therefore, in order to be healthy, they need:

- Appreciation,
- Dignity, and
- Freedom of association.

According to a study on the relationship issue of appreciation, conducted in the years 2000 to 2001, the top three areas in which appreciation is important are development toward adulthood, achievements by teens/preteens and morals demonstrated by teens/preteens. This demonstrates that the best way to have a good relationship with an adolescent is through appreciation (Parenting Adolescents, 2001:4-5). According to the United Nations Human Rights System (2002:1), the rights of children, such as the right to freedom of association, are

important. An adolescent has the right to associate with the members of his/her community or peers. This will enhance the psychosocial development of an adolescent and leads to self-worth and a healthy self-concept. If this right is not observed, adolescents become frustrated, which leads to feelings of inferiority, hopelessness and anti-social behaviours.

3.2.8 Theme 8: Educational needs

Education as a need emerged during the data analysis. Facilities and constraints were identified as categories of this theme. The participants in this study mentioned education as a need that has an effect on the promotion of their health. They regarded education as a pathway to better their lives. It was further added that education is a right of all participants and of all individuals, irrespective of life situations. The categories and subcategories within this theme are displayed in Table 3.2.8 below.

TABLE 3.2.8: THEMES 8: EDUCATIONAL NEEDS

NO	THEMES	CATEGORIES	SUBCATEGORIES
8.	Educational needs (3.2.8)	• Facilities (3.2.8.1) • Constraints (3.2.8.2)	• Need for school materials (3.2.8.1.a) • Long distance to school (3.2.8.2.a) • Lack of libraries and facilities for career guidance (3.2.8.2.b)

3.2.8.1 Category: Facilities

Facilities: Data

The respondents mentioned a need for school materials such as books, stationery, school bags, lunch boxes and school uniforms.

- **Need for school materials**

The participants mentioned that:

> *"Books are needed - text books because at school they want text books."*
>
> *"We have no text books; we need school uniform, clothes, as well as raincoat and umbrellas for rainy days."*
> *"I also need a drawing book so that I am able to use at school."*
>
> *"I need school fund, colouring book, as well as Grade 4 books for next year."*
>
> *"I also need a school bag, because other children take our things from us because I use a plastic bag to carry."*
>
> *"Plastic sometimes is torn."*
>
> *"The principal questioned me regarding my school fund."*
>
> *"I did not pay because there is no money."*
>
> *"I need a note book to write in."*

When the topic of the need for school materials was further explored during the follow-up interviews, the researcher wanted to learn more about this subcategory and how these families coped without school materials. To the same information that was mentioned during the first interviews, the participants added and emphasised that they use old and repaired uniforms and are assisted by their neighbours, friends and peers. The participants also expressed that they have no facilities for career guidance. Good education remained their focus in the research discussions.

Facilities: Literature control

To acquire more knowledge, adolescents as learners should be exposed to learning resources and instructional processes. Matlala (1999:1) mentions that, in order for the new outcomes-based curriculum to produce, as it aims, learners who are creative and creative thinkers, these learners must have access to learning resources. According to the author, an outcomes-based curriculum can only be effective if learners have access to learning resources, policy centres and school libraries. The participants expressed a need for exposure to libraries in order to acquire the information that would improve their education and health.

In confirmation of what the participants have mentioned, the Constitution of the Republic of South Africa, 1996, states that, to heal the division of the past and establish a society based on democratic values, the Bill of Rights should be adhered to (Bill of Rights, 2002; South Africa, 1996b). Section 29 of this Bill specifies that everyone has the right to:

- Basic education, and
- Further education that is available and accessible.

The Constitution further indicates that everyone has the right to receive an education in one of the official languages of their choice. The state further must take the following into account:

- Equity, and
- Practicality of education in the institutions.

Section 29 of the Constitution (South Africa, 1996b) further mentions that no one should be subjected to discriminatory actions and these institutions should be registered institutions. The government has committed itself to the above. In support and confirmation of constitutional implementation, Deputy Minister of Education, Mr M Mangena (South African Government Information 2003b:1), indicated that a library should be available as the origin of innovative ideas rather than merely as a place in which books are stored.

Gravett and Geyser (2004:6) add that the higher education system will have to:

- Provide equal access and fair chances of success to all students,
- Develop programmes leading to qualifications that will meet the country's employment needs, and
- Promote critical and creative thinking.

There should be continuity from primary and secondary education levels to the tertiary education level. Adolescents in schools should be well prepared to enter tertiary institutions.

Esiet (2002:2) indicates that the government of Nigeria had similar problems as South Africa, but approved a national curriculum for sexuality education at senior secondary and tertiary levels. This shows a focus, not on ordinary education, but on comprehensive education that includes health education.

3.2.8.2 Category: Constraints

Constraints: Data

Within the theme of education as a need, the category of constraints emerged. The category of constraints was further divided into the following subcategories: long distance to school; and lack of libraries and facilities for career guidance.

- **Long distance to school**

The participants experienced barriers to education.

The following quotations are relevant:

> *"I need transport money for winter school at Sekhululekile."*

> *"I want a bicycle because the school is far."*

> *"I do not have the transport to go to school."*

"I travel a long distance."

- **Lack of libraries and facilities for career guidance**

The participants mentioned that:

> *"Some parents who are working use to take their children out. …They take them to the zoo, Carousel hotel, and to the library."*
> (This referred to parents that are able to provide their children with access to facilities that could broaden their perspectives and offer career possibilities).

When the topic of the lack of libraries and facilities for career guidance was further explored during the second round of interviews, the researcher wanted to determine participants' needs regarding the lack of facilities. The participants mentioned that they use their brothers or sisters' and neighbours' old books to read and increase their knowledge. However, they emphasised that there was still a need for a library.

Constraints: Literature control

Various constraints are experienced by school children, particularly those residing in rural areas. These rural areas experience geographical, social and financial barriers. The school institutions are neither accessible nor available to the children (Joseph Rowntree Foundation, 2005:1-4). Children are forced to travel a long distance to reach their institutions.

In their Assessment Country Report, Botswana, a developing country and neighbour to South Africa, reported that there has been a pattern of poorer provision of educational resources in rural and remote areas since 1977 (Botswana, 2000). This pattern continued until the year 1990. The improvement came in the year 1997 when progress on education services for disadvantaged people was made. In emphasising the improvement of education, South Africa, as a democratic country, experienced the following similar problems:

- Variations in the value attached to school services,
- Inequalities during the apartheid era,
- Absence of data and information to review school health services and to document the impact it has on child health in South Africa, and
- Competition for limited resources.

(Department of Health, 2003:3).

These experiences led to the current improvement of the educational system. According to Education Rights Project (2001), some societies in South Africa historically have been, and will continue to be, denied access to basic education. Rural children are still forced to travel long distances to reach their school. In the above-mentioned project, it was indicated that farm schools are those in greatest need. South Africa has two varied situations. It is developed in urban areas, such as big towns and cities, but it is poor and undeveloped in rural areas, such as farms (Education Rights Project, 2001).

3.2.9 Theme 9: Spiritual needs

The need for the spiritual emerged during the data analysis. The focus was on the needs related to church services and other spiritual needs. Health promotion and spirituality are concepts that are related and interlinked. When one is spiritually satisfied, one's health is promoted. The participants' spiritual needs were fulfilled through praying together, attending church services, the nurturing role of family members, the implementation of their values and residing in a safe environment.

Table 3.2.9 on page 105 displays the category and subcategory identified within the theme spiritual needs.

TABLE 3.2.9: THEME 9: SPIRITUAL NEEDS

NO.	THEME	CATEGORY	SUBCATEGORY
9.	Spiritual needs (3.2.9)	• Church services and other related needs (3.2.9.1)	• Prayer, attending church ceremonies and religion (3.2.9.1.a)

3.2.9.1 Category: Church services and other related needs

Church services and other related needs: Data

Church services and other related needs emerged as category during the data analysis. Within this category, the subcategory of prayer, attending church ceremonies and religion was identified.

- **Prayer, attending church ceremonies and religion**

The following quotes are relevant:

> *"I request shoes to go to church service."*
>
> *"We also want to attend the church."*
>
> *"The church enables people to pray for each other and love each other."*

When the topic of prayer, attending church ceremonies and religion was further explored during the follow-up interviews, the researcher wanted more information that might be important to the survival of these participants. No further new information was gained. The participants placed emphasis on the same aspects and indicated that religion was important to them.

Church services and other related needs: Literature control

The nurturing role of the church was mentioned as relieving tension in these families and promoting spiritual contentment. In order to promote their health, the

family should be provided with a safe environment to practise their spiritual beliefs.

Spector (2004:104) suggests that religion plays a vital role in one's perception of health and illness. He further mentions that an individual's interpretation of the environment and events within the environment (such as practising religion) is strongly determined by culture and ethnicity (Spector, 2004:104). The families who participated in this study have their own cultures and belong to various ethnic groups. As religion and the environment (determined by culture and ethnicity) are interlinked, spirituality should be regarded as an integral part of a comprehensive strategy aimed at promoting health. The physical, psychological and spiritual health and well-being of the individual should be promoted, as the body, mind and spirit are so inexorably linked.

Spector (2004:116) indicates that, when a person is experiencing a spiritual illness, spiritual healing could apply. In this case the origin of suffering is regarded as a consequence of personal sin, and repentance will then lead to healing. In contrast to the above, because of changes in religious beliefs that occur as children enter and pass through adolescence, Youth Worker (1995:2) questioned whether adolescents could exhibit any real spirituality. However, the participant adolescents in this study clearly exhibited spiritual needs.

According to Andrews and Boyle (2003:436), studies conducted amongst African-Americans indicated that they use their religious beliefs as coping strategies when under the stress of care giving. Health and illness is regarded as a family affair by most African-American families. It is negotiated and understood within a family context. Family members are consulted and involved with regard to etiology of disease, severity and treatment options (Giger & Davidhizar, 2004:285). In an Appalachian society[3] when a person is sick, the family members surround the sick person and provide the needed care.

[3] The Appalachians are a mountain system in E North America.

It seems that irrespective of ethnicity, people have their own and unique way of contributing to their religion as a whole. They act in this manner in order to enhance coping within themselves. Similarly, Tjale and De Villiers (2004:162) recommend that patients' wishes with regard to prayer and other religious ceremonies be carried out while they are under the care of health practitioners. Considering that their parents are no longer alive, the participant adolescents' needs with regard to religion and church attendance are understandable.

3.2.10 Theme 10: The need to be a whole person

The need to be a whole person as theme emerged during the data analysis. Only one category, to fit into their family and society, and one subcategory, emotions because of limited choices, emerged. Table 3.2.10 displays the category and subcategory within the theme the need to be a whole person.

TABLE 3.2.10: THEME 10: THE NEED TO BE A WHOLE PERSON

NO.	THEME	CATEGORIES	SUBCATEGORIES
10.	The need to be a whole person (3.2.10)	• Fit into the family and society (3.2.10.1)	• Emotions because of limited choices (3.2.10.1.a)

3.2.10.1 Category: Fit into the family and society

- ***Fit into the family and society: Data***

The participants expressed their need to fit into their family and society. They believed that in order to fit into the family, they needed belongings, such as a house and furnishings.

- **Emotions because of limited choices**

The participants expressed emotions and volition as:

> *"We want a brick house. We need chairs to give visitors."*

"We want school uniform – at school they want school uniform every day."

" We need fridge because during hot weather we make people tired."
("Tired" was expressed in an emotional way. Because of the hot weather, they tend to become emotionally exhausted.)

"I do not have a mirror or dressing table to look after myself before going to school."

"We need clothing to be like other children."

"If there are parties we are not like other children."

"Again to be socially acceptable one needs to have own property."

(Emotions of sadness were perceived when the quotes above were mentioned.)

When the topic of emotions because of limited choices was further explored during the follow-up interviews, the researcher wanted to determine how the participants cope if they cannot fit into their families and society. One family member mentioned that they sing traditional or Christian songs to cope with the situation. They believe that through song they could communicate with their ancestors who would give them the power to build a house that would belong to them. The participants emphasised that they wanted to be accepted by their families, neighbours and society at large.

Need to be a whole person: Literature control

Although humanistic existentialism theory states that there is no one who is complete, the participants wanted to be whole person. Furthermore, as is mentioned in Table 3.2.10, there exists a gap within these families. Van der Walt *et al.* (1990:23) emphasise that in existentialist terms an individual is constantly coming into being and never attains a perfect state of life. It is difficult to deal with the loss of a parent, but a guardian should be appointed to provide for the

orphans' needs regarding the promotion of their health, to ensure that they fit into their family and society. Adaptation, on the other hand, may be promoted in these families because they have to cope with what they have as families. Traditionally each family has a way of coping with life stressors. For example, where families have lost a parent, extended families strive toward meeting the needs of all members in order to normalise the situation.

A holistic approach to treatment (treating a person as a whole) means attending to the physical, social and psychological aspects of the client (Menninger Clinic, 2005:1). The health of families will be promoted if all their needs, including their spiritual needs, are addressed.

3.2.11 Theme 11: Support needs

Support emerged as an important need in the promotion of the health of these families. The participants mentioned the need for support in health promotion. The need for support focused on internal and external support systems. Table 3.2.11 displays the categories and subcategories regarding support needs in the promotion of health.

TABLE 3.2.11: THEME 11: SUPPORT NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
11.	Support needs (3.2.11)	• Internal support (3.2.11.1) • External support (3.2.11.2)	• Family members 3.2.11.1.a) • Community (3.2.11.2.a) • Government (3.2.11.2.b)

3.2.11.1 Category: Internal support

Internal support: Data

Only one subcategory emerged from the category of internal support, namely family members with their belief system that contribute to the orphans' support.

Internal support refers to the support that the participants receive from their family members.

- **Family members**

The participants in the study expressed that:

> *"We need a person to encourage us because we are fighting."*
>
> *"The house that we use is not safe. There are rats and cockroaches."*
> (They implied that they needed help and support to solve their problems.)

When the topic of support by family members was further explored during the second round of interviews, the researcher wanted to determine how family members enhance internal support. The participants confirmed their ongoing problem of the lack of an adult to encourage them.

Internal support: Literature control

In support of the above statements, Ramsden (2002:23) suggests that families who care for other people's children should be supported, for example financially through state grants. Many of these children will be taken care of by their grandmother or another elderly relative, who may need extra help. He continues to say that children may need material, emotional and social support. This support is needed in promoting the health of the orphans.

A South African study by Social Policy Research (1997:135) mentions that it is preferred that where possible families should solve their own problems. They should abstain from the use of statutory and mainstream voluntary family service provision. The families need to adhere to their customs and traditions of coping in order to survive and promote their health.

3.2.11.2 Category: External support

External support: Data

External support as a category also emerged during the data analysis. Subcategories that emerged were members in the community (teachers, peers and neighbours) and government.

- **Community**

Community was identified as one subcategory of external support. The participants expressed it as follows:

> *"We need TV because we want to avoid going to other families."*
> (Meaning that they do not want to be disturbing other families by coming to them for TV.)
>
> *"We need fridge because we do not want to put water at next-door families."*
>
> *"These children have no books and clothing."*
> (This was said in a context where it was clear that they needed the support of the community for this and they want to be able to study like all other learners.)
>
> *"The money for these children is taken by a social worker."*
> (The support came via the social worker, who is seen as a member of the community.)
>
> *"If the money is yours, you control it better."*
> (Referring to a member of the community responsible for controlling the finances they wanted to control the money given to them.)

When the subcategory of community was further explored during the follow-up interviews, the researcher wanted to further examine the support the participants receive from the community. The participants indicated that the Moretele-Sunrise

Hospice provided them with a small amount of groceries and that, if the groceries were depleted, they sought assistance from their aunt and next-door neighbours.

- **Government**

The participants mentioned that:

> *"At least if the government can help to reduce the load from me. It should provide us with food and school materials."*
> (This substitute parent of adolescents orphaned by HIV/Aids is only 24 years old.)

When the topic of government was further explored during the second round of interviews, the researcher wanted to determine how the participants thought the government should help them. The participants mentioned that the government should assist them in obtaining food, clothing and school materials.

External support: Literature control

The participants mentioned community members (such as social workers, peers and neighbours) and government as part of external support.

Supporting the statements above, Ramsden (2002:24) emphasises that any person, such as a neighbour or teacher, can act as a foster parent through children's court. The case could however be reviewed every two weeks to check that the child is cared for. Foster parent cases are reviewed every two years in SA; in cases where people act as places of safety, the cases are reviewed every two weeks. Various researchers are striving toward investigating the support that is relevant to specific communities. Richter and Peu (2004:38-9) assist in the investigation of the supportive needs of informal caregivers who are serving families of this nature. Their study mentions that the government should make sure that the following are provided as support:

- Finance,
- Water,

- Means to empower the community,
- Security,
- Materials for home-based care, and
- Sufficient medicine.

3.2.12 Theme 12: Social needs

Social needs also emerged as theme during the data analysis. The focus was on the social needs related to interaction with others (non-professionals) and the social needs that professionals can help with to promote the families' health. The social needs apply to both the orphans and their substitute parents. These social needs would assist the orphans in thinking critically and contribute to their recreation.

Table 3.2.12 displays the categories and subcategories regarding social needs in the promotion of health.

TABLE 3.2.12: THEME 12: SOCIAL NEEDS

NO.	THEME	CATEGORIES	SUBCATEGORIES
12.	Social needs (3.2.12)	• Social needs related to interaction with others (3.2.12.1)	• Recreational activities (3.2.12.1.a)
		• Social needs that professionals can help with (3.2.12.2)	• Social service (3.2.12.2.a)

3.2.12.1 Category: Social needs related to interaction with others

Social needs related to interaction with others: Data

Only one subcategory emerged under this category, namely recreational activities. It should be noted that the emphasis in this subcategory is on *activities* – under category 3.2.4.2 the *facilities* are mentioned.

- **Recreational activities**

The participants expressed that:

> *"I need money for educational tours so that I learn things during these tours."*
>
> *"We want to take trips to Durban to be like other children."*
>
> *"We want basic needs such as recreation centres."*
> (The context of this quote actually emphasised the activity aspect.)
>
> *"We need radios because we wish when we hear people playing their radios."*
> (Listening to the radio was also regarded as recreation.)
>
> *"We need television because we look at the TV at other homes and we come back home very late."*
>
> *"We need music system because it is too quiet at home."*
>
> *"We want a video to observe films because we do not have them."*
>
> *"We also need a TV game and a TV set."*

When the topic of recreational activities was further explored during the follow-up interviews, the researcher wanted to further understand the participants' recreational needs and how these families cope with the lack of activities. The participants added no new data.

Social needs related to interaction with others: Literature control

Television and radio emerged amongst all the families and was explored as an important social need. Elfituri, Elmahaishi and MacDonald (1999:2) indicate that the radio as a medium influences the behaviour of people positively. They emphasise that there is a need to use different educational and recreational media in future planning. The radio provides researchers, health educators,

policy makers and others with the information and materials they need, while at the same time providing a recreational activity.

In support to the value of recreation, Ramsden (2002:14) indicates that children have the right to play, to recreation and to participate in cultural activities. The involvement of adolescents in traditional games, if encouraged, could promote the health of these families and help them cope with stressors.

3.2.12.2 Category: Social needs that professionals can help with

Social needs that professionals can help with: Data

Social needs that professionals can help with emerged as the category during data analysis. One subcategory further emerged, namely social services.

- **Social services**

The participants mentioned that:

> *"We need finance and our blankets are old."*
> (This was said in a context referring to a social worker that can assist.)
>
> *"These children have no books and clothing."*
>
> *"The money for these children is taken by a social worker."*
> (The context referred to indicated that this kind of social service did not help a lot.)
>
> *"If money is yours you control it better. I suffer a lot."*
>
> *"I do not receive a pension fund, and after the death of my husband the kids were forced to leave school."*

During the follow-up interviews, the researcher wanted to further explore the importance of social services and how these families coped without available social services. The participants emphasised the same issues.

- ***Social needs that professionals can help with: Literature control***

Substitute parents, such as sisters and the elderly, who participated in the study, mentioned that social clubs, social relief, radios and videos help the orphans to forget their painful and poor conditions. If social pensions could be provided to these orphans, their life would be easier. In traditional families, it is common to substitute a parent with any willing member of the family. It was also indicated that individuals who are raised in an extended family will be able to learn from many role models. Therefore, an extended family has an ability to meet a huge proportion of its needs from within (Rosneath Farm, 2002).

Various healthcare professionals, such as nurses, doctors, social workers, therapists, alternative healthcare providers and technicians, are providing essential social services, such as hospice, home health care, daycare centre and emergency services, to the adolescents (Lundy & Janes, 2001:124-5). These services contribute to the development and sustainability of the community.

The National Association of Social Workers (2005) mentions the many social problems facing adolescent youths that have increased the complexity of helping them to cope. The association further determined and described standards according to which social workers should address the problems experienced by adolescents. These standards were developed due to budget, resource, and personnel shortages. In one of the standards developed, it was indicated that knowledge about positive adolescents included knowledge about:

- Family, school, community and cultural processes that allow and help adolescents move toward independence, and
- Opportunities for adolescents to establish positive relationships with open expression of thoughts and feelings with family members, peers, and adult role models such as teachers, clergy and sports team coaches.

Therefore, the need for professionals that can help the adolescents was considered very important. Currently in South Africa, social workers provide comprehensive services to the community at large.

3.2.13 Theme 13: Needs related to technology

Technology related needs was the thirteenth theme that emerged during the data analysis. It focused on telecommunication and other appliances.

Table 3.2.13 displays the categories and subcategories regarding needs related to technology in the promotion of health.

TABLE 3.2.13: THEME 13: NEEDS RELATED TO TECHNOLOGY

NO.	THEME	CATEGORIES	SUBCATEGORIES
13.	Needs related to technology (3.2.13)	• Telecommunication (3.2.13.1) • Other appliances (3.2.13.2)	• Computers, telephones (3.2.13.1.a) • Microwave and kettle (3.2.13.2.a)

3.2.13.1 Category: Telecommunication

- ***Telecommunication: Data***

Telecommunication and other appliances emerged as categories of the theme technology related needs. Telecommunication can be used for providing health education or to contact people when needed. The participants expressed the need for telecommunication in promoting their health.

- **Telephones and computers**

They described their telecommunication needs as follows:

> *"We need telephone in the house in order to communicate with social worker to help us."*

"We need telephone container because I want to run a business with telephones."

"At school you find that after listening to news, you are asked to tell what the news were all about".

When the topic of computers and telephones was further explored during the second round of interviews, the researcher wanted to further explore how these participants coped without these appliances. The participants said that they use public telephones to communicate with the community.

- ***Telecommunication: Literature control***

Telecommunication refers to communication over a distance by cable, telephone, or broadcasting (Pearsall, 2002:1472). In this study, telecommunication was regarded as essential in order for the families to be able to exchange information with their external environment, for example relatives.

Communication is the two-way process whereby families share their experiences on life situations. It is essential to the health promotion of families, particularly where they share information on the principles of health promotion. Kessler (2002:6) says that, in learning communication skills, the adolescents express themselves more effectively, fully, and authentically. Furthermore, communicating teaches one the skills of assertiveness and thus satisfies one's needs. The participants in this study mentioned telecommunication and the radio as systems that carry messages regarding health promotion. The discussions on telecommunication concentrated on social workers and health services, while discussions regarding radio were centred on information and awareness.

Telecommunication plays an important role in the environment of families with adolescents orphaned by HIV/Aids in rural Hammanskraal. It is a system that connects families with each other. It was also mentioned as a system that contributes to promotion of health in families.

Kessler (2002:7) stated that communication provides students with a crucial skill that helps them in learning, as well as in relationships. Good communication empowers the learner with the skills of promoting their lifestyle, as well as their health.

Communication is a process where a person exchange feelings, desires, needs, information and opinions with others (McCubbin & Dahl, 1985, as cited in Friedman, Bowden & Jones, 2003:267). Friedman *et al.* (2003:267) indicate that communication is a symbolic, transactional and a two-way process of creating, generating, gathering and sharing meanings in the family. The participants in this study demonstrated the desire and need for communication. The participant families need a form of communication available to them, in order for them to be able to communicate in case of emergency or any other important incident. This study will assist policy makers in the fulfilment of the need for communication as an integral part of the promotion of health in rural families.

Peterson (1999:1) says that instrumental communication enables individuals to fulfil common family functions. Although the participants of this study mentioned the use of telephones in sharing health issues, if the health issues are not well communicated, the whole communication aspect could be jeopardised. Peterson further emphasises that, when communicating with young children, it is important that adults listen carefully to what the children are saying without making unwarranted assumptions. The researcher also had to listen carefully to the participants when they expressed, for example, their need for a telephone as a means to communicate.

3.2.13.2 Category: Other appliances

Other appliances: Data

Other appliances emerged as a category and, from this, microwave and kettle as the only subcategory.

- **Microwave and kettle**

"There is no kettle or microwave."

"The microwave warm [sic] the food when we go to school."

When the topic of microwave and kettle was further explored, the researcher wanted to determine how the participants coped without these appliances. The participants mentioned that they use tins or pots to cook food and boil water.

Other appliances: Literature control

A kettle and microwave were described by the participants as their needs related to technology and in the promotion of health. These appliances are used to purify water and sterilise milk, as well as for cooking, baking, and preserving food for consumption. They contribute to the promotion of the health of communities. For example, diarrhoea sufferers are given a mixture of boiled water (boiled in either the microwave or a kettle), sugar and salt as treatment. Therefore, these appliances are important in the promotion of these families' health (Lundy & Janes, 2001:126).

3.3 DISCUSSION OF FIELD NOTES

Field notes (observational and personal notes) were taken during group interviews with families with adolescents orphaned by HIV/Aids, who met the inclusion criteria, on pre-arranged dates and times. Field notes included both empirical observations, as well as interpretations. The researcher wrote down her emotions, expectations and prejudices that helped with the final product (De Vos, 2002:304-5).

Observational notes

Observational notes are descriptions of events, information and conversations, including aspects such as time, place, activities and dialogue, as observed by the

researcher. These descriptions of events are based on what was experienced through watching and listening during the research process. Observations were made to check the basic needs of families that participated in the study. Resources such as food, water and electricity, toilets and houses were noted.

The researcher obtained a broad view of the participants' situation during the research process and, through watching and listening, tried to capture how these families could promote their health. The variety of activities related to health promotion, the needs of the participants, and relationships in the family members' social environment were captured for further analysis by the researcher. A variety of events, times, places, play patterns, desires, interests, pleading and hiding expressions, as well as communication patterns, were noted and analysed.

Observations relating to time, living conditions and survival techniques were noted. During the research process, time was not considered as an important aspect by participants. During the visits, the families always delayed the process of interviewing. The researcher had to wait up to 30 minutes before the family was settled. The members of families urged the researcher to visit their homes daily, even though the researcher was engaged with her job.

The environments where the group interviews were conducted looked similar and shabby. As indicated in Chapter 2, the majority of families were living in tin houses in a rural, developing area. During the research process, actual observations revealed that one of families did not have food for breakfast. The researcher had to organise breakfast before the group interviews could start. A loaf of brown bread was bought from the tuck shop, so that the family could have something to eat. Hunger makes concentration, and especially verbal communication, difficult.

The majority of family members substitute meat with chicken legs. It is the most affordable and therefore popular protein source available in rural areas. One

family used pap[4] leftovers as the substitute to a lunch meal. They had these pap remains with tomato soup. This indicates that, although these people are poor, they have special and unique ways of surviving. Theoretical notes (researcher's interpretation of observations) clarifying the observational notes are set out in Table 3.3 below.

TABLE 3.3: OBSERVATIONAL AND THEORETICAL NOTES

NO.	OBSERVATIONAL NOTES	THEORETICAL NOTES (Researcher's interpretation of observations)
1.	At first members of the families were slightly scared to communicate freely with the researcher but later they indicated that *"how important it is to have a visitor like you"*.	At first it was clear that the participants had resistance due to lack of educational status and confidence, as well as respect for researcher.
2.	Dancing of the young members of the family who were not part of the research process.	With time the children of these families demonstrated and expressed their happiness and acceptance by dancing.
3.	During the researcher's first visit to their home, she observed that one teenager disappeared during the interview.	It may have been that the teenager feared that the researcher would question her on her present health status, with regard to her possible pregnancy.
4.	Continuous arguments between grandmother and the adolescents were observed during interviews. The grandmother looked depressed and frustrated.	The arguments among these members indicated a sort of information transfer to the researcher because the grandmother had no means to report the teenager. It further revealed lack of relations between the grandmother and the adolescents and their disregard and/or lack of understanding of the position and the role of grandmother in their life. It further emphasises the need for children to be brought up by their biological parents. Frustration on the part of the grandmother could have resulted from the realisation of the adolescents' lack of understanding. This could be observed as an attempt to communicate the difficult position in which she finds herself to the researcher.
5.	The researcher observed in one of the houses the abnormal behaviour of a teenager who on various occasions was very dirty and refused to wash.	The behaviour of one of the adolescents was socially unacceptable, and possibly indicated a psychological stressor.
6.	During the visits, a young teenager was observed visiting next-door neighbours in order to dance with them because he did	This shows an intrinsic relation to music. This also indicates the young teenager's boredom, which influenced him to mix with

[4] Porridge, usually of mealie meal.

	not have a music system or radio in his own house.	his peers. Visiting neighbours helps him to relieve boredom.
NO.	**OBSERVATIONAL NOTES**	**THEORETICAL NOTES (continued)**
7.	On various occasions, a young lady found it very difficult to cope with the children she is caring for. The members of this family had the tendency of playing in the street first thing in the morning.	This is clearly indicative of lack of basic needs such as food, electricity and water. If these are not available at home, the children will leave home and become street children.
8.	In one family, an old grandmother, who was wearing mourning attire for her husband's death, shared the story of the cause of his death. The husband was buried a few months ago.	This woman, who has lost her husband in the past year and is adhering to traditional practices, is still looking after adolescents. The attire displays respect for the one who has passed away. It is seen mostly in women.
9.	On some occasions, neighbours looked through the windows and fences to see what the researcher brought and then came and asked the refunding of their borrowed food parcels.	It was clear that the neighbours were curious to see whether the visitor would really assist the family so that they can claim back what they had spent on them.
10.	One grandmother said: *"I do not know where I can take these children because they do not respect me."*	It is indicative of a parent who is really tired of caring for children who do not listen and who are not her own children.
11.	In one family, the children pretended to be a family with working parents. One of the children would act as the parent by pushing a wheelbarrow full of imaginary groceries. Another acted as the other parent and others as children. They happily ran to the parent pushing a wheelbarrow full of plastic Checkers[5] bags and said to them: *"Come, let us go and have cakes and sweets!"*	These children were simulating a family with an employed member. They craved for sweets and cakes. This indicated that the absence of parents is felt particularly if the children are very small. Therefore, they simulated a situation to satisfy their inner feelings. The unpacking of imaginary groceries in the form of shopping bags, indicates that there is a need for at least one parent who is working.
12.	One family, who was highly involved in the research project, participated in singing spiritual songs. When the researcher knocked at the door, they would open the door and laughed and welcomed her.	This family probably uses song when they are faced with difficulties in order to adjust to the difficult situation caused by the passing away of parents.
13.	The researcher observed mice in the house of one family. Nobody was allowed to kill these mice. The family indicated that they were humans turned into rats by witches and that they would not eat the food or any other thing in the house.	The family believed that the mice were associated with witchcraft.
14.	On the first day, one of the families' houses was very dirty and untidy. Their table was dusty and the researcher requested a duster to remove the dust from the table.	The family was not aware that cleanliness was important. After the first contact with the researcher, the family did a thorough spring-cleaning to prepare for the interviews with the

[5] Checkers is the name of a grocery store.

		researcher. During the follow-up visits the house looked clean.
NO.	**OBSERVATIONAL NOTES**	**THEORETICAL NOTES (continued)**
15.	In these families, the grandmothers often raised their voices as if quarrelling with the children.	This is indicative of a grandmother who cannot cope with the socialisation of these children.
16.	One young lady burst into tears when the researcher started asking a research question. The researcher had to pause, and supported her emotionally.	The situation appeared to be difficult for the young lady as the number of children she had to care for was demanding.
17.	A very young adolescent lowered his/her voice during the group interviews.	This might be an indication of a child with lack of confidence and fear, particularly because they were not used to the researcher.
18.	The participants reacted non-verbally by smiling, frowning, crying, humming and hawing (finding it difficult to answer), looking down, as well as hiding.	These non-verbal cues are indicative of a person who is afraid of exposure and who wants to hide emotional pain.
19.	The participants felt proud when what they mentioned during the group interviews was validated.	This shows confidence in the needs that they have identified, even those that were irrelevant.

Personal notes

Personal notes are references to all experiences, reflections, feelings, and reactions of the researcher that occurred during the research process. The researcher experienced various feelings and reactions during the data collection process and all these feelings and reactions were noted and recorded. Reflections and experiences were discussed before the start of interview group discussions.

Before the commencement of each of the interviews, the researcher felt psychologically stressed because the participants had no food to eat before the interview process started. The researcher realised that she had to buy loaves of bread to feed the families before the interviews. Often families would spend the day without a meal. Often at some stage in the morning, some adolescents would be absent because the neighbours then would give them something to eat. Even

though the majority of the participants were poor and hungry, they managed to participate in the study.

The researcher observed mixed feelings and reactions amongst the participants. Younger children were full of joy when the food was served. Older participants, particularly older adolescents, used to cry when they had to share their experiences. The researcher experienced sadness the way these families lacked basic needs for survival. The experiences of these participants affected the researcher in such a way that she felt she had to assist in requesting stands for building houses for these families. The researcher also encouraged the Moretele-Sunrise Hospice in Hammanskraal in sustaining a feeding scheme project for these families.

3.4 SUMMARY

The results of the research have been presented and form the foundation of the development of health promotion guidelines for families with adolescents orphaned by HIV/Aids (see Chapter 4). Tables and figures were used to present the analysed data (see Tables 3.2.1-3.2.13 and Figure 3.1 on page 126). The analysed data were confirmed by means of a literature control. Limitations were identified during the study and will be presented in Chapter 6.

The diagram (conceptual framework) on page 126 (Figure 3.1), displaying and summarising the thirteen themes, provided the basis for the development of preliminary guidelines. The researcher realised that these themes were similar to what Maslow described in his theory the "*Hierarchy of Human Needs*". During the data gathering and analysis processes, the researcher realised that Maslow's Hierachy of Human Needs theory could be consulted in the process of developing preliminary guidelines. The theory and its applicability to this study will be described and discussed in detail in Chapter 4.

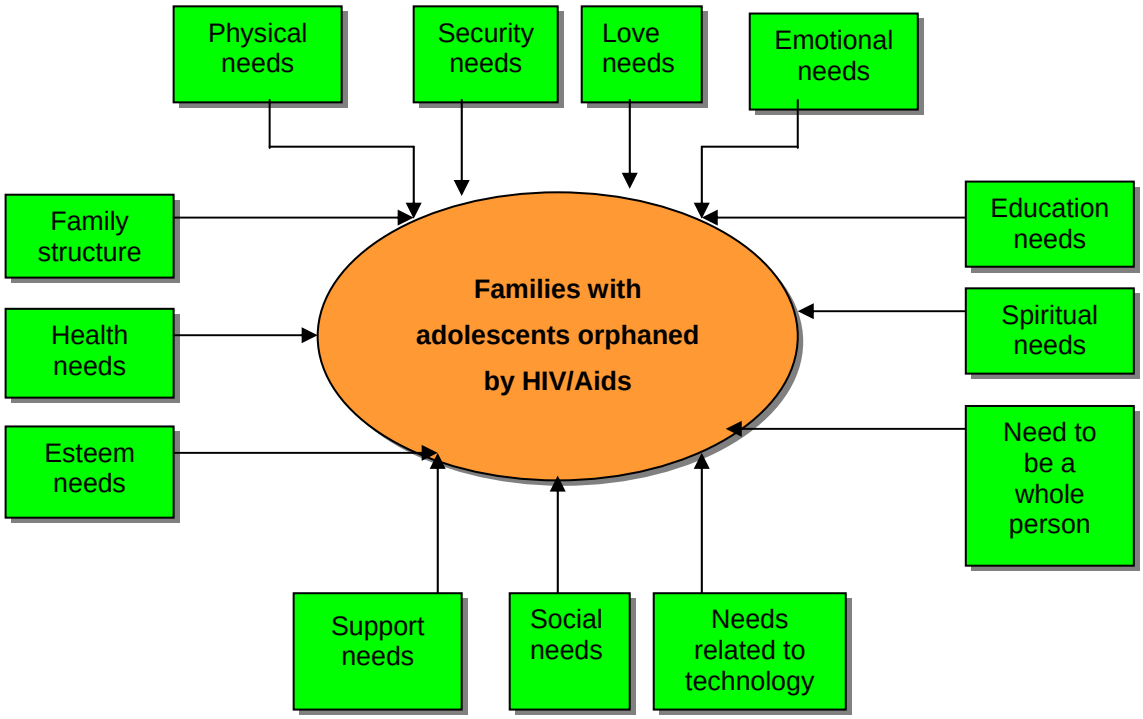


FIGURE 3.1: FRAMEWORK OF RESULTS FOR GUIDELINE DEVELOPMENT

CHAPTER 4

DISCUSSION OF EMPIRICAL PART OF THE RESEARCH WITH REFERENCE TO AN APPLICABLE THEORY *(MASLOW'S HIERARCHY OF NEEDS)* AND MODEL FOR HEALTH PROMOTION *(MULTILEVEL APPROACHES TOWARD COMMUNITY HEALTH)*

4.1 INTRODUCTION

The previous chapter contained the empirical results and literature control of the study. The results regarding the health promotion needs of families with adolescents orphaned by HIV/Aids were discussed. To a great extent, these needs are similar to those described in *Maslow's Hierarchy of Needs* theory, which describes the basic needs of humans. In this chapter, *Maslow's Hierarchy of Needs* theory is discussed and compared to the themes identified in the study (Benson & Dundis, 2003:317).

In addition to *Maslow's Hierarchy of Needs* theory, the researcher also made use of the *Multilevel Approaches Toward Community Health* (*MATCH*) model. In this model, illness prevention is emphasised. Because illness prevention is part of health promotion, the researcher made reference to this model in the discussion of the development of health promotion guidelines in Chapter 1 (see Section 1.8.3). The researcher chose the *MATCH* model, which includes the government, organisation and individual, because of its comprehensiveness. The model serves as a framework for the formulation of health promotion guidelines, which are described in Chapter 5.

4.2 *MASLOW'S HIERARCHY OF NEEDS* THEORY

The *Maslow's Hierarchy of Needs* theory can be used as a guide to the promotion of health (DeMarco & Tilson, 1998:1) because its structure entails

meeting first lower order and then higher order needs. Individuals responsible for health promotion should know the importance of the arrangement (from lower to higher order) of *Maslow's Hierarchy of Needs* and how these needs can be met. It is of vital importance that it is understood that lower order needs must be met before higher order needs can be considered. Lower and higher order needs could form the frame of reference for the planning of health promotion programmes.

The structure of lower to higher order needs is presented in Figure 4.1.

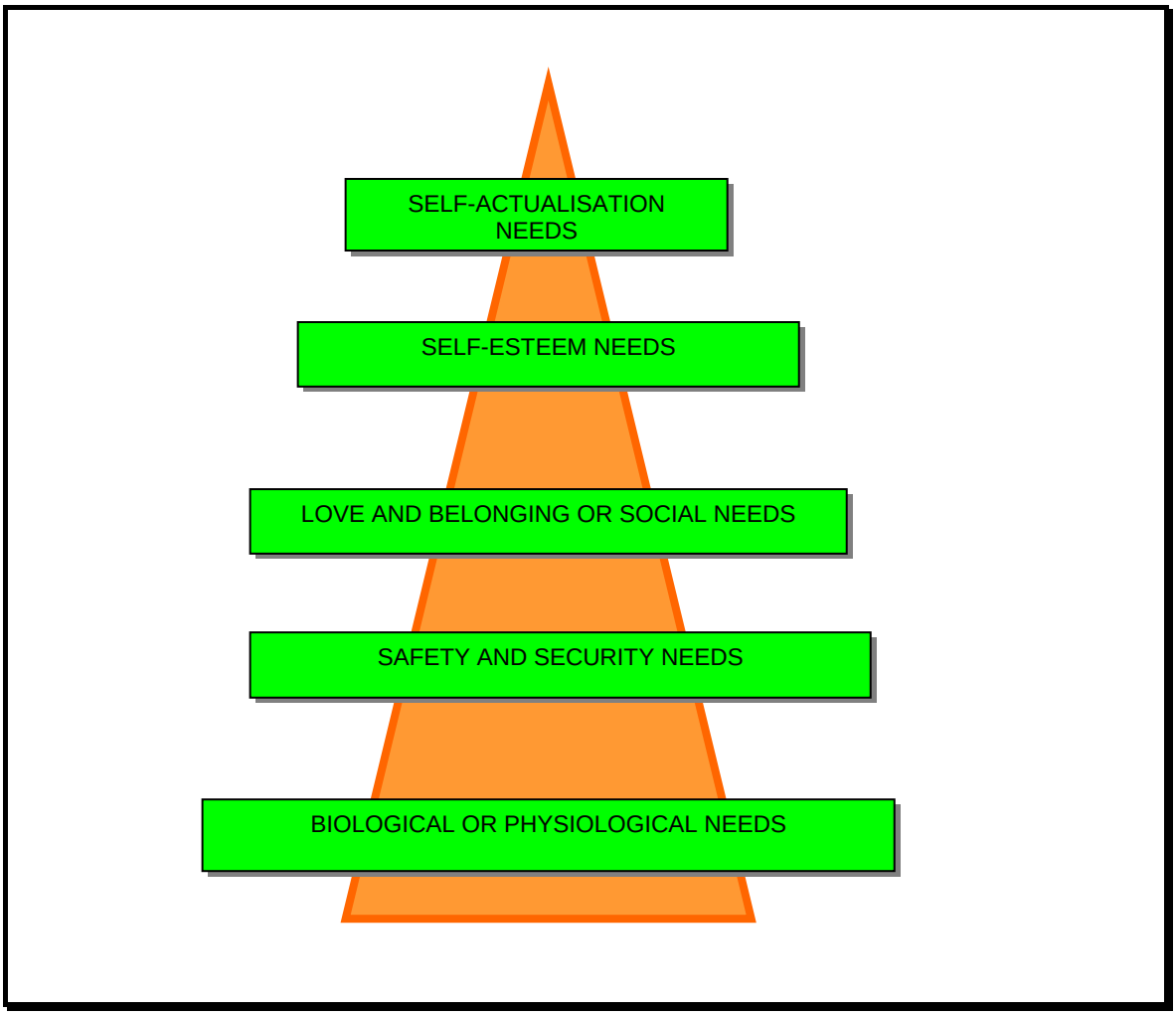


FIGURE 4.1: MASLOW'S HIERARCHY OF NEEDS THEORY

(Chapman, 2005; Robbins, 2001:156; Smeltzer & Bare, 2004:5)

Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner (2004:311) state that *Maslow's Hierarchy of Needs* theory (1954) is twofold – it is based on man and

the arrangement of his needs. According to the theory, man is unique and is continuously becoming or coming into being. Sartre (1957:9-16) states that human beings are capable of making decisions to improve their living conditions, thus continuously developing themselves. During the development process, individual needs are satisfied. Therefore, in a situation of growth and development, it is expected that after lower order needs (physiological and security needs) are satisfied, the higher order needs (love and belonging, esteem and self-actualisation needs) in the hierarchy can be addressed (Huitt, 2004:1).

4.2.1 Biological or physiological needs

The first level is basic needs, such as the need for food, water, shelter, warmth, sex and sleep (Nel *et al.*, 2004:311; Smeltzer & Bare, 2004:5). The fulfilment of these needs is essential for the biological functioning and survival of the individual. The conditions in which the research participants lived place serious limitations on the fulfilment of basic needs. The children did not have a regular supply of food and on some nights had to go to bed without supper. If basic needs are not satisfied, all human behaviours will be directed toward trying to fulfil them. In this research, it was found that the lack of food, water and warmth even influenced their choice of games. The children mimicked parents arriving home after work with groceries.

4.2.2 Safety and security needs

Robbins (2001:156) states that immediately after the physiological needs are satisfied, the needs of the next level, namely safety and security, emerge. An individual will use the energy gained through the satisfaction of the needs on the first level to satisfy safety needs critical for survival (Robbins, 2001:156). Robbins (2001:156) further states that there is a need for security and protection from physical as well as emotional harm. The research participants tried to provide for their own safety by staying indoors at night and by comforting one another. This gave them a sense of safety and security, as their shelters were in a poor state and they were exposed to the elements. One of the needs related to safety and security is the need to be free from stress (Benson & Dundis, 2003:315). The

research participants had only themselves to depend on which resulted in high levels of stress.

4.2.3 Love and belonging or social needs

Social needs include the need for affection and love, as well as the need to belong or be affiliated with someone (Huitt, 2004:1). In a social environment, people interact in different ways. Huitt (2004:1), and Louw and Edwards (1993:435) state that because individuals affiliate with others in a social environment, they are accepted as human beings. According to Robbins (2001:156-7), only once an individual is safe and in control of the threats in his/her environmental, can he/she interact with the external environment. This results in a social environment in which individuals are accepted and friendships can start (Robbins, 2001:157). The research participants initially seemed to keep a certain distance from the researcher during the interviews. This showed that they were uncertain. Once they had come to know the researcher, they came closer as a sign of wanting to belong and be accepted by the researcher.

4.2.4 Self-esteem needs

Louw and Edwards (1993:435) state that self-esteem refers to an individual's self-respect and esteem of others. Self-esteem involves the need to achieve, to have self-confidence, independence, freedom and recognition, and to be appreciated (Nel *et al.*, 2004:211-12). The two aspects of the need for self-esteem are the need for an individual to see him/herself in a positive way and the need for respect and approval from others (Benson & Dundis, 2003:315). The research participants expressed a desire to be respected by their schoolmates, neighbours, families and teachers. They also wanted to be treated like other children even if their parents were not alive.

4.2.5 Self-actualisation needs

If the previous levels of needs are satisfied, individuals will search for opportunities to apply their skills to the best of their ability. Heylighen (1992:41)

states that self-actualisation is reached when all the needs are fulfilled, particularly the highest needs. This author also emphasises that self-actualisation corresponds to psychological health (Heylighen, 1992:41). This indicates that, when an individual's potential is developed, he/she feels healthy and satisfied. Huitt (2004:2) indicates that self-actualisation is regarded as the highest level of need and individuals have an obligation to themselves to become what they are capable of becoming. Huitt (2004:2) further adds that self-actualisation focuses on personal growth, self-fulfilment, the realisation of one's potential, helping others to find self-fulfilment and realising others' potential. According to Robbins (2001:156), self-actualisation is the drive to become the best that one is capable of becoming. The adolescents who participated in this research felt that it was necessary to become educated.

4.3 REASONS FOR USING *MASLOW'S HIERARCHY OF NEEDS* THEORY

Academics, professionals and others use *Maslow's Hierarchy of Needs* theory daily because of the following reasons:

- *Maslow's Hierarchy of Needs* theory provides a useful framework within which to understand the needs and expectations of clients (Benson & Dundis, 2003:319; Smeltzer & Bare, 2004:5).
- It is used to identify and meet the needs of individuals in a variety of situations (Nel *et al.*, 2004:311).
- A very clear differentiation is made between higher and lower order needs (Smeltzer & Bare, 2004:5). In other words, *Maslow's Hierarchy of Needs* theory can be used to describe the needs of individuals at different levels (Huitt, 2004:2).
- When used as a framework for assessment, it helps professionals to assess the environmental and personal needs that must be fulfilled before health promotion can take place (Green, Lewis & Bediako, 2005:28).
- It provides information on the lower and higher order needs of humans in general (Green *et al.*, 2005:28).
- It points out the importance of personal growth and self-actualisation in the context of needs (DeMarco & Tilson, 1998:1).

- According to Robbins (2001:157), *Maslow's Hierarchy of Needs* theory has a significant influence on the individual's motivation for fulfilling a particular need.

In view of the above, the researcher has chosen *Maslow's Hierarchy of Needs* theory as a basic framework within which to identify the needs of the research participants. It is appropriate to use *Maslow's Hierarchy of Needs* theory in this study because the needs of participants, which have been identified, explored, described and arranged into themes, are compatible with the theory. The theory can also serve as a framework for the development of health promotion guidelines.

4.4 REMARKS AND COMMENTS ON *MASLOW'S HIERARCHY OF NEEDS* THEORY

Maslow's Hierarchy of Needs theory can be seen as a guide to the attainment and satisfaction of human needs. Maslow indicates that, to an extent, people need to control their environment in order to manipulate it according to their needs (Nel *et al.*, 2004:313). If the environment is threatening and, for example, cannot be controlled, it will result in fear and anxiety, which may have undesirable consequences (Nel *et al.*, 2004:313).

Despite the practical aspects of *Maslow's Hierarchy of Needs* theory outlined above, there are some criticisms of the theory (Jordaan & Jordaan, 2003:583). Once such criticism is that the development of needs does not necessarily follow the pattern proposed by *Maslow's Hierarchy of Needs* theory and variances as a result of the uniqueness of each individual can occur. Allender and Spradley (2005:289) confirm that although *Maslow's Hierarchy of Needs* theory proposes a hierarchy of order, it will not always be followed because of the differences in individual cases. For example, if a mother has to nurture and feed her baby in a threatening environment, the aspect of protection will be uppermost in her mind. This is supported by Booyens (1993:443) who states that even Maslow argued at some stage that individuals cannot always be motivated in similar ways due to differing circumstances.

Jordaan and Jordaan (2003:583) further mention that this theory has been criticised for being socio-politically insensitive. For example, once an individual's most basic needs have been satisfied, his/her aspirations to satisfy higher needs may be blocked by oppressive political systems. These kinds of systems condemn certain individuals to a life of poverty and misery, which leads to a focus primarily on lower level needs. The satisfaction of needs therefore depends on the socio-political and economic situation of the country (Jordaan & Jordaan, 2003:584).

It is also important to note that *Maslow's Hierarchy of Needs* theory may be influenced by experience, age, personality and cultural background (Maslow, 1970 in Kenyon, 2004:12). *Maslow's Hierarchy of Needs* theory can be used as a guide in health promotion, but Zuluaga (2000:320) cautions that lifestyle choices affect the level of health and perceived wellness. Zuluaga goes on to state that if the individual's choices are limited, his/her lifestyle will ultimately be affected. In the case of families with adolescents orphaned by HIV/Aids, limitations to their lifestyles need to be taken into account. Developing their potential will contribute to the strategies that can be used in health promotion (Zuluaga, 2000:320).

Although there is a general acknowledgement, acceptance and support by researchers for Maslow's concepts of basic human needs (Zuluaga, 2000:318), some critics argue that his hierarchy of needs is only really relevant when looking at the behaviour of people at a specific socio-economic level, referred to as the middle class in Western societies (DCForum, 2000:180). This argument is not entirely correct, as the theory has been successfully used in some underdeveloped and developing African countries where communities are poor (Green, Botha & Schönfeldt, 2004:47). In a research study of the assessment of needs in a rural community on a commercial farm in South Africa, Green *et al.* (2004:46) used *Maslow's Hierarchy of Needs* theory with success, despite the rural status and poverty of the community in which the research was conducted.

Green *et al.* (2005:28) mention that it was suggested that *Maslow's Hierarchy of Needs* theory could be used as basis to encourage a community in Texas to change its health behaviour. The theory could serve as framework to assist

health professionals in implementing interventions that are directed to health promotion at the level of the higher as well as lower order needs. These interventions, however, also have to focus on the environmental factors that influence health. The intervention outcomes can be achieved by encouraging healthcare providers to constantly increase their own skills in assisting clients with focusing on health promotion (Green *et al*., 2005:28).

The researcher is of the opinion that *Maslow's Hierarchy of Needs* theory can be used to guide the health promotion of people in developing communities, such as the communities of the participants involved in this research. It can also guide the researcher in the development of health promotion guidelines to address needs on all levels.

De Lange (2002:1) supports the above and notes that although the theory is arranged in a patterned hierarchy of needs, these orders exist and serve as a guide only. In an article entitled "Towards co-operative governance in the development and implementation of cross-sectoral policy: Water policy as an example", MacKay and Ashton (2004:1-2) made use of *Maslow's Hierarchy of Needs* theory but focused mainly on the need for water as a physiological need.

Allender and Spradley (2005:289) point out that in the community, the client's needs must be considered when planning health education programmes. With its lower and higher levels of needs, *Maslow's Hierarchy of Needs* theory can guide the health education planners to ensure that all needs are addressed in health promotion programmes.

4.5 IMPLICATION OF *MASLOW'S HIERARCHY OF NEEDS* THEORY APPLIED TO THIS STUDY

It became evident to the researcher that the 13 themes identified in this study and described in Chapter 3 correlated with *Maslow's Hierarchy of Needs*. Table 4.1 on page 135 illustrates how the 13 themes fit into the structure of *Maslow's Hierarchy of Needs.*

TABLE 4.1: THE THEMES OF THIS RESEARCH IN TERMS OF MASLOW'S HIERARCHY OF NEEDS THEORY

MASLOW'S	THEMES IDENTIFIED
1. Biological needs	Physical needs (Theme 1) Healthcare needs (Theme 6)
2. Safety and security needs	Safety and security needs (Theme 2) Support needs (Theme 11)
3. Love and belonging or social needs	Love and belonging needs (Theme 3) Family structure as needs (Theme 5) Social needs (Theme 12)
4. Self-esteem needs	Esteem needs (Theme 7) Emotional needs (Theme 4) Educational needs (Theme 8)
5. Self-actualisation needs	Needs to be a whole person (Theme 10) Needs related to technology (Theme 13) Spiritual needs (Theme 9)

4.5.1 Biological or physiological needs

Two themes identified in the study correspond with the lowest level of *Maslow's Hierarchy of Needs* theory. These themes are physical and healthcare needs. The researcher realised that it is the lack of resources that results in the lack of fulfilment of physiological needs and contributes to the problems regarding the survival of individuals. When these needs are not met, individuals work toward meeting them merely to survive.

General needs regarding physical health are included under the umbrella of biological needs. When basic healthcare needs are satisfied, the individual and his/her family experience optimal health and are therefore empowered to meet higher order needs, such as the maintenance of effective interpersonal relationships in the family (Louw & Edwards, 1993:435).

4.5.2 Safety and security needs

The second level of *Maslow's Hierarchy of Needs* theory deals with safety and security needs. In the empirical part of this study, the researcher identified the participants' need for safety and security as well as needs related to support. These needs fit into the second level of Maslow's theory. Safety and security focus on protection, law and order, and stability, which create an environment in which individuals can feel safe (Nel *et al.*, 2004:311; Robbins, 2001:156). People need to be protected and feel secure (Robbins, 2001:156).

4.5.3 Love and belonging or social needs

An individual needs to be loved in order to be able to love others (Ramsden, 2002:14; Sadock & Sadock, 2000:6). Three themes, namely family structure, love and belonging needs and social needs correspond with the third level in *Maslow's Hierarchy of Needs* theory. Maslow includes family, affection, relationships and work groups in this level (Benson & Dundis, 2003:318; Green *et al.*, 2005:28; Robbins, 2001:156).

4.5.4 Self-esteem needs

Self-esteem refers to the state in which an individual feels competent, confident and self-assured through an educational process that empowers him/her (Benson & Dundis, 2003:315). It is the state in which it is evident that the individual has some vision for the future, for example the pursuit of education in order to acquire a specific position in the community (DeMarco & Tilson, 1998:1).

The researcher realised in this research that educational, emotional and esteem needs are themes that correspond with the self-esteem level of Maslow's theory. Education heightens an individual's feeling of self-worth and individuals must be emotionally mature in order to fit well into education and employment places. Emotional maturity refers to the level at which an adolescent is able to identify with society and accept its norms (Murray & Zentner, 2001:547). Adolescents can be said to be mature when they accept themselves and have the skills necessary

for healthy functioning in society (Murray & Zentner, 2001:547; Stanhope & Lancaster, 2000:535). An adolescent's self-esteem is therefore important. Self-esteem is the determination of one's self-worth through self-evaluation (Maslow, 1970 in Kenyon, 2004:8-9).

Self-esteem is determined by internal esteem factors, such as self-respect, autonomy, competence, mastery and achievement, and external esteem factors, such as status and recognition (Green *et al.*, 2005:28; Robbins, 2001:156). Although the participants of this research looked poor, they desired the strength to achieve what other people were achieving.

Kenyon (2004:8) concludes that the fulfilment of self-esteem needs leads to a feeling of self-confidence, worth, strength, capability and adequacy, of being useful and needed in the world.

4.5.5 Self-actualisation needs

The three themes of the need to be a whole person, the need related to technology and spiritual needs correspond with the highest level of need in Maslow's theory. The researcher believes that the need to be a whole person is, in a sense, similar to self-actualisation and, therefore, it was fitted in with this level.

Self-actualisation is fundamentally different from the previous levels of needs in the sense that it leads to self-growth (Heylighen, 1992:41). Growth and self-fulfilment are cornerstones of self-actualisation (Nel *et al.*, 2004:212). According to Sadock and Sadock (2000:6), self-actualisation is a drive to fulfil one's unique potential.

The participants of this study emphasised needs related to the use of technological products, such as telephones, computers, microwave ovens and other items that, in most cases, they did not have. Access to and the ability to use technology can contribute to personal growth and self-fulfilment. Louw and Edwards (1993:435) and Jordaan and Jordaan (2003:582) note that self-

actualisation also entails that people discover themselves and fully realise their potential, thus achieving personal growth.

4.6 THE USE OF THE *MULTILEVEL APPROACHES TOWARD COMMUNITY HEALTH (MATCH)* MODEL IN THIS RESEARCH

Maslow's Hierarchy of Needs theory was used to structure the needs identified by the participants in the study. By utilising this theory in health promotion, healthcare personnel ensure that all the needs of the individual and/or group are met. However, the theory does not indicate how to meet the specific needs. Therefore a model was selected to determine strategies to plan and implement health promotion. The *MATCH* model was chosen and used in conjunction with *Maslow's Hierarchy of Needs* theory. The *MATCH* model was chosen because it provides a conceptual framework for the understanding of health promotion interventions at governmental, organisational and individual levels (Simons-Morton, Simons-Morton, Parcel & Bunker, 1988:25). This model advocates participatory approaches to health promotion, which, especially through the mobilisation and leveraging of resources, could address the problem of health promotion (Green *et al.*, 2005:27).

The *MATCH* model shows how people at governmental, organisational and community level can utilise policies, practices, programmes, facilities and resources to attain reasonable health promotion outcomes in a multilevel approach. Although it was originally developed for illness prevention, it can be adapted for health promotion programmes and therefore also in the case of families with adolescents orphaned by HIV/Aids. The same resources and strategies are used in health promotion and illness prevention, as illness prevention is part of health promotion.

As families with adolescents orphaned by HIV/Aids identified and described their needs during the research process, the necessity for patterned interventions to meet these needs as discussed above emerged (Simons-Morton *et al.*, 1988:25). The *MATCH* model emphasises personal and environmental conditions that influence the health of individuals. Personal conditions that can influence health

and wellness are, inter alia, age, race and gender (Simons-Morton *et al.*, 1988:25). Environmental conditions that can influence the health and wellness of the community are, inter alia, institutional arrangements, water, sanitation, and occupational hazards (Green *et al.*, 2005:27). The model had to be adapted in order to be applied to fit into the study context and the broader South African perspective.

Below, an overview of the model is first presented unchanged (Figure 4.2) followed by the adjustments made to suit this research (Figure 4.3). All levels of the *MATCH* model were used with some modification of selected aspects at governmental, organisational and individual levels. At governmental level, the changes relate to government and community leaders, as well as to the objectives. At organisational level, the researcher selected only a few decision makers, such as managers and traditional leaders, as they represent organisations. At individual level, adjustments were made regarding the individual at risk. The individuals at risk are the participants of this study. With regard to the health status of the target group, the terms mortality, morbidity and wellness were replaced with the term increased wellness. The other aspects remained unchanged.

4.6.1 Overview and description of the *Multilevel Approach Toward Community Health (MATCH)* model

The *MATCH* model was developed in the United States of America by Simons-Morton, Simons-Morton, Parcel and Bunker of the universities of Texas (University of Texas Health Science) and Virginia (George Mason University) (Simons-Morton *et al.,* 1988:25). According to the developers of this model, implementing public or community health care includes three kinds of preventive services, namely:

1. Those that are directed toward making the environment healthy,
2. The personal preventive services directed toward protecting the health of the individuals, and
3. A combination of the services mentioned in 1 and 2.

(Simons-Morton *et al.*, 1988:25).

These services need to be understood by the public or community, and communities need to interact with their environment in such a way that the environment will contribute to their health. Green *et al.* (2005:27) add that there should be an understanding of environmental variables that contribute to healthy lifestyles and behaviours. If this kind of understanding is demonstrated, health can be promoted.

The developers of the *MATCH* model define health promotion in relation to individual, organisational and government supports that contribute to behaviour conducive to good personal and environmental health (Simons-Morton *et al.*, 1988:25). Edelman and Mandle (2002:16) define health promotion as the science and art of helping people to change their lifestyles in order to move toward a state of optimal health. These definitions have elements that indicate that personal and environmental conditions influence health (see Figure 4.2). Although the authors identified the above conditions that are conducive to health, they did not provide detailed information regarding these conditions.

Simons-Morton *et al.* (1988:25) emphasise that individuals, organisations and the government can influence intervention strategies for health promotion (see Figure 4.2). On both organisational and governmental levels, individuals are involved in the planning and implementation of health promotion programmes aimed at wellness.

The *MATCH* model views wellness and health promotion from a personal and family perspective. Wellness is an integrated method of functioning which is oriented towards maximising the potential and capability of the client (Cookfair, 1996:149). Because the *MATCH* model is comprehensive, it is regarded suitable for this research. The model is comprehensive in the sense that health promotion is addressed at individual, organisational and governmental levels. If health promotion were approached from individual to governmental level, an optimum level of health care could be attained. Community nurses are in a position to influence the government and organisations to contribute to health promotion programmes in general, but also specifically of families with adolescents

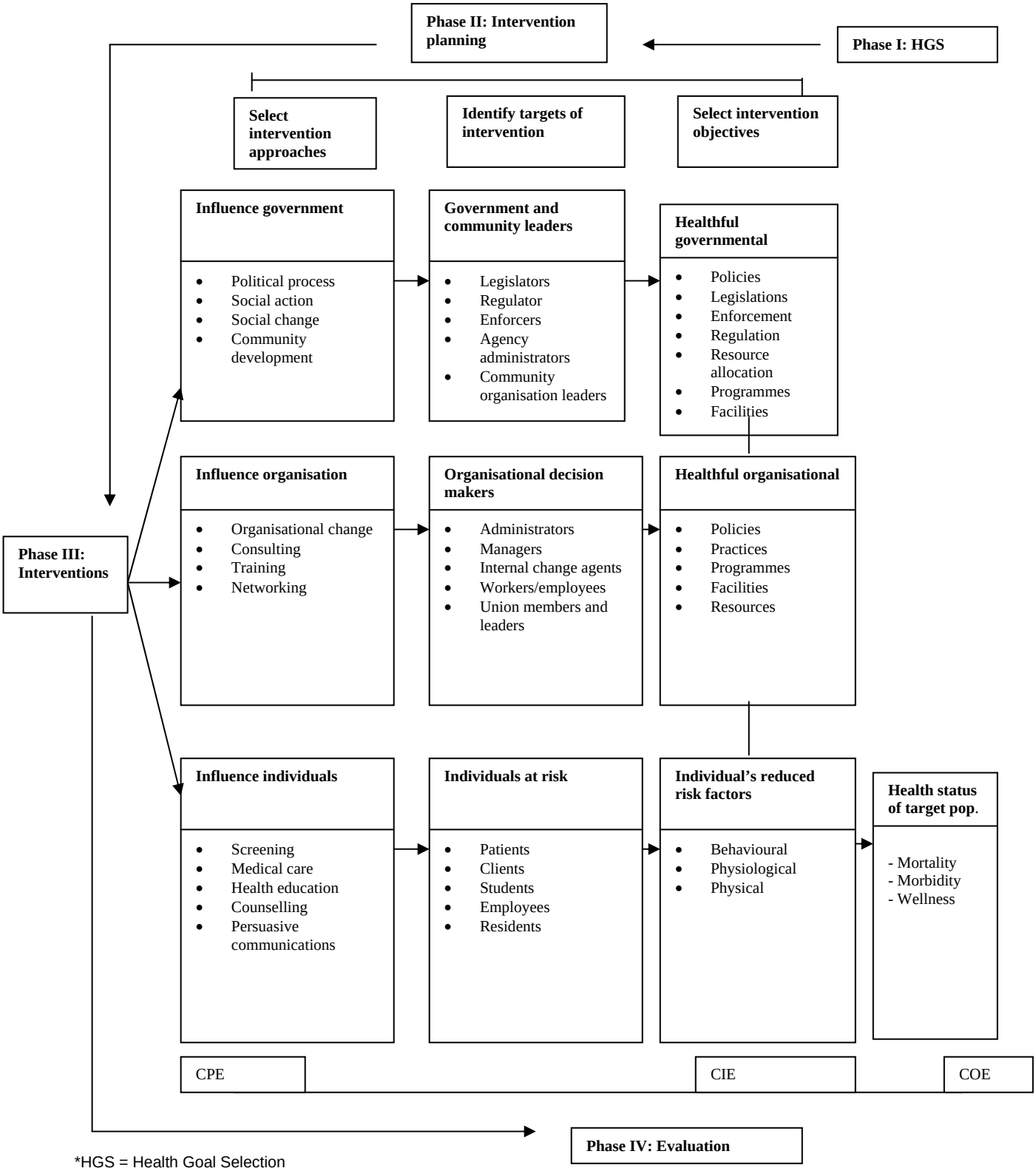
orphaned by HIV/Aids. Therefore, the guidelines developed should assist nurses to promote the health of these families.

The model focuses on personal and environmental factors that influence health. These can be classified as operating on three major levels, namely at governmental, organisational and individual levels. The components of this model include influencing individuals to reduce personal risk factors for disease, influencing organisations and governments to reduce environmental risk factors for disease and facilitating positive influences on personal behaviours and physiology (Simons-Morton *et al.*, 1988:25).

Figure 4.2 on page 142 is a graphical representation of the model which is discussed below.

(a) Phase I of the *Multilevel Approach Toward Community Health (MATCH)* model – goal selection

Goal selection for health promotion programmes can follow on the assessment of individuals, families and groups for health problems. Health goal selection usually occurs in specific contexts at governmental and organisational level in the community and may include settings in the community such as clinics, hospitals and schools. In this phase, the health goals relevant for the target population are selected (Kelly, Baldyga, Barajas & Rodriguez-Sanchez, 2005:4). Individuals or organisations that develop community health programmes may be responsible for a specific population (clinic or community) or for a specific health problem (e.g. cancer, heart disease, teenage pregnancy). The choice of target population or health goals may be directed by existing priorities. In some cases, the target population itself, once identified, may suggest its own goals. The target population is made up of all individuals whose health is a concern (Kelly *et al.,* 2005:4). The *MATCH* model is utilised to manage a comprehensive health promotion/illness prevention programme implemented when a large group of people require intervention.



*HGS = Health Goal Selection

*CPE = Conduct Process Evaluation

*CIE = Conduct Impact Evaluation

*COE = Conduct Outcome Evaluation

FIGURE 4.2: MATCH MODEL FOR COMMUNITY HEALTH INTERVENTION (SIMONS- MORTON ET AL., 1988)

The rationale for the selection of a target population is to ensure that the focus of the assessment is on the identified population only (Chappell, Funk, Carson, MacKenzie & Stanwick, 2005:356). A comprehensive assessment of the target population should be conducted. Goal selection can be based on a comprehensive epidemiologic assessment, a mandated area of topics, the intervener's personal or professional interest in a health problem, client requests or the requests of community organisations or groups (Chappell *et al*., 2005:356). In other words, the goals will be selected after a comprehensive epidemiologic assessment of the individuals, families and community (Chappell *et al*., 2005:356). The selection of goals is usually a group effort that involves the community taking decisions for the promotion of its own health. According to the model, health goals can be aimed at the reduction of morbidity rates or at an increase in the wellness of the population (Simons-Morton *et al.*, 1988:28).

(b) Phase II of the *Multilevel Approach to Community Health (MATCH)* Model – intervention planning

Phase II of the *MATCH* model takes place at governmental, organisational and individual level, discussed below.

Governmental level

In this phase, interventions, such as political processes, social actions, social change and community development, as planned by government, are activities that can be utilised to promote the health of the community. The targets of intervention (role players who are involved in planning and implementation) are people functioning at governmental level with authority, power, and influence to create change from the highest level downwards (Figure 4.2). Government and community leaders, such as legislators, regulators, enforcers, agency administrators and community organisation leaders, are involved. The objectives for health promotion at governmental level are focused on the development and implementation of policies, legislation and regulations, the enforcement of regulations, resource allocation and utilisation of facilities (Simons-Morton *et al.*, 1988:30).

Organisational level

At organisational level, decision makers, such as administrators, managers, internal change agents, workers or employees, union members and leaders, are involved. The decision makers influence organisational change to achieve health goals through consulting, training and networking. The interventions are identified and selected for their feasibility and appropriateness for health promotion purposes. The intervention approaches at organisational level focus on selected objectives based on the development and implementation of internal policies, practices, programmes, facilities and resources (Simons-Morton *et al.*, 1988:30).

Individual level

At individual level, the intervention approaches that influence individuals to change their behaviour are identified and selected for their feasibility and appropriateness in achieving the goals described above. Interventions can be of diverse natures, from varying theoretical backgrounds, and of different intensities (Simons-Morton *et al.*, 1988:30). At individual level, intervention approaches such as screening for health problems, health care, health education, counselling and persuasive communication are selected and planned to achieve the health goals.

The intervention approaches for this level are directed to the targets of intervention, namely the individuals at risk (see Figure 4.2). These can be patients, clients, students, employees and residents. The objective is to reduce risk factors through behavioural, physiological and physical change. If the individuals' risk factors are reduced, the mortality and morbidity rates become reduced and there will be an improvement of wellness (Simons-Morton *et al.*, 1988:30).

(c) Phase III of the *Multilevel Approach Toward Community Health (MATCH)* model – intervention

Phase III involves the development and implementation of the interventions selected in Phase II. The materials for health promotion are developed and tested

for their feasibility. Additional personnel for health promotion are hired as needed. The meetings or class sites are scheduled and interventions are conducted. Figure 4.2 shows how the sequence of events resulting from intervention relates to the other phases of the model.

Government level

At governmental level, the appropriate interventions, target of interventions and intervention objectives selected in Phase II are developed and implemented. At this level, the individuals who influence the government to achieve the health goals are legislators, regulators, enforcers, agency administrators and community organisation leaders. These government officials focus on the selected objectives mentioned above.

According to Simons-Morton *et al.* (1988:31), the influencing of local government leaders to reduce hazards for unintentional injury in their communities is an example of governmental level interventions. The authors (Simons-Morton *et al.*, 1988:32) describe how, through an invited conference at Galveston, the community and government leaders were influenced to create communitywide changes and government actions directed toward decreasing unintentional injury, morbidity and mortality. In this case, government actions included controlling and enforcing mandatory safety restraints, providing safe road and traffic control, requiring automobile safety inspections, and the passing and enforcing of drunk and driving laws in the community.

Organisational level

At organisational level, the individuals who influence the organisation to achieve health goals include the administrators, managers, internal change agents, workers or employees, union members and leaders. These decision makers focus on selected objectives based on policies, practices, programmes, facilities and resources of importance to organisations, such as NGOs. These decision makers influence families and individuals through training programmes,

consultation and networking in order to bring about change in health (Simons-Morton *et al.,* 1988:30).

Simons-Morton *et al.* (1988:31) use the example of the occurrence of hypertension as an untreated condition in the community and the measures to decrease its prevalence. In this case, the practitioner can influence the government to fund hypertension screening programmes, and support hypertension research and education campaigns.

Individual level

At individual level, the individuals who are influenced through screening, health care, health education, counselling and persuasive communication are patients, clients, students, employees and residents. These individuals are at risk and focus on selected objectives based on behavioural, physiological and physical change. These changes are observed through the improvement of their health status, including the reduction in morbidity and mortality, and increased wellness (Simons-Morton *et al.*, 1988:29).

(d) Phase IV of the *Multilevel Approach Toward Community Health (MATCH)* model – evaluation of achievements

In Phase IV, an evaluation of intervention is done to determine if the stated aims and objectives have been achieved. The interventions process and the results are evaluated on three bases, namely the process, impact and outcome.

In the process evaluation, the application of the intervention approaches is examined. The impact and health outcome evaluations assess whether health goals and the intervention objectives of Phase I and Phase II were achieved (Simons-Morton *et al.*, 1988:30).

4.7 REASONS FOR CHOOSING THE *MULTILEVEL APPROACHES TOWARD COMMUNITY HEALTH (MATCH)* MODEL

The *MATCH* model was chosen to guide the process of health promotion in this study. The model is comprehensive as it involves various approaches, sets targets and specifies objectives, and involves all stakeholders. At the same time, it is a fairly simple model that involves the government, organisations and individuals (Simons-Morton *et al.*, 1988:34).

The model follows clear steps regarding intervention approaches, stakeholders and objectives at the levels mentioned (Figure 4.2). The key role players involved at the three levels can influence the extent of health promotion. It is self-evident why it is necessary to involve the government, organisations and individuals when planning any health promotion programme aimed at changing the health behaviour of the community. The government has an influence on the health of the community, and government policies, legislature and resource allocation are important as promoting the health of the community takes place within expected norms. The involvement of the government and organisations in health promotion should be encouraged by nurses in order to achieve sustained provision for basic needs, which in turn will contribute to health promotion. The involvement of individuals is important because, as an individual's level of understanding regarding health promotion issues improves, his/her health status may also improve.

Cookfair (1996:157) argues that stakeholders from institutions and political action groups can make significant contributions to health promotion. Nurses should ensure that their voices are heard among these stakeholders so that the health of individuals can be improved. According to Cookfair (1996:155), the *MATCH* model itself is viewed as a model for wellness and health promotion from a personal and family perspective. Because the model is based on wellness, it is appropriate for this research. The research aimed at developing guidelines for health promotion to improve the health of families with adolescents orphaned by HIV/Aids. The focus is therefore on wellness in the broader sense of the word.

The major strengths of the *MATCH* model are its applicability to a wide variety of community health topics, settings and target individuals, its accommodation of a variety of intervention methods and its ability to facilitate simultaneous actions at a number of levels. The model also focuses on matching appropriate interventions to desired objectives.

The model accommodates a variety of intervention methods and theoretical approaches at government level (political process, social action, social change and community development), organisation level (consulting, training and networking) and individual level (screening, medical care, health education, counselling and persuasive communication) (Simons-Morton *et al.*, 1988:34). The model is recommended as a useful, easy-to-apply framework that can facilitate action by a variety of people to improve the public's health through the planning of programmes that consider both environmental and personal change (see Figure 4.2), which is of utmost importance in guideline formulation in the context of this research.

4.8 APPLICATION OF THE *MULTILEVEL APPROACHES TOWARD COMMUNITY HEALTH (MATCH)* MODEL IN THE CURRENT RESEARCH

A revised *MATCH* model, specifically applied to the health promotion needs of families with adolescents orphaned by HIV/Aids is represented in Figure 4.3 on page 151. This revised model and its applications are discussed below. In the application of the model, literature is used to substantiate the relevant arguments.

While the original model was developed and implemented in the United States of America, the researcher realised that the context differed from the one in South Africa. The South African context requires unique ways of promoting the health of individuals as a result of its disease profile and unique circumstances. The researcher transformed and revised the original model to suit the objectives of this specific study.

According to the Global Health Sector Strategy for HIV/Aids, 2003-2007 (WHO, 2003), a successful response depends on the active engagement of people living with and affected by HIV/Aids. In this study, a successful response is determined by how willing families with adolescents orphaned by HIV/Aids are to participate in changing their lifestyles through health promotion strategies. Interventions needed for families with adolescents orphaned by HIV/Aids are reflected in the development of a guideline for their health promotion. Actions such as health promotion strategies should be formulated to help families to cope and assist them where necessary.

It is important that all the individuals, families and groups take responsibility for their own health improvement (Van Wyk, 1999:30), but it is the responsibility of the government to provide these people with the necessary facilities and programmes for health promotion. Although the government is expected to provide resources, Edelman and Mandle (2002:16) argue that active strategies for health promotion depend on the personal involvement of the individual in adopting any proposed programmes.

In the research conducted by Zuluaga (2000:317), it was found that various intervention strategies, such as community action, mobilisation of resources and the linking of health promotion programmes, should be implemented to improve the health of people, including families with adolescents orphaned by HIV/Aids.

The adolescents in this research emphasised that they need to be educated, to be socially supported and to have healthcare services suitable for them in order to fit well into the society. Irrespective of their status, these adolescents have the same rights as other children and should be given the same opportunity as other children to improve their health. In the absence of their own parents, the government has the responsibility to provide the resources needed to develop the potential of each orphan. Only then can these adolescents be taught to take responsibility for their own health and health promotion. The revised *MATCH* model displayed in Figure 4.3 on page 151 indicates the attendant responsibilities on governmental, organisational and individual level.

4.8.1 Phase I of the revised *Multilevel Approaches Toward Community Health (MATCH)* model – health goal selection

In the revised model (see Figure 4.3 on page 151), health goals for the target population (families with adolescents orphaned by HIV/Aids) are selected, using the results of the research described in Chapter 3. In this chapter, the health promotion goals of the participants are identified, explored and described. The themes that were identified and fitted into the *Maslow Hierarchy of Needs* theory resemble the needs that should be addressed in order to achieve the health promotion goals of the target population.

The current situation of the families with adolescents orphaned by HIV/Aids is related to the needs of these adolescents, including the need for housing, clean water, sanitation, recreational facilities, food and nutrition, safety, love and belonging, self-esteem and self-actualisation (see Table 3.2 and 4.1). The researcher made use of the revised *MATCH* model to develop the guidelines based on the findings of the research. Cookfair (1996:205) emphasises that broad goals should be based on the opportunities for interventions.

4.8.2 Phase II and III of the revised *Multilevel Approaches Toward Community Health (MATCH)* model – planning and interventions

Planning is a logical, systematic, decision-making process that requires an orderly programme of action designed around specific goals (Dreyer, Hattingh & Lock, 1997:18). In applying Phase II of the revised model (see Figure 4.3 on page 151), the focus is on the planning of interventions to the benefit of the health of the research participants. Interventions planned should therefore be appropriate and relevant to these families (Simons-Morton *et al.*, 1988:30).

Figure 4.3 on page 151 displays the four different phases of the revised *MATCH* model.

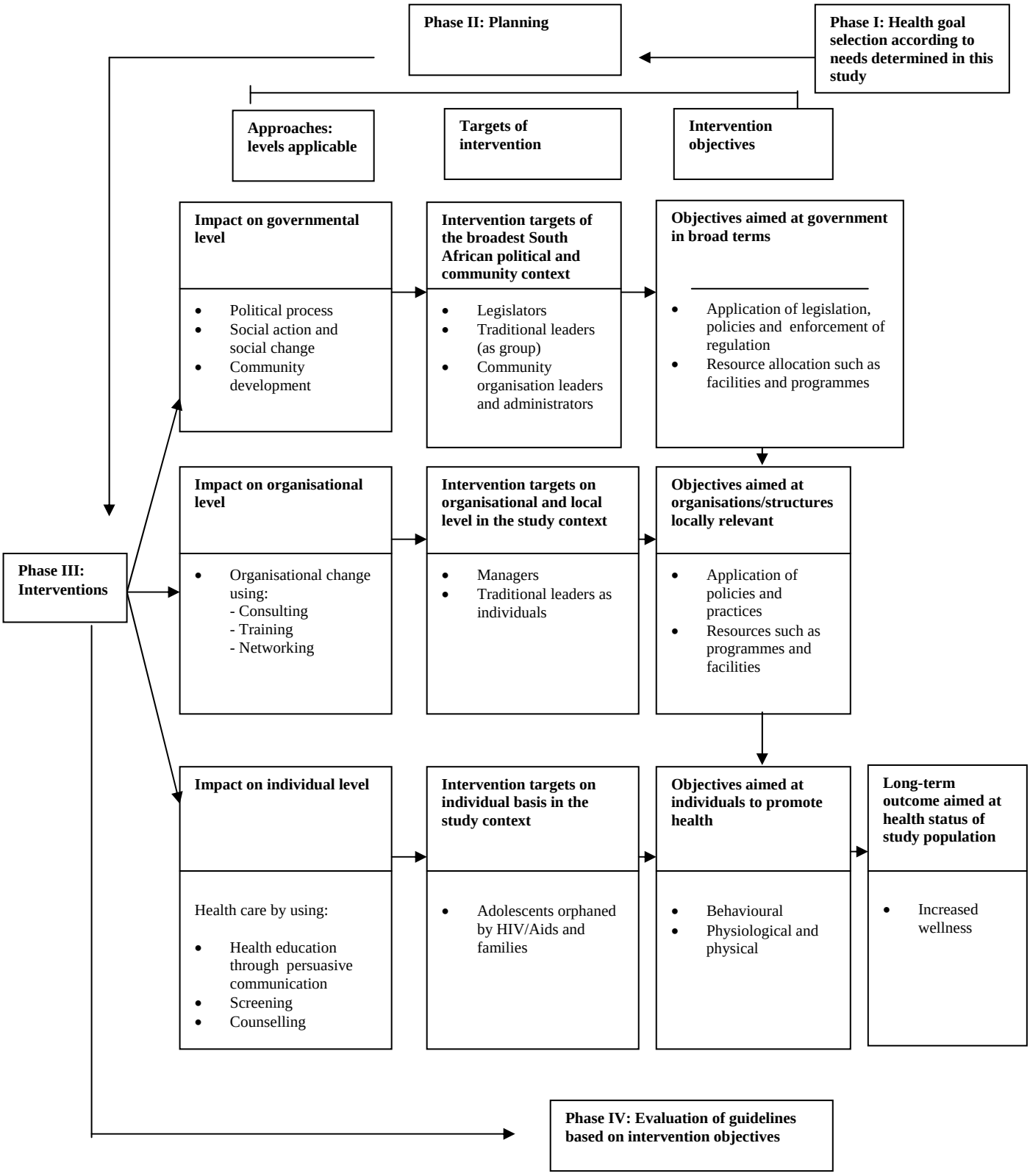


FIGURE 4.3: THE REVISED MATCH MODEL – THE HEALTH PROMOTION OF FAMILIES WITH ADOLESCENTS ORPHANED BY HIV/AIDS

In Phase II, the planning of the applicable interventions, including the selection of approaches for applicable levels (governmental, organisational and individual), the identification of targets of interventions and the selection of intervention objectives, is conducted. Cookfair (1996:205) supports the above statement and states that planning involves the analysis of the current situation, forecasting the future situation and looking for opportunities for intervention.

Goeppinger (1984) in Lundy and Janes (2001:50-51) indicates that in planning, the following criteria should be observed: community awareness regarding the health problem, community motivation to bring about change, the team's ability to influence problem solution and the availability of expertise. Families with adolescents orphaned by HIV/Aids must be aware of the health problems and be motivated to solve these problems with the assistance of the government and relevant organisations. In the revised *MATCH* model, the strategies for planning interventions on governmental, organisational and individual level to promote the health of families with adolescents orphaned by HIV/Aids are displayed (see Figure 4.3 on page 151).

The health promotion strategies at governmental level involve political process, social change and action, as well as community development (Simons-Morton *et al.*, 1988:29). The strategies to promote health at organisational level involve consulting, training and networking to bring about organisational change. At individual level, the strategies for planning of interventions include health education through persuasive communication, screening and counselling. Therefore, importantly, the second and third phases of the revised *MATCH* model are to a large extent interlinked so that the planning of the intervention automatically results in the development of the intervention. These phases are inseparable, as the planning flows over into implementation of the intervention.

Phase III involves the implementation of the interventions planned in Phase II. These interventions include the developing and testing of any materials needed to implement the programme for health promotion (Shekelle *et al.*, 1999:595). This phase addresses all phases, as well as the process of developing

guidelines. Meetings with selected stakeholders in the community form part of Phase III.

In the planning and implementation of a programme to improve the health of families with adolescents orphaned by HIV/Aids, the three levels namely, the governmental, organisational and individual levels, are applied and discussed individually, as part of the development of guidelines. The order of discussion is centred on the approaches, targets and interventions at the different levels. The discussions of these levels will be theoretically supported to ensure trustworthiness. The summaries concluding each section are recommendations that serve as the foundation for the preliminary guidelines.

4.8.2.1 (A) Impact at governmental level

The government has a responsibility toward the health promotion of the entire population. Its structures cannot be ignored when the health promotion of families with adolescents orphaned by HIV/Aids is at stake. In Chapter 2 of the Constitution of the Republic of South Africa, it is stated that the Bill of Rights is the cornerstone of democracy in South Africa. The people of South Africa have rights and responsibilities, and should be treated with dignity and be allowed to practise their freedom responsibly (South Africa, 1996b:7). In reference to this research, current government policies and guidelines including the Bill of Rights were consulted, as these serve as guides to the promotion of the quality of life and health of any community. Orphans as citizens of South Africa have the same rights as all other South Africans. They have, inter alia, the right to life, access to clean water, sanitation, and shelter. They also need governmental support in terms of the provision of healthcare services, schools and recreation facilities, in order to lead a life of dignity as social beings.

At governmental level, the intervention approaches that can be used are political processes, the management of social action and social change, and programmes for community development. These intervention approaches involve key role players, such as legislators, traditional leaders, and community organisation leaders and administrators. Simons-Morton *et al.* (1988:33-4) state that health

and health promotion are enterprises in which a variety of professionals can make a contribution, including nurses, laypeople, institutions and political action groups. These role players must be involved in the planning and implementation of health promotion programmes as needed by families with adolescents orphaned by HIV/Aids.

(a) The use of political process for health promotion

Health promotion and political processes

Health promotion may be regarded as a process and as an outcome. It is a process whereby the government, organisations and individuals interact to bring about changes to the health behaviours of society (Pearson & Care, 2002:177). It becomes an outcome when people in a political action attain its objectives. The families who participated in this research could change their lifestyle only if their health promotion needs are provided for. These needs include, among others, safety and security needs, healthcare needs, educational needs and needs related to the availability of technology. The participants of this research emphasised their basic needs, such as for food, water, sanitation and proper housing, as necessary to enable them to promote their own health.

Health promotion and political process are two concepts that are closely connected to one another. The government's responsibility toward its people and thus its obligation to promote the health of its people can be considered as a strategy to oblige the government to develop policies and guidelines on health promotion. The political process is an action where the electorate and government officials exercise their powers. Yoder-Wise (1999:417) adds that politics is a process of human interaction within structures such as organisations. When people interact, they share ideas and knowledge that can contribute to changing policies regarding, in this case, health promotion. Therefore, nurses' involvement in political processes can enhance the development and implementation of health promotion programmes aimed at society in general as well as at specific groups, such as families with adolescents orphaned by HIV/Aids.

Health promotion is commonly interlinked with terms such as health education and disease prevention (Rafael, 1999:24). It is used to describe disease prevention or changes of lifestyle. Health education as a strategy for health promotion can be regarded as a political process as nurses use their knowledge to influence change in individuals' health behaviour. The same principles are applicable when government officials use their power to campaign for positions in a political system. It is essential that nurses participate in politics in order to influence the government to provide facilities and resources for health education and health promotion programmes. The *MATCH* model is aimed at motivating nurses to cooperate with the government at national, regional and local levels in order to provide society, and thus also the participants included in this study, with the necessary resources to meet their needs.

The revised *MATCH* model as utilised in this study calls for the involvement and assistance of the government and various interested organisations (see Figure 4.3) to reshape and strengthen the existing health promoting behaviours of families with adolescents orphaned by HIV/Aids to the benefit of their health. It is important that the government, organisations and families with such adolescents create good working relationships, which are conducive to health promotion, with one another.

The use of lobbying as a strategy in a political process

As indicated in the revised *MATCH* model, political processes (see Figure 4.3) could be used as a strategy in this study context through the application of legislation, policies and regulations, the allocation of facilities and the development of health promotion programmes. The findings of this research study (see Table 3.2) reveal the needs of the families that can be met on individual level with government assistance. This may necessitate the development of legislation, policies and regulations.

One way of interacting with the government in order to sensitise it to the needs of the people is by lobbying. Lobbying is defined as a group of people seeking to influence legislators on parliament issues (Concise Oxford English Dictionary,

2002:832). According to Rothberg (1985:133-4), various international organisations for nurses have been lobbying for political actions to give nurses recognition for their contribution to the delivery of health care. Block and Jamerson (2005:30) describe various strategies of lobbying for political action. Communication and education are regarded as the core of this process.

In recent years in South Africa, nurses have become more involved in the political processes of the country (Mzolo, 2001:20). Nurses should be urged to make use of their networking skills to the benefit of the people, in this case, families of adolescents orphaned by HIV/Aids. The needs that can be addressed on this level are physical and physiological, safety and security, love and belonging, healthcare, educational, support and social needs, as well as needs related to technology (see Table 3.2).

In the revised *MATCH* model, emphasis is placed on the use of persuasive communication to influence families with adolescents orphaned by HIV/Aids to change unhealthy behaviours and support their existing health promoting behaviours. As keen supporters of health promotion, nurses play a significant role in the implementation of health policies that encourage the health promotion of the community. Persuasive communication serves as an effective wellness strategy to convince people to make use of the services provided through the implementation of policies (Beu, 2003:141).

The roles, responsibilities and involvement of nurses in a political process

As indicated in the revised *MATCH* model (see Figure 4.3), effective health promotion requires the participation of the government, organisations and individuals to influence the community to practise better health behaviours. This partnership can assist families with adolescents orphaned by HIV/Aids to improve their living conditions, in terms of housing and their environment, and to take part in health promotion activities.

Nurses have a responsibility to interact with government and relevant organisations on behalf of the community to ensure that policies are formulated

and the necessary resources allocated in order to better the health of the community (Hammanskraal Local Government Councillors, 2005). Once policies have been implemented, nurses are involved in the rendering of the services that have been developed as a result of the policies. Nurses' responsibility to influence governmental decision-making does not stop once the policies have been developed. They have to ensure that the services are rendered and that the community receives high quality care (DPSA, 1997).

Gatherings such as health and policing forums (Hammanskraal Local Government Councillors, 2005) can be utilised by the government to consult various stakeholders during the planning process, as well as to evaluate the quality of the services by involving the recipients of the care in discussions of the efficacy of the programmes. The government can also make use of such meetings to make people aware of behaviour that jeopardises the health of the community. Professionals like nurses are included in the forums in order to motivate the people of the community to change behaviours that are detrimental to their health.

In South Africa, government officials sometimes use political meetings to communicate with the community regarding matters of concern to them. This was confirmed during a discussion with a local councillor in Hammanskraal (Hammanskraal Local Government Councillors, 2005), in which it was noted that policies related to health are often communicated through civic meetings to enhance speedy information distribution. Nurses working in the public sector can utilise these meetings to make government officials aware of the needs of the community. The revised *MATCH* model indicates that nurses should be given the opportunity to become involved in the political processes to the benefit of the community.

The nursing profession has been slow to acknowledge and use its power to support and influence healthcare policy. According to Ennen (2001:557,561), although nurses are reluctant to see themselves as politically active, they are practising (nursing) within a socio-economic and political context on a daily basis. The patients' social, economic and political positions must be taken into account

when their health care (health promotion) is planned. Nurses are important role players in public health, as they are often required to expand their role as nurse to that of social worker and financial manager in the absence of other professionals, especially in rural areas. If nurses practise within these spheres, it is obvious that they can have a tremendous impact on the political situation of the country as far as healthcare and related policies are concerned.

Lundy and Janes (2001:188) state that nurses' involvement in political processes can relate to the drafting of a bill, the provision of a testimony for the health of the society and lobbying with community members to facilitate change of health threatening behaviour. O'Dowd (1999:8) states that nurses and other public sector professionals are the social entrepreneurs of the future and will have new powers that enable them to serve the community by interacting with governmental authorities. As spokespeople for the community, they can ensure that policies are made and implemented to serve the community.

According to Hubbard, Werner, Cohen-Mansfield and Shusterman (1992:858), when the government cooperates with the community, the isolation of the community is reduced leading to an increase in the self-esteem of the people. Messages of health promotion can be conveyed during these encounters.

Yoder-Wise (1999:418) defines power as the ability to influence others in an effort to achieve goals. Nurses have expert knowledge that can be used to advise government officials regarding health policies that deal with health promotion. Nurses have to be made aware of the power of their knowledge and that they can use this knowledge to the benefit of the people that they serve.

Ennen (2001:561) suggests that in order to be able to influence the government, nurses must be able to communicate well, and cooperate with other professional associations and the community at large. Ennen further states that nurses should be able to create an atmosphere of collegiality in order to ensure cooperation and collective action. Political action has to become part of community nurses' scope of practice in order to ensure that legislation favours the community and promotes the health of its members.

(b) The use of social action and social change for health promotion

The concept social action

Social actions are the behaviours of an individual in response to his/her subjective evaluation of the motives of others and the values and goals of the society in which he/she lives (World Book Dictionary, 1994:1983). The outcomes of social action are regarded as social change (Flynn, Ray & Selmanoff, 1987:239). Nurses as agents for health promotion are regarded as participants that can exert influence, through social action and social change, on individuals and the community for better health. These nurses can utilise their skills and knowledge to work as a team in order to influence health policies regarding health promotion. Social action and social change form part of the *MATCH* model and can be used to influence policy makers and community leaders to develop health promotion programmes based on the findings of this research.

Social action can be used by nurses to influence politicians and others to prioritise the needs of the participants of this research, including the need for housing, food, education and health care (see Table 3.2). Orphaned adolescents are part of the impact of HIV/Aids and need proper strategies and monitoring to assist them and ensure their survival. The findings of this research clearly show that these adolescents need specific support to attain healthy lifestyles. Nyambedha, Wandibba and Aagaard-Hansen (2003:310) and the White Oak Report (2000:6) state that in order to monitor and decrease the impact of HIV/Aids, appropriate intervention strategies need to be implemented as a matter of urgency.

Community nurses have the responsibility to take social action in order to make people aware that they are responsible for their own health. The Ottawa Charter for Health Promotion drawn up during a conference about health promotion in 1986 and the findings of the Jakarta Leading Health Promotion Conference held in 1997 emphasised that health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to well-being and thus involves other sectors too (Ottawa Charter for Health Promotion, 2007).

The barriers to social action

Social action includes being knowledgeable about laws and health policies. If nurses and the community are not knowledgeable, health problems may be experienced. Lack of knowledge among nurses can negatively influence health promotion in the society leading to poor health. Boswell, Cannon and Miller (2005:5) state that inexperienced nurses can negatively affect the involvement of society in social action, which will ultimately lead to poor health promotion. An efficient information system enables nurses to fully participate in social action and will thus influence the development of health policies.

A lack of communication is one of the barriers for social change that may affect the promotion of health (Ekstrom & Sigurdsson, 2002:291). Nurses should therefore try to attend all kinds of meetings where information regarding health matters is communicated and disseminated.

Nurses are ideally suited to take part in social action to the benefit of the community, as they comprise the largest health professional group. They also have first-hand information regarding the needs of the community, as they are often the first point of contact for patients when they visit a healthcare facility (Flynn *et al.*, 1987:239). Although a substantial number of nurses occupy high positions in the South African government and governmental institutions, there are only a limited number of nurses who are involved in the programmes of the local authority in the community (Flynn *et al.*, 1987:239). As indicated in the revised *MATCH* model (see Figure 4.3), social action and social change are approaches that can be used for health promotion at governmental level through the formulation and implementation of policies and legislation, as well as the allocation of resources.

Nurses play a vital role in changing the health behaviours of a community within its social environment. Community nurses as the pillars of the society and have an obligation to empower the community in order to change behaviour that is detrimental to their health (Mulaudzi, 2005:59).

Strategies to enhance social action and social change

The mobilisation and allocation of resources as a collaborative effort between the government and organisations in the community can enhance social action (Hoffman, 2003:75). It is, however, not enough for the government alone to challenge the environmental risks that influence the health of the community. Partnership in this instance is radically needed to achieve a better life (Lundy & Janes, 2001:388; Reuter & Williamson, 2000:21).

In the South African context, the Minister of Social Welfare, Dr Zola Skweyiya, emphasised the importance of meeting the needs of children in collaboration with NGOs (Skweyiya, 2005a:1). Meeting the needs of these children is part of the social action expected of community nurses. The Minister further states that women and children constitute the largest segments of poor people in South Africa and that they are the most vulnerable members of society (Skweyiya, 2005a:6). The mobilisation of resources, the facilitation of collaborative networks and strategic partnerships should assist in health promotion programmes that could be nurse driven (Brown, Zavestoski, McCormick, Mayer, Morello-Frosch & Altman, 2004:58). Training is also one of the approaches to health promotion that can bring about organisational change (see Figure 4.3).

(c) The use of community development for health promotion

The concept community development

Community development (see Figure 4.3) is one of the approaches that can be used by the government to influence health promotion based on the application of policies and legislation, and the allocation of resources such as facilities and programmes. Lindsey, Stajduhar and McGuinness (2001:829) and Coulson, Goldstein and Ntuli (2002:132) define community development as the process by which the community defines its own health needs, decides collectively how these needs can be attained, determines the priority for actions and specifies a process of voluntary cooperation aimed at improved physical, social and economic conditions. Such actions lead to the promotion of health. Community

development comprises of citizen involvement action, voluntary participation, cooperation and collaborative problem solving. Community development is also a process whereby the government empowers its citizens with the skills to manage their own environment. In community development, various multidisciplinary team members from the government and other organisations participate in the planning and implementing of health promotion programmes in order to meet all the physical needs, such as housing, water, sanitation and food, of the community. Among these members are nurses, who very often play a leading role in changing the health behaviour of the community through community development.

Community development is a way of helping the community to help itself. Nurses have to encourage the community to participate actively in order to gain the benefits of community development (Billings, 2000:475). Community development is vital to successful community awareness, as the community is expected to identify its own problems and decide how to deal with these problems. The participation of the families in this study in community development will enhance their development and contribute to their capacity building.

Community development involves the local empowerment of organised groups of people through collective decision-making projects and the development of programmes and policies that affect them as a community (Coulson *et al.*, 2002:133; Kuokkanen, Leino-Kilpi & Katajisto, 2002:328). It should be regarded as an important tool in changing health threatening behaviours of the community. This process can only be put in motion if the government, the community and nurses work hand in hand. Community development is not an isolated activity but an activity that takes place within the community and with the support of government in order to reduce health problems or risks.

The process of community development

Community development is a process that involves various steps that assist the community to implement health promotion strategies. It has been defined as a

mass process designed to create conditions of economic and social progress for a whole community through involvement, participation and development (McKenzie, Pinger & Kotechi, 1997:109). During this process, according to Brown (1994:353-4), contacts, trust and relationships are made and sustained.

Nurses work with the community to identify healthcare concerns or needs, such as housing, food, water and sanitation (Brown, 1994:35), identify and clarify the obstacles (Swanepoel, 2002:1-4), and implement the action community development process with measures to sustain it. During community development, the people of the community learn methods to promote health from one another and enjoy the benefits of participation. The end result of community development is empowerment. Empowerment is the provision of knowledge, self-confidence and authority to clients to enable them to use their own judgement (Booyens, 1999:3; De Beer & Swanepoel, 2003:133). In the context of this study, community development will assist families with adolescents orphaned by HIV/Aids to gain knowledge regarding changing their behaviour and sustaining existing health promoting behaviours.

The role of the nurse in community development

Community nurses have fundamental roles to play in community development. Community development is a prerequisite for the successful implementation of primary healthcare. According to the African National Congress (1994:20) and Dennill *et al.*, (2002:2), primary health care should be accessible and available to the community. Individuals, families and the community should be given the opportunity to participate fully at a cost that they can afford to maintain an optimum level of health at every stage of their development. Nurses should encourage the community to participate in the spirit of self-reliance and self-determination, but, at the same time, act as leaders and experts in community development (WHO, 1988:15). The people of the community have to be given an opportunity to attend a variety of events that will empower and develop them, and thereby make them knowledgeable about health. Projects that promote health should be made available to disadvantaged and vulnerable families, such as those of the study population.

Community development fits well into the scope of practice of nurses. In the standards of practice of the College of Nurses of Ontario (2004:4), it is stated that nurses should be involved in community development and the planning of services for the community. In their scope of practice of nurses, the Department of Education, Science and Technology of Australia (2001:5) states that nurses are expected to face the challenges of nursing education, including increased client expectations regarding community development and community-based primary healthcare services. The South African Nursing Council (SANC) in their Charter of Nursing Practice states that nurses should take part in health promotion activities to improve the health of the community (SANC, 2004:36-7). Community nurses are expected to assess the needs and resources of the community. They then need to develop and implement culturally sensitive community development programmes. Nurses should involve families in community development programmes regarding health needs.

Nurses and other professionals are increasingly expected to practise within a community-based healthcare service (Lindsey *et al.*, 2001:834). The nurse as community developer has to possess moral principles, personal integrity, expertise, future orientedness and sociability regarding health promotion (Kuokkanen *et al.*, 2002:329). Lindsey *et al.*, (2001:834) emphasise that social action is part of community development and is seen as both task and process orientated. It is concerned with increasing the community's ability to solve problems, as well as the achievement of sustainable change. With reference to the findings of this research, nurses have to empower these families with information regarding health promotion in order to increase their capabilities and capacity building. These families have to be guided to solve their own problems and sustain such capabilities. Community development has to be planned in such a way that it is locally and socially relevant. In other words, it has to be based on the needs of local people such as the population of this study.

From the above discussions, it is clear that by influencing the government on health promotion policies during the political process, and implementing social action and community development activities, nurses can change the behaviour of the community. On the basis that this study is concerned with health promotion

principles, and the development and implementation of guidelines for health promotion, the implication is that nurses have to collaborate with government representatives to promote the health of the community at grassroots level.

4.8.2.1 (B) Intervention targets of the broadest South African political and community context

Individuals with authority and power can influence the government to create change through health promotion (Simons-Morton *et al.*, 1988:30). These individuals, according to the revised *MATCH* model (see Figure 4.3) are legislators, traditional leaders and administrators. Nurses should use their knowledge and skills to influence these leaders.

(a) Legislators

The participants of this study expressed the desire that the government provide them with the necessary resources to meet their basic needs such as housing, food and nutrition, clean water, sanitation and recreational facilities. Guidelines for health promotion have to include the contribution that government can make through its legislators to provide the basic means of daily living as a foundation for health promotion.

In the Constitution of the Republic of South Africa, 1966, it is stated that the judicial system exists to protect the people of South Africa and their rights as human beings (South Africa, 1996b). These include the right to health care, housing, clean water and proper nutrition. Nurses have the obligation to make governmental representatives, such as legislators, aware of the basic needs of vulnerable groups such as families with adolescents orphaned by HIV/Aids.

Health policies are developed (at governmental level) and implemented on provincial level under the authority of the Minister of Health. Research findings such as the guidelines for health promotion developed in this study should be incorporated into the development of such policies.

The people in the local authorities are mainly responsible for the implementation of health policies that were developed at governmental level. As they have direct contact with the community, they are well positioned to influence the health behaviour of the people. However, their responsibility is also to give feedback to the authorities at regional, provincial and governmental level on the limitations and feasibility of the programmes and policies. They also have to convey the needs of the community to the policy makers. Nurses should therefore be willing to cooperate with local authorities in the identification of the needs of the people (see Table 3.2), as well as the implementation of any health-related programmes.

(b) Traditional leaders

Traditional leadership has been a thorny concept in South Africa since colonialism and continues to be in the current dispensation (South African History, 2005:1). As they are regarded as pillars in the community, the revised *MATCH* model (see Figure 4.3) includes traditional leaders as members of the community who may have an influence on the health of the community.

Traditional leaders are respected in the community and should therefore be consulted before the health promotion needs of the community can be assessed. They also have to be involved in the implementation of health promoting strategies once their permission for the implementation of such programmes has been obtained.

Even in the twenty-first century, traditional leaders remain a challenge, in terms of how they can be included in health promotion programmes, to many health professionals (South African History, 2005:1). However, it is vital that the traditional leaders in the community are consulted before the initiation of any health project in order to enhance the continued participation and involvement of the whole community (South African History, 2005:1).

(c) Community organisation leaders and administrators

Community organisations can contribute to the promotion of health of adolescents orphaned by HIV/Aids. Community organisations can include governmental organisations or NGOs that are managed by leaders and administrators from the community. They serve as an extended arm of the government and various international organisations, particularly at rural areas. They are committed to serve their communities through capacity building strategies (Davids, Theron & Maphunye, 2005:67). Examples of these organisations are community police forums (De Beer & Swanepoel, 2003:221-4), care groups (such as informal caregivers) and groups of volunteers that dedicate themselves to the service of mankind. Nurses should participate in these organisations in order to promote the health of the community. Nurses should cooperate with the organisation, but need not become members of the organisation. The leaders and administrators of these organisations are important role players in the promotion of health as indicated in the revised *MATCH* model, as they are in the position to sensitise their organisations to the needs of the community, specifically those referred to in this study.

In support of the importance of partnership in health promotion, Lundy and Janes (2001:374) state that the leaders and administrators of NGOs can be involved in monitoring and improving the living conditions of the people their organisations serve. In many cases, the latter refers to vulnerable groups, such as the families included in this study. Nurses should collaborate with the organisations that are active in specific areas to avoid duplication of services and support programmes. The Northern Ontario School of Medicine (2005:3) confirms that nurses should conduct sustainable health research in order to prevent duplication of services. Chaundry, Polivka and Kennedy (2000:79) emphasise that nurses have to collaborate with leaders to avoid fragmentation of services. However, it should be ensured that, when providing health promotion to the community, nurses collaborate effectively with these leaders as they effect change in the community.

Leaders of organisations such as those at Moretele-Sunrise Hospice in Hammanskraal where this study was conducted provide care to people who are

infected and affected by HIV/Aids. The leaders of this hospice organisation render social relief services to a number of villages, and thus assist the government in the fight against HIV/Aids and poverty in rural communities (Sebanyoni-Matlhasedi, 2005). Cooperation with the leadership of this hospice is essential and it should be ensured that the health promotion guidelines developed as part of this study take into account the contribution the hospice is making to the health promotion of families with adolescents orphaned by HIV/Aids.

4.8.2.1 (C) Objectives aimed at government in broad terms

As stated in the revised *MATCH* model (see Figure 4.3), the objectives of governmental involvement are related to the application of relevant legislation, the formulation of policies, the enforcement of regulations and the allocation of resources regarding a health promotion programme. Nurses have a vital role to fulfil regarding the setting of objectives and the planning of ways to meet the objectives.

(a) Application of legislation, policies and enforcement of regulations

A policy is an authoritatively stated course of action that guides decision-making (Allender & Spradley, 2005:368). It is a document that clarifies how an institution, organisation, agency or government can exercise its authority. Policies state how a country and organisations should spend money, how power is shared and how resources are distributed. In South Africa, these aspects are guided by the Constitution (South Africa, 1996b). Policies are based on the group's goals and exist to provide guidelines for reaching the stated goals. Policies are documents that are written to guide those involved in the implementation of legislative frameworks regarding activities such as health promotion. They can help in the process of decision-making within the broader context of the government. Well-formulated policies regarding health promotion guide nurses to engage in strategies to promote healthy lifestyles. Therefore, guidelines for health promotion cannot be compiled in isolation from government laws and policies. Policies have to be based on the peoples' needs, for example the needs of

adolescents documented in this research (see Table 3.2). Nurses have to influence politicians to take action regarding the improvement of the health of the people that have selected them to serve in government.

As previously indicated, formal legislative processes are followed in order to establish laws, policies and regulations (Lundy & Janes, 2001:186). This legislation governs the day-to-day and long-term running of the country, including healthcare plans implemented nationally and locally in the provinces and districts of South Africa. Legislation and policies, which may include health policies, are inseparable. Laws, to an extent, authorise what should be included in policies. In brief, legislation, policies and laws should be taken into account in the development of guidelines for health promotion (Lundy & Janes, 2001:186).

Van Niekerk (2001:56) states that, traditionally, nurses have lacked power to influence policy making at national level, and involvement in policy making and the changing of healthcare structures present a challenge to all nurses. Even today, nurses are faced with the challenge of being involved in policy making, and the interpretation and application of policies. Nurses as healthcare providers are required to participate in policy making so that they can influence health education programmes in rural and urban areas.

Policies on various aspects are available, but specifically existing policies regarding health promotion (Department of Health, 2003; Department of Health, 2001b) need to be taken into account in the development of guidelines for the improvement of the health of families with adolescents orphaned by HIV/Aids.

(b) Resource allocation such as facilities and programmes

The World Book Dictionary (1994:1779) defines resources as any supply that will meet a need. The objectives of resource allocation are based on availability, accessibility and affordability of programmes and facilities. These resources are necessary for the implementation of any service including healthcare programmes. Resources can be machines, products, human resources and other materials. The allocation of resources determines how the needs of the people

like adolescents orphaned by HIV/Aids can be met. In reference to the findings of this research, the allocation of resources plays an important role in the development of guidelines relevant to health promotion particularly in the community. If resources were equally distributed, the healthcare provision in this country would improve.

According to the WHO (2003:22), the HIV/Aids challenge cannot be met without additional and sustained allocation of resources. In *Strategic Priorities for the National Health System*, the Minister of Health, Dr Tshabalala-Msimang, states that despite the remaining challenges, good quality services need to be accessible and affordable and the mobilisation of resources improved (Department of Health, 2004:7,11). Guidelines for the health promotion of families with adolescents orphaned by HIV/Aids have to address the available resources, but should also give realistic indications of the resources needed to improve the health of this vulnerable group.

Facilities

Various facilities, such as clinics, hospitals, and other home-based care settings, can be used as facilities in primary healthcare settings to enhance continuity of care, and therefore promote the health of families with adolescents orphaned by HIV/Aids. In order to ensure an adequate and comprehensive health promotion programme, the facilities have to be equally distributed among all communities. In a study entitled “The educational and supportive needs of informal caregivers working at Refentse clinic, Hammanskraal”, Richter and Peu (2004:39) confirmed that the government must support the community with the necessary resources and security measures to enable both professionally trained and informal healthcare workers to provide their services to the community. The presence and proper utilisation of appropriate facilities would contribute toward health promotion at local and district levels.

Facilities in primary health care should be equally provided irrespective of the area (Swanepoel, 2002:6). This is a cornerstone principle in the implementation of primary health care and thus also health promotion programmes. In its

description of strategies to promote youth and adolescent health, the South African government emphasised that it considers this group as a priority group that deserves the best possible healthcare service (Department of Health, 2001b:10).

Programmes

In addition to facilities, existing programmes are resources that could be utilised to implement government policies. Nurses have to be up to date regarding existing programmes. If programmes focussed on the healthcare needs of all people of South Africa could be implemented according to the needs of local people, the health status of families with adolescents orphaned by HIV/Aids, for example, would also improve. Programmes such as community development projects empower the community, as well as promote their health (Billings, 2000:475). Health promotion of vulnerable groups such as these families can only be attained if the community, the government and NGOs work as a team.

(c) Summary: Impact at governmental level, intervention targets and objectives aimed at government in broad terms

Nurses are the pillars of healthcare services and have the power to influence policy makers, such as legislators and traditional leaders, to support health promotion programmes based on existing policies and resources. These policies and resources have to be utilised according to the health promotion needs of families with adolescents orphaned by HIV/Aids. The proposed guidelines, which are discussed in the next chapter, must be implemented to the benefit of this most vulnerable group. The *MATCH* model was used as a guide in the development of these guidelines. The themes (described in Chapter 3) identified from the findings of this research were compared and fitted into *Maslow's Hierarchy of Needs* theory (see Table 4.1). This forms the basis of the preliminary guidelines. The responsibility remains with the nurse to influence the government as a deciding power. This could be achieved if nurses were involved in the political process.

4.8.2.2 (A) Impact at organisational level

At organisational level, nurses can influence managers and traditional leaders (see Figure 4.3) to achieve health promotion goals through consulting, networking and training. Health promotion objectives can be achieved through the application of policies and implementation of programmes, as well as the responsible allocation of resources (programmes and facilities). An organisation focuses on a central purpose and goals that are formulated to enhance its achievement. These organisations may be formal or informal (governmental and non-governmental) in nature. In each organisation, there is a leadership that coordinates its running.

Allender and Spradley (2005:817) and Lundy and Janes (2001:374) state that governmental organisations and NGOs should work in partnership in order to monitor and manage the services provided to the community. Nurses are obliged to cooperate with such organisations when they implement health promotion activities. The participants of this study noted that the Moretele-Sunrise Hospice provided them with food parcels to help them survive. In the development of health promotion guidelines for these families, cooperation with organisations such as the hospice is essential.

Community organisations have certain strengths that keep them functioning (De Beer & Swanepoel, 2003:114-9). The strengths of organisations that contribute to a healthy lifestyle should be simultaneously utilised by nurses and coordinated to prevent duplications. The involvement of organisations in the development of health promotion programmes is therefore inevitable. Nurses and organisations should attempt to influence each other through consulting, training and networking to the benefit of the community. These approaches have to be integrated with the implementation of health promotion programmes such as the one proposed for families with adolescents orphaned by HIV/Aids (see Chapter 5).

(a) Organisational change through consulting, training and networking

Positive organisational change is the key to quality improvement. It is needed for the optimum functioning of organisations involved in health promotion. These changes take place on a continuous basis and are determined by changes in the community and governmental structures. The changes happen in some cases without proper planning. In other cases, it is the result of thorough planning. The Northern Ontario School of Medicine (2005:3) states that partnership and opportunities have to be created to improve existing disparities in organisations. As professionals, nurses can support organisations to implement changes after a comprehensive assessment has been done of the communities that the organisations serve.

In support of the impact of nurses on organisations, the Foundation of Nursing Studies (2001:2) states that several studies have been conducted on the involvement of the nurse in organisational development, operation and evaluation. It is essential that the organisation's officials are involved in the development and implementation of the health promotion programmes, as these officials have the skills and knowledge to make valuable contributions.

Consulting

Consultation is a process of negotiation. It is the act of seeking information or advice and provides the opportunity to exchange ideas or to talk things over (World Book Dictionary, 1994:446). Consultation helps a person to plan properly by considering more than one opinion. Consultation is not an isolated process, as it can be used nationally and internationally. It is the sharing of information with others.

In the revised *MATCH* model (see Figure 4.3), consultation is applied as an approach. In the context of this study, it can be used to meet the health promotion needs of families with adolescents orphaned by HIV/Aids. According to Chapman (2005:2), consulting people and helping them to understand does

not affect one's position but strengthens it and can thus lead to quality health care.

The Foundation of Nursing Studies (2001:3) states that if nurses are involved in organisational development, they should focus on evidence-based practice in order to improve the health of the community. The Foundation emphasises that nurses have the skills to make a difference in the development of guidelines, protocols and policies, and by revising current practices.

The Moretele-Sunrise Hospice in Hammanskraal is an example of an organisation that has a consultation role in promoting the health of families with adolescents orphaned by HIV/Aids. The participants had a longstanding relationship with the hospice that could be further strengthened through the inclusion of more health promoting services for the adolescents and their families. Organisations such as the Hospice complement the government's provision of health promotion services. Although these organisations may have limitations, their contribution should not be underestimated (Lundy & Janes, 2001:374). Nurses should consult these kinds of organisations before they plan services so that existing services are not duplicated. Organisations play an important role in the functional implementation of community development, and nurses can collaborate and consult with these organisations (De Beer & Swanepoel, 2003:121).

Training

Training is the process that results in the empowerment of people with knowledge and skills that can be used at personal, family, community and even broader levels (Pocket Oxford Dictionary, 1996:969). Capacity building is one of the key responsibilities of organisations. The promotion of the health of the community is an example of a possible result of capacity building.

For example, various organisations, such as the Moretele-Sunrise Hospice in Hammanskraal, train informal caregivers in the community in order to empower them with the necessary skills. Sebanyoni-Matlhasedi (2004), the manager and

founder of the hospice, is one of the pioneers of the provision of this training. The training is a continued effort to assist the government in the provision of trained manpower. The inclusion of these kinds of organisations is therefore well motivated.

Nurses should realise that they have a fundamental role to play in influencing organisations regarding the training of non-professional healthcare workers in the provision of needs at grassroots level. Hope and Timmel (1996:206) state that training for transformation is designed to assist in the development of self-reliant communities. Services for the training of the community need to be accessible and available in order to empower its members. This approach integrates the participation of the community in solving their own problems. It implies that training should be directed in such a way that it will enhance change in health behaviour, and, therefore, health promotion.

Networking

In networking, people exchange ideas and information with others. It can be an instrument used to reach people who are near and far to provide advice that may contribute to health promotion through the planning of applicable and appropriate strategies and programmes. Networking is a continuous process that is inherent in professions such as nursing. Networking refers to the exchange of information that is accessible and includes aspects such as time management and general organisation (Royle & Blythe, 1998:71-2). Nurses should use networking in order to influence organisational change in a positive way.

Various types of formal network exist, such as the support networks that often occur in organisations. Support networks can occur in different types of organisation, such as governmental organisations and NGOs.

Networking with nurse managers in different organisations is important because this can stimulate the consolidation of resources to the benefit of the community (Booyens, 1993:481). It provides the nurse with opportunities to enhance capacity building through training for the needy community.

Consultation, training and networking can ease the development and implementation of health promotion guidelines for families with adolescents orphaned by HIV/Aids in order to meet their needs as shown in Table 3.2.

4.8.2.2 (B) Intervention targets at organisational and local level in the study context

Individual leaders such as managers can contribute to health promotion programmes at both organisational and local levels. They play an important role in working hand in hand with nurses to influence organisations to promote the health of the community. These individuals will now be discussed separately.

(a) Managers

A manager is an organiser, leader, controller and evaluator (Allender & Spradley, 2005:50). At organisational and local levels, managers and leaders are there to administer and manage the activities of the organisations in the community. Nurses should identify and cooperate with managers of organisations in the community in order to influence them regarding health promotion programmes. For a manager to function effectively in the community, he/she needs to have certain inherent characteristics. Nurses should identify managers in the community who can:

- Be visionary,
- Think strategically,
- Plan effectively,
- Contribute to policy implementation,
- Manage change according to the needs of the community,
- Work effectively in teams, partnerships and alliances with organisations and the families (ICN, 2005:3), and
- Understand health system reform and its impact, within a specific context.

These characteristics are also appropriate for nurses who have to develop and implement the guidelines relevant to this study. Nurses should be seen as

leaders, community workers, change agents and consultants in making contact with these families. Nurses can bring about change in health care because they have the skills and power to effect change in health promotion.

Nurses also have to look for managers or leaders who have business skills, such as resource management, communication, negotiation and motivation skills and who can influence others to effect change in the community. In the revised *MATCH* model, it becomes clear that managers and traditional leaders can influence health promotion programmes. The ICN (2005:2) is of the opinion that nurses as managers or leaders plan services, and allocate and manage resources.

(b) Traditional leaders

When entering a village for any planned projects, the traditional leaders should be consulted and informed of what is planned, and their consent to proceed with such projects obtained. Traditional leaders are traditionally elected and are called chiefs and village headman. These leaders are recognised by the Constitution of the Republic of South Africa and can have a profound influence on the health promotion of families with adolescents orphaned by HIV/Aids. Moran (1996:28) states that the Constitution recognises the authority and customary laws of traditional leaders, and that the laws of parliament could be written to accommodate traditional leaders and their impact on the community. Therefore, the involvement of these leaders can be beneficial in the planning and implementation of health promotion programmes.

The levels of powers of traditional leaders are seen at local government where they work with the council in the implementation of local laws. Moran (1996:28) emphasises that traditional leaders are democratically represented in parliament in order to be advocates for their traditional and customary laws. Therefore, the involvement of the traditional leaders in the promotion of the health of the community will influence the health behaviour of the people.

Traditional decision-makers can help organisations to meet the needs of the community. These needs may include those needs related to health promotion discovered in this study (see Table 3.2). The role they play assists the communities to take responsibility for their own health. Traditional leaders were also discussed as a political concept under individuals as intervention targets in the broader South African political and community context.

4.8.2.2 (C) Objectives aimed at organisations/structures locally relevant

The intervention approaches at organisational level are based on selected objectives. These objectives are aimed at organisations or structures and should be based on current application of policies and practices, as well as the allocation of resources, such as programmes and facilities. The application of policies and practices, and the allocation of resources are discussed below.

(a) Application of policies and practices

Policies and practices guide all involved in the delivery of health services and, in this case, specifically in the development of health promotion programmes. When setting intervention objectives regarding health promotion, current policies and practices should be looked at, improved on and what is working and what is not discussed. Various policies, such as health promotion programmes, were planned by the South African Department of Health. These policies need to be used at district and local levels. The *Policy Guidelines for Youth and Adolescent Health* (Department of Health, 2001b) and *School Health Policy and Implementation Guidelines* (Department of Health, 2003) are examples of policies that can be consulted and are relevant in this research context.

The objectives should be based on the policies and practices that nurses will use when promoting the health of families with adolescents orphaned by HIV/Aids, because policies constitute governing frameworks (structures, processes and outcomes) (Allender & Spradley, 2005:368). The structure of the policies is made up of programmes, services and health providers, as well as targeted clients. The targeted clients in this research context are families with adolescents orphaned

by HIV/Aids. The process is the manner in which agencies, programmes and services are to be provided, managed and funded, as well as how clients are going to access services (Allender & Spradley, 2005:368). Health policy outcomes are actual consequences of health policy implementation and are based on their effectiveness, efficiency, equity, innovativeness and empowerment. The discussion above suggests that the development of health promotion guidelines should be based on current health policy and its frameworks for implementation.

(b) Resources such as programmes and facilities

Organisations such as the Moretele-Sunrise Hospice (Sebanyoni-Matlhasedi, 2005) have health promotion programmes in place but limited resources available to them. For example, the Hospice can cater for 78 villages with food parcels and provide home-based care to families in need (see Chapter 3), but it is impossible to do more because of a lack of resources.

(c) Summary: Impact at organisational level, intervention targets and objectives aimed at organisational structures locally relevant

The researcher's aim is to select the intervention approaches that can influence organisations to assist nurses and these families to promote their health in a sustainable manner with limited resources. It would not be easy without the involvement and participation of organisations with an interest in health promotion of the community. The relevant policies and practices need to be made available in the best interests of the community. It is clear that organisations play a major role regarding the fulfilment of physical, safety and social needs, which contributes to the health promotion of families with adolescents orphaned by HIV/Aids.

4.8.2.3 (A) Impact at individual level

Nurses today have opportunities to make a significant impact on individual lives and positively affect the health of society by assisting people to make informed and healthy lifestyle choices (Scottish Parliament, 2004). The training that nurses undergo orientate them to being people-centred and equip them with the knowledge, skills and attitudes needed to promote the health of individuals, families and the community (Flynn *et al.*, 1987:240). The influence of nurses on individuals can be exerted through health education, persuasive communication, screening for existing health problems and counselling. As health promotion, wellness and self-care become increasingly important, there is a need for the provision of continuous health education to individuals, and, in the study context, to families with adolescents orphaned by HIV/Aids.

Smeltzer and Bare (2004:6) state that health is a lifestyle oriented toward wellness. Health promotion strategies, such as screening for diseases, lifetime health monitoring programmes, environmental and mental health programmes, risk reduction and health education, are necessary to achieve this lifestyle.

(a) Health care through health education by means of persuasive communication

Health care has traditionally been disease-oriented. Currently, there is a great emphasis on health care, which includes health promotion, because people live in a time where communicable and chronic diseases are increasing (Smeltzer & Bare, 2004:6). To reduce the number of hospital admissions (Department of Health, 2001a:5), nurses need to provide health education aimed at reducing diseases and other health problems to the community.

Dreyer *et al.* (1997:7) emphasise that the philosophy of community health flows from the sense of national responsibility and the community's awareness of the value of good health. The provision of good health care should be regarded as a priority by all, from the government down to the individual client, who needs to be informed through health education that health care leads to wellness. Health

education as an approach is relevant to the development of health promotion guidelines in this study context.

Health education is one of the fundamental roles of nurses that need to be taken into account. Health education is a process in which nurses teach clients in order to empower and enable them. These clients will later teach each other. The objectives of health education in the community are to:

- Define their own health problems and needs,
- Understand how to resolve their problems,
- Decide on the most appropriate action to promote healthy living and community well-being (WHO, 1988 in Dreyer *et al*., 1997:33; McKenzie *et al.,* 1997:119).

Health education is a strategy for health promotion in which health-related values, attitudes and lifestyles are consolidated and decision-making about a variety of health behaviours takes place (Ochieng, 2003:61). If an individual is engaged in health education, his/her health behaviour is influenced and may change. It is necessary to provide health education through persuasive communication because this addresses health problems and guides healthy behaviour. Persuasive communication is a process of using communication to change opinions – in this case on health. Persuasive communication should be coupled with health education in order to change the health behaviour of the community.

(b) Screening

Through the process of screening, nurses help to diagnose diseases early and thus facilitate immediate intervention. Individuals need to be screened properly and regularly, and be provided with health care if a problem arises. Screening is the assessment of asymptomatic individuals for the purpose of diagnosing them for the likelihood of developing a particular disease. According to Young, Van Niekerk and Mogotlane (2003:29), one of the primary healthcare services that need to be provided through the district healthcare system is the screening for common diseases by primary healthcare nurses.

Nurses are facing various health challenges, such as chronic and acute diseases like HIV/Aids, which affect individuals in the community. There is a need for knowledgeable, dedicated and committed nurses who will conduct effective screening to detect health problems. Guidelines should include screening as a process of health promotion within this study context.

Bourbonniere (2004:529) states that studies suggest that nurses can improve symptom management by implementing screening, especially amongst clients in rural areas. Diseases, such as cancer and other chronic diseases, can be detected early if screening is conducted at an early stage. Screening as a preventive measure, should be conducted regularly in order to prevent diseases and promote the health of individuals and families.

(c) Counselling

Evian (2000:268-9) states that counselling is a process of allowing the client to understand his/her condition for the purpose of accepting that condition. Counselling in combination with health education needs to be facilitated in order to reach the highest level of wellness. Counselling as an adjustment strategy helps families to cope with limited resources. During counselling, the counsellor and the client explore issues and problems together in order to find new or different approaches to dealing with them.

Gibson, Swartz and Sandenbergh (2002:29) state that counselling entails helping individuals to cope with their feelings. The nurse as counsellor should simultaneously carefully listen to and support the client. In this research context, adolescents orphaned by HIV/Aids should be helped to cope with life without parents. Therefore, the counselling of adolescents orphaned by HIV/Aids should be included in the development of health promotion guidelines.

4.8.2.3 (B) Intervention targets on individual bases in the research context

At individual level, members of families with adolescents orphaned by HIV/Aids are targets for intervention. During the empirical research process, these families

provided suggestions for health promotion programmes to modify their health behaviour and therefore the development of guidelines directed toward such families.

(a) Adolescents orphaned by HIV/Aids

In this study, the families with adolescents orphaned by HIV/Aids are at risk because they have no parents and experience a lack of resources to fulfil essential needs.

Characteristics of adolescents

The adolescents that participated in the research process were in their early stage of adolescence, that is between the ages 10 and 17 (see Chapter 2). Adolescents at this stage of development have various characteristics that influence their health promotion. One of these is their sexual development. The sexual development of adolescents orphaned by HIV/Aids could impact their health promotion needs (see Chapter 3) and should therefore be addressed.

Adolescents of these ages could be sexually active and, because they lack the guidance of their biological parents, need assistance to understand the stage they are going through. They are vulnerable to STDs, like HIV/Aids, as well as the abuse of alcohol and drugs (Department of Health, 2001b:23). In terms of this research, their sexuality plays an important role. Sexuality encompasses both physical and sexual characteristics. The following characteristics resemble the needs of adolescents that should be addressed during the development of guidelines for their health promotion (Murray & Zentner, 2001:550):

- The adolescents are in search of their identity as a whole person, including their identity as a sexual person. This is crucial to this study, as these adolescents are searching under the guidance of their grandparents, instead of their parents.
- They fulfil the roles of both men and women.

- They have attitudes, behaviours and feelings toward themselves, the opposite sex and sexual behaviour.
- They have relationships, and experience affection and caring between people.
- They need to touch and to be touched.
- They need to be recognised and accept themselves and others as sexual beings.

Orphaned adolescents have a need to have their biological parents present, although this is not possible. Some of these adolescents stay in shacks. During the researcher's most recent visits (August 2005) to these families, two adolescents were reportedly pregnant and had dropped out of school. The guidelines should encourage positive relationships between these adolescents and their grandparents.

Experiences of adolescents such as those in the study

Orphaned adolescents have varied experiences. They experience tension, stress, emotional and physical strain, and overwork (Department of Health, 2001a:10). These adolescents take on adult responsibilities prematurely and later have some difficulties coping. They find it very difficult to fit in with their peers because of their dual responsibilities as adolescents and parents. They experience lack of spiritual and social support, and therefore become involved in premature sexual activity or relationships.

Future of adolescents

Some of these adolescents dream about a prosperous future. Some of them are faced with uncertain futures and are full of doubts. They have doubts about their future because of the absence of their biological parents. The stress of considering their future can lead to hopelessness. Health promotion guidelines formulated should take into account the future of these adolescents and the need to sustain the quality of their lives. There is a need for adolescents to be made

aware of friendly clinic initiatives and be encouraged to participate in such initiatives (Juszczak & Cooper, 2002:437; Reproductive Health Research Unit, 2000:6). The aim of the Reproductive Health Research Unit (2000:6) was that healthcare services should be more accessible to adolescents and national standards should be established for the benefit of such adolescents.

4.8.2.3 (C) Objectives aimed at the individual to promote health

The objectives at individual level are aimed at behavioural, physiological and physical factors regarding health promotion. These objectives are also aimed at increasing the wellness of adolescents orphaned by HIV/Aids.

(a) Behavioural aspects

The objectives at individual level are directed toward changing the health behaviour of individuals, families and the community through health education, screening and counselling strategies (Ochieng, 2003:61). Coulson *et al.* (2002:55) point out that studies on health behaviour focus on the beliefs, attitudes and values of the people concerned. These authors (2002:55) also emphasise that health promoters need to understand the dynamics associated with the beliefs, attitudes and values of adolescents orphaned by HIV/Aids regarding behaviour change. A client with a positive attitude toward health promotion and strong beliefs and values can be well influenced to change his/her behaviour. It is clear that behaviour, attitudes, beliefs and values are interconnected. In order to change behaviour, attitudes should first be changed (Louw & Edwards 1993:775). It is therefore important that all health promoters should orientate themselves to the beliefs, attitudes and values of adolescents orphaned by HIV/Aids before initiating any health promotion programme targeted at them.

Beliefs

A belief is an opinion of what is held to be true or real (World Book Dictionary 1994:184). Beliefs can affect the health of adolescents orphaned by HIV/Aids (Papadopoulos, 2006:11-13). It is therefore crucial that the beliefs of adolescents

orphaned by HIV/Aids and what they need in terms of health education are understood, because different proponents of health promotion, from a variety of belief systems, may influence health promotion strategies.

Medical sociology and anthropology have contributed a lot in the sense that valuable insights have been gained on how health beliefs form part of religious beliefs (Coulson *et al.*, 2002:57). Especially in South Africa, professionals involved in health promotion need to be very careful not to impose Western lifestyles, and views of health and disease on clients. These professionals need to intensively explore the beliefs of the community in which they are involved before initiating any health promotion strategies regarding behaviour change. A culture's beliefs regarding illness and disease should be taken into account.

Attitudes

Peu, Troskie and Hatting (2001:18) indicate that attitudes are a permanent state of readiness of mental organisation and predispose an individual to react in a unique characteristic way to any object or situation. Therefore behaviour can be predicted. However, adolescents of these ages do not yet have extensive attitudes toward health. Considering this, health promoters can influence these adolescents positively regarding health promotion.

Attitudes have dimensions of direction, strength and centrality (Louw & Edwards, 1993:773). Direction involves favour for or against something, while strength involves strong or weak feelings. Centrality involves the extent to which the attitude is important to an individual in relation to his/her other attitudes. It is the physiological response of the individual that makes him/her react in such a unique way. Attitudes need to be taken into account in assessing, planning, implementing and evaluating the health promotion particularly of adolescents. Therefore, as key planners, the health promoters should observe the dynamics of attitudes when they are involved in health education programmes.

Current studies suggest that there is an association between individuals' attitudes and behaviour. However, assumptions that an individual's attitudes are linked to

his/her health behaviour are incorrect (Coulson *et al.*, 2002:59). Edelman and Mandle (2002:98) state that attitudes act as barriers to communication. This implies that nurses who have stereotyped or biased attitudes toward clients' issues are limited and fail to assess and communicate the real problem of the client, thus distorting communication.

Values

Values are important to health promoters because they influence the sustainability of any health promotion attempt. Giger and Davidhizar (2004:123) state that values can be viewed as individualised sets of rules by which people live and are governed. These authors emphasise that values serve as a cornerstone for beliefs, attitudes, and behaviours. Various values, such as those of a particular culture, may influence an individual's health behaviour (Giger & Davidhizar, 2004:123; Papadopoulos, 2006:11-13). These values have a profound influence on the individual and are believed to exist on an unconscious level (Giger & Davidhizar, 2004:123). An individual with a strong value system for health promotion adjusts easier to principles of health promotion (Giger & Davidhizar, 2004:123). However, an individual with a weak value system for health promotion as a result of other circumstances associated with, for example, culture, may ignore the necessity of health promotion. Therefore, health promoters should take the cultural values of adolescents orphaned by HIV/Aids into account when developing and implementing guidelines to promote their health.

(b) Physiological and physical aspects

The development of a health promotion programme should also focus on the physiological and physical aspects of individuals and families. Health promotion should be directed toward the functioning of the body or how the body carries out its life-sustaining activities (Smeltzer & Bare, 2004:6). Health promotion strategies should be aimed at ensuring normal and optimal functioning, thereby increasing wellness. These strategies may include prescribing exercise or rest.

(c) Summary: Impact on individual level, intervention targets and objectives aimed at individual to promote health

The aim of the researcher is to select the intervention approaches that will influence individuals to change their unhealthy behaviours regarding health and illness, as well as physiological and physical behaviours, through persuasive communication or through health education, screening and counselling. However, this is not easy without the involvement and participation of the individuals in promoting their health in a hassle-free environment. The development and formulation of guidelines should focus on healthcare activities, such as screening, health education and counselling for families with adolescents orphaned by HIV/Aids. It should be aimed at behavioural, physiological and physical changes that will lead to increased wellness.

4.8.2.3(D) Long-term outcomes aimed at health status of research population

The implementation aspects of the revised *MATCH* model for the development and implementation of health promotion guidelines are aimed at increasing wellness among adolescents orphaned by HIV/Aids. Families with adolescents orphaned by HIV/Aids are not static but will change through time.

(a) Increased wellness

The wellness of adolescents orphaned by HIV/Aids in this research will be enhanced through self-care, the satisfaction of basic needs, and support (Evian, 2000:90). Increased wellness will be demonstrated among these families through the acceptance of the influence of the nurse. It is, however, important for all nurses who work with these families to educate them how to increase their own wellness by changing their behavioural, physiological and physical states, belief systems, and values and attitudes related to their health. Wellness can also be increased through screening, the provision of health care and health education, and the counselling of these families regarding their daily life activities.

The capacity building and empowerment of these families will increase their wellness status. Coulson *et al.* (2002:184) emphasise that health promotion should be carried out by and with the people, and not on or to them, because this will improve their ability to take action, as well as the capacity of groups, organisations or the community to influence the determinants of health. These authors also state that when improving the capacity for health promotion of the community, practical education, leadership training and access to resources are required. It is very important to harness social, cultural and spiritual resources in an innovative way, particularly during the development of guidelines (Coulson *et al.,* 2002:184).

The *Batho Pele Principles* (DPSA, 1997) state that the departments should implement special programmes for the improvement of service delivery to physically, socially and culturally disadvantaged people. These principles apply to the participants of this research, as they will be able to access special services for better care. Nurses who are willing to serve their clients accordingly will increase the wellness of their communities. Therefore nurses should develop and implement these health promotion guidelines to change the health behaviour of different communities. It can be concluded that the end result of the application of the revised *MATCH* model to this research is increased wellness, which will remain the focus.

4.8.3 Phase IV of the revised *Multilevel Approaches Toward Community Health (MATCH)* model – evaluation of implemented guidelines based on intervention objectives

Evaluation is an important part of determining whether the formulated objectives were achieved. It is “the process by which community health planners determine the value or worth of the objective of interest by comparing it against a standard of acceptability” – it is concerned with whether or not established goals were met (Helvie, 1998:425).

The evaluation of the implementation of the guidelines is the final process. The researcher will ensure that the guidelines are implemented and evaluated first on

a small scale (pilot testing) and later on a larger scale. The participants of this research serve as the pilot population. The implementation of the guidelines on a larger scale could be conducted in a village. Formative evaluation was conducted throughout the process in order to determine any problem with or the appropriateness and relevancy of the guidelines. The summative evaluation process will be conducted as part of postdoctoral studies. The results of the implementation and evaluation will be compiled and communicated through published articles. The aim of the implementation of health promotion guidelines is to change the behaviours of families with adolescents orphaned by HIV/Aids in order to increase their wellness.

4.9 CONCLUSION

The discussions of the comparison between *Maslow's Hierarchy of Needs* theory and the research findings, as well as the use of the revised *MATCH* model (see Table 4.1 and Figure 4.3) served as a guide to the researcher in terms of the level of development, validation and description of the preliminary guidelines for the health promotion of families with adolescents orphaned by HIV/Aids in a rural community. The discussions regarding the intervention approaches, targets for intervention and objectives at governmental, organisational and individual level of the revised *MATCH* model guided the researcher toward developing and formulating preliminary guidelines. The preliminary guidelines are an integration of this study and *Maslow's Hierarchy of Needs* theory, as well as some aspects of the revised *MATCH* model. The development, validation and description of preliminary guidelines follow in Chapter 5. The summaries are recommendations that serve as the foundation for the preliminary guidelines.

CHAPTER 5

DEVELOPMENT OF THE GUIDELINES FOR THE HEALTH PROMOTION OF FAMILIES WITH ADOLESCENTS ORPHANED BY HIV/AIDS IN RURAL HAMMANSKRAAL

5.1 INTRODUCTION

In Chapter 4, the research findings were discussed in the context of the relevant literature, including *Maslow's Hierarchy of Needs* theory and the revised *MATCH* model, which were analysed individually and theoretically supported. Themes were identified within the frameworks of the theory and model, which, with the empirical part of the study, formed the foundation for the development of the guidelines. The 13 themes identified during the data analysis corresponded with the levels of *Maslow's Hierarchy of Needs* theory. In the course of the application of the *MATCH* model to the literature review, summaries were included at the end of each discussion. These summaries form part of the development of the guidelines. This chapter focuses on the process to develop guidelines for the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal. The processes described in the *MATCH* model were used as an outline for the formulation of the guidelines and *Maslow's Hierarchy of Needs* theory was integrated and used in the implementation of the guidelines.

The framework represented in Figure 5.1 on page 193 is an illustration of how the various elements mentioned above were merged to form a system to guide the formulation of the guidelines. *Maslow's Hierarchy of Needs* theory and the *MATCH* model were merged in order to demonstrate how the different levels within the model contribute to the promotion of the health of families with adolescents orphaned by HIV/Aids.

Government and the biological, safety and security needs of the participants were placed on the same level (the blue level), because nurses and other healthcare providers can influence legislators, traditional leaders and administrators through lobbying, social action, social change and community development to ensure that these needs are met. The researcher believes that it is the shared responsibility of the government, through its social services unit, and the families to address these needs because, as the study clearly shows, the families involved lack the resources to do so alone. Shared responsibility implies that if the government provides for their needs, the families are responsible for the management, control and preservation of the resources provided.

Organisation was displayed on the same level (the yellow level) as the social, safety and security needs, as well as biological needs, of adolescents orphaned by HIV/Aids. This was because nurses and other healthcare providers must engage in consultation, training and networking with organisations in order to meet these needs. Organisations are defined as independent, private, non-profit institutions that support the development of the communities in which the families live (De Beer & Swanepoel, 2003:110). After analysing and interpreting the data, the researcher came to the conclusion that organisations, in partnership with the government, can provide poor families with supportive resources.

Individuals were placed on the level (the red level) encompassing all the needs of the participants. Nurses must provide health education, screening and counselling to families with adolescents orphaned by HIV/Aids in order to contribute to the promotion of behaviour that will lead to increased wellness. Each family has to be made aware of their health promotion needs and encouraged to take responsibility for the utilisation of the services provided by the government. Nurses must act as change agents in order to ensure that families access and preserve resources for health promotion, such as health education. It is important that the government first takes primary responsibility for ensuring that services for the provision of health promotion needs are allocated in a sustainable manner, and then, importantly, that families take secondary responsibility for accessing these services within the community.

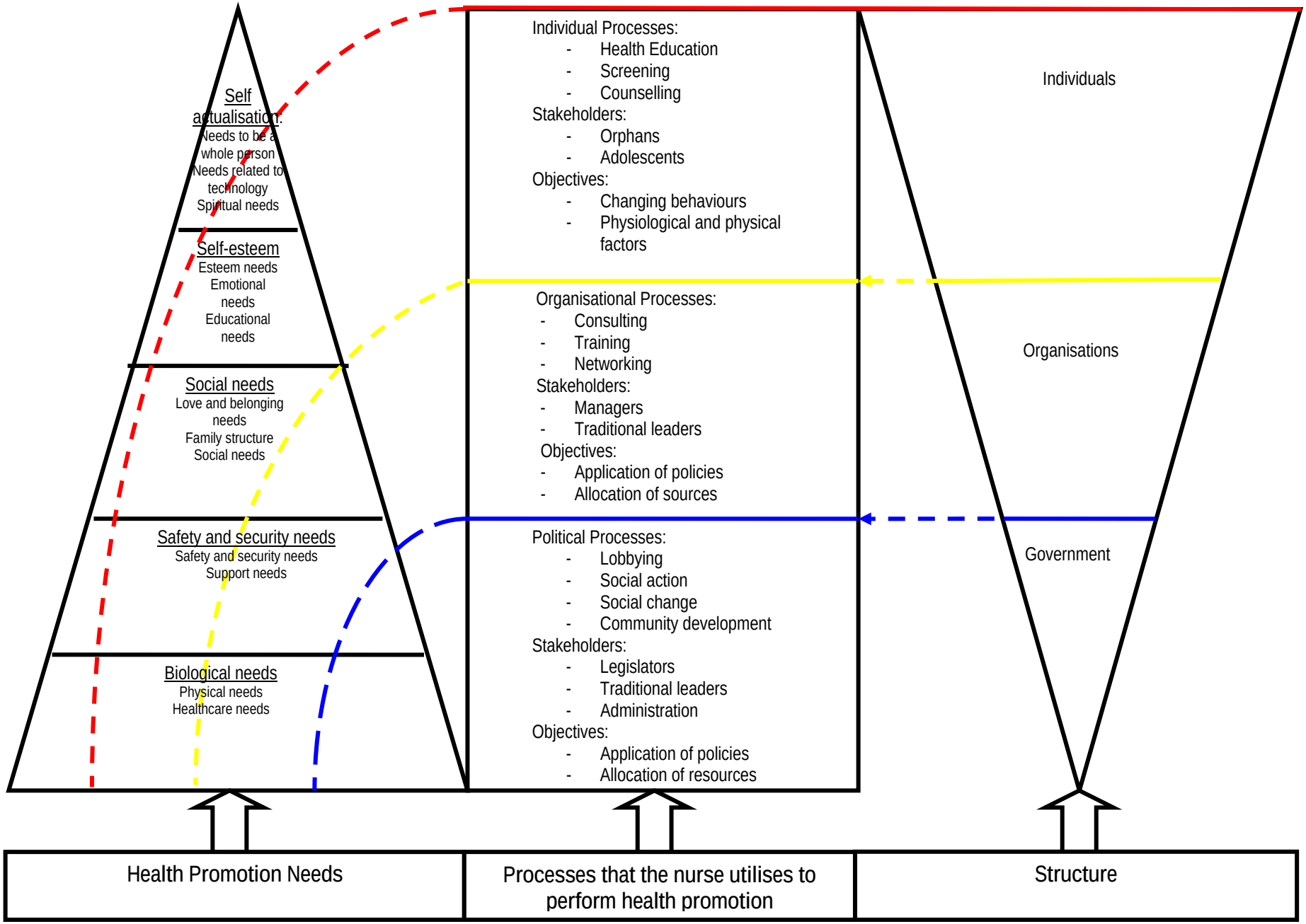


 FIGURE 5.1: CONCEPTUAL FRAMEWORK ON THE INTEGRATION OF EMPIRICAL FINDINGS, MASLOW'S HIERARCHY NEEDS THEORY AND MATCH MODEL THAT GUIDED DEVELOPMENT OF GUIDELINES

5.2 FORMULATION OF THE GUIDELINES

Guidelines serve as a tool to aid decision-making for health care (Thompson & Dowding, 2002:160). Guidelines within the study context were formulated in order to guide the health promotion of families with adolescents orphaned by HIV/Aids. These guidelines are prescriptive and could therefore result in significant health outcomes (Good & Moore, 1996:75).

Guidelines can lead to cost-effective use of available resources and can also increase resource use in the sense that when they are effectively developed, they contribute to the promotion of healthy behaviour.

Guidelines are recommendations and, in this study, aim to assist nurses and other stakeholders to promote the health of the community (Appleton & Cowley, 1997:1008; Good & Moore, 1996:75; Mead, 2000:113; Shekelle *et al.,* 1999:593). These recommendations were initially formulated as preliminary guidelines, which ultimately, after evaluation and revision, become the final guidelines developed in this study (Good & Moore, 1996:75).

Below the functions of guidelines in health care are listed, with each function followed by an application to the study context.

- *Guidelines promote self-regulation*: When using guidelines, individuals' use of healthcare services is regulated (Pinkney-Atkinson, 1995:2). Guidelines will direct individuals as to how to conduct health promoting procedures or activities. In reference to this study, nurses and other healthcare workers will be able to use these guidelines to promote the health of families with adolescents orphaned by HIV/Aids. They will also have the opportunity to ensure capacity building through the participation of these families. Health education activities will be planned and conducted with these families in order to improve their health behaviour.

- *Guidelines have the potential to empower consumers of healthcare services, thus enabling them to make choices regarding change in their health behaviour (Mead, 2000:113):* Guidelines not only assist individuals in making choices about health behaviour, but also provide a framework within which messages can be conveyed to them and the services they receive can be evaluated, rather than focusing on their ill-health.

- *Guidelines can potentially maintain and improve the quality of care and assist clients and healthcare providers to reduce uncertainties and enable decision-making (Pinkney-Atkinson, 1995:2):* Guidelines can be used to assist in the allocation of health resources, including human, financial and physical resources. Because they are integrated with *Maslow's Hierarchy of Needs* and the *MATCH* model contexts, the guidelines developed in this study will help nurses and other healthcare workers, with the support of all levels of government, to ensure that the basic needs of these families are met. Thompson and Dowding (2002:160) state that guidelines are only valid if they improve the quality of care when implemented. In the study, the guidelines aim to improve the quality of care by assisting healthcare providers to make valid decisions regarding health promotion.

- *Guidelines promote acceptable norms and standards of health promotion (Pinkney-Atkinson, 1995:2):* Certain norms and standards are used to measure the effectiveness of guidelines. Guidelines can assist nurses and other healthcare providers to provide a set standard of health promotion. These guidelines should be ready, written and evaluated instruments. The guidelines developed in this study could therefore set the standard for promoting the health of adolescents orphaned by HIV/Aids.

- *Guidelines are cost effective and cost contained:* When guidelines are set and available, health institutions can hire experts to deliver particular services specified in the guidelines (Pinkney-Atkinson, 1995:2). In this study, the guidelines will contain costs because they will clearly state what needs to be budgeted for. Guidelines also make recommendations for

appropriate health promotion strategies with the aim of promoting the health of the families in general.

- *Client education:* Guidelines could be used as an educational tool for health promoters to disseminate health information to individuals (Pinkney-Atkinson, 1995:2). In this study, the guidelines serve as ready and available tools for health promoters to provide health education to families with adolescents orphaned by HIV/Aids. These adolescents will also be able to access health promotion information in the community.

- *Guidelines provide direction to nurses in their decision-making about specific actions regarding health promotion interventions* (Strohschein *et al.*, 1999:85): Nurses and other healthcare providers can make use of the guidelines developed in the study to make decisions. In cases where it is difficult to decide on specific interventions, the guideline may provide clarity.

- *Guidelines provide nurses and other healthcare providers with synthesis of the best available research evidence*: Evidence-based practices are implemented where guidelines like these are used (Mead, 2000:110). Because the development of the guidelines was based on researched data, they can answer specific questions about health promotion needs.

5.3 DEVELOPMENT OF GUIDELINES IN HEALTH CARE

Well-developed guidelines therefore have the potential to enhance the appropriateness of the practice of nurses and other healthcare providers, and, in this study context, improve the quality of care of families with adolescents orphaned by HIV/Aids. This may lead to the achievement of better family health outcomes through health promotion activities. Capacity building for nurses and other healthcare providers could be enhanced through the process of guideline development, thus increasing wellness amongst these adolescents and their families.

According to Pinkney-Atkinson (1995:3), there are various ways to develop guidelines. As previously mentioned, the development, formulation and description of guidelines in this study were based on the empirical data and literature. Furthermore, a modified and adjusted methodology for the development of guidelines adopted from the Manual for Royal College of Nursing Institutes, 2000 (Thompson & Dowding, 2002) was used.

5.4 GUIDING ATTRIBUTES TO BE FOLLOWED WHEN DEVELOPING AND EVALUATING THE GUIDELINES

During the development of guidelines, a certain set of attributes of quality should be taken into consideration. The guidelines should have these attributes, because if they do not, the development process may result in imperfect recommendations (Thompson & Dowding, 2002:157). The guiding attributes represented in Table 2.4 in Chapter 2 and summarised in Table 5.1 formed the basis for the development and evaluation of the preliminary guidelines in this study.

TABLE 5.1: GUIDING ATTRIBUTES OF GUIDELINES DEVELOPMENT

ATTRIBUTES	CLARIFICATION
Clarity and presentation	The guideline is easily understandable, specific, unambiguous and clearly presented. The intention of the guidelines and who will be involved were indicated. Various approaches to health promotion for families with adolescents orphaned by HIV/Aids are indicated.
Effectiveness	Quality health promotion is based on the clinical effectiveness - the extent to which health status of families with adolescents orphaned by HIV/Aids can be expected to be enhanced by various health promotion interventions.
Validity	The guideline is based on the analysed data, best available evidence and an applicable model and theory.

ATTRIBUTES	CLARIFICATION (continued)
Relevance	The guideline is relevant in terms of the need for the planning and implementation of health promotion programmes and activities for orphaned adolescents.
Comprehensiveness	The guideline ensures a comprehensive approach to the health promotion of adolescents orphaned by HIV/Aids. This approach includes physical, social, emotional, spiritual and psychological aspects.
Applicability	The target users of the guidelines are clearly defined. The guidelines should be adequate disseminated, implemented and evaluated.
Acceptability	The guidelines are both realistic and ambitious, and reflect the policies of the Department of Health.

Sources: Agree Collaboration (2003); Pinkney-Atkinson (1995:12); Thompson & Dowding (2002:157); UNAIDS (1999)

5.5 GUIDELINES DEVELOPMENT PROCESS USING THOMPSON AND DOWDING METHODOLOGY (PRESENTED UNCHANGED)

In this section, the process of guidelines development is first described and presented unchanged (see Figure 5.2 on page 199) as indicated by Thompson and Dowding (2002:151).

Later, in the adjusted process, it is clearly indicated what changes were made, and why and how the process was changed (see Figure 5.3 on page 203).

One of the key attributes of a guideline is that the recommendations should be based on available and current evidence (Thompson & Dowding, 2002:151). Therefore, guidelines should be based on research findings, clinical expertise and specific information provided by the client, such as preferences and the acceptability of an intervention (Thompson & Dowding, 2002:151).

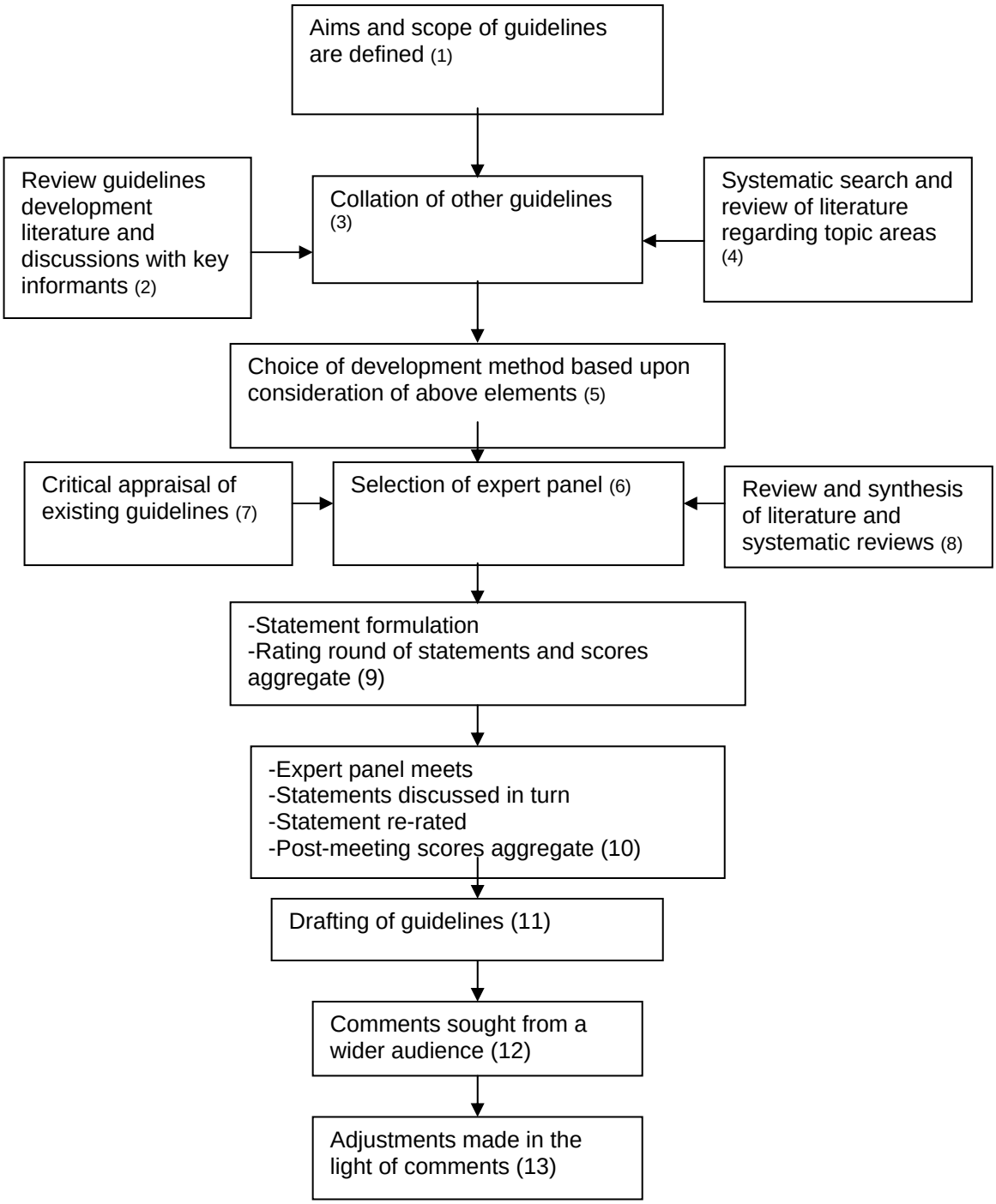


FIGURE 5.2: METHODOLOGY FOR GUIDELINES DEVELOPMENT USING FORMAL CONSENSUS PROCESS

Source: Thompson & Dowding, 2002:157

Thompson and Dowding (2002:152) followed the formal consensus process because this provided a structure for guideline development where group participants had to discuss the content of the guidelines and reach agreement regarding their development. These authors also wanted to enhance decision-making and improve outcomes (Thompson & Dowding, 2002:157). The guidelines development process followed a series of steps as outlined in the Thompson and Dowding guideline development process (the steps are displayed in Figure 5.2 on page 199). The development process is first presented unchanged and then presented as it was adjusted to suit this study.

For the purpose of illustrating the process by using an example, the above guidelines development process was implemented for the development of pressure ulcer risk assessment and prevention guidelines.

STEP 1

The scope and aims of the guidelines are clearly defined. These include the overall aim of the guidelines, the specific question and the target group.

STEP 2

Literature on guidelines development is reviewed and discussions with the informants conducted.

STEP 3

The guidelines are collated with other existing pressure ulcer guidelines.

STEP 4

Literature is systematically searched and reviewed on the mentioned topic areas.

Note: steps three and four are taken concurrently and influence one another

STEP 5

The choice of development method is based upon consideration of the elements in Figure 5.2 and Step 1, 2 and 3 (Thompson & Dowding, 2002:156).

STEP 6

Existing guidelines are critically appraised.

STEP 7

The expert panel is selected. This is to ensure that the information provided by participants is supplemented by an interpretation of the content. The other reason for the inclusion of an expert panel is to resolve legitimate conflicts over values (Thompson & Dowding, 2002:152). The expert panel is responsible for appraising and rating the guidelines critically.

STEP 8

Literature is systematically reviewed and synthesised (again).

STEP 9

The statements are formulated and a rating round is conducted via post. Scores are aggregated.

STEP 10

The expert panel meets again and guideline statements are discussed in turn. These statements are re-rated and a post meeting held where scores are aggregated.

STEP 11

The guidelines are drafted for presentation.

STEP 12

Comments from a wider audience are sought.

STEP 13

The adjustments are made in the light of these comments.

The researcher, after a comprehensive review of the methodology of guidelines development, adjusted and consolidated certain steps of this methodology. The adjustments and modifications are described in detail in the following section.

5.6 PEU'S ADAPTED GUIDELINES DEVELOPMENT METHODOLOGY BASED ON THE THOMPSON AND DOWDING (2002) METHODOLOGY

For the purpose of this study, Thompson and Dowding's methodology for the development of guidelines was consulted. According to these authors, the quality of the guidelines development process is important because it influences the credibility and validity of the guideline (Thompson & Dowding, 2002:152).

In this study, the researcher followed certain steps to develop health promotion guidelines for families with adolescents orphaned by HIV/Aids (see Figure 5.2), with some of the original steps omitted and others adjusted and integrated (see Figure 5.3). The methodology for the original development process followed 13 steps, but, in this study, only eight steps were followed. The researcher chose to follow the modified version of Thompson and Dowding's (2002:157) formal consensus process, because the methodology provided a structure for the group decision-making process by adopting rating methods to represent the extent of agreement concerning predefined content (Thompson & Dowding, 2002:153).

In Figure 5.3 on page 203, the adapted guidelines development methodology as it was used in this study is presented and described. The changes that were made, as well as how and why these changes were necessary, are also indicated.

STEP 1: AIMS AND SCOPE OF THE GUIDELINES

Firstly, in this step, the scope and aims of the guidelines were clearly defined. In the guidelines development process, one of the key initial tasks of the researcher is to define the scope of the guidelines, as this helps the group to ascertain the most appropriate development strategy and to clarify the question they seek to answer (Agree Collaboration, 2003:5). The researcher did not adjust but used this step as it is outlined in the original methodology. This was because the scope of the guidelines, derived from the analysed, verified data and identified themes, with reference to *Maslow's Hierarchy of Needs* theory and the *MATCH* model, formed the basis of the guidelines.

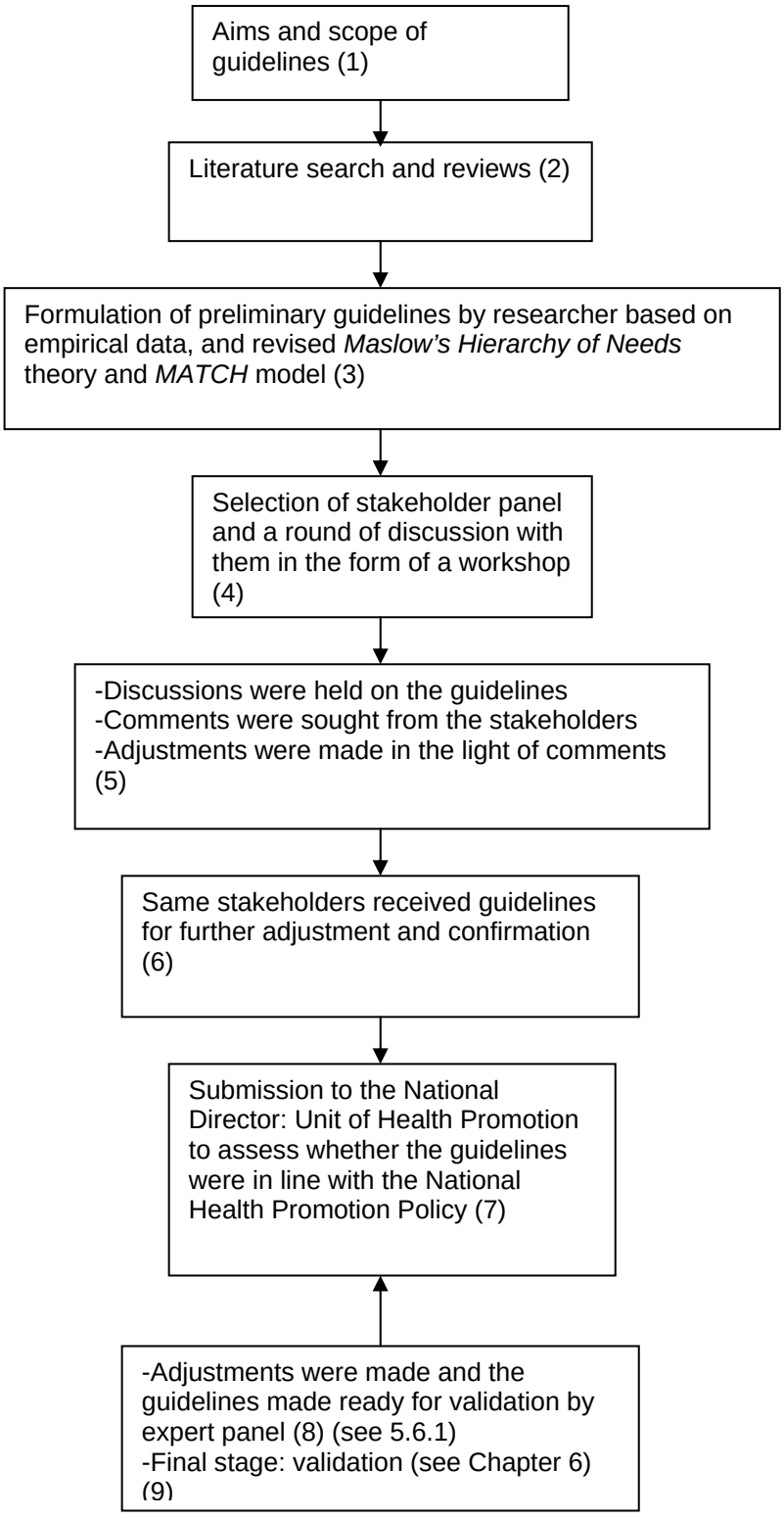


FIGURE 5.3: METHODOLOGY FOR GUIDELINES DEVELOPMENT USING FORMAL CONSENSUS PROCESS AS ADAPTED AND APPLIED BY PEU

Source: Adapted from Thompson & Dowding, 2002:157

STEP 2: LITERATURE SEARCH AND REVIEWS

Literature search and reviews on the scope of the content were conducted during the empirical phase of the study. *Maslow's Hierarchy of Needs* theory and the *MATCH* model were later consulted and integrated (see Chapter 3 and 4 for more details). The second and third steps of the original process were omitted, because there were no existing health promotion guidelines to review and collate with the new guidelines. Step 4 of the original process, which consisted of a systematic search and review of the literature, became Step 2 of the modified version.

STEP 3: FORMULATION OF PRELIMINARY GUIDELINES BY RESEARCHER BASED ON EMPIRICAL DATA, AND REVISED *MASLOW'S HIERARCHY OF NEEDS* THEORY AND *MATCH* MODEL

The researcher drafted and formulated preliminary guidelines based on scientifically verified empirical data, with reference to the revised *Maslow's Hierarchy Needs* theory and *MATCH* model. The guidelines were based on the processes of the *MATCH* model, integrated with *Maslow's Hierarchy Needs* theory. The researcher omitted Step 5 of the original process because this step was based on the choice of guidelines development method in Step 1, 2, 3 and 4, of which Step 3 and 4 were omitted in the modified process. Therefore the next step was to formulate preliminary guidelines to serve as a guide.

STEP 4: SELECTION OF A PANEL OF STAKEHOLDERS AND A ROUND OF DISCUSSION WITH THEM IN THE FORM OF A WORKSHOP

A panel of stakeholders was selected based on their involvement, knowledge and experiences with orphaned children and HIV/Aids care. These stakeholders were representatives of and advocates for orphaned children, and acting as multidisciplinary team members. A round of discussions was scheduled and conducted with the panel. Before the workshop, the researcher presented an overview of the nature of the study and its objectives and methodology to the participants.

STEP 5: COMMENTS RECEIVED FROM A PANEL OF STAKEHOLDERS AND ADJUSTMENTS MADE

The stakeholders discussed the contents of the guidelines. The participants' comments regarding the individual guidelines were used to make the necessary adjustments. The guideline document was then prepared for the next step. Step 9 of the original process was omitted, but certain aspects were used in Step 5 and 6 of the modified process, in which stakeholders were given the opportunity to further adjust the guidelines. Step 9 of the original process was omitted because it was not applicable, as the guidelines were discussed and adjusted in Step 4 and 5. These two steps are in a sense an integrated phase.

STEP 6: SAME PANEL OF STAKEHOLDERS RECEIVE GUIDELINES FOR FURTHER ADJUSTMENT AND CONFIRMATION

Two to four weeks after the first round of discussions, the panel of stakeholders received the guidelines, with adjustments made, for further comments and confirmation. For this step, a group meeting was not necessary. The same group of participants were requested in writing to participate in this round and the documents (request letter, check list and instructions) delivered personally to them. Instructions on how the evaluation should be conducted were also included. The participants were requested to suggest changes or confirm the accuracy and applicability of the guidelines. The researcher personally collected the guidelines from the participants in order to prevent documents being lost. Comments received from the participants were assessed, adjusted and refined. Adjustments were only made if they were recommended by the majority of the participants. The researcher formulated Step 6 in the modified process by adapting and integrating Step 10 of the original process. Some of the aspects of this step were not applicable. Aspects of Step 11 and 12 of the original process were also integrated into this step.

STEP 7: SUBMISSION OF THE GUIDELINES TO THE NATIONAL DIRECTOR: UNIT OF HEALTH PROMOTION FOR ASSESSMENT

This step entailed the presentation of the revised guidelines to the National Director: Unit of Health Promotion in order for this directorate to assess and comment on whether the guidelines were in line with the National Health Promotion Policy. Efforts from the office of the director were directed toward a critical analysis of the developed guidelines. The guidelines were returned within two weeks by the office of the Health Promotion Directorate. This step is a unique step, which the researcher conducted in order to further clarify the guidelines.

STEP 8: DISCUSSION OF THE GUIDELINES WITH THE NATIONAL DIRECTOR: DEPARTMENT OF HEALTH FOR ADJUSTMENTS AND CONFIRMATION

This step focused on the same aspects as Step 13 of the original process. The guidelines received from the office of the Health Promotion Directorate were analysed for any additional information. Few comments were made by the Director: Unit of Health Promotion. The researcher took these comments into consideration. In the original process, the thirteenth and final step focused on the adjustments, and the researcher did the same in the modified process. The document was then made ready for validation by the expert panel, which was knowledgeable and skilled in guidelines development and validation.

5.6.1 The guidelines development group

Thompson and Dowding (2002:152) state that the composition of a guidelines development group is an essential factor in the eventual validity and acceptability of the resultant guidelines (Duff *et al.*, 1996a, in Thomson & Dowding, 2002:152). To ensure that all aspects of the guidelines development process are attended to, it is important that the group is multidisciplinary (Thompson & Dowding, 2002:152). Shekelle *et al.* (1999:596) agree that the “development of guidelines requires sufficient resources in terms of people with wide range of skills.” Various

stakeholders with diverse characteristics were involved in this guidelines development process (see Table 5.2).

To successfully develop guidelines, it may be necessary to convene more than one discussion (Shekelle *et al.*, 1999:593). In this study, a panel of stakeholders was involved in the guidelines development process as it was described above. Members of the group were requested in writing to participate. The letter of request informed them about the research topic, the problem statement, the significance of the study, the study objectives, the methodology adopted and what was expected of them.

These stakeholders were purposely selected based on their involvement with HIV/Aids orphans. Those selected were given two weeks before the workshop to prepare themselves. The preparations included familiarising themselves with the guidelines and what was expected of them during the workshop. At the start of the workshop, the researcher presented an overview of the empiral part of the study, the findings obtained, and the manner in which the findings, theory and model were used to develop the preliminary guidelines.

When the guidelines development/refinement process began, participants were informed of their responsibilities and how individual guidelines would be discussed. The researcher conducted the workshop with the assistance of the study supervisor and co-supervisor, who throughout the discussions also provided input. Guidelines were analysed separately and discussed until consensus within the group was reached. For each guideline, comments and suggestions were sought and adjustments made. The guideline document was then made ready for further adjustment and confirmation.

After the adjustments were made, the guideline documents were sent to the panel of stakeholders for further adjustment and refinement. The participants were again requested to participate, in the form of a letter or telephone call. The participants were informed of what was expected of them in the further development of the guidelines The participants were given two weeks to reconsider the guidelines for further input. Motivations were required for further

adjustments suggested. Changes would only be made if they were suggested by the majority of the stakeholders. After two weeks, the researcher collected the guideline documents from the participants. The guidelines were analysed for any adjustments made and prepared for validation by an expert group who was knowledgeable and skilled in guidelines development and validation.

5.6.2 Descriptive information of the panel of stakeholder participants

Various stakeholders who were involved in HIV/Aids programmes were involved in the development of the guidelines. Table 5.2 provides a description of the participants.

TABLE 5.2: DESCRIPTIVE INFORMATION OF THE STAKEHOLDER GROUP PARTICIPANTS

No.	PROFESSIONAL QUALIFICATIONS	OCCUPATION	INVOLVEMENT IN CARE OF CHILDREN ORPHANED BY HIV/AIDS	EMPLOYER	PROF. EXPERIENCE
1	Dipl. General Nursing. Midwifery. Community Nursing, BCur Ed et Admin, Nursing Education and Administration	Chief Professional Nurse	Provides primary healthcare and community services to orphaned children	Jubilee District Hospital	26 years
2	Dipl. General Nursing. Midwifery. Nursing Education, Nursing Administration MCur Community Nursing	Chief Professional Nurse	Provides primary health care	Phedisong Clinic, Odi Sub-district	17 years

No.	PROFESSIONAL QUALIFICATIONS (continued)	OCCUPATION	INVOLVEMENT IN CARE OF CHILDREN ORPHANED BY HIV/AIDS	EMPLOYER	PROF. EXPERIENCE
3	Dipl. General Nursing. Dipl. Primary Healthcare, Midwifery. Nursing Education, Nursing Administration, Community Nursing	Assistant Director	Teaches primary health care and community nursing	SG Lourens College of Nursing	30 years
4	Dipl. General Nursing. Midwifery. Nursing Education, Nursing Administration Community Nursing	Lecturer	Teaches nursing science	SG Lourens College of Nursing	5 years
5	Dipl. General Nursing. Midwifery. Nursing Education, Nursing Administration Community Nursing	Professional nurse	Directly involved with orphaned children	Moretele-Sunrise Hospice	30 years
6	BA in Social work MCur in Social work	Social worker	Directly involved with orphaned children	Moretele-Sunrise Hospice	16 years

No.	PROFESSIONAL QUALIFICATIONS (continued)	OCCUPATION	INVOLVEMENT IN CARE OF CHILDREN ORPHANED BY HIV/AIDS	EMPLOYER	PROF. EXPERIENCE
7	National Cert. In Reception year teaching	Teacher	Directly involved with orphaned children	Go - Tumile Daycare Centre	19 years
8	Degree in Theology Honours in Theology	Student Minister	Involved with orphan projects in the church	Melodi ya Tshwane	6 years
9	Matriculation	VCT Counsellor	Involved in HIV/Aids programme for youth	LoveLife and Madisa Clinic	5 years
10	Matriculation	Councillor and community worker	Involved in HIV/Aids and youth programme	Moretele Local Municipality	10 years
11	Diploma in Policing	Police officer	Involved in crime reduction	Mabopane Police station	20 years
12	BA Social Science Dipl. Health Promotion	Health promotion officer	Involved in health promotion programmes	National Department of Health	17 years

5.6.3 The developed guidelines

In this section, the guidelines that were formulated by the researcher are presented. These guidelines as they are presented here include the comments and input of the panel of stakeholders (described above) as well as the input of the experts that participated in the validation process (see Chapter 6).

(a) The aims of the guidelines

The aims of the guidelines are to:

- Promote the health of the families with special emphasis on adolescents orphaned by HIV/Aids.
- Assist the national, provincial and local government, as well as organisation policy makers, to integrate these guidelines when planning for the improved health of these families.

(b) The scope of the guidelines

The scope of practice for these guidelines includes nurses and other healthcare providers, as target users of the guidelines, and families with adolescents orphaned by HIV/Aids, who are the target recipients.

Guideline 1 to Guideline 9 are discussed and presented separately (page 212 to 229). The formulation of each guideline is followed by the rationale for its inclusion in the set of guidelines and the operationalisations. The validation, reviewing and updating of the guidelines are addressed next.

Guideline 1

Lobbying to influence the application of policies and legislation as well as the allocation of resources by legislators, traditional leaders and administrators in order to ensure provision of biological, safety and security needs that lead to healthy living.

(i) Rationale

Health is central to overall human development and poverty reduction (ICN, 2004:23). In order to improve health, biological needs must be addressed as they are essential to all living creatures. These needs should regularly be provided for in order to ensure quality of life by encouraging the growth and development of individuals and families (Louw & Edwards, 1993:436). Government institutions and officials (legislators, traditional leaders and administrators) fulfil an important role in the provision of the resources needed to provide for the biological needs of adolescents orphaned by HIV/Aids in the absence of their parents who could have provided for these needs.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- take the responsibility of conducting and compiling family studies, community profiles and research reports in order to describe the needs of adolescents orphaned by HIV/Aids,
- make government officials aware of the needs of adolescents orphaned by HIV/Aids,
- sensitise the government regarding the importance of basic needs, such as food, safe water, sanitation and proper housing, and encourage the proper management of social support programmes,

- invite relevant and interested government officials, as well as local traditional leaders, to workshops and forums to share the information collected and compiled within the community regarding the biological, safety and security, and social needs of the community,
- identify orphans in need of care and refer them for social security,
- develop a plan of action with the community representatives regarding the provision for biological, safety and security, and social needs that lead to conditions for healthy living,
- act on behalf of the adolescents with policy makers/management (legislators, traditional leaders, community organisations and administrators) to supply services for health promotion in order to meet the biological needs of adolescents,
- participate in local council meetings to influence parties concerned to ensure service delivery at grassroots level,
- initiate forums for different stakeholders to influence the formulation, application and evaluation of policies and legislation regarding the basic needs of adolescents,
- actively involve adolescents in community projects and make these legislations available to them,
- encourage governmental officials to implement public policies to ensure the safety of the people, in this case, orphaned adolescents living without adult supervision,
- encourage the community to work hand in hand with the Department of Safety and Security to improve their own security, and
- support local initiatives regarding provision for the basic needs of adolescents orphaned by HIV/Aids through consultation, interpretation and application of relevant legislation regarding provision of housing and food as basic needs.

Guideline 2

Through **social action** nurses bring about **social change** to assist the government to mobilise resources, to facilitate collaborative networks in health promotion regarding safety, security and biological needs of adolescents orphaned by HIV/Aids.

(i) Rationale

The government has a major role to play in ensuring the provision for the basic needs of families with adolescents orphaned by HIV/Aids. The government has to ensure that nurses are allocated to communities in order to provide for these families. These nurses should act as sources of information and advice to the affected families. The families should be provided with information on nutritional foods, social relationships and safety. Zuluaga (2000:320) confirms that people should be informed about freedom from potential physical harm. This can only be achieved through the dissemination of information at community level. Therefore nurses should interact with the communities to bring about healthy life changes.

The Health Development Agency (2004:2) states that action needs to be taken in order to induce the media to influence government officials to mobilise resources to provide for the health promotion related needs of families, such as those with adolescents orphaned by HIV/Aids.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- act as agents to bring about change regarding health promotion in the lives of individuals and families,
- align themselves with the governmental policies aimed at improving social or living circumstances, determine ways to mobilise resources made

available by government and investigate possibilities to form collaborative partnerships with governmental departments to provide for the biological, safety and security, and social needs of adolescents orphaned by HIV/Aids,

- assess current statistics of HIV/Aids, sensitise the community to these statistics, and plan and implement programmes in cooperation with the community and with governmental support to reduce the incidence of HIV/Aids,
- take part in community actions to ensure that social support programmes such as poverty alleviation (housing and feeding schemes) are being managed and used in a responsible way,
- mobilise the community to form policing forums to identify and address the safety and security needs of orphaned adolescents,
- encourage the community to cooperate with the Department of Safety and Security and be responsible for the orphans in the community,
- ensure that the community accesses information in the form of health education and pamphlets regarding good health behaviour in order to enhance social change,
- ensure that the services provided by the government relating to the biological, safety and security, and social needs of the community are utilised by orphaned adolescents in a responsible manner to the benefit of their general health, and
- enhance the atmosphere of safety and security to allow for the optimal development of the adolescents.

Guideline 3

Nurses involve legislators, traditional leaders and administrators in **community development** to enhance health promotion behaviours in families with adolescents orphaned by HIV/Aids to address their safety and biological needs.

(i) Rationale

Community development is an approach that nurses can use to involve governmental officials and community members in promoting the health of the community and families with adolescents orphaned by HIV/Aids, based on the application of policies and legislation as well as the allocation of resources, such as facilities and programmes. Lindsey *et al.* (2001:829) and Coulson *et al.* (2002:132) state that community development is a process by which the community defines its own health needs, decides collectively how these needs can be attained, and determines the priority for actions, as well as specifies a process of voluntary cooperation aimed at improved physical, social and economic conditions. Such actions lead to the promotion of health. It requires the involvement of citizens, voluntary participation, cooperation and collaborative problem solving. Through community development, nurses influence the government to empower its citizens with the skills to manage their environment. Community development is a way of helping the community to help itself and is a key to successful community awareness.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- empower interested community groups to identify the healthcare concerns of adolescents in relation to housing, food, water and sanitation, and involve the local traditional leadership to support efforts to supply these resources,

- encourage the community to participate actively in the planning and implementing of community development projects concerning the provision for and maintenance of basic needs, thus leading to self-help projects,
- work with government officials to sensitise the community to the importance of community development projects,
- reach consensus with government officials, traditional leaders and the community regarding the establishment and sustainability of community development projects,
- empower interested community members in collaboration with the government to assist orphaned adolescents and their families in accepting responsibilities for self-care and development,
- empower families regarding production, handling of food and preparation of nutritious meals,
- empower the community and families with adolescents in order to ensure capacity building and development,
- share their future vision with the adolescents who participate actively in local projects,
- give direction to an organisation or an effort by assisting in the formulation of development objectives,
- promote proactive management of the needs of adolescents that will lead to continuous change in the environment,
- encourage families to contribute toward their own safety and security through simple safety domestic principles, and
- ensure that the community and families are made aware of the existing projects so that these families could take part in any activity.

Guideline 4

Nurses **consult** and influence organisational stakeholders such as managers and traditional leaders with regard to application of policies and allocation of resources.

(i) Rationale

Consultation is a process of negotiation. It is an act of seeking information or advice and encounters to exchange ideas or to talk things over (World Book Dictionary, 1994:446). It helps a person to plan properly by considering more than one opinion. Chapman (2005:2) adds that consulting people and helping them to understand does not affect one's position but strengthens it, thus leading to quality health care.

The Foundation of Nursing Studies (2001:3) mentions that if nurses are involved in organisational development, they have to focus on evidence-based practice in order to improve the health of the community. The Foundation further emphasises that nurses have the skills to make a difference in the development of guidelines, protocols and policies and by revising current practices. Organisations play an important role in the functional implementation of human development, and nurses can collaborate and consult with these organisations (De Beer & Swanepoel, 2003:121).

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- consult and meet with organisational managers and traditional leaders (networking) to assist in the provision of biological, safety and security, and social needs of families with adolescents orphaned by HIV/Aids,

- consult people and help them to understand the situation surrounding orphans' lives and what measures can be implemented to contribute to their quality of life,
- consult organisational managers to identify and utilise available and existing resources to the benefit of the orphaned adolescents,
- liaise with managers and traditional leaders to plan and manage health-related services for the health promotion of these adolescents,
- negotiate cooperation with organisations to share existing resources for the health promotion of adolescents and their families,
- consult the public through meetings regarding the current organisational policies and legislations regulating provision for basic needs, as well as the interpretation of such policies,
- conduct proper assessment of needs of clients before recommending support from organisations, and
- conduct consulting workshops in order to bring everyone on board with regard to policy implementation.

Guideline 5

Nurses influence organisational managers and traditional leaders to **train** the community to utilise available support programmes responsibly.

(i) Rationale

Training is a process resulting in the empowerment of people with knowledge and skills that can be used on personal, family, community and wider levels (Pocket Oxford Dictionary, 1996:969). In training, members of the community are empowered and gain expert power to provide others with information (Richter & Peu, 2004:36). Organisations have to take the responsibility of training the community in order to enhance capacity building. Capacity building is one of the key responsibilities of organisations. Therefore, nurses have to influence such organisations to empower the community to take care of themselves.

Training is also a continued effort to assist the government in the provision of trained manpower. For example, organisations such as the Moretele-Sunrise Hospice in Hammanskraal train informal caregivers in the community in order to empower them with the necessary skills (Sebanyoni-Matlhasedi, 2004). The inclusion of organisations that provide training in health improvement is therefore advantageous. Hope and Timmel (1996:206) add that training for transformation is designed to assist in the development of self-reliant communities. Programmes for the training of the community need to be accessible and available in order to empower community members. This approach to training integrates community participation and problem solving and the result is a community that solves its own problems. It also implies that training should be directed in such a way that it enhances change in the health behaviour of communities.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- identify training needs and opportunities for families with orphaned adolescents,
- identify and compile a profile of organisations that provide health- related support programmes that can be utilised by families with adolescents orphaned by HIV/Aids,
- identify and compile the biological, safety and security, and social needs of adolescents that can be addressed by support programmes offered by government and non-governmental organisations, and train families with adolescents orphaned by HIV/Aids how to utilise these programmes,
- cooperate with organisations to make support programmes available for the empowerment of orphaned adolescent and their families,
- assist organisations to train non-professional healthcare workers to contribute to the health promotion of orphaned adolescents in the community,
- ensure that orphaned adolescents are supported through training programmes in the development of health promoting behaviour, and
- ensure that training programmes to promote health for the community are accessible, available, sustained and conducted according to local health promotion needs.

Guideline 6

Nurses develop and utilise **networks** consisting of accessible and relevant services to the benefit of orphaned adolescents and their families regarding their health promotion needs.

(i) Rationale

Networking is a continuous process that is inherent in professions such as nursing. It refers to the exchange of information that is accessible and includes aspects such as time management and general organisation (Royle & Blythe, 1998:1-2). Nurses should use networking in order to influence organisational change in a positive way to assist the community.

In networking, people exchange ideas and information with others. It is an instrument that can be used to reach people who are near and far, to provide advice that may contribute to health promotion through the planning of applicable and appropriate strategies and programmes. Various types of formal networks, such as support networks, exist, as networking occurs daily in some organisations. The network support could be from different organisations and include both governmental organisations and NGOs.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- consult and meet ('network') with organisations for the purpose of identifying and meeting the biological (food, water, housing and sanitation), safety and security (finance and physical security) and social needs (recreational) of adolescents orphaned by HIV/Aids and their families within the scope of their relevant policies and practices,

- involve both organisational managers and traditional leaders in creating networks for the provision for health promotion needs (see Figure 5.1),
- involve managers and traditional leaders in health promotion programmes to improve the health status of families with adolescents orphaned by HIV/Aids,
- 'network' to exchange information regarding available health promotion support programmes in order to enhance cooperation and the sharing of resources to the benefit of the families with adolescents orphaned by HIV/Aids,
- exchange information that is accessible and available, and that includes aspects such as time and general organisational management,
- 'network' with various organisations in order to influence organisational change in a positive way to assist the community, and
- organise meetings and workshops to attract and strengthen the network of cooperating organisations.

Guideline 7

Nurses utilise **health education** as a strategy to conscientise families with adolescents orphaned by HIV/Aids about health promotion needs and health behaviours.

(i) Rationale

Health education is one of the fundamental roles of a nurse that needs to be taken into account. Health education is a process in which nurses teach clients in order to empower and enable them. Traditionally, health care was disease-oriented, but in recent times, because communicable and chronic diseases are on the increase, greater emphasis has been placed on health care that includes the promotion of good health (Smeltzer & Bare, 2004:6). To reduce the load of hospital admissions (Department of Health, 2001a:5), nurses need to implement health education aimed at reducing the rate of diseases and other health problems.

Dreyer *et al.* (1997:7) state that the philosophy of community health flows from the sense of national responsibility and the awareness of the community of the value of good health. Good health care should be regarded as a priority by all stakeholders, from the government down to the individual client, who needs to be educated through health education about health care that leads to wellness.

Health education is a process that enables individuals and families to control their own health problems and reduces the rate of ignorance amongst families. It is a strategy for health promotion where health-related values, attitudes and lifestyles are consolidated and decision-making about a variety of health behaviours takes place (Ochieng, 2003:61).

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- identify the health education needs of orphaned adolescents, which will assist in the development of a culture congruent with the health education programme,
- collaborate with the community to identify and address obstacles that may hamper health promotion interventions,
- identify the learning principles that influence health education amongst the adolescent population,
- plan and implement health education programmes to make adolescents aware of the benefits of health promoting behaviour,
- assist families with adolescents orphaned by HIV/Aids to identify their own health promoting needs, to plan appropriate, feasible interventions and to determine what support programmes should be utilised,
- offer information on available resources to affected families, refer them to healthcare centres where and when necessary and support them in utilising available resources,
- encourage health promoting behaviour and assist or refer in cases of the occurrence of socially unacceptable behaviour,
- ensure that health education programmes not only focus on individual behaviour change but also facilitate healthier lifestyles for the whole family and community,
- reduce the load of hospital admissions by conducting health education aimed at reducing the rate of diseases and other health problems, and
- ensure that all needs indicated by *Maslow's Hierarchy of Needs* theory (biological, safety and security, social, self-esteem and self-actualisation) are included in health education programmes in order to conscientise families with adolescents orphaned by HIV/Aids about the necessity of developing health promoting skills.

Guideline 8

Nurses **screen** families with adolescents orphaned by HIV/Aids to identify their health promotion needs (biological, safety and security, social, self-esteem as well as self-actualisation needs) that promote healthy lifestyles.

(i) Rationale

Screening is the assessment of people who are asymptomatic for the purpose of diagnosing them for the likelihood of a particular disease. It is used to protect the general population from disease and facilitate early detection of disease (Webb, Bain & Pirozzo, 2005:291). Young *et al.* (2003:29) state that one of the primary healthcare services to be provided through the district healthcare system is the screening of common diseases by primary healthcare nurses. The problems identified during the research process (see Table 3.2) indicate the role such screening programmes can play in identifying common diseases timeously so that a diagnosis can be made and the condition treated before complications occur.

According to Bourbonniere (2004:529), studies suggest that nurses can improve symptom management by improving screening, especially amongst clients in rural areas. Diseases such as cancers and other chronic diseases can be detected early if screening is conducted at an early stage. Screening as a preventive measure should be conducted regularly in families and individuals to prevent disease and promote health.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- assess adolescents who are asymptomatic for the purpose of diagnosing them for the likelihood of a particular disease,

- identify and describe common illnesses that families with adolescents orphaned by HIV/Aids suffer from and plan screening services specific to their needs,
- identify community resources (governmental and non-governmental) to render healthcare services to families with adolescents orphaned by HIV/Aids in order to ensure that screening services are accessible to them,
- identify self-esteem and self-actualisation behaviours that contribute to healthy lifestyles for adolescents,
- through the process of screening, determine the health status of the families, plan appropriate interventions, manage the treatment and care, and evaluate the interventions to ensure they are effective,
- conduct home visits to determine and evaluate the health promotion needs of adolescents that will assist in planning for better health, and
- work with the community to identify adolescents in need of care through notification and referral by community members.

Guideline 9

Nurses **counsel** families with adolescents orphaned by HIV/Aids to cope with loss and limited resources and to meet their health promotion needs (biological, safety and security, social, self-esteem and self-actualisation) in order to enhance quality of life.

(i) Rationale

Counselling is a process of allowing the client to understand his/her condition for the purpose of accepting that condition (Evian, 2000:268-9). Counselling in combination with health education should be facilitated in order to assist clients to reach the highest level of wellness. Counselling as an adjustment strategy helps families cope with the limited resources they have to meet their health promotion needs. In counselling, the counsellor and client together explore issues relating to needs and problems that affect the provision of needs in order to find new or different approaches to dealing with them (Evian, 2000:268-9).

Gibson *et al.* (2002:29) state that through counselling, clients should be assisted to cope with their feelings, problems and the lack of provision for their needs. The nurse as counsellor should listen carefully and support the client in order to satisfy his/her needs. In this research context, adolescents should be helped to cope with life without parents, and particularly, to meet the needs that, if unsatisfied, could inhibit their development.

(ii) Operationalisations

Nurses, in collaboration with other healthcare providers:

- assess the need for counselling adolescents regarding their current and potential problems,

- help adolescents and others to cope with their feeling of loss by making support measures and community resources available,
- involve families with adolescents in establishing health forums that address the issue of coping with the death of parents and surviving with limited resources,
- plan and implement actions that lead to optimum health,
- provide culturally sensitive guidance regarding access to resources and support in order to satisfy basic, safety and security, love and belonging, self-esteem and self-actualisation needs,
- develop, gather and generate information regarding support structures and programmes that can assist families with adolescents orphaned by HIV/Aids to cope with the loss of parents and survive with limited resources,
- ensure the availability of valid information for counselling regarding the provision for basic needs,
- collaborate with government, organisations and families to support adolescents orphaned by HIV/Aids in developing positive coping mechanisms and adhering to societal norms and values,
- encourage and make orphaned adolescents aware of the need to respect their grandmothers and grandfathers and other family members who serve as substitute parents in order to provide for their basic needs.

5.7 VALIDITY OF THE GUIDELINES

The validity of the guidelines was ensured through triangulation (the use of both a workshop with a panel of stakeholders and a final expert panel in the development and validation of guidelines). Extensive literature reviews suggest that the validity of guidelines depends on the expert knowledge of the participants, how evidence was identified and synthesised, and how recommendations were developed (UNAIDS, 1999:5). In this study, the researcher identified, analysed and synthesised evidence suggestive of preliminary guidelines. The knowledge of the expert group also contributed to the validity of the instrument used during the development of the guidelines.

Guidelines should be available for external review in order to ensure validity. In this study, the guidelines were scrutinised by independent experts, and their comments were considered and, if supported by the majority of experts, used for guideline refinement. Certain areas of the guidelines were amended and modified. This process enhanced the validity of the final guidelines and increased the likelihood that clients would benefit from them (Agree Collaboration, 2003:62).

Guidelines with greater scientific validity are those that are developed by most key disciplines and will also ensure an explicit connection between the recommendations and the evidence (Thompson & Dowding, 2002:158). Using various skilled and knowledgeable experts and a collaborative approach can enhance the credibility of the guidelines. The participants involved in the validation process ensured that the guidelines were framed in a practical format. It should be noted that the participation of the expert group could have a positive impact on the adoption and implementation of the guidelines (Thompson & Dowding, 2002:159).

5.8 REVIEWING AND UPDATING THE GUIDELINES

Guidelines should be externally reviewed to ensure content validity, clarity and applicability (Shekelle *et al*., 1999:596). The guidelines in this study were validated by nurse experts with experience in guideline development. Guidelines

should be updated regularly and the date for upgrading specified (Shekelle *et al.*, 1999:596). The guidelines developed in this study should be updated every three to five years once they have been implemented.

5.9 SUMMARY

In summary, the researcher worked collaboratively with various participants at various times to develop, validate and describe guidelines that are relevant to families with adolescents orphaned by HIV/Aids.

In this chapter, the challenges associated with the development of valid guidelines were highlighted (Thompson & Dowding, 2002:160). The development and validation of guidelines for the health promotion of families with adolescents orphaned by HIV/Aids were also dealt with. This chapter followed the process of the development of these guidelines, in which preliminary guidelines were formulated and refined according to the consensus of participants. The guidelines were then described and presented. The next and concluding chapter contains the conclusions, recommendations and limitations of the study.

CHAPTER 6

REVIEW OF THE FINDINGS, VALIDATION AND DESCRIPTION OF THE GUIDELINES WITH APPLICABLE RECOMMENDATIONS, LIMITATIONS, IMPLICATIONS AND CONCLUSIONS

6.1 INTRODUCTION

In Chapter 1, the topic of the study is introduced. The significance of the research is discussed and the framework of the methodology presented. Chapter 2 describes the methodology of the study. In Chapter 3, the findings of the empirical part of the study are presented and theoretically confirmed. Chapter 4 integrates literature from different sources, by means of a model and theory, in order to aid the guidelines formulation process. In Chapter 5, the researcher describes the process of developing and validating the guidelines. Chapter 6 is a review and summary of the findings of the study, and includes a description of the guidelines, the limitations, implications and recommendations of the study.

The focus of the study was guided by the aim of the study, which was to develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids. Based on the above aim, the following objectives were formulated as a guide:

- Explore and describe the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal, and
- Develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

6.2 REVIEW AND SUMMARY OF THE FINDINGS

6.2.1 Objective 1

To explore and describe the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

This objective was achieved in the empirical part of the study in which qualitative methodology was used. Thirteen themes (see Chapter 3), with categories and subcategories, were identified. A literature control was conducted. The conclusions of the individual themes are summarised below.

THEME 1: BIOLOGICAL NEEDS

Physical needs are regarded as basic needs for all people, irrespective of age, status, place of origin and cultural background. The majority of participants of this study were poor and emphasised that the following needs had to be met in order to improve their health status:

- Food and nutrition,
- Water and sanitation,
- Proper housing,
- An environment conducive to sleep and rest, and
- Facilities for exercising.

THEME 2: SAFETY AND SECURITY NEEDS

Participants regarded safety and security as an important condition of human survival. The main focus of this theme was on physical and personal security, as well as financial security. The participants' need for physical and personal security manifested in their need to have a stand with housing of their own. At the time of the study, the majority of participants had only shacks.

The participants' also expressed a need for financial security, because, although the families survived with what they received from the hospice and money from elderly family members' pension funds, they did not find it easy to do so. They stated that they needed employment with a sufficient income in order to ensure their survival.

THEME 3: LOVE AND BELONGING NEEDS

The participants expressed the need to be loved by both family members and non-family members. Love results in the feeling of belonging. The participants emphasised that they wanted to be accepted by society despite their being poor.

THEME 4: EMOTIONAL NEEDS

The participants also emphasised the need for recreational facilities. The children of these families lacked this and, when they became bored, misbehaved. The participants also mentioned that they needed older people who could give them appropriate advice. The elderly participants indicated that the orphans had no respect for them.

Feeling fear was an emotion that the participants identified and related to *inter alia* funeral ceremonies within families.

Stigma, which the participants felt was discriminating, was also discussed during the study. The participants were concerned that many people in the community would focus on the children's status as orphans.

THEME 5: FAMILY STRUCTURE

The participants emphasised the need for both internal and external family structures. The need for internal structure refers to the need for parental care. They believed that their parents would have been in a better position to take care of their physical needs. According to the participants, a complete family is a nuclear family, with both parents present. A nuclear family serves various

functions to family members. These functions include socialisation, affection, reproduction, health care, and economic and educational functions. The absence of parents in a nuclear family often leads to poor living conditions, and subsequently, poor health status.

THEME 6: HEALTHCARE NEEDS

The need for health care was identified by the participants as most important to the survival of these families. Their main focus was on the availability of clinics, personnel, and the timeous management of general health problems. The majority of participants emphasised that in order for them to have good health, there must be well-resourced general health care for the community and adequate, well-trained personnel that can cater for the maintenance of the health care of their families and the community. Counselling and better general hygiene were also emphasised by participants as stimulating health promotion. The participants understood the interrelatedness of hygiene and health, because they stated that the house should be cleaned daily and that it was important to ensure that the food and water they consumed were clean.

THEME 7: ESTEEM NEEDS

Self-esteem involves the need to achieve, have self-confidence, be independent, have the freedom to choose options, be recogised for one's abilities, and appreciate achievements and limitations. The participants' main focus was on each person's need for respect, the recognition of self-esteem and the acknowledgement of his/her dignity. The participants felt that they had to be respected and recognised by their friends and families in order to feel happy. This included the respect of schoolmates, neighbours, families and teachers. The participants also indicated that they wanted to be recognised in the same way as other children who have parents were. They felt that when a person has parents, he/she is provided with the means to satisfy certain needs and be treated with dignity.

THEME 8: EDUCATIONAL NEEDS

It was revealed that the need for education affects the promotion of the health of adolescents. In addition to this, the participants indicated that education as every child's right should be attained. The participants discussed the facilities available to them for education as well as the constraints that restrict their education. The participants emphasised that their families, as families caring for adolescents orphaned by HIV/Aids, required better education. The families were concerned about the provision of school materials. They felt that children should be provided with the school materials needed to improve learning and teaching. The participants also mentioned the long distances that had to be traveled to reach school and the lack of libraries in the area.

THEME 9: SPIRITUAL NEEDS

Health promotion and spirituality are interrelated concepts. The participants indicated that their spiritual needs were fulfilled by praying together and attending church services, and through the nurturing role of family members, as well as the implementation of the family's values.

THEME 10: THE NEED TO BE A WHOLE PERSON

The participants revealed that they had a need to be regarded as a whole person. Although humanistic existentialists state that no one is complete, the participants wanted wholeness. According to them, to achieve wholeness, all basic needs must be met and the family given recognition by the community.

THEME 11: SUPPORT NEEDS

Support to vulnerable families was highlighted by the participants. They mentioned the need for support specifically in health promotion. These support systems had to take the form of both internal (family) and external (community) agents. The participants stressed that they needed support from their family

members. They also added that the community and the government could act as a support system for them and their families.

THEME 12: SOCIAL NEEDS

The participants expressed a need for recreational activities and social services. The need for entertainment in the form of television and radio was emphasised. These items can contribute to the health promotion of individuals if they are available and used in a responsible manner. Televisions and radios could be used to disseminate health promotion information through the media to the community. Usually rural communities without televisions rely on their radios for health information offered by community radio stations. The participants also mentioned that they would like to use traditional and cultural play activities to improve their quality of life through the achievement of a healthy lifestyle.

THEME 13: NEEDS RELATED TO TECHNOLOGY

Technology is necessary to survive but is difficult to access, especially in rural areas. The participants felt that families with adolescents orphaned by HIV/Aids needed telecommunication support, through telephones and computers, in order to assist them in developing health promotion skills. Telecommunications can provide these families with information related to healthy living. One participant added that telephones are needed to communicate with a social worker during difficult times or when a specific need arises.

6.2.2 Objective 2

To develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

This objective dealt with the development and validation of health promotion guidelines for families with adolescents orphaned by HIV/Aids. The development of health promotion guidelines took place during the first phase of the research

(see Chapter 1 to 3) and was consolidated during the second phase of the research (see Chapter 4 and 5).

6.3 GUIDELINES DEVELOPMENT

The development and formulation of guidelines are discussed in Chapter 4 and 5. The guidelines were based on empirical findings, as well as *Maslow's Hierarchy of Needs* theory and a revised version of the *MATCH* model. Both the model and the theory guided the researcher in formulating the guidelines. The findings of the empirical part of the research were first correlated with *Maslow's Hierarchy of Needs* theory. The *MATCH* model was then used to formulate guidelines to direct interventions to address the needs of the families in the study through health promotion. The *MATCH* model was selected for this as it includes interventions on governmental, organisational and community level (see Chapter 4 and 5).

6.3.1 Methodology for guidelines development

The methodology for the development of the guidelines is clearly described in Chapter 4 and 5 (for more detailed description see sections 4.2; 4.6; 5.5 and 5.6).

a) Guiding attributes

Throughout the development of the guidelines, certain attributes were observed and applied to ensure the development of quality guidelines (see Chapter 5, Table 5.1).

b) Guidelines development group

A panel of stakeholders was involved in the development of the guidelines. The description of this group is clearly outlined in Chapter 5 (see Table 5.2).

6.3.2 Validation of guidelines

The development and validation of the guidelines are discussed in Chapter 5. The participants who were involved in this validation process were nurse experts with knowledge and skills in the development and validation of guidelines. In Chapter 5, it is also clearly indicated how literature was consulted to extract guiding attributes to ensure the quality of the guidelines. The attributes that guided the development of the guidelines were modified and constructed into a check list for rating the guidelines.

Table 6.1 displays this check list. The criteria and rating scales of the check list are explained in the table. The ratings are as follows: strongly disagree (1); disagree (2); agree (3); and strongly agree (4). Guiding attributes to be followed in guideline development were explained in Section 2.7.3 (see Table 2.4).

TABLE 6.1: CHECK LIST AND RATING SCALE FOR VALIDATION OF GUIDELINES

CHECK LIST	RATING SCALE			
	STRONG=LY DISAGREE (1)	DISAGREE (2)	AGREE (3)	STRONG=LY AGREE (4)
Clarity and presentation The guidelines are easily understandable, specific, unambiguous and clearly presented. The intention of the guidelines and who will be involved are indicated. Various approaches to health promotion for families with adolescents orphaned by HIV/Aids are indicated.				
Effectiveness Quality health promotion is based on the clinical effectiveness and the extent to which the health status of families with adolescents orphaned by HIV/Aids can be expected to be enhanced by various health promotion interventions.				
Validity The guidelines are based on the analysed data, and the best available and correctly interpreted evidence as well as an applicable model and theory.				

CHECK LIST (continued)	RATING SCALE			
	STRONG= LY DISAGREE (1)	DISAGREE (2)	AGREE (3)	STRONG= LY AGREE (4)
Relevance The guidelines are relevant in terms of the need for the planning and implementation of health promotion programmes and sustained activities for orphaned adolescents.				
Comprehensiveness The guidelines ensure a comprehensive approach to the health promotion of adolescents orphaned by HIV/Aids. These include, among others, the physical, social, emotional, spiritual and psychological aspects. Emphasis is on self-care and wellness.				
Applicability The target users of the guidelines are clearly defined. The application of the guidelines relies on adequate dissemination, implementation and evaluation strategies.				
Acceptability The guidelines are realistic and are in line with policies (Youth and Adolescent Health Promotion and School Health Policies) of the Department of Health.				

Adapted from Agree Collaboration, 2003; Pinkney-Atkinson, 1995:12; Thompson & Dowding, 2002:157; and UNAIDS, 1999.

Table 6.2 on page 241 indicates the score for each guideline. Eleven individuals were requested to validate the guidelines. Only one did not do so but provided additional comments to the researcher. The ratings were as follows: strongly disagree (1); disagree (2); agree (3); and strongly agree (4).

The green blocks are the scores of the respondents who either agreed or strongly agreed with the items in question. The majority of respondents (90%) indicated that they agreed or strongly agreed with the items in question. One respondent (10%) felt that guidelines 1, 2, 3, 4, 5, and 6 were not comprehensive and two respondents (20%) believed that guidelines 7 and 9 were not comprehensive.

TABLE 6.2: RATED GUIDELINES (N=10)

CHECK LIST	Clarity				Effectiveness				Validity				Relevance				Comprehensiveness				Applicability				Acceptability			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
GUIDELINE 1		1	7	2			7	3			9	1			6	4		1	7	2		1	8	1		1	8	1
GUIDELINE 2			8	2			8	2			7	3			6	4		1	8	1		1	5	4			6	4
GUIDELINE 3			9	1			7	3			8	2			7	3		1	7	2			8	2			8	2
GUIDELINE 4			8	2			7	3			9	1			7	3		1	7	2			9	1			10	
GUIDELINE 5		1	6	3		1	6	3			8	2			7	3		1	8	1		1	6	3			6	4
GUIDELINE 6			9	1		1	7	2			10				6	4		1	7	2		11	7	2			8	2
GUIDELINE 7		1	7	2			7	3			9	1			6	4		2	5	3		1	6	3		1	6	3
GUIDELINE 8		1	7	2		1	6	3			8	2			6	4			6	3		1	7	2		1	7	2
GUIDELINE 9		1	8	1		1	7	2			9				6	4		2	5	3			6	4			6	4
TOTAL SCORE		5	69	16		4	62	24			77	12			57	33		10	60	19		16	62	22		3	65	22

These respondents indicated that they could only agree with the comprehensiveness of the physical and social aspects of the guidelines in question. They disagreed with the comprehensiveness of the emotional, spiritual and psychological aspects. The orange blocks are the lowest scores of the items in question. Only one individual who was asked to validate the guidelines did not do so, but instead provided extensive comments on the guidelines. These comments were analysed and integrated into the guidelines.

a) Guidelines validation group

Eleven knowledgeable and skilled nurses critically analysed the guidelines according to the set criteria. The panel who had been invited to participate in the validation of the guidelines was briefed about what was expected of them as well as the process to be followed in the development of the guidelines. This included a summary of the contents of Chapter 1, 2, 3, 4 and 5.

Validation is a crucial process. Therefore, the selection of the individuals on the panel was purposive and served to give credibility to the quality of the guidelines. The expert respondents were recognised as having the scientific and academic capacity to validate the guidelines. Their involvement could therefore ensure a positive influence on the guideline uptake (Thompson & Dowding, 2002:159).

b) Descriptive information of validation group

Different multi-professional and academic expert respondents were involved in the validation process (see Table 6.3).

TABLE 6.3: DESCRIPTIVE INFORMATION OF THE EXPERT RESPONDENTS

NO.	PROFESSIONAL QUALIFICATIONS	OCCUPATION	INVOLVEMENT IN GUIDELINE VALIDATION	EMPLOYER	PROFESSIONAL EXPERIENCE
1.	PhD (International Health Policy) - School of Tropical Medicine, University of Liverpool, UK MA (Public and Social Administration) Brunel University, UK BA Honours (Psychology) – University of Ghana RNT – registered nurse tutor (University of Ghana) RN – registered general nurse (UK) RMN – registered mental nurse (UK) RM – registered midwife (UK)	Associate Professor of Nursing	Various policy guidelines	Faculty of Health Sciences, University of Cape Town	Course Director (UK) International healthcare trainer (UK & Uganda) Racial Awareness & Equal Opportunity Consultant (UK)
2.	D Litt et Phil, MSc, BSc, Nursing Education, RN, RPN, RNE	University Academic (Professor)	Examined and validated guidelines for postgraduate masters and PhD students at the University of KwaZulu-Natal, University of the Free State, University of the Witwatersrand, Unisa, and University of Ghana	University of KwaZulu-Natal, Durban	Entered nursing in 1971, worked as a registered nurse from 1975 to 1983, lecturer in nursing from 1984 to 1992 in Nigeria, 1992 to 1996 in Botswana, 1997 to 1999 in Natal, Senior Lecturer from 1999, Associate professor in 2002, and head of school of nursing, University of KwaZulu-Natal since 2004

NO.	PROFESSIONAL QUALIFICATIONS	OCCUPATION	INVOLVEMENT IN GUIDELINE VALIDATION	EMPLOYER	PROFESSIONAL EXPERIENCE (continued)
3.	DCur, MCur, B Hons Nursing, BCur, Dip. Psychiatric Nursing, Dip. in Nursing Administration, Dip. Intensive Care Nursing, General, Community Nursing, Midwifery, Nursing Education.	Nursing Academic	Assessor	University of Stellenbosch	33 years' nursing experience (13 years' academic and 20 years' clinical experience)
4.	BCur; BCur Honours MCur (Public Health) DCur (Community Health)	Associate Professor	Assessor	Department of Health Studies, University of South Africa	33 years' nursing experience (30 years' academic and 3 years' clinical experience)
5,	PhD, Cur, BSc (Hons), BSc (Nursing), Dipl. Nursing Education, Dipl. Nursing Administration, Dipl. Community Health	Senior Lecturer	Assessor	Department Of Nursing Science, University of Pretoria	13 years' nursing education, 14 years' hospital, 10 years' nursing manager, and 3 months' academic experience
6.	PhD	Senior Lecturer	Validated guidelines	Gauteng Province and University of Pretoria	Physiotherapy teaching, management, head of department and chairperson of School
7.	PhD, M Ed, BCur I et A Hons, BCur I et A, General Nurse, Midwife, Community Health Nurse, Nurse Manager, Nurse Educator	Senior Lecturer	Validator and assessor	Department of Health Sciences, University of Pretoria	27 years' experience (15 years' academic experience)

NO.	PROFESSIONAL QUALIFICATIONS	OCCUPATION	INVOLVEMENT IN GUIDELINE VALIDATION	EMPLOYER	PROFESSIONAL EXPERIENCE (continued)
8.	PhD, M (ECI), BCur Hons (Industrial Psychology, BA Cur, B. Art et Science	Senior Lecturer	Developed guidelines	University of Pretoria	22 years' clinical experience, 2 years as part-time lecturer and I year as full-time lecturer.
9.	PhD, M ED, DTO, B Sc Physiotherapy.	Lecturer	Evaluator	University of Pretoria	32 years' lecturing and 2 years' clinical experience.
10.	MPH, B (C0.T)	Senior Lecturer	Evaluator	University of Pretoria	24 years' experience (11 years' academic experience).
11.	D Litt et Phil., MA Cur (Ethos and Transcultural Nursing)	Nursing Academic (Senior Lecturer)	Assessor	Department of Health Studies, UNISA	19 years' academic experience

6.4 DESCRIPTION OF THE FINAL GUIDELINE

The guidelines were developed and reformulated by the researcher, revised by a panel of stakeholders, and validated by experts in the development of guidelines (see Chapter 4, 5 and 6). The description of the final set of guidelines followed a series of steps that are described in Chapter 2, 4, 5 and 6. The following are the components of the guidelines:

- Name of the guidelines
- Objectives
- The scope of the guidelines
- Guidelines development
- Methodology for guidelines development
- Guidelines development group
- Validation of the guidelines
- Guidelines validation group
- Ensuring validity of the guideline

- Reviewing and updating of the guidelines

6.4.1 Name of guidelines

The name of the guidelines was determined by the topic of research, which emphasised health promotion as the phenomenon of interest. The name is as follows:

"Health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal"

6.4.2 Overall objectives

The overall objectives of the guidelines are clearly stated in Chapter 5 as well as the guideline document.

6.4.3 The scope of the guidelines

The scope of practice for these guidelines includes nurses and other healthcare providers as the target users of the guidelines and families with adolescents orphaned by HIV/Aids as the target recipients.

6.4.4 Guidelines development

Guidelines can be used by health promoters and workers as an educational tool to disseminate health information to the community (Pinkney-Atkinson, 1995:2). The guidelines developed in the course of the study are ready and available tools for nurses and other healthcare providers to provide health education to adolescents and their families. Guidelines can also provide direction to nurses and other healthcare providers in their decision-making regarding specific health promotion interventions (Strohschein *et al.*, 1999:85). Nurses and other healthcare providers could use these guidelines to plan health promotion activities for families with adolescents orphaned by HIV/Aids. In cases where it is

difficult to decide on specific interventions, these guidelines could also provide clarity.

6.4.5 Methodology for guidelines development

An overview of the methodology for the development of the guidelines is provided with reference to the way in which the empirical data were gathered to determine the health promotion needs of families with adolescents orphaned by HIV/Aids.

6.4.6 Guidelines development group

A description of the attributes of the stakeholders who were involved in the development of the guidelines is available.

6.4.7 Validation of the guidelines

The method followed when the guidelines were validated is clarified.

6.4.8 Guidelines validation group

The guidelines validation group is clearly described and the method used to select the group members discussed.

6.4.9 Validity of the guidelines

The measures taken to ensure the validity of the guidelines are clearly described in Chapter 5.

6.4.10 Review and updating of the guidelines

The way in which the guidelines could be reviewed and updated is indicated in Chapter 5.

6.5 RECOMMENDATIONS

In view of the guidelines that were developed in the course of this study, which aimed to structure the health promotion of families with adolescents orphaned by HIV/Aids, the following recommendations are made:

- All government officials (legislators, traditional leaders and administrators) should be involved in the development and implementation of the necessary policies and legislation in response to nurses' lobbying to provide for the health promotion needs of families with adolescents orphaned by HIV/Aids.

- Through social action, the government and nurses should mobilise resources in order to facilitate social change and establish collaborative networks in health promotion in order to address the basic needs of families with adolescents orphaned by HIV/Aids.

- Nurses, legislators, traditional leaders and administrators should be involved in community development in order to enhance the health promotion behaviours of families with adolescents orphaned by HIV/Aids.

- Organisational stakeholders (managers and traditional leaders) should be consulted regarding the application of policies and the allocation of resources.

- Nurses should influence organisational managers and traditional leaders to train the community to utilise available support programmes responsibly.

- Nurses should develop and utilise networks consisting of accessible and relevant services to the benefit of orphaned adolescents.

- Continuous health education should be provided in order to conscientise families with adolescents orphaned by HIV/Aids about health promotion needs and behaviours.

- Families with adolescents orphaned by HIV/Aids should be screened in order to identify their health promotion needs and promote healthy lifestyles.

- Nurses should ensure that families with adolescents orphaned by HIV/Aids are provided with counselling to help them cope with their loss and limited resources, and to meet the needs of these families.

6.6 RECOMMENDATIONS FOR FURTHER RESEARCH

Based on the above recommendations, the following further research could be conducted:

- An assessment of the views of community nurses and other healthcare providers regarding the implementation of the guidelines.
- An evaluation of the implementation of the guidelines, with emphasis on the operationalisations regarding families with adolescents orphaned by HIV/Aids.
- An assessment of the impact of the implementation of the guidelines on the health promotion of families with adolescents orphaned by HIV/Aids.

6.7 IMPLICATIONS

According to the results of the study, orphaned adolescents act as parents and have their own ideas of how to ensure that family members are provided with their basic needs. These basic needs are at times not provided for because of the poverty in which these families live. The results emphasised the need for the provision of human needs as outlined in *Maslow's Hierarchy of Needs* theory. The results have various implications on nursing education, community health nursing, policy makers and research, which are discussed below.

6.7.1 For nursing education

The curriculum in South Africa should be designed to accommodate and address the health promotion needs of orphans in South Africa. Nurses need to understand the factors that influence the health of adolescents orphaned by HIV/Aids as well as how to deal with these factors through health promoting activities. Nurses should be taught to use *Maslow's Hierarchy Needs* theory to assess their needs and plan healthcare services, and should be trained to use models such as the *MATCH* model to plan appropriate health care for the community, including communities with adolescents orphaned by HIV/Aids. Families with adolescents orphaned by HIV/Aids should be involved in the assessment of their own needs regarding health promotion and be made aware of how to address them.

6.7.2 For community health nursing

- Community nurses should lobby for the allocation and mobilisation of resources for the health promotion of adolescents orphaned by HIV/Aids.
- Community nurses should assess, plan, implement and evaluate health education programmes that deal with the provision for the health promotion needs of families with adolescents orphaned by HIV/Aids.
- Community nurses should bring about change through collaborative networks in health promotion, specifically with regards to the provision for basic needs.
- Nurses should be taught how to use the steps of the *MATCH* model. These are: the selection of the goals of health promotion; the planning of health promotion; the use of intervention approaches; and the use of evaluation as an outcome in health promotion. Nurses should take the various approaches, the targets of the intervention as well as the intervention objectives into consideration when promoting the health of the community, including communities of families with adolescents orphaned by HIV/Aids.

6.7.3 For policy makers

- Policy makers should be made aware that nurses have the power and capability to develop and implement policies regarding health promotion. Nurses should therefore be involved at all levels of policy making.
- The South African government should involve nurses when planning new legislation regarding health promotion amongst adolescents. Nurses have tremendous influence on the community to change their unhealthy healthcare practices.
- Policy makers should support local initiatives such as the implementation and evaluation of current developed guidelines on health promotion.

6.7.4 For nursing practice

Nurses should practise according to the scope of practice outlined in the Nursing Act, 1978 (Act No. 50 of 1978), as amended, as well as the Charter of Nursing Practice, 2006. This Act authorises nurses to practise within legal frameworks. This legislation emphasises health promotion activities such as the facilitation of the attainment of optimum health for all individuals (Searle & Pera, 1995:181). From this study, nurses are expected to act on behalf of adolescents orphaned by HIV/Aids in order to influence legislature and traditional leaders to supply health promotion services to meet their biological needs. Nurses should therefore ensure that they include the following in their practice:

- Actively involve the adolescent population in community projects and make the legislation regarding health promotion available to them.
- Ensure that the services provided by the government relating to the safety, security and biological needs of the community are utilised by adolescents orphaned by HIV/Aids in a responsible manner to the benefit of their general health.

6.7.5 For research

Participatory research processes should be conducted with families with adolescents orphaned by HIV/Aids so that these families can realise that they are able to ensure that they adopt and sustain a quality lifestyle.

6.8 LIMITATIONS

Various limitations of the study apply. The study was conducted in a rural community and the findings are specific to the area. It can therefore not be taken for granted that the results of the study can be generalised in other contexts. In addition to this, the guidelines have not been tested in any clinical setting and it can therefore not be assumed that they will achieve their intended purpose.

6.9 CONCLUSION

The purpose of the study was to develop health promotion guidelines for families with adolescents orphaned by HIV/Aids. The following two objectives guided the researcher:

- Explore and describe the health promotion needs of families with adolescents orphaned by HIV/Aids in rural Hammanskraal, and
- Develop and validate health promotion guidelines for families with adolescents orphaned by HIV/Aids in rural Hammanskraal.

The researcher made use of a qualitative, exploratory and descriptive paradigm coupled with regular observational methods. The study identified various health promotion needs of families with adolescents orphaned by HIV/Aids and these were used as a guide to developing health promotion guidelines for nurses and other healthcare providers. The needs identified in the course of the study were in line with those of *Maslow's Hierarchy of Needs* theory. The researcher therefore used this theory, as well as the *MATCH* model, in the development of the guidelines. The themes identified during the research process were correlated with *Maslow's Hierarchy of Needs* theory to add to the credibility of the

guidelines. Both the theory and the model were analysed and integrated to serve as a guide for the formulation and development of the preliminary guidelines.

The researcher then formulated preliminary guidelines for the health promotion of families with adolescents orphaned by HIV/Aids. These were given to a panel of stakeholders for development, adjustment and confirmation. The adjusted preliminary guidelines were then submitted to the office of the Director of Health Promotion to ascertain if the guidelines were in line with health promotion policies. The guidelines were then prepared for expert individual respondents to validate and rate according to the given criteria. The guidelines were validated, adjusted and confirmed. Based on the results of the study, the research question, purpose and objectives were attained.

The results of this study will contribute toward the knowledge base regarding improvement of the health promotion of families with adolescents orphaned by HIV/Aids in rural Hammanskraal. Guidelines developed from the study findings should enable the rendering of adequate and/or improved health promotion to orphans, families and communities affected by HIV/Aids, and assist the government in making policies on health care based on empirical data. In this study, capacity building among families will be enhanced by their participation in health promotion activities.

The final guidelines should be prepared for piloting before implementation and, after being implemented, the guidelines should be reviewed and updated regularly in order to ensure their credibility and sustainability.

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ANNEXURE A TO ANNEXURE L

ANNEXURE A

REQUESTING PERMISSION TO CONDUCT RESEARCH IN THE HAMMANSKRAAL MUNICIPALITY IN THE PROVINCE NORTH WEST

ANNEXURE B

LETTER FROM THE JUBILEE DISTRICT HOSPITAL PERMITTING RESEARCH

ANNEXURE C

LETTER OF APPROVAL FROM THE UNIVERSITY OF PRETORIA ETHICS COMMITTEE

ANNEXURE D

CONSENT FORM FOR PARTICIPANT FAMILY MEMBERS INVOLVED BY SOCIAL WORKER

ANNEXURE E

CONSENT FORM FOR PARTICIPANTS INVOLVED BY RESEARCHER

ANNEXURE F

INTERVIEW GUIDE

ANNEXURE G

TRANSCRIPT OF FOCUS GROUP INTERVIEW

TRANSCRIPT OF FOCUS GROUP INTERVIEW

FIRST VISIT

Researcher: Good morning, all of you.

Participants: Good morning.

Researcher: It appears that you are the family that works together in all what you do and I really appreciate that.

Participants: It is true that we work as a unit.

Researcher: The purpose of this visit is to determine what you need in order to promote your health. Firstly, let me explain what health promotion is. Health promotion, simply put, is a way of helping people to live a good life. For one to live a good life is to have what is necessary, those things that will contribute to a good life style. For you to be able to work as a team, I would like you to answer the following question: *What do you need in order to promote your own life?* Health promotion again is improving one's health. Now you are requested to elaborate more on the things that will contribute to your health promotion. Who is starting? O! Little girl, do you want to go first?

Participant : Yes. We need a house that belongs to us.

Researcher: Why do you need a house?

Participant : Because when you are in a house, you are safe and no one will interfere with your daily activities

Researcher: Is this not a house?

Participant : No, this is not our house, it has an owner.

Researcher: Next, what else do you need in order to promote your own health?

Participant : I need a bicycle that I can use for transport. Mmm-----mm----- and a television.

Researcher: Why do you need a TV?

Participant : It relieves the boredom and it will occupy one … not to be involved in bad street activities like fighting with others.

Researcher: How does the TV relieves your boredom?

Participant : Because we listen to the news, how other people cope with the difficulties, and we also enjoy the music on the television.

Researcher: Anything else?

Participant: We need money to pay for a burial society because if one of our members dies, we will never be able to bury her/him. We also need food because it gives us energy. We will never go hungry if we have food.

Researcher: What else do you need in order to promote your own health?

Participant: We need health care such as the clinic. We are turned away from the clinic when we visit it for any health problems.

Again we need education, mmm-------because if you are educated, you are able to look after yourself.

Researcher: What do you mean when you say: when you are educated, you are able to look after yourselves?

Participant: If you are educated, you will get the employment and earn money. With the money you are able to buy things that you need such as food and clothing.

Researcher: What else?

Participant: We need an electric stove for cooking. We have nothing for cooking. We need clothing - uniforms because we do not have enough clothing. I need money for school fees, to pay at school.

Researcher: Are these what you need? Tell me more about what you need in order to promote your health?

Participant: We need water for daily activities in our home and our own yard.

Researcher: Why do you need your own house? Tell me more?

Participant: Because we have no stand. We have hired a stand. While residing on this stand, we sometimes experience problems amongst ourselves such as fighting.

Researcher: Why are you fighting?

Participant: We are fighting each other because there is no parent who can guide us. We all act as parents. We do not listen to each other.

Researcher: What other needs do you have?

Participant: We are unable to pay for community services, such as bills, because we do not have money. I have no money to buy a braai pack for our club society in the street.

REPEAT VISIT

Researcher: I would like to greet you again. We will continue with the needs that contribute to your own health promotion. I am still going to ask the same question. Please feel free to discuss what you need to promote your health. What do you really need to promote your own health?

Participant: We need a TV because we want to avoid going to other families. We need a fridge because we do not want to fetch our water from the family next-door.

Researcher: What else?

Participant: A radio is needed for recreation because it will make it easier for us to live here. We also want clothing to look like other children. We want a brick house with windows.

Researcher: Why do you want a brick house? Tell us more.

Participant: Because this house is old and leaking. We struggle to get water and water is sold at 50 cents per 20 litres. We want to take trips to Durban to be like other children, because when you visit you learn many things.

Researcher: What else?

Participant: I need my own bed because biting insects enter the house-----sh-sh.sh.

Researcher: Lady, What else do you need?

Participant: We need somebody who could take care of us.

Researcher: Why somebody who could take care of you?

Participant: Because she will look after us. Books are needed, especially text books, because at school they want us to have text books.

Researcher: What else? Sesie, is there something you want to add?

Participant: We need a telephone container because I want to run a telephone business. I need blankets because I do not want to feel cold. We need electricity that is problem free because our electricity is giving us problems. It is unsafe and not in good order. We need sofas/lounge suit because we want to sit properly at home.

Researcher: Sesie, what else do you need?

Participant: We need a specialist doctor to examine our young brother---who has nose bleeding (epistaxis)---continuously. He has sores on his legs and on the head.

Researcher: What else?

Participant: We need a grocery cupboard to store food in order to avoid cockroaches and crawling insects from infecting the food.
We need water because we usually fetch water from our neighbours, and sometimes we buy water for 50 cents per 20 litres. We only have time to fetch water from our neighbours after they have fetched water. We need chairs to offer our visitors and an iron because we want to iron our clothes. I need shoes because we do not want to go barefoot. We need security - walls ---because there are many criminals around. We need telephones-----if there are problems –we must be able to call for help.

Researcher: Do you have more to say?

Participant: We need an elderly person to take care of us, because my younger sister is at the hospital, she is being discharged and now there is nobody to sign her out so that she can come home.

Researcher: Brother, what do you need to promote your own health?

Participant: Eee----We need cement to fill up the gaps in the floor because this house is old and shabby. The house that we use is unsafe, there are cockroaches and rats.

Researcher: Is anything left out?

Participants: No.

Researcher: I would like to take this opportunity to thank all of you for taking part in this research process. The results of this research will be communicated to you and any future plans. I thank you once more.

ANNEXURE H

LETTER REQUESTING STAKEHOLDERS TO PARTICIPATE IN THE GUIDELINES DEVELOPMENT WORKSHOP

ANNEXURE I

DESCRIPTIVE INFORMATION OF GUIDELINES DEVELOPMENT GROUP

ANNEXURE J

LETTER REQUESTING EXPERTS TO PARTICIPATE IN GUIDELINES VALIDATION

ANNEXURE K

DESCRIPTIVE INFORMATION OF GUIDELINES VALIDATION GROUP