A SOCIO-EDUCATIONAL STUDY OF THE IMPACT OF HIV/AIDS ON THE ADOLESCENT IN CHILD-HEADED HOUSEHOLDS

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A SOCIO-EDUCATIONAL STUDY OF THE IMPACT OF HIV/AIDS ON THE ADOLESCENT IN CHILD-HEADED HOUSEHOLDS

by

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DECLARATION

I, Jyothi Arjun Chabilall, declare that this dissertation is my own. It is being submitted for the Degree of the Master of Education at the University of Pretoria. It has not been submitted before, for examination at any other University.

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Signature

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Date

DEDICATION

This study is dedicated to my parents the late Arjun Khubar Singh and Omila Devi Singh who were both laid to rest on 09 January 1999 and to my late mother-in-law, Mrs R.C. Gangai. The emphasis that they placed upon educational achievement and their unquestionable concern for the underprivileged and those with special needs, act as an unwavering source of inspiration to those of us who love them.

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"Ideally, children would live in a world without AIDS. But our world is not like that. HIV exists in every corner of the planet, and children and young people are its prime targets. Every day, six thousand young people under 24 are infected with HIV. Every day, two thousand infants contract HIV through mother-to-child transmission. Every day, more than six thousand children are left orphans by AIDS, a third of them under 5 years old. And everyday, sixteen hundred children die of AIDS." **(Piot 2002)**

ABSTRACT

This is a scientific exploration of the manner in which HIV/AIDS impacts upon the adolescents that are orphaned by AIDS and obliged to live in a child-headed household. What is apparent is that empirical research based on the socio-educational conditions of orphans in child-headed households is a neglected field of study since there is mainly anecdotal evidence of the phenomenon. The central issues of the study are the socio-educational impact of the pandemic upon such children. This study aims to explore, describe and interpret the phenomenon of HIV/AIDS within the context of the participants' (adolescents in child-headed households) perspectives of their life-world. Apart from endeavoring to gain an insight into the way in which the social and educational aspects of the adolescents' lives are affected the study attempts to create an awareness that will assist NGOs and the Departments of Education and Welfare in their effort to mitigate the impact of HIV/AIDS.

The research abides by a qualitative methodology and an interpretive approach since the children are to be studied in their natural setting of their homes. The researcher employed a face-to-face technique in the form of interviews and observations of the adolescents in their natural environments as well as the *Sack's Sentence Completion Technique* to accumulate data for the investigation. The social epidemiology theory served as a theoretical framework for this study.

Findings of the study have revealed that HIV/AIDS has a definite negative impact on the social and educational lives of orphans in child-headed households. The study has further revealed that poverty, the lack of support and social discrimination experienced by the orphan in child-headed households, impact negatively on their social lives and education. Further, this research has exposed that orphans in child-headed households are vulnerable since they carry the burden of stigma and discrimination. These unfortunate children are forced to abandon their schooling because of financial constraints, and in many cases take care of ailing parents and assume adult responsibilities in their homes. Also, the South African Educational system has not adapted in keeping with current trends and needs to create more flexible learning opportunities that cater for children who will otherwise have to abandon their studies.

KEY WORDS

- HIV/AIDS
- RURAL
- CHILD-HEADED
- INDO-AFRICAN
- ORPHANS
- SOCIO-EDUCATIONAL
- ADOLESCENTS
- PANDEMIC
- POVERTY

TABLE OF CONTENTS

CHAPTER 1 - ORIENTATION AND BACKGROUND

CHAPTER 2 - A SOCIO-EDUCATIONAL STUDY OF ADOLESCENCE AS A DEVELOPMENTAL PHASE

CHAPTER 3 - SOCIO-EDUCATIONAL STUDIES OF THE IMPACT OF HIV/AIDS ON ADOLESCENTS ORPHANED BY AIDS IN FOREIGN COUNTRIES

CHAPTER 4 - THE SOCIO-EDUCATIONAL IMPACT OF HIV/AIDS ON ORPHANS OF AIDS IN SOUTH AFRICA

CHAPTER 5 - DISCUSSION OF THE EMPIRICAL RESEARCH

CHAPTER 6 - FINDINGS AND RECOMMENDATIONS

REFERENCES

APPENDICES

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

ACESS	Alliance for Children's Entitlement to Social Security
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
ASSA	Actuarial Society of South Africa
CINDI	Children in Distress
CSG	Child Support Grant
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HIVSP	HIV/AIDS/STD Strategic Plan for South Africa 2000-2005
NCF	National Children's Forum
NGO	Non-governmental Organization
NPA	National Programme of Action for Children
OVC	Orphans and vulnerable children
UN	United Nations
UNAID	Joint United Nations Programme on HIV/AIDS
USAID	The United States Agency for International Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1. AIM OF THE CHAPTER

The aim of the chapter is to provide a background and orientation of the socio-educational problems experienced by orphans of AIDS and those orphans in child-headed households. The chapter provides a scientific exposition against which the dissertation should be read and understood.

1.2. INTRODUCTION

> ***"Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatised by society through association with HIV/AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without services and support systems in impoverished communities."*** *(Smart 1999:20)*

[1]HIV/AIDS cannot be considered a disease any longer but a pandemic of complex related problems with dire consequences (Coombe 2002a:vii). Statistics (UNAIDS/WHO 2003:3) indicate that by 2002 approximately **40 million** people around the world were living with HIV and **2,5 million** of them were children under the age of 15. Globally, by the year 2002, there were **14 million** children who were orphans (AVERT.ORG 2003b:1). Many of these were children in child-headed households, who were forced to fend for themselves, abandon their studies, were most vulnerable to abuse and had to

[1] The term "HIV/AIDS" will be used as such in the course of this dissertation and not HIV/Aids.

often seek work to survive. This means that even if they are fortunate enough to have their own homes, they still need food and school fees (McGreal 2001:1).

Up until the end of 2002 approximately **26.6 million** adults and children living with AIDS were from sub-Saharan Africa while **4.6 to 8.2 million** lived in South and South-east Asia (UNAIDS/WHO 2003:3). UNICEF statistics (Bellamy 2003:56) in 2003 indicated that **2.5 million** people had died of HIV/AIDS in the sub-Saharan African region leaving behind even more children to join the 11 million children already orphaned. Of the **14 million** orphans (AVERT.ORG 2002b:1) the AIDS pandemic has left behind worldwide, it is estimated that 11 million live in sub-Saharan Africa. In parts of east and southern Africa ten percent of all orphans of AIDS live in homes headed by children (McGreal 2001:1).

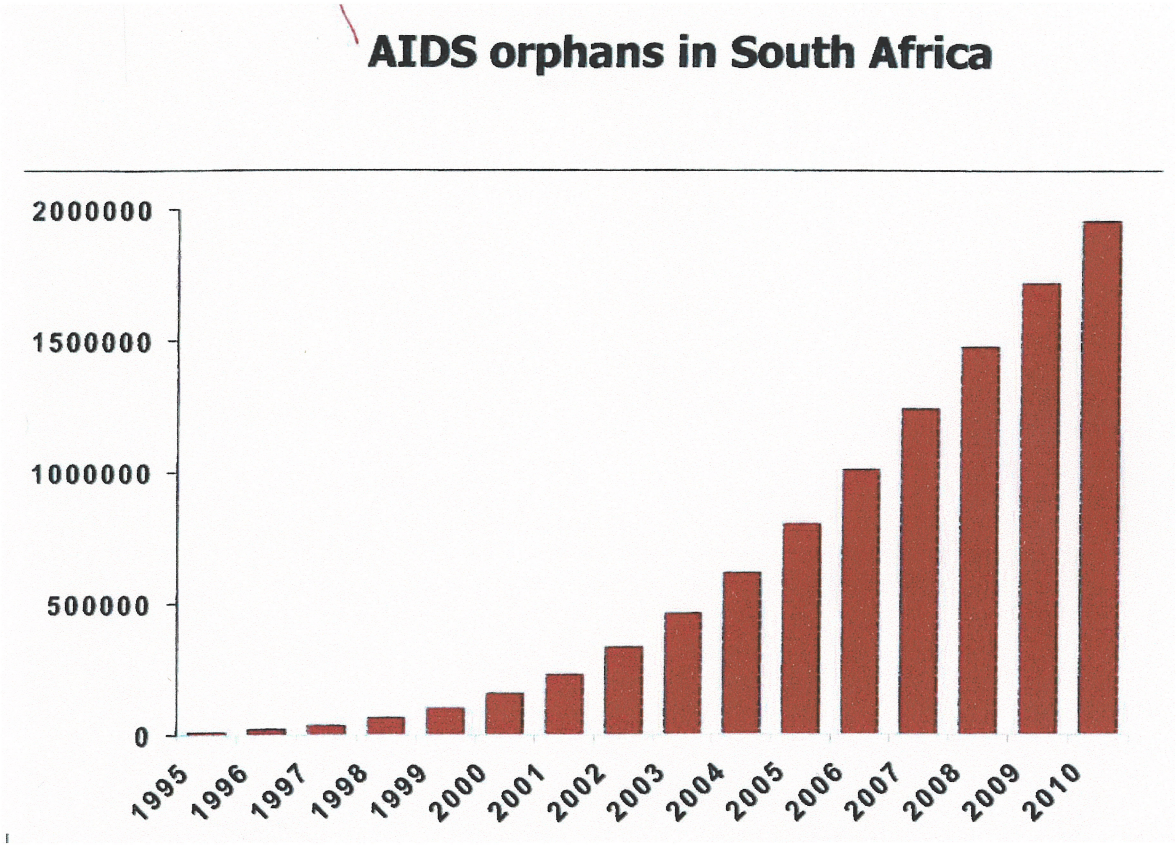
The pandemic in African countries such as South Africa, Zambia, Botswana and Swaziland (Coombe 2000a:1) is generating orphans so quickly that family structures such as the extended family can no longer cope. Families and communities throughout Africa are barely able to fend for themselves, let alone cater for the orphans who are experiencing severe socio-educational deficiencies. Infected adults are leaving behind a generation of young children to be raised by their grandparents or left on their own in child-headed households. (UNAIDS 2000:28).

Research (Loening-Voysey [2]& Wilson 2002:2) shows that HIV/AIDS is the primary factor contributing to the existence of the large number of orphans in South Africa. An estimation by the Actuarial Society of South Africa (Turkington 2002:1) states that as at 2002 there were approximately **280 000 maternal orphans** (children who had lost their mothers to HIV/AIDS) and that there were about **640 000 AIDS orphans** in South Africa presently. According to Dorrington [2]and Johnson (2002:46) South Africa's levels of orphan hood are predicted to rise dramatically since these figures are still in

[2]Take note that '&' will be used if the reference appears within brackets but 'and' will be used when the reference is used in the course of the text. This does not apply in the Bibliography.

the early stages in relation to other African countries. It is estimated that by the year 2010 there will be nearly two million orphaned children in South Africa and this will be the biggest socio-educational challenge for both the public and private sectors. This statistic is supported by the information provided by Whiteside (2002:23) on the following page:

FIGURE 1: AIDS ORPHANS IN SOUTH AFRICA



Source: Whiteside 2002:33

The above statistics underscore the tragic South African situation pertaining to orphans of AIDS and the magnitude of the problem in the future. This information supports the statistics provided by the Actuarial Society of South Africa referred to earlier.

HIV/AIDS has impacted most severely upon the world's youngest (children and adults) and most vulnerable citizens (young girls), initiating psychosocial and educational distress and increasing material hardship (UNAIDS/WHO 2002:28-29). Adolescents worldwide, who are orphaned as a result of AIDS, are exposed to anxiety, fear, sorrow, loss, stigma and discrimination, and isolation since the essential relationships within the context of the family are being destroyed (Coombe 2002c: 141; Giese 2002b: 2). In child headed households, adolescents are especially vulnerable since they are at greater risk of malnutrition, illness, abuse, child-labour, sexual exploitation and socio-educational difficulties (SAHARA 2002a: 4).

Socio-educational difficulties experienced by children could be in the form of a lack of parental guidance and support to continue with schooling, late schooling, discrimination at school level, absenteeism or complete drop out in order to take care of ailing parents or family members, the lack of funds to pay school fees, the inability to purchase school accessories and the necessary funds to be able to participate in sporting activities (Bellamy 2003:50). Peter Badcock-Walters (2002:98) argues that HIV/AIDS can be considered to be the "largest, single threat to the education process" and that any threat that decreases the role of education impacts adversely upon personal, community and national development.

Although information regarding child-headed households is limited, a report by Deborah Ewing (2002:38) confirms that such households may be headed by adult siblings of orphans, by school-going adolescents or by children caring for terminally ill parents with no adult supervision or support. Within the South African context the situation of orphans in child-headed households is exacerbated by the extreme poverty and the AIDS epidemic. The various social and educational problems of orphaned children in conjunction with a discussion of present research in South Africa can assist to mitigate the adverse conditions of these orphans as indicated in Chapter 4 of this study.

The choice of locating a sample in Kwa-Zulu Natal for the empirical research of this study is based on the fact that the majority of orphans in child-headed households are located in the Kwa-Zulu Natal.

1.3. PROBLEM STATEMENT

The above is indicative of the fact that many adolescents who are orphaned by AIDS find themselves in positions of control within their own households and are socially and educationally affected. HIV/AIDS has been responsible for more child-headed households than any other phenomenon and is a *"chronic stressor"* (Ebersohn & Eloff 2002:78) since children are compelled to take on positions of caregivers as well as breadwinners (Giese 2002b:1).

The adolescent AIDS orphan in a child-headed household appears to be a phenomenon prevalent predominantly in the rural areas of Kwa-Zulu Natal and thus sadly a neglected area of both research and support. The advantage that such a child in the suburban areas has, is that there are institutions that are able to cater for their needs. On the other hand, institutional care is less accessible to vulnerable children including orphans of AIDS in rural areas.

The adolescent in a child-headed household may experience inter-alia the following problems:

- Depleted **financial resources** of the family, often forcing the orphan to abandon [3]his education to survive (Coombe 2002c: 122). These households usually lose out on the previously available income, medical and insurance benefits and treatment costs. Since there is a reduced capacity to generate work, the sale of valuable assets might have to be considered (Coombe 2002c: 122). The devastating impact of both HIV and poverty upon the adolescent orphan mean

[3] The word 'his' is meant to refer to either his or her.

that children's basic needs of food, housing, school fees, medicines, water, proper sanitation and transport are not met (Giese 2002b:3-4). The adolescent is faced with the anxiety, fear and frustration of this **financial strain** since the productive family members are now severely ill or have passed on and he has to now take on the responsibility of providing for his siblings (Ebersohn&Eloff 2002:79).

- The cruel reality of **poverty** that is thrust upon the naïve orphan and the **stigma and discrimination** attached to HIV/AIDS result in feelings of guilt, shame and denial (Loening-Voysey 2001:3). It has been reported that members of the community who are ignorant of the actual effect of the disease, fear the consequences of linking themselves to the abandoned children believing that the latter have brought shame to the community. Hence, the denial of vital social, emotional and economic support and consequent **abuse** of these orphans. Research also reveals that an increasing number of children **refuse to attend school** as a result of the scorn that they have to endure from being part of AIDS-affected households (Hepburn 2002:93).

- The trauma of being rejected by the community is exacerbated by the **adolescent's new adult responsibilities**, which include providing security and food to dependent siblings and taking care of sick family members (Ebersohn&Eloff 2002:78). The adolescent AIDS orphan sacrifices the opportunity to have a secure future by dropping out of school in order to care for incapacitated parents. These "**child-nurses"** are forced to deal with the ordeal of the prolonged and unpleasant effects of AIDS upon their loved ones and expose themselves to HIV as well as the opportunistic diseases that eventually kill the patient (Beresford 2002:6).

- The stress adolescents suffer as a result of having to adopt the roles of caregivers and providers impacts upon their physical and mental health and their

educational aspirations (Coombe 2002c: 131-133). Research has shown that children affected by AIDS are frequently **absent** from school and are finding it more **difficult to pay attention** in the classrooms – hence there are substantial **school dropout rates** due to deprivation, disease and distress (Coombe 2002c: 131:133). This could be attributed to the fact that the orphans, especially those in child-headed households, have become **breadwinners** and have added responsibilities, which include seeking employment in order to provide for their siblings. Studies in most African countries have displayed that orphans of AIDS are less likely to attend school than those who have not lost a parent (UN Fact Sheet 2001:2). Giese (2002:65) asserts that orphans, who have limited resources and inadequate adult supervision, "are more likely than their peers to drop out of school." They are also deprived of the benefit of the control and support of some of their teachers and peers as a result of the secrecy revolving around the pandemic.

In the light of the above problems experienced by adolescents affected by AIDS in child-headed households, the **main research questions** for this particular research may be described as follows:

- What is the impact of HIV/AIDS on the social lives and education of adolescent orphans in child-headed households?
- To what extent are the above-mentioned problems that are experienced by orphans of HIV/AIDS, replicated in this study?
- What problems, unique to the sample under study, need to be recorded?
- Are there any new recommendations, suggested by the study that may be taken to mitigate the impact of HIV/AIDS as experienced by orphans of HIV/AIDS in child-headed households?

1.4. AIM OF THE STUDY

The primary aims of this study are:

- To investigate and discuss the socio-educational impact of HIV/AIDS on the lives of adolescents who are orphaned by the pandemic and forced into child-headed households.
- To ascertain the extent to which the above-mentioned problems (stated in the problem statement) experienced by orphans of HIV/AIDS, are replicated in this study.
- To determine what problems that are unique to this study, need to be recorded.
- To provide innovative guidelines that may assist to mitigate the impact of HIV/AIDS as experienced by AIDS–affected orphans.
- To investigate by means of an empirical study the socio-educational impact of HIV/AIDS on adolescent orphans in child-headed households in the rural areas of KZN and to present recommendations and conclusions from the findings in an attempt to mitigate the impact of HIV/AIDS on these adolescents.

Before one proceeds to the accomplishment of the primary aims, one must embark upon an in-depth study into:

(a) Adolescence as a developmental phase with special reference to the adolescents' cognitive-, physical-, emotional-, moral-, social- and connotative development.

(b) A situational analysis of the impact of HIV/AIDS on adolescents (orphaned by AIDS) in child-headed households internationally and in South Africa.

(c) The socio-educational impact of poverty and HIV/AIDS on adolescents orphaned by HIV/AIDS in child-headed households.

(d) The kind of support (educationally, socially, financially, emotionally), adolescents in child-headed households receive from families, schools, NGO's, communities and the State.

1.5. SIGNIFICANCE OF PROPOSED STUDY

South African children affected by AIDS face not only the horror of losing their families to the pandemic but also the risk of growing into dysfunctional adults within a society where individuals are estranged and deprived. Without the care and supervision of their parents or caregivers they are unable to function as productive human beings within their own social circles let alone the broader context beyond.

The significance of this study is emphasized in the problem statement, which indicates that the study investigates the impact of HIV/AIDS on the social and educational lives of adolescents in child-headed households. The findings of the study also present recommendations that attempt to mitigate the impact of HIV/AIDS on these adolescents.

This study attempts to reveal the manner in which adolescent AIDS orphans in child-headed households are forced to take up new responsibilities which entail caring for ailing parents and siblings - hence the pressures of new problems – educational and social with the accompanying financial, emotional and psychological problems (NPA: National Programme of Action 2001:88). It probes to reveal how and why adolescent-children are compelled to carry heavier workloads, abandon school, perform more general household duties, forced onto the streets and even compelled to indulge in criminal activities. It further attempts to investigate how adolescents in child-headed households cope with stigma, discrimination, economic difficulties, school attendance,

fees, distress, trauma, personal grief, loss of identity, shame as well as the fear of abandonment, rejection and death.

In addition, this study provides guidance to schools, churches, NGO's, governments and researchers on how to address the phenomenon of child-headed households and to mitigate the impact of HIV/AIDS on orphaned children. The research provides a scientific background of the socio-educational impact of HIV/AIDS on adolescents in child-headed households in both the International and National arenas. It aims to elucidate the unique manner in which HIV/AIDS affects adolescents in child-headed households in South Africa.

Since research based on the socio-educational impact of HIV/AIDS on adolescents in child-headed households is limited, there is an urgent need for scientific information that will assist to analyze and relieve, to some extent, the problems relating to these children's social and educational situations. This field of study is certainly under-resourced since much of the research conducted in the field of HIV/AIDS, concentrates on the medical aspects of the virus. More knowledge on this topic will consequently expose the effects of the pandemic upon the child-headed home, thus contributing towards the distinct approaches that could be utilized in order to assuage the impact of HIV/AIDS on the adolescent in such homes.

1.6.CONCEPTUALIZATION

1.6.1. The concept "socio":

The concept "socio" that stems from the concept "social" is said to have the following meanings:

- Social life
- ' People in relation to one another, for example: intimate, personal, social, public;

- To share with others (for example: a common neighbourhood, values, interests, beliefs);
- Participation between people;
- People uniting in a community or society;
- Communication (interaction) between people; and
- All the phenomena of living and working together. (Le Roux 1993:13)

The term "socialization" that stems from "socio" is the process through which children acquire behaviour, skills, motives, values, beliefs and standards that are characteristic, appropriate and desirable in their culture (Mussen, Conger, Kagan and Huston 1990:514). The concept "socio" refers to experiences, usually controlled, that improve the individual's ability to participate in group life," (Good 1973:539). The meaning attributed to the concept socio or "social" is "in its broader sense, pertaining to the interaction of organisms in groups; in its narrower sense, descriptive of an individual's ability to get along with others," (Good 1973:538).

With reference to this study, the concept "socio" will refer to the experiences, participation and communication in which the adolescent orphaned by HIV/AIDS in a child-headed household is involved in with particular reference to his siblings, his peers, members of the extended family, his teachers and society.

1.6.2. The concept "educational":

The term "**educational**" stems from the word "**education**" which means:

- *Any process, formal or informal, that helps develop the potentialities of human beings, including their knowledge, capabilities, behaviour patterns, and values.*
- *The developmental process provided by a school or other institutions that is organized chiefly for instruction and learning.*

- *The total development acquired by an individual through instruction and learning (*Hawes & Hawes 1982: 73*).*

In relation to this study, the concept "educational" refers to the education at formal (at school or any other institution) or informal institutions (the home) that helps develop the potentialities of orphaned adolescents, including their knowledge, capabilities, behaviour patterns and values.

1.6.3. The concept "adolescent":

"A child changes into an adult during ***adolescence****, a period lasting from about 11 to about 18 years of age. The changes that take place during adolescence include not only physical events but also psychological and social ones."* (Smart and Smart 1977: 491).

"The adolescent is the youth at the stage between childhood and adulthood, termed adolescence." (Marshall 1998:7). According to the Oxford Dictionary of Sociology (Marshall 1998:7), the adolescent is considered to be unstable and flexible, one who stands on the brink of personhood looking for an image that he cannot yet envisage or attain.

In relation to this study, the concept "adolescent" will refer to any child from the age 13 to 18 years who is orphaned as a result of HIV/AIDS. The term will incorporate both puberty as well as adolescence.

1.6.4. The concept "household":

The Oxford Dictionary of Sociology (Marshall 1998:283) provides the meaning as *"A group of persons sharing a home or living space, who aggregate and share their incomes, as evidenced by the fact that they regularly take meals together"* (Marshall 1998:283). In terms of the Dictionary of Education *(Good 1973:287)* the concept is considered as being *"defined by the Bureau of the Census for the 1970 census (and) includes all the persons who occupy a house, room or group of rooms, or apartment that constitutes a unit dwelling: a household may contain more than one family," (Good 1973:287).*

In relation to this study, the term "child-headed household" will refer to all children (normally siblings) who occupy or share a home which is controlled by one or more children (adolescent/s) who assume/s the role of the parent, caregiver or principal earner since the adult who is supposed to be responsible for the home is too ill with the virus or has passed on as a result of HIV/AIDS.

The words '*household'* and the word '*home'* may be used interchangeably in some instances.

1.6.5. The concept "orphans":

According to Ali (2002: 2), orphans -*"are those children whose parent or parents have passed away from birth to the age of eighteen or twenty-one years old, as well as those above these ages but are still going to school, or do not have any means of looking after themselves and those being looked after by guardians who are unable to support them."*

UNAIDS/UNICEF (2002:8) suggests the following definitions:

*"**Maternal orphans** are children whose mothers, and perhaps fathers, have died (includes double orphans"*, that is those children who have lost both parents*).*

***"Paternal orphans** are children whose fathers, and perhaps mothers, have died (includes double orphans)."*

***"Double orphans** are children whose mothers and fathers have both died."*

The South African Oxford School Dictionary (Hawkins 2000:306) refers to the orphaned child as *"a child whose parent(s) are dead"*.

For the purposes of this study, the term "orphan will refer to a child whose parent(s) have passed away.

1.6.6. The concept "AIDS":

According to Van Dyk (2001:4), the acronym stands for "Acquired Immune Deficiency Syndrome". The virus is acquired and not inherited and the body is unable to defend itself against the HI virus thus displaying various signs and symptoms of pathological conditions.

According to Whiteside & Sunter (2000:1), AIDS is explained as follows:

The 'A' stands for Acquired. This means the virus is not spread through casual or inadvertent contact like flu or chickenpox. In order to be infected, a person has to do something, which exposes them to the virus.

'I' and 'D' stand for Immunodeficiency. The virus attacks a person's immune system and makes it less capable of fighting infections. Thus, the immune system becomes deficient.

'S' is for Syndrome. AIDS is not just one disease but it presents itself as a number of diseases that come about as the immune system fails.

For the purposes of this study, the concept "AIDS" will be considered as "AIDS" which is the acronym that stands for Acquired Immune Deficiency Syndrome. The disease is

acquired and presents itself as a number of diseases displaying various signs and symptoms of pathological conditions, which eventually cause death.

1.6.7. The concept "HIV":

According to Barnett & Whiteside (2002a:30), HIV stands for Human Immunodeficiency Virus. The above researchers uphold that "for the infection to occur, the virus has to enter the body and attach itself to host cells." The HIV then targets the particular CD4 positive T cells, which organize the body's entire immune response. The virus also attacks immune cells called macrophages, which are there to consume foreign attackers and recognize these in the future. Once the virus has entered the CD4 cells, they cannot be identified and destroyed by bodily defense mechanisms. A constant conflict follows between the virus and the immune system.

In relation to this study, the concept "HIV" will stand for Human Immunodeficiency Virus.

1.6.8. The concept "impact":

It has been somewhat difficult to glean specifically what academics consider to be the meaning of the concept "impact".

According to the South African Oxford Schools Dictionary (Hawkins 2000:221) the concept "impact" refers to "an influence or effect."

The concept in relation to this study will refer to the effect that HIV/AIDS has upon the lives of adolescents in child-headed households, from a social and an educational perspective.

1.7. RESEARCH METHODOLOGY/STRATEGY

1.7.1. Theoretical Framework

Since the focal point of this inquiry is the socio-educational impact of HIV/AIDS upon adolescents orphaned by AIDS in child-headed households, it can be classified as a **social epidemiological study** (Weiss & Lonnquist 2000:35). Such studies give attention to the causes and distribution of diseases and impairments within a population but from a socio-cultural perspective. Within the current context, social epidemiologists explain social inequalities in health by focusing on three explicit theories (Krieger 2001:669):

- **Psychosocial:** This theory presents the query as to why only certain people who are exposed to germs become infected and why not all people who are infected develop a disease (Krieger 2001:668). John Cassel (1921-1976) was of the view that there were groups of natural factors that were capable of altering human resistance by significant means and making specific individuals comparatively more vulnerable to these ever-present agents in the natural world that cause diseases such as tuberculosis, schizophrenia and suicide. Some of the most apparent psychosocial factors that appear to explain the theory are: social disorganization, rapid social change, marginal status in society, social isolation, bereavement and the buffer to all the foregoing factors is social support. Cassel advocated that in order to make constructive strides towards minimizing disease it was crucial to enhance and bolster the social support rather than decrease the exposure to stressors.
- **Social production of disease and/or political economy of health:** The fundamental assumption of this theory is that 'economic and political institutions and decisions that create, enforce and perpetuate economic and social privilege and inequality are root or fundamental

causes of social inequalities in health' (Krieger 2001:670). Within the context of such an ideology, the relief stems from tactics for community 'empowerment' and social transformation. Other important aspects are amendments to social inequities that pertain to race/ethnicity, gender and sexuality according to socio-economic criteria and across diverse societies.

- **Ecosocial theory and related multi-level frameworks:** These are graphic descriptions of innovative structures to clarify existing and variable models of disease dissemination that refuse to settle in a specific plane but are *'multidimensional and dynamic'* (*Krieger* 2001:271).

The ecosocial theory and related multi-level frameworks are supposed to clarify patterns of health, disease and well being as biological expressions of social interactions, consequently engendering fresh information and resolution. However, Krieger (2001:674) also emphasizes that the socio-epidemiological field is a largely *under-theorized* and *under-researched* field of study that requires a concerted united effort by biologists and sociologists to remove ambiguity and provide new foundations for action towards a healthier world.

Krieger (2001:668) is of the view that there is a definite correlation between the general health patterns of communities and levels of social deprivation and privileges. Since social conditions in which people live, influence physical well being, clinical and sociological approaches need to be examined concurrently to determine the dissemination and determinants of states of health (Proietto 2001:1&5). Proietto (2001:5) considers that there is a dire need for biological studies to take into consideration behavioural and environmental factors within diseases promotion programmes and treatment activities. Hence, there must be a collective investigation of details such as culture, environment, government policy, socio-economic status, educational attainment, social networks and work demands together with the biological studies.

Progress and transformation within any society appear to result in systematic modifications in the patterns of **morbidity**[4] and **mortality**[5] within that society (Weiss & Lonnquist 2000:37). Accordingly, one discovers that death and disease affect the social environment and cultural features of the people who are exposed to them. Subsequently, the vision of social epidemiologists can manipulate the outlook of state reimbursement procedures and the priorities of health and social services. In the same vein, circumstances such as social class, race and poverty appear to have a significant effect upon the life expectancy and mortality within certain communities (Weiss & Lonnquist 2000:43). These theories are apparent in the researcher's groundwork with respect to orphans who are directly affected by the morbidity and mortality within their immediate social circles as a result of HIV/AIDS.

In this case the researcher is challenged to expose the relationship between South African facts and figures concerning HIV/AIDS and the socio-educational world of the adolescents selected for the study. Studies (Booysen, van Rensburg, Bachmann, Engelbrecht, & Steyn, 2002; Booysen, 2003; Barnett, & Whiteside, 2002) thus far in South Africa verify that the pandemic has thrived in areas where there is dismal poverty and a lack of social, educational and financial support. The preliminary investigation and literature study in the preceding paragraphs pertaining to the psychosocial production of disease and/or political economy of health and ecosocial theory and related frameworks and theories of social epidemiology are all relevant to this study with special reference to HIV/AIDS. These theories are all in search of explanations for the social inequalities in health, disease distribution and causation. The researcher's preliminary inspections for a suitable sample have revealed that the effects of the pandemic have been overt in areas where there is abject poverty, pronounced unemployment, substandard living conditions and a lack of social support. In the light of this it stands to reason that whether the life-worlds of the participants of this study are affected directly or indirectly by the presence of HIV/AIDS, their socio-educational lives will suffer formidable changes.

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[4] **morbidity**[1]: *refers to the amount of disease, impairment and accident in a population – for several reasons, a concept more difficult to measure than mortality* (Weiss & Lonnquist 2000:48).

[5] **mortality**[2]: *refers to the number of deaths in a population* (Weiss & Lonnquist 2000:41).

1.7.2. Paradigmatic Perspective

Since the designated exploration is a study towards illumination and understanding (Mc Millan & Schumacher 2001:15-16), a **qualitative** approach is preferred. This can be considered as an interactive qualitative inquiry and the study originates from a view of the reality (Smit 2001:5) of HIV/AIDS with the existence of **child-headed households** in certain parts of the country. Hence, the researcher seeks to understand this particular complex view of both the educational and social circumstances of the adolescent who is directly affected by HIV/AIDS.

The researcher conducted an in-depth qualitative study into HIV/AIDS, one that explored, described and explained (Mc Millan & Schumacher 2001:397) the way in which the phenomenon affects adolescent orphans of AIDS within the educational and social spheres. The coping mechanisms of the children were also scrutinized via the analysis. The study assumed an interpretative perspective (Smit 2001:2) since the adolescent orphans of AIDS were studied in their natural environment of their homes where there was no adult supervision other than the fleeting visits by concerned neighbours, volunteer workers, members of Non-Governmental Organizations (NGO's) and distant relatives. It stands to reason that the researcher's access to the reality of the impact of HIV/AIDS on orphans was via the meanings that these adolescents assign to the virus and its effects upon their lives. The researcher then attempted to elucidate the phenomenon of HIV/AIDS within the context of the participant's lives and from their perspective of their life-world. Thus, interpretation inclined towards the researcher gaining an insight into the social and educational impact in terms of assets, socio-educational and financial resources as well as the psychosocial support systems that the children had in the face of the pandemic.

The advantage of utilizing a qualitative research methodology is that there exists the potential for a valuable input to educational theory, policy and practice (Moola 1996:45).

The study allowed for the consequential amalgamation of policy and practice and improve the strategies vis-à-vis HIV/AIDS and children.

1.7.3. Research Design

A **research design** "*describes the procedures for conducting a study, including when, from whom and under what conditions the data will be obtained" (Mc Millan & Schumacher 2001:30-31).* The research design also includes the manner in which the research is set up, what happens to the subjects during the research process and what methods of data collection are used.

The **case study design** was utilized focusing particularly on the socio-educational perspective. This methodology is appropriate since the *"qualitative case-study is an intrusive, holistic description and analysis of a single instance, phenomenon or social unit"* (Merriam 1998:21). The emphasis in this kind of research is upon the phenomenon of HIV/AIDS and the social unit is the group of selected adolescent orphans as per the definition that has been provided in chapter one of this dissertation. Results appear in the form of rich, comprehensive descriptions (Merriam 1998:28) that facilitate the researcher's grasp of the phenomenon of AIDS in the light of orphans in child-headed households.

This interactive, qualitative inquiry in the form of a case study research design made use of meetings, face-to-face interview techniques, observation and the *Sack's sentence completion technique* to facilitate the collection of data from the children who had been selected, within their natural settings (McMillan & Schumacher 2001:35) that is in their homes IN THE RURAL AREAS OF Kwa-Zulu Natal. The researcher then unravelled the phenomenon by examining the data garnered by these means according to the perception that the children had.

The study extended the researcher's experience of the phenomenon and she was able to grasp the way in which the adolescent orphans in child-headed households cope with the

effects of HIV/AIDS especially within the social and educational milieu (Merriam 1998:30-31). Consequently, the study resulted in an enhanced awareness of the position of these vulnerable South African children most severely affected by the pandemic.

1.7.4. Research Roles

The research roles refer to the "*relationships acquired by and ascribed to the researcher in interactive data collection, appropriate for the purpose of the study*" (McMillan & Schumacher 2001:599).

For the purposes of this study two research roles were adopted:

1.7.4.1. The researcher was a participant observer and attempted to secure a position (even on a voluntary basis) within the NGO that allowed constant home and school visits and personal contact with the relevant participants to glean relevant data thereby.

1.7.4.2. The researcher also adopted the role of an interviewer and observer, establishing a research role when requesting an appointment and explaining the purpose and confidentiality of the study (McMillan & Schumacher, 2001; 435).

The research role dictated the progress of the study to a large extent and its success depended on the level of trust and acceptance that the researcher was able to achieve. The research role did affect the data collected so too did the presence of the interpreter. Therefore, the interpreter too had to develop a relationship of trust and acceptance so that the study would produce authentic and useful data.

1.7.5. The Process

The research process generally involved several phases that were not necessarily chronological, nor a methodical step-by-step procedure.

1.7.5.1. Selecting the Case

The favoured theme stemmed from the concern of the United Nations at the time the project had been initiated, about the sudden increase in the numbers of child-headed households worldwide and more especially in the sub-Saharan African region. This raised issues of concern within South Africa about children's ability to cope with the basic needs of attaining food, education, money and psychosocial support in the face of such adversity as HIV/AIDS.

1.7.5.2. Selecting the Site

Preliminary investigation, by the researcher, discovered a probable sample in the Pietermaritzburg area of Kwa-Zulu Natal. The adolescents orphaned by AIDS were eventually found in Willowfontein, a township west of Pietermaritzburg. On the advice of the social worker at Thandanani Children's Foundation in Pietermaritzburg, a meeting was set up between the volunteer workers who assisted this NGO in the area of Willowfontein and the researcher. These were the suitable candidates for the investigation since they were totally without adult supervision and control and relied on the NGO and their neighbours for their basic needs. All the **initial subjects** visited were at school (even 20-year-olds) and had lost either one or both parents to HIV. It is often the case that the one parent dies of AIDS while the other abandons the children.

1.7.5.3. Negotiating Access

Bonga Mbele, the social worker from The Thandanani Children's Foundation was approached with the request that a sample was necessary in order to carry out research in the area. The volunteers were then contacted in order to assist with arrangements to meet with the participants. The volunteers, who assisted the children with their basic requirements, acquired the necessary permission to allow for the study. The researcher

visited the children only after the volunteers had made the necessary arrangements regarding permission since these are important moral considerations. The ethical concern was of particular import since in this case in point as the general attitude towards HIV/AIDS is still a sensitive issue. It was also important to create some form of rapport and trust between the researcher and the participants in order that there will be a significant degree of honesty in the children's responses to the questions posed.

1.7.5.4. Purposeful Sampling

McMillan & Schumacher (2001:598) consider that purposeful sampling involves a "*strategy to choose small groups or individuals likely to be knowledgeable and informative about the phenomenon of interest*" or a "*selection of cases without needing or desiring to generalize to all such cases*". The onus was upon the researcher to make use of purposeful sampling (Mc Millan & Schumacher 2001:400-401) in the selection of a small "information-rich" group of adolescent orphans in child-headed households. Such a sample might have proved to be knowledgeable about the phenomenon and could supply information that was to be useful to the study.

Within the research of orphans of AIDS, there were many definitions of the term "child-headed", thus, the search for an appropriate sample took the researcher to many different locations before the one most relevant to this research, was secured. The term "**child-headed household**" followed the reference as given in 5.4.3. of chapter one.

The chosen sample conforms to the requirements of purposeful sampling since the selected groups of "orphans of AIDS in child-headed households" were small and provided the vital feedback regarding the manner in which they are affected socially and educationally as a result of the pandemic. In addition, the researcher confirms that even though the results provided invaluable information it will not be feasible to generalize these results to all such cases.

1.7.5.5. The Participants

The Thandanani Children's Foundation has been working with a group of children from the Willowfontein area near Pietermaritzurg in Kwa-Zulu Natal. The researcher was notified by a representative of the Foundation about the existence of a suitable sample in the area and meetings resulted in visits. At the outset six households were visited by the researcher, however the eldest child in three of these was twenty years of age – therefore these samples did not fall into the required category.

The final nominated participants are from 15 to18 years of age and living in four different child-headed households around the poorer sections of the Willowfontein area just outside Pietermaritzburg. The researcher selected these 15 to 18 year-olds regardless of whether they were at school or not. Hence, adolescents from four different households were chosen:

- **Household 1**: - Seventeen-year-old **at** school living with twin sister;
- **Household 2**: - Fifteen-year-old **NOT** at school (with six-month-old baby);
- **Household 3**: - Eighteen-year-old **at** school; and
- **Household 4**: - Sixteen-year-old **at** school living with brother.

The above participants complied with the requirements as noted in the opening chapter of this dissertation.

1.7.5.6. The Research Team

As there was a language barrier, the researcher had to work with the assistance of a competent interpreter so as not to lose vital information that the children could better express in their mother tongue. The research was conducted with the help of the Thandanani volunteer worker and the interpreter. The interpreter was selected for his competence at his work for a legal firm where part of his duties included interpretation whenever necessary.

Especially for this particular study, the research team ought to display the following salient characteristics that make a good researcher, interviewer or observer (Smit 2001:8):

- Tolerance for ambiguity;
- Sensitivity;
- Respect;
- Sound communication skills;
- Empathy;
- Good listening skills;
- Ability to create an atmosphere of trust and acceptance;
- The wisdom to wait to be accepted; and
- The ability to be flexible and resilient.

1.7.5.7. The Fieldwork

This aspect of the study was carried out with the support of the Thandanani staff and their volunteers. After the meeting with these parties the necessary ethical issues were resolved and appointments made to meet with the selected participants of the study. Meeting the children on the first few occasions was important since this afforded the researcher the opportunity to gain the trust and confidence of the adolescents. The interview with the children at their homes created the ideal opportunity for the researcher to observe them in their natural settings and reveal those aspects of their domestic lives that the children might not want to in their responses to the interviewer. The next meeting took place in a community hall where the children were asked to complete the *Sack's Incomplete Questions* and proclaim their three wishes.

1.7.6. Data Collection Strategies

Data was collected over a period when persistent fieldwork is necessary. The adolescent orphans of AIDS selected for the study were observed and interviewed in their natural settings such as their homes in order to reflect realistic life experiences accurately. (McMillan & Schumacher 2001: 408). This study applied the interview, observation and the *Sack's Sentence Completion Technique* as data collection strategies.

1.7.6.1. Interviews

This strategy involved semi-structured individual interviews (Mouton 2001:105) with the adolescent orphans via whom they revealed the manner in which they conceived of their worlds and the way in which they have been affected by the HIV/AIDS pandemic. These in-depth, face-to-face interviews presented the participant's visualization of their world and the justifications that they provided (Mc Millan & Schumacher 2001:443-444). The researcher created a setting whereby the interviews were carried out in conjunction with the observations so as to assist to formulate a global picture of the participants in relation to the phenomenon.

The interview (see Appendices) took the form of a standardized open-ended interview where the same questions were asked in the same order to all the participants and the exact form and content was predetermined (Mc Millan & Schumacher 2001:443-445). It was preferable that the interviews were semi-structured and the questions, open-ended to allow for complete individualistic expression. In order to ensure that no aspect of the participant's views and opinions was lost, the interpreter provided exact translations of the responses given by the children in their mother tongue. The researcher was aware of the system of coding that could be applied but preferred not to use this method of collating data.

1.7.6.2. Observation

This was an additional data-collection technique that permitted the researcher to use the natural setting of the interview situation to determine more from the participant's non-verbal signals about his knowledge base, skills, resources and support systems. Participant observation in the form of intensive observing and listening allowed the researcher to "*obtain people's perceptions of events and processes expressed in their actions*" (Mc Millan & Schumacher 2001:437-440).

During the interview process the researcher was able to observe the subjects in relation to their the home and its contents which provided an idea about the subjects' home environment, social class and status, economic situation, poverty, culture, ethnicity, socialization or social isolation, gender and sexuality.

The non-verbal cues that were exhibited appeared in the form of facial expressions, gestures, tone of voice, body movements and other non-verbal social exchanges. Since the researcher was of a different background and culture she had to rely a great deal upon the interpreter and volunteers for additional information that she might have considered insignificant. It was also important to ensure that the interpreter notified the researcher of certain unusual cultural and traditional expressions so that the latter noted their meanings and inferences.

Another aspect of importance with regard to observation was the researcher's ability to take note of the home and its contents, which might have verified or disproved some of the details provided by the participants during the interview and sentence completion.

1.7.6.3. *SACK'S SENTENCE-COMPLETION TECHNIQUE*

This technique operated on the basis of a semi-structured approach and was most apt for this study as it gave attention to the evaluation and disclosure of dominant personality characteristics and problems (Abt & Bellak 1959:357). It was important to note at the

outset that although the *Sack's Sentence Completion Technique* had been developed in America by Joseph M. Sacks and other psychologists, it is most suitable for this study of South African adolescents as the questions are not ethnically biased.

Four distinct fields are focused on:

- Family;
- Heterosexual relationships;
- Interpersonal relationships; and
- The self-concept.

Questions had deliberately not been presented to the subjects in the above categories so as to prevent mechanical responses and answers have been re-organized into these categories later (See Appendices) for the purpose of analysis.

Such a procedure was beneficial in that the researcher was able to acquire an insight into the participant by evaluating his individual responses pertaining to the self as well as his involvement and interpretation of his life-world. With particular reference to the study itself, the sentence completion technique was well designed to expose:

- Ideas that could be further scrutinized;
- Assessments that had been made earlier could be confirmed; and
- If the participant had been incapable of verbalizing his thoughts during the interview, he was able to disclose information that was fundamental to the inquiry during this procedure.

This semi-structured technique also enabled the researcher to take note of certain aspects of the self that the participant might not have revealed or the researcher might not have deemed pertinent during the interviews and observation. The distinctive attribute of the sentence completion technique was that when the child completed or even partially completed any response he allowed the researcher to view his world as he perceives or experiences it. The connotations that the participant provided were willfully brought to the fore enlightening the researcher about the adolescent's appreciation of his interactions and values within his personal life-world (Smith 1990:112).

The *Sack's Sentence Completion Technique* enabled the researcher to fill in spaces and authenticate data that he had already obtained from alternate research techniques about the following:

- The quality and content of the adolescent's self-image;
- His relationships with his late parents, his siblings, his educators and his male and female peers;
- Disconcerting emotional experiences presenting as nervousness, shame at being discriminated against by others as a result of the virus, his personal inadequacy and qualms about problems in general;
- His individual construal of his future, proposed strategies and stance on matters affecting his life; and
- His personal denunciation and censure of others as well as his personal inclinations and interests.

The *Sack's Sentence Completion Technique Questionnaire is attached as Appendices.*

1.7.7. Validity and Reliability

Internal validity or the credibility (Smit 2001:10) of this research was ascertained by checking transcriptions made from audiotapes against the researcher's field notes of the interviews. However, it must be noted that it is possible to lose vital inferences as a result of cultural differences and language. The translations provided by the interpreter might have also lost some of their accuracy in that some ideas could not be translated literally from Zulu to English. The researcher is human anyway and the primary instrument of data gathering and analysis. It was possible for the research to be tainted by the unconscious prejudices or biases of either the interviewer or the translator. Although the researcher has provided an extensive detailed study description, the transferability or external validity (Smit 2001:10) will depend on the reader, his perceptions and judgements.

The researcher can increase the reliability and dependability of the research by ensuring that the recorded data is what in fact occurred during the actual study. The transcriptions of the recorded interviews were corroborated with the field notes. In addition, the results of the study would be consistent and dependable if the assumptions and theories are adequately explained. If various data collection methods are applied to link the data as in this case, the investigation can be said to be dependable.

1.7.8. Potential Data Collection Errors

Essentially, since this is a study of the socio-educational impact of HIV/AIDS upon orphaned adolescents it could be regarded as a challenging, thorny issue. Thus, the potential for errors in this case could be that much greater than in other studies. HIV/AIDS is still viewed with trepidation and sometimes indifference by societies and can therefore jeopardise the success of data collection. In order to obviate this problem the researcher tried to secure a firm relationship with the parties involved to ensure that there is trust and honesty all round.

According to Mouton (2001:106-107), the researcher needed to be wary of the following latent errors especially with regard to this study:

- Interview bias is allied with the personal characteristics of the researcher in the form of perceived affiliation, race and gender (Neumann 1997:259-260). The researcher, as a middle class, Indian female would invariably had certain biases and would have needed to conduct the research according to an emic approach whereby the phenomenon was viewed via the perceptions of the participants (Mc Millan & Schumacher 2001:474).
- The biased observer or interviewer or research selectivity effect occurred as a result of the alternatives with reference to research methods, data

and questions apart from the decision about what to observe, settle on or overlook (Stern 1979:73).

- Social desirability effects exemplify the situation when participants express what they think they "should" believe or what they feel satisfies the interviewer rather than what they actually consider the truth (Stern 1979:65).
- Demand characteristics involve the participant's ability to yield answers that they suspect the researcher would prefer.

Considering that children are the focus of this investigation one could expect that they might have been too perturbed and distressed to discuss the circumstances around the virus that has disrupted their lives so drastically. The researcher ought to have ensured that the type of questions and the manner of collecting data did not create further trauma for the child.

1.7.9. Limitations of and Assumptions in the Research Design

The biggest anticipated barrier was the question of stigmatization, which is rife in any community where HIV/AIDS is prevalent. It was also expected that adolescents in the age group 13-18 would have been far more secretive as is found under normal circumstances – therefore the need to gain the confidence of the subjects in order that they would have been more receptive to the need for the research.

Also, access to the subjects themselves depended on the attitude of the community and the legal implications of the research .The question of language and interpretation was also considered since cultural differences can affect the eventual outcome of the study and results. The very nature of the study was expected to hold the interest of the researcher long after it had been completed and it is hoped that from the point of initiation that positive changes can occur to prove the need for such a study.

The language barrier might have proven to be a limitation since it is possible that the gist of a response could have been lost in the translation thereof. The researcher would have found it impossible to work without a translator. Even if audiotapes of the interviews were made, it is sometimes impossible to pick up pertinent indications as a result of the language hurdles.

1.7.10. Data analysis and Interpretation

A detailed analysis of the interviews and initial observations identified and explored themes and concepts relevant to the requirements of the study. The researcher ensured that as data was scrutinized and endorsed, interpretations always returned to the manner in which HIV/AIDS impacts upon the social and educational aspects of the lives of adolescent orphans.

The main issues analyzed with reference to the impact of HIV/AIDS on the developmental phases of the adolescent were:

- Cognitive development;
- Physical development;
- Emotional development;
- Moral development;
- Social development;
- Connotative development;
- The acquisition of identity; and
- The attainment of emancipation.

It was also important to evaluate the child's relationships with his siblings, male and female peers, neighbours and teachers. The role of the school in the adolescent's life was been apparent from the child's responses regarding his teachers, ability to cope with schoolwork and his relationships with the learners in his classes.

The researcher was required to work with the contents of interviews by analyzing the substance of each, consider the connotations of each key word, symbol, assertion or implication. Each of the interviews and the results of the *Sack's Sentence Completion Technique* exercises necessitated classification of details according to the core of each question and incomplete sentence so as to facilitate suitable breakdown of results. Further, this was corroborated with the researcher's field notes based on the observations made especially during her interviews.

1.7.11. Research Ethics

Eisner (1998:213) considers that "unethical behaviour has no place in qualitative research" and that researchers ought to adhere to strict principles, concepts and considerations with regard to research ethics. While social research may be the establishment of knowledge and change for the better, it can prove harmful to those who are being researched.

This study is one of those that commands a particularly principled researcher who does not sacrifice the well being and confidentiality of his subjects for the sake of fame and recognition. HIV/AIDS is a sensitive issue that requires that the researcher investigate and interviews with the necessary empathy. Hence issues pertaining to the virus will require confidentiality and genuine consideration in that the identity of the participants is not revealed to prevent any discrimination and shame. The researcher informed the participants that the study was supposed to reveal the social and educational impact of HIV/AIDS upon the adolescent orphans who live in child-headed households. This was explained to the adolescents in such a manner so as to avoid any misunderstandings later.

The question of '*informed consent*' according to Eisner (1998:214) implies that the researcher and participant know prior to the investigation what the study involves and what the possible effects could be. Researchers paid particular attention to the potential

for pain and the serious problems that could result from a lack of confidentiality and the remiss to provide the protection of informed consent. In this study the participants were adolescent orphans of AIDS and one had to be careful about whom the informed consent should be acquired from. Many queries arose as a result of this:

- Was the consent of the child (minor) legal?
- Could a volunteer take responsibility to sign the consent form for the child even though this is not the legal guardian of the orphan?
- Was the researcher flouting some ethical or legal ruling in her use of orphans without legal guardians as participants in this study?

Many of the dilemmas from the ethical perspective were apparent in the process of data collection. During this period the researcher had to ensure the anonymity of the participants as a result of the attitude of people in general towards the issue of HIV/AIDS. The adolescents were told that their identities would be kept secret if they so wished and that they could opt out of the programme at any time that they so wished. People have the right to anonymity and should the data collection process compromise this right by restricting the individual's freedom thereafter, information had to be withheld even if it were to benefit the public at large. The children were also informed that they need not respond to any of the questions that made them uncomfortable or distressed.

The process of data collection in a study dealing with HIV/AIDS does not enjoy the freedom of choice of involvement that other issues enjoy. The question of discrimination and the stigma attached to the virus invariably dictated the need for sensitivity towards the participants and the nature of the questions to be posed. Hence, it was the onus of the researcher and interpreter to be circumspect in the collection, analysis and publication of data. Respect for the privacy and well being of the participants was vital and should confidential information be revealed inconsiderately, this could have aggravated the psychosocial problems of the adolescent.

It is often the situation with social scientists that participants see the researcher as a willing listener and one who will solve **all** of their problems since questions are being asked about them. Without sacrificing the rapport that has been established, the researcher must explain his role clearly and not take advantage of the support she is able to afford the troubled participant (Eisner 1998:217-218). In this particular investigation, the adolescents are obviously searching for solutions to their social, educational and financial problems and the danger is that the researcher may be held responsible if there are eventually no resolutions in sight.

It is imperative that the researcher did not mislead, deliberately deceive or withhold information from the participants, as this could be a violation of basic human rights. Since researchers involved in qualitative studies are compelled to provide detailed reports at the end of a study, these indiscretions can result in embarrassment and condemnation for the researcher.

1.8. PLAN OF STUDY

1.8.1. CHAPTER 1: Orientation and Background

This chapter serves as an orientation and justification for the study. It outlines the effect of the pandemic internationally, nationally and more specifically within the province of Kwa-Zulu Natal, where the effects are most deleterious. It also analyzes the socio-educational problems of the adolescents in child-headed households in relation to the research problem statement and aims of the study, provides an explanation of the key concepts and creates an awareness of the background within which the study is to be understood.

1.8.2. CHAPTER 2: A socio-educational study of adolescence as a developmental phase

This chapter deals with the general development of the typical child during puberty and the adolescent phase. The subject matter in this chapter exposes the way in which adolescents during this phase develop according to academics with special reference to the social and educational development. This is done in order to be able to later present a comparative study in Chapter 6.

1.8.3. CHAPTER 3: Socio-educational studies of the impact of HIV/AIDS on adolescents orphaned by AIDS in foreign countries

The third chapter provides a more detailed situational analysis of the socio-educational impact of HIV/AIDS on adolescents and orphans in child-headed households in selected foreign countries.

1.8.4. CHAPTER 4: The socio-educational impact of HIV/AIDS on orphans of AIDS in South Africa

In this chapter, the main focus of the research discussed in detail revolves around the socio-educational impact of HIV/AIDS on orphans of AIDS and orphans of AIDS in child-headed households in South Africa and the rural areas of Kwa-Zulu Natal.

1.8.5. CHAPTER 5: Discussion of the empirical research

This chapter discusses the findings of the empirical research that were generated using a variety of methods (as discussed in chapter 1). Various aspects of the procedure such as

the nature and the selection of the sample, the area of investigation, the method of investigation and the research design are discussed.

1.8.6. CHAPTER 6: Findings and recommendations

This chapter presents a synthesis of the main findings from the literature study and from the empirical research. Recommendations are made from the findings of the literature study as well as from the findings of the empirical research.

Finally, an evaluation of the research will be presented. Further, the implications of the study as well as the setbacks that were encountered during the research proper will be discussed. Recommendations for further research will be outlined.

1.9. CONCLUSION

The literature study and the Problem Statement are indicative of the fact that orphans of HIV/AIDS do experience social and educational problems. However, there is a lack of information regarding adolescents in child-headed households. There is a definite need for more research and more consistent data based on the circumstances of children orphaned by AIDS. Research may help to establish acceptable strategies with reference to orphans in child-headed households regarding their security, education, social life and welfare. It is clear that these issues have to be addressed in order that steps can be taken towards the mitigation of the socio-educational problems experienced by orphans in child-headed households lest another generation is lost.

CHAPTER 2

A SOCIO-EDUCATIONAL STUDY OF ADOLESCENCE AS A DEVELOPMENTAL PHASE

2.1. AIM OF THE CHAPTER

Since the subject matter of this dissertation involves a particular developmental phase of a child (**adolescence**) it is imperative that this phase is scientifically discussed at the outset. Hence the aim of this chapter is to execute this task and outline the major characteristics of puberty and adolescence as envisaged by researchers and academics on the subject. This chapter revolves around the psychosocial as well as the educational development of adolescents. Hence, characteristics other than these will be discussed only briefly. The abject conditions of the HIV /AIDS orphan will also be dealt with concisely. It is essential that the specific contention in this chapter includes the theme of the study therefore at various stages a comparative line of reasoning in relation to the adolescent AIDS orphan in a child-headed household will be presented.

2.2. INTRODUCTION

The influence that HIV/AIDS may have on the development of a child, is described by UNICEF as follows:

" A child's progression through basic developmental stages is jeopardized if HIV-related illness reduces then ends a parent's capacity to provide consistent love and care. Development is also jeopardized if HIV/AIDS causes social isolation, stigma, discrimination or otherwise disrupts the experiences normal within a child's community." (UNICEF 2001:7).

Considering the above quotation, it is certainly necessary for any discussion revolving around the impact of HIV/AIDS upon the adolescent to include the way in which the normal development of an adolescent is affected by the pandemic. The development of the child is a steady process and differs from individual to individual depending on personal as well as environmental factors (Pretorius 2002:1). Adolescent years introduce the key concerns of identity and identity diffusion, which include primary modification in personal maturity (Sprinthall & Sprinthall 1977:205). According to Pretorius (2002:1) factors that influence the physical, spiritual, mental, social and psychological development of the child could be:

- *"The ethnic group to which he belongs"*
- *"The climate in which he grows up"*
- *" The milieu in which he grows up"*
- *"The socio-economic level at which the child finds itself"* and
- *"Whether the child is a boy or a girl"*.

During the adolescent phase there are significant immediate as well as long-term physical, social and psychological effects which influence behaviour and attitudes. These effects consequently need vital rational adjustments and the need to adjust one's attitudes, morals and interests (Hurlock 1973:223). An analysis of the above factors revealed that the adolescent is susceptible to the effects of his interaction with the immediate family, the extended family, the society, the school or any adult who bears an influence upon the child's growth in any respect. AIDS related deaths are resulting in a vast number of homes where children are required to cope on their own with no adult supervision and support. The prior chapter will bear testimony to the fact that many adolescents orphaned by AIDS will not have the natural benefit of adult guidance and will consequently be compelled to devise their own means of developing in the above respects (UNICEF 2001:7).

2.3. DEFINITIONS

For the purposes of this particular chapter the following definitions will apply:

2.3.1 Developmental Tasks

"A developmental task is a task which arises at about a certain period in the life of an individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks," (Havinghurst 1972:2).

Vrey (1979:10-11) considers the word '*development'* to be a "*gradual process of taking shape"* – hence "*developmental tasks*" are deemed to be "*mile-stones*" in an individual's life, ones that accomplish the various goals of "*becoming*". By enhancing his physical and psychological abilities, the child is able to advance towards adulthood.

It is unfortunate that most adolescents from households affected by AIDS are unable to enjoy the benefits of this **gradual** progress towards adulthood since their lives do not follow even remotely the route of other fortunate adolescents in the world. As a result of critically ill or absent parents, these children are thrust into situations that demand the mental faculties and physical fortitude of adults. They are often required to become caregivers and 'parents' to siblings younger than they are, besides having to create the means to overcome financial problems that they face as a result of their parents being indisposed (UNAIDS/UNICEF 2002:9).

2.3.2. Adolescence

This is a phase of an individual's life and not a duplication of the concept "adolescent", which refers to an individual in a specific age group. Since this chapter deals with a

specific period or phase in a child's life, it is imperative to define this period and the relevant characteristics.

The opinion of Mwamwenda (1995:63) is that the period of adolescence "*ranges from about 12 to about 21years.*" The academic supplements the contention with the notion that this "*fascinating, interesting and challenging*" phase of life is accompanied by development and transformation in the child's physical, social, cognitive, emotional, physiological and psychological characteristics.

Prinsloo and Du Plessis (1998:132) consider that adolescence " *overlaps puberty and represents the phase of physical and mental maturation.*" This is a time of "*internal disquiet*" (Pretorius 2002:31) and obstinacy when the pace of maturity is at a peak. According to Smart and Smart (1977:491), adolescence refers to the period that may extend from about eleven (11) to eighteen (18) years of age in a person' life. The adolescent phase also includes psychological and social changes. Hurlock (1993:222-223) states that early adolescence is approximately the period from age sixteen or seventeen while late adolescence lasts until the age of eighteen.

Pretorius (2002:31) and Gillis (1997:71) divide the period of adolescence further into the following three phases:

a) ***Early adolescence*** (junior high school: 11-14 years): There is rapid physical and sexual maturation

b) ***Middle adolescence*** (senior high school: 14-18 years): A period that displays psychological independence, adaptation and learning to handle heterosexual relationships;

c) ***Late adolescence***: (18-21 years): This stage incorporates the final year(s) at school and moves on to the attainment of a stable sense of individual identity and commitment to ultimate social roles, value systems and aims.

For the purposes of this study, 'adolescence' refers to the period or phase that encompasses young people from the age of 13 to 18 years. This period is accompanied by specific developments in the child, namely, physical, social, cognitive, emotional, connotative, moral, physiological and psychological.

2.4. DEVELOPMENTAL LEVELS OF ADOLESCENCE

Taking into consideration the above definitions, it is important to outline the most outstanding developmental levels of the adolescent.

2.4.1. Cognitive Development

Van Dyk (2001:181) is of the opinion that abstract thoughts, the aptitude to make intelligent assessments, logical deliberation and the self-absorption of the adolescent are all vital facets of any discussion on HIV/AIDS. Adolescents develop the capacity to think about possibilities and assumptions, which are characteristics that allow for the contemplation of future consequences to present actions (Van Dyk 2001:181). This point of view is especially important for the adolescent's deliberation upon the immediate and far-reaching risks or benefits of behaviour.

AIDS may impact negatively on the academic performance of orphans who are affected. The adolescent may experience lowered concentration levels at school as a result of the stress he is exposed to with added responsibilities at home and negative reactions from neighbours, teachers and friends. Such adolescents are less egocentric and display limited or no interest in their schoolwork. Since their parents are either debilitated or have passed on, the adolescents do not enjoy loving care, protection and encouragement that parents normally provide. The absence of such positive support in the adolescent's life may contribute to a negative self-esteem. Should such a situation

arise, it can inhibit his self-actualization - hence his ability to realize his true potentials, abilities and talents is stifled.

2.4.1.1. Concrete Operational Phase

Piaget's phases of cognitive development depict the concrete operational stage as the period between later elementary to the middle school years (Woolfolk 1993:34-37). By this term **"concrete operations",** Piaget refers to "hands-on" thinking. Basically, the adolescent is able to:

- Recognize *the logical stability of the physical world*;
- Appreciate that elements can be altered and still preserve many of their fundamental characteristics;
- Understand that these modifications can be reversed.

Once the child is able to handle operations such as conservation, classification and seriation, the child eventually develops a complete and logical system of thinking. Children at this stage can imagine several different alternatives to a given situation without actually making the changes physically. Nonetheless, such a child is still incapable of logically evaluating theoretical problems relating to the synchronization of many aspects simultaneously (Woolfolk 1993:36-37).

2.4.1.2. Formal Operational Phase

This, by Piaget's (Woolfolk 1993:31-37) stages of cognitive development, is the final stage. Children at this phase are at Junior or Senior High School (Van Dyk 2001:181). These adolescents are competent enough to think in abstract terms and be able to think about probabilities (Van Dyk 2001:181). They are able to think hypothetically and establish possible forthcoming consequences of their current actions. Most adolescents

realize that they cannot solve all their problems by applying concrete operations and that a mental system for controlling sets of variables and working through possibilities is necessary. Hence, the phase of formal operations, when the focus of thinking shifts from what **is** and **what might be.** The **hallmark** of formal operations is **hypothetico-deductive reasoning** – which demands that the adolescent begins by ascertaining all the features that might influence a dilemma and then figures out and assesses precise explanations scientifically. Formal operations also include **inductive reasoning** or the use of unambiguous explanations to pinpoint general principles (Woolfolk 1993:37-38).

The structured, scientific philosophy of formal operations necessitates the methodical creation of distinctive potentials within particular situations. The adolescent's aptitude to deliberate over hypothetical possibilities, isolate all the potential permutations and evaluate personal assessments lead to fascinating conclusions (Woolfolk 1993:38).

2.4.1.3. Scientific thinking

The adolescent's heightened personal and social adventures invariably lead to a more defined ability to consider life rationally and realistically (Hurlock 1973:225). Together with this innovative sense of rationality, the adolescent evolves into a questioning being with reference to his approach to life in general, thinking critically. Sprinthall & Sprinthall (1977:134) allude to the fact that by the time children reach the age of sixteen, which coincides with adolescence, they "*develop full formal patterns of thinking*" and are proficient in the capacity to accomplish rational, conceptual methods. The adolescent's ability to recognize the relationship between theory and evidence and to think scientifically allows for the exclusion of myths and typecasting (Van Dyk 2001:182). The child is therefore able to consider each problem in its entirety and from all perspectives.

However, despite the fact that biological maturation regulates the adolescent's aptitude to achieve the phase of 'formal operations' (Mwamwenda 1995:98) to a great extent, this

realization also depends on the suitability of the child's environment (Mwamwenda 1995:98). Children who have the love, care, protection, support, encouragement and shelter which are vital in their lives, develop a positive self-esteem (Khoza & Xhakaza 2003:33-34). The perception is that children who do not receive the correct environmental inspiration and who come from underprivileged surroundings will fall short in the way of qualitative concepts. Some adolescents become so weighed down when there are destructive encumbrances of any sort that they are unable to make rational decisions or cope with these stresses (Van Dyk 2001:182). Consequently, although the victim of AIDS may develop into a rational, levelheaded adolescent, this can all be ruined completely on the significant absence or death of either parent. At that point the youth is pressurized into the position of custodian, facing conditions that are out of the ordinary and that require the stability and sagacity of an adult.

Generally, there is a tendency among the adolescents to examine social, political and religious systems and values and a direct rejection of hypocrisy (Mussen, Conger, Kagan & Huston 1990:582-583).

2.4.1.4. Adolescent egocentricity

Van Dyk (2001:182) alludes to a key concept that is apparent during adolescence and that is **adolescent egocentricity,** which encompasses the knack of being single-minded, thus becoming exceptionally self-conscious. On the other hand, they can believe that they are special and that their personal encounters are completely different from those of others.

Research conducted earlier by Mussen et al (1990:584) reveals the same results that adolescents become reflective and analytical and could appear to be ego-sensitive, often believing that others too are concerned primarily with them. This creates feelings of self-consciousness (Mussen et al 1990:584). Under normal circumstances, adolescents often experience high levels of confusion and stress, which could affect formation of the self-concept negatively. It is therefore imperative that the effect of HIV/AIDS upon their lives

does not further hinder the formation of positive self-awareness and self-confidence (Van Dyk 2001:189). The stigma and discrimination that often accompany the pandemic (HIV/AIDS) can ultimately lead to a heightened sensitivity and negative self-consciousness under the circumstances distinct from other complex emotions that are normally experienced by adolescents.

2.4.2. Physical Development

Children differ from one to the other in respect of the escalated growth or the escalated height and weight occurring at puberty (Mussen et al 1990:570). This physical development is accompanied by sexual awakening, novel physical changes and a general sense of restlessness accompanied by a heightened self-consciousness (Pretorius 2002:32). The adolescent's awareness of himself will depend primarily upon the way in which his peers and family view the physical transformations that occur (Mwamwenda 1995:68). Mwamwenda (1995:68) states further that cultural expectations for physical looks and aptitude determine whether the self-esteem of the adolescent will be enhanced.

It is important for adolescents to accept their physical changes and appearances. For girls from a Western culture it is important to be slender while in some African cultures it is important for women to have a "fuller" figure. Accepting ones body is very important for the adolescent because it may lead to a disturbed image of the child's own body (Thom, Louw, Van Ede, & Ferns 2001:397). These researchers ((Thom et al 2001:397) uphold that typical failure to accept their bodies (adolescents) as they develop is one of the reasons for a negative self-concept and lack of self-esteem.

The adolescent's physical transformation and growth has a direct bearing upon the social development (Louw, Edwards & Orr 2001:19). Adolescents display a sense of

"social competency" (Hurlock 1973:231) allowing them to behave appropriately under various circumstances and to gain a new self-confidence (Louw et al 2001:19).

In girls, menstruation is a serious concern given that the resultant physical changes together with the discomfort, pain and emotional changes like mood swings and depression, exacerbate the problems for example that the developing adolescent already has. With physical development comes interest in the opposite sex and this also leads to confusion and sensitivity.

Within the context of child-headed households where parents are either dead or incapable of providing supervision and guidance regarding the physical changes occurring at the time, this is a traumatic and confusing period of adaptation for the already disorientated adolescent. Unlike adolescents in households where there are physically and mentally competent parents, the "caretaker" adolescent sees himself as a symbol of authority within this child-headed household. The latter's physical transformation and growth encourages his younger siblings to view him as they would one of the adults who would normally take care of them in their life-world (Van Dyk 2001:9). Impoverished social conditions lead to school drop-outs who are compelled to be at home to take care of ailing parents and perform adult household tasks. Accordingly, Van Dyk's (2001:9) perception is that the adolescent's social development is inhibited since he has the grueling task of being custodian of his siblings and "nurse" to his parents.

Together with this perplexity the adolescent has to deal with the baffling sexual awareness and figure out how to handle this. It is especially crucial to point out this aspect of sexual adjustment, as innocent orphans of AIDS are often victims of sexual abuse stemming from their physical transformation and growth and the nonexistence of adult guardianship.

2.4.3. Emotional Development

Mwamwenda (1995:75-76) believes that the adolescent goes through a multitude of emotive levels in relationships with equals, teachers, families and other members of the

social group. The above physical and mental characteristics justify the reason for the periods of puberty and adolescence being known as the "storm and stress" periods (Hurlock 1973:229). The constant probing intermingled with failure and success, stress, despair, dejection and emotional perplexity produce emotional outbursts and emotional stress (Hurlock 1973:229).

Adolescents' single-minded obsession with regard to themselves consequently results in apprehension, remorse and sometimes humiliation (Van Dyk 2001:183). Van Dyk (2001:183) is of the view that if the adolescents are exposed to or affected by the virus, they can go through negative emotions, mood swings, angry outbursts, which may be followed by feelings of anxiety, guilt, shame and embarrassment. The youth is bombarded by a multitude of emotional fluctuations from exuberance of a great social life to loneliness, disparagement and inferiority (Pretorius 2002:33-34). Orphans of AIDS are often discriminated against during the parents' or caregivers' period of illness. They are vulnerable after the death of the parent or caregiver and may become the innocent victims of discrimination, stigma and abuse.

A study of 1219 adolescents in 1999 by Lewis and Frydenberg (2002: 419-420) confirms that the adolescent's skill to handle stress is important for the physical fitness and enthusiasm of the individual. Should the adolescent's coping strategies be ineffective this will lead to damaging social and emotional upheavals. The conclusions reached on completion of the study indicated that the adolescent's "*failure to cope triggers off increased coping activities of all kinds and that over-use of non-productive strategies interferes with the capacity to use productive coping.*"

The emotional tension at this phase could be attributed to the theory that adolescent boys and girls see themselves as being under extreme social pressure (Mussen et al 1990:229). Many adolescents may be emotionally or mentally ill equipped to handle the confusing situations that they are confronted with. However, the degree of emotional instability and trauma will differ according to each youth and according to the stimuli

that give rise to them. The manner in which each will handle these stresses will vary from sullen silences to unruly criticism. This period is also marked by incidents highlighting varying degrees of emotional maturity when they are compelled to get a proper perspective on issues thus learning to avoid emotional outbursts typical of this age-group (Mussen et al 1990:229).

Emotional stability is achieved when they are cleared of pent-up emotional energy in their middle adolescence (Hurlock 1973:230). At this stage, adolescents are finally able to reason in diverse ways and demonstrate profound insight into their personal feelings as well as those of others (Van Dyk 2001:183). Van Dyk (2001:183) also concludes that the heightened emotion that exists in the early adolescents reduces annually until emotional adulthood is achieved.

According to Gouws & Kruger (1996:94) adolescents experience the following emotions:

- Anxiety: This could be fear of something, which cannot be determined.
- Guilt: This could be due to conflict between an adolescent's values and behaviour.
- Aggression: This could serve a positive force or negative force if the adolescent cannot control himself – showing that he is being rejected or feels uncertain.
- Wrath and quarrelsomeness: This could happen due to an unsuccessful strife for independence, which makes the adolescent angry and frustrates him.
- Jealousy and spitefulness: This can happen as a result of material things, sport and academic achievement of others or even because of popularity.

It is difficult to imagine that adolescents orphaned by AIDS, often without prior warning, must deal with the issues of growing up while they cope with unusual adult responsibilities in child-headed households, the fear of abandonment, rejection and death.

Landry and Smith (1998:9) consider that adolescents need to cope not only with their own development, but also with the poor health and looming death of at least one parent. HIV/AIDS may cause social-emotional dysfunction within adolescents, which can be related to a lack of interest in life, an inhibited sense of purpose, apathy and a weakened socio-emotional expression The direct effect of the latter depends on the situation at home (ailing parents or parents who have passed on), the development level of the child and the availability of social support (Landry & Smith 1998:160-168).

The adolescents in this situation have to face psychological and financial stresses as a result of the lack of parental support. Adolescents orphaned by AIDS often have difficulty relating to and trusting others, have a poor self-image and feel helpless and fearful (Khoza & Xhakaza 2003:32). Feelings of dejection, listlessness, a desire to be alone and sleeplessness may develop and cause depression (Hartzell 1984:1-9). Some adolescents are worried and preoccupied with the problems they face at home. Under normal circumstances many adolescents are ill equipped to handle conflicting emotions – it is difficult to consider how they cope with such dramatic changes in the face of HIV/AIDS (Hartzell 1984:1-9).

2.4.4. Moral Development

For the development of the adolescent's personal value system, he must be critical of existing values and decide which are acceptable to him (Van Dyk 2001:183). Abstract thinking will allow the adolescent to accept that each person thinks differently and to approach moral issues responsibly. According to Van Dyk (2001:183), '**principled moral reasoning**' consents to the acknowledgment of varied interpretations of differences of opinion. Adolescents consequently prefer to champion personal and civil rights that endorse a value system beneficial to the entire community (Van Dyk 2001:183).

Moral options that an adolescent may consider appropriate may not always be in harmony with the tried and tested moral norms established by his parents. Adherence to these moral principles and the extent to which he will contravene these will depend upon the personal ability to conceptualize moral issues and also upon the parent-child relationship that exists (Mussen et al 1990:642-643). At most times such behaviour leads to a contradiction of the norms and conflict with authority figures (Prinsloo & Du Plessis 1998:150-152).

Inspired by Piaget, Lawrence Kohlberg (Woolfolk 1993:79-81) projected a series of points of proper moral reasoning on three planes:

- **Pre-conventional**: a stance whereby conclusions are established exclusively on a person's individual wants and perspicacity;
- **Conventional**: where the viewpoint of the general public and the law are taken respect; and
- **Post-conventional**: where declarations are established on conceptual, individual philosophies that are not automatically demarcated by the regulations of that society.

Moral reasoning is allied to both cognitive as well as emotional development (Woolfolk 1993:81). Specifically formal operations and empathy are predominant in the progress through Kohlberg's stages. Abstract ideas become progressively more significant in the higher stages of moral development. Empathy and the faculty to perceive another's point of view and to visualize other foundations for laws and rules come about from adolescence onwards. This gives rise to sharing with others, being of assistance to others and protecting others (Woolfolk 1993:83).

Berk (1997:498) maintains that Kohlberg's stages are clearly associated with age. However, cross-cultural research suggests that certain levels of communal complexity are necessary for the success of the higher stages. The wisdom of moral reasoning is

somewhat linked to varied moral conduct. An amalgamation of an adolescent's personal disposition and the way he is nurtured lead to unassuming steadiness in moral self-determination from childhood to adolescence (Berk 1997:498).

It is difficult (yet not impossible) for adolescents in child-headed households to develop personal value systems and moral reasoning without the guidance of significant adults in their life-worlds (Berk 1997:498). HIV/AIDS can influence the adolescent's quality of life – the choice between right and wrong lies with himself. Life-skills programmes can assist the adolescents to identify risk behaviour and protect themselves from the dangers of sexual promiscuity, which could lead to HIV/AIDS (Berk 1997:498).

Rebellious conduct amongst adolescents is frequently the consequence of a family atmosphere in which there is constant conflict, where hostile activities are the order of the day, where there is extensive indigence together with a bleak living environment and cultural veneration of brutality (Berk 1997:498).

Generally, in child-headed households, adolescents who are affected by AIDS, lack the wholesome guidance and supervision that lead to morally upright behaviour. Should their parents have inculcated such behaviour within them during their childhood, the adolescents are able to maintain the morally respectable conduct of the past.

2.4.5. Social Development

2.4.5.1. Peer-Group Influence

A change in the youth's perception that parental approval is always of sole importance stems from the fact that the acceptability by his peers at especially secondary school level holds far more weight. The family influence in the adolescent's life decreases and approval of the peer group becomes essential for fear of being isolated from the group

(Louw et al 2001:19). However, even though they meet with parental disapproval, they follow the group's lead in many respects (Prinsloo & Du Plessis 1998:40). This association with others in the same age group proves to be beneficial for various reasons such as assisting with becoming liberated from one's parents and emergent social skills to deal with family, the community and colleagues in the future (Mwamwenda 1995:71). Varying cultural practices dictate the rate at which sexual activity begins. However, adolescence does lead to the urge towards emotional intimacy between the sexes (Hurlock 1973:228).

The need to be socially acceptable combines with the need for intimacy with the opposite sex – thus the perfect arena for social practice in this phase of their lives (Hurlock 1973:228). Just as physical looks, the body, scholastic success, excellence in sports and social skills are important at puberty, this also holds true during adolescence. A hectic social life is indicative not only of popularity but acceptance. The adolescent's search for self-identity is facilitated by the social interaction with the peer group which provides enlightenment on certain aspects of life as they are all experiencing similar problems (Mwamwenda 1995:71). Interaction with the peer groups may also help the adolescent to compete with them as an indication of his own abilities.

To the youth, the peer group acts as the source of reference that sways behaviour and actions persuasively (Prinsloo & Du Plessis 1998:42). Copley (1993:101) states that the "gang" or group sometimes promotes destructive tendencies and controls the likes, dislikes and interests of the youth. A further explanation states that apart from norms that define acceptable behaviour, the peer group also assists the adolescent to ascertain gender roles and reactions. Prinsloo (1998:42) holds that even though peer groups wield pressure to conform, they facilitate affable companionship, cooperation and mutual understanding. Nevertheless, this needs to become a balanced process since excessiveness in either direction could result in severe problems later. Mwamwenda (1995:72) declares that there are those adolescents who are conventional in their outlook - consenting to and appreciating the meaning and objectives of norms, ethics, aspirations, procedures and conventions.

However, Hurlock (1993: 231) is of the opinion that *"as adolescence progresses, peer-group influence begins to wane"*. This occurs for two reasons. Firstly, since the need for social identity supersedes the need to conform to the peer group – hence the influence begins to diminish. The other reason is that the adolescent gradually begins to stay away from large groups, displaying a preference for smaller, closer friendships.

The above scenario is definitely not what one finds within the framework of the child-headed home which is the focus of this study. Once the adolescent takes the role of head of the household and caregiver to his parents and other ailing family members, the peer group may segregate and snub him/her (Louw et al 2001:19). These children are rejected by the very peers who would have influenced them positively had they not been exposed to the shame and discrimination of being part of an AIDS-affected family. Louw et al (2001:19) are also of the view that the adolescent who finds it almost impossible to belong to a social group displays signs of losing his/her identity within the context of the home, extended family, society and school for this reason.

2.4.5.2. Changes in Social Behaviour

Whereas the earlier years depicted a dislike for the opposite sex, adolescence highlights the total opposite where the youth look forward to social activities that are heterosexual in nature (Hurlock 1973:231). Hurlock (1973:231) purports that the novel attitude towards the opposite sex invariably leads to better understanding of one another regardless of the sex and more amiable social relations. Personal attitudes towards different groups, cultures and races will depend upon the influence of the environment, parents, friends and associates. Hurlock's (1973:231) opinion is that when the adolescent is involved in activities between different groups, the process exhibits the ability to adapt and display a greater sense of tolerance of individual differences.

Many adolescents from HIV/AIDS-affected families experience discrimination and victimization from schools (Coombe 2002c). This causes the orphaned adolescent to withdraw from the school and society and to avoid socializing with his peers. His life becomes lonely and isolated since the important source of support in the form of his friends and peers, disappears. Due to the nature of the disease (HIV/AIDS), many orphans wrestle with the secrecy and disclosure (Coombe 2002c). He does not have the freedom and support structure to express his emotional conflicts with his friends. This leaves him lonely and helpless (Coombe 2002c).

Interaction could sometimes lead to confrontation, hostility and distorted communications (Prinsloo & Du Plessis 1998:46). Prinsloo and Du Plessis (1998:46) continue the argument by stating that groups belonging to similar cultures will invariably be able to predict and understand the behaviour of others within the group. Findings from these researchers (Prinsloo & Du Plessis 1998:46) proved that contact and interaction between different cultural groups assists the youth in the elimination of prejudices and tensions.

Lightfoot and Healy's (2001:484-489) view is that adolescents who are orphaned by AIDS and who do not have a support system, experience their condition as well as their circumstances negatively, whereas AIDS orphans who have strong support tend to live positively according to their set goals.

Battles and Wiener (2002:161-168) verified that the wider the adolescent's social network is, the less negative is his behaviour. Although the support of his classmates and friends have a positive effect on the adolescent, the support of adults like his parents and teachers has a more constant influence upon the adolescent. This form of support assists the adolescent against depression and isolation and improves his self-worth. Research by Battles and Wiener (2002:161-168) has found that "*perceived social support from both familial and non-familial contacts (classmates, teachers and friends) explained a significant amount of the variance in psychological adaptation*".

2.4.5.3. Family Relationships

The tension and conflict that results among parents and the adolescent children is almost inevitable. Neither side can be held responsible for the friction, since rapidly changing ideology, standards and culture lead to total misunderstanding between the two groups. Adolescents appear to find it difficult to communicate with their "out-dated" parents while the latter consider their children's objections and failure to toe the line as a sign of blatant rudeness.

The adolescent seeks independence and autonomy and questions his parents' values, interests, attitudes and opinions as he seeks for his own. This may lead to a conflict between parent and adolescent but the nurturing background of the parent determines to a great extent the level of conflict between parent and adolescent.

Mwamwenda (1995:72-73) considers the conflict between parent and adolescent to be an affirmation of the child's independent lifestyle and that the parents invariably have a greater sway upon the adolescent's morals, professional options and political philosophy while peers shape the adolescent's physical appearance and group interaction. Should the viewpoint of Mwamwenda be taken seriously, it stands to reason that adolescents who are orphaned by AIDS will find it almost difficult to realize their personal ambitions without parental support. Although these children are left to their own devices and placed in positions of authority somewhat prematurely this does not mean that the task is pleasurable. The adolescents have to deal with emotional turmoil and nervous tension that no youngster under normal circumstances would. In most cases the parents are either too ill or have passed on and cannot provide the moral encouragement that the child so requires for effective social integration or socialization.

Older adolescents also appear to want to exercise the same degree of control over younger siblings and until some compromise is reached there will be constant

disagreement and rivalry. Sibling rivalry is also a spot of bother requiring an understanding between them to reduce the tension (Hurlock 1973:250-251). Conflict between siblings depends largely on the order of birth, gender and age differences (Gouws & Kruger 1996:110).

Once a sibling is accepted as head of the child-headed household, his image as a "co-opted" parent is entrenched. Although there is a sense of assertiveness on the part of the "head", this is not an authoritative relationship. Since the children are left to their own devices they seek comfort in one another and they are caring, tolerant, warm and supportive. Conflict appears to arise only if there is a threat to the general well being of the household (Mwamwenda 1995:72-73).

The opinion of Landry and Smith (1998:5) is that those families affected by HIV/AIDS often require professionals who can support the children with social services and the assessment of overall neurological and physical health. Their perception is that these interventions follow the child's developmental progress and pave the way for physical, social or psychological therapy that may be necessary. Should one of the parents be critically ill then the developmental outcomes differ with the adolescent being exposed to various unusual stressors such as financial restraints and care giving. In conjunction with this is the fact that; should the adolescent be HIV positive, he/she may need a range of rehabilitative and educational facilities to aid the learning process (Landry & Smith 1998:5).

The deprived adolescents do not have the advantage of benefiting from their parent's advice and approval regarding long-term plans, nor their guidance to form ethical standards and a morally upright belief system. They are pressurized by commitments to ailing parents and to their siblings to absent themselves from school or to drop out completely and invariably have less time for socializing with their friends. The adolescent's new responsibilities, the sudden change in family roles and the

accompanied stigma to HIV/AIDS results in his withdrawal socially from his friends and society.

2.4.6. Connotative Development

Every adolescent desires the freedom of choice in decision-making in order to accomplish his aspirations (Gouws & Kruger 1996:145-146). These are individuals whose desire to become adults is motivated by the potential to exercise the free will to make the decisions that are acceptable to him. Thus, the adolescent is always emotionally, cognitively and connotatively involved in making his own decisions.

Orphans of AIDS are like all other adolescents who covet the wealth, success, stability and perhaps eminence of thriving adulthood. They wish to become responsible adults who prosper in the working world. Much to their disappointment, their aspirations may be curbed by the fact that they do not have any parents, they live in the dire poverty, their educational progress can be hampered by the lack of funds to purchase uniforms and they may become socially isolated due to the stigma attached to HIV/AIDS (Mwamwenda 1995:72-73).

2.4.6.1. Striving for Emancipation

The ultimate goal of the identity-seeking adolescent is to be emancipated and self-sufficient. In order to make unlimited strides toward being self-supporting and free of adult authority symbols they work towards achieving emotional and social liberation. Adolescents want to be independent but are nonetheless dependent on their parents. Should their parents and educators be acceptable role models, they will fashion their lives and identities around these adults, seeking to take responsibility for their own decisions and actions without fear of reprimand (Pretorius 2002:36).

Adolescents strive to shed the excessive domination by authority figures in their lives and slowly become more self-sufficient and autonomous. They avoid the extreme domination generally exerted by parents and educators and strive to exercise self-affirmation and emancipation. Should there have previously been disproportionate power, the result will be a developmental battle between dependence and independence within the youth. In the main adolescents want to demonstrate the ability to be rational in thought and action, making sensible choices according to their own norms and values that hopefully coincide with those of their role models (Pretorius 2002:36).

However, there are instances when the youth prefer to engage in exciting new experiences far removed from their mundane daily lives. This will promote new forms of consciousness and involvement in unusual events. Moral options that an adolescent may consider appropriate may not always be in harmony with the tried and tested moral norms established by his parents. Adherence to these moral principles and the extent to which he will contravene these will depend upon the personal ability to conceptualize moral issues and also upon the parent-child relationship that exists (Mussen 1990:642-643). At most times such behaviour leads to a contradiction of the norms and conflict with authority figures (Prinsloo & Du Plessis 1998:150-152).

Like other adolescents, the adolescent in a child-headed household is also ambitious and strives towards one day becoming a responsible working adult with a family. Unfortunately, his efforts might be thwarted by the fact that he has no parents, he is growing up under the most poverty-stricken and stigmatized conditions and he might not be able to complete his schooling.

The notion of emancipation that is hankered after by adolescents universally is thrust upon the unsuspecting orphan in an AIDS-affected, child-headed household. There is no adult authority-figure in these surroundings and the freedom the child 'enjoys' is certainly not what he has aspired towards. This situation inhibits his emancipation and

self-actualization because the lack of parental support and guidance does not allow him to realize his potentials.

2.5.1. SELF-ACTUALISATION AND FULFILMENT OF NEEDS

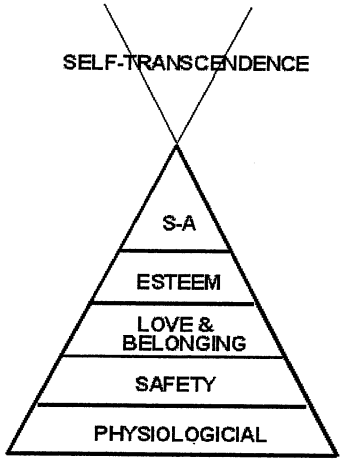
According to Abraham Maslow, **self-actualisation** is regarded as "***the optimal realization of a child's talents, abilities and potentials once his physiological, social and security needs have been met***" (Prinsloo & Du Plessis 1998:16).

Each child has an inherent desire to actualize his potential to the fullest (Pretorius 1994:20-21) by:

- Searching for growth experiences;
- Needing to grow;
- Becoming (including becoming an adult);
- Functioning as fully as possible;
- Uplifting yourself;
- Wanting to do it yourself;
- Wanting to become someone yourself;
- Striving for emancipation (independence);
- Changing in a positive way; and
- Learning, knowing and understanding.

Fulfillment of the child's needs is facilitated by the child's social context particularly his social and educational situations and guidance and requires that basic needs are met before the fulfillment of other needs (Pretorius 1994:30-31; Le Roux 1992:4;) as depicted by the graphic below – Figure 2 (Daniels 2001:4). Hence the child should be encouraged to strive towards the fulfillment of higher needs at each stage. The **hierarchy of needs**, as outlined by Maslow (Prinsloo & Du Plessis 1998:16;), is depicted thus:

Figure 2.1. Maslow's Hierarchy of Needs



SOURCE: Daniels (2001:4)

Accordingly the child's basic needs are:

- **Physiological or physical needs**: the needs for water, nutrition, rest, etc;
- **The need for safety or security**: the need to feel safe and free from danger;
- **Social needs**: the need for security and a feeling of belonging, to be loved and cared for;
- **Esteem or I-needs**: basically socio-affective needs that lead to self-confidence and a positive self-concept and involves the need for personal value, to be acknowledged and respected, to feel valuable and important; and
- **Need for self-actualization**: striving to realize one's full potential – to know and to understand and the meeting of cognitive needs.

Within a social milieu (Pretorius 1994:32) involving the family, the school and society, the child's life is influenced and develops as it is influenced in the pursuit of self-realization.

2.5.2. IDENTITY ACQUISITION

Sprinthall and Sprinthall (1977:211) expound the issue of identity acquisition most accurately when they declare that this period is "*like entering a foreign country without knowing the language, the customs, or the culture, only its worse because the teenager doesn't even have a guidebook.*" The manner in which the adolescent sees him/herself will form the basis of his adult personality. Erikson is of the view that a tough, concrete foundation will create a stable self-identity and not an eternally rootless identity (Sprinthall & Sprinthall 1977:211). The "*storm and stress*" of adolescence and the passionate need for seclusion guide the young person's sense of introspection and self-discovery. The early stages of puberty are especially noted for this but a changed social behaviour develops as adolescence progresses (Pretorius 2002:34).

Pretorius (2002:34) further states that greater self-awareness leads to the following typical questions:

- *Who am I?*
- *What am I like?*
- *Where do I fit in?*
- *Where am I going?*
- *What is the meaning of my personal life?*

The process of analysis and acquisition of these answers lead to a **personal identity** and development (Pretorius 2002:34).

Copley (1993:97) considers that the adolescent's sense of identity is connected to instinctive systems of association with others in the internal or external world. Prinsloo and Du Plessis (1998:148) refer to Erikson's concepts of the *period of identity crisis"* when these young individuals attempt to determine personal identities that will prevent role confusion later. The adolescent is compelled to deal with "*internal, cognitive, and glandular*" developments while trying to confront various inconsistent and changing external regulations (Sprinthall & Sprinthall 1977:211). The assertion continues in the vein that the self-identity progresses and stabilizes during the period of adolescence.

Mussen, Conger, Kagan, & Huston (1990:622) confirm that a period of active searching and confusion invariably leads to a strong sense of identity and such individuals are likely to become more independent, innovative and diverse thinkers. Prinsloo and Du Plessis (1998:148) further emphasize Erikson's concepts of ***identity foreclosure*** and ***identity confusion***. *"**Identity foreclosure** is an interruption in the process of identity formation."* Such youth are more stereotyped and shallow, concentrating on religious morals and are distinctly approval-motivated, building their self-respect largely upon the deference and opinions of others. Although there may be little or no difference between these adolescents and their peers with reference to intelligence, they display a sense of rigidity in response to nerve-racking cognitive tasks (Mussen et al 1990:621). In the case of ***identity confusion,*** adolescents have low confidence, childish moral reasoning, are generally impetuous and lack cognitive skills. These youth are theoretically labeled as those who never *"find themselves"* displaying inconsistent loyalties and avoid commitments (Mussen et al 1990:621).

The adolescent's self-discovery and acquisition of a particular identity will be determined by the important example set by mature adults whom the former can identify with (Mussen et al 1990:621). Taking into account the situation of the adolescent orphans of AIDS in child-headed households, it is reasonable to conclude that the parents are often gravely ill or that one or both have passed on and can no longer influence the identity of the child positively during these crucial years.

Prinsloo and Du Plessis (1998-148) propose that an adolescent (youth) is an individual in his own right. This distinctiveness of each one will determine the extent to which each has the potential for the fulfillment of ***"self-actualization or self destruction."*** The intimate self-consciousness of the adolescent leads to gradual self-discovery as with any mentally fit individual. Hence, the self-concept or self-identity is formulated via personal insight into oneself. A heightened self-esteem does not necessarily mean that the adolescent is an exceptional success in all fields of participation but rather that he is more self-assured in those activities that he usually excels at. Attitudes of educators and parents can assist the individual to construe disappointment appropriately and not in a manner in which "self-esteem" or "self-acceptance" may be destroyed (Vrey 1979:61). For the adolescent in a child-headed household the process of "self-actualization" or the realization of the adolescent's potentialities, abilities and talents will be constrained by his personal conditions, which are restricted by poverty and the lack of parental or adult supervision (Vrey 1979:61).

Pretorius (2002:38) advocates that the attainment of identity is both a social as well as a pedagogical concern since it is attained as a result of intelligent intermingling with significant others especially educators and parents, who act as solid influences. This personal identity also stems from the individual conception of how others "see" and accept them and will be negligible without this social milieu. The assertion by Prinsloo & Du Plessis (1998:149) is that usually adolescents are drastically affected by certain adverse factors when there is an identity crisis. These may be:

- *Radical changes in the home situation, family, the school and society;*
- *Inadequate guidance during the early stages of identity acquisition;*
- *Contact inflation;*
- *A mass culture;*
- *The authority crisis;*
- *Alienation;*
- *The crisis of norms and religion.*

The above factors could be detrimental to the adolescent's successful attainment of the self-identity hampering his self-assurance, interaction, identification, self-image and uncovering and actualization of meaning (Prinsloo & Du Plessis 1998:149). This may result in isolation, an ineffective future and inadequate communication skills. In view of the tribulations the AIDS-affected adolescent is subjected to the above descriptions aptly express the reasons why this child will be unable to achieve a positive self-identity. Academics such as Coombe (2002c:122) and Barrett (2002:5) who are cited in Chapter 1, have fittingly illustrated the anguish that these orphans undergo.

Under normal circumstances the adolescent seeks fundamental symbols of reference and boundaries in order to construct an astute and consequential perspective of the world and a tangible self-identity. Displaying a sense of responsibility on the path to self-acquisition, they appreciate themselves as "fact" and as "now" and exercise " freedom of choice" (Pretorius 2002:36). Pretorius (2002:36) further expostulates that adolescents discover a gist of their own lives in the context of being responsible and *"in the task-based character of their existence."* Even a relationship with God can provide the depth of meaning to the youth's lives.

Pretorius (2002:36) further illustrates the educator's duty in the process of assisting the adolescent on the way to his/her attainment of personal identity:

- *Transferring norms and values*
- *Raising the adolescent's awareness of personal responsibility*
- *Shaping the conscience*
- *Shaping the sense of responsibility*
- *Assistance with the attainment of independence and the discovery of personal freedom*
- *Helping to interpret the meaning of things that happen in the world at large as well as in the personal life*
- *Supporting by means of religious interaction*

Adolescents affected by HIV/AIDS have the same dreams and aspirations that others in their age group do (Louw et al 2001:22). However, their levels of anxiety are higher and they begin to perceive themselves as being different from their peers as a result of the virus. This eventually results in a feeling of hopelessness and negative self-worth (Louw et al 2001:22).

2.6. DEVELOPMENTAL TASKS DURING ADOLESCENCE

The period of adolescence focuses on evolving into responsible adults – hence the developmental tasks of this period demand preparation for adulthood. These children attempt to move away from juvenile behaviour and way of thinking. This is an exacting task and not all girls and boys in this age group of 13 to 18 master these and this is especially true of late maturers. The changes that should be made are not automatic and mastering these tasks results in a maturity that allows the young adult to deal with the stresses of early adulthood (Hurlock 1973:225).

The discussion that follows will refer to the developmental tasks:

2.6.1. Achieving new and mature relations with age-mates of both sexes:

Sexual maturation is achieved during adolescence and requires that girls and boys should begin to see themselves as women and men respectively. Pretorius (2002:380) emphasizes the need for these adults-to-be to exercise more collaboration towards fulfilling common objectives and to be less relentless in their need for control and their attitudes towards others. The influence of the school upon the lives of these youth is of all importance since adolescents begin to pattern their behaviour of the role models here. Early adolescence displays a tendency to identify with friends of the same sex including activities and socials representative of a mini-society.

Late adolescence results in an interest in the opposite sex and involvement in the activities that include both sexes. There is a need to acquire approval of the opposite sex and relationships move towards being romantic in nature (Hurlock 1973:245). The appreciation of the peer group controls the actions of the adolescents, since they want to be part of the group and will, on the outside, resort to similar dressing, hairstyles and language use to do this. However, within them, they will remain as individuals. It is imperative for the adolescent to develop adequately socially as any shortcoming here could result in an insecure unhappy adult life. Individuals who lack cooperative skills can later experience severe marital conflicts, childish dependency or willful domination (Pretorius 2002:39).

Hurlock's view (1993:226) is that together with parents, schools and colleges are apt institutions for adolescents to attain the necessary expertise and know-how for successful and significant social development. They create the means whereby the children are able to participate in get-togethers that will enhance sociability.

Pretorius (2002:39) quotes Duvall and Miller's opinions regarding those tasks that adolescents ought to be engaged in:

- *Becoming an acceptable member of one or more groups of peers*
- *Making friends with members of both sexes*
- *Going out with a girlfriend/boyfriend and handle social situations in a relaxed way*
- *Experiencing loving and being loved in love relationships, with or without pre-marital sex*
- *Adapting to the peer group at school, in the neighbourhood and society*
- *Acquiring social skills (problem resolution, handling conflict, making decisions and evaluation of social experiences)*
- *Achieving a strong emotional bond with a possible future marriage partner.*

Chapter 1 of this research study explicates that it is quite difficult in South Africa for most adolescent AIDS orphans in child-headed households to have the benefit of peer group approval, to be fortunate to have affectionate social associations or to experience intense meaningful attachments with members of the opposite sex. This is in consequence of the children being ostracized by their peers for being a part of AIDS-affected families even if the adolescents themselves are not HIV-positive.

2.6.2. Achieving a masculine or feminine social role:

Within the particular culture that they belong to, girls and boys are compelled to identify realistically with what it means to belong to each sex and what sex roles will be approved of by that said community. From puberty boys are encouraged to display their "powerful" male roles while girls accept their "weaker sex" appeal (Hurlock1993: 248).

Pretorius (2002:39) is critical of the age-old theory that a boy can look forward to the prestige of being a man in his society while the girl has to resign herself to the mediocre role of wife and mother. However, there are an increasing number of girls who are shedding these beliefs by accepting top posts that give them more freedom of choice and new opportunities without sacrificing marriage. Both male and female roles have changed dramatically of recent providing a more democratic role for the new-age female. The introduction of women into the labour force has lead to an enhanced status, uninhibited sexual behaviour and marriage with children for these women. Roles that were previously frowned upon by traditionalists are being accepted more often than not and involve greater assistance around the home by the "boys" (Pretorius 2002:40).

In some child-headed households the orphans are compelled to replace the authority figure with the eldest female child should there be no one else to assume the role. She is compelled to take over the traditional role of a mother. This enhanced status emerges prematurely but the girls are nevertheless expected to take control of their parents' homes, exercise the necessary control and make important decisions. Although this is not

customary in most cultural groups, these young children have to take charge of younger siblings and find appropriate channels to provide for the families well being (UNAIDS/UNICEF 2002:9). Should there be no females in the families, the eldest boys are often required to adopt these adult roles, dropping out of school and seeking employment to keep their families going.

2.6.3. Accepting one's physique and using one's body effectively:

Definite physical changes that appear at an accelerated pace during puberty result in maturity of build as well as sexual individuality in the adolescent stage. By the latter phase the youth is able to discern what he will look like physically as an adult. Generally girls between 13 and16 display a tendency to develop faster than boys physically and are also more mature than boys of the same age. Individual differences should, however be taken into account (Pretorius 2002:40).

Adults may consider the adolescent's obsession with his appearance somewhat abnormal but it is a vital part of the adolescent's self-concept and will affect the self-concept negatively or positively as the case may be (Vrey 1979:168). It would appear that every society places great value upon what each considers an attractive physical appearance and adolescents assess themselves thus making constant comparisons in the process. Pretorius (2002:40) considers that this personal estimation of the adolescent, which may be a *source of interest, pride, security, doubt, worry, a high or low self-concept* could be the cause of behavioural and learning problems at a later stage.
According to Pretorius the following developmental tasks concerning the physique of the adolescent are particularly important:

- *Acceptance of the "new, changed body*
- *Accepting as normal physical differences between the self and peer group members of the same and opposite sex*

- *Understanding of the implications of changes during puberty, together with healthy anticipation of maturity as man or woman*
- *Caring for the own body for the sake of health, optimal development and acceptance by others*
- *Acquisition of physical skills necessary for a variety of recreational, social and family situations*
- *Reorganization of the self-concept and acceptance of the own appearance and physical changes (Pretorius 2002:40).*

The adolescent orphaned by AIDS, who is automatically slotted in as head of a child-headed household, has no guidance and support as to how he ought to be adapting to accept his changing body. He is compelled to develop the skills to focus on himself while he also discovers the skills to take care of his siblings. Lack of guidance on how to be assertive and responsible may result in the abuse of the orphaned adolescent.

2.6.4. Desiring, accepting and achieving socially responsible behaviour:

Vrey (1979:170) maintains that an adolescent who is not accepted positively often displays temperamental and apprehensive behaviour. It is therefore of the essence that the adolescent is able to develop a positive self-concept by reacting confidently in his relationships and optimistically towards his aspirations. The adolescent does not necessarily categorize his desires and actions in order to achieve "*self-actualization*" but he needs to "*understand*" and motivate him towards "*personal adequacy*" – hence should the adolescent feel that he "*belongs*", and that he is accepted by "*the people he values*", his attempts to be socially acceptable are successful (Vrey 1979:166). Since the *older* (above 18) adolescent is afforded the chance to acquire wider prospects during social participation the youth's *"social insight"* is heightened and he becomes more discerning in his assessments of other members of the group. The adolescent is also in better control of his actions and is able to reach more acceptable standards with reference to desirable

behaviour. As a result of the level of maturity the adolescent is able to be more responsible in the manner in which he conducts himself. Adolescents begin to mould their behaviour to conform to the expectations of the moral codes as laid down by figures of authority. They ought to be able to control their previous impulsive behavioural mishaps of puberty and early adolescence and make educated decisions (Hurlock 1973: 242).

The development of enhanced social, political, ethical and religious ideals ought to be born at this stage. Pretorius (2002:40-41) applies the opinion of Havighurst in order to hypothesize the "basic change in ideology":

"*As social and economic change has speeded up during the past hundred years, the proportion of the ideology of the adult generation which intellectually active adolescents can easily accept is growing smaller. They must examine critically the reigning ideology of their parents and their teachers. The traditional ideology is no longer credible.*"

In the child-headed household, the orphan is deprived of a suitable figure of authority that can guide him towards a correct code of conduct. The development of such an adolescent's self-concept is determined by whether or not he is accepted positively by others who can contribute to the formation thereof. Should the orphan suffer the stigma and discrimination that normally accompanies HIV/AIDS, this could result in anti-social behaviour.

2.6.5. Achieving emotional independence from parents and other adults:

Pretorius (2002:41) upholds the theory that it is imperative for adolescents to free themselves from the earlier ties with their parents to some extent and develop into self-sufficient thinking individuals. The emancipation of a child is intricate and requires that the adolescent acquire the expertise necessary to be competent in an adult world (Very 1979:175). Neither parent nor child will find this a painless task since it will involve the

release of the adolescent into the strange world of adulthood and a release from the protected environment of home. The adolescent wishes to become self-sufficient, but is fearful. On the other hand the parent wants his child to achieve this independence but is afraid of what could happen to such a naive individual. Such a situation could produce conflicting outcomes where the adolescent may become rebellious towards the interfering parent or the adolescent could succumb to fear against the wishes of his parents (Pretorius 2002:41).

Should the adolescent come from an austere home environment, with little freedom, he may direct the revolt towards the school and teachers in order to assert himself. If the adolescent is unable to execute this task successfully, they often become maladjusted, inadequate decision-makers, needy adults reliant upon parental guidance and emotionally immature. Vrey (1979:175) upholds that in order for the adolescent to be able to make "*independent moral judgements*" and to take "*responsibility*" for his own decisions, there has to be a useful sense of direction in relation to the outside world and the formation of a "*functional life-world*". Pretorius (2002:41) extends this theory by providing two main factors that result in conflict in this developmental task within the context of modern Western society:

- Should the pace of social transformation in the form of activity and standards be too fast for the older generation, this will result in a generation gap.
- Despite the urgent need to be independent, some adolescents are sometimes compelled to reside at the family home for extended periods prior to marriage because of the lack of financial independence (2002:41).

Pretorius (2002:41) continues by outlining the two phenomena that teachers and parents consider to have an adverse effect upon this developmental task:

- Student activism – which leans towards socio-political change and freedom of speech for the youth
- Student apathy – revolves around the "drop-out" phenomenon when pupils or students abort their studies.

The theory of Vrey (1979:177) illustrates that the nature of the adolescent's relations with the parents are the determining factors when considering the success or otherwise of the adolescent's progress towards self-sufficiency. The "unconditional acceptance" of the parents and the security afforded by them through times of stress can help stabilize the individual.

2.6.6. Preparing for an economic career:

The most important symbol of maturity apart from selecting personal items and intimate friends is being able to earn a salary. The stance held by Pretorius (2002:42) is that modern Western society does not readily permit adolescents to act independently as adults.

Pretorius (2002:42) alludes to research that maintains that within the age group 15-20 there is a general preoccupation with career planning and preparation. The adolescent ought to narrow the gap between childhood and the adult's economic system by moving positively towards financial sustainability.
It is essential that adolescents accomplish the following in order to complete this developmental task:

- Begin a career that will encourage responsibility, apply acquired knowledge and the necessary skill and work energetically towards profitable avenues
- Be explicit about ones sex-role in respect of anticipated work and family

- Realistically select possible professions bearing in mind personal interests, capabilities and opportunities
- Work diligently in the direction of specialization and obtaining and keeping a particular position (Pretorius 2002:43).

An orphan of AIDS in a child-headed household might face a bleak future since he will be unable to look forward to the stability and success of proper employment if he is unable to acquire the financial and emotional support while he is still at school.

2.6.7. Preparing for marriage and family life:

The attraction that develops for the opposite sex during early adolescence grows stronger later and forms a starting point for marriage. The adolescent is then required to develop a congenial stance with regard to a family life and having children. Females especially need to learn about family management. Individual ideals and current trends in society will determine the stance each adolescent will adopt towards marriage. Predominantly attitudes are normal but strongly influenced by personal family experiences during childhood. Pretorius (2002:42) states that similar social backgrounds will lead to successful marriages. The academic (Pretorius 2002:42) extends the discussion to include the two developmental tasks necessary for a happy marriage:

- *The realization of adequate relationships with peer group members of the opposite sex*
- *The realization of emotional independence from the parents.*

Pretorius (2002:39) enhances this discussion of such developmental tasks by stating that:

- All adolescents ought to attempt to cultivate their personal, sensible and proper attitudes in order to appreciate what marriage and family life really is.

- They should contribute in some way to the everyday tasks and bliss of family life.
- They must ascertain the difference between true devotion and obsession.
- They ought to acquire fulfilling I-You relationships by going out with and becoming involved with members of the opposite sex.
- The adolescent's ability to be decisive in matters concerning further education, military service, engagement, marriage, etc. is imperative (Duvall & Miller 1985:242).

2.6.8. Acquiring a set of values and an ethical system as a guide to behaviour – developing ideology:

Together with the acquisition of a personal identity the adolescent should attain a value system that will act as a guide for the reactions and the formation of a personal perspective of humanity, life and the world. Many young people display a keen interest in philosophical, religious and political problems as a result of the need to form a socio-political-ethical ideology. This will then allow them to make well-informed decisions in conflicting situations stemming from their personal principles and morals. Formal operational deliberations allow the adolescent the privilege of a personal standpoint on religious and ethical issues (Vrey1979: 180-186).

The manner in which an adolescent determines what is right and what is wrong embodies the moral development of an individual (Mwamwenda 1995:149-150). With reference to the development of an adolescent Mwamwenda cites Piaget's stage of "*morality of co-operation*". This is the stage when the child is fully responsive to moral realism but deems rules to be accommodating and variable to suit the individual without encroaching upon the individual's rights. Any child requires guidance towards moral development, however the orphans of AIDS have no such guidance and moral foundation. He is exposed to the adult world sans solid morals, a situation that makes him vulnerable. He is

"free" but at greater risk of abuse for the reason that he lacks parental protection and moral reasoning.

2.7. CONCLUSION

The adolescent has more or less the same characteristics in his development except where cultural practices influence development. The basic physical, cognitive, emotional, moral and connotative development of the adolescent is for the most part influenced by the domestic and social background that he hails from. The adolescent develops and functions as a unit and the developmental levels take place in interaction with one another.

The tragedy is that HIV/AIDS has a negative effect on the development of the adolescent since it inhibits self-actualization, introducing a plethora of psychosocial and educational tribulations into the lives of the vulnerable adolescents. For such adolescents development varies since the child is required to adopt an adult role within a 'dysfunctional' household. Helpless adolescents are compelled to take care of terminally ill parent/s, then face discrimination and the prospect of life without parental support and financial backing in order to survive and continue with their education, sometimes long before they would under normal circumstances.

CHAPTER THREE

SOCIO-EDUCATIONAL STUDIES OF THE IMPACT OF HIV/AIDS ON ADOLESCENTS ORPHANED BY AIDS IN FOREIGN COUNTRIES

3.1. AIM OF THE CHAPTER

"More than 113 million school-age children are out of school in developing countries, two-thirds of them are girls. Of those who enter school, one out of four drops out before attaining literacy. At least 55 of the poorest countries seem unlikely to achieve EFA (Education for All) by 2015, and 31 of these countries are also among the 36 worst affected by HIV/AIDS" (The World Bank 2002:xvi).

The aim of this chapter is to provide a detailed situational analysis of the socio-educational impact of HIV/AIDS upon orphans in selected countries throughout the world. Countries selected are those where orphans of AIDS are experiencing notable sociological, educational and psychological problems and where the situation is particularly of international concern since the prevalence of HIV/AIDS is high. However, it must be noted that as a result of a scarcity of available information on child-headed homes worldwide, the ideas in this chapter pertain predominantly to orphans of AIDS in general. Various prominent academics working in this field are quoted and the efforts of non-governmental organizations especially those in Africa are highlighted.

In the discussion that follows, it will become apparent that statistics and information pertaining **specifically** to adolescent AIDS orphans and especially those in child-headed households are difficult to come by (Aggleton & Parker 2002:5-6; UNAIDS/WHO 2002:31). The reasons for this may vary from the fact that families do not readily admit

to having AIDS or that people are unaware that deaths have been caused by HIV/AIDS to the fact that State Departments are reluctant to conduct statistical research for fear of exposing victims to the stigma and bigotry that follow such disclosure (Aggleton & Parker 2002:5-6). Another reason is that very little research has been conducted on HIV/AIDS adolescent orphans in child-headed homes and the educational and social conditions under which they live (UNAIDS/WHO 2002:31). It should also be borne in mind that the statistics in this regard are constantly changing even on a daily basis (UNAIDS/WHO 2002:5). Research (Ainsworth & Filmer 2002:8) has revealed that although there is a stark parallel between orphan rates and HIV prevalence (the percentage of people living with AIDS) there is also a vast discrepancy between the two since orphan rates depend upon AIDS through "*cumulative AIDS deaths*", while HIV prevalence depicts the percentage of the population that is "*infected and is still alive*" (Ainsworth and Filmer 2002:8).

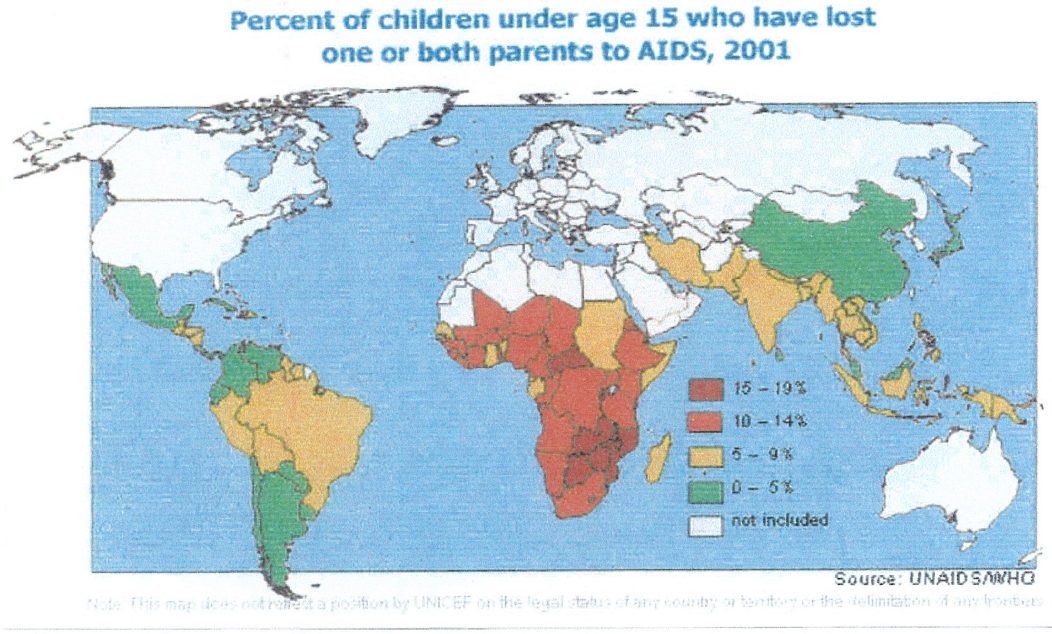
3.2. INTRODUCTION

In order to fully appreciate the catastrophic effect of HIV/AIDS upon the adolescent orphan, UNAIDS as well as WHO (UNAIDS/WHO 2002) regard it imperative to consider the global statistics regarding present and projected adult deaths. This is crucial since millions of adult-deaths are the reason that children, worldwide, (The World Bank 2002:16) are left abandoned and compelled to adopt adult roles prematurely.

This devastating pandemic has spanned over three decades depriving many countries such as Uganda, India, Rwanda, Zimbabwe, Botswana and South Africa of valuable resources and powerless children of their able-bodied parents. With reference to this study, by the year 2002 the statistics indicated that the adults living with AIDS (37 million), the newly affected adults with AIDS (4.2 million) and adults who have died of AIDS (2.5 million) are especially important since these have an indisputable bearing upon the children who remain behind and are adversely affected socially, educationally and psychologically (UNAIDS 2002:6). This is a particularly significant statistic since it

will have a positive influence upon the number of children who become orphans as a result of the pandemic (UNAIDS/WHO 2002:28) as the following map denotes:

FIGURE 3.1: Percent of children under age 15 who have lost one or both parents to AIDS, 2001



Source: UNAIDS/WHO (2002)

Figure 3.1 verifies that orphans of AIDS make up a major component of the millions of children below the age of 15, who have lost a mother or both parents. The above representation also depicts the dire situation in especially sub-Saharan Africa where the percentage of children under 15 orphaned by AIDS ranges from ten percent to as high as nineteen percent. The issue of the greatest humanitarian concern at present is that the majority of 14 million children presently orphaned by AIDS live in sub-Saharan Africa (Fahlen 2002:7). East Asian and South American countries follow (5-9%) and the pattern is that HIV/AIDS is gaining momentum in these areas. By the year 2010, the pandemic will almost triple the number of orphans in sub-Saharan Africa, who will have lost both their parents (UNAIDS/UNICEF 2002:6). Statistics supplied by Barnett and Whiteside (2002a:197-198) indicate that although as many as 95% of the worlds AIDS orphans

appear to live in Africa, startling figures are becoming evident even in Asia and America. The authoritative standpoint (Fahlen 2002:7) is that even widely successful preventative measures and a fall in the rate of infections at this stage, will not prevent most people who are already infected from dying of the related diseases. Consequently millions more children will be deprived of their parents in the future.

Ainsworth and Filmer (2002:7-9) assert that in countries where HIV has escalated swiftly but where there is a definite decrease in AIDS mortality, there is understandably an insignificant impact upon orphan rates. However, in countries such as Uganda where the pandemic is advanced, HIV prevalence may have waned or is constant but orphan rates are nevertheless high (UNAIDS/UNICEF 2002:9).

3.3. THE SOCIAL AND EDUCATIONAL EFFECTS OF HIV/AIDS UPON CHILDREN IN FOREIGN COUNTRIES

Apart from the worsening economic circumstances, which may include the loss of inheritances, the children orphaned by AIDS, suffer severe social and emotional stress in the form of anguish over the bereavement of the parent, panic about what is yet to come, prejudice, shame, isolation and physical and sexual mistreatment (UNAIDS/UNICEF 2002:9).

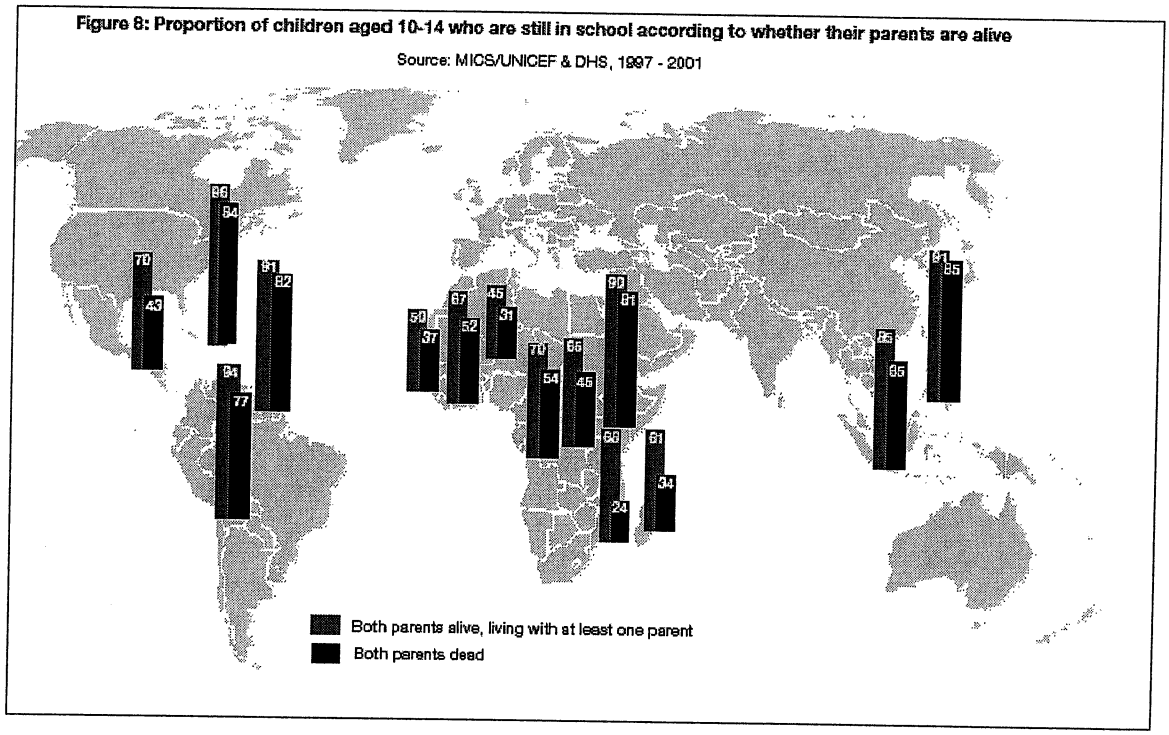
Adolescent AIDS orphans are abruptly exposed to all sorts of disturbances in their young lives – their societal functions, their privileges and obligations are all altered considerably (Barnett & Whiteside 2002a:206 Bennell, Hyde & Swainson 2002:1-2). No more are they reliant children but they have to prematurely don the cloaks of adulthood which help them to cope with the additional stresses in their young lives (UNAIDS/UNICEF 2002:9). A UNAIDS report (UNAIDS/UNICEF 2002:9) argues that vulnerable children worldwide are forced to take on further responsibilities ranging from finding new ways of generating income and taking care of ailing family members. Furthermore, financial restraints result in the orphans of AIDS being deprived of the security of education and

social services and being unable to handle the unexpected psychosocial stresses (UNAIDS/UNICEF 2002:10).

Researchers from different parts of the world, in the field of HIV/AIDS, such as Ainsworth & Filmer (2002), Ayieko (1998), Desmond & Gow (2002), Phiri & Webb (2002) and Kelly (2002) all agree that AIDS has had the most devastating effect on the safety, education, social life, health and survival of all children in affected areas worldwide. These devastating effects could lead to psychosocial distress, deepening poverty and severe material hardship. Barnett and Whiteside (2002a:197-198) maintain that the survival mechanisms of previously resilient communities, is beginning to fold under the immense strain of the pandemic. Hence, the perspective of these researchers is that orphans are struggling to survive on their own in child-headed households (Barnett & Whiteside (al 2002a:206). For the adolescent orphan in a child-headed household, the pandemic has brought with it the trauma of watching helplessly as first one parent then the other grows ill and dies (UNAIDS/UNICEF 2002:9).

Bellamy (2001:1) asserts that the disease impacts negatively not only upon the child's endurance, welfare and development but especially upon the being of the society that the said child stems from. The observation of Coombe (2002b:10) is that the greatest deprivation in the lives of adolescent AIDS orphans is the lack of formal education. Coombe (2002b:10) further stresses that, countries such as Botswana, South Africa, Swaziland, Zimbabwe and Zambia have accumulated evidence to indicate that pupils' enrolment at school is being hampered directly or indirectly by HIV/AIDS. The figure below highlights the (worldwide) proportion of children aged between 10-14 who are still in school according to whether their parents are alive. As a result of the United Nations definition it is difficult to acquire information with reference specifically to the age group 13-18, however for the purposes of exhibiting the gravity of the situation pertaining to AIDS orphans, the statistics on the next page shall be utilized to substantiate the cause for extreme concern worldwide:

FIGURE 3.2: Proportion of children aged 10-14 who are still in school according to whether their parents are alive:



Source: UNAIDS/UNICEF 2002: 10

The diagram aptly illustrates the discrepancy between school-attendance of orphans versus non-orphans. The above statistics for children attending school display that the percentages of children whose parents have passed on are much lower than those for children whose parents are **still** alive. This indicates that the presence and influence of the parents contribute to positive school attendance. Considering the percentages made available, data for the South American states and the sub-Saharan African countries are of singular concern. If one were to analyze these statistics from an HIV/AIDS perspective it could be concluded that the reason for this could be the orphans' lack of funds to pursue further schooling, the agony of the shame associated with the disease, the absence of parental support or the liability of domestic chores that hamper progress (Coombe 2002b:5).

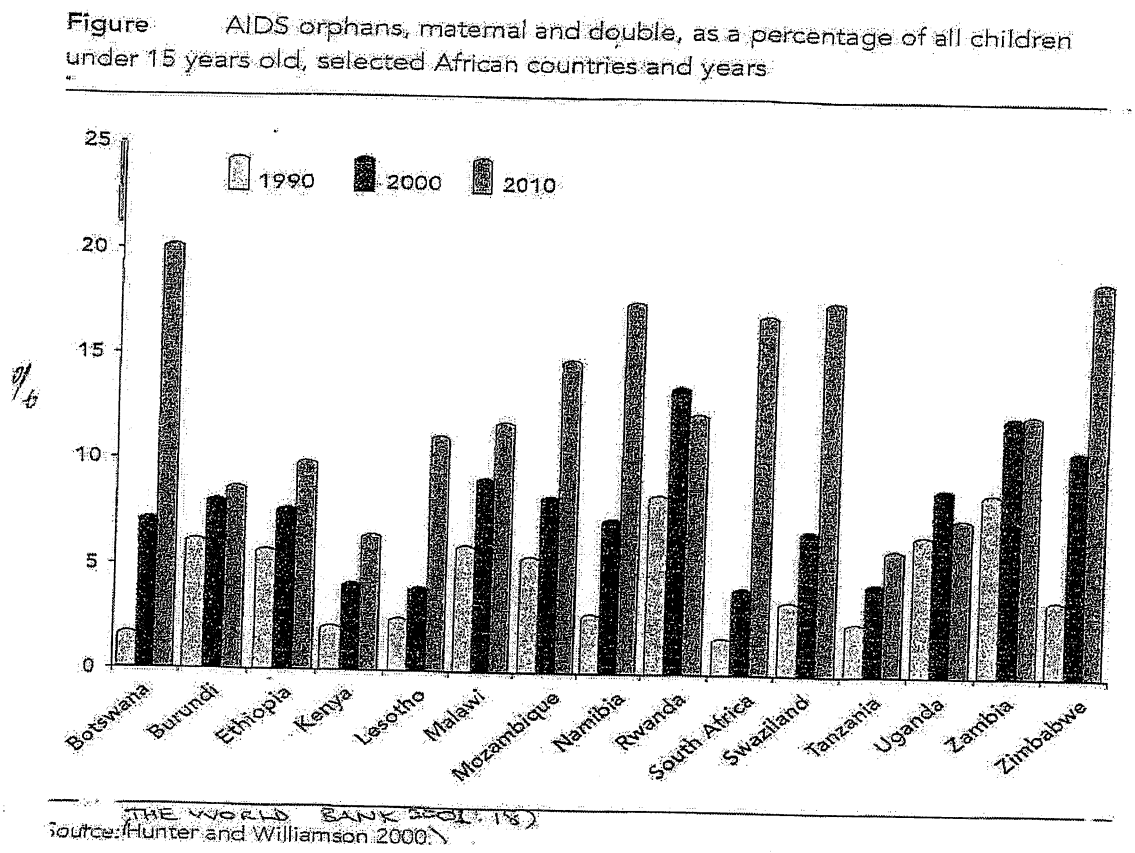
Researchers (Coombe 2002b:10, Ayieko 1998, Booysen, Van Rensburg, Bachmann, Engelbrecht & Steyn 2002:3 and Desmond & Gow 2000:14-15) agree that some of the factors that affect education and social welfare among adolescents are likely to be decreased resources, high parental death rates that precipitate poverty, inadequate funds to pay for schooling and the need to take care of the ailing. A study by UNICEF (UNAIDS 2002:10), which explored the effects of orphaning upon labour and education, revealed that "*In all countries, children aged 5-14 who had lost one or both parents were more likely to be working more than 40 hours a week*".

Williamson and Hunter (2002:2) also report that AIDS is altering the entire social image in the most affected countries and giving rise to unique child welfare dilemmas. Children are compelled to abandon their schooling in order to care for ill parents or get jobs in order to support their families (Associated Press 2002:2).

3.4. AFRICA

The table below provides an indication of the statistics related to orphans generally in various groups and countries in the African regions. These distressing statistics reveal the need for desperate action to facilitate effective methods to address the educational and social welfare issues with special reference to orphans:

FIGURE 3.3: AIDS orphans, maternal and double, as a percentage of all children under 15 years old, selected African countries and years:



Source: The World Bank (2002:18)

Figure 5 reveals shocking **anticipated 2010** statistics of AIDS orphans as a percentage of all children under 15 years old in countries such as Botswana (over 20%), Namibia and Swaziland (almost 20%), South Africa (almost 18%) and Mozambique (+15%). Regardless of what is to come the dramatic increase in percentages in these countries from 1990 to 2000 is just as great a cause for concern and ought to have initiated constructive programmes towards combating the virus and its effects. The discrepancy in the Rwandan statistics from under 10% in 1990 to almost 15% in 2000 might have been aggravated by the genocide in that country but lower percentages are predicted in 2010. According to the diagram, the percentage of AIDS orphans below 15 in Zambia moved from below 10% to between 12% and 15% but is expected to stabilize as a result of the positive steps being taken to stem the tide of the pandemic. Uganda foresees an even

more optimistic future in that percentages in this country are expected to fall by the year 2010. However, the same cannot be stated about Zimbabwe where the staggering increase from below 5% in 1990 to above 10% in 2000 is forecast to jump to almost 20% in 2010.

The crisis in sub-Saharan Africa (a term which refers to all the countries south of the Sahara Desert) denotes that the number of children orphaned by HIV and AIDS is escalating resulting in more orphans who are destined to survive in child-headed households (Cohen 1999:4). Bennell, Hyde and Swainson (2002:49) suggest that the number of orphans in conflict-affected areas has increased dramatically as a result of HIV/ AIDS. Orphans *"already exceed 20% of the under 15 population in at least six countries (Malawi, Rwanda, Uganda, Zambia and Zimbabwe)"* (Bennell et al 2002:49).

Research by Barnett & Whiteside (2002a:197-8) pointed out that of recent the extended families in sub-Saharan Africa and Southern Africa (Coombe 2002b:5-6) have been unable to attend to the needs of the child survivors of the pandemic for economic and material reasons. Children have been caste out, having to fend for themselves or being left in the care of extremely ill or old grandparents. According to Coombe (2002b:11) too many HIV/AIDS-affected learners cannot continue with school because of their poor physical and financial conditions. Orphans often have to quit school in order to become decision-makers taking on the responsibilities of supervising younger siblings and providing an income for the family (Lyons 1998:5). The coping skills of these orphans in either case, is questionable (Krift & Phiri 1998:1-2).

3.5. ZAMBIA

The current HIV/AIDS predicament in Zambia is considered to be one of the worst epidemics in the world. A UNICEF report (1997: 2) estimated that in excess of 7% of Zambia's 1 905 000 households were without an adult member, being headed by children, that is, a boy or girl aged 14 or less. Epidemiological Fact Sheets compiled by

UNAIDS, UNICEF and the World Health Organization (2004:2) place the statistics for Zambians by the end of 2001 as follows:

TABLE 3.1: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN ZAMBIA

ADULTS AND CHILDREN	**1 200 000**
Adults (15-49)	**1 000 000**
Women (15-49)	**590 000**
Children (0-15)	**150 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**120 000**
ESTIMATED NUMBER OF ORPHANS	**570 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

A paper delivered by M.J.Kelly at the XIth International Conference on AIDS & STDs in Africa (ICASA) gives prominence to the fact that *"Zambia is currently experiencing the worst HIV/AIDS epidemics in the world, one result being that between one third and one quarter of the children aged below 15 have lost one or both parents"* (Kelly 1999:1). The burden of the children is a key issue requiring urgent attention. Geoff Foster of the Family AIDS Caring Trust in Zimbabwe (UNAIDS 1997:3) has stated that the demise of the orphan's grandparent creates the situation where there is no-one else

in the extended family to take care of the children and this gives rise to orphan households headed by older brothers and sisters.

It is apparent that chiefly the formal education sector is suffering. Studies (Kelly 1999:3) in the Copperbelt – one of the areas most severely affected by HIV/AIDS in Zambia – illustrate that the principal reason for inferior school attendance and enrollments was the lack of funds to pay school fees. This was a direct result of fixed earnings being halted or being channeled towards "palliative" care of the ailing parent/s. A 1996 UNICEF report confirms the close association between school attendance and AIDS by stating that the sudden break in attendance is the consequence of the child being unable to afford school anymore (Kelly 1999:4).

By and large orphans are less likely to have access to a suitable education as a result of various mitigating circumstances such as the lack of funds for school fees, the need for the adolescent orphan to work in order to supplement the income and the shame and embarrassment to face others. Research (Barnett & Whiteside 2002a:202) in Zambia illustrates that there is a dramatic drop in the numbers of children of school-going age who are **actually** attending school. This state of affairs can be attributed in large part to the AIDS pandemic but is also prejudiced by the mediocre standard of education in the country, the effects of indigence and levels of unemployment.

Kelly (1999:3-4) verify the theory that orphans from AIDS-affected homes are more likely than non-orphans to drop out of school. Evidence (Kelly 1999:3-4) indicates that in two high-density areas in Lusaka it was "*found that of 1,359 children aged 18 and below, 67% had lost one or both parents*" and approximately 7% of them had abandoned their schooling in the 12 months before the study (Kelly 1999:4). However, in Zambia orphans are not differentiated against and it is believed that when NGO workers and researchers begin to ask to count AIDS orphans they are introducing a stigma that never existed prior to then (Barnett & Whiteside 2002a:122).

3.6. ZIMBABWE

In Zimbabwe The National AIDS Council (Phiri & Webb 2002:20), assesses that over 900 000 children have lost one or both parents as a result of HIV/AIDS thus far. By the end of 2001 the following statistics were available regarding AIDS:

TABLE 3.2: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN ZIMBABWE

ADULTS AND CHILDREN	**2 300 000**
Adults (15-49)	**2 000 000**
Women (15-49)	**1 200 000**
Children (0-15)	**240 000**
ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**200 000**
ESTIMATED NUMBER OF ORPHANS	**780 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

With 200 000 AIDS-related deaths and 780 000 children having lost at least one parent as a result of an AIDS-related illness, there are various associated problems relating to the educational, social, financial and psychological lives of AIDS orphans in Zimbabwe. Many orphans are left on their own in child-headed households having to take care of themselves while others are cared for by NGO's. The AIDS Orphan Trust has been

taking care of a particularly **small** group of approximately 1500 children allowing them to remain in their homes where they are visited by trained caregivers who teach them survival techniques. Orphan support in the form of the FOCUS project in Zimbabwe is a programme of Family AIDS Caring Trust (FACT). By recruiting women from the villages and people from church groups, they identify, monitor and assist orphans of AIDS. The volunteers are able to recognize the deficiencies in the children's lives and afford emotional and spiritual support. Abuse and exploitation of the children appear to decrease when there are frequent visits by the monitors and caregivers (Phiri & Webb 2002:20-21).

The educational circumstances in Zimbabwe expose the fact that 99% of children attended school before the death of the mother but the percentages fell dramatically on the mother's death to 80% in urban areas and 93% in rural areas. The burden of domestic and farm chores seemed to fall upon these adolescent orphans and if they did continue with their schooling they were unable to attend regularly (Barnett and Whiteside 2002a:204).

3.7. MALAWI

As the following statistics indicate, the catastrophic effect of extremely high levels of HIV, have overwhelmed Malawi:

TABLE 3.3: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN MALAWI

ADULTS AND CHILDREN	**850 000**
Adults (15-49)	**780 000**

Women (15-49)	**440 000**
Children (0-15)	**65 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**80 000**
ESTIMATED NUMBER OF ORPHANS	**470 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

As at 2001 there were 470,000 children orphaned by AIDS (AVERT.ORG 2002b:6) of which 400,000 were below 15 years of age (UNICEF 2003c:1), Believing that the community would be able to focus on and assist to alleviate this critical situation, the Government established the National Orphan Task Force in 1991 and the National Orphan Care Guidelines in 1992.

Despite the fact that orphans in Malawi have extended families on both sides, that is, maternal and paternal relatives, they are sometimes forsaken, poverty-stricken children with nowhere to go and are subjected to further emotional trauma by having to struggle with adult roles (Ali 1998:2). In most cases the only options available to them are to drop out of school, to look for casual labour or sometimes to marry earlier than they normally would so as to support the younger siblings (Ali 1998:7). They lack proper care and counselling to be able to handle hardship and grief.

Coombe's research (2002b:11) for this country depicts that for 1999 the percentage of children at school who had lost one or both parents increased from 12% to 17%. The study provides additional data to state that a third of the children were absent from school since they had to care for the ill and double the percentage for those who had lost both

parents. In addition, children who had lost both parents were twice as likely to drop out of school (17%) during 2000 while the average age for these pupils was approximately six months older than the average age for that grade (Coombe 2002b:11).

Research (Ali1998: 2) in Malawi indicates that more children orphaned by AIDS, were found in the rural rather than the urban areas. This could be attributed to the fact that the children return to their home village to be cared for by the extended families on the deaths of their parents.

Orphans of AIDS are often exposed to unfamiliar cultural practices for example the imposed right of the husband's family to take property belonging to the orphans' family; hence, the orphans are left destitute (Ali 1998:6) (Khonyongwa 1998:1). The orphans are also subjected to the law that gives the paternal uncle the right to decide whom they will reside with after the demise of their parents. Apart from this the uncle, is entitled to conduct the property sharing at his discretion. Unfortunately, where there is a surviving wife, she is not automatically entitled to an inheritance.

According to Ali (1998:12-13) families in Malawi do not appreciate the significance of providing for the educational and psychosocial needs of the child orphaned by AIDS. Hence, the children who are compelled to live on their own, battle with acceptance of the parents' deaths as well as the loss of support (Ali 1998: 12-13; Krift and Phiri 1998:3). Results from a study by Ali (1998:7) reveal that child-headed households are more apparent as a result of the following:

- The demise of the parents;
- Relatives refuse to take care of the orphans because of the stigma attached to the latter or since their relationship with the relatives have not been pleasant;

- Immediately after they lost their parents, children were sometimes taken in by their relatives but moved out on their own after they were abused (Ali 1998:7).

Once they are abandoned, the beleaguered orphans battle to eke out a living and frequently drop out of school to engage in chance employment to support themselves and their siblings.

The Community based options for protection and Empowerment (COPE) of Save the Children (US) in Malawi can be credited for the creation of effective programmes that lend a hand to communities that assist children affected by HIV/AIDS to pay school fees and run their homes. This programme is a forerunner in the creation of effective methods by using already established social and community structures in order to assist children affected by HIV/AIDS (Phiri & Webb 2002:22-23).

3.8. UGANDA

As early as in 1998 the view of Fiala (1998:6) was that there were in excess of 3 million children already being subjected to the effect of the pandemic in Uganda alone.
Most recent studies indicate that over 1,5 million children have been orphaned since the pandemic began in Uganda but the tide has turned with the combined effort of political commitment and the involvement of all sectors of society to assist in the reduction of HIV infection rates (UNAIDS, UNICEF & WHO 2004:2).

Statistics provided by UNAIDS, UNICEF and WHO (2004:2) for the period up to 2001 present the following picture:

TABLE 3.4: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN UGANDA

ADULTS AND CHILDREN	**600 000**
Adults (15-49)	**510 000**
Women (15-49)	**280 000**
Children (0-15)	**110 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**84 000**
ESTIMATED NUMBER OF ORPHANS	**880 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

If one were to consider the number of adults (510,000) living with AIDS and the number of women (280,000), it is simple to deduce that the situation regarding orphans of AIDS in Uganda is a serious challenge to the resources of the country. Estimates of recent suggest that 2314 per million people were living with AIDS as at 2002 (Bukenya 2002:2). Far more critical than this statistic, is that the substantial number of parental deaths has intensified the unfortunate situation of the orphaned children who were still living as at 2001 (880,000) in this country. A Swiss-American Foundation, the Association Francois-Xavier Bagnoud (FXB) (Monk 2000:7) that is assisting orphans in the area has found that in a place called Luweero in Uganda over half of the children had lost their fathers and that their mothers were absent (Barnett &Whiteside 2002a:98).

Children in this country have been found to experience anguish some time prior to the deaths of their parents as a result of the seriousness of the AIDS-related diseases (NADIC

2001:4). After the traumatic death of their parents, these children experience a general lack of "*family guidance and emotional support, limited access to education, inadequate socialization, nutrition, material and financial support*" (NADIC 2001:4). Studies indicate that the extended families are now unable to absorb the burden of the considerably excessive numbers of orphans since care costs more than these families can afford (Barnett & Whiteside 2002:204-205 & 207).

The pandemic has already created the phenomena of child-headed households (Fahlen 2003:7). As a result of parental deaths, children have no protection and little status or rights in the community (Bukenya 2002: 2). A study by Monk (2000:12) of the orphan situation in Uganda emphasizes the severe educational, sociological, financial and psychological effects of the pandemic upon paternal orphans in particular. Poverty, school fees and general uneasiness (that is disruptive) have led to low literary levels (Bukenya 2002:1-2). It is less probable that orphans will be able to afford the privilege of appropriate education and the death of a parent invariably diminishes the chances of the child being able to attend school at all (Barnett & Whiteside 2002a:16). The psychosocial stress experienced by children orphaned by AIDS and struggling to survive in child-headed households in Uganda is further aggravated by the stigma associated with HIV/AIDS.

3.9. KENYA

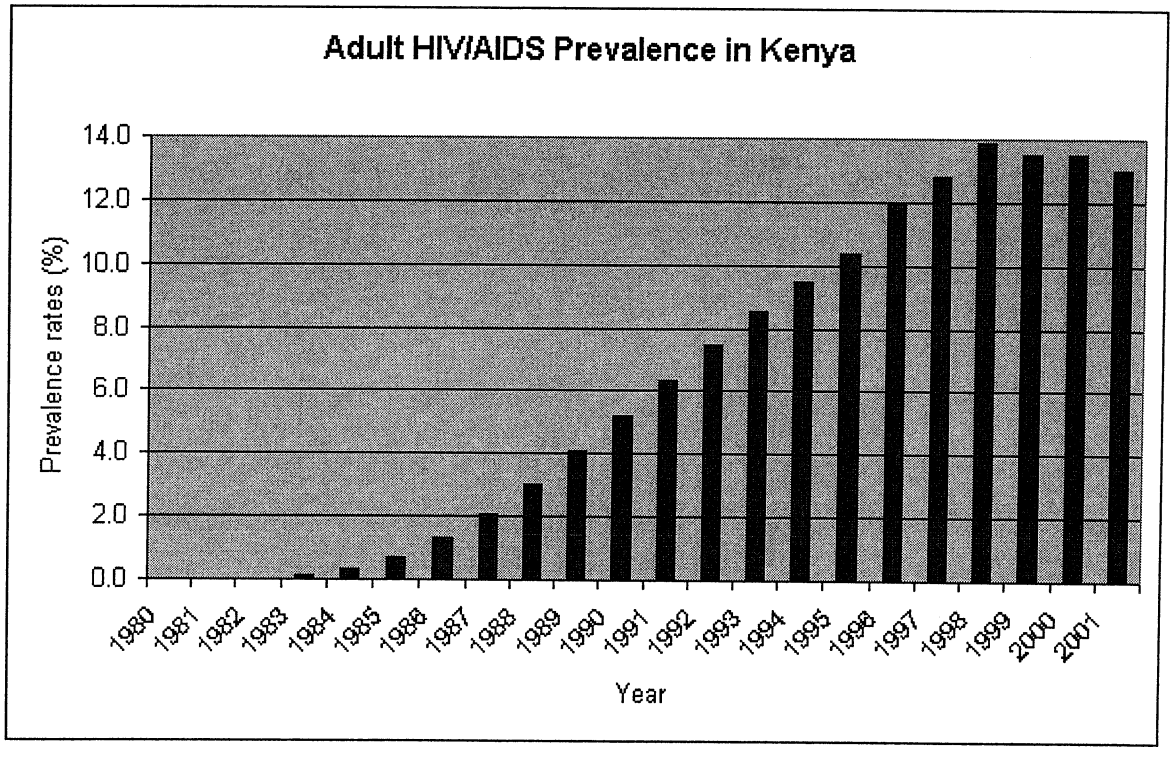
In Kenya, HIV/AIDS has given rise to more or less one million orphaned children (Francais 2001:1) and contributed to the increase in the number of street children in urban areas (Human Rights Watch 2001:3). The outcome of this critical situation is that children in Kenya are facing psychological trauma, separation, hazardous labour and neglect. In addition to this the children are forced to act as the primary care-givers of their dying parents and siblings left in their care (Human Rights Watch 2001:6-7; Harmon 2001:2-3). Harmon (2001:2-3) is of the view that these orphans must be afforded free school, counselling, healthcare and training to help them cope in their parentless

environments. Since the beginning of the epidemic in 1984 (UN 1999), there were approximately 730,000 children under the age of 15 who had lost their mothers or both their parents as a result of AIDS by 1999.

When Kenyan President Moi had declared HIV/AIDS a "national disaster" in 1999, it was estimated that one person out of every nine was already infected with HIV (Human Rights Watch 2001:2). Consequently, the National AIDS Control Council (NACC) was established to control the spread of the virus in conjunction with UNICEF and WHO.

The statistics (Computervisions:2) below verify the need for constant update of intervention, investigation as well as treatment:

FIGURE 3.4: Adult HIV prevalence in Kenya

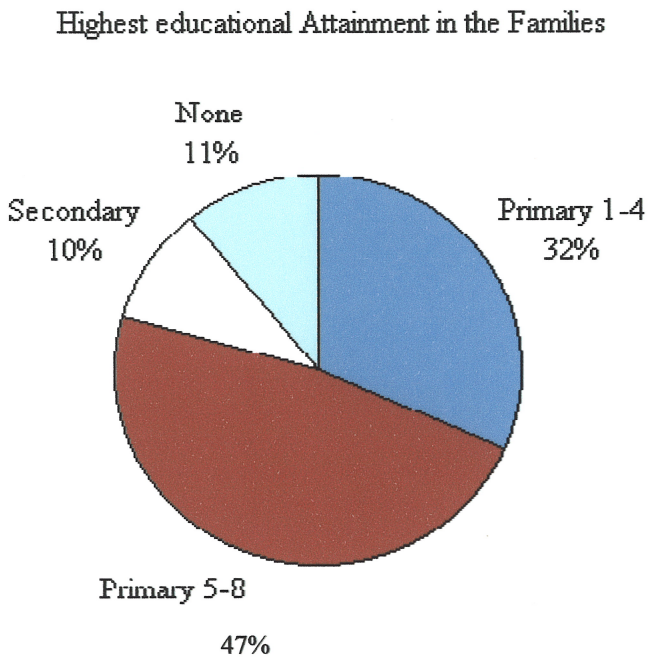


Source: Computervisions:2

It is apparent from the above figure that there has been a steadily alarming increase in HIV/AIDS prevalence each year. The rate of prevalence appears to have peaked between 1998 and 1999 and then started to lessen thereafter. The reduction in the number of adults infected with HIV was not instantaneous but can be attributed to the fact that early commitment by Kenyan authorities brought on constant intervention and investigation together with proper treatment in order to fight the rapid spread of the HIV/ AIDS pandemic. The high percentage of adult HIV/AIDS prevalence in the graph is indicative of the high mortality rate among adults and the high numbers of orphans and children in child-headed households.

The figure below illustrates that children orphaned by AIDS achieved minimal levels of education:

FIGURE 3.5: Highest educational attainment in the families



Source: AYIEKO (1998:10)

For the purposes of this study the above data is important since it demonstrates that too many adolescent orphans are not able to achieve their academic ambitions. It is important to note that the percentage of adolescent orphans that manage to achieve secondary school level is a paltry 10%. This is indicative of the fact that orphans are not permitted to go on to the secondary school level in a vast number of cases. The highest (47%) that most orphans achieve is the Primary 5-8 level which forms the major portion of the graph. The research revealed various reasons for the above trend:

- Poverty
- Lack of funds
- Malicious caregivers who prevent orphans from going to school in order to impede their future earning potential
- Embarrassment at the way in which their parents died
- Being stigmatized as AIDS orphans
- Believing that their parents had been bewitched as a result of their superior education
- A lack of parental supervision and back-up
- Arduous domestic chores
- School attendance was not seen as a priority in many families
- Education costs from standard 8 and form 4 are too costly and school necessities are unaffordable.

Since there are numerous parental deaths, the extended family reinforcement system, already weakened by droughts, famine and civil unrest is being tested to the limit and incapable of offering any more support to orphans. Harman (2001:2) reports that Tobias Odero, a counsellor with the Baltimore-based Christian Children's Fund (CCF), is adamant that the children who are orphans of AIDS ought not to be institutionalized since the process only adds to the already harrowing ordeal of having to cope with the death of

their parents. Hence, his contribution to the system is to visit these children in their homes daily in order to assist with finances and morale. As a result of the high daily death rate (500 per day), the relatives who would traditionally take care of these orphans are basically weighed down (Harman 2001:2).

The orphan of AIDS becomes the innocent victim of this lack of shared liability. The age-old tradition of the spirit of caring among relatives is dissipating from the pressures of major financial needs and the primal intuition to take care of one's own. Soaring funeral expenses and medical bills restrict the relative's ability to offer further assistance to members beyond the immediate family. The already burdened extended family is often unable to afford further school fees and related educational expenses for the orphans of AIDS placed in their care. This leads to high drop-out rates of children orphaned by AIDS in Kenya.

An in-depth study (Ayieko 1998:1) into the phenomenon of child-headed households in Kenya by Ayieko verifies the premise that the concept of child-headed households is becoming more numerous in rural areas. The report (Ayieko 1998) states that in most cases where appropriate subsistence measures are not made before the parents pass on, the orphans are left with inadequate or no means at all. Hence children who are compelled to bear the brunt of such dispossession are deprived of their childhood and often their right to a proper education.

3.10. TANZANIA

Statistics provided by Barnett and Whiteside (2002a:212) indicate that between one-third and one-fifth of children in Tanzania have lost one or both parents to AIDS. An offshoot of this is that such children face the acute stress of having to deal with educational, psychological as well as social problems such as social insecurity and the lack of

confidence in general. A survey based on statistics regarding AIDS orphans in Tanzania exposed that child-headed households are more common among orphans of AIDS than among any other orphan (Barnett and Whiteside 2002a:212).

Projections (Fox 2001:26) with reference to HIV/AIDS in Tanzania reveal that by the year 2010 there will be 4,2 million orphans. Statistics in relation to AIDS supplied to UNAIDS (Fox 2001:25) were as follows:

TABLE 3.5: HIV/AIDS STATISTICS FOR HIV/AIDS IN TANZANIA

• **HIV positive adults**	**1.3 million**
• **AIDS-related deaths**	**140 000**
• **Children who have lost at least one parent to an AIDS-related illness**	**1.1 million**

Source: Fox (2001:25)

The above statistics present a bleak picture of Tanzania, suggesting that with the AIDS-related deaths of 140,000 people, 1.1 million children have been orphaned. It would stand to reason, therefore that the demise of the 1,3 million already infected adults will result in a social catastrophe of unimaginable magnitude. USAID predicts (Madorin 2000:1) that by 2010 there will be 4.2 million orphans in Tanzania if an effective yet inexpensive treatment is not developed in the near future, but judging by the above figures, this disaster is not too far of.

Many orphans in Tanzania have to deal with the responsibilities that other children with parents would have to face much later in their lives (Madorin 2000:1). These AIDS orphans are facing material impediments in the form of unpaid school fees, other related expenses such as the cost of uniforms and the costs of food and clothing. Older children orphaned by AIDS and living in child-headed homes, have more demanding

responsibilities, which require them to be of assistance to their siblings to survive as well (Madorin 2000:2).

The HUMULIZA (Novartis Foundation: 1-3) has embarked on a fourteen-week program for sets of orphans, in order to attempt to alleviate the children's psychological and social problems by applying the "child-to-child" approach. In this way the children are able to exchange ideas, discuss similar experiences and lose some of their bitterness and sorrow by recognizing that there are many others like them. This project aims at training teachers, members of NGO's, churches and women's social groups who will be able to assist the children who are orphaned by HIV/AIDS. The project also joins forces with UNICEF Tanzania while the latter is creating an experimental undertaking supporting orphans and creating better educational opportunities for the adolescent orphans in this country (Novartis Foundation: 2-3). Consequently it is anticipated that school attendance and educational progress will be positive.

Within the course of their research in Tanzania, Phiri and Webb (2002:30) uphold that households, community members and families are taking the initiative to look after orphans by paying attention to their needs and providing the necessary educational and psycho-social support. However, these researchers (Phiri & Webb 2002:30) deem that such programmes should be sustained and that resources should filter down to the communities effectively. On the other hand it is imperative that well-meaning organizations do not create the impression that the resources will provide **certain** solutions to **all** the problems of the desperate communities. Funding and ability structuring should work hand-in-hand in order to provide the necessary structures that will lead to these efforts to create better learning opportunities and psychosocial support for the orphans of AIDS.

3.11. BOTSWANA

Botswana is a sub-Saharan African country with a population of 1.6 million that has had the highest per capita incidence (Brigaldino 2002:1) of HIV/AIDS in that, at the end of 2002 an approximate 330 000 of the adult population is infected with HIV (AVERT.ORG 2003e:1). As a result of these adult deaths there will be a multitude of sorrowful AIDS orphans struggling to survive under the most trying circumstances (Daniel 2003:2). Daniel (2003:2-3) extends the assertion upholding that the relatives, who under normal circumstances ought to take care of these children, have abandoned them. Further, these orphans of AIDS are excluded and marginalized (Daniel 2003:2) by the communities they live in, sometimes sexually abused and often lose their properties and belongings. Their profound emotional and mental distress is intensified by the ensuing sense of bleakness from which there appears to be no escape after their parents pass on.

At the end of 2001 estimates indicated (AVERT.ORG 2002b:5) that 69,000 children had lost their parent/s to the pandemic but projections are that the number will exceed 200, 000 by 2010 (Brigaldino 2002:1). The statistics below provide evidence of the HIV prevalence rate in Botswana, which is the highest thus far worldwide. The life expectancy in this country is 39 years and would have been 72 years had there been no AIDS in the country (Fredriksson & Kanabus 2003:1).

TABLE 3.6: ESTIMATED NUMBER OF ADULT AND CHILDREN LIVING WITH HIV/AIDS DURING 2001 IN BOTSWANA

Adults and children:	**330,000**
Adults (15-49):	**300,000**
Women (15-49):	**170,000**
Children (-15):	**28,000**
Adult rate (%)	38.3%

Estimated number of orphans

Estimated number of children who have lost their mother or father or both parents to AIDS and who were alive and under age15 at the end of 2001:

Current living orphans: **69,000**

Source: UNAIDS/WHO 2002:1

A study in Botswana (Barnett & Whiteside 2002a:204) exposed that normally orphans began to perform poorly at school immediately after the death of a parent. Orphans from the poorest communities and socio-economic backgrounds displayed signs of poor nutrition, poor care and neglected education. Coombe (2002b:34) and Daniel (2003:3) are of the view that the most recurrent justification for orphans of AIDS becoming school drop-outs or under-achievers, was that they lacked the material means to meet fundamental requirements (Coombe 2002b:34). Teachers and schools in Botswana have begun to provide a range of services such as supplying essentials, networking with children within AIDS-affected households in order reduce stress on children, keeping an eye on orphan welfare, assisting with emotional needs and behaviour disturbance (Coombe 2002b:34).

Various NGO's, government departments as well as the private sector established a National Orphan Programme in April 1999 to accommodate and cater for these orphaned children (AVERT.ORG 2002b:5). These interested organizations work with the intention to evaluate and form guidelines, foster the capacity of established institutions, make available communal welfare services, encourage a cooperative spirit in proposals and supervise and appraise activities. One key objective of the Programme was to set up a comprehensive National Orphan Policy, which was based on the Convention on the Rights of the Child. Measures have been taken to remedy this tragic situation by providing food, clothing and uniforms for school to destitute orphans (Daniel 2003:3). These steps were introduced by the Botswana Government by means of the 'Short Term Plan of Action on the Care of Orphans in Botswana' (STPA), which had been extended to last until 2003 (Daniel 2003:4). The government of Botswana appears to have obviated

the problems of orphans to a significant degree in that children are kept at school and they are able to attain satisfactory grades (Coombe 2002b:34).

The Bobirwa Orphan Trust is made up of community volunteers and local extension staff from government who identify and register orphans. They then establish the kind of assistance that each orphan needs, helping local groups to purchase food, clothing and blankets as well as paying for school fees, uniforms and other educational requirements (AVERT.ORG 2002b:5). UNDP is also providing the necessary funding for local communities in Botswana to assist AIDS orphans. The House of Hope project in Palapye district and the Maun Orphan Care programme in the Nqamiland district provide home-based care for the terminally ill and education, training and welfare services for the orphans of AIDS (UNAIDS 2002:3).

3.12. INDIA

Boseley (2002:1) is of the opinion that the largest number of AIDS orphans around the world – 1.2 million in 2001- emanates from India (Boseley 2002:1). The report declares that these shocking figures are set to increase in five years to 2 million and to 2.7 million in ten years. Debatably, below 1% of the population **have** HIV/AIDS (Step Forward 2003:1), however, if one were to consider that this adds up to probably 4 to 5 million people who are HIV-positive, then India certainly has great cause for concern. The tragedy of Indian statistics is that the maximum proliferation of HIV/AIDS is among the sexually active and most industrious individuals of the age group 15-44 years (Verma, Ravi, Salil, Mendoca, Veera, Singh, Prasad & Upadhyaya 2002:3).

By the end of 2001 (UNAIDS, UNICEF & WHO 2004:2) the following statistics in relation to HIV/AIDS in India were available:

TABLE 3.7: ESTIMATED NUMBER LIVING WITH HIV/AIDS

ADULTS AND CHILDREN	**3 970 000**
Adults (15-49)	**3 800 000**
Women (15-49)	**1 500 000**
Children (0-15)	**170 000**

Source: UNAIDS, UNICEF & WHO (2004:2)

The following statistics (Step Forward 2003:2-4) substantiate the above and provide an accurate view of the path of the pandemic in India:

- In India, the quality of education as well as the pupil enrollment has always been a disconcerting issue. AIDS has certainly intensified the problem given that unexpected financial pressures and psychosocial concerns often do not allow children to complete their schooling.
- The Indian government has released statistics that indicate that from 1994-1995 merely 62% of boys and 47% of girls had enrolled at primary schools in the country.
- The **300 million poverty-stricken** Indians in that country have no access to basic needs such as food, shelter and clothing. This grave state of affairs is aggravated by the physical, economic and emotional impacts of HIV/AIDS.
- In India alone approximately 1,600 people become newly infected and about 1,000 die of AIDS-related diseases **each day**.
- Unfortunately, almost one-third of all people living with HIV/AIDS in India are **women**.
- It is envisaged that by the year 2005, 5-10% of children in India below the age of 15 will lose their parents to AIDS.

It is particularly crucial to take into consideration the number of orphans who will be left behind, thus affecting the social and educational resources of this country. Proportionately the number of children orphaned by AIDS is lower in this country when seen against figures provided for sub-Saharan Africa **but** Capua (2002:1) condemns India for neglecting this HIV/AIDS issue as the African countries had previously done. De Capua believes that eventually the situation will deteriorate to having "tens of millions of orphans within the next decade"(De Capua 2002:1).

According to Coombe (2002:39), the impact of the pandemic upon education in countries such as India, where the prevalence of AIDS is low, will not be uncovered in the very near future since comparatively minimal percentages of learners and educators are affected by AIDS. If one were to take into consideration that for every nine persons around the world who is HIV-infected, one comes from India, together this does not constitute even 5% of the total Indian population and an even smaller proportion of the education community itself. In the same vein, Boseley (2002:1) contends that the proportion AIDS orphans is lower than in some sub-Saharan African countries where the basic constitution of the family is breaking down because of the demise of a generation of parents. Nevertheless, Countess du Boisrouvray (De Capua 2002:1) is of the view that HIV is "*running silently*" in India and the leaders could learn valuable lessons from Africa and take the necessary steps in order to obviate a disaster.

3.13. CONCLUSION

"Despite a widespread belief that orphans are well-served by AIDS care organizations, there is a growing realization that such care is inadequate and that children orphaned by AIDS are in reality often a neglected group" *(UNAIDS 1997:5).*

It is quite apparent that in a country like Uganda where the issue of HIV/AIDS was restricted early in its progression the state is still faced with the problem of orphans of AIDS despite the necessary steps that were taken. This could be attributed to the fact that the progression of HIV was restricted but the after-effects of AIDS will take decades to overcome. Other countries around the world ought to take a leaf out of this book in order to realize that even if a cure for AIDS was discovered at this stage, the psycho-social and educational problems of orphans and child-headed households will persist for decades to come.

An important observation is that in all countries around the world, especially in third world countries, orphans in child-headed households are faced with fundamentally the same problems, which are financial restraints, poverty, stigma and discrimination, social and emotional stress, unfamiliar adult responsibilities, loss of inheritance, panic regarding the future, isolation, absenteeism, dropping out of school and physical and sexual abuse.

The pandemic has consciously affected countries - whether first or third world – but the difference in prevalence, and incidence within each has been dependent upon the economic infrastructure and the manner in which social, welfare and educational state organizations have handled the crisis. Each country will execute initiatives according to their own educational, social and welfare structures in conjunction with that countries traditional and cultural background. The support offered by external organizations such as UNICEF and UNAIDS will therefore have to be mindful of this.

CHAPTER 4

THE SOCIO-EDUCATIONAL IMPACT OF HIV/AIDS ON ORPHANS OF AIDS IN SOUTH AFRICA

"Every child in South Africa will feel the impact of HIV/AIDS. For some, it will be far removed, while for others it will be within them destroying their immune system, and eventually leading to their death... Children are experiencing, and will experience at an increasing rate, the deaths of their parents, other family members, teachers and at times their peers. Deaths will affect the provision of services, education, health and welfare. Children will grow up in societies where death is a common experience, affecting them emotionally, economically and psychologically. The epidemic violates many of the fundamental rights of South African children" (Desmond and Gow 2002b:3).

4.1. AIM OF THE CHAPTER

The aim of this chapter is to elucidate the manner in which children orphaned by HIV/AIDS are affected in South Africa and in the province of Kwa-Zulu Natal. The latter is the province where the empirical research for this study on child-headed households will be conducted. This chapter will concentrate on Kwa-Zulu Natal in the hope that the information provided by the study will impart constructive elements to support and smooth the advancement towards the mitigation of the effects of the pandemic upon children, chiefly orphans of AIDS. However, it must be reiterated that research based on the socio-educational conditions of orphans in child-headed households is a neglected field of study since there is only anecdotal evidence of the phenomenon. Definitions provided in earlier chapters of this study will apply to this discussion on South Africa and Kwa-Zulu Natal.

4.2. THE IMPACT OF HIV/AIDS IN SOUTH AFRICA

4.2.1. INTRODUCTION

In South Africa, there are great demands upon social and educational structures as a result of the vast number of children orphaned by AIDS (Barrett 1998:4). However, for orphanhood, these are still early days of South Africa's AIDS pandemic since the appalling degree of orphan hood being experienced elsewhere in Africa is yet to come (Johnson & Dorrington 2001:5). What is disconcerting about the South African scenario is the fact that bearing in mind the approximately 6.5 million people (Giese & Meintjes 2003:1) who are infected with HIV thus far, there might just be far more orphans of AIDS in this country than in any other in times to come.

The enormous strain caused by HIV/AIDS upon the government resources; Non-Governmental Organizations (henceforth referred to as NGO's) and the extended family system make the future appear rather bleak (Barrett 1998:4). Kehler (2003:47), in an examination of the South African Draft Children's Bill to be tabled in Parliament, emphasizes the dramatic increase in child poverty and child-headed households in the country. The argument in Kehler's (2003:47) report illustrates that **six out of every ten** children in South Africa live in poverty. As indicated by McKay (2003:26) of Save The Children Fund in the UK, South Africa has approximately 100 000 child-headed families presently.

Children, who are the most vulnerable, lose their parents and caregivers, have to leave school to assume adult responsibilities and cannot afford school because breadwinners are too ill to work (Desmond 2003:4). According to Giese (2002b:1) the majority of children in South Africa do not benefit from their rightful claim to shelter, food, education, family care, health care and protection. Although the pandemic is not the

major reason it is nevertheless one of the primary causal factors why children live under such disastrous circumstances.

Orphan hood is not a unique social issue within the South African society. Nonetheless, the emergent orphans of AIDS have begun to weigh heavily upon the present social and educational institutions, evolving diverse family structures, especially in the form of child-headed households (Fox, Oyosi & Parker 2002). Some of these children will grow up without proper education, love, care and guidance towards proper basic social skills and cultural knowledge. They may even suffer the discrimination and stigmatization attached to HIV/AIDS (Fox et al 2002).

The National Children's Forum (NCF) arranged to bring together 90 HIV affected children from around South Africa in order to allow the children to share experiences (Giese 2002b:1). Some of the most significant findings pertinent to this study were:

- Children affected by HIV/AIDS were not being supported by the school system. Educators were often totally unaware that these vulnerable children could not afford fees, uniforms or even food, had to take care of ailing adults or siblings **and** were required to bring in an income. Hence, they found it more convenient to be absent for lengthy periods of time and eventually just to drop out of school since the added pressures did not allow them to continue.

- These affected children gradually began to believe that HIV is spread by touching since they were discriminated against in all facets of their lives including the schools where children kept away from them. The maternal orphans were particularly affected by their circumstances having to face extreme poverty and increased neglect and vulnerability to abuse.

- Child-headed households were growing in number and these courageous orphans of AIDS were compelled to take on the roles of caregivers and

providers relying mainly on the generosity of their neighbours and the services of NGOs and CBOs.

- Although the extended families were supposed to care for the orphans of AIDS, they were responsible to a significant degree for the mistreatment, inequity and disregard that the orphans were forced to undergo.

- The conference with the orphans also exposed the fact that poverty and HIV/AIDS had become inseparable when children wished that they could have provisions, clothing, water, school fees, medication, means of transport and love.

4.2.2. THE PREVALENCE OF HIV/AIDS IN SOUTH AFRICA

UNAIDS and WHO (2002:2) calculations at the end of 2001 estimated that there were 5 000 000 adults and children who were infected with HIV by that time. During the year 2003, the recorded rate of mortality in South Africa was 650 000 – 200 000 more deaths than there would have been had AIDS not been a factor (Keeton 2003:18).

Fox, Oyosi & Parker (2002:8) are of the opinion that antenatal surveys are indicative of the magnitude of the calamity of the HIV/AIDS pandemic facing South Africa. Their study revealed different estimates from those of UNAIDS and WHO (2002), which elucidate that:

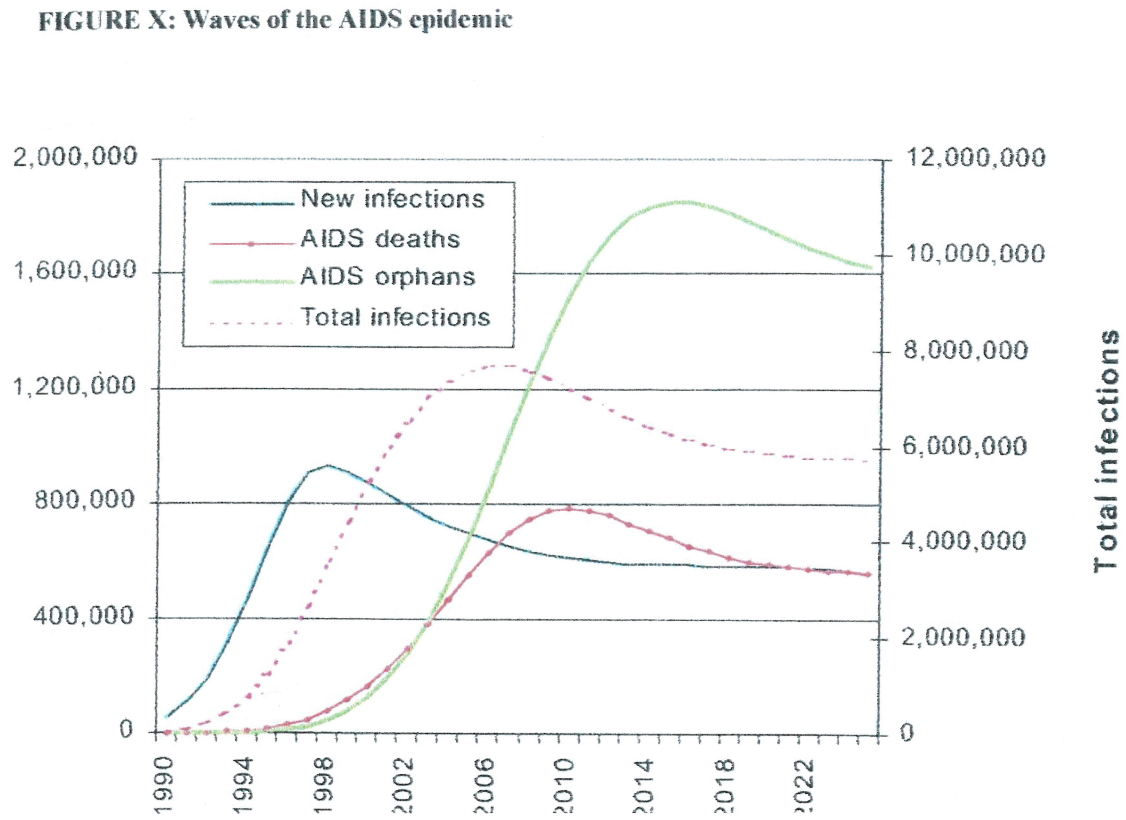
- About 4.7 million people were HIV infected by 2002; and
- Estimates of the rate of infection suggest that 2.5 million women and 2.2 million men between the ages 15-49 had become infected by 2002.

Giese and Meintjes (2003:1) consider that the following statistics have a significant influence upon the prevalence of AIDS in South Africa and the impact upon orphans of AIDS:

- 700 000 South Africans had died of AIDS as at July 2002;
- Approximately 6.5 million people (including 3.2 million women of child-bearing age – 15-49) were estimated to be HIV+ by 2003.

This standpoint will support the view that such statistics are surely influential upon the manner in which children are affected by HIV/AIDS. Fox et al (2002:8) maintain that in South Africa the epidemic is slowly intensifying since the greater part of HIV positive adults are still asymptomatic – hence the numbers of orphans are bound to increase dramatically over the years to come. It is significant to note that it is not relevant whether the children themselves are **infected,** but the **direct impact** – educationally, socially, materially, economically, and emotionally - upon the lives of millions is **central** to this study. According to Whiteside (2002:6) in 2002 there were approximately 300 000 orphans of AIDS in South Africa. Academics Rehle and Shisana (2003:7) in a paper discussing the Epidemiological and Demographic HIV/AIDS projections for South Africa, maintain that the projected numbers of orphans is 2.5 million by 2012. This is supported by the following illustration, which explicitly depicts future statistics:

FIGURE 4.1: WAVES OF THE EPIDEMIC



Source: Johnson & Dorrington (2001:6)

The above representation clearly depicts the South African situation with regard to HIV infections, AIDS deaths and orphans from 1990 together with future predictions of the path of the pandemic. The pictorial representation is indicative of the series of "waves" which demonstrate the long-term impact of the pandemic. It is apparent that the wave of new HIV infections reached the pinnacle in 1998 with approximately 930 000 infections in a year and the wave of total infections are set to reach a summit around 2006 at about 7.7 million infections. AIDS deaths, that are expected to peak soon after, approaching 2010 at about 800 000 deaths per annum, will be followed by the wave of AIDS orphans around 2015 resulting in almost 1.85 million children under the age of 15 whose mothers die of AIDS.

As indicated by the Children's Rights Centre in Durban (Gow & Desmond 2002:53), it is essential that more verifiable data about the location and condition of children orphaned by AIDS be made available. Researchers such as Dorrington & Johnson (2001 23-25) are of the opinion that there is a problem regarding the compilation of data and statistics of AIDS orphans in any country even South Africa. The data will depend on the number of AIDS deaths and these will depend on the statistics provided by health authorities (Keeton 2000). Secondly, the definition of the concept "orphan" needs to be uniform in order that all provinces should provide estimates based on the same definitions.

The Bambisanani Project (2001) cited by Fox et al (2002:10-11) validate that most of the children in this dire situation declare that their most vital needs were material in the form of food, clothing, bedding, medical care, money, grants, shelter and scholastic requirements like books and uniforms.

4.2.3. THE PREVALENCE OF ORPHANS OF AIDS IN SOUTH AFRICA

The discrepancies regarding the exact numbers of orphans of AIDS and the numbers of child-headed households in South Africa can be attributed to the fact that each group or individual researcher conducting the research applies definitions of these concepts as they see fit. With reference to this study one will find discrepancies with regard to the adolescent phase and age limits as well as the definitions of paternal, maternal and complete orphans – hence there are differences in the researcher's results even though they occur in the same time frame.

The following are some of the statistics supplied by *bona fide* studies:

- The inference by **UNAIDS** regarding the number of AIDS orphans in South Africa is that by 2005 there is likely to be approximately one million such children, a figure that is set to double by the year 2010 and reach 5.7 million by the year 2015 (**Dorrington & Johnson** 2002:47). **Dorrington & Johnson** (2002:47) further explain that statistics relating to the number of **paternal orphans** below the age 18 will be in excess of 4.7 million by the year 2015.

- On the other hand, **Whiteside** (2002:xi) proclaims that this is a situation of catastrophic magnitude since there were approximately 300 000 AIDS orphans in South Africa in 2002 – a figure that is set to increase almost 600 % to about 2 million by the year 2015. In comparison to the statistics provided by Dorrington and Johnson (2003:7) (4.7 million by 2015), Whiteside's figures are conservative.

- Contrary to others, **Mvulane** (2003:29) considered the number of orphans of AIDS to be 600 000 during 2003. Mvulane (2003:29) further stipulates that in 2002, 73% of the 204 000 children who had lost their **mothers**, had lost them to HIV/AIDS.

- **National statistics** also provided by Mvulane (2003: 29) suggest that as of July 2002 there were 885 000 children under the age of 18 who had lost a mother.

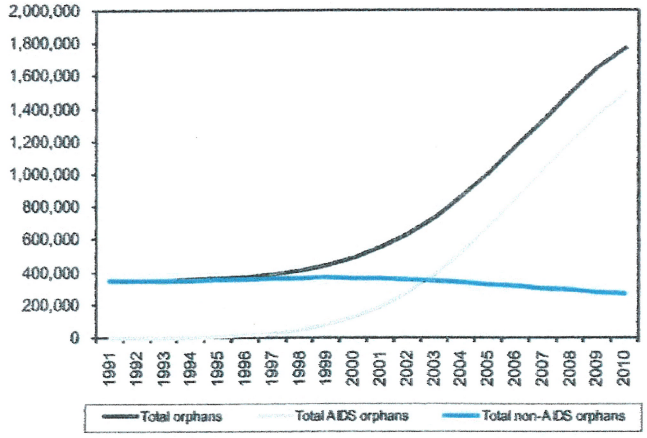
The information below provided by the Medical Research Council of South Africa (Dorrington, Bradshaw & Budlender 2002:29) supports the above projections of Whiteside (2002:xi), Keeton (2000:1) and Desmond & Gow (2002b:47):

FIGURE 4.2: Maternal orphans under 15 years, South Africa

South Africa

Maternal orphans under 15 years, South Africa

Year	Total orphans	Total AIDS orphans	Total non-AIDS orphans
1991	346 751	227	346 524
1992	347 701	581	347 120
1993	350 631	1 398	349 234
1994	355 642	3 162	352 480
1995	363 299	6 736	356 562
1996	373 229	13 469	359 760
1997	388 824	25 520	363 305
1998	412 435	45 799	366 635
1999	447 522	77 887	369 636
2000	493 846	124 989	368 857
2001	555 684	190 993	364 691
2002	636 876	279 102	357 774
2003	739 572	391 052	348 520
2004	865 216	527 054	338 162
2005	1 011 457	684 364	327 093
2006	1 172 985	857 201	315 784
2007	1 336 483	1 034 085	302 398
2008	1 499 424	1 208 646	290 777
2009	1 647 293	1 367 926	279 367
2010	1 770 870	1 502 457	268 413



Source: Dorrington, Bradshaw & Budlender 2003:29

The above statistics denote that, as at 2003 the total number of maternal orphans of AIDS (Dorrington et al 2003:29) is **391 052**, which is **more than half** of the total number of all the orphans in South Africa (636 876). According to the graph, the total number of orphans is set to soar as a result of the escalation in the number of orphans of AIDS in the years to come and will be roughly 1,8 million by the year 2010. In contrast, the number of non-AIDS orphans is predicted to decrease by the year 2010. Whiteside's results (2002:6) do, to some extent agree with what is stated by Dorrington et al (2003:29) in that the orphans of AIDS constitute almost half of the orphan population in South Africa.

It is apparent from the information given in FIGURE 4.1. and FIGURE 4.2. that the high prevalence of HIV in South Africa will lead to devastating circumstances for the

children left behind. Taking into consideration the UNAIDS definition of the term "orphan" (as mentioned in previous chapters) the predicted increase (according to FIGURE 4.2.) in AIDS orphans climbs dramatically from 124 989 in the year 2000 to 1 502 457 in 2010 (Dorrington et al 2003:29).

4.2.4. THE IMPACT OF HIV/AIDS ON AFFECTED FAMILIES IN SOUTH AFRICA

A number of children in South African households will find that their orphan hood is initiated even before the death of their parents (Johnson & Dorrington 2001:27). Once the parent becomes ill as a result of an AIDS-related disease, the income that the household relied on is no longer available. This sudden change in economic circumstances as well as having to watch their parents dying is exceptionally harrowing for the orphans (Johnson & Dorrington 2001:27).

Traditionally, within the South African context extended families coped with the increased burden of care whenever they were required to take on the orphans of their relatives. However, of recent the extended family system has displayed signs of flagging as a result of the exceptional number of orphans that are placing a strain on the extended family (McGregor 2002:2). Barrett (1998:5-6) reveals that the extended family's inability to cope results in child-exploitation and school-drop-outs as there is no money for school fees, hence children are being made to work to supplement household income.

Kalideen (2003:5), Gow & Desmond (2002:48) and Louw, Edwards & Orr (2001:4) find that families are affected in the following ways:

- The coping mechanisms of South African extended families and communities have become beleaguered with the increasing number of orphans of AIDS;
- Extended families are unable to absorb orphans into their communities;
- Families are overstressed;
- The stigma associated with HIV/AIDS and the orphans places undue stress upon the extended families;
- Orphans who do not live with adults, live in extreme poverty, are malnourished and drop out of school;
- Orphans of AIDS are psychologically disturbed because of watching their parents die; and
- The pandemic has resulted in many children taking on adult roles, being denied their right to education and being excluded by societies whose attitudes and policies are rooted in ignorance and discrimination.

A study (Beresford 2002:6) conducted on 771 households in four South African provinces by the Abt Associates and commissioned by Henry J. Kaiser Family Foundation displayed the following:

- 72% of the households were headed by women – one in five was a pensioner;
- 31% of the household heads were either AIDS sick or chronically ill which meant that this was the late undiagnosed stage of HIV;
- In excess of 20% of the children had been orphaned by AIDS;
- Of every 12 children, one (8%) looked after an AIDS sick adult;

- One in eight people said that monetary or physical pressure prompted them to send their children somewhere else to live that is plus 33% with another parent and 35% with grandparents;
- Girls were twice as likely to drop out of schools than boys were;
- Only 4% declared that they reduced expenses on school fees as a result of AIDS.

The South African situation displays a higher percentage of households that are headed by minors than those where there are **no** adults present (Desmond et al 2003:56). The **1999 October Household Survey** (Desmond et al 2003:57) indicated the following:

TABLE 4.1: 1999 October Household Survey (OHS)

	Child-headed households	Households containing no adults	Households containing only over 70's and under 18's
1999 OHS	**0.25%**	**0.19%**	**0.22%**

Source: Desmond et al 2003:57

The above are percentages of all households included in the Survey. However, the proportion of child-headed households appears to be much higher in the 1996 Census than the October Household Survey of 1999. Ziehl (Desmond et al 2003:58), who has worked with data from the 1996 Census, is critical of the authenticity of such data, stating that the report considered children under 4-years of age as heads of households in some cases. These discrepancies alone will indicate the difficulty that exists in the compilation of such data (Desmond et al 2003:58). These academics estimate that teenagers head the majority of child-headed households (Desmond et al 2003:58).

4.2.5. THE IMPACT OF HIV/AIDS ON THE EDUCATION OF ORPHANS OF AIDS IN SOUTH AFRICA

"The paradigm of education is shifting, and we must change our concepts and planning principles, or watch the achievements registered by EFA **(English For All)** ***being steadily undone. We must move from a narrow 'HIV education' curriculum campaign toward a broader 'HIV and education' paradigm"*** (Coombe 2002c:149).

There has been little empirical investigation into the socio-educational impact of HIV/AIDS on orphans of AIDS since the evidence thus far has been anecdotal (Ewing 2002:38). In addition, although these reports have exposed the impact of the pandemic upon orphans generally, no empirical research has been done specifically on the educational and social impacts of AIDS on orphans in child-headed households.

Coombe (2002c:129) and Rees (2000:3) are of the view that as a result of HIV/AIDS, there will be a dramatic reduction in the quality of education in South Africa. HIV/AIDS will lead to a reduction in general populations, thus there will be fewer pupils attending school (Kelly 2000a:11-15). Reduced school populations can also be attributed to poverty and the inability of children in child-headed households to pay their school fees as there will be no regular income or that money will be required to pay for medical care rather than education. Kelly (2000a:13) is of the view that orphans are more likely than non- orphans to drop out of school.

A sadly neglected segment of the AIDS arena is that of the manner in which children are getting by in the face of the trauma and the effect on the child's education (Coombe 2002b:19). Despite the South African policy of free education for all since 1994, the numbers of school-leavers has increased significantly (Gow & Desmond 2002:6). Children affected by AIDS are unable to attend school regularly because of the responsibilities at home where they are required to take care of sick parents and take

over adult duties. Gow & Desmond (2002:6) also see the urgent demand for suitable learning prospects to cater for the needs of those orphans who suffer confusion or seclusion, for those who care for younger children and for girls who are required to care for the sick.

A study by Booysen, Van Rensburg, Bachmann, Engelbrecht and Steyn (2002) in Welkom and Qwa-Qwa in the Free State Province, concentrated on the socio-economic impact of HIV/AIDS on households and communities. This research (Booysen et al 2002:3) also revealed that 8.9% of children between 14-18 were not attending school - 60.7% of these orphans were female indicating that female children especially were compelled to abandon their schooling on the death of their parents (Booysen et al 2002:3).

Within the South African context, HIV/AIDS is likely to increase the number of orphaned children, absenteeism and school dropout rates, produce declining school enrolment rates and deepen poverty (Coombe 2002c:131; Rees 2000:3). Coombe (2002c:131) continues with the contention by declaring that although South African population growth will be maintained, there will be greater evidence of school dropouts and non-attendance among those adolescents who become caregivers and those who have to work to support their families (Coombe 2002c:131).

The effect of the pandemic upon educators is also significant since their approach, practices and expertise can be instrumental in supporting orphans with their day-to-day problems (Kelly 2000a:13-15). Unfortunately, teacher mortality and the loss of productivity as a result of sick teachers are impacting negatively upon the education of orphans of AIDS. The system is unable to deal with the demand created by the loss of so many teachers who are victims of HIV and AIDS.

The successful functioning of the education system is challenged by the morbidity and mortality caused by HIV/AIDS. According to the Department of Education statistics in 2000 (Coombe 2000b:36), 12% of all educators (375 000 teachers, 5000 inspectors and advisors and 68 000 managers and support personnel) were HIV positive. This would mean that over 53 000 educators will die by 2010 or between 88 000 and 133 000 educators if there is a prevalence of 20%-30%. This would result in the loss of the most experienced senior teachers, managers, teacher educators and professors.

4.2.6. THE IMPACT OF HIV/AIDS ON THE RIGHTS OF ORPHANS IN SOUTH AFRICA

In any consideration of orphans in child-headed households it is imperative to take cognizance of the Rights of the Child within the South African milieu. In South Africa the constitution incorporates the fundamental rights of the child which include (Barrett 1998:3-4; UNAIDS 2003):

- **The right to equality and non-discrimination.** Children are especially affected in that:
  - Children who are diagnosed to be HIV positive and/or live in HIV households, are vulnerable to discrimination and rejection from relatives, schools and crèches;
  - If they are disabled and affected by HIV/AIDS, they are doubly discriminated against since there are no provisions made;
  - Refugee children whose parents have died of AIDS are in greater need of assistance because of their isolation from their extended families and own communities; and
  - The number of street children as a result of orphanhood is on the increase and they are at a greater risk of abuse, exploitation and a very poor standard of living.

- **The right to dignity.** Children are directly affected by HIV/AIDS and consequently:
  - They are more vulnerable to sexual exploitation and abuse;
  - Children are exposed to trauma and neglect long before their parents pass on;
  - The children have to contend with discrimination and the associated stigma of being a part of households affected by HIV/AIDS.

- **The right to life, including socio-economic rights for example basic education**. This right is being affected:
  - Children who are affected by HIV/AIDS are more likely to drop out of school as there is not enough money to pay for school fees, uniforms and books;
  - Children are being forced to sacrifice their schooling in order to take care of ailing parents;
  - There are few resources and facilities that promote healthy children in an HIV/AIDS positive environment especially for children from birth to six years of age;
  - There is no official policy and no assistance to help and provide community resources for the basic needs of young orphaned children;
  - There is an absence of a subsidy for food, water and shelter; and
  - Teachers themselves are untrained, overpaid and affected by HIV/AIDS.

- **The right to family care or parental care, or appropriate alternative care.** This will be influenced by:
  - The increased rates of children being orphaned;
  - Stressed families with decreased ability to cope with increasing demands;
  - Poor quality family life; and
  - Increased numbers of children being orphaned and decreased monitoring of children who are informally placed within the extended family system.

- **The right to basic nutrition, shelter, basic health care services and social services and the child's best interests are of primary importance in every matter concerning the child.** This right is being violated by:
  - Inadequate Legal Provision to address the changing nature of the basic needs of the children;
  - Inability of children who are orphaned to obtain access to social services because they cannot apply for such grants for themselves and they experience infinite impediments when they apply for identity documents;
  - Increased dispossession of inheritance of property, savings and insurance;
  - Increased mortality rates of orphans – death rates are higher among these children; and
  - Parents and caregivers who are sick and those who are orphaned are less likely to have preventative and curative health care provided.

The above Rights are certainly applicable in respect of the theme of this study in that researchers such as Giese (2002) and Proudlock (2002) are of the opinion that these Rights have been violated due to HIV/AIDS in this country. Orphans in child-headed households are tormented as caregivers to dying adults, as classmates of infected and affected learners and as onlookers to death from a myriad of painful AIDS-related diseases. They are eventually deprived of the comfort of family life, adequate protection, adequate shelter, equitable education and wholesome food. The only course towards the development of exceptional educational and social development for adolescent orphans of AIDS is via the advancement of these Rights of the Child (Reynolds 2003:8-10).

The South African Draft Children's Bill (Kehler 2003:50) that is in the process of being tabled in Parliament makes provision for children affected by HIV/AIDS and those in child-headed households. These children are defined as those 'in especially difficult circumstances' and requiring special attention. Kehler (2003:51) is of the view that the Bill *'places a legal obligation on all spheres of government and society to not only*

identify child-headed households but also to support and assist their functioning in communities'. This integrated and holistic approach will ensure that community-based structures are strengthened in order that the children's health and educational needs are taken care of.

4.2.7. THE SOCIAL EFFECTS OF HIV/AIDS ON ORPHANS IN SOUTH AFRICA

Booysen (2003:1) is of the view that most affected households are the victims of a 'vicious cycle of poverty and HIV/AIDS'. This is evident more especially if the particular household has suffered a recent illness or death and had to incur substantial medical or funeral expenses. It is quite obvious that the extended family system and caregivers are totally overcome by the pandemic, unemployment and poverty to be able to assist in the needs of orphans of AIDS (Martin 2003:37). Affected families undergo financial transformation in that regular income is decreased or that they are unexpectedly subjected to chronic destitution.

A recent report (Kalideen 2003:5) released by the United Nations Children's Fund (UNICEF) found that orphans live in increasing poverty once their parents have died. The report further claimed that the children were malnourished, dropped out of school, were increasingly used as child labour and were psychologically affected by the trauma of watching their parents die (Kalideen 2003:5-). The stigma attached to AIDS and fear of being landed with the burden of orphans affected by AIDS, prompt members of the extended family network to refuse to take over the responsibility of caring for these children (Sherriffs 1997:82). Hence, the orphans are traumatized by the abandonment. Further, trauma may result when they are compelled to live with strangers who abuse them.

Even prior to the death of a parent, the child is challenged by the psychosocial distress of this debilitating illness and becomes apprehensive about the future. Once the parent passes on, children orphaned by AIDS may have to cope with severe financial, educational and psychosocial difficulties (Marcus 1999:42-43). The Bambisanani Project (2001) in the Eastern Cape (Fox et al 2002:11) presents the view that the orphan's emotional welfare is threatened both prior to the parent's death and after. The children who were interviewed for the study believed that they were deprived of affection and attention when they themselves were sick, that they did not enjoy any leisure time nor were they privileged to have parental guidance and companionship.

Daniel (2003:2-3) reports that hidden psychosocial 'wounds' in the form of the stigma, discrimination and rejection that they experience, affect the educational achievement of the orphans. On account of the fact that stigma and discrimination foster further intolerance and social isolation children become victims of AIDS when they are sometimes refused admission to schools. Apart from the community, the relatives, who are expected to take care of these children on the death of the parent, abandon them for fear of being shamed themselves. This tribulation and the inept approach the orphans utilize to cope with it, traps them within an orbit of loss and despair with no prospect of escape. Children affected by the endemic disease are given no choice in the matter of having to deal with ailing dying parents, the strain of having to persevere in an environment demanding the maturity of adulthood, a predicament that is accompanied by prejudice and rejection, and the eventual calamity of parental death.

A study (Louw et al 2001:25) indicates that the ever-increasing number of orphans in South Africa is definitely going to impact upon the societies from which they come. Giese (Gow & Desmond 2002:66) is of the perception that children who grow up in environments devoid of parental supervision and support could create less productive adults who may display strong anti-social behaviour. In the long term the consequences are going to prove most detrimental to the progress of the country and the youth will be driven towards deviant behaviour.

Fox et al (2002:11) draw attention to the fact that studies in South Africa disclose that when financial support is provided, the less material needs in the form of the child's emotional and psychological welfare are neglected. An analysis (Fox et al 2002:14) of South African orphans and other vulnerable children presented conclusions that these particularly difficult psycho-social circumstances imposed by the HIV/AIDS pandemic brought on various divergent behaviour patterns – ways in which the children tried to cope. These could appear as minor acts of crime, rape, teenage pregnancy, immoral behaviour and a general lack of discipline. Fox et al (2002:14) refer to the Bambisanani Project (2001) declaring that children will develop as determined by the norms and values of their communities. Hence their view is that the South African situation displayed marginal community support systems that could prove beneficial to the well being of children in distress. Should there be more encouraging conditions for the children, pre- and post parental deaths, they will be able to cope more effectively after the ordeal (Fox et al 2002:14).

Adolescents in the family are required to take on adult roles and additional household tasks. Hence children (some even from the age of 12) are forced to take on "adult responsibilities". Apart from the trauma of suddenly becoming head of a household, some of these orphans are required to act as "guardians" to their younger siblings (Louw et al 2001:25). Therefore, researchers like Desmond & Gow (2002b:18-19), Coombe (2000a:15) and Fox et al (2002:9) expound that this actuality in the shape of child-headed households creates responsibilities and restricts their social life and access to education for orphans who would otherwise be adequately catered for by their healthy parents.

A report by Dorrington and Johnson (2002:48-49) further emphasizes the reality that extended families are now unable to cope with the growing number of children in need as a result of the extreme poverty. The once strong community-based support within the South African society is over-burdened by the large numbers of children orphaned by AIDS and the sudden appearance of child-headed homes is commonplace as a result of

the financial burden such children become for the extended family (Fox et al 2002:9; Dorrington and Johnson 2002:48-49; McGregor 2002:2; Barrett 1998:5-6). Fox et al (2002:9) also indicate that the orphans incorporated within the extended families are often subjected to blatant abuse and indifference, being exposed to arduous household tasks.

The Bambisanani Project 2001 (Fox et al 2002:10) disclosed that HIV/AIDS was one of the chief roots of orphanhood. The research findings (Fox et al 2002:10) revealed that the children reacted differently to the demise of their parents depending on whether:

- Children with other siblings and one surviving parent are in an insecure, apprehensive state.
- The impact of the pandemic is more pronounced if the children are aware that the virus is sexually transmitted and that the death of one parent is to be followed in time by the death of the other. Hence, the total loss of parental support, which is exacerbated if parents and family members do not make adequate preparations for later.
- Children whose needs are catered for and who are aware what their situations will be after their parents' deaths since wills are signed by the parents, move into orphanhood more comfortably. In sharp contrast others face the loss of home and other property to certain members of the community because their parents die intestate. This results in school dropouts and to social problems.
- Children who are deprived of an effective support system may be compelled to survive without any outside assistance at all.

Preliminary research to this study has revealed that children in households where there were critically ill and dying adults were notably more traumatized psychologically (Daniel 2003:2). Their previously secure lives are unexpectedly threatened by the sudden halt of the regular income that the parent/s were able to provide up to that time,

bigotry by those they had considered close to them and their having to watch over critically ill parents, caregivers or siblings. Such trauma results in the child's having to deal with dropping out of school, social isolation, taking on adult responsibilities, hunger and being deprived of adult supervision and care (Daniel 2003:15-16).

4.2.8. THE IMPACT OF POVERTY AND HIV/AIDS ON ORPHANS IN SOUTH AFRICA

"HIV is not a disease of the poor, but the poor are at higher risk of HIV infection, the poor are more vulnerable to HIV infection, and the disease makes the poor poorer." (Carol Coombe 2002c:122).

According to Giese (2002a:62), children who are part of infected households are all the more burdened because of the bias stemming from HIV as well as the associated poverty. Barnett & Whiteside (2002b:3) are of the opinion that AIDS exacerbates poverty, leading to *'financial, resource and income impoverishment'* and also emphasizes the social inequalities that already exist.

Guthrie (2003:16) concurs with Desmond and Gow (2002:65) in the assertion that the impact of HIV/AIDS and the concept of 'poverty' do not just relate to the insufficiency of income but also encompass the lack of income, lack of opportunities, lack of access to assets and credit, as well as social exclusion and the frustration of having to drop out of school.

Orphans of AIDS and children in child-headed households are found chiefly in societies where there are complex social problems such as destitution, abuse, lack of running water and essential food (McKay 2003:26). These extremely poor children are always mocked at and left out of social groups by their peers and other members of the

community. After the deaths of their parents, orphaned children are frequently abandoned in child-headed homes with no adult supervision and no source of income (Gow & Desmond 2002:36). They are deprived of the support of peers and educators once they forsake their studies for the reasons that there is restriction on funds available and there is no suitable adult control (Giese 2002:65).

It is evident that HIV/AIDS has lead to increased poverty among children in South Africa. Gow & Desmond (2002:36) make reference to ACESS (Alliance for Children's Entitlement to Social Security) 2001 in their assertion that as at 2002 approximately 12 million of the 17 million children in South Africa could be categorized as being poverty-stricken. A survey (Streak 2002:1) conducted by the Human Sciences Research Council (HSRC) in 2002 revealed that 75% of South African children aged from 0 to 17 lived below the poverty line of R400/month per capita and 57% below the poverty line of R200/month per capita in 1999. In comparison, in 2002, 11 million children aged from 0 to 17 years are severely poor in the sense that they are now living below the poverty line of R200/month according to the value of the Rand as at 1999 (which converts to R245-00 according to the value of the Rand in 2002). South Africa's poorest children emanate primarily from Kwa-Zulu Natal, Eastern Cape, Limpopo and North West provinces (Streak 2002:1).

South African statistics (Martin 2003:37) indicate that a minimum of R490 per month is required to meet the basic needs of children but the real situation in 2003 stood as:

- Roughly 14.3 million children (75%) live in poverty – on less than R490 per month;
- Nearly 11 million of the above children live in extreme poverty – on less than R245 a month;
- Orphans receive a child support grant of R140-00 per month from the Government but only 2,7 million children receive this state grant (Van der Westhuizen 2003:7).

Manicom and Pillay (2003:94-96) are most critical of the Child Support Grant for women and children, stating that the system does not provide acceptable financial assistance for those in need. They support the perception of ACESS in that 60 percent of South African children (0-17) live in the lower 40 percent of South Africa's households and that R140-00 is not sufficient to cover even the most basic wants of the children.

The standpoint of a researcher namely, Guthrie (2003:16) is that the socio-economic situation in South Africa has not been transformed since 1994 instead it appears to have deteriorated. Kath Defilippi (Keeton 2000:2), the executive director of the South Coast Hospice Association in Kwa-Zulu Natal proclaims that the extensive indigence in this region deteriorates into "horrific poverty" once families are affected by AIDS. Rising unemployment levels particularly in the Black population and the rural areas are the major force behind the epidemic. It is apparent that the child's poverty stems from the fact that the child's parents or caregivers who are sick or who have died, are unable to provide for the basic needs of the child and the onus therefore falls upon the state.

4.2.9. STRATEGIES TO MITIGATE THE IMPACT OF HIV/AIDS ON ORPHANED CHILDREN

Giese (2002b:1), an HIV/AIDS programme co-ordinator at the Children's Institute at the University of Cape Town, declares that South Africa is equipped with the perfect policies to make children the priority but it is unfortunate that there is constant infringement of the child's rights to shelter, food, education, family care, health care and security. Her view is that the pandemic is a major contributor to this adverse situation and that the services being offered by the State do not reach the majority of the resultant vulnerable children and orphans, above all, those in child-headed households. It is also apparent that the National Welfare system is buckling noticeably

under the strain of the thousands of children orphaned by AIDS (Mvulane 2003:29-30; Halkett 1998:10).

Thus far the South African Government has created the following strategy and policy documents to reduce the impacts of the pandemic upon this country's children (Giese & Meintjes 2003:42-43):

- **The National Integrated Plan (2002-2005).** This Plan which aims to form a partnership with all organizations, institutions, churches, communities and the private sector, is structured to deal with 'prevention, treatment, care and support, legal and human rights, research, monitoring and evaluation' of all people affected by HIV/AIDS;

- **The National Integrated Plan for Children Infected and Affected by HIV/AIDS** (NIP) (1999). This plan was initiated by the Directors General of the national Departments of Health, Education, Social Development and Finance in December 1999 specifically to provide for the needs of children;

- **The National AIDS and Children Task Team (NACTT) (2002)** was reconstituted as the National Action Committee for Children Affected by HIV/AIDS (NACCA) in order that there is teamwork between all the representatives from the different state departments, international development agencies and national NGO's to render the best possible service;

- **The Department of Social Development** and the **Nelson Mandela Children's Fund** assisted in the organization of a conference in June 2002 that brought about further changes when NACCA (above) was requested to develop action plans for children affected by HIV/AIDS with regard to housing, education and

recreation, food security, training and capacity building, database and communication, care and support, and social security and placements;

- **The Department of Social Welfare 2002 National Guidelines** for social services for children infected and affected by HIV/AIDS were formulated in order to assist service providers and government officials working with children and caregivers;

- The National project, **Circles of Support** that endeavors to work actively at eradicating the stigma and discrimination against children affected by HIV/AIDS and to promote community support for all vulnerable children, was established in 2002; and

- **The Child Support Grant** has of recent been increased from children under the age of 9-years to children under the age of 14-years, a strategy that is to be put into action gradually over the next three years.

The Draft Children's Bill that was presented by the South African Law Commission in 2002 (Kehler 2003:48) is due to replace the Child Care Act (No 74 of 1983). This document calls attention to 'primary prevention and early intervention services' with the aim of providing support and services to families at risk.

Despite the above-mentioned strategies that are implemented it still appears that many of the poor orphaned children are not being adequately assisted to deal with their bleak conditions. Makasi (2002:1) also emphasizes that in South Africa HIV/AIDS is not solely a health issue but a "*developmental issue*". The dire need for the support of orphans ought to be dealt with as a matter of some urgency considering the daily increase in the number of children who are affected by AIDS and the encumbrances

that face them. There is a need to preserve the family unit despite the catastrophe and for the Departments of Education and Social Welfare Services to aid these parentless children to deal with the their harsh conditions.

4.3. THE IMPACT OF HIV/AIDS ON KWA-ZULU NATAL

4.3.1. THE PREVALENCE OF AIDS ORPHANS IN KWA-ZULU NATAL

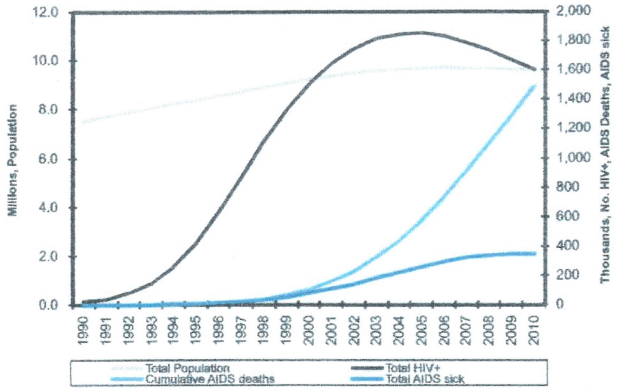
Research (HopeHIV 2002:1) highlights the fact that the province of Kwa-Zulu Natal is the hardest hit by the HIV/AIDS pandemic including the majority of South Africa's orphans who come from child-headed households. As at July 2002 approximately one third of the 700 000 South Africans who died of AIDS were from Kwa-Zulu Natal Giese & Meintjes 2003:1).

The high mortality rate in Kwa-Zulu Natal has left many children orphaned and in child-headed households. The perception of researchers and academics (Sherriffs 1997:82) in the World Health Organization and locally was that HIV thrives in unstable societies – hence the predicament in Kwa-Zulu Natal. As indicated by the illustration below, the statistics pertaining to the number of people who are HIV+, the number of cumulative deaths and the total number who are AIDS sick paint a grim picture for the Province:

FIGURE 4.3: Total population, number of HIV+ and AIDS sick people and cumulative deaths, Kwa-Zulu Natal:

KwaZulu-Natal

Total population, number of HIV+ and AIDS sick people and cumulative AIDS deaths, KwaZulu-Natal



Year	Total Population	Total HIV+	Cumulative AIDS deaths	Total AIDS sick
1990	7 514 578	18 614	104	168
1991	7 696 067	40 451	276	410
1992	7 879 173	81 336	677	943
1993	8 052 556	151 171	1 548	2 012
1994	8 223 087	261 854	3 319	4 020
1995	8 384 742	423 140	6 716	7 584
1996	8 529 882	633 695	12 839	13 417
1997	8 714 258	873 713	23 252	22 422
1998	8 890 733	1 112 987	40 352	36 528
1999	9 057 974	1 326 931	66 733	54 885
2000	9 211 922	1 504 196	105 340	79 238
2001	9 348 732	1 643 162	159 216	108 569
2002	9 464 671	1 745 490	231 265	143 222
2003	9 556 833	1 813 217	323 962	181 582
2004	9 623 198	1 848 217	438 910	222 153
2005	9 663 375	1 853 006	576 305	261 660
2006	9 678 981	1 831 347	734 535	296 928
2007	9 673 613	1 788 587	910 100	324 457
2008	9 652 692	1 731 160	1 097 978	342 129
2009	9 622 429	1 666 034	1 292 322	348 975
2010	9 589 177	1 599 512	1 487 357	345 949

Mortality rates for children and adults, KwaZulu-Natal

Source: Dorrington, Bradshaw & Budlender (2002:16)

The above table places the cumulative number of AIDS deaths for 2003 as being 323 962 and for 2004, 438 910 which in turn impacts upon the large number of orphans of AIDS that adult deaths will precipitate. It is also of particular relevance that although the number of people sick with AIDS will decrease, the number of cumulative deaths is still expected to escalate.

Kwa-Zulu Natal was estimated to have had between 197 000 and 278 000 orphaned learners under the age of 15 as a result of the pandemic (Louw et al 2001:25). Ebersohn & Eloff (2002:78) maintain that research in the area confirmed that there were about

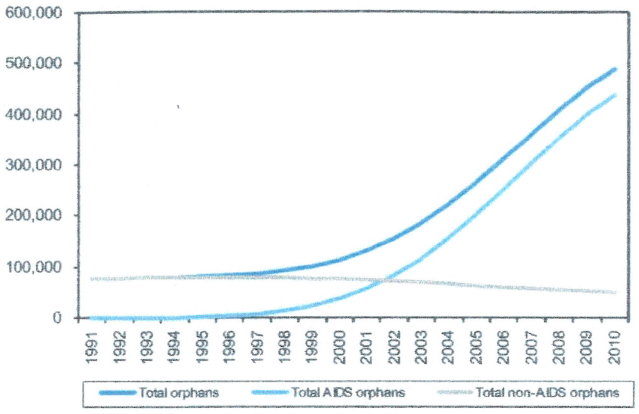
4570 child-headed households in the province of Kwa-Zulu Natal. However, statistics provided by the Durban Child Welfare Society (Mvulane 2003:29) in Kwa-Zulu Natal indicate that there has been an increase of 300% in orphan cases between 2001 and 2002. Just in Umlazi and Durban the increase in HIV/AIDS orphans is documented at 250%. By the year 2010 the total number of orphans of AIDS is likely to be in excess of 450 000 (Whiteside & Sunter 2000:71-72). The study by Dorrington et al (2002:17) (below) confers, to some extent, with this assumption:

FIGURE 4.4: Maternal orphans under 15 years, Kwa-Zulu Natal

KwaZulu-Natal

Maternal orphans under 15 years, KwaZulu-Natal

Year	Total orphans	Total AIDS orphans	Total non-AIDS orphans
1991	77 770	73	77 697
1992	78 601	188	78 412
1993	79 553	452	79 102
1994	80 724	1 013	79 710
1995	82 280	2 132	80 148
1996	84 558	4 228	80 329
1997	88 084	7 924	80 160
1998	93 603	14 042	79 561
1999	102 108	23 590	78 518
2000	114 732	37 683	77 049
2001	132 440	57 375	75 065
2002	156 048	83 501	72 547
2003	186 196	116 537	69 659
2004	223 023	156 412	66 611
2005	265 861	202 277	63 584
2006	313 039	252 370	60 669
2007	361 398	303 682	57 717
2008	408 367	353 445	54 922
2009	451 525	399 028	52 496
2010	487 920	437 651	50 269



Population pyramid in 2000 and 2010, KwaZulu-Natal

Source: Dorrington, Bradshaw & Budlender (2002:17)

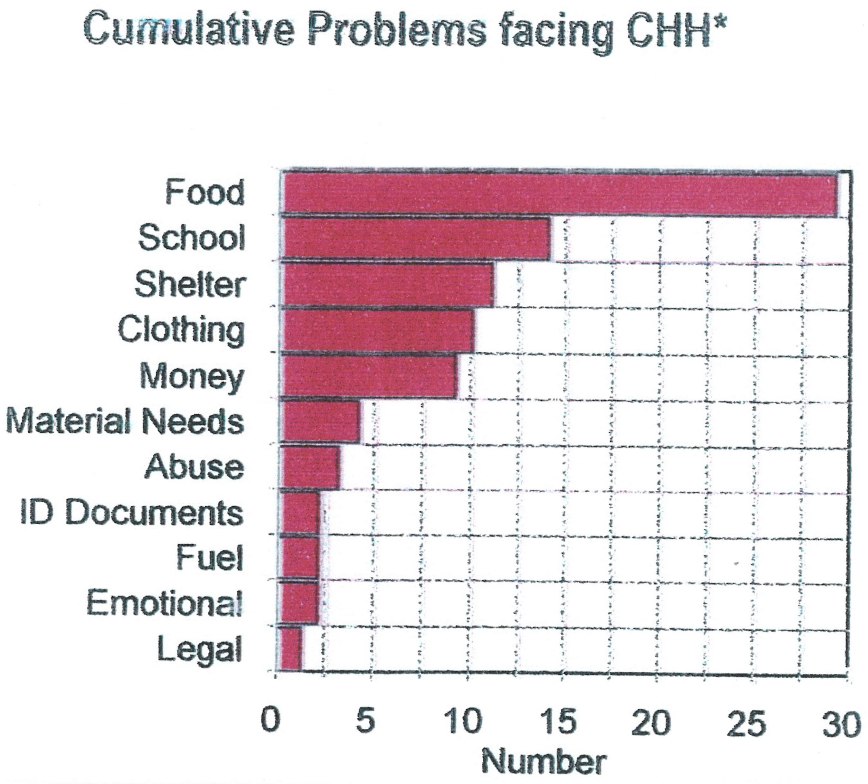
This study considers the projected figure of maternal orphans under 15 years of age at 437 651 in comparison to total numbers of non-orphans as 50 269 for the same period. The diagram is also illustrative of the fact that the number of AIDS orphans is set to spiral at an alarming rate – a situation that does not bode well for the Province with regard to the care and attention of such orphans.

4.3.2. THE PREVALENCE OF POVERTY AND THE EFFECT OF HIV/AIDS ON ORPHANS IN KWA-ZULU NATAL

Desmond, Richter, Makiwane and Amoateng (2003:56) consider the issue of child-headed households in Kwa-Zulu Natal to be *'an emotive and tragic story'*. Many teenagers are forced into adult roles, having to provide care and financial support after their parents or caregivers pass on. In a report on the effect of AIDS upon family life in Kwa-Zulu Natal (hereafter KZN), Clarke (2002:22) proclaims that orphans live in a world where poverty and trauma is rife, an austere world in which they are completely at sea in the campaign against hunger and death. A survey by the Human Sciences Research Council revealed that child poverty rates in KZN were 80% in 1999. If one were to analyze the needs of orphans of AIDS in the form of food, clothes, water and shelter, one will recognize that these are all poverty related, accentuating the correlation between poverty and HIV/AIDS in Kwa-Zulu Natal (Giese & Meintjes 2003:46; Booysens 2003:17).

The graph on the following page illustrates the results of a study conducted by the Thandanani Project by Strode (2003:42). This study places the necessities of the orphans of AIDS in order of importance:

FIGURE 4.5: Cumulative Problems facing Child-headed households



SOURCE: STRODE (2003:42)

The above illustration serves to emphasize that the most important basic necessity of food is lacking in almost every household (Strode 2003:42). Strode (2003:42) also confirms that the lack of any regular income makes it impossible for the orphans to fulfill any material needs - hence they are often unable to attend school since they are unable to pay school fees. As indicated above the orphans consider that they are also deprived of proper shelter, clothing and money. The issue of abuse of the orphans does not feature prominently within the context of this study.

Child poverty is a major concern in KZN and community care programmes such as Thandanani in Pietermaritzburg emphasize the need for the community and households to incorporate these orphans within their folds in order to assist the costs that the State will normally incur (Gow & Desmond 2002:52-53). The following tables reveal the

grim situation in the Province and the logic behind the view that the pandemic is spreading rapidly as a result of this state of poverty (Streak 2002:2; Gow &Desmond 2002:53-55):

TABLE 4.2:

CHILD POVERTY RATES, ESTIMATES OF POOR CHILDREN AND CHILD POVERTY SHARES BASED ON OCTOBER HOUSEHOLD SURVEY 1999 AND POVERTY LINE OF R400/MONTH CAPITA:

Province	Child poverty rate in 1999 (%)	Estimated number of children in 2002	Estimated number of poor children in 2002	Child poverty share in 2002 (%)
KZN	**80.0%**	**4 106 547**	**3 286 470**	**23**

Source: Streak 2002: 3

TABLE 4.3:

CHILD POVERTY RATES IN 1999 AND ESTIMATED NUMBERS AND SHARES OF POOR CHILDREN BASED ON OCTOBER HOUSEHOLD SURVEY 1999 AND A POVERTY LINE OF R200/MONTH PER CAPITA:

Province	Child poverty rate in 1999 (%)	Estimated number of children in 2002	Estimated number of poor children in 2002	Child poverty share in 2002 (%)
KZN	**62.9**	**4 106 547**	**2 584 250**	**23**

Source: Streak 2002:4

The above assessments are based on the view of Booysen (2003:10) who upholds that the poverty line provides a standard of the extent of poverty within certain communities. Table 4.3 confirms that the child poverty rates in Kwa-Zulu Natal are about 80% and that the estimated number of poor children (column 4) which is 3 286 470 is the highest in South Africa (Streak 2002:3). This is emphasized in the last column of the figures, which highlights that Kwa-Zulu Natal has a 23% child-poverty share in South Africa – the highest in the country (Streak 2002:3). Table 3 identifies that the child poverty rates for a poverty line of R200/month is still 23%.

Case (2003:1-2) upholds the theory that orphans of AIDS in Kwa-Zulu Natal face financial ruin and deprivation since they need to cope with a sudden loss of regular income that had been provided by the afflicted member of the family. In order to take care of medical bills and funeral expenses they may have to sell furniture and other household belongings. School dropouts are a common feature among orphans of AIDS who will be unable to afford school fees and purchase schoolbooks and stationery. It becomes more important for them to buy food rather than go to school. Once orphans in child-headed households are unable to pay school fees, they are most likely to abandon their studies (Strode 2003:63). The heads of these child-headed households lacked the emotional stability to devise the necessary means whereby they could access education. Orphans in child-headed households affected by HIV/AIDS are more likely to be shunned by communities and eventually social events do not include them.

4.3.3. STRATEGIES TO MITIGATE THE IMPACT OF HIV/AIDS ON ORPHANED CHILDREN IN KWA-ZULU NATAL

Spain (2000a:1) is of the view that children who have been abandoned, orphaned or displaced are at risk of being alienated or deprived as a result of the stigma attached to the virus. In order to inhibit any dysfunctional development, the Cindi-network works tirelessly to ensure that the children they are able to assist, develop socially, educationally and intellectually (Spain 2000a:2). Orphans of AIDS are identified and supported using the most inventive measures since financial assistance is dependent upon the contributions of important sponsors.

A major part of the work of the Thandanani Association includes the care and education of AIDS Orphans (Fox et al 2002:15-16) since the Foundation believes that it is a child's right to education. They are currently assisting communities in Pietermaritzburg and Richmond to access social grants in order that the vulnerable are able to alleviate some of their financial burdens and ensure definite schooling for the children (Thandanani 2003). However, sponsors and donations enable the project to assist the children to pay school fees and purchase uniforms. Statistics for April 2002 to March 2003 highlighted the following:

- 212 children were assisted with food parcels;
- 609 children were helped to pay school fees for 2002/03 and 2003/04;
- 123 children's cases were opened by the social worker;
- The Thandanani Bursary Programme assisted 264 children in 46 different schools to pay their fees in 2002 and was rewarded with a pass rate of over 80%.

The Sinosizo Project is a home-based care programme that works with some 900 families by seeing to the needs of children between the ages 9 and 14 who are the primary caregivers of their parents and younger siblings. Children in the area faced

many problems that others like them did not normally have to - finding ways of disposing of soiled bandages and incontinence pads, look for sustenance and prepare food for their families, fetch water for drinking, cooking, bathing and washing clothes and carry smaller children on their backs. The children are given the responsibility of administering medication to their parents but often there is none to give to their dying parents – hence the children are party to their parents' deaths (Coombe 2002c:135).

The Ingwavuma Orphan Care project was set up in June 2000 (Barnard 2003:29) and has at present the highest number of orphans of AIDS in the country. Statistics for the region as at September 2002 were:

- 865 orphans (both parents dead)
- 228 children living with dying parent(s)
- 107 abandoned children.

Basic social problems include the lack of access to clean water, toilets and electricity. The customary extended family is still evident in this area but is unable to cope with the catastrophic effects of the pandemic. Hence, orphans, hunger and child-headed households are widespread, with orphans totaling almost 2000 (Kehler 2003:47-51;Morin 2004:15). Children from homes affected by HIV/AIDS often cannot afford to pay mortuary fees and bury their parents in their own back yards (Kehler 2003:47-51;Morin 2004:15). The problem with applying for foster-care grants is that there is no regional office for the Department of Home Affairs and there are protracted delays in the processing of birth and death certificates (Kehler 2003:47-51;Morin 2004:15). The welfare office in this region is inundated with the demands for further food parcels and is unable to process any more foster grants because of time-restraints (Mvulane 2003:30).

Academics affirm that the abject poverty and hardship that such orphans face can be equated to that of protracted incurable afflictions where the family generally finds it

difficult to handle the psycho-social and economic tribulations that accompany the illness (Gow & Desmond 2002:53). They point out the views of the Child Rights Centre in Durban that there is far too little confirmation available about child-headed households and anecdotal evidence does not suffice. There is a pressing need for there to be more consistent records about the location and living conditions of orphaned children to be able to offer funding and address the issue of the children's vulnerability.

4.4. CONCLUSION

If one were to analyze the information provided in this chapter, the statistics pertaining to the percentage of HIV/AIDS adult deaths at the given moment and that which is anticipated in this country will reveal that this will invariably lead to an unprecedented increase in the number of orphans in years to come. As a result, such a picture ought to merit greater awareness and action towards the care and protection of the most vulnerable victims – the orphans in child-headed households.

These are children who lack the adult supervision and guidance and financial stability that would have, under normal circumstances, assisted them to become steady, competent members of their communities. Many orphans in child-headed households in South Africa are deprived of an effective support system and are compelled to survive without any outside assistance at all. In the light of the above, more research is needed to mitigate the impact of HIV/AIDS on the adolescent in the child-headed household. In order to obviate the disaster of having dysfunctional adults in future societies as a result of poor psychosocial and educational development, it is incumbent upon government, social and education departments and NGO's to make a concerted effort towards ensuring that adequate psycho-social, educational and financial support is afforded to orphans of AIDS in child- or adolescent-headed homes.

CHAPTER 5

DISCUSSION OF THE EMPIRICAL RESEARCH

"To me the future looks like it is fading away because I live unhealthily sometimes and sometimes I live in hope that if I can complete school, I can have a nice life" *Research Subject No. 1.*

5.1. AIM OF THE CHAPTER

This chapter serves to illustrate explicitly the second part of this study, which is the empirical research. Since research conducted by the HSRC and the MRC in South Africa have drawn attention to the gravity of the HIV/AIDS situation in the Province of Kwa-Zulu Natal, this region of the province was deemed a suitable choice as a site. The chapter aims to do a qualitative study involving four adolescents in child-headed households affected by AIDS. The study involves various steps, procedures and comments that will be described fully in this chapter.

5.2. INTRODUCTION

The research was conducted in the rural area of Willowfontein, which is just west of Pietermartzburg. Initially, ten households were visited with the intention of procuring a suitable sample. Subsequently, only four of these were selected, as these were the only ones that fitted the requirements of the definitions as stipulated in Chapter 1 of this study. The heads of these child-headed households ranged from 15 to 18 years of age and included three females and one male. Data collection was conducted by means of

informal interviews as well as semi-structured interviews, observation and the *Sack's Sentence Completion Technique*. The Appendices are illustrative of each and have been submitted herewith. Analysis of the *Sack's Sentence Completion Technique* was carried out categorically as explained in Chapter 1 and indicated in the Appendices.

After the necessary permission was sought and forms signed consenting to the study, the research process began. The initial visits allowed for identification of the appropriate samples and the introduction of these adolescents to the research process. Later visits involved the interviews, observations and the administration of the *Sack's Sentence Completion Technique.*

The following results also include the researcher's analysis of the relevant social, educational and psychological effects of HIV/AIDS upon the subjects individually. A discussion of the effects of poverty upon the research subjects and the effect of HIV/AIDS upon the education of the subjects follows these results and analysis.

It must be emphasized that this is a qualitative study on a small sample. Although the results are pertinent to the social group in question, it may not be generalized to the wider population.

5.3. HOUSEHOLD NO. 1 - SUBJECT: Thembelihle

5.3.1. The Interview

5.3.1.1. Biographic Particulars

General

Name: Thembelihle
Date of Birth 02/11/86
Age: 17 year-old
Sex: Female
Grade: 9
School: Willowfontein Intermediate School
Place of residence: Willowfontein
Race: Black
Language Spoken: IsiZulu

- **Family composition and Background**

Thembelihle is one of the girls in a set of female twins. In comparison to those homes around them, the wattle and daub home their parents have left them is fairly big (3 rooms and a kitchen). The subject and her twin sister lost their parents within one month of each other during the latter part of 2002 and this proved particularly stressful for them, as they have no other siblings. They revealed that they do not have an extended family support system but are popular in their neighbourhood and seem to have kind friends who socialize with them and share their problems. Regardless of their exacting circumstances, they are quite proficient at keeping themselves alive from donations, but do become utterly emotional in troubled times.

- **Food Intake**

Thembelihle states that she and her sister do not have any money to purchase food and rely on what is given to them by others. According to the subject, they are able to ensure that the food that The Thandanani Children's Foundation provides for them lasts them through the month and that they are able to have three very small meals a day. Their basic diet consists of rice and potato chips. They even have the same for breakfast, substituting the rice with bread at times and prefer this to beans and porridge. They are able to have tea regularly due to the kindness of their neighbours. Since there is no feeding scheme at

school, they carry bread and potato chips to school if they have sufficient to carry them through the day. This shortage of food and an imbalanced diet result in poor concentration at school and has a negative effect upon the subject's performance at school. Discussion with the subject has revealed that this is accurate as they are often tired and find it difficult to focus at school.

- **Background information and traumatic experiences regarding the Father**

Thembelihle's father had not been ill for a very long period but he became progressively worse with time. The subject was first aware of her father's illness in April 2002 and he passed on in October of the same year. She was not aware of what caused his death, as he never told her what the illness was and no one else did either. Since the subject and her sister felt more helpless and afraid, they cried a lot but were nevertheless attentive to his needs during his illness. Her grades at school deteriorated and she was compelled to leave school for a while as she and her sister had to take on unfamiliar adult responsibilities. She was extremely distraught on the demise of her father since she experienced a mixture of emotions such as sadness, apprehension, fear and loneliness. Since their father's illness there is a shortage of food, no income at all, no adult support or supervision, no money to pay school fees or purchase other necessities and she has just the clothes that she had when her parents were alive. It is quite apparent that the subject had been closer to her father and that she longs for the comfort and protection that he had afforded her.

- **Background information and traumatic experiences regarding the Mother**

According to the subject, her mother had been ill for much longer than her father but her mother passed away in November 2002. She attributes her mother's death to a prolonged severe bout of pneumonia since nobody - least of all her mother - discussed her mother's ill health with the child. With both her parents critically ill at the same time, Thembelihle and her sister were prone to bouts of extreme sorrow and despair but were obliged to assist their parents at all times. By the time her mother passed on, she was utterly panic-stricken and looked to her friends for solace through the process of mourning both her parents. The subject had to share household chores with her twin sister, missing her devoted mother's cooking and devotion.

5.3.1.2 HIV/AIDS and household relationships

Although it has been verified that the subject's parents had died of AIDS-related illnesses, she does not refer to the virus at any stage. However, she does concede that all parents ought to discuss their illnesses openly with their children so that the latter may prepare themselves emotionally as well as practically for the deaths. Children will also know how and why their parents have passed on. Thembelihle recognized the importance of parents selecting a guardian who will take proper care of the children later. She was of the view that it was not shameful for parents to suffer or die from AIDS.

The subject and her twin sister have always lived in this family home and have no other siblings. The decision to live in their family home was made jointly by the two sisters as they grew up in their parent's home. She is comparatively composed regarding this and prefers living in this home despite not having adult or sibling support. For the first time she refers to some family who lives in Dalton and where she would otherwise choose to live.

Thembelihle is still perturbed by the fact that she does not know how or why her parents passed away and that they are left without money and there is no one to assist them in their times of need. She has photographs of her parents but they do not look at these often as these reminders of their parents, distress them.

5.3.1.3 Social Life

Thembelihle and her sister spend free time playing with friends, listening to music or attending church programmes and services. Regardless of the time she spends with others the major part of each day is spent with her sister whom she confides in. She confesses that even at school they are treated well by their friends and classmates and are not victims of stigma or discrimination. Should there be a problem she would like to discuss with an adult, Thembelihle goes to Nestor, the Thandanani Children's Foundation volunteer who accompanied us since the lady takes an interest in them. The subject stated emphatically that she found certain adults objectionable since they borrowed stuff from them and took advantage of them by not returning these. She was aware that these adults treated them despicably since there were no adults to stand up for them.

5.3.1.4 Emotional well-being

The subject does admit that there are times when she has found it necessary to defend her sister or herself against discrimination and insults from neighbours or the other children. She does not enjoy being alone and if she is not with her sister she spends time with her friend Mpume. Thembelihle does feel pangs of anguish when she considers their basic needs – her basic physiological needs as well as the security needs are unfulfilled in her case (Chapter 2 – 5.1). She admits that she never contemplates running away from home and is really happy everyday when she spends time with her sister and their friends. When she is reminded of her parents, she finds that it affects her performance at school since she becomes extremely emotional.

5.3.1.5 Schooling

The teachers at Thembelihle's school are at most times kind and teach them well but are also sometimes discriminatory towards them ever since they lost their parents. This invariably leads to a negative self-concept as her **"esteem or I-needs"** are unfulfilled (Daniels 2001:4). Although she is attentive during the lessons, she finds that teachers can lack the compassion and thoughtfulness that she would prefer they have especially under these circumstances. The subject chooses to go to school and will be happy if her teachers will assist them in those subjects that they find difficult. At one time Thembelihle and her sister had to absent themselves frequently to take care of their critically ill parents but they now attend school conscientiously.

The Thandanani Children's Foundation pays their school fees timeously and helps to purchase their books and pens in order to guarantee that the sisters are able to go to school without having to worry about these expenses. Their school uniforms had been purchased by their mother prior to her illness.

The children in Thembelihle's class are more considerate than the teachers since they are neither rude nor insulting towards them and they have many kind friends, both at home and at school. The subject admits that they do not encounter any situations involving learners at school who deliberately isolate them and they are readily welcomed into group activities. However, it seems as if the children whom the subject encounters are far more tolerant than the adults.

5.3.1.6 Future perspectives and ideals

By the subject's own admission, she is determined to overcome this abject poverty and deprivation that appears to hold her down and actualize her potential to uplift herself (Pretorius 1994:20-21). Her dreams appear in the form of securing suitable employment and living a comfortable life thereafter. The lack of ambition with reference to a tertiary education results from the fact that she is not being guided in that direction and is

certainly not aware of any opportunities that may be available to her. For this reason, her physical and safety needs take precedence over the need to achieve since she lacks the necessary adult guidance and financial support to realize her full potential (Chapter 2 - 5.1).

5. 3.2. *SACKS SENTENCE COMPLETION TECHNIQUE*

3.2.1. Category I: Family

- **Mother**

14. My mother *was not a person who liked to talk too much. She only taught us respect.*
29. My mother and I *cared about each other so much but Mama would get very angry when we were naughty or if we did not listen to her.*
44. I think that most mothers *(no response).*
59. I like my mother but *when she punished me for doing wrong, I felt like I was being abused.*

- **Elucidation of the subject's perception of the mother**

Despite the authoritative manner in which Thembelihle's mother had reared her, the child acknowledges that she had been very fond of her mother and had respected her. She does confess, however that the punishment was sometimes akin to abuse.

- **Father**

1. I feel that my father *if he were still alive, he would have bought me everything I needed and when our school visited somewhere I would not miss a trip.*
16. If my father would only *have told us that all that he had was ours.*
31. I wish my father *wherever he is can bring us good luck in our efforts.*

46. I feel that my father is *(no response)*.

- **Elucidation of the subject's perception of the father**

Thembelihle saw her father as a provider who made certain that his children's needs were met. The implication in the child's response to question 16 is that the father had omitted to make known the legal inheritance of the children. This situation might have encouraged male members of the paternal family to lay claim to the father's property on his death. According to Zulu culture, the vulnerable children would not have had any recourse to protect their own interests.

- **Family**

12. Compared with most families, mine *I picture a bit differently because of the financial problems we are facing.*
27. My family treats me like *(no response)*.
42. Most families I know *they are rich and living a high life.*
57. When I was a child, my family *used to be a happy family and lived happily.*

- **Elucidation of the subject's perception of the family**

It is somewhat improbable that other families in the area are in actuality far better off (financially) than Thembelihle's humble family of two. Although all the families in the area appear to be poverty-stricken, the subject's responses are indicative of her perception of their plight. She recalls pensively the happy times spent with her complete and contented family in the past.

5.3.2.2. Category II: Sexual

- **Being a woman**

10. My idea of a perfect woman *is that she should pull herself together and not be found anywhere at anytime.*
25. I think most girls *they get boyfriends and practice sex and get AIDS and HIV and die.*
40. I believe most women *they are in a tough situation.*
55. What I like least about women *(no response).*

- **Elucidation of the subject's perception of being a woman**

Thembelihle focuses on the issue of promiscuity and HIV/AIDS in her responses regarding women indicating that she is fully aware of the disastrous effects of the pandemic. She also acknowledges that women are generally in vulnerable positions that do not allow them wide-ranging choices. She is also indirectly condemning the abuse of women in her community.

- **Heterosexual perceptions**

11. When I see a man and a woman together *I think of my mother and father.*
26. My feeling about married life is *that it is difficult sometimes and nice at other times because you have to look after a big family.*
41. If I had a love affair *(no response).*
56. My love life - *I have no love life because boys are destroying girls.*

- **Elucidation of the subject's perception of heterosexual relationships**

Although Thembelihle is reminded of her parents when she sees another man and woman, she communicates a disapproving approach towards young males in her responses. She might react in this manner because of her intense fear of being attacked as they are without adult protection or because they feel threatened by some of the discrimination directed at them. This stance will probably require therapy in order to permit her to develop a positive mind-set towards the opposite sex.

5.3.2.3. Category III: Interpersonal relationships

- **Friends and acquaintances**

8. I feel that a real friend *is someone whom I can trust with my confidential secrets.*
23. I don't like people *who are naughty like males.*
38. The people I like best *are my friends and people who help me.*
53. When I'm not around my friend's, *I used to be alone.*

- **Elucidation of the subject's perception of friends and acquaintances**

It is evident that the subject places absolute faith in friendships and finds comfort in her own trustworthy friends. Any form of assistance that she can obtain also engenders feelings of warmth within her. However, she reiterates her misgiving about boys and their intentions. As a result of her having to share the home with just her sister she feels vulnerable and fearful of being assaulted or abused.

- **Superiors**

6. The male teachers at our school *they treat us very well and treat us very well as if we were their own children.*
21. In school my teachers *teach us well, we listen to them when they teach us. They don't scold us for nothing.*
36. When I see the teacher coming *I get worried when I have not done my homework that he had given me.*
51. People whom I consider my superiors *are the SANDF as the National Servicemen and I admire them and would like to be one of them.*

- **Elucidation of the subject's perception of superiors**

While Thembelihle respects the authority of the teachers at her school, she also acknowledges that they are very good at their work and seem to treat all children fairly. She appears to be satisfied with the school she attends and does not mention any form of bigotry. It appears unusual that she thinks highly of the SANDF, which probably stems from her association with someone close to her who is in the SANDF or the work that might have been done by the organization in that area.

- **People in charge**

4. If I were in charge *I will be very happy and can help people who are looking forward to reaching their destiny (goals?).*
19. If people work for me *I can treat them well and pay them good salaries.*
34. The people (children) who do things for me – *I am so happy because they help me with lots of things that I want.*
48. In giving orders to others, *I do so in a peaceful manner because I do not want to do so loudly and scold them.*

- **Elucidation of the subject's perception of people in charge**

To Thembelihle, it is more important to create peace, happiness and satisfaction among those one is in charge of rather than to wield fierce authority. An assertion of power is not a priority in her mind since she has never been in such a position and does not conceive that control is necessary for successful leadership. She is assisted by others in her community who are compassionate and therefore considers it her duty to reciprocate when she may be able to, later. She also wants to be helpful to others so that they can be successful when she is in charge. Her responses are moreover indicative of her awareness that money and a constant income are important in any individual's life.

- **Peers**

13. At school I get along best with – *subjects such as isiZulu, English, HSS and N.S.* (confused about question?).
28. Those at school with me *we treat each other very well we all do not fight.*
43. I like working with people *because I can get a lot of information from them.*
58. Other children in my class *we treat each other well.*

- **Elucidation with reference to peers**

The responses to these questions are indicative that Thembelihle has many friends and is not a victim of discrimination or isolation as far as her peers are concerned. It is important to note that this amicability is mutual since she also appreciates all the benefits of noble friendships.

5.3.2.4. Category IV: Self-concept

- **Fears**

7. I know it is silly but I am afraid of *(no response).*
22. Most of my friends don't know that I am afraid of *(no response).*
37. I wish I could lose the fear of *(no response).*
52. My fears sometimes force me to *lose hope and say I am ready for anything that might happen to me.*

- **Elucidation of fears**

Thembelihle fails to respond to any of the questions that will expose her fears and anxieties. She seems to see the need to remain resilient in the face of their adversity by not exposing those aspects of her character that others will see as helplessness and defenselessness. She finally relents, stating that from time to time, when times are exceptionally demanding, this unknown fear compels her to become despondent and give in.

- **Guilt feelings**

15. I would do anything to forget the time *(no response).*
30. My greatest mistake was *(no response).*
45. When I was younger, I felt guilty about *(no response).*
60. The worst thing I ever did *(no response).*

- **Elucidation of guilt feelings**

Thembelihle's lack of response to these questions is indicative of her resolve to be secretive about her personal guilt and actions that she might be ashamed of.

- **Personal strengths**

2. When everything seems to be against me *I ignore them and keep my mouth closed because I don't want to talk.*
17. I believe that I have the ability to *complete school and see what I can do afterwards.*
32. My greatest weakness is *(no response).*
47. When luck turns against me *I used to say that only God knows because people say they do not care.*

- **Elucidation of personal strengths**

According to Thembelihle, the most appropriate manner in which she chooses to deal with her traumatic experiences is by pushing these out of her mind and ignoring them. This myopic approach permits her the false comfort to contend with her daily life by dealing with just what she prefers to. The subject displays an unyielding resolve to see herself through her schooling so as to be able to contend with the tribulations of the future. Perhaps she does not mention anything about tertiary education because of a lack of guidance or a sense of responsibility towards her sister.

- **The Past**

9. When I was a child *I used to love to play and eat food.*
24. Before I was at school (*no response).*

39. If I were a little child again *I would like to remain little and not grow older anymore.*
54. The thing I remember most about my childhood *is to play.*

- **Elucidation with reference to the past**

Thembelihle yearns for the blind faith and self-indulgence of her childhood when the lack of responsibilities allowed her to concentrate just on childish pastimes. At this stage of her young life she is suddenly faced with the ordeal of tackling adult responsibilities because she is an orphan of AIDS.

- **The future**

5. To me the future looks *frightening because I live in unhealthy conditions but sometimes I live in hope that I can complete school and have a nice life.*
20. I look forward to *my schoolwork and to pass and go on to work.*
35. Some day I *(no response).*
50. When I am older *I would like to be alone and enjoy my money when I am working.*

- **Elucidation with reference to the future**

Each of these responses underscores the child's optimism despite her predicament. Within the context of accepting her currently deplorable living conditions, she is able to see herself labouring through school and finally in securing a job that will lead to a more promising future.

- **Goals and Ambitions**

2 .I always wanted to *have a big house and lots of money and be a rich woman.*
18. I could be perfectly happy if *I can complete school and find myself work.*
33. My secret ambition in life (*no response).*
49. What I want most out of life *is to work when I am finished with my studies.*

- **Elucidation of goals and ambitions**

Thembelihle is completely selfish in her personal ambitions since her goals revolve around individual improvement with no recognition or acknowledgement of others who might be assisting her at this point in time. It is ironic that although she is one of a twin with no other sibling, she does not include her sister in her plans for the future. The desire to improve academically reiterates her strong determination, while knowing full well that she may not have the means to finish school if it isn't for the generous sponsorship she obtains from the Thandanani Children's Foundation.

5.3.2.5. Three wishes

1. *I wish to finish school and to get work.*
2. *I wish to be famous and live a high life.*
3. *I wish to live with my family forever and give them everything they want when I am working.*

- **Summary of the three wishes**

This is the only time when Thembelihle includes her family in her plans for the future and an expression of her sincere desire to provide them with whatever they want when she has achieved financial security. Under the present miserable conditions she hangs on to her dreams somewhat unrealistically in order to achieve the financial and

emotional security that she believes she can. However, it is unlikely that under the present circumstances, where there is a total lack of any moral, parental and financial support structures, that she will be able to finish school. Hence, all her other aspirations may also not be realized since she may not be able to fulfill her desires because of the lack of support and her disadvantaged circumstances (Prinsloo & Du Plessis 1998:19-20).

5.3.3. Interpretation of Thembelihle's development as an adolescent

The procedure followed below will conform to the developmental levels of adolescence as defined in chapter 4.1 to 4.6 of chapter 2 of this study.

5.3. 3.1. Cognitive Development

Thembelihle displays signs of being an effective facet in the decision-making process of this humble child-headed household in which the twins share responsibilities and make decisions for their mutual benefit. The subject is able to conceptualize specifics regarding their predicament and the somewhat bleak future that they are compelled to face. She is fully aware of the consequences of her actions as an orphan and how the community's actions affect their lives. She often displays a resolve whereby she is able to deal with their underprivileged social conditions although she appears weighed down by the problems. She does, however believe that her situation is completely unlike those living around her – but this is not true since the locals are all in a similar economic situation.

5.3.3.2 Physical Development

The subject displays an advanced state of physical maturity. She appears to be extremely aware of her body and displays a heightened self-consciousness, especially regarding her clothes that she feels are now too small for her. The adolescent's mother

had passed on during a critical period in her life when she was in need of guidance to be able to accept the confusing physical changes and thus develop self-confidence.

5.3.3.3 Emotional Development

As a consequence of the lack of parental guidance, the subject is often exposed to emotional turmoil culminating in utter despair. During the course of the interview, she broke down completely when she had to respond to questions relating to the deaths of her parents. Furthermore, the subject admits that she prefers not to be exposed to any reminders of her parents' as she is unable to handle this. She is unable to employ the necessary coping strategies that adolescents in other circumstance are equipped with in order to be able to handle such stresses. The sheer vulnerability of the subject, within the context of the HIV/AIDS scenario, is even more pronounced by damaging social and emotional upheavals leading to feelings of inferiority.

5.3.3.4 Moral Development

Thembelihle and her twin sister are obliged to decide on the rights and wrongs of everyday situations. She has internalized a set of norms and values, which allow her to make her own decisions and adopt a responsible approach to moral issues. This is apparent in the manner in which she views relationships with members of the opposite sex, her philanthropic spirit, the fact that she is disdainful of ill-disciplined and disrespectful children and her view of an ideal woman. The subject is fully aware of the need to be morally upright and aware of the dangers that lurk from being a part of a parentless home. Kind friends visit the sisters regularly and together they have developed a spirit of sharing.

5.3.3.5 Social Development

Acceptance by her peers is all important in the subject's life at this stage as the absence of her parents makes it possible for her to obtain some degree of guidance. Such interaction with her peers allows for the formation of a positive self-identity. The adolescent's friends facilitate companionship, co-operation and mutual understanding. There is also the same spirit of camaraderie at school where the subject is accepted unconditionally.

5.3.3.6 Connotative Development

There is an underlying impassioned plea to become self-sufficient but there is no support system or extended family to lend a hand. In the absence of her parents to guide the adolescent towards a meaningful goal and with no guidance towards tertiary studies from her teachers, she lacks proper direction to achieve her personal goals and aspirations. Thembelihle requires adult guidance and the necessary finance to finish school and secure appropriate employment. Her three wishes emphasize that she is like any other adolescent who is desirous of the better life free of financial burdens - but her aspiration to strive on towards a tertiary level is curbed by poverty as well as the lack of suitable adult role models. She is left to her own devices in how she ought to help make sensible choices in the unusual events she faces as a decision-maker in a child-headed household.

5.3.4. Conclusion

5.3.4.1. Education

Thembelihle's education had been affected most during the period when she had to assist her sister to nurse their exceptionally ill parents just before they passed away. It was during this period that she was compelled to absent herself from school for long periods of time in order to perform household tasks and to take care of her parents since there was no one else to do so. These stresses together with her obvious inability to cope with the sudden and inexplicable deaths of both her parents within such a short period of time resulted in her academic failure during that year.

However, the subject has since been able to settle into a routine despite the fact that she is still coming to terms with her parents' absence. She is determined to continue with her education at all costs as she sees this as the ticket to a better life ahead and she therefore strives towards emancipation by eagerly learning and trying to understand (Pretorius 1994:20). The Thandanani Children's Foundation helps by ensuring that her school fees are paid and by providing some books and stationery.

Thembelihle's only cause for concern is the fact that her teachers' attitudes have changed towards her sister and her since their parents' deaths. She feels that they ought to pay more attention to their personal needs and problems. The twin sisters support each other through troubled times at school and look forward to a brighter future. She is influenced emotionally, cognitively and connotatively by the attitudes of her teachers, her fears of boys, some of the peers who treat them unfairly and the novel responsibilities at home which may lead to a lack of concentration at school. Her fears and anxieties impact negatively upon her hope to finish school and to improve her situation.

5.3.4.2. Social Life

The subject displays a general satisfaction with her friends and most of her neighbours who are kind and generous. Whenever the research team visited the modest home, there were children of the same age group visiting, sharing the simple meals with the twins. Thembelihle admits that these friends are always a tower of support to them and they are able to share their problems with them. She is also reliant upon the emotional support afforded by Nestor, the volunteer who visited the home with the research team. The two sisters are particularly distressed by the form of discrimination that they experience sometimes from the teachers at school who are not at all helpful to them. A few of their neighbours take advantage of their parentless state by borrowing their possessions and denying having done so. The subject and her sister are too afraid to demand the return of these items and simply do without so as not to cause a problem since they fear any form of violence or abuse. This is indicative of the fact that the subject's desire to be safe and protected are not being met (Pretorius 1994:30-31) as a result of being a part of a child-headed household affected by AIDS.

The church group that she belongs to provides spiritual support but there are far too many destitute families to cater for and the church is unable to provide any material assistance. They have no income to purchase any food or clothes and do not appear to have any adult relatives who take an interest in their well-being. Thembelihle displays sound moral and social principles that are evident in her views concerning the ideal woman and what she considers inappropriate behaviour with boys.

5.4 HOUSEHOLD NO. 2 - Ntombifuthi

5.4.1 The Interview

5.4.1.1. Biographic Particulars

- **General**

Name: Ntombifuthi
Date of Birth 22/7/88
Age: 15 year-old
Sex: Female
Grade: Not at school (last - grade 7)
School: Willowfontein Primary School
Place of residence: Willowfontein
Race: Black
Language Spoken: IsiZulu

- **Family composition and background**

The father of this subject has passed on but little mention is made of him as she declares that she and her sister do not remember him. Ntombifuthi's mother is said to have abandoned her and her sisters when they were very young and vulnerable and when they needed her most. They have no idea whether she is still alive as she was quite ill at the time she left them.

Ntombifuthi was compelled to abandon her schooling since she fell pregnant and had to take care of her baby, as there are no adults in this home. The father of the subject's baby is in prison and cannot provide any financial support to Ntombifuthi. The paternal grandparents of the baby do have some contact with the child but it is not clear whether they offer any form of assistance at all. This is an extraordinary situation as she

(Ntombifuthi) is now the head of this household as her sixteen-year-old sister who lives with her, is still at school. In addition to her own baby and her sixteen-year old sister, Ntombifuthi has to also take care of her three-year-old nephew who is the son of her twenty-two-year-older sister who has also disappeared.

The family lives in a wattle and daub house that is approximately 8 square meters. Like many others around them living in abject poverty, the parents of these sisters too had built this home on a piece of vacant property. The house consists of only one bed and two pieces of a very old lounge suite. The house has electricity but no running water.

- **Food Intake**

This family (the two sisters, nephew and the baby) lives mainly on the rice and beans that Thandanani Children's Foundation provides and makes the ration last as long as they can. Whenever they are fortunate enough to obtain food from elsewhere they are able to eat three meals a day. Ntombifuthi had not eaten the previous morning but had eaten rice and beans for lunch and supper on that day. Apart from water she did not have anything else to drink.

The sisters make use of a paraffin-stove to prepare their meals. They obtain what little food they can from kind neighbours who have any to spare as well as from the Thandanani Children's Foundation. The Thandanani Children's Foundation does not provide food on a regular basis as they rely primarily on sponsorships.

- **Background information and traumatic experiences regarding the Father**

Ntombifuthi's father had abandoned them before his death when she was a little girl. She cannot remember when he left them or when they were informed that he had passed on. All she remembers is that they did not have any shelter when he abandoned them. She is

quite indifferent in all her responses concerning her father stating that she was too young to have any meaningful recollection of their relationship.

- **Background information on the Mother**

Ntombifuthi's mother had abandoned the family when she became very ill and found the task of supporting her family a formidable one. She has never made any contact with this family since. The subject does not know if her mother is still very ill or if she is still alive but declares that the latter had remarried once she moved away. Ntombifuthi is critical of her mother in that she has lots more chores to perform in her mother's absence. She also maintains that from the time their mother left, they have had insufficient food, money and clothes. She misses her mother's cooking and the love and care that she feels her mother would have provided.

5.4.1.2. HIV/AIDS and household relationships

When their father passed on as a result of AIDS-related illnesses, it had been their mother's (who was also HIV+) decision that they live in this particular home. Initially there were four sisters in this household but now there are just Nthombifuthi and her sister. No mention is made of the one sister at all while the other has apparently walked out on her son and disappeared. Neither the subject nor the sister who lives with her has any idea where their two elder siblings are. They appear to be quite content living in their rather humble home on their own and are fully aware of the consequences of becoming HIV-positive. Despite being the younger of the two remaining sisters, Ntombifuthi is the more assertive and responsible of the two sisters. She is the one who makes all the major decisions and takes control in this child-headed household. Apart from the clothes that were left behind by their mother, the sisters do not have any other items of special significance. The scholar (Ntombifuthi's sister who is attending school) obtained her school uniform from a child at school who had outgrown these.

5.4.1.3. Social life

In her spare time Ntombifuthi reads when she does not have to look after her baby. She also attends church services regularly. Ntombifuthi is particularly close to her remaining sister and is able to confide in her whenever she has a problem. She and her sister do not have anyone else whom they can confide in. They nevertheless do not feel that other adults or their peers treat them unfairly or discriminate against them in any way. They have friends who visit regularly. The girls appeared to be quite popular in the local community in a positive sense and both girls and boys visited to check on either the baby or the nephew.

Despite not having the necessary adult-presence in their home, the sisters feel safe and are satisfied that their need for security has not been violated (Pretorius 1994:30-31). The subject is apparently not socializing, as she had been accustomed to in the past when she had a boyfriend. Having a responsibility towards her child, she is unable to behave as another 15-year-old would. She is also committed to caring for her nephew as well as her sister who is at school and to see to their daily needs.

5.4.1.4. Emotional well-being

Despite their challenging circumstances, Ntombifuthi and her sister do not express any unhappiness. During the study there was a relaxed, cordial atmosphere in which both the researcher and the interpreter were comfortable. Ntombifuthi was emphatic that they did not get into fights with others or become cross or frustrated at any time. It is most unusual that Ntombifuthi gave the impression that she did not experience any stigma or discrimination, isolation or fear in her life.

She became sad at the question concerning their greatest cause for concern and this was indicative of a yearning for her absent mother. They would have been more contented had their entire family remained as a unit and would have been more competent at

handling the difficulties that they experience. Regardless of these tribulations the subject herself had never entertained the idea of deserting her family or her responsibilities. It is apparent that her sister is her greatest source of inspiration and Ntombifuthi ensures that her sister is still able to attend school despite their financial deprivation.

5.4.1.5. Schooling

Since Ntombifuthi parents were absent there was no control or guidance with respect to norms and values. She was inexperienced and free to do as she wanted – hence she fell pregnant and had to leave school. Consequently, Ntombifuthi had to leave school in order to survive and to support her sister, her nephew and her baby financially. There is no support from the school or the community as this is a poor neighborhood. Ntombifuthi sees education as the only means by which children like her will be able to shed the burden of their destitution. By her own admission, she realizes that her irresponsibility when she fell pregnant prevented her from attending school. She regrets this and is now aware that had this not occurred she would have been able to realize the dreams that seem beyond her reach now. If there is any way in which she can realize this dream to return to school, she will.

5.4.1.6. Future perspectives and ideals

Ntombifuthi is realistic about the fact that without a proper education she cannot look forward to achieving any highly paid job. All she can hope for is that some kind foster family will take the entire family in, take care of her nephew and baby and allow her to go back to school. Without this she will have to find any suitable employment and try to support her "family" adequately.

5.4.2. *SACKS SENTENCE COMPLETION TECHNIQUE*

5.4.2.1. Category I: Family

- **Mother**

14. My mother *she made me feel so sad for going away with another man and left us in poverty.*
29. My mother and I – *I feel that she left us because she did not care about us and she never came back.*
44. I think that most mothers *should get together in their spare time and talk about their children's future and their lives.*
59. I like my mother but *she disappointed me for leaving us and going away from home.*

- **Elucidation of the subject's perception of the mother**

Ntombifuthi exhibits a profound sense of anguish, disillusionment and dejection at her mother's abandonment and neglect of them. It is apparent that the subject is of the view that their lives would have been less stressful and different had their mother been more caring of them and had not gone away. She blames their impoverishment upon their mother's absence and considers that they would not have been poverty-stricken had they enjoyed maternal support. Her mother's presence would have also allowed Ntombifuthi to still attend school and the education would have helped to alleviate them from this destitution. She is also critical of her mother's lack of interaction with other mothers and considers that such interaction would have deterred her from such drastic action as leaving her children to marry someone else.

- **Father**

1. I feel that my father *(no response).*
16. If my father would *(no response).*
31. I wish my father *were still alive. I wouldn't have to live this life of poverty that I am living now.*
46. I feel that my father is *(no response).*

- **Elucidation of the subject's perception of the father**

Ntombifuthi is less eager to discuss her father than her mother. This could be attributed to the fact that she did not know her father well enough as he left them when they were too young to recall much detail about him. The subject nevertheless expresses the view that she is aware that his presence would have ensured a superior life for the family. This could have also influenced their school attendance and social life.

- **Family**

12. Compared with most families, mine *I see a very big difference because they are always happy compared to ours. And I don't have parents.*
27. My family treats me like – *every member of the family - sometimes there would be a misunderstanding among us, but it soon goes away.*
42. Most families I know *have parents who are working but they are also needy like we are.*
57. When I was a child, my family *(no response).*

- **Elucidation of the subject's perception of the family**

Ntombifuthi is fully aware of the manner in which her family differs from others in their constitution. However, she concedes that there is little or no financial difference between them and these families, as poverty is a factor common to all people living in this area

whether they are employed or not. Furthermore, the subject conveys the belief that families where the parents are still alive are much more contented than those where the parents are absent. She also confesses that there is friction between her and her sister at times but that they are able to resolve these issues in time.

5.4.2.2. Category II: Sexual

- **Being a woman**

10. My idea of a perfect woman *(no response).*
25. I think most girls *(no response).*
40. I believe most women *(no response).*
55. What I like least about women – *they spend most of their time with their children.*

- **Elucidation of the subject's perception of being a woman**

The subject's lack of response to any of the questions based on women is indicative of the absence of a suitable role model in her life. Ntombifuthi is unable to offer a considered opinion regarding females in general. The only opinion she presents is in her misinterpretation of the last question where she expresses the view that it is imperative that women spend quality time with their children.

- **Heterosexual perceptions**

11. When I see a man and a woman together (*no response).*
26. My feeling about married life is *when two people love each other and treat each other like their parents did and are faithful to each other.*
41. If I had a love affair *(no response).*
56. My love life – *I fell in love hoping that my boyfriend will help me and my sisters financially.*

- **Elucidation of the subject's perception of heterosexual relationships**

Ntombifuthi, like any typical adolescent believes in the ideal love relationship within a stable home. She presumes that her parents had enjoyed such a relationship even though she has declared in other questions that she did not know her father well enough to provide an opinion of him. Despite being the younger of the two remaining sisters, the subject considered her pregnancy as a means to a better life. Perhaps she had not anticipated her boyfriend's imprisonment or the possibility that he will not be able to provide for them at all. At this stage she seems to enjoy her baby but is remorseful of her behaviour since her problems have merely intensified.

5.4.2.3. Category III: Interpersonal Relationships

- **Friends and acquaintances**

8. I feel that a real friend - *are my parents, my sister. But, unfortunately I do not have parents and I am very worried and angry.*
23. I don't like people *use drugs, those who sell their bodies in order to get money and those who abuse others.*
38. The people I like best *are my sister's, my child, my sister's child and those who support us.*
53. When I'm not around, my friends *I am with my sisters.*

- **Elucidation of the subject's perception of friends and acquaintances**

Although friendships are an important facet of Ntombifuthi's life, she prefers to associate with the family members who are close to her - such as her sisters. Her relationships with her sisters and the two children (her nephew and her own baby) are considered unconditional since they are most important people in her life. Despite her own indiscretion in falling pregnant, Ntombifuthi is vociferous in her criticism of those who are promiscuous. Although she does not mention them, there were always friends at her home. She also states unequivocally that they do not have problems with any of their neighbours and acquaintances.

- **Superiors**

6. The male teachers at our school *treat us well. They teach us well and never treat us badly.*
21. In school my teachers *take care of me as my parents.*
36. When I see the teacher coming *(no response).*
51. People whom I consider my superiors *are my President Thabo Mbeki and many more leaders.*

- **Elucidation of the subject's perception of superiors**

Even though Ntombifuthi is not at school any more she still has positive recollections of school and her teachers. She also idealized the school situation since she saw her teachers as parental figures. People she considers as being superior are political figures. But from the interview it is clear that she had no support from the school or the society they live in, not to drop out of school.

- **People in charge**

4. If I were in charge *I would be very happy because I could help those people who need help.*
19. If people work for me *I can be very happy because I can recognize myself as a human being among people.*
34. The people (children) who do things for me – *I would like to thank my older sister because she is the one who helped me a lot.*
48. In giving orders to others, *I order them not to leave me alone for a long time and go far from home.*

- **Elucidation of the subject's perception of people in charge**

It is understandable that as a fifteen-year-old adolescent, Ntombifuthi has no idea about the way in which people in positions of authority ought to operate and this is most apparent in her response to question 48. Her greatest concern is to be a humanitarian and assist others who are basically in the same needy situation that she is in. She stresses the need for people to display gratitude for what others do for them just as she bestows appreciation upon her sister for her help. Ntombifuthi does not fit into an authoritarian profile but she does lean towards being a fitting leader – hence her ability to take control in her home situation despite being the younger of the two sisters living in this home. She is socially dependant and expresses a fear of loneliness and isolation when she says that she does not want to be left alone. She nevertheless has an innate desire to appear as a dignified human being with a healthy self-esteem, respect, recognition and a sense of self-importance.

- **Peers**

13. At school I get along best with *(no response).*
28. Those at school with me *(no response).*
43. I like working with people *because they look after each other as family members.*

58. Other children in my class *(no response).*

- **Elucidation with reference to peers**

It stands to reason that Ntombifuthi will not be able to respond to questions about school as she is at present not at school. However, she does see the need to respond to question 43 in which she reiterates the idea of philanthropy. It appears as if Ntombifuthi experiences socio-affective needs (Pretorius 2000:27) in that she displays a need for a better social relationship that includes acceptance and belonging, love and care.

5.4.2.4. Category IV: Self-concept

- **Fears**

7. I know it is silly but I am afraid of *(no response).*
22. Most of my friends don't know that I am afraid of *(no response).*
37. I wish I could lose the fear of *(no response).*
52. My fears sometimes force me to *be close to my sisters and if they are not around it will be my friends.*

- **Elucidation of fears**

Even though the subject does not wish to state exactly what her fears are, she does succumb to some extent in question 52. Without revealing the exact nature of the fear, she reveals that she finds solace in her sisters or her friends being close at hand at all times. It seems that her biggest fear is loneliness or isolation. It is one of the rare occasions when Ntombifuthi mentions her friends.

- **Guilt feelings**

15. I would do anything to forget the time *only if I can have everything I need.*
30. My greatest mistake was *to get pregnant while I was at school, which caused me to drop out of school.*
45. When I was younger, I felt guilty about *dropping out of school because of the baby.*
60. The worst thing I ever did *was to have a baby before I was ready.*

- **Elucidation of guilt feelings**

As she has revealed in another section of this questionnaire, Ntombifuthi's reason for "falling in love and becoming pregnant" was that she thought that it was the best way for her to get financial support for her sister, her nephew and herself. Since her boyfriend has now been imprisoned and she has to take care of the baby by herself, she experiences pangs of guilt at what she has been reduced to. Her pregnancy and motherhood inhibit her socially and educationally.

- **Personal strengths**

2. When everything seems to be against me *(no response).*
17. I believe that I have the ability to *do anything that is good and right.*
32. My greatest weakness is *to have an unnecessary baby at my age.*
47. When luck turns against me *I talk to my older sister because she is the one who understands me.*

- **Elucidation of personal strengths**

Ntombifuthi displays strength of character and sheer determination in her response to question 17, which underlines her courage in taking control of the affairs of this

household despite her sister being the elder. She nonetheless is comforted by her sister's constant presence and support. Although there is this inherent strength to handle daily life, there is also a limitation in her capacity to deal with the presence of the baby whom she now sees as an encumbrance and a barrier to her personal ambitions and her social life.

- **The Past**

9. When I was a child (younger) *I should play a lot.*
24. Before I was at school *I used to see my future as being bright but when I had to stop going to school everything changed.*
39. If I were a little child again *I would like to be together with my parents and go back to school.*
54. The thing I remember most about my childhood *is to be around my father, my mother and my sisters.*

- **Elucidation with reference to the past**

In this summation of the past, Ntombifuthi reveals her confidence at the stage when she had the full support of her parents and sisters. During that phase she envisioned positive prospects ahead as she was still attending school and considered education as a key to progress and success in her life. The comfort of her past has been shattered by her pregnancy and the sudden loss of those who were dear to her. She has been thrust into a bizarre position of responsibility where she has to drop out of school and act as mother and head of a child-headed household.

- **The future**

6. To me the future looks *(no response).*
20. I look forward to *doing my schoolwork.*

35. Some day I *wish to go back to school but before I go back to school I wish to find work so that I can support my child and the rest of my family.*
50. When I am older *I would like to help and look after my family, as we are orphans.*

- **Elucidation with reference to the future**

Ntombifuthi experiences great difficulty in accepting the reality of her situation in that she cannot realize her future aspirations. Although she resolves to take care of her family in a responsible manner, she also contemplates, almost idealistically, her return to school.

- **Goals and Ambitions**

3. I always wanted to *live a happy life.*
18. I could be perfectly happy if *I can get an education until I become a normal person like other people in life and have everything I need.*
33. My secret ambition in life *is to get work and to go back to school.*
49. What I want most out of life *is education and work so that I can look after my family.*

- **Elucidation of goals and ambitions**

The subject's pitiable personal circumstances cannot provide her with the happiness and success that she deems education and employment could have brought her. She considers her life as being totally 'abnormal' wherein her concept of 'normality' encompasses the attainment of the highest education levels and subsequently, everything that a person may need in life. She has no peace of mind as they lack the necessary protection that children of their age group ought to enjoy. Her physical needs in the form of food, shelter, proper sanitation, etc. are also not satisfied. She would prefer to satisfy these needs by having a job and what she considers a proper education.

5.4.2.5. Three wishes

1. *If I can be adopted by people who can look after me like my parents treated me when they were still with me, I can be very happy.*
2. *I wish to finish school and get myself work so that I can be able to look after my family like my sisters and do lots of things for them.*
3. *I wish to own a nice home and be a future wife like all the other women.*

- **Summary of the three wishes**

The subject acknowledges that under the present circumstances, it appears quite improbable that she will achieve her desire to complete her schooling, have a decent family life and cater for the needs of her family. Her acceptance of the restrictions of those who live around her and who cannot assist her to alleviate the sufferings of her family, encourage her to consider the option of a foster home as a source of liberation. Perhaps, in her case this would be unrealistic as she has the added burden of a baby, her sister and a nephew.

5.4.3. Interpretation of Ntombifuthi's personality

The procedure followed below will conform to the developmental levels of adolescence as defined in chapter 4.1 to 4.6 of chapter 2 of this study.

5.4.3.1. Cognitive Development

Despite possessing maturity beyond her years, the subject is fully aware that she is unable to solve all the difficulties that life directs at her. She considers the future critically and stresses the importance of education, which she has been deprived of her own indiscretion. The subject is totally self-conscious and is of the view that others are always concerned about her family and what they are doing.

5.4.3.2 Physical Development

Ntombifuthi is short but displays a full figure since she is still breast-feeding her baby. It would appear that her advanced physical development has influenced the way in which she thinks very much like a mother would. The sister, who is older than she is, verifies this by stating that the subject is very strict about her following rules set by the latter and is the head of that household. Ntombifuthi accepts her physical appearance and the "adult" role she is required to play in her home.

5.4.3.3. Emotional Development

The period of "storm and stress" typical of the period of adolescence is evidently exacerbated by this adolescent's lack of experience in having to deal with "adult" responsibilities that have been thrust upon her. The subject's premature physical transformation has a direct bearing upon her social development. She experiences negative emotional trauma from her state of parentlessness, her fear of being alone, her guilt feelings about falling pregnant and having to drop out of school. As part of her strange adult responsibilities, she has to play a maternal role and lacks gratification of her personal socio-affective needs. This results in turmoil and mood swings that lead to anxiety, guilt and shame.

5.4.3.4 Moral Development

The reasoning behind Ntomifuthi's falling pregnant was that the father of her child would help her to look after her family. Unfortunately for her, the father of her baby was charged and convicted for a crime and is presently serving sentence. Hence her pathetic predicament – she has to take responsibility for her actions and look after her sister and her nephew as well as give up her education. The presence of her mother could have helped preclude such misguided reasoning and trauma for the young, single parent. It is quite obvious that she is now even more determined to be morally upright and insists on her sister's being so. From her own experience it seems that she has developed a personal value system. She emphasizes the importance of loyalty and faithfulness in relationships and she does not like people who indulge in anti-social and immoral behaviour.

5.4.3.5. Social Development

The reason for Ntombifuthi's pregnancy could be attributed to her obvious lack of parental guidance and supervision. Her justification for her pregnancy was that she considered this as a way whereby her family could be relieved of their financial burdens and who would be able to guide them. On the contrary, the pregnancy had merely intensified the situation since the family was now worse off than before. The subject's social group appears to be as close as they had previously been, for although she does not mention her friends all the time, the home was always full of Ntombifuthi's and her sister's friends. This may be attributed to the presence of the baby. The subject had not experienced any rejection on account of the baby's presence. Rather, the local society had displayed a sense of discrimination against them because of the subject's own domestic crisis prior to the baby's birth. It is obvious from her responses and the interview that Ntombifuthi is inhibited in her social development as she is unable to go out with her friends as she used to prior to the birth of he baby. As head of this child-headed household, she is compelled to take her household tasks seriously and act in an adult-like manner rather than the way an adolescent of her age normally would. Hence, her social

development as a 15-year-old has been ruined and accelerated to a point well beyond her years.

5.4.3.6. Connotative Development

The subject has freedom of choice to make major decisions but it may not be the choices that she would have really wanted to have to make since she does not find the task pleasurable. As head of this household, Ntombifuthi has to decide on level-headed choices and ensure that there is always a warm and democratic atmosphere in their home. Although she regards education as being of ultimate importance and wishes to some day complete her schooling, she knows it is not probable that she would. Her objective is to obtain a decent job and to take care of her family but the chances are slim because of the lack of suitable qualifications.

5.4.4. Conclusion

5.4.4.1 Education

Ntombifuthi's education was interrupted by her pregnancy. When she realized that her family was left without financial assistance, she decided to take the matter into her own hands and considered the option of ensnaring a suitable male into a relationship where he would be obliged to support them. At the time her failure to complete school appeared to be of far less concern than the fact that she was incapable of feeding her family. Unfortunately for the subject, the plan did not resolve their problems but created additional financial burdens and the loss of educational opportunities for her.

It was observed during the course of the research that the subject was particularly hard upon her older (16 year-old) sister thus emphasizing her attitude towards the importance of education in their lives. She ensures that her sister's school fees are paid by the Thandanani Children's Foundation and that her sister has all the stationery and books via the same means. To her, education can lead to the alleviation of all of their problems and

yield a far superior life. She is adamant that she will find a way to complete her education and hopes that a foster home can take them all in – a statement which accentuates her need to actualize her full potential (Chapter 2 – 5.1; Pretorius 1994:20-21). However, she obviously lacks the appropriate support and circumstances that would have allowed her to explore life under the guidance of her parents or another suitable adult (Pretorius 1994:28-29).

5.4.4.2. Social life

There exists a positive interaction between the subject and the peer group milieu (Prinsloo & Du Plessis 1998:20), which is evident in the fact that numerous friends visit their home regularly to share both their problems as well as their food with them. Even though she does not seem to take advantage of this, the subject is certainly not short of helpers to watch over her baby! Her social life has been stymied by the fact that she considers her role as head of the household as being of utmost importance. Ntombifuthi does not want to neglect any aspect of her foreign adult responsibilities by going out with her friends while she has responsibilities at home. However, she has to allow her older school-going sister to go on with her own life and to socialize with her friends. This fact does not impact negatively on her relationship with her sister since they are very close. Neither the personal circumstances of the family, nor the teenage pregnancy have created any form of discrimination from friends and neighbours, who are kind and helpful at all times despite their own deprivation and destitution.

Despite her fifteen years, Ntombifuthi is able to head and control this child-headed household most effectively. There is no income to purchase food, clothes and pay for the baby's needs. The prison sentence imposed upon the baby's father has not helped alleviate the situation. However, the family is able to make do with the donations they receive from the Thandanani Children's Foundation and their generous neighbours.

5.5. HOUSEHOLD NO. 3 - SUBJECT: Brenda

5.5.1. The Interview

5.5.1.1. Biographic Particulars

- **General**

Name: Brenda
Date of Birth 13/9/85
Age: 18 year-old
Sex: Female
Grade: 10
School: Kwamthiyane Secondary School
Place of residence: Willowfontein
Race: Black
Language Spoken: IsiZulu

- **Family composition and background**

Brenda lives with her younger sister (who is also at school) in their parental home, which is made of wattle and daub. The house appears to be large in comparison to others that were visited but is in very poor condition. The two sisters mutually decided to live in their family home after the deaths of their parents and their younger brother. They have taken the initiative to try to renovate the house with the help of an uncle who visits them occasionally. The girls do not want to discuss the other smaller, more solid structure built with the same materials on the same property and would not say who lived there. It would appear, though, that the girls were occupying that smaller structure while they renovated the other. An unusual observation bearing in mind the underprivileged environment is that the late father's motor vehicle is parked in the driveway and the sisters insist on keeping the car as they look forward to driving it in future. Of all the

subjects visited, these two sisters seem to be the best of in terms of property that their father appeared to have left behind for them.

- **Food Intake**

Brenda admits to having three small meals a day. Her basic diet is *phuthu* (cooked mealie meal) and potatoes. The day prior to the interview her breakfast and lunch consisted of rice and potatoes and supper was *phuthu* (cooked mealie meal) and potatoes. It is apparent that the girls do not enjoy a varied and balanced diet. They never drink anything other than water. The aunt who sometimes checks on them is able to provide some of their food while the Thandanani Children's Foundation assists with beans and rice. The child admits that the food is insufficient for the two of them and they often go to bed hungry. The subject admits that none of their neighbours helps them in this regard since they are discriminatory towards them since the deaths of their parents.

- **Background information and traumatic experiences regarding the Father**

Brenda's father who had not been ill for a very long time passed away in 2001. She believes that the cause of his death was TB but he had never discussed his illness with them. Even though her aunt discussed the illness with them, she did not provide any details. During the father's illness, Brenda cried a lot since she felt helpless and did not have her mother's support. Nevertheless, she was very attentive to her father's needs. She was particularly distraught once he passed on and found consolation in talking to her sister. Brenda reveals that her school attendance suffered as a result of her father's illness and even more so after his death. This eventually culminated in her losing a year at school. The subject was then compelled to take care of their extremely ill brother who passed away in 2002 soon after their father's death. Brenda and her sister have been in dire straits ever since because there is little or no food and no money as neither of the sisters are working. They also have no clothes other than those that they had when their parents were alive. Generally, the subject expresses feelings of sadness, anxiety and fear

since she longs for her late family, is unsure of their future and is always afraid of their being attacked. The subject misses her father's mere presence and the protection he afforded them.

- **Background information and traumatic experiences regarding the Mother**

The subject lost her mother in 1998 after a short bout of what she believes was pneumonia. This appears to have been a particularly trying time for her, as she had to help her ailing mother while she tried to deal with the trauma of her mother's illness – the illness appears to have been severe. Brenda's sister was her source of comfort during the illness and her mother's death. It was then that the subject found that she could not even cry any more. The father informed the girls that their mother had pneumonia. Even though the subject had to take care of her mother, she did not miss school or allow her schoolwork to suffer. This situation appears to have been far worse during the father's illness and after his death. The mother's demise also affected the subject's sense of well-being and security and the sadness she experiences is as a result of her longing for the love and care her mother constantly gave her. Her mother's death came at a critical time in the subject's life as she had just reached puberty and required all the guidance that a mother normally gives her daughter.

5.5.1.2. HIV/AIDS and Household Relationships

Brenda is of the view that parents or guardians ought to talk about their health conditions to their children in order that the latter will know why their parents died and what to do thereafter. The subject also expresses the need for suitable guardians to be appointed by the dying parents. There is some reluctance to discuss the possibility of AIDS being the cause of the parents' deaths. However, it is apparent that the neighbours stay away from the sisters and do not offer any form of assistance either because they themselves are poor or that they are biased.

The household had once been made up of the parents, 2 boys and 3 girls prior to the parents' passing on. However, prior to the parents' illness, it appears as if the other two older siblings (23 years & 24 years) had moved on with their lives. The implication is that the elder sister is now residing with the aunt who watches over the girls occasionally. The subject and the sister who lives with her do visit the aunt's home occasionally. This creates much sadness and anger within the subject since she feels forsaken and vulnerable. She nevertheless declares that all the siblings get on well but that they do not visit the two sisters as often as they ought to.

Although the subject states that nothing about her parents' demise bothers her, this does not appear so from her reaction to the question. It is apparent from the body language and the fearful manner in which she steals a glance at her elder sister that she does not reveal her true feelings. Her eyes fill with tears and she suddenly crosses her legs and folds her arms tightly. She refuses to look up at us and does not respond for a long time. The interpreter also mentions that her reaction was indicative of certain unresolved issues as well as the deep sorrow she tries to hide. Brenda and her sister have photographs of their late parents and look at these rarely since these make them exceptionally depressed.

5.5.1.3. Social Life

Most of Brenda's free time is spent with her sister whom she lives with and she is able to discuss any problem with her. Should her sister not be available to help her at any given time, Brenda seeks out her cousin who lives nearby. There are no adults they can turn to other than the rare contact with their aunt, their sister who lived elsewhere and the Thandanani volunteer. Contact with other adults is minimal but she makes it known that they do not treat them tactlessly. There was no evidence of other adolescents who were their friends or visited the home at any time. Brenda admits that she has sincere friends at school who treat her well but there were no visitors or friends at any time when the researchers visited the subject's home.

5.5.1.4. Emotional well-being

The subject's constant furtive looks in her sister's direction whenever she is asked a question is indicative of the fact that she is probably afraid of her sister's concern about what she may reveal. Although she has good friends at school, she is totally reliant upon her sister for emotional comfort and support. Brenda admits that her sister is the one person she admires most.

She is quite explicit regarding her feelings of sadness and longing for her parents. Her fear of being alone and unprotected creates a longing for the warmth and security that her father's presence had afforded them. Brenda's socio-affective needs are not satisfied as a result of her parent's absence. Her unhappiness and apprehension stem from the fact that there is a constant need for food and other basic necessities. There is no income as neither of them works and they rely on whatever they are given by others. Brenda appeared to be rather ill during the first interview and the researcher put this down to her poor diet. It has been established that she is pregnant and had not revealed this to us. This might explain her furtive glances in her sister's direction whenever she answered questions. She might have been pregnant at the time -therefore having guilt feelings.

5.5.1.5. Schooling

The subject looks forward to going to school and never entertains any notion of leaving school. She makes friends easily at school and there is hardly any friction amongst them. Her class- and schoolmates are most agreeable and never tease her about her orphan-status or her parents' illness. Her one wish is that they try to assist her more in her studies. Brenda does admit that often she does not finish her homework but refuses to say why.

Questions relating to teachers demonstrated that Brenda's teachers are not rude in any way but they do not pay any special attention to her scholastic needs. She feels that she will benefit from extra attention in subjects such as Accounting. Brenda's teachers are aware of her being an orphan and appreciated the many problems she is experiencing, but they do not discriminate against her in any way. She prefers that they treat her as they do all the other children.

Brenda declared that there are many items that she needs for school but has to do without since she cannot afford them. They are unable to afford school fees or purchase books and pens since there is no income. The volunteer from the Thandanani Children's Foundation stated that the NGO assists in the payment of these children's school fees annually. A second-hand uniform was given to the child by an aunt and she washes and wears this daily. She believes that her progress at school will be better if she were able to afford the appropriate stationery and is able to eat proper meals so that she can concentrate.

5.5.1.6 Future perspectives and ideals

Brenda was hesitant to discuss any of her future plans and desires during the interview. However, she did express a desire to complete her schooling successfully and become a professional. She did not appear to have any idea on how or at which tertiary education institution she would be able to continue with her learning as there was apparently no guidance forthcoming from the school or the family.

5.5.2. *SACKS SENTENCE COMPLETION TECHNIQUE*

5.5.2.1.Category I: Family

- **Mother**

14. My mother *was always with me to care for me.*
29. My mother and I – *were always with me.*
44. I think that most mothers *care for their families.*
59. I like my mother but *I feel miserable because I will never see her again.*

- **Elucidation of the subject's perception of the mother**

Brenda misses her mother dearly in the absence of the love and constant attention she had received from her. Her misery and depression at this stage obviously emanates from her being deprived of this relationship so early in her life.

- **Father**

1. I feel that my father *died and my feelings are so bad because I can't get everything that I want.*

16 .If my father would only – support me with school *until I had finished and I could have gone to college or the Technikon.*

31. I wish my father *was alive.*
46. I feel that my father is *dead.*

- **Elucidation of the subject's perception of the father**

Brenda's view of her father was that he provided benevolently for the family. Hence, his absence affects her life dramatically in that she is deprived of the very things she considers important such as her education. She evidently yearns for that financial backing that would have allowed her to improve her own life.

- **Family**

12. Compared with most families, mine *is very bad because I've got no-one to talk about my secrets.*
27. My family treats me like – *like as if I've got my parents.*
42. Most families I know *are my relatives.*
57. When I was a child, my family *used to take us out visiting.*

- **Elucidation of the subject's perception of the family**

A negative perception of families in general is apparent especially from questions 12 and 27. It is evident that Brenda takes the word "family" to mean the "relatives" or the "extended family", that have distanced themselves from her. Her response to question 27 amplifies her perception that there is none who really cares about them and their needs. The last response is indicative of the close bond between the family and relatives that had existed prior to the parents' death. There is an underlying sense of bitterness from being isolated from all those who were so close to the family prior to their parents' absence.

5.5.2.2. Category II: Sexual

- **Being a woman**

10. My idea of a perfect woman *is a woman who always takes care of her family and respects others.*
25. I think most girls *like me.*
40. I believe most women *are suffering because they are not working.*
55. What I like least about women – *is respect.*

- **Elucidation of the subject's perception of being a woman**

Brenda seems to place great store by the sense of independence workingwomen can experience and the high esteem that **all** woman can command. The poverty and suffering around her clearly generates within her a tenacious standpoint that women who are financially independent do not experience any hardship. Her response to question 25 is indicative of the fact that it is important that others find her likable and respect her.

- **Heterosexual perceptions**

11. When I see a man and a woman together *I always think of my parents being together.*
26. My feeling about married life is *to have a good man, home and a good life.*
41. If I had a love affair *(no response).*
56. My love life – *respect myself.*

- **Elucidation of the subject's perception of heterosexual relationships**

It is obvious from Brenda's response to question 11 that her parents had enjoyed a loving marriage. She looks back at her parents' relationship in order to work towards a similar union in her own life - one of understanding and respect. Her response to question 56 reiterates the importance of respect and self-respect in her life and that she believes that relationships can succeed if respect is present. Her lack of response in question 41 might reveal that she is as yet unattached or that she is embarrassed to discuss a love affair or that she might feel guilty about being pregnant and keeping it a secret.

5.5.2.3. Category III: Interpersonal Relationships

- **Friends and acquaintances**

8. I feel that a real friend *is a person who is always with me through thick and thin.*
23. I don't like people *talk about me.*
38. The people I like best *are my family.*
53. When I'm not around, my friends *I feel unhappy.*

- **Elucidation of the subject's perception of friends and acquaintances**

Friendships play a crucial role in Brenda's life and she believes that these associations ought to be categorically sincere since they must endure enjoyable and unpleasant times. These friends of hers are all important and their absence leads to a sense of melancholy in her life. Ironically, she now includes "family" in this category and could possibly be referring to her "immediate" rather than her "extended" family. Brenda is also aware of the criticism leveled at them by critical people and dislikes people who do this. This is indicative of the discrimination that they experience from neighbours as a result of the parents' deaths.

- **Superiors**

6. The male teachers at our school *treat me well.*
21. In school my teachers *treat me well.*
36. When I see the teacher coming *I feel scared.*
51. People whom I consider my superiors *are my relatives.*

- **Elucidation of the subject's perception of superiors**

The theme of "respect" pervades, above all, Brenda's school life where she is able to command the respect that she so dearly craves in all spheres of her life. Her notion is that the positive assessment of her superiors, in this case, her teachers, incorporates the integrity with which they view her. If one considers previous statements concerning her relatives, it would stand to reason that Brenda considers her relatives (question 51) in a more arrogant light in that they are inaccessible to her.

- **People in charge**

4. If I were in charge *it seems I should feel guilty.*
19. If people work for me *I can be much happier.*
34. The people (children) who do things for me – *I do appreciate them.*
48. In giving orders to others, *(no response).*

- **Elucidation of the subject's perception of people in charge**

Brenda creates the impression that she deems power to be a source of manipulation and exploitation perhaps because she has never occupied such a position of authority. Her response to question 48 does convey the message that she cannot see herself in such a position of authority. She nevertheless acknowledges that it is imperative for people in command to appreciate that, which is done for them.

- **Peers**

13. At school I get along best with *my friend.*
28. Those at school with me *are undermining me.*
43. I like working with people *because I like to communicate with people.*

58. Other children in my class *undermine me.*

- **Elucidation with reference to peers**

The subject does acknowledge the presence of friends and that communication is of paramount importance in her life in order that all the people she knows get on well with one another. It is difficult to pinpoint the subject's exact interpretation of the word "undermine". Should one consider the true meaning of the word then it would appear as if Brenda feels a lack of respect from her friends at school – a point that contradicts what she said previously.

5.5.2.4. Category IV: Self-concept

- **Fears**

7. I know it is silly but I am afraid of *being proposed by them.*
22. Most of my friends don't know that I am afraid of *snakes.*
37. I wish I could lose the fear of *teachers.*
52. My fears sometimes force me to *cry.*

- **Elucidation of fears**

These responses are indicative of the many fears that plague Brenda's life in the form of predominantly boys, teachers and snakes. She could also be displaying a fear as a result of the lack of a protective, authoritative figure in her life. Although she has previously pointed out that she prefers to find a good person to marry, she seems afraid that the ones who come forward may not be the ones she will choose. Her apprehension where teachers are concerned reiterates the idea that they are symbols of authority and are generally approached with some trepidation but she fervently wishes to get rid of this fear. When any of her fears becomes unbearable, she deals with them by crying because

she feels unprotected and lacks the comfort of parental security. She may also have had a secret fear of falling pregnant.

- **Guilt feelings**

15. I would do anything to forget the time *when my mother passed away.*
30. My greatest mistake was *I could not remember.*
45. When I was younger, I felt guilty about *my life.*
60. The worst thing I ever did *(no response).*

- **Elucidation of guilt feelings**

Although it is acceptable that Brenda has not recovered from her mother's death, it is obvious that she has problems coping with her guilt feelings. Her answer to question 45 affirms that she experiences remorsefulness about life in general but she does not wish to specify what it is that she is actually guilty about (might have been the pregnancy). She is evasive in her responses to questions that inquire about her worst error and her most appalling action/s. It seems as if Brenda's most terrible action is something that she genuinely prefers to forget. However, she does not seem to be coping with her life in general as a result of her determination to obliterate this "evil" and she does not have the professional assistance to be able to confront it.

- **Personal strengths**

2. When everything seems to be against me *I remember my parents.*
17. I believe that I have the ability to *sing.*
32. My greatest weakness is *laziness.*
47. When luck turns against me *I will buy a beautiful house and go to tertiary school when I'm finished with school.*

- **Elucidation of personal strengths**

Brenda's sense of hopelessness in the previous set of questions does not filter through this set. She conveys a strong sense of determination to succeed and considers the memory of her late parents to be a source of inspiration to her. The absence of logical thinking might be responsible for her misinterpretation of question 47, but the response nevertheless exemplifies her fervent desire to succeed.

- **The Past**

9. When I was a child (younger) *my desire was to finish school and get a nice job.*
24. Before I was at school *it was very nice to be at home.*
39. If I were a little child again *I wouldn't know what's happening in this world.*
54. The thing I remember most about my childhood *is that I had a quarrel with my sister.*

- **Elucidation with reference to the past**

Regret and guilt feelings infiltrate Brenda's submissions here. It is apparent that her relationship with the only sibling who cares about her is of utmost importance to Brenda in that a once-off quarrel with her sister still bothers her and she mentions this. The use of the past tense in question 9 is a notion that goals are assumed to be inaccessible at this stage because of the change in the child's social and financial circumstances. Here again is the implication that the home had been a source of happiness.

- **The future**

5.To me the future looks *dark.*
20. I look forward to *finish school.*
35. Some day I *feel miserable.*
50. When I am older *(no response).*

- **Elucidation with reference to the future**

Despite the bleak reality that she faces the subject displays a determination to succeed in her studies at school. However, there is this sporadic misery that reminds her of the reality of her situation. There is a positive correlation between the answer to question 5 and the lack of response to question 50 in that realistically the "darkness" is indicative of the fact that the subject cannot imagine what her life would be like when she is older as there is no guidance in respect of her life after school.

- **Goals and Ambitions**

3.I always wanted to *respect other people and always to love the young people and adults.*
18.I could be perfectly happy if *I can get a job.*
33.My secret ambition in life *(no response).*
49.What I want most out of life *is a good job.*

- **Elucidation of goals and ambitions**

The resolve that Brenda has demonstrated in other sections is noticeable here again. To the subject, happiness goes hand-in-hand with love, respect and personal job satisfaction. The extreme poverty she experiences has created within her that a job is the only way to alleviate them from their indigent state. The independence that a job will provide

encourages her to pursue this dream relentlessly but there is still no perspective of life once she completes her schooling.

5.5.2.5. Three wishes

1. *I wish to finish school.*
2. *I wish to get a professional job.*
3. *I wish to buy a beautiful house.*

- **Summary of the three wishes**

All three of Brenda's wishes denote her heartfelt yearning to uplift herself from the impoverishment that pervades her life at present. Her initial wish verifies that she is cognizant of the fact that the following two will be fulfilled only if the first is accomplished. Obtaining a professional qualification entails having access to funds to study, which is somewhat debatable in her case unless she is able to obtain a bursary or donation. The final wish accentuates the initial assertion that Brenda is determined to distance herself from the indigence and unattractiveness around her. She is left without any guidance regarding her ability to work towards a university or college education. All of these characteristics contribute to her yen for complete financial independence, enhancement and what she sees as the appropriate way of life.

5.5.3. Interpretation of Brenda's personality

The procedure followed below will conform to the developmental levels of adolescence as defined in chapter 4.1 to 4.6 of chapter 2 of this study.

5.5.3.1. Cognitive Development

Brenda displays a concise interpretation of characteristics that highlight her realization of Piaget's formal operational phase in her recognition and acceptance of death and love. She is also capable of rational and realistic thinking – her academic progress will substantiate this. Nonetheless, she suffers a deep sense of guilt and remorse, which in variably results in a low self-esteem. The sudden death of both her parents has destroyed the only source of encouragement that she had. She is also highly aware of the prejudices of others and is often subjected to unfair bigotry.

5.5.3.2. Physical Development

Although Brenda was unusually willowy, She was tall and displayed normal pubescent development of an adolescent in her age-group. She was sexually aware and mentioned a fear of boys and teachers during the *Sack's Sentence Completion Technique.* It was later discovered that the subject had been in the early stages of pregnancy during the initial visit and had to abandon her schooling closer to the birth of the baby.

5.5.3.3. Emotional Development

It is clear that the subject is finding immense difficulty in dealing with the deaths of her parents. They have been abandoned by the extended family and are discriminated against by their local society perhaps because of the stigma people have placed upon the pandemic of HIV/AIDS. Brenda's coping strategies are unproductive which give rise to damaging social and emotional upheavals. Her despair is obvious in her extended periods of sullen silences. The fact that she experiences anxiety from being unprotected, results in a negative impact upon her schoolwork.

5.5.3.4. Moral Development

It can be argued that, without her parents, Brenda has been ineffective in developing proper moral reasoning and behaviour – hence her pregnancy. On the other hand, the question of abuse cannot be discounted in that she seems to display an obsessive fear of being hurt.

5.5.3.5. Social Development

The subject and her sister were fortunate in that they had the benefit of parental guidance until recently. Contrary to their previous family life, Brenda and her sister are leading extremely lonely lives at the moment. They seem never to be visited by friends and are not too friendly with their neighbours either. An effective support system is non-existent and their only visitors are an uncle and aunt who sometimes check on the two sisters. Within the context of the extended family, she has been neglected and isolated in the sense that nobody cares about her. The neglect could also arise from the fact that the extended family is in the same indigent situation and cannot support the sisters. However, she does have friends at school who treat her well.

5.5.3.6. Connotative Development

Brenda displays a strong character at times and the willpower to strive towards a better life for herself and her sister. This is suggested in her responses when she declares that she is determined to finish school and have a decent job. However, her endeavour towards a better life is doomed by the fact that she is pregnant and would have had to leave school. This could perhaps be the reason why she always guiltily glanced at her sister before she responded to queries.

5.5.4. Conclusion

5.5.4.1. Education

Brenda's mother's illness and death in 1998 had not been as disruptive to her schooling as was her fathers' illness and demise in 2001. She had been unable to cope with the loss of her parents and the loss of a younger brother soon after so much so that she lost a year of school as a result. It is ironic that even though Brenda displayed an eagerness to pursue her schooling, it was brought to our notice some time later that she was pregnant at the time of the interview. Invariably she would have had to abandon her studies in order to have the baby and this will result in her academic career coming to a halt if she is unable to find someone to care for the baby. Brenda obviously lacked the proper guidance regarding abuse or knowledge about contraceptives that would have assisted her in averting such a situation.

She is a quiet yet popular pupil and has many friends at school. She places great emphasis upon the importance of her friends and her appreciation of their support. Some of her responses do indicate that there are certain pupils at her school who are insolent towards them. Her concern at school is that teachers at her school do not pay attention to their individual needs and she is unable to cope with subjects such as Accounting. However, despite their personal circumstances, the teachers are not discriminatory in any way.

Brenda and her sister relied on the Thandanani Children's Foundation for the payment of their school fees and provision of most of their stationery and books. There is absolutely no income in this household and the girls are also reliant upon this NGO for their food supplies. An aunt has kindly provided second-hand uniforms and the subject makes sure that hers is washed daily. Brenda is emphatic that should she be able to afford the correct stationery and books and eat wholesome meals, she will be more successful at school.

5.5.4.2. Social life

The subject and her assertive sister are determined to continue relentlessly towards their prior goals. Although the subject admits to having some friends, the two were always alone at home when the researchers visited. Brenda is totally submissive and reliant upon the direction provided by her sister within the context of their particularly private lives. The subject and her sister appear to be victims of stigma and discrimination since their neighbours do not communicate with them. Brenda and her sister yearn for the close relationship that had existed preceding their parents' passing away. Apart from the fact that they do not have too many friends around, they feel isolated from the their relatives as a result of the circumstances surrounding the loss of their parents. Besides, it might be that Brenda's extended family is just as destitute and poverty-stricken as the girls are and cannot offer any assistance to them.

There is no one to provide any income since both the girls are at school. Hence, the clothes they have are mainly those that were purchased by their parents. Food is made available by the Thandanani Children's Foundation and they ensure that the rations last the period for which they are provided. Brenda admits that an uncle checks on them from time-to-time but does not say whether he assists them financially.

Brenda was found to have been far more honest and forthright in her responses in the *Sack's Sentence Completion* section than in the interview where she depended on her sister's reaction to each question.

The community (Pretorius 1994:32) does not fulfill the important function of supporting in the Brenda's development. In this case Brenda and her sister are weak, isolated individuals within an unfriendly world and cannot therefore graduate beyond the need to survive, the need for safety and the desperate desire to be loved and cared for (Prinsloo & Du Plessis 1998:18-20). It is therefore hardly likely that Brenda will be able to attain the satisfaction of her need to be recognized and valued or even to actualize her potentials (Pretorius 1994:30-31).

5.6. HOUSEHOLD NO. 4 - SUBJECT: Jeffrey

5.6.1. The Interview

5.6.1.1. Biographic Particulars

- **General**

Name: Jeffrey
Date of Birth 21/12/85
Age: 17 year-old
Sex: Male
Grade: 10
School: Ikusaselihle Secondary School
Place of residence: Willowfontein
Race: Black
Language Spoken: IsiZulu

- **Family composition and background**

Jeffrey, his younger brother and younger sister had always lived with their mother in their home. After she passed on in 1999, the boys decided to continue living in the modest abode that they were familiar with since they had a benevolent neighbour who had lent a hand during their mother's illness and promised the boys' mother that she would watch over them after her death. Their sister was taken to an aunt's home as the latter felt the need to protect her young niece. The small house is similar in structure to all the others visited in that they are built of wattle and daub. The structure does not appear to be very solid and bits of the walls began to fall during the course of one interview as it was raining quite heavily. Jeffrey and his brother have a small vegetable patch that provides

them with food for themselves as well as an income since they are able to sell produce to people in the neighbouring township where they obtained better prices.

- **Food Intake**

The subject stated that they were generally able to have three meals a day. Their basic diet consists of beans, spinach and rice. For some reason the boys declared that they had not eaten anything the day prior to the first visit. Their neighbour provides some of their food whenever she can and the Thandanani Children's Foundation supplies rice and beans regularly. The boys, unlike their female counterparts were unable to ensure that the rations provided lasted the month it was meant to.

- **Background information and traumatic experiences regarding the Father**

Jeffrey has been informed that his father passed on in 2000 but he has no recollection of him because this parent had never lived with the boys and their mother. He is not aware of how his father died and is totally indifferent in his responses to questions regarding the latter.

- **Background information and traumatic experiences regarding the Mother**

According to the subject, his mother had been ailing for a long time prior to her death in December 1999. He confirmed that his mother was being treated for tuberculosis at the local clinic for the period when she was ill but the treatment did not help her recover. The mother never discussed any other illness that she might have been suffering from with the subject. Nobody else discussed their mother's illness with them either.
Jeffrey and his brother had to eventually put their sorrow aside and assisted their mother with household tasks while taking care of her all the time she was gravely ill. Had he not been exposed to such training during this period he would have found this very difficult since his cultural background did not encourage male participation in such activities.

Consequently, his grades suffered and he lost a year at school, as he had to do more domestic chores, take care of his younger brother and sister and create means whereby they would be able to survive. There was no income at all to pay for the food and clothes that the boys and their sister needed.

The subject displays indisputable melancholy when he is reminded of his late mother. He is apprehensive about the future and becomes exasperated when he questions why this had to be their fate. Jeffrey is cognizant of the inadequacies and the shortcomings of his being from this particular social-milieu. Despite his desperate need to be respected and recognized, this aspect creates a disadvantage in his pursuance of self-actualization (Pretorius 1994:30-31; Prinsloo &Du Plessis 1998:16-18).

5.6.1.2. HIV/AIDS and Household Relationships

The subject is insistent that children ought to be informed by their parents what their health status was at the time of their death. He is of the viewpoint that children will react realistically and be prepared psychologically. Children will also be fully aware of the reasons for their parents' deaths and not have to rely on the various rumours that they are exposed to after their parents are deceased. He is grateful that his mother had arranged with their neighbour to take care of them after her death. He would have preferred it if his mother had told him what was wrong with her since he is of the view that he might have been able to have helped her recover.

Jeffrey verbalized his unhappiness and annoyance at having his sister live elsewhere but accepted that she was out of harm's way there with his aunt. He suspects that his sister is unhappy about this arrangement therefore he and his brother visit her at least once a month whenever finances allow them. The caregiver appointed by the boys' mother is a thoughtful, generous and philanthropic person. However, the subject and his brother

prefer to live at their mother's home rather than with this childless neighbour although they have an amicable relationship with her.

5.6.1.3. Social life

During their free time the brothers played soccer or enjoyed music and dancing with their friends or girlfriends. The boy spent most of his time with his friends but consulted the caregiver if he encountered problems. He just wished that his caregiver had been in a position to assist them to improve their shelter. Apart from prejudice displayed by some of the learners at school, Jeffrey does not appear to be exposed to any form of stigma and discrimination from the people around him. They do not feel isolated since there is a constant flow of friends in and out of their home and their caregiver is exceptionally attentive to their needs.

5.6.1.4. Emotional well-being

Occasionally, Jeffrey feels exceptionally heartbroken and he often becomes anxious about their state of affairs especially when they have to go to bed without food. He admits to becoming frustrated when he realizes how fragile their home is and that they do not posses the wherewithal to repair it properly. The thought of running away does sometimes cross his mind since this will allow him to go into the city to find a good job and take proper care of his brother and sister. He is happiest when he is playing with his friends and is a big fan of David Beckham.

5.6.1.5. Schooling

Jeffrey's teachers are aware of their pitiable situation and he will prefer a little more thoughtfulness on their part. On the other hand, the children in his class are definitely not prejudiced but are particularly supportive and considerate.

The Thandanani Children's Foundation has helped Jeffrey and his brother by paying their school fees and purchasing their stationery. A generous member of the community gave the boys second-hand school uniforms. Their major problem seems to be the lack of food at most times and the need for proper casual clothes and shoes at the moment. Jeffrey is focused and performs well at school, standing out as a leader. In his free time he is occupied both at school and at home with the task of assisting other learners who are struggling with their academic work.

5.6.1.6. Future perspectives and ideals

Jeffrey is an ambitious person and does not hide the fact that he wishes to become a social worker or a teacher in order that he will be able to give back to his community in some way. However, he lacks academic or professional guidance as to how he ought to go about applying himself towards this achievement.

5.6.2. *SACKS SENTENCE COMPLETION TECHNIQUE*

5.6.2.1. Category I: Family

- **Mother**

14. My mother *was very respectful to others because she was not interested in anyone.*
29. My mother and I – *was respectful to all who were older than her.*

44. I think that most mothers *do not like children because they are having abortions.*
59. I like my mother but *I would have done something if I had the money to help her.*

- **Elucidation of the subject's perception of the mother**

Jeffrey's responses to these questions concerning his mother are indicative of the importance of respect in her life and that this was instilled in the children as well. It is obvious that Jeffrey loved and respected his mother in a manner that she was proud of. During the course of the interviews, the subject also displayed this kind of respect towards the researcher. In his response to question 44, Jeffrey condemns the immoral sexual behaviour of certain children in the area and the helplessness of their mothers in this matter. He is also condemning of his mother's secrecy regarding her illness since he is of the opinion that he could have helped her recover had he known more.

- **Father**

1. I feel that my father – *I cannot comment about my father because I did not know him and he passed away when I was little.*
16. If my father would only – *he left us when I was young.*
31. I wish my father - *was a popular man because some people told me that.*
46. I feel that my father *was not fair because he left us when we were young.*

- **Elucidation of the subject's perception of the father**

Jeffrey has a fairly objective perception of his father. Although he condemns his father for abandoning them when they were young and vulnerable, he does concede that his father had been a well-liked individual in this community. He avoids being critical where his father is concerned because he believes that he is not qualified to do so.

- **Family**

12. Compared with most families, mine *was a poor family because I could do nothing.*
27. My family treats me like – *well because they did everything that I needed.*
42. Most families I know *are poor because they do not have a lot of things.*
57. When I was a child, my family *used to hold me like a baby.*

- **Elucidation of the subject's perception of the family**

Jeffrey accepts that his family is as poverty-stricken as many others in Willowfontein, if not more so. In his opinion, he was never deprived of anything that he desired. At the present time, the subject acknowledges the love, warmth and respect with which he was nurtured regardless of their lack of resources. The spirit of decency obviously filters down from the manner in which his mother had carried herself.

5.6.2.2. Category II: Sexual

- **Being a man**

10. My idea of a perfect man *(no response).*
25. I think most girls *are clever girls because their teachers told them about AIDS.*
40. I believe most women *have no future because they become pregnant when they are too young.*
55. What I like least about women – *is I respect them but not all but some of them.*

- **Elucidation of the subject's perception of being a woman**

There is an unmistakable distinction between the way in which Jeffrey looks at those women (females) who are licentious and those he considers worthy of praise. It is important to him that the school is educating pupils about HIV and AIDS. Jeffrey

admires those girls who are intelligent enough to take heed of the advice given by the teachers. He also discusses those women who knowingly fall pregnant and therefore face poverty and bleak futures. The subject is of the view that such wanton behaviour will not allow women to uplift themselves from the impoverished lives that people in this area appear to be condemned to.

- **Heterosexual perceptions**

11. When I see a man and a woman together *I feel very bad because I think of the days when my mother and father must have been together.*
26. My feeling about married life is *to go to Durban and play music like Kwaito, Rib and Rage.*
41. If I had a love affair *I will build a house and buy my girl a cow and all the things she needs.*
56. My love life – *is to love my life and to build my future in my life.*

- **Elucidation of the subject's perception of heterosexual relationships**

Jeffrey would prefer to believe that his parents had once enjoyed a loving, happy marriage. He bases his personal dreams of heterosexual relationships on this belief but he is determined to pay the proper *lobola* (payment made to bride's father or elder) and provide completely for his loved one's needs. His love for music, his obsession with security, and devotion towards others who are close to him and the security of a successful, content future all blend into his concept of goals and aspirations.

5.6.2.3. Category III: Interpersonal Relationships

- **Friends and acquaintances**

8. I feel that a real friend *yes because they are real true friends.*
23. I do not like people - who *are those people who smoke ganja or cigarette and drink alcohol.*
38. The people I like best *are those who do something for me like give me food.*
53. When I'm not around, my friends *I read my books and newspapers.*

- **Elucidation of the subject's perception of friends and acquaintances**

Friendships play a major role in the subject's life and he values his friends dearly. This was apparent by the fact that on each visit to this home, there were always other boys around who are obviously loyal friends of the subject and his brother. Jeffrey condemns immoral, unhealthy social habits and adamantly dissociates himself from people who indulge in such behaviour. He also displays an appreciation for those who are responsible for his survival by providing him with food. The subject emphasizes the need to improve intellectually in order to be able to accomplish his ambitions.

- **Superiors**

6. The male teachers at our school treat us well and respect us very well.
21. In school my teacher(s) *was a very respectable man who taught all the children who liked him.*
36. When I see the teacher coming *I feel well because I was not afraid of some teachers.*
51. People whom I consider my superiors *is a teacher because she teachers me well.*

- **Elucidation of the subject's perception of superiors**

Teachers play a significant role in Jeffrey's life since he affords them the respect that his mother had inculcated in him. Even though he considers them to be his superiors, he does not fear them. The attitude of Jeffrey's teachers also appears to be positive towards him. They do not treat him differently from the other children.

- **People in charge**

4. If I were in charge *I will be very happy because I will always think about food.*
19. If people work for me *I will have a future to do something like helping people to teach them something good for the future.*
34. The people (children) who do things for me – *are the people that are good because they are big in life.*
48. In giving orders to others, *I will not.*

- **Elucidation of the subject's perception of people in charge**

Jeffrey is of the opinion that the people in charge ought to be able to provide for the upliftment of his community. He looks up to those who assist him and who give unconditionally. Within the realm of his dreams, he looks forward to a future when he will reciprocate by assisting others in need. Although he displays an optimistic attitude towards his capacity to be able to assist others to remove themselves from poverty and need in the future, he is at the same time adamant that he will not order people around. He lacks experience in these matters.

- **Peers**

13. At school I get along best with *a subject like history and agriculture because I like these subjects.*
28. Those at school with me *are bad because they laugh at everything we do.*
43. I like working with people *because I like to help those people who have HIV and AIDS.*
58. Other children in my class *are those who are not respectful to others.*

- **Elucidation with reference to peers**

In response to these questions involving his peers, Jeffrey reveals that there are those children who look down upon him and jeer at him because of his personal circumstances. The stigma and discrimination that he experiences stem from the other children's lack of respect and tolerance. His own interpretation of question 13 merely displays his choice of favourite subjects. It becomes apparent that Jeffrey considers HIV/AIDS as the source of the other children's discrimination and reiterates his desire to assist those who are affected by the pandemic. He considers it important that people are aware of the seriousness and the implications of HIV/AIDS.

5.6.2.4. Category IV: Self-concept

- **Fears**

7. I know it is silly but I am afraid of *(no response).*
22. Most of my friends don't know that I am afraid of *exposing that I am an orphan.*
37. I wish I could lose the fear of *the existence of ghosts.*
52. My fears sometimes force me to *(no response).*

- **Elucidation of fears**

The subject's lack of response to questions 7 and 52 indicate that he does not wish to expose his weaknesses as well as the manner in which he reacts when he feels threatened or afraid. Nevertheless, he does concede that it bothers him that he is an orphan and feels that this is why others are derogatory towards him. He therefore expresses a desire to suppress this fact. He displays a sense of inadequacy in his fear of ghosts and he has no suitable adult to discuss this issue with.

- **Guilt feelings**

15. I would do anything to forget the time *like reading newspaper and going to school.*
30. My greatest mistake was *to go to town without permission.*
45. When I was younger, I felt guilty about *going out to play with my friends and leaving my mother alone when she was ill.*
60. The worst thing I ever did *was to block a goal when we were playing soccer.*

- **Elucidation of guilt feelings**

The subject's response to question 15 could have a bearing on his feeling guilty about wanting to abandon his learning and seek employment in order to provide for his brother and sister. Question 45 highlights a childish response to go out and play rather than remain at home with an ailing mother. On hindsight he condemns his selfishness to choose recreation. This sense of guilt is indicative that he had never considered the severity of his mother's illness nor the fact that she would pass on so quickly. He even considers simple actions such as his inability to perform well in a game of soccer as a betrayal to his friends.

- **Personal strengths**

2. When everything seems to be against me *I talk to my friends if I have any problem.*
17. I believe that I have the ability to *do something to help others because of the future and this is the time to do something.*
32. My greatest weakness is *(no response).*
47. When luck turns against me *I talk to my friends.*

- **Elucidation of personal strengths**

Jeffrey's determination to convince his community to free themselves from the depths of depression and poverty is foremost at all times in his responses. He considers his friends to be his greatest source of comfort and he knows that they will assist him always. Again he is hesitant to expose any weaknesses that may be used against him.

- **The Past**

9. When I was a child (younger) *I was very poor.*
24. Before I was at school *I was a man who did know something like draw something that we were drawing.*
39. If I were a little child again *I will be playing with toys like a baby and crying for something that I like.*
54. The thing I remember most about my childhood *is playing soccer and jumping.*

- **Elucidation with reference to the past**

Although the subject recalls happy, playful days of his childhood, he is fully aware that even then there was poverty, helplessness and hardship. His reference to being 'a man' in question 24 could be attributed to the positive association between education and success. Hence, he will be able to extricate himself and his family from their desperate conditions.

- **The future**

5. To me the future looks *so bad because I have no money to do everything.*
20. I look forward to *build my future because I like the community and to talk to them like my future.*
35. Some day I *want to be a teacher or social worker to help other children like me.*
50. When I am older *I will be a teacher because I like teaching children.*

- **Elucidation with reference to the future**

Realistically, Jeffrey's view of his future is clouded by doubt and failure since the lack of financial support will not allow for personal improvement. All the same, he does not abandon his determination to become a teacher or a social worker and lend a hand to others. In all his discussions about the future Jeffrey concentrates on enhancing his own situation in order to be able to encourage others to do the same and never just for personal gains.

- **Goals and Ambitions**

2. I always wanted to *have money to buy food and clothes.*
18. I could be perfectly happy if *I can get a job.*
33. My secret ambition in life *doing well in school and at home and to build my big house.*

49. What I want most out of life *is money to do something like buying a car.*

- **Elucidation of goals and ambitions**

The subject is typical of adolescents all over the world in his ambition to get a job, build a house and buy a car. However, his primary goal is to have sufficient money to be able to feed and clothe his family and himself. Obtaining any form of employment is seen as an opportunity to fulfill these targets and provide the basic necessities that they lack at the moment.

5.6.2.5. Three wishes

1. *I wish to buy a nice car and build a big house at home.*
1. *I wish to play for Orlando Pirates.*
2. *I wish to get my driver's license to drive a car.*

- **Summary of three wishes**

These are the desires typical of any male – the middle-class dream that will ensure that he is far removed from the abject poverty of his present living conditions. However, in Jeffrey's case, these are somewhat unrealistic if he is unable to procure the necessary financial support. Living as he does, with his brother, it is hardly likely that he will be able to fulfill these wishes without some form of monetary patronage that so many of the children in this area urgently require. The apparent lack of parental guidance, his lack of exposure to the outside world and his low level of maturity are all to blame for his dreams.

5.6.3. Interpretation of Jeffrey's personality

The procedure followed below will conform to the developmental levels of adolescence as defined in chapter 4.1 to 4.6 of chapter 2 of this study.

5.6.3.1. Cognitive Development

The subject demonstrates a sense of responsibility, reliability and abstract thinking beyond his years. He is emphatic regarding his attitude towards promiscuity and AIDS. His perception allows him the ability to consider each new problem in its entirety and not to become overwhelmed by any. The extraordinary circumstances that he faces require the sagacity of an adult.

5.6.3.2. Physical Development

Jeffrey is sexually sensitive to normal adolescent behaviour of a boy of his age. He admits to having a girlfriend and is not embarrassed to concede this. Considering his awareness of HIV/AIDS and his condemnation of promiscuity, this is a safe relationship. Physically, he is a well-built lad and his brother looks up to him as the head of this household – a role he assumes without question.

5.6.3.3. Emotional Development

It is apparent that Jeffrey is proficient at handling a multitude of emotional levels in his relationships with his peers, teachers and family. The one most outstanding feature of Jeffrey's character was that he did not display an adolescent-like single-mindedness with himself. The profound insight in his responses always indicated a philanthropic spirit in that he cared more about the pathetic plight of others rather than his own. He

even suggests that he feels guilty about leaving his mother alone while he played with his friends and for not having helped more her while she was ill. At the time of her illness and her death Jeffrey was traumatized and feared the consequent reactions from others to his becoming an orphan. He tries to overcome his fears and at one stage even considers the challenging task of leaving home to work in order to support his family.

5.6.3.4. Moral Development

This home is free of any conflict and hostility. The subject displays abstract ideas that are indicative of a superior state of moral development. Jeffrey is empathetic towards all those whom he comes across especially others in his deprived society. He is always mindful of his mother's insistence upon the need for respect towards others, especially his teachers. Regardless of his personal deprivation, he does not lack respect for others, but he openly condemns immoral sexual behaviour particularly from females.

5.6.3.5. Social Development

The subject is considered as a leader by his peers and although he lacks parental guidance, is constantly conscious of his mother's nurturing. He is popular and interacts mainly with his friends rather than his family – hence a strong peer group influence exists. The extended family is almost non-existent apart from the aunt with whom the subject's sister lives. Admittedly, at times there is evidence of some form of discrimination against them at school. Jeffrey is determined to improve himself in order to assist others. He does experience emotional turmoil when he considers his long-term plans, seeing that he is fully aware that he cannot achieve his goals without constructive financial and emotional support.

5.6.3.6. Connotative Development

Jeffrey is determined to accomplish his objective regardless of being fully aware that they are somewhat idealistic. He seeks emancipation and upliftment while he adheres to his moral principles. Regardless of his personal deprivation, he does not lack respect for others, the respect that his mother had instilled in them. He is motivated to complete his studies and become a teacher or a social worker in order to uplift the lot of his indigent community.

5.6.4. Conclusion

5.6.4.1. Education

Jeffrey is disturbed at the fact that he lost a year of his schooling when he had to take over household chores as a result of his mother's sudden illness. He was unaccustomed to these tasks and would often choose to ignore his mother's needs in order to play with his friends – an action he regrets now. However, he has adapted to his role of head of this child-headed household and attends school regularly. Jeffrey's positive self-concept and the support system in the form of The Thandanani Children's Foundation as well as the caregiver selected by his mother will assist him in his pursuit of independence and prosperity (Pretorius 1998:20-21). Despite the impoverished social milieu, his need for security and a sense of belonging are not jeopardized in any way (Pretorius 1998:30-31). This will probably facilitate his desire to become a teacher or a social worker if he is able to obtain financial assistance.

The subject finds that although his classmates are considerate and helpful, other children at school are more biased and tease him because of his domestic situation. According to Jeffrey, education is the key to his being able to assist other victims of HIV/AIDS to overcome the stigma attached to the pandemic. Therefore, he is

determined to proceed towards a tertiary education that will enable him to work with his own disadvantaged community.

The payment of school fees and the purchase of stationery as well as some books are taken care of by the Thandanani Children's Foundation. Jeffrey is well aware that his opportunity to further his education depends on the generosity of sponsors associated with NGO's.

5.6.4.2. Social life

Jeffrey and his brother are fortunate enough to be taken care of by their neighbour who had promised their dying mother to take care of the boys after her demise. Their home is a meeting place for their supportive friends who share their lives and hardships. The subject appears to be a popular boy among his classmates whom he assists with homework regularly.

The Thandanani Children's Foundation provides the subject and his brother with basic foodstuff but they admit that this does not last the time it is meant to. They are unable to purchase any other items such as casual clothes and shoes and rely on generous sponsors for this. Their neighbours are just as destitute as they are and cannot assist the subject with any provisions. However, Jeffrey admits that there is a sense of amicability among the people in this community, which is rare. It is possible that Jeffrey is self-confident since he does not feel threatened or anxious in any way (perhaps because he is a boy) and also that he does not encounter any radical bigotry.

The subject is extremely disturbed that his only sister is in the care of an aunt who resides some distance away but accepts that it is for the good of his sister. They long to see their sister more often but they can do so only when there is sufficient money from the sale of the vegetables that they grow.

5.7. THE EFFECTS OF POVERTY UPON THE RESEARCH SUBJECTS

All four of the subjects are living in the same rural area and under the same social and economic circumstances - hence, the same disadvantaged social milieu both physically and socially (Prinsloo & Du Plessis 1998:19-20). Poverty has played a significant role in further exacerbating their wretched living conditions, making their path towards self-actualization all the more difficult. Moreover, they have all been abandoned by their extended families because these families are probably in the same deprived situation as the children are probably since the extended families are prejudiced towards these orphans of AIDS.

Thembelihle, Brenda and Jeffrey were exposed to "orphanhood" before their parents passed away, since their parents were unable to support these children when they were ill. With no income and a slowly dying parent to care for, the traumatized children were driven further into the state of abject poverty. Ntombifuthi's situation was even more severe than the other three because she had her baby, a little nephew and her school-going sister to take care of. Hence, it is evident that all the orphans struggle to satisfy even their most basic human need of hunger and thirst as depicted by Maslow (Pretorius 1994:30) since none of them has any constant support system and cannot purchase food, clothes and any other basic necessities.

The adolescents often go to bed without food and do not have hygienic routines as a result of the lack of readily available running water in this rural area. The orphans' social milieu (Pretorius 1994:32) takes the form of one that is basically poverty-stricken - where the community is in dire need of financial assistance. Despite the fact that the adolescents discussed their church attendance, there is obviously no financial support available from these religious groups.

Jeffrey is the only orphan who has a caregiver who had been chosen by his mother prior to her death. The neighbour provides moral support and cooks meals making use of the foodstuff provided by The Thandanani Children's Foundation. She is unable to provide any financial or material support as she too is unemployed and has no other form of support. It is worthy of note that Jeffrey's support system as well as the fact that he is a male precludes him from the anxieties that the girls experience regarding their need for safety on Maslow's hierarchy of human needs (Pretorius 1994:30-31).

The orphan adolescents' main source of support is the Thandanani Children's Foundation, an NGO in Pietermaritzburg. The Foundation takes care of the school fees and arranges for regular (often monthly) food vouchers. However, the Foundation relies on sponsorship. With other areas and many more children in similar living conditions to take care of, it is impossible for the Foundation to do more than this.

5.8. THE EFFECTS OF HIV/AIDS UPON THE EDUCATION OF THE RESEARCH SUBJECTS

The Thandanani Children's Foundation ensures that Jeffrey, Brenda and Thembelihle are able to attend school by paying their school fees timeously. However none of can be victimized or refused admission National Education Policy Act 27 of 1996 (Government Gazette 1999:12) to any of the schools according to the laws relating to education in South Africa. Local schools do not appear to discriminate against any of the research subjects in any way. However, the schools are not active in supporting them to alleviate the inhibiting circumstances at their homes.

Literature has demonstrated that often adolescents living in child-headed households are compelled to abandon their schooling as a result of the further schooling expenses that they incur. However, all of them who are at school display a concern about whether they will be able to complete their schooling. They are fully aware that they will be able to

uplift themselves from their abject conditions only if they are able to obtain suitable employment after completing grade twelve. Within the context of Maslow's hierarchy of human needs the orphans' display (in their responses regarding their three wishes) that they too desire the prestige, status and sense of adequacy that the fourth stage (basic socio-affective needs for example being acknowledged and respected) is generally supposed to fulfil (Pretorius 30-31).

Ntombifuthi, research subject 2, displays a deep desire to be able to continue her schooling where she left of. However, she is unable to do this as long as she has the baby to take care of by herself. Thembelihle and Brenda had to drop out of school when they were compelled to take care of their ailing parents. Moreover, Brenda has to drop out of school when she falls pregnant. It is likely that these two girls were not fortunate enough to have the parental/adult guidance or the appropriate knowledge about sexuality to avert such a situation. The three adolescents at school were also emphatic that they could not afford school accessories in the form of sports kits and study material, lunch or the luxury of participation in any sporting activities. Wherever possible, the school provided books and stationery if generous sponsors were not forthcoming.

Within this underprivileged community schools are unable to create feeding schemes to cater for the needs of orphans of AIDS and children like them. The adolescent orphans are deprived of taking part in regional and provincial activities because they cannot afford the outfits and equipment as well as the travelling costs of such participation. Hence the children are unable to distinguish themselves on the sports field beyond school level.

5.9. CONCLUSION

It is apparent from the preceding discussion that HIV/AIDS impacts negatively upon the research subjects who are orphans of AIDS in child-headed households, since they lack the necessary guidance and support those parents normally provide. Hence, their social lives as well as their educational and aspirations are stymied by the fact that their lives are transformed to accommodate for their lack of parental support.

Being orphans in child-headed households, HIV/AIDS has impacted negatively on the research subjects' self-actualisation and ambitions. They find themselves in insecure and apprehensive states. They want to finish school knowing that they do not have effective support systems to attain their ambitions. Furthermore, they are compelled to take care of themselves, their siblings, their homes and their personal needs without proper guidance, which disregard their personal ambitions. It is obvious that the education of the research subjects has suffered in the sense that two of the four subjects had to temporarily abandon their studies to take care of their ailing parents and two had to drop out of school permanently. The lack of an effective support system also had a negative effect on the research subjects socially. They were all abandoned by their relatives and sometimes suffered the stigma and discrimination that becomes apparent with the pandemic. Nevertheless, the research subjects are all emphatic about the fact that they want to extricate themselves from their indigent environment in order to enjoy what they considered "better" lives.

The support that a child receives influences his social and educational ambitions. In the case of the fourth research subject, the support he receives from his neighbour affords him more stability and he has a greater chance of realizing his goals. This is contrary to the future aspirations of the other subjects who are deprived of support and cannot achieve their goals under the present circumstances.

CHAPTER 6

FINDINGS AND RECOMMENDATIONS

"This is not a time for indecision and prevarication. It is not a time for preoccupation with supposedly insuperable difficulties. Nor is it a time for indefinite plan making. It is – especially - not a time for grandiose schemes designed to attain perfection. It is unlikely that in our lifetimes we will attain perfection in Africa. Let us attain something less than perfection in the lives of enough Africans to save them from death by AIDS." -Justice Edwin Cameron, New York, 2001- (Avert 2003:1).

6.1. AIM OF THE CHAPTER

This final chapter of the study serves to assimilate all the information gleaned during the literature study and the empirical research. Once the background literature study is examined in relation to the research findings, it is possible to verify or refute the stance of the many researchers who have been referred to during the course of the study. The chapter also presents recommendations from the findings of the study with special reference to the literature study and the qualitative research conducted on orphans of AIDS in child-headed households in Kwa-Zulu Natal.

6.2. INTRODUCTION

The research is relevant to the study of HIV/AIDS in South Africa since the recommendations and findings reached by the researcher may prove to be beneficial to the mitigation of the social and the educational conditions prevailing in the lives of orphans of AIDS, especially those who live in child-headed households.

6.3. PROBLEM STATEMENT AND AIMS

To reiterate what was mentioned in Chapter 1 of this study, the problem statement and the main aims of this study are as follows:

6.3.1. PROBLEM STATEMENT

Adolescents orphaned by AIDS are compelled to occupy positions of control within their family homes since their parents have died as a result of AIDS-related diseases, their parents were too ill from AIDS-related diseases to perform parental duties or their parents have abandoned them after becoming HIV-positive.

Due to the lack of parental support the orphans of AIDS are found to be divest of the following necessities:

- **Physiological needs** in the form of shelter, security and food which result in poor concentration at school;
- **Socio-affective needs** in that they lack love, acceptance and warmth; and
- **Need for self-actualization** whereby the orphans of AIDS in child-headed households cannot realize their potentials, abilities and talents but in this case they are deprived of important educational support.

It becomes apparent that the orphans of AIDS undergo inter-alia the following tribulations:

- AIDS is a drain on the financial resources of the family, creating anxiety, fear, frustration and financial strain since the industrious members of the family are now severely ill, have passed or have abandoned the children and the orphans have to take on the responsibility of providing for their siblings;

- Poverty, stigma and discrimination which take their toll as a result of the orphans' being part of HIV/AIDS-affected households, being denied vital social, emotional and economic support and sometimes becoming victims of abuse;
- The adolescent's taking on new adult responsibilities include providing security and food to dependent siblings and taking care of sick family members;
- The orphans' having to experience suffer trauma, which implicates upon their physical and mental health and their educational aspirations; and
- The orphans dropping out of school in order to take care of their ailing parents and responsibility towards dependant siblings.

In the light of the above problems the **problem statement** is formulated as follows:

- What is the impact of HIV/AIDS on the social lives and education of adolescent orphans in child-headed households?
- To what extent are the above-mentioned problems that are experienced by AIDS-affected adolescents, replicated in this study?
- What problems, unique to the sample under study, need to be recorded?
- Are there any new recommendations, suggested by the study that may be taken to mitigate the impact of HIV/AIDS as experienced by HIV/AIDS-affected adolescents?

6.3.2. AIM OF THE STUDY

The primary aim of this study will be as follows:

- To investigate and discuss the socio-educational impact of HIV/AIDS on the lives of adolescents who are orphaned by the pandemic and forced into child-headed households.
- To ascertain the extent to which the above-mentioned problems as stated in the problem statement are replicated in this study.
- To determine what problems that are unique to this study, need to be recorded.
- To provide innovative guidelines that may assist to mitigate the impact of HIV/AIDS as experienced by HIV/AIDS –affected orphans.
- To investigate by means of an empirical study the socio-educational impact of HIV/AIDS on adolescent orphans in child-headed households in the rural areas of KZN and to present recommendations and conclusions from the findings in an attempt to mitigate the impact of HIV/AIDS on these adolescents.

6.4. MAIN FINDINGS FROM THE LITERATURE STUDY

The Problem Statement and the Aims of the study have been mentioned in the preceding paragraphs. What follows are the most important findings in this chapter.

6.4.1. CHAPTER 1

This chapter delineates the pandemic (HIV/AIDS) internationally, nationally as well as within Kwa-Zulu Natal. The Problem Statement and the Aim of the study in relation to

the socio-educational problems of adolescents in child-headed households (as already mentioned) are analyzed. The following are important findings in this chapter:

- Around the world, 11 million of the **14 million** orphans of AIDS live in sub-Saharan Africa. In parts of east and southern Africa 10% of all orphans of AIDS live in homes headed by children.
- Infected adults are leaving behind a generation of young ones to be raised by their grandparents or left on their own in child-headed households.
- AIDS does not just impact socially, educationally and psychologically upon the children who have **already** been orphaned by AIDS but also on those whose parents require constant care during the illness.
- Children worldwide, who are orphaned as a result of AIDS, are exposed to anxiety, fear, sorrow, loss, stigma and discrimination, and isolation since the essential relationships within the context of the family are being destroyed.
- Socio-educational difficulties experienced by such children could be in the form of a lack of parental guidance and support to continue with schooling, late schooling, discrimination at school level, the need for adolescents to absent themselves from school or drop out completely in order to take care of ailing parents or family members, the lack of funds to pay school fees, the inability to purchase school accessories and the necessary funds to be able to participate in sports activities.
- The problem of child-headed households is not clearly understood and unfortunately there is scant data on the figures relating to children currently living in such situations.
- Information regarding the impact of HIV/AIDS upon adolescents in child-headed households is limited.

6.4.2. CHAPTER 2

This chapter outlines the major characteristics of the developmental levels and tasks of the adolescent. It has focused on the cognitive, emotional, social, moral and connotative

development as well as the tasks that adolescents ought to accomplish. The impact of HIV/AIDS upon the development of the adolescent is also discussed.

The following were the major findings:

- Apart from the normal changes with regard to the development of the adolescent, the lives of those adolescent orphans who live in child-headed households are drastically changed further when their parents pass away. The stigma and discrimination attached to the pandemic of HIV/AIDS inhibits their socio-affective development. Further, the adolescent's educational development is affected due to the lack of financial support and parental guidance, a situation that often culminates in the adolescents' having to drop out of school.
- Factors that influence the physical, spiritual, mental, social and psychological development of the adolescent could be the ethnic group, climate, milieu, socio-economic level and gender of the child. Within the context of the South African situation, HIV/AIDS appears to impact upon the poor, low socio-economic groups and affects children physically, socially, educationally and psychologically on account of parental mortality.
- HIV/AIDS influences adolescent social behaviour and attitudes once children who are deprived of parental guidance display deviant behaviour such as ill-timed pregnancies and absconding from school.
- The following findings regarding the adolescents' developmental levels are important:

    - **Cognitive Development**: An adolescent's ability to make intelligent assessments and logical deliberations together with his self-absorption are all vital facets of any discussion on HIV/AIDS. Adolescents develop the capacity to think about possibilities and assumptions that permit them to contemplate future consequences to present actions and deliberate upon the immediate and far-reaching risks or benefits of behaviour. HIV/AIDS may lead to lowered concentration levels, emotional disturbances, behaviour

changes and disturbances as well as an effect upon the thinking processes of the adolescent. It may cause failure at school due to these emotional disturbances that invariably leads to school-drop outs. At that point the youth is pressurized into the position of custodian, facing conditions that are out of the ordinary and that require the stability and sagacity of an adult.

- **Physical development:** This aspect of development involves sexual awakening, novel physical changes, a general sense of restlessness and a heightened self-consciousness. Adolescents experiment with sex and it is much easier for adolescent orphans in child-headed households to deviate – behaviour that ultimately lead to unwanted pregnancies. Self-awareness will depend upon the way in which his peers and family view the physical transformations that occur. Cultural expectations for physical looks and aptitude determine whether the self-esteem of the adolescent will be enhanced. HIV/AIDS affects the adolescent's financial situation and their access to food and clothes – hence this may result in malnutrition and a clumsy appearance.
- **Emotional development**: The adolescent experiences a multitude of emotive levels in relationships with equals, teachers, families and other members of the social group. If the adolescents are exposed to or affected by HIV/AIDS, they can go through negative emotions, mood swings, angry outbursts, which may be followed by feelings of anxiety, guilt, shame and embarrassment. Emotional fluctuations range from exuberance of a great social life to loneliness, disparagement and inferiority once they become orphans who are discriminated against during the parents' or caregivers' period of illness. They are vulnerable after the death of the parent or caregiver and may become the innocent victims of abuse.
- **Moral development**: Abstract thinking allows the adolescent to accept that each person thinks differently and to approach moral

issues responsibly. Empathy and the faculty to perceive another's point of view and to visualize other foundations for laws and rules come about from adolescence onwards resulting in a spirit of sharing. For the adolescent, different cognitive-moral ways of thinking, give rise to the development of a personal value system. Moral reasoning is allied to both cognitive as well as emotional development. Abstract ideas become progressively more significant in the higher stages of moral development. The moral development of an adolescent in a child-headed household is influenced by the lack of parental moral guidance, risky sexual behaviour, a poor self-concept and conflict due to stigma and discrimination.

- **Social development**: During adolescence, the family influence decreases while approval of the peer group becomes essential for fear of being isolated from the group. The adolescent's search for self-identity is facilitated by the social interaction with the peer group which provides enlightenment on certain aspects of life as they all experience similar problems. Once the adolescent takes the role of head of the household and caregiver to his parents and other ailing family members he is often rejected by the very peers who would have influenced him positively had he not been exposed to the shame and discrimination of being part of an AIDS-affected family. The adolescent who finds it almost impossible to belong to a social group displays signs of losing his identity within the context of the home, extended family, society and school for this reason. He does not have the freedom and support structure to express his emotional conflicts with his friends. This leaves him lonely and helpless. Support from friends, teachers and the community may assist the adolescent against depression and isolation and improves his self-worth.
- **Connotative Development:** Adolescents are individuals whose desire to become adults is motivated by the potential to exercise the free will to make the decisions that are acceptable to them. Thus, the

adolescent is always emotionally, cognitively and connotatively involved in making his own decisions. Orphans of AIDS are like all other adolescents who covet the wealth, success, stability and perhaps eminence of thriving adulthood. They wish to become responsible adults who prosper in the working world. Much to their disappointment, their aspirations may be curbed by the fact that they do not have any parents, they live in the dire poverty, their educational progress can be hampered by the lack of funds and they may become socially isolated and helpless due to the stigma attached to HIV/AIDS.

- The adolescent aspires towards the following **developmental tasks**:
    - Achieving new and mature relations with age-mates of both sexes;
    - Achieving a masculine or feminine role;
    - Accepting one's physique;
    - Desiring, accepting and achieving socially responsible behaviour;
    - Achieving emotional independence from parents and other adults;
    - Preparing for an economic career;
    - Preparing for marriage and family life; and
    - Acquiring a set of values and an ethical system as a guide to behaviour developing ideology.

6.4.3. CHAPTER 3

This chapter imparts a comprehensive situational analysis of the socio-educational impact of HIV/AIDS upon orphans in selected countries throughout the world. There is evidently a scarcity of available information on the impact of HIV/AIDS on adolescents in child-headed households worldwide and statistics in this regard are constantly changing even on a daily basis.

- **HIV/AIDS AS A GLOBAL PANDEMIC:** Adults living with AIDS (2002) (37 million), the newly affected adults with AIDS (2002) (4.2 million) and adults who had died of AIDS (2002) (2.5 million), are statistics that are especially important since these have an indisputable bearing upon the children who remain behind and are adversely affected socially, educationally and psychologically.
- The majority of the 14 million children presently orphaned by AIDS live in sub-Saharan Africa. By the year 2010, the pandemic will almost triple the number of orphans in sub-Saharan Africa, who will have lost both their parents.
- Apart from the worsening economic circumstances, which may include the loss of inheritances, the children orphaned by AIDS, suffer severe social and emotional stress in the form of anguish over the bereavement of the parent, panic about what is yet to come, prejudice, stigma, discrimination, shame, isolation and physical and sexual mistreatment.
- Researchers from different parts of the world, in the field of HIV/AIDS agree that AIDS has had the most devastating effect on the safety, education, social life, health and survival of all children in affected areas worldwide.
- Factors that affect education and social welfare among adolescents are likely to be decreased resources, high parental death rates that precipitate poverty, inadequate funds to pay for schooling and the need to take care of the ailing. The high rate of school drop-outs in affected countries is a cause for concern.

- The extended families in sub-Saharan Africa and Southern Africa have been unable to attend to the needs of the child survivors of the pandemic for economic and material reasons. Children have been caste out, having to fend for themselves or being left in the care of extremely ill or old grandparents.

- **ZAMBIA**: The current HIV/AIDS predicament in Zambia is considered to be one of the worst epidemics in the world. A UNICEF report estimated that in excess of 7% of Zambia's 1 905 000 households were without an adult member, being headed by children, that is, a boy or girl aged 14 or less. With no one else in the extended family is able to (due to economic reasons) take care of the children this inevitably gives rise to orphan households headed by older brothers and sisters. The adverse effects of HIV/AIDS upon the formal education sector in Zambia is most apparent in the severely affected Copperbelt region where inferior school education and diminished enrollment are the result of the lack of funds to pay school fees. Available funds are being utilized for palliative care and orphans are compelled to work to avoid shame and embarrassment.

- **ZIMBABWE**: The National AIDS Council assesses that over 900 000 children have lost one or both parents as a result of HIV/AIDS thus far. The estimated number of orphans in this country is 780 000. Orphan support in the form of the FOCUS project in Zimbabwe is a programme of Family AIDS Caring Trust (FACT). By recruiting women from the villages and people from church groups, they identify, monitor and assist orphans of AIDS. Statistics are indicative of the fact that there is an approximate 19% decrease in the number of orphans of AIDS attending school after the death of their mothers. Orphans of AIDS have to perform household and farm chores and are therefore unable to attend school regularly. In Zimbabwe orphans from child-headed households

are compelled to take care of themselves if the relevant NGOs cannot take them under their wings.

- **MALAWI**: An estimation of the number of orphans in Malawi is 470 000. Despite the fact that orphans in Malawi have extended families on both sides, that is, maternal and paternal relatives, they are sometimes forsaken, poverty-stricken children with nowhere to go and are subjected to further emotional trauma by having to struggle with adult roles. More children are orphaned by AIDS, in the rural rather than the urban, areas. Families in Malawi do not appreciate the significance of providing for the educational and psychosocial needs of the child orphaned by AIDS. The Community based options for protection and Empowerment (COPE) of Save the Children (US) in Malawi can be credited for the creation of effective programmes that lend a hand to communities that assist children affected by HIV/AIDS to pay school fees and run their homes. During 2000 it had been estimated that children who had lost both parents were twice as likely to drop out of school while there was also a greater number of school dropouts in the rural rather than the urban areas.

- **UGANDA**: As early as in 1998 there were in excess of 3 million children already being subjected to the effect of the pandemic in Uganda alone. Most recent studies indicate that over 1,5 million children have been orphaned since the pandemic began in Uganda but the tide has turned with the combined effort of political commitment and the involvement of all sectors of society to assist in the reduction of HIV infection rates. The majority of the orphans of AIDS in Uganda lack family guidance and support. Therefore, they have limited access to education, inadequate social interaction, poor nutrition and no material support. Since the indigent extended families are unable to take on the responsibility of looking after orphans of AIDS and paying school fees,

there is evidence of low literary levels among children orphaned by AIDS.

- **KENYA:** HIV/AIDS has given rise to more or less one million orphaned children and has contributed to the increase in the number of street children in urban areas. The concept of child-headed households is becoming more numerous in rural areas but the extended families are unable to afford the upkeep of more children. When orphans of AIDS in Kenya are compelled to become the primary caregivers of dying parents and siblings, they become victims of severe psychological trauma, separation and abuse. The poverty-stricken orphans are often not permitted to go on to secondary school because of the lack of funds, malicious caregivers, stigma and the fact that education at that level is far too costly.

- **TANZANIA**: Between one-third and one-fifth of children in Tanzania have lost one or both parents to AIDS. An offshoot of this is that such children face the acute stress of having to deal with educational, psychological as well as social problems such as an inferior level of education, social insecurity and the lack of confidence in general. A survey based on statistics regarding AIDS orphans in Tanzania exposed that child-headed households are more common among orphans of AIDS than among any other orphan. Orphans are expected to deal with educational and psycho-social problems together with adult responsibilities and material impediments. The HUMULIZA, an NGO operating in this country, has embarked on a fourteen-week program for sets of orphans, in order to attempt to alleviate the children's psychological and social problems by applying the "child-to-child" approach. This project aims at training teachers, members of NGO's, churches and women's social groups who will be able to assist the children who are orphaned by HIV/AIDS. There is evidence of communities and families in Tanzania that are attempting to prevent

school drop-outs by taking care of orphans and ensuring that expenses such as school fees are met.

- **BOTSWANA**: Approximately 38% of the adult population is infected with HIV. At the end of 2001 there were 69,000 children who had lost their parent/s to the pandemic but projections are that the number will exceed 200, 000 by 2010. Orphans from the poorest communities and socio-economic backgrounds displayed signs of poor nutrition, poor care and neglected education. They lacked the material means to meet fundamental requirements since the extended families were themselves too poor to assist them. Teachers and schools in Botswana have begun to provide a range of services such as supplying essentials, networking with children within AIDS-affected households in order to reduce stress on children, keeping an eye on orphan welfare, assisting with emotional needs and behaviour disturbance. The National Orphan Programme was created in April 1999 to accommodate and cater for orphaned children. These steps were introduced by the Botswana Government by means of the 'Short Term Plan of Action on the Care of Orphans in Botswana' (STPA), which had been extended to last until 2003. The government of Botswana appears to have obviated the problems of orphans to a significant degree in that children are kept at school and they are able to attain satisfactory grades.

- **INDIA**: The largest number of AIDS orphans around the world – 1.2 million in 2001- emanates from India. Widespread poverty compounds the effects of HIV/AIDS and there are presently 300 million poverty-stricken Indians. By the year 2005, 5-10% of children in India below the age of 15 will lose their parents to AIDS. Researchers and academics uphold that the inferior quality of education in India is now exacerbated by the HIV/AIDS pandemic. There is a significant drop in learner-enrollment in the country as school fees are unaffordable despite concessions by the schools. Extended families are either too poor or too

afraid to take on the responsibility of orphans of AIDS as a result of the discrimination attached to the pandemic.

6.4.4. CHAPTER 4

This chapter clarifies the manner in which children orphaned by HIV/AIDS are affected socially and educationally in South Africa and in the province of Kwa-Zulu Natal. The following are important findings in the chapter:

- Reports illustrate that six out of every ten children in South Africa live in poverty.
- In 2002 there were approximately 300 000 orphans of AIDS in South Africa.
- South Africa has approximately 100 000 child-headed families and projected numbers of orphans for the year 2012 are approximately 2.5 million.
- Within the South African context the increased number of children orphaned by HIV/AIDS will exacerbate absenteeism and school dropout rates, producing declining school enrolment rates and intensifying poverty.
- Previously, extended families coped with the increased burden of care whenever they were required to take on the orphans of their relatives. However, of recent the extended family system has displayed signs of flagging as a result of the exceptional numbers of orphans that are placing a strain on the extended family.
- Adolescent orphans in child-headed households:
  - Are required to care of sick family members and their younger siblings;
  - Suffer confusion or seclusion and discrimination;
  - Undergo further stress if there has been recent illness or death and substantial medical or funeral expenses;
  - Face unfamiliar responsibilities and restricted social lives;

- Have to leave school because they lack the necessary educational, financial and parental support;
- Experience unfulfilled needs such as basic food and shelter, socio-affective needs in the form of love and acceptance as well as self-actualization that assists them to realize their full potential;
- Have no moral guidance since even the extended family isolates them;
- Are deserted by their friends and family.

- When financial support is provided, the less material needs in the form of the child's emotional and psychological welfare are neglected. Complex psycho-social circumstances imposed by the HIV/AIDS pandemic bring on various divergent behaviour patterns such as premature pregnancy and anti-social behaviour in children who are trying to cope.
- The concept of 'poverty' does not just relate to the insufficiency of income but also encompasses the lack thereof, the lack of opportunities, as well as social exclusion and the frustration of having to drop out of school.
- Kwa-Zulu Natal was estimated to have had between 197 000 and 278 000 orphaned learners under the age of 15 as a result the pandemic and a 23% child-poverty share in South Africa – the highest in the country.
- Being the hardest hit by the HIV/AIDS pandemic, Kwa-Zulu Natal will understandably have the majority of South Africa's orphans in child-headed households.
- It is apparent that the poverty in child-headed households stems from the fact that the child's parents or caregivers who are sick or who have died, are unable to provide for the basic needs of the child. This results in poverty and trauma and an infringement of the child's rights to education, family care, health care and security.

6.5. MAIN FINDINGS FROM THE EMPIRICAL RESEARCH

In the course of the discussion of this chapter, there will be cross-referencing with previous chapters and especially with the views of academics in previous chapters. Page numbers and chapters will not be quoted. The following findings from the empirical research illustrate the effect of HIV/AIDS on the development of the adolescents in child-headed household:

6.5.1 COGNITIVE DEVELOPMENT

In many cases AIDS may impact negatively upon the academic performance of affected orphans where they begin to display lowered concentration levels as a result of the stress and trauma, the added responsibilities at home and the negative reactions from neighbours, friends and teachers. However, Thembelihle, Brenda and Jeffrey (the three subjects still at school) have been able to overcome the distress that they had to experience when their parents became severely ill and then died and are coping admirably with academic demands. None of the research subjects appeared to display a limited interest in their schoolwork although they lacked the support, love, care and protection of their parents. Unfortunately, Thembelihle and Brenda dropped out of school for one year because they had to take care of their ailing parents.

As Van Dyk (2001:181) states, Thembelihle and Jeffrey are typical adolescents in their age group who are capable of the capacity to think about possibilities and assumptions that allow them to deliberate upon the merits of present actions in relation to future consequences, risks or benefits of such behaviour. Despite their impoverished, AIDS-affected social and educational environment they display depth of cognitive development and accept the death of their parents.

Woolfolk's (1973:38) observation is that adolescents develop an aptitude to deliberate upon hypothetical possibilities and evaluate their personal assessments. Thembelihle falls short in this regard since she portrays the unrealistic perception that she and her sister are in a far worse financial situation than their neighbours since we were informed that the neighbourhood was generally poor. This perception might stem from the fact that other homes were fortunate to be parent-headed households. The lack of financial support and guidance prevent her from attaining any qualification from a tertiary institution.

Thembelihle, Ntombifuthi and Brenda support Hurlock's (1973:225) theory that an adolescent is able to think rationally and realistically, for despite their AIDS-affected situation, they understand fully their poverty-stricken circumstances that might impose limitations upon their future aspirations. The deaths of their parents occur at a phase in their lives when they are unable to cope with the pressures of new responsibilities without the assistance of some adult. However, even their poverty-stricken neighbours as well as their relatives (who shun them since they are orphans of AIDS), are unable to afford them the comfort and support they require to fulfill their socio-educational aspirations. They are restricted in this regard by the dearth of monetary benefaction, proper adult guidance, unfamiliar grown-up responsibilities in their homes, ignorance and the lack of any form of adult support.

Although Jeffrey is a victim of AIDS, he is nevertheless a rational, level-headed adolescent who is able to consider each problem in its entirety (Van Dyk 2001:182). He is also able to consider his future as being part of the process of upliftment within his community as a teacher or a social worker. Other subjects of the study did not look beyond finishing school and obtaining what they considered good jobs.

According to Van Dyk (2001:182), some adolescents become weighed down with destructive encumbrances that they cannot make rational decisions or cope with the

stresses of these child-headed households. Nevertheless, Thembelihle and Jeffrey display the resolve that permits them to deal with their underprivileged social conditions although they are burdened by their personal situation as orphans of AIDS.

Ntombifuthi is a prime example of an adolescent who was pressurized into a position of custodian and panicked into making a mistake that she would regret for the rest of her life. Although she loves her baby dearly, she is fully aware that her reason for having the baby was short-sighted and that she had ruined all her chances of overcoming their desperate poverty-stricken lives by educating herself. It was disappointing to note that Brenda too fell pregnant later despite her ability to be more rational and aware of the consequences of promiscuous actions - hence both the volunteer and the researcher considered the possibility that she had been abused. Her behaviour during the interview was especially disconcerting in that she kept looking (in fear) at her sister who was seated some distance away before she responded to certain questions.

It is apparent that being an orphan of AIDS has inhibited Brenda's academic self-actualization to realize her maximum potential. Brenda's self-actualization is inhibited by her parents' unexpected deaths and her unwanted pregnancy that appear to be holding her back from optimally realizing her personal success (potentials and abilities). She seems to display a low self-esteem and also lacks the love, care, support, encouragement and shelter that constitute a proper environment (Mwamwenda 1995:98) to develop a positive self-esteem (Khoza & Xhakaza 2003:33-34).

Under normal circumstances, adolescents experience high levels of confusion and stress (Mussen 1990:584) and the effects of HIV/AIDS can hinder the formation of positive self-awareness and self-confidence (Van Dyk 2001:189). This is typical of what happens to Brenda who becomes a victim of stigma and discrimination that intensifies her sensitivity and self-consciousness. She also has to drop out of school when she later falls pregnant.

6.5.2. PHYSICAL DEVELOPMENT

Just as Mwamwenda (1995:68) states, Thembelihle (mother of a baby) and Brenda (who falls pregnant) showed evidence of an awareness of themselves. Van Dyk (2001:9) considers that this is a traumatic and confusing period of adaptation for the already disorientated adolescent. This keen awareness normally depends primarily upon the way in which peers and family view the physical transformations that occur. However, these two female subjects appear to find some difficulty adjusting to their physical maturation without the assistance of their mothers and are awkward about ill-fitting clothes. It was later discovered that Brenda's self-consciousness stemmed from her being in the early stages of pregnancy. It is uncertain if Brenda was an innocent victim of sexual abuse, stemming from her physical transformation and growth and the nonexistence of adult guardianship. Unlike them, Jeffrey is sexually sensitive and admits to having a girlfriend.

On the other hand, Ntombifuthi is more relaxed about the dramatic changes in her appearance after the birth of the baby. Despite being the younger of the two sisters, she has been allocated the position of head of this child-headed household. She definitely suits the role since she is physically as well as cognitively superior to her sixteen-year-old sister who voluntarily accepts her as the person of authority.

Ntombifuthi, who is the mother of the baby, displays a fuller figure than girls of her age, as she is still breast-feeding. All the same, she accepts her body, which is consistent with the assertion of Thom, Louw, Van Ede, & Ferns (2001:397). These academics argue that it is very important for the adolescent to accept her body. Failure to accept their bodies as they develop is one of the reasons for a negative self-concept and lack of self-esteem among adolescents.

The reaction of Thembelihle to the curious attention of the boys in her community upholds the view of Louw, Edwards & Orr (2001:19) who assert that with physical development comes interest in the opposite sex and this also leads to confusion and sensitivity. This research subject finds the attention somewhat disconcerting and this does little to enhance her self-esteem. Brenda too, displays a low self-esteem as a result of her personal feelings of guilt and remorse as well as the unfair bigotry that she and her sister appear to be subjected to.

The physical development exhibited by Jeffrey obviously supports the theory of Louw, Edwards & Orr (2001:19), who consider that the adolescent's physical transformation and growth has a direct bearing upon their social development. The strength of character that Jeffrey exhibits stems from his acknowledgment of his own physical maturity and positive self-concept. In keeping with the view of Van Dyk (2001:9), his younger brother looks up to him as the head of this household and does not appear to doubt his leadership. This adolescent, as well as Thembelihle display a sense of *"social competency"* allowing them to behave appropriately under various circumstances and to gain a new self-confidence conforming to the views of both Hurlock (1973:231) and Louw et al (2001:19).

The age, physical maturity and impoverished social conditions of Thembelihle, Brenda and Jeffrey lead to their being forced to drop out of school when they were compelled to be at home to take care of their ailing parents and perform adult household tasks. Consequently, each adolescent's social development is inhibited since he has the grueling task of being custodian of his siblings and "nurse" to his parents. However, all three were able to later return to school to continue with their studies after their parents passed on.

6.5.3. EMOTIONAL DEVELOPMENT

Thembelihle, Ntombifuthi and Brenda are typical examples of the adolescents described by Hurlock (1973:229), experiencing the normal "storm and stress" periods. However, these characteristics are exacerbated in all four of the research subjects who have to face psycho-social and financial stresses as a result of the lack of parental support, together with the despair, dejection and emotional perplexity from being orphans in AIDS-affected households. The subjects were always conscious of the fact that their academic aspirations could be terminated at any time should the support from the Thandanani Children's Foundation be terminated at any point in the future.

Feelings of apprehension, remorse and humiliation, as purported by Van Dyk (2001:183) in a report on adolescents, are confirmed by the emotional behaviour of Thembelihle and Brenda. Further verification is presented in all four of the orphans' negative emotions, mood swings, angry outbursts (at times), which may be followed by feelings of anxiety, guilt, shame and embarrassment, particularly at school. The emotional outbursts and emotional stress that Ntombifuthi exhibits can be attributed to her having to take control of a household that consists not only of her sixteen-year-old sister but her baby as well as her nephew – at just fifteen!

Similar to some adolescents in this age-group discussed by Mussen (1990:229), Brenda seems prone to sullen silences in order to get a proper perspective on issues thus avoiding emotional outbursts. Jeffrey, Ntombifuthi and Brenda also seem to sometimes reason in diverse ways and demonstrate profound insight into their personal feelings as well as those of others.

Thembelihle, Ntombifuthi and Jeffrey are sometimes discriminated against at school, by learners or educators which results in their being bombarded by a multitude of emotional fluctuations from the exuberance of a great social life to loneliness, disparagement and inferiority after the parents passed away. These three subjects are

vulnerable after the death of their parents and have become the innocent victims of discrimination, stigma and probably abuse (as the case may be with Brenda).

Just as Lewis and Frydenberg (2002: 419-420) found in their study, the subjects in this research sometimes also presented ineffective coping strategies which lead to damaging social, educational and emotional upheavals. All of the subjects appear to be under social pressure and are therefore unskilled at handling the confusing situations that they are confronted with. Jeffrey, unlike the other subjects, did not display a single-minded obsession with himself but a philanthropic spirit indicating that he was desperate to alleviate himself and his community from its dire situation.

Thembelihle, Brenda and Jeffrey needed to cope not only with their own development, but also with the poor health and looming death of at least one parent. As a result these three subjects including Ntombifuthi, were required to cope with unusual adult responsibilities in child-headed households, the fear of abandonment, rejection and death.

Landry & Smith (1998:160-168) also present the notion that HIV/AIDS may cause social-emotional dysfunctioning of adolescents, which can be related to a lack of interest in life, an inhibited sense of purpose, apathy and a weakened socio-emotional expression, which are characteristic of Brenda due to her pregnancy. Together with Thembelihle (who has a baby), she is also representative of those adolescents described by Khoza & Xhakaza (2003:32) as having been orphaned by AIDS and having difficulty relating to and trusting others, having a poor self-image and feeling helpless and fearful.

6.5.4 MORAL DEVELOPMENT

Each of the research subjects is left to his or her devices and compelled to make the choice between right and wrong. However, it is difficult (yet not impossible) for Thembelihle, Ntombifuthi, Brenda or Jeffrey to develop personal value systems and moral reasoning without the guidance of significant adults in their life-worlds. Berk (1997:498) maintains that the wisdom of moral reasoning depends on an adolescent's personal disposition and the way he is nurtured leading to unassuming steadiness in moral self-determination from childhood to adolescence.

It is apparent that the maturity and abstract thinking that Ntombifuthi and Jeffrey display allow them to accept that each person thinks differently and to approach moral issues sensibly. This is in accordance with Van Dyk's concept of '**principled moral reasoning'.** Jeffery in particular typifies adolescents who prefer to champion civil rights that endorse a value system beneficial to the entire community and he attributes this to the respectable upbringing of his late mother. Despite her own error, Ntombifuthi insists that her sixteen-year-old sister not make the same mistakes that she has.

Jeffrey was the only subject who demonstrated an awareness of HIV/AIDS, the precautions he exercised and his condemnation of promiscuity. Both Thembelihle and Jeffrey have good internalized moral principles and live by their own persuasions and beliefs. As Mussen (1990:642-643) declares, the orphan's observance of moral principles and the extent to which he will contravene them will depend upon the personal ability to conceptualize moral issues and also upon the parent-child relationship that existed. Ntombifuthi considered her relationship as a means to an end of their problems once she, her elder sister and their nephew, were abandoned by all the adults in the family, Unfortunately for her, she did not have the foresight to realize that the pregnancy would merely aggravate their problems. Hence, even though she is not ostracized by the society she lives in, she has forsaken her education and cannot seem to find a way to return to school. In Brenda's case, there appears to be a question of

abuse as a reason for her pregnancy. She too had to abandon her academic aspirations in order to have the baby. Under the circumstances can it be declared that the two subjects fall short in terms of their moral development or are they pathetic victims of the HIV/AIDS pandemic? They are the victims of HIV/AIDS but have learnt that their actions (in falling pregnant) were wrong and they now regret such actions.

6.5.5. SOCIAL DEVELOPMENT

The work of Woolfolk (1973:83) stresses that empathy and the faculty to perceive another's point of view come about from adolescence onwards, giving rise to sharing with others, being of assistance to others and protecting others. This attitude is prevalent in the behaviour of Jeffrey who is caring and philanthropic. Ntombifuthi also exhibits these characteristics by standing by her family regardless of their adversities.

Thembelihle is of the view that social acceptance by her peers is important as Mwamwenda (1995:71) and Prinsloo (1998:42) affirm, since social interaction with the peer group provides clarification on certain aspects of life as they all experience similar problems and identify with one another. She can be grateful for this companionship, especially within the school, since Louw et al (2001:19) and Strode (2003) maintain that often when the adolescent takes the role of head of the household, the peer group may isolate and snub him/her.

All four of the subjects are orphans and do not have any adult or parental support or moral encouragement for there to be effective social integration or socialization. Perhaps this is the reason why Ntombifuthi and Brenda fall pregnant. Hurlock (1973:228) allows that varying cultural practices prescribe the rate at which sexual activity begins, but the pregnancies of Ntombifuthi and Brenda can be attributed to the lack of parental guidance with respect to the urge towards emotional intimacy between the sexes. Brenda is exposed to further discrimination and isolation and has to move away elsewhere to have the baby. On the other hand, Ntombifuthi does not become a victim of stigma normally associated with HIV/AIDS even after the baby's birth and she declares that no-one treats them badly.

Prinsloo et al (1998:42) and Copley (1973:101) both consider the peer group to be an acceptable part of the adolescent's life since it makes it possible for camaraderie, collaboration and reciprocal tolerance to exist. Although they battle with secrecy and disclosure, the lives of Thembelihle, Ntombifuthi and Jeffrey are testimony to this as they obviously rely on these relationships since no other close relationships exist in their lives. Hence, their days are filled with their dealings with their friends - the sharing and socialization they experience from these associations which will invariably lead to accepting and realizing the meaning and objective of norms, ethics, aspirations, procedures and conventions, reciprocally with their friends.

Brenda is probably at the stage described by Hurlock (1973: 231), when *"peer-group influence begins to wane"*, seeing that she and her sister seem to stay away from large groups, favouring, smaller, closer friendships. This definitely emphasizes the absence of her parents and creates a sense of longing to have them around, especially now that she is pregnant. Brenda is also the only research subject who conforms to the theory proposed by Louw et al (2001:19) who declare that the adolescent who finds it insufferable to belong to a social group shows signs of losing his/her identity within the milieu of the home, extended family, society and school.

Adolescents from AIDS-affected families who experience discrimination and victimization tend to withdraw from the school and society. Ntombifuthi avows that she does not experience any intolerance from any source. However, Jeffrey has encountered some prejudice at school from pupils who are not his friends and who tease him about his domestic situation and he and his brother have been cut off from the extended family. Thembelihle's encounters with her aggressive neighbours and their isolation from the extended family are examples of her personal experience of the stigma normally associated with HIV/AIDS.

Lightfoot and Healy (2001:484-489) and Battles and Wiener (2002:161-168) promote the idea that a wide social network acts as a strong support for the adolescents who are

orphaned by AIDS since the association allows them to live positively and avoid depression and isolation. Despite their deprived circumstances the joy of being part of a social group is apparent in the lives of Thembelihle, Ntombifuthi and Jeffrey.

6.5.6. CONNOTATIVE DEVELOPMENT

Pretorius (2002:36) is of the belief that if the orphans' educators are suitable role models, they can make sensible choices according to their own norms and values that coincide with those of their educators. Should their educators have been effective role models, Thembelihle and Jeffrey could have shaped their lives and identities around these adults. Unfortunately, Brenda and Ntombifuthi too do not appear to have such adult role models in their lives and have to take responsibility for their own decisions and actions.

Thembelihle, Ntombifuthi, Brenda and Jeffrey are all orphans of AIDS who yearn for the prosperity, stability and prominence of thriving adulthood. They wish to become responsible adults who prosper in the working world. The realistic presumption of Mwamwenda (1995:72-73) is that their aspirations may be restrained by the fact that they do not have any parents, they live in dismal indigence, their educational development can be hindered by the need of funds and they may become secluded due to the shame assigned to HIV/AIDS. The three orphans (Brenda, Thembelihle and Jeffrey) who are still at school have a desire to finish school to have good jobs. Unfortunately, their hard work and their self-actualization might be curbed by the fact that they have no parental support and are growing up in the most impoverished environment, together with the fact that they might not be able to complete their schooling. They rely fully on the support of the Thandanani Children's Foundation to pay for their school fees and to provide their most basic needs.

Thembelihle has an ardent desire to become independent but she has no support system to realize her meaningful goals. She displays frustration at being left to her own devices and act as decision-maker in the most difficult situations. Ntombifuthi is in the most unenviable situation in that she has freedom of choice but this is not a pleasurable task

since she is only fifteen-years of age and responsible for the lives of three others in her household, one of whom is her baby, another a nephew and the third, an older sister. Brenda is not the head of her household but lives in disenchantment and the shadow of fear for her elder sister, accompanied by a bleak future because of her pregnancy.

Jeffrey is the only one of the four who displays a tenacious, naive determination to uplift himself from his impoverished surroundings, regardless of the obstacles in his way. He is certainly aware of these but he nevertheless seeks emancipation. He is confident in his standing as a learner, optimistic about the future and focused on his desire to become a teacher or a social worker.

6.6. RECOMMENDATIONS

6.6.1. INTRODUCTION

Little research has been conducted in respect of orphans of AIDS in child-headed households and it is imperative that The Department of Education, The Department of Social Welfare, Department of Health, Department of Justice, policy-makers, schools and NGOs take these recommendations seriously and implement them in order to mitigate the impact of AIDS in child-headed households. During the course of this study it was discovered that although the number of orphans of AIDS is steadily escalating and a cause for concern, there are other vulnerable children who are in the same disadvantaged situation educationally and socially, who also require the same attention.

Proper systems to assess the needs of orphans affected by AIDS will enable such orphans to access services that cater for their special needs. In order to be able to facilitate effective rehabilitation and support programmes, The Department of Education, The Department of Social Welfare, Department of Health, Department of Justice, policy-makers, schools, NGOs and affected communities will require the following:

- An appropriate working definition of the term "child-headed household"

- An efficient classification of such "child-headed households"
- A constructive process of supervision of "child-headed households".

However, it must be noted that all these procedures have to be put into place WITHOUT isolating or prejudicing the orphans of AIDS in any way during the identification process.

An integrated course of action will certainly be effective in stemming the tide of AIDS in South Africa while it contributes towards the mitigation of social and educational problems that emanate. It is all very well to have constructive policies in place but the effective implementation of such policies is far more important to the well-being of the orphans of AIDS and other vulnerable children.

6.6.2. TOWARDS THE MITIGATION OF THE IMPACT OF HIV/AIDS ON EDUCATIONAL ISSUES

It is recommended that:

- Orphans of AIDS in child-headed households be exempt from the payment of school fees especially if they come from child-headed households. This should also include supplying school books gratis to orphans of AIDS;
- State subsidies take into account such expenses as feeding schemes at rural HIV/AIDS-affected schools since these schools are experiencing great difficulty in implementing the much-needed feeding system;
- School Guidance Counsellors be re-instated (even if they are to be itinerant in particular areas) in order to facilitate a practical support system for orphans of AIDS and other vulnerable children. Orphans of AIDS require the care and counselling that will enable them to take care of younger siblings and take on adult responsibilities in parentless households;

- Educators are trained to become more vigilant in order to identify, guide or refer those orphans who have been abandoned, those who are being abused or girls who fall pregnant and have to abandon their studies;
- Educators are trained to understand the impact of HIV/AIDS on adolescents in child-headed households as well as on their loved ones (siblings). Furthermore, it is necessary for them to have knowledge of adolescents and their developmental levels in addition to their needs so that adolescents in child-headed households can be assisted in the appropriate way;
- Effective homework programmes be implemented at school in order to assist orphans of AIDS and other vulnerable children who are unable to complete their homework efficiently as a result of their inappropriate domestic environments that are not conducive to studying, the lack of adult supervision or the fact that they have take care of extremely ill parents, caregivers or relatives and function as adults;
- The school supervises the home-based-care programmes in conjunction with Social Welfare Departments in order that the academic progress of learners is not hindered by domestic demands;
- Itinerant teachers and flexible learning periods or programmes be introduced by the Department of Education in order to cater for the needs of children who have to take over adult duties in their homes and those who are compelled to take care of dying parents, caregivers or relatives;
- An inter-sectorial system involving security police, welfare officials, educators, community leaders and learners themselves be implemented in order to ensure the safety of vulnerable orphans of AIDS who do not have supportive adults to turn to. This system will encourage learners to be more confident about attending school;
- Effective Life Orientation Programmes at schools function to address the problems related to stigma and discrimination of children in child-headed households or affected by HIV/AIDS.

6.6.3. TOWARDS THE MITIGATION OF THE IMPACT OF HIV/AIDS ON SOCIAL ISSUES

It is recommended that:

- The community and churches should be made aware of the problems of the adolescents in child-headed so that peer groups, teachers and community leaders be able to reach out when they are needed. There should be better co-ordination between all service-providers in order to deliver a sustainable support system in affected communities;
- The process of identification, classification and supervision of orphans of AIDS be a combined effort of the Department of Social Welfare, Department of Education, Department of Health, NGOs and the community in order to produce the most feasible guardianship structures for such vulnerable children without exposing them to further stigma and discrimination. This may result in less abuse of adolescents in child-headed households and acceptance and support of theses orphans by their extended families;
- The system of Child Support Grants ought to make it feasible for children to be able to access funds that are due to them despite the absence of a supervising adult. Most orphans of AIDS are experiencing difficulty in obtaining any such support since they cannot obtain identity documents timeously and as minors they are unable to apply for grants on their own strength. The situation is that much more desperate for adolescents who fall pregnant;
- Orphans of AIDS have access to vouchers (provided by the State to enable them to purchase necessities) that will assist them with the running of their homes without too much of a delay, after their parents lose their jobs and require constant care and medical attention. This is when the children feel most vulnerable as they suddenly have to cope with adult responsibilities, loss of constant income and expenses that overwhelm them;

- Employers must implement procedures that will ensure that benefits due to AIDS-affected employees are received by them or their immediate family even when the employees are too ill to be able to collect these themselves. Children are often unaware of the benefits due to their parents who are unable to return to places of employment without prior notice to their employers;
- Social workers operate in close conjunction with the Department of Justice in order to prevent misappropriation of the benefits due to orphans in child-headed households. It is often found that cultural practices leave the orphan or critically ill wives no recourse to what legally belongs to the immediate family;
- Poverty-stricken rural areas be considered in the provision of proper sanitation, water, electricity and public transport so as to assuage the problems experienced by orphans so as to ensure a healthy lifestyle for them in the absence of the parents;
- Social and Educational programmes such as Love Life and Soul City ought to include proper therapy and counselling to enable these vulnerable children to develop effective coping strategies in order to be able to handle the subsequent stress, anxiety, fear and frustration that accompany such circumstances;
- Community education regarding the spread of AIDS ought to emphasize that it is essential to avoid looking at orphans of AIDS as being a source of shame and fear, thus discriminating against them and isolating them. The tribal and cultural leadership can be encouraged to assist in changing the mindset of the rural communities so as to prevent blatant bigotry. These leaders together with religious leaders and educators at school level can also ensure that the vulnerable children are able to access the vital social, emotional and economic support that is available to them.

6.7. SHORTCOMINGS OF THE RESEARCH

The limitations discussed in Chapter 1 ought to be considered in conjunction with the following shortcomings that were exposed by this research:

- The stigma associated with the HIV/AIDS pandemic does not allow for easy identification of the research subjects.
- Since the accessibility of these particular orphans of AIDS is limited, they are invariably over-used as samples by various researchers and become accustomed to the methods and what is expected of them rather than providing fresh information.
- The research is based on only four research subjects, which makes generalization of results difficult.
- The language barrier does not allow for the researcher to catch valuable information that is often lost in translation as well as noteworthy, typical cultural intimations that the interpreter might not be aware of.

6.8. RECOMMENDATIONS WITH REGARD TO FURTHER RESEARCH

From the findings of this study it is recommended that further research should be done on adolescents in child-headed households in the following areas:

- The vulnerability of adolescent girls in child-headed households;
- The accommodation and support of adolescents in child-headed households by schools and communities; and
- Training programmes for educators on how to understand and support adolescents in child-headed households.

6.9.CONCLUSION

This dissertation addresses the impact of HIV/AIDS upon the adolescents in child-headed households and highlights the unique problems generated by the empirical research. New findings from the empirical research have also resulted in new recommendations that suggest that the effect of HIV/AIDS in relation to adolescent orphans in child-headed households needs to be addressed urgently. These findings confirm that HIV/AIDS impacts negatively upon the social lives and education of the orphans of AIDS and that the numbers of HIV/AIDS orphans is growing exponentially in South Africa.

Although the subjects used in the research are all from a previously disadvantaged community, their social conditions have been exacerbated by abject poverty. An important finding of this research is that poverty and the support, or lack thereof, determines the extent to which the lives of the orphans of AIDS are influenced socially and educationally. The lack of an effective support system inhibits the self-actualization of the orphans in child-headed households. Orphans, like Jeffrey (fourth research subject) are able to achieve their ambitions and fulfill their self-actualization because they have adequate support systems. The necessary support that the orphaned adolescents receive from friends, teachers and the community assists them to deal with depression and discrimination in order to improve their self-worth. In contrast, the other three research subjects are representative of those orphans who are unable to realize their aspirations as they lack effective support systems.

The recommendations of this research, guide NGOs, The Department of Education and The Department of Welfare towards the mitigation of the socio-educational problems that the orphans of AIDS face. Positive steps in this direction will also instill the necessary skills and knowledge to ensure that the adolescents orphaned by AIDS will be productive members of South African society in future with the capacity to help not only themselves but others. Thus, this dissertation can contribute constructively in

assisting in the mitigation of the socio-educational problems of adolescents in child-headed households.

REFERENCES

Abt, L. E. & Bellak, L. 1959. Projective psychological - Clinical approaches to the total personality. New York: Grove Press.

Aggleton, P & Parker, R. 2002. A conceptual framework and basis for action: HIV/AIDS stigma and discrimination. UNAIDS. http://www.unaids.org.

AIDS 2002 Barcelona database. XIV International AIDS Conference July 7-12 2002, Podium. http://www.aids2002/children.htm/

AIDS Helpline. 2000. HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. February.

Ainsworth, M and Filmer, D. 2002. Poverty, AIDS and children's schooling: A targeting dilemma. World Bank research working paper 2885. September.

Aita, J. 1999. AIDS observance focuses on orphans. *Washington File United Nations Correspondent*, USIA. Washington: Washington File – December 1.

Ali, S. 1998. Community perceptions of orphan care in Malawi. http://www.cindi.org.za.

Ankrah, E.M. 1994. The impact of HIV/AIDS on the family and other significant relationships. The African clan revisited, In Bor R & Elford J, The family and HIV. London: Cassell.

Associated Press 2002. Africa facing crisis of AIDS orphans. MSNBC.com. http://www.msnbc.com

AVERT.ORG database 2002a. AIDS orphans in Africa. http://www.avert.org/aidsinafrica//

AVERT.ORG database 2003b. HIV/AIDS in Botswana. http://www.avert.org/aidsinafrica//.

AVERT.ORG database 2003c. How many people in Africa are infected with HIV/AIDS? HIV/AIDS in Africa. http://www.avert.org/aidsinafrica

AVERT.ORG database 2003d. HIV/AIDS statistics in Africa. http://www.avert.org/aidsinafrica

Ayieko, M.A. 1998. From single parents to child-headed households: The case of children orphaned by AIDS in Kisumu and Siaya districts. Study Paper No. 7. HIV and Development Programme UNDP database. http://www.undp.org/

Badcock-Walters, P. 2002. Education. In Jeff Gow & Chris Desmond (ed), *Impacts and Interventions*. Pietermaritzburg: United Nations Press: p 95-110.

Ballantine, J.H. 1983. Sociology of education. Englewood-Cliffs NJ: Prentice- Hall.

Barnard, A. 2003. Holding homes together through the AIDS crisis. *Children First*, April/May 2002, 6(42): p 29-30.

Barnett, T & Whiteside, A. 2002a. AIDS in the twenty-first century disease and globalization. Hampshire: Palgrave Macmillan.

Barnett, T & Whiteside, A. 2002b. Poverty and HIV/AIDS: Impact, coping and mitigation policy in Giovanni Andrea Cornia (ed), "*AIDS, Public Policy and Child Well-Being*". UNICEF.

Barrett, K. 1998. The rights of children: Raising the orphan generation. http://www.cindi.org.za.

Battles, H.B. & Wiener, L.S. 2002. From adolescence through young adulthood: psychosocial adjustment associated with long-term survival of HIV. *Journal of Adolescent Health*, 30(3): p 161-168.

Bellamy, C. 2001. Urgent action for children on the brink. Executive speeches. New York: UNICEF Press Centre.

Bennel, P., Hyde, K. & Swainson, N. 2002. The impact of the HIV/AIDS epidemic on the education sector in Sub-Saharan Africa. Sussex: Centre for International Education, University of Sussex, Institute of Education. February.

Beresford, B. 2002. A lost generation. *Mail & Guardian,* October 4-10. http://www.mg.co.za.

Berk, L. E. 1997. Child development. Fourth edition. Illinois State University, Massachusetts: Allyn and Bacon.

Booysen, F. 2003, Poverty dynamics and HIV/AIDS-related morbidity and mortality in South Africa, Paper presented at International Conference on "*Empirical evidence for the Demographic and Socio-Economic impact of AIDS*". University of Natal, Durban, South Africa: 26-28 March.

Booysen, F., van Rensburg, D., Bachmann, M., Engelbrecht, M. & Steyn, F. 2002. The socio-economic impact of HIV/AIDS on households in South Africa. *AIDS Bulletin*, March 2002 11(1).

Boseley, S, 2002. 13.4m children are AIDS orphans. *The Guardian*, Thursday July 11. http://www.guardianunlimited.co.za/

Bradshaw, D., Johnson, L.; Schneider, H.; Bourne, D. & Dorrington, R. 2002. Orphans of the AIDS epidemic – The time to act is now, *MRC Policy Brief*, No. 2 May. Cape Town, South Africa: MRC.

Brembeck, C. S. 1966. Social foundations of education U.S.A.: Michigan State University, U.S.A: John Wiley & Sons Inc.

Brigaldino, G. 2002. Living with AIDS: The experience of Botswana. OpenDemocracy Ltd. www.opendemocracy.org.

Brittain, V. 2001. AIDS plays havoc with Africa's children. *The Guardian.* Wednesday June 6. http://society.guardian.co.uk/

Bukenya, A. 2002. Promoting strategies for community care of vulnerable children in Uganda: Background to the setting up of children's homes. Kampala: Ministry of Education.

Case, A. 2003. Economic and social costs of death. *KZNe News*, Volume 1, Number 8. July. Durban, South Africa: The MRC Kwa-Zulu Natal Forum.

Chakraborty, J., Chrisstie, M. and Zominhthanga, J. 2001. A looming crisis: Orphans in India before the impacts of HIV/AIDS. *ORPHAN ALERT*: International Perspectives on Children left behind by HIV/AIDS, Foundation and Association of Francois-Xavier Bagnoud. http://www.albinasactionfororphans.org/

Clarke, L. 2002. The orphans of AIDS. *Sunday Tribune News.* Sunday, October 27: p 22.

Cohen, D.1999. The HIV epidemic and the education Sector in sub-Saharan Africa. UNDP Issues Paper 32. *The HIV epidemic and the education sector in sub-Saharan Africa*. http://www.undp.org/hiv/publications/index

Cohen, D. 1999. Responding to the socio-economic impact of the HIV epidemic in Sub Saharan Africa: Why a systematic approach is needed. UNDP. March 1999. http://undp.org/hiv/publications/index.

Cohen, D. 2002. HIV and education in sub-Saharan Africa: Responding to the impact. *Perspectives in Education*, July, vol. 20(2): p 13-23.

Coombe, C. 2000a. The impact of HIV/AIDS on the education sector (Part 5). HIV/AIDS and the education sector: The foundations of a control and management strategy in South Africa. Pretoria, June.

Coombe, C. 2000b. Keeping the Education System Healthy: Managing the Impact of HIV/AIDS on Education in South Africa. *Current Issues in Comparative Education*, Columbia: Teacher's College Columbia. December.

Coombe, C. 2001. HIV and Education: Strolling behind a Galloping Pandemic (abstract). Cape Town, South Africa: National Union of Educators/EVALUNET.

Coombe, C. 2002a. HIV/AIDS and education. *Perspectives in Education.* July 2002, vol. 20(2): p vii-x.

Coombe, C. 2002b. Mitigating the Impact of HIV/AIDS on Education Supply, Demand and Quality. In Giovanni Andrea Cornia (ed) *AIDS, Public Policy and Child Well-being.* UNICEF.

Coombe, C. 2002c. The social context of education. Pretoria: University of Pretoria: p129-135.

Coombe, C. & Kelly, M. J. 2000. Education as a vehicle for combating HIV/AIDS. Mini Virtual Conference. Cape Town, South Africa: National Union of Educators.

Computervisions.com. www.student.unsw.edu.au/handbook/courses/comp9517.shtml.

Copley, B. 1993. The world of adolescence: Literature, society and psychoanalytic psychotherapy. London: Free Association Books.

Crewe, M. 2000. Education at the crossroads. Paper presented at the Convention of African School Leaders. St Stithians College, 23rd August.

Crewe, M. 2001. Mythologies and crisis. Paper delivered at National Union of Educators Conference. Cape Town. National Union of Educators in collaboration with Evalunet. August 24th.

Csete, J. 2001. Kenya: Government neglects AIDS orphans: Million s of kids in Africa lack State protection. New York: Human Rights Watch press release. June 25.

Daniel, M. 2003, Children without parents in Botswana: The safety and beyond. Paper delivered at the International Conference on "*Empirical evidence for the demographic and socio-economic impact of AIDS*" University of Natal, Durban, South Africa: 26-28 March.

Daniels, M. 2001. Maslow's Concept of Self-Actualization. Liverpool John Moores University. http://www.michaeldaniels.co.uk.

Daphne, B. (ed) 1987. The implications of AIDS for children in care. London: Ashdown Press.

Davis, G. 2002. Suffer the little children. *FAIRLADY* – October 9: p 52-56.

De Capua, J. 2002. India and China Fail to Learn Lessons from Africa on HIV/AIDS. Washington UTC 05 Dec 2002, 17:55. www.africaaction.org/desk/voa0105.htm.

Desmond, C. 2002. A deadly dose of inertia. *Children First,* 6(44): p 1.

Desmond, C. 2003. Focusing on the last two years. *Children First,* Special Edition 2003, Durban: p3-5.

Desmond, C. & Gow, J. 2002a. Sickness, death and poverty – our bequest to orphans. *Children First,* 6 (40): p19-24.

Desmond, C. & Gow, J. 2002b. The current and future impact of the HIV/AIDS epidemic on South Africa's children. In Giovanni Andrea Cornia (ed) "*AIDS, Public Policy and Child Well-Being*". UNICEF.

Desmond, C. Richter, L. Makiwane, M. and Amoateng, A. 2003. Dissecting our understanding of who is at risk. *Children First*, Special Edition 2003, Durban.

Dorrington, R., Bradshaw, D. & Budlender, D. 2002. HIV/AIDS profile in the provinces of South Africa. Indicators for 2002. Cape Town: The Centre for Actuarial Science, MRC South Africa & The Actuarial Society of South Africa. November.

Dorrington, R. & Johnson, L. 2002. Epidemiological and Demographic. In Jeff Gow & Chris Desmond (ed), *Impacts and Interventions*. Pietermaritzburg: United Nations Press: p 13-57.

Durkheim, E. 1956. Education and society. New York: Free Press.

Duvall, E.M. & Miller, B.C. 1985. Marriage and family development. New York: Harper and Row.

Ebersohn, L. & Eloff, I. 2002. The black, white and grey of rainbow children coping with HIV/AIDS. *Perspectives in Education,* July 2002, vol. 20(2): p 77-86.

Eisner, E.W. 1998. Ethical tensions, controversies, and dilemmas in qualitative research. *The Enlightened Eye*. Qualitative inquiry and the enhancement of educational practice.

Erskine, S. 2001. Current trends in HIV. *AIDS Analysis Africa*, 12(2): p 12-13.

Ewing D. 2000. Where love is the only therapy. *Children First,* 4(31): p10-13.

Ewing, D. 2002. Welfare. In Jeff Gow & Chris Desmond (ed), *Impacts and Interventions.* Pietermaritzburg: United Nations Press: p 79-93.

Fahlen, M. 2002. HIV/AIDS – a double humanitarian challenge. HIV/AIDS and security. UNAIDS. http://www.unaids.org

Fiala, C. 1998. AIDS in Africa – The Ugandan example, VIRUSMYTH HOMEPAGE. http://www.aidsmyth.com/news@aidsmyth.com

Final Rapid Appraisal Report on HCBC projects. 2002. South African Department of Social Development & Department of Health 2002. South Africa. February.

Foster, G. 2002. Beyond education and food: Psychosocial well being of orphans in Africa. *ACTA PAEDIATR*, 91: 502-504.

Foster, D. & Louw-Potgieter (ed) 1995. Social Psychology in South Africa: Lexicon Publishers.

Fox, S. 2001. Investing in our future. Psychosocial support for children affected by HIV/AIDS. A case study in Zimbabwe and United Republic of Tanzania, July.

Fox, S., Oyosi, S. & Parker, W. M. 2002. Children, HIV/AIDS and Communication in South Africa: A literature review. Johannesburg, South Africa: The Centre for AIDS Development, Research and Evaluation (Cadre).

Fredriksson, J. & Kanabus, A. 2003. HIV/AIDS in Botswana. April 2003:12-13. http://AVERT.ORG

Gebru, M., Atnafou, R. 2001. Transitioning from institutional care of orphans to community-based care: The experience of Ethiopia's Jerusalem Association Children's Homes, *International Perspectives on children left behind by HIV/AIDS. ORPHAN ALERT,* Foundation and the Association of Francois-Xavier Bagnoud: p 22-23.

Giese, S. 2000. Providing for the 'orphan generation'. *Children First,* 4(31): p 38-40.

Giese, S. 2001. Blamed, beaten and abused. *Children First,* 5(39): p 3-5.

Giese, S. 2002a. Health. In Jeff Gow and Chris Desmond (ed). *Impacts and Interventions.* Pietermaritzburg: United Nations Press: p 59-77.

Giese, S. 2002b. A call for co-ordinated action for children affected by HIV/AIDS. Paper delivered at a conference hosted by the Department of Social Development and the Nelson Mandela Children's Fund 2-5 June 2002.

Giese, S. & Meintjes, H. 2003. The challenge lies in implementing policy. *Children First*, Special Edition: p 42-49.

Gillis, H. 1997. Counselling young people. Pretoria: Kagison Tertiary.

Good, C. V. 1973. Dictionary of Education. U.S.A.: Mc Graw- Hill Book Company.

Gouws, E. & Kruger, N. 1996. The adolescent. An educational perspective. Johannesburg: Heineman.

Gow, J. & Desmond, C. 2002. Impacts and Interventions. The HIV/AIDS Epidemic and the Children of South Africa. Pietermaritzburg: United Nations Press.

Gow, J., Desmond, C. & Ewing, D. 2002. Children and HIV/AIDS. In Jeff Gow and Chris Desmond: *Impacts and Interventions*. The HIV/AIDS epidemic and the children of South Africa. Edited by. UNICEF. Pietermaritzburg: United Nations Press.

Green, L. 2002. African AIDS orphans' lives focus on basic survival. General Board of Global Ministries, December 20, 2002.

Guba, E.G. & Lincoln, Y.S. 1994. Competing paradigms in qualitative research. Thousand Oaks: Sage Publications.

Guest, E. 2001. Children of AIDS – Africa's orphan crisis. Pietermaritzburg: University of Natal Press.

Guthrie, T. 2003, Socio-Economic transformation: Are we going backwards? *Children First,* Special Edition: p16-25.

Guthrie, T., Jacobs, M., King, M.S., Dawes, A., Giese, S., Proudlock, P. & Berry, L. 2002. Social security benefits for children and families: Report of the Committee of inquiry into a comprehensive social security system. (Consolidated Report). Children's Institute: university of Cape Town. 15 June.

Halkett, R. 1998. Enhancing the quality of life for children without parents in the South African context. Paper presented at CINDI Conference – July.

Harber, M. 1998. Developing a community-based AIDS orphan project: A South African Case Study.

Harmon, D. 2001. Life skills for young orphans. The Christian Science Monitor. October 02,2001. http://csmonitor.com

Havighurst, R.J. 1976, Developmental tasks and education. New York: David McKay.

Hawes, G. R. & Hawes, L. S. (Ed.) 1982. The Concise Dictionary of Education, U.S.A.: Van Nostrand Reinhold Company.

Hawkins, J. 2000. South African Oxford School Dictionary.

Hepburn, A. 2002. Increasing primary education access for children in AIDS-affected areas. *Perspectives in Education,* July2002, vol. 20(2). Pretoria: University of Pretoria: p 87-98.

HIV/AIDS & STD Strategic Plan for South Africa 2000-2005.

Holahan, C. J. 1982. Environmental Psychology.New York: Random House.

Hopehiv Projects 2000. South Africa: HopeHIV. www.hopehiv.org.

Human Rights Watch 2001. KENYA: In the shadow of death: HIV/AIDS and children's rights in Kenya. June, 13(4)(A). http://www.hrw.org

Hunter, G.J. & Williamson, I.P. 2000. Children on the Brink: Executive Summary: Update and estimates and Recommendations for Intervention. Washington:USAID. http://www.usaid/gov/pubs/hiv_aids/childrenreport.pdf/

Hurlock, E. B. 1973. Child Development. Singapore: McGraw-Hill Company.

Hurlock E. B. 1981. Developmental Psychology: A Life-span Approach. New Delhi: Tata McGraw-Hill Publishing Company Ltd.

Husen, T. & Postletwaite, T. N. (ed. In-chief) 1991. The International Encyclopedia of Education. Oxford: Pergaman Press.

Johnson, L. & Dorrington, R. 2001. The impact of AIDS on orphanhood in South Africa: A Quantitative Analysis. October 2001. Rondebosch, South Africa: Centre for Actuarial Research. University of Cape Town.

Kalideen, N. 2003. Women bear brunt of 11-million AIDS orphans. Pretoria News: Pretoria. 27 November 2003. www.pretorianews.co.za.

Keeton, C. 2000. S.Africa- AIDS-orphans: AIDS epidemic hits breadwinners, forces orphans into adulthood. *Agence France-Presse.* November 28, 2000. http://www.afp.com.

Keeton, C. 2003. Statistics do bear grim testimony to AIDS horror. http://www.afp.com.

Kehler, J. 2003. In the best interests of a child: thoughts on the Draft Children's Bill from a gender perspective. *Agenda, No.* 56:

Kelly, M.J. 1999. The impact of HIV/AIDS on schooling in Zambia. Paper for presentation at XIth International Conference on AIDS and STD'S in Africa (ICASA). Roundtable on the social impact of HIV/AIDS. Mulungushi International Conference Centre, Lusaka. 12 September.

Kelly, M.J. 2000a. Meeting the educational needs of orphans and vulnerable children (OVCs). Paper presented at presentation and discussion at Eastern and Southern Africa Regional Workshop on OVCs, Mulungushi Conference Centre, Lusaka. 7 November.

Kelly, M.J. 2000b. The encounter between HIV/AIDS and education. Zimbabwe: UNESCO.

Kelly, M. J. 2002. Preventing HIV transmission through education. *Perspectives in Education*, 20(2). Pretoria: University of Pretoria: p 1-12.

Kezaala, R. & Bataringaya, J. 1998. The Practicalities of Orphan Support in East and Southern Africa – planning and implementation of multi-sectoral social services for children and child careers. The practicalities of orphan support in East and Southern Africa. Paper presented at CINDI Conference. July.

Khonyongwa, L 1998. Children and families affected by HIV/AIDS. Paper presented at CINDI Conference. July 1998. http://www.cindi.org.

Khoza, V. 2002. Teaching is everyone's job. *Children First,* June/July 2002: p 36-37.

Khoza, V. & Xhakaza, P. 2003. Children and families affected by AIDS. *Children First* August/September: p 32-34.

Krieger, N. 2001. Theories for social epidemiology in the 21st century: an eco-social perspective. *International Journal of Epidemiology 2001*, 30, Great Britain: International Epidemiological Association: p 668-677.

Krift, T & Phiri, S. 1998. Developing a strategy to strengthen community capacity to assist HIV/AIDS-affected children and families: The COPE Program of Save the Children Federation in Malawi.

Landry, K. & Smith, T. 1998. Neurocognitive effects of HIV infection on young children: Implications for assessment. *Topics in Early Childhood Special Education*, Fall 98, 18(3): p 9.

Lawrence, J. 2002. The internet and social development: African voices on HIV/AIDS and education. *Perspectives in Education,* 20(2): p 75.

Leedy, P. D. 1993. Practical Research, Planning and Design. New York: Macmillan Publishing.

Le Roux, J. (ED.) 1993. The Black Child in Crisis: A Socio-educational perspective, Vol. 1. Pretoria: J.L.van Schaik (Pty) Ltd.

Levy, M. 2000. Lifting the death sentence of ignorance. *Childrenfirst,* June/July 2000, 4(31): p 5-9.

Lewis, R. & Frydenberg, E. 2002. Concomitants of failure to cope: What we should teach adolescents about coping. *British Journal of Educational Psychology,* Vol. 72, Part 3 September 2002. London: YHT Ltd.

Lightfoot, D.A. & Healy, C. 2001. Career development, coping and emotional distress in youth living with HIV. *Journal of Counselling Psychology*, 48(4): p484-489.

Loening-Voysey, H. & Wilson, T. 2002. Approaches to caring for children orphaned by AIDS and other vulnerable children: Essential elements for a quality service. Paper delivered at conference hosted by the Department of Social Development and the Nelson Mandela Children's Fund 2-5 June.

Louw, N., Edwards, D. & Orr, J. 2001. HIV/AIDS: Care and support of affected and infected learners. *A guide for educators*, Department of Health, Republic of South Africa, Government Printers, Pretoria.

Lyons, M. 1998. The impact of HIV and AIDS on children, families and communities: risks and realities of childhood during the HIV epidemic. HIV and Development Programme, Issue Paper No. 30. UNDP. http://www.undp.org.

Mabusela, Shirley 2001. It's my life. *Children First,* .4(34): p 14-18.

Machel, G. 1998. Opening Speech, CINDI Southern African Conference entitled, The Orphan Generation. http://www.cindi.za.org.

Madorin, K. 2000. When parents die of AIDS: The children of Kagera, Tanzania, Novartis Foundation for Sustainable Development, http://www.foundation.novartis.com/social_development/children_aids_tanzania.

Makasi, C. 2002. HIV/AIDS workshop. Address delivered at the conference hosted by the Department of Social Development and the Nelson Mandela Children's Fund 2-5 June.

Mandela, N. 2002. Call to action on orphans and vulnerable children. UNICEF Press Center: Executive Speeches. Johannesburg. 10 September. http://www.unicef.org

Mangena, M. 2002. Address delivered at the National Conference on HIV/AIDS in the Education Sector: An educational coalition against HIV/AIDS. Midrand, Gallagher Estates, 30 May 2002 – 1 June.

Manicom & Pillay. 2003. Limitations of the child-support grant for women and children: A case-study of Northdale. *Agenda,* Number 56.

Marcus, T. 1999. Wo! Zaphela Izingane - It is destroying the children – Living and dying with AIDS. Prepared for the Cindi Network. http://www.cindi.org

Marshall, G. (Ed) 1998. Oxford Dictionary of Sociology. New York: Oxford University Press.

Martin, P. 2003. Vigilance and participation key to improvements. *Children First*, Special Edition: 37-41.

Mason, B. 2001. The effects of the AIDS epidemic on Southern Africa's Children. World Socialist Website. www.w.s.w.s.org.

Maxwell, J. 2000. Africa's lost generation. AIDS: Africa in peril. http://www.cnn.com/SPECIALS/2000/aids/stories/women.children/.

Mc Greal, C. 2001. Orphans of AIDS face lonely struggle for life. *The Guardian,* December 1, 2001. http://www.societyguardian.co.uk.

Mc Gregor, L. 2002. Where school is a dream. *The Guardian*, April 23, 2002 http://www.societyguardian.co.uk.

McKay, V. (Co-ord. Ed.) 1995. A Sociology of Education, Johannesburg: Lexicon Publishers.

McKay, P. 2003. Invest in families for the sake of the children. *Children First,* April/May 2002,6(42): p 26-28.

McMillan J. H. & Schumacher S. 2001. Research in Education, A Conceptual Introduction, 5th ed. Addison Wesley Longman Inc.

Medinnus, G.R & Johnson, R.C. 1976. Child and adolescent psychology. New York: Alfred A. Knopf.

Merriam, S.B. 1998. Qualitative research and case study applications in education. San Francisco: Jossey-Bass.

Mkhabela, S. 2002. A call for coordinated action for children affected by HIV/AIDS: address at Conference on Children Affected by HIV/AIDS. Nelson Mandela Children's Fund: 2-5 June. Eskom Conference Centre, Midrand.

Monk, N. 2000. Underestimating the magnitude of a mature crisis: Dynamics of orphaning and fostering in rural Uganda, *ORPHAN ALERT:* International Perspectives on Children left behind by HIV/AIDS, Foundation and the Association of Francis-Xavier Bagnoud. http://www.albinasactionfororphans.org.

Moola, N. 1996. Reconstructing educational psychology in the South African context: school system consultation as a dimension of service delivery. Cape Town: University of Cape Town.

Mouton, Johann 2001. How to succeed in your master's and doctoral Studies. A South African Guide and Resource Book. Pretoria: Van Schaik.

Mouton, J. & Marais, H.C. 1996. Basic concepts in the methodology of the social sciences. Pretoria: Aurora Printers.

Mussen, P. H., Conger, J. J., Kagan, J. & Huston, A. C. 1990. Child Development and Personality. U.S.A.: Harper Collins Publishers.

Mvulane, Z. 2003. Orphans have nowhere to turn. *Children First*, 7(49): p29-31.

Mwamwenda, T. 1995. Educational psychology: an African perspective. Durban: Butterworths.

Mwase, Cynthia 2000. Schooling cannot be sacrificed. *Childrenfirst,* 4(31): 23-25.

NPA (National Programme of Action). 2001. The impact of AIDS on children in 2001: A report on the state of the nation's children: Kwa-Zulu Natal.

NADIC (National AIDS Documentation Centre) 2001. The Uganda Control Project (UACP), Uganda AIDS Commission, National update – June 2001, http://www.nadic.com

Novartis Foundation. 2001. Alone and Helpless? AIDS orphans in Tanzania, Social Development/ Psycho-social support for AIDS orphans in Tanzania, Novartis Foundation for Sustainable Development. http://www.foundation.novartis.com/social_ development/

Nyirenda, C. 1996. Impact of HIV and AIDS on Families and Children. *Issue Paper No. 22,* HIV and Development Programme. UNDP AND UNICEF. http://www.undp.org

Oberholzer, I. 2003. Die belewendes wereld van die adolessent met MIV/VIGS. MEd. dissertation (unpublished). Pretoria:UNISA.

Orphan Care 2002, AIDS orphans in Natal, South Africa. Ingwavuma, http://www.orphancare.org.za/files/

Phiri, S. & Webb, D. 2002. The impact of HIV/AIDS on orphans and programme and policy responses in Giovanni Andrea Cornia (ed), "*AIDS, Public Policy and Child Well-Being*". UNICEF.

Piot, P. 2002. Speech to the United Nations General Assembly Special Session on Children. New York, Friday 10 May 2002. UNAIDS Speeches Speech by Peter Piot to the UN General Assembly Special Session on Children. http://www.unaids.org.

Prinsloo E. & Du Plessis S. 1998. Socio-education I & II BEd study guides. Department of Educational Studies. Pretoria: University of Pretoria.

Pretorius, J.W.M. (Ed) 1998. Socio-pedagogics 2000. Pretoria. J.L.van Schaik.

Pretorius, J.W.M. 2002. Lecture notes for Hammanskraal. University of Pretoria.

Proietto, R. 2001. Social Epidemiology. *EPI North,* Winter 2001, 13(1).

Proudlock, P. 2002. Child Care Act Discussion Paper. The Children's Institute (UCT). The AIDS Law Project (University of Witwatersrand) & The Alliance for Children's Entitlement to Social Security, April.

Rajah, Yasmin 2001. Support in the face of grief and loss. *Children First,* 5(37): p 26-27.

Ramsden, N. 2001. Sharing skills for self-help. *Children First*, 5(35): p 34-37.

Reader's Digest Family Word Finder. 1978. The Reader's Digest Association Inc. Great Britain: Clark, Doble & Brendon Ltd.

Rees, S. 2000. Action plan to counter the HIV/AIDS pandemic. HIV/AIDS Readings: Education Sub-Committee Policy Discussion Meeting: 23 October.

Rehle, M. & Shisana, O. 2003. Epidemiological and Demographic HIV/AIDS projections: South Africa. *Africa Journal of AIDS Research*, 2(1), South Africa: p 1-8.

Reid, E. 1993. Children in families affected by the HIV epidemic: A strategic approach. *Issue paper No. 13.* UNDP.HIV and Development Programme. UNDP and UNICEF. http://www.undp.org.

Reynolds, N. 2003. State needs a BIG idea to save our children. *Children First*, 7(49).

Russel, M. & Schneider, H. 2000. A rapid appraisal of community-based HIV/AIDS care and support programs in South Africa. Centre for Health Policy. Johannesburg: University of Witwatersrand.

SAHARA. 2002a. Children and Youth. Social aspects of HIV/AIDS. http://www.sahara.org.

SAHARA. 2002b. South African actions and recommendations. Social aspects of HIV/AIDS. http://www.sahara.org.

Segu, M. & Wolde-Youhannes, S. 2001. A mounting crisis: Children orphaned by HIV/AIDS in semi-urban Ethiopia: International perspectives on children left behind by HIV/AIDS.

Sherriffs, P. 1997. The orphan generation. *Femina*, May 1997: Durban: p 81-84.

Sinnah, J. 1999. Orphans and Vulnerable Children. General Board of Global Ministries.

Skweyiya, Z.S.T. (Minister) 2002. Speech delivered at the opening of the conference hosted by the Department of Social Development and the Nelson Mandela Children's Fund. Gauteng. 2-5 June.

Smart, R. 1999. Children living with AIDS in South Africa, Executive Summary. Save the Children Fund UK. November.

Smart & Smart. 1997. Child development and relationships. 3rd ed. New York: Macmillam Publishing Company Inc.

Smit, B. 2001. Introduction to Qualitative Research. Pretoria: University of Pretoria.

Smith, L.M. 1990. Ethics in qualitative field research: An individual perspective. In E.M. Eisner & Peshkin (Eds), *Qualitative inquiry in education: The continuing debate*. NEW York: Teacher's College Press.

Spain, Y. 2000a. Solutions in addressing AIDS orphans. http://www.togan.co.za/cindi.

Spain, Y. 2000b. Cutting through the red tape. *Children First,* 4(32).

Sprinthall, R.C. & Sprinthall, N.A. 1977. Educational Psychology: A developmental approach. Reading: Addison-Wesley.

Srikameswaran, A. 2000. One legacy of the slaughter: 400,000 'unaccompanied' youngsters. http://www.postgazette.com

Step Forward 2003. India. www.stepforchildren.org/countries/india.htm ←Underline?

Stern, P.C. 1979. Evaluating social science research. New York: Oxford University Press.

Strachan, K. 2000. AIDS orphans - putting faces to the figures. *Community-based care*. Issue No. 58, December.

Streak, J. 2002. Provincial child poverty rates and numbers based on poverty lines of R400 and R200 and October Household Survey data. *Child Poverty Monitor #1.* South Africa: IDASA – Budget Information Service 27 August.

Streak, J. 2003. Child-poverty, child socio-economic rights and Budget 2003. *Budget Brief No. 125*. IDASA Budget Information Service 14. March.

Strode, A. 2003. The nature and extent of problems facing child-headed households within the Thandanani Programme. Pietermaritzburg: Ann Strode Consulting cc: Nonkosi Developmental Services cc. March.

Sykes, J.B (ed) 1983. The Concise Oxford Dictionary of current English. Oxford: Clarendon Press.

Thandanani website. 2003. http:// www.thandanani.org.za.

The World Bank. 2002. Education and HIV/AIDS: A window of hope. http://www.worldbank.org.

Thom, D.P., Louw, A.E., Van Ede, D.M. & Ferns, I. 2001. *Adolessente in Menslike ontwikkeling.* Kaapstad: Kagiso.

Turkington, T. 2002. Orphaned and excluded. *The Teacher.* September 13.

UNAIDS. 1997. Children living in a world with AIDS: Children orphaned from AIDS. http://www.unaids.org. World AIDS Day.

UNAIDS. 1997. Children living in a world with AIDS: Children orphaned from AIDS. World AIDS Day 1997. http://www.unaids.org

UNAIDS. 2000. Report on the global HIV/AIDS epidemic. http://www.unaids.org.

June.

UNAIDS. 2001. Fact Sheet. http://www.unaids.org

UNAIDS. 2002. HIV/AIDS: A strategic approach. http://www.unaids.org.

UNAIDS database. http://www.unaids.org.

UNAIDS/UNICEF. 2002. Children on the Brink 2002. A Joint Report on Orphan Estimates and Program Strategies July 2002. UNAIDS, http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002a. India: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002b. Kenya: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002c. Malawi: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002d. South Africa: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002e. Uganda: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002f. Zambia: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/UNICEF/WHO. 2002g. Zimbabwe: epidemiological Fact Sheets - 2002 Update. http://www.unaids.org.

UNAIDS/WHO. 2002. AIDS epidemic update - December 2002, Joint United Nations Programme on HIV/AIDS (UNAIDS) & world Health Organization (WHO), Geneva, Switzerland. http://www.unaids.org.

UNAIDS/WHO. 2003. AIDS epidemic update. December 2003. http://www.unaids.org.

UNICEF. 2001. The state of the world's children. New York: UNICEF.

UNICEF. 2002a. Orphans and other children affected by HIV/AIDS. New York: UNICEF. http://www.unicef.org. July.

UNICEF. 2002b. UNICEF end decade databases - HIV/AIDS. http://www.unicef.org.

UNICEF. 2003a. – At a glance: India Statistics. UNICEF. http://www.unicef.org.

UNICEF. 2003b. Definitions. UNICEF. http://www.unicef.org.

UNICEF. 2003c. Malawi: Southern African crisis. UNICEF. http://www.unicef.org.

UNICEF. 2003. Care and support for orphans and families affected by AIDS. UNICEF: HIV/AIDS. http://www.unicef.org.

Van den Aardweg, E.M. & Van den Aardweg, E.D. 1988. Dictionary of Empirical Education / Educational Psychology. Pretoria: E. E. Enterprises.

Van Der Westhuizen. 2003. Weeskinders kan styg tot 1 miljoen in 2015. *Beeld.* 17 Junie.

Van Dyk, A. 2001. HIV/AIDS care and counseling. Cape Town: Pearson Education South Africa.

Van Niekerk, J. 2001. Unseen, unreported, unprotected… *Children First,* 6(41): p 28-31.

Veriava, F. 2003. Law on fees should guarantee learning. *Children First,* 7(48): p 8-9.

Verma, R. K., Salil, S., Mendonca, V., Singh, S.K., Prasad, R. & Upadhyaya, R.B. 2002. HIV/AIDS and children in the Sangli District of Maharashtra (India) (preliminary version) in Giovanni Andrea Cornia "*AIDS, Public Policy and Child Well-being*". UNICEF.

Vrey, J.D. 1979. The self-actualizing educand. 3rd impression. Pretoria: University of South Africa.

Weiss, G.L. & Lonnquist, L.E. 2000. The Sociology of Health, Healing, and Illness, Upper Saddle River: Prentice Hall.

Whiteside, A. 2002. Economic and Demographic impact of HIV/AIDS. USAID. http://www.usaid.org.

Whiteside, A.W. (ed.) 2001. AIDS and poverty: the links. *AIDS Analysis Africa*, 12(2) Aug/Sept 2001. South Africa: Whiteside and van Niftrik Publications (Pty) Ltd.

Whiteside, A. & Sunter, C. 2000. AIDS the challenge for South Africa. Goodwood, South Africa: Human & Rousseau.

Williamson, I.P. & Hunter, G.J. 2002. The Australian Survey. www.sli.unimelb.edu.au/research/publications/lpw_other_publ.html.

Wood, G. & Mason, B.A. 1997. The impact of HIV/AIDS on orphaned children in Kwa-Zulu Natal. Kwa- Zulu Natal, South Africa: CINDI. December 1997. www.cindi.za.org.

Woolfolk, Anita E. 1993. Educational Psychology. Fifth edition. Rutgers University, U.S.A.: Allyn & Bacon.

Wright, Janelle 2001. Working on the front line. Built Environment Support Group, July.

APPENDIX A

IDENTIFICATION DATA

1.1. Introduction: My name is Jyothi Chabilall and I need to interview children between the ages 13-18 here in _____ in order to find out how they live without their parents and how they manage to survive.

1.2. I am going to ask you some very personal questions. I will not discuss any of your answers with anyone else. Your name will not be written on the form and will never be used in connection with any information you give me. You do not have to answer a question if you do not feel comfortable and you can ask me to stop the interview at any time you want. But I want you to understand that if you are able to answer honestly, we will be able to understand what people think, say and do about orphans. Your guardian or caregiver can sit with us if you want him/her to. We will be very grateful if you help us with this interview. The interview should take about 30 minutes.

1.3. Will you answer these questions for me, please?

1.4. I must tell you that some of these questions may cause you to feel very sad and upset, since they describe the very difficult times in your life. The benefit of helping us is that we can arrange for you to be helped by others who are qualified to help you solve your psychological and social problems. We can also give you the addresses of those who can assist you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by the respondent)

_____

(Signature of witness certifying that informed consent has been given verbally by respondent)

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE			
INTERVIEWER			
COMMENT			

INTERVIEWER: _____ DATE OF INTERVIEW: _____

SECTION 1: BACKGROUND INFORMATION

1.1. In what month and year where you born?

MONTH/YEAR: _____
DON'T KNOW: _____
NO RESPONSE: _____

1.2. RECORD SEX OF THE RESPONDENT: _____

1.3. What language do you speak most of the time? _____

1.4. Have you ever been to school? _____

1.5. If No, why have you never been to school?

DEATH OF PARENTS/GUARDIANS: _____
FINANCIAL PROBLEMS: _____
ILLNESS: _____
LACK OF SCHOOL SPACE: _____
LACK OF SUPPORT: _____
DON'T LIKE SCHOOL: _____
OTHER: _____

1.6. If Yes, are you currently at school? _____

1.7. Which school do you go to? _____

1.8. What grade are you in? _____

1.9. If you had attended school up to a point, in which year did you last attend school?

_____

1.10. State the reasons why you are unable to go back to school?

AWAITING RESULTS: _____
COMPLETED SCHOOL: _____
DEATH OF PARENT/S/GUARDIANS: _____
DROP OUT: _____
FAILED EXAMINATIONS: _____
FINANCIAL PROBLEMS: _____
GOT A JOB: _____
ILLNESS: _____
LACK OF SCHOOL SPACE: _____
LACK OF SUPPORT: _____
NOT ENROLLED YET: _____
PREGNANCY: _____
STILL YOUNG: _____

****

SECTION 2: FOOD INTAKE

2.1. How many meals do you usually have a day? _____

2.2. What kinds of foods do you usually eat? _____

_____

_____

2.3. Did you eat anything yesterday? _____

2.4. What did you eat yesterday? MORNING? _____

_____

_____

LUNCH TIME? _____

_____

_____

_____

EVENING TIME? _____

_____

_____

DON'T KNOW? _____

NO RESPONSE: _____

2.5. What did you drink yesterday apart from water? _____

2.6. Who normally provides you with food? _____

2.7. Is this food sufficient for each day? _____

****

SECTION 3: PSYCHOSOCIAL ISSUES

3.1 BACKGROUND INFORMATION AND TRAUMATIC EXPERIENCES REGARDING THE FATHER

3.1.1. Is your father alive? _____

3.1.2. Was he very ill for a long time? _____

3.1.3. When did he pass away? _____

1.1.3. What do you think was the cause of his death?

HIV/AIDS: _____
TB: _____
PNEUMONIA: _____
LONG ILLNESS: _____
ACCIDENT: _____
BEWITCHED: _____
MALARIA: _____

** 3.1.5. What did do to make yourself feel better when your father was ill?

CRIED: _____
TALKED TO FATHER: _____
TALKED WITH RELATIVE: _____
PLAYED WITH FRIENDS: _____
HELPED HIM: _____
NOTHING: _____
OTHER: _____

** 3.1.6. After you father died how did you try to make yourself feel better?

CRIED: _____
TALKED TO FRIEND: _____
TALKED WITH RELATIVE: _____
NOTHING: _____

3.1.7. Did your father ever discuss his health condition with you before he died? _____
_____
_____

3.1.8. Did anyone else discuss this with you? _____
_____
_____

3.1.9 Who did? What did they tell you? _____
_____
_____
_____

3.1.10. What has changed in your daily life since your father died:

NO SHELTER: _____
MY SCHOOL ATTENDANCE HAS DECLINED OR STOPPED: _____
MY GRADES HAVE WORSENED: _____
I HAVE TO DO MORE CHORES: _____
I HAVE TO TAKE CARE OF SMALLER CHILDREN: _____
I HAVE TO TAKE CARE OF MY PARENT: _____
WE HAVE NO/LESS FOOD/MONEY/CLOTHES: __
_____
STARTED SCHOOL LATE: _____
NOTHING AT ALL: _____

3.1.11. How do you feel about your everyday life since your parents have passed on?

SAD/UNHAPPY: _____
WORRIED: _____
ANGRY: _____
SCARED: _____
ALONE: _____
DETERMINED: _____
RELIEVED: _____
HAPPY: _____
OTHER: _____

**3.1.12. What do you miss most about your father? _____
_____
_____
_____

****

SECTION 4. PSYCHOSOCIAL ISSUES

BACKGROUND INFORMATION AND TRAUMATIC EXPERIENCES REGARDING THE MOTHER

4.1. Is your mother alive? _____

4.2. Was she very ill for a very long time? _____

4.3. When did she die? _____

4.4. What do you think caused her death?

HIV/AIDS: _____
TB: _____
PNEUMONIA: _____
LONG ILLNESS: _____
ACCIDENT: _____
BEWITCHED: _____
MALARIA: _____
STROKE: _____
ABORTION: _____
OTHER: _____

**4.5. What did you do to make yourself feel better when your mother was ill?

CRIED: _____
TALKED TO FATHER: _____
TALKED WITH RELATIVE: _____
PLAYED WITH FRIENDS: _____
HELPED HER: _____
NOTHING: _____
OTHER: _____

**4.6. What do you do to help you feel better since your mother's death?

TALKED TO FRIEND: _____
TALKED WITH RELATIVE: _____
CRIED: _____
NOTHING: _____
OTHER: _____

4.7. Did your mother discuss her health condition with you? _____

_____

_____

4.8. Did anyone else discuss this with you? Who? _____
_____
_____

4.9. What did this person tell you? _____
_____

4.10. What has changed in your life since your mother's death?

MY SCHOOL ATTENDANCE HAS DECLINED OR STOPPED: _____
MY GRADES HAVE WORSENED: _____
I HAVE TO DO MORE CHORES: _____
I HAVE TO TAKE CARE OF SMALLER CHILDREN: _____
I HAVE TO TAKE CARE OF MY PARENT: _____
WE HAVE LESS/NO FOOD/MONEY/CLOTHES: ___
_____
OTHERS: _____
_____

**4.11. How has the loss of your mother affected the way you feel about life?

SAD: _____
WORRIED: _____
ANGRY: _____
SCARED: _____
ALONE: _____
DETERMINED: _____
RELIEVED: _____
HAPPY: _____
OTHER: _____

**4.12: What do you miss about your mother?

COOKING: _____
CARE: _____
LOVE: _____
NOTHING: _____
TIME WITH HER: _____
OTHER: _____

****

SECTION 5: HIV/AIDS ISSUES AND HOUSEHOLD RELATIONSHIPS

5.1. Do you think parents/guardians should talk about their health condition with their children? _____

5.2. Why?

SO CHILDREN CAN PREPARE EMOTIONALLY: _____

_____

SO CHILDREN CAN PREPARE PRACTICALLY: _____

_____

SO CHILDREN CAN AVOID AIDS THEMSELVES: _____

_____

SO CHILDREN CAN KNOW WHY THE PARENT/S DIED: _____

_____

SO CHILDREN CAN KNOW WHAT TO DO WHEN THE PARENT/S DIE: ____

_____

SO THAT WILLS/PROPERTY CAN BE DISCUSSED: _____

_____

SO THAT GUARDIANS CAN BE APPOINTED: _____

_____

5.3. If no, why?

I CAN'T STAND IT: _____

IT IS UPSETTING, SAD TO TALK ABOUT: _____

THERE IS NOTHING ONE CAN DO TO PREPARE: _____

CHILDREN MAY NOT KEEP A SECRET: _____

IT IS SHAMEFUL FOR PARENTS TO SUFFER/DIE FROM AIDS: _____

_____

5.4. Have you always lived in this home?

_____

5.5. If No, where did you live before this and why did you move to this place? _____

_____

_____

_____

5.6. How many children lived with you in your parent's home before moving? _____

_____

5.7. How many have the same parents as yourself? BOYS: _____

GIRLS: _____

5.8. How many of these children still live with you in the same household? _____

_____

5.9. Do you have any brothers and sisters living elsewhere? BOYS: _____

GIRLS: _____

5.10. With whom are they living? Why?

_____

_____

_____

5.11.How often do you visit them? _____

_____

5.12.How do you feel about being separated from your brothers and sisters?

SAD: _____
SORROWFUL: _____
WORRIED: _____
ANGRY: _____
SCARED: _____
ALONE: _____
DETERMINED: _____
RELIEVED: _____
HAPPY: _____
OTHER: _____

5.13. How do you get along with your other brothers and sisters? _____

_____

_____

5.4. How do you get along with your guardian/caregiver? _____

_____

5.15. How do you feel about living in this home? _____

_____

5.16. Give reasons why you feel this way?

THERE IS FOOD: _____
THERE ARE CLOTHES: _____
THEY TREAT ME WELL: _____
PAY FOR SCHOOL: _____
I AM BEATEN: _____
I AM MISTREATED: _____
HAVE MORE CHORES: _____
OTHER: _____

5.17. Where would you live if you had the choice? _____
_____
_____

5.18. How do you spend your free time?

FOOTBALL/OTHER SPORTS: _____
TAKING "DRUGS": _____
BEING WITH FRIENDS/PLAYING: _____
_____
BEING WITH FRIENDS/DRINKING BEER: _____
_____
GOING TO CHURCH: _____
DANCE, MUSIC, DRAMA: _____
HAVING BOY/GIRL FRIEND: _____
READING: _____
CRAFTS, WEAVING, ART, BASKETRY: _____
_____
OTHER:
_____

5.19. With whom do you spend most time? _____

5.20. What do you do when you have a problem? _____
_____

5.21. Who is the first person you talk to when you have a problem? _____
_____

5.22. If this person is not available, who is the next person you go to when you have a problem?_____
_____

5.23. What is your relationship with your guardian? _____

5.24. Before the guardian began to take care of you how often did you see her/ him? ____
_____

5.25. How well did you know her/him at that stage? _____
_____

5.26. Do you like her/him now that she/he is taking care of you? _____
_____
_____

5.27. What is different about your life since you live in this household? _____

5.28. How has living with this guardian affected the way you feel about life? _____

5.29. What would you like your guardian to do more of? _____

5.30. What would you like your guardian to do less of? _____

5.31. Do you think that adults treat orphans differently from other children? _____

5.32. If yes, how do they treat orphans differently? _____

5.33. Do they treat you in this way? _____

5.34. How does this make you feel? _____

5.35. Does your guardian treat you better, the same or worse than other/his own children?

5.36. How are the other children treated? _____

5.37. How does such treatment make you feel? _____

5.38. Is there anything still bothering you about your parents' death? _____

_____

_____

5.39. If yes, what is it? _____

_____

_____

_____

5.40. Do you have any special items of your mother/father/guardian? _____

_____

5.41. What are those items that you have? _____

_____

_____

_____

5.42. When do you look at these things? _____

_____

5.43. How do you feel when you see these things? _____

_____

5.44. Who made the decision for you to live in this house? _____

_____

****

SECTION 6: EMOTIONAL WELL-BEING

6.1. How often do you have scary dreams? _____

_____

6.2. How often do you feel unhappy? _____

_____

6.3. How often do you get into fights with the other children? _____

6.4. How often do you prefer to be all alone, instead of with others? _____

6.5. Whom do you like to play with? _____

6.6. How often do you ever feel worried? _____

6.7. What kind of things do you worry about? _____

6.8. How often do you feel cross or frustrated? _____

6.9. How often do you feel happy? _____

6.10. What makes you happy? _____

6.11. How often do you feel like running away from home? _____

6.12. When did you start feeling this way? _____

6.13. Tell me something that makes you happy? _____

6.14. Whom do like or admire most? Why? _____

6.15. What are your plans for the future?

SECTION 7: SCHOOL

7.1. Do your teachers know about your parents/guardians death? _____

_____

7.2. Do the teachers treat you differently since your parents/guardians death? _____

_____

7.3. How would you like them to treat you? _____

_____

7.4. Do they pay special attention to your needs? _____

_____

7.5. Are they rude or insulting to you? _____

7.6. Are they considerate about the problems that you are experiencing? _____

_____

_____

7.7. Which particular problem would you like them to be considerate about? _____

_____

_____

7.8. Are still able to pay your school fees? _____

_____

7.9. Do you ever feel as if you would like to work or remain at home instead of going to school? _____

_____

_____

_____

7.10 Do the children in your class treat you well? _____

_____

7.12. Do you feel that they could be more considerate? _____

_____

_____

7.13. How would you like them to treat you? _____

_____

_____

7.14. Are the children rude to you because of the way in which your parents died? _____

_____

_____

7.15. Do the children call you names? _____

_____

7.16. Do you have a problem having friends at school? _____

at home? _____

7.17. Are you able to afford to buy: a) books? _____

b) pens? _____

7.18. Can you afford your uniform? _____
_____

7.19. Are you often absent because you have to take care of an ill person at home? _____
_____
_____

7.20. Is there any reason why you do not have the time to complete your homework everyday? _____
_____
_____

7.21. Do you have to do without anything because you cannot afford it? _____
_____
_____

7.22. Is there anything that you would like to have for school but cannot afford? _____
_____
_____
_____

APPENDIX B

THE SACKS SENTENCE-COMPLETION TECHNIQUE

DATE: _____

NAME: _____

AGE: _____

SEX: _____

STANDARD: _____

ADDRESS: _____

INSTRUCTIONS

Below are 60 partly completed sentences. Read each one and finish it by writing the first thing that comes to your mind. There are no right or wrong answers. Work as quickly as you can. If you do not know what to write for a particular sentence, circle it and come back to it later.

1. I feel that my father .....
.....
.....

2. When everything seems to be against me.....
.....
.....

3. I always wanted to .....
.....
.....

4. If I were in charge.....
.....
.....

5. To me the future looks.....
.....
.....

6. The male teachers at our school.....
.....
.....

7. I know it is silly but I am afraid of.....
.....
.....

8. I feel that a real friend.....
.....
.....

9. When I was a child (younger).....
.....
.....

10. My idea of a perfect woman.....
.....
.....

11. When I see a man and a woman together.....
.....
.....

12. Compared with most families, mine.....
.....
.....

13. At school I get along best with.....

.....

.....

14. My mother.....

.....

.....

15. I would do anything to forget the time.....

.....

.....

16. If my father would only.....

.....

.....

17. I believe that I have the ability to.....

.....

.....

18. I could be perfectly happy if .....

.....

.....

19. If people work for me.....

.....

.....

20. I look forward to.....

.....

.....

21. In school my teachers.....

.....

.....

22. Most of my friends do not know that I am afraid of.....

.....

.....

23. I do not like people who.....

.....

.....

24. Before I was at school.....

.....

.....

25. I think most girls.....

.....

.....

26. My feeling about married life is.....

.....

.....

27. My family treats me like.....

.....

.....

28. Those children at school with me.....

.....

.....

29. My mother and I.....

.....

.....

30. My greatest mistake was.....

.....

.....

31. I wish my father.....

.....

.....

32. My greatest weakness is.....

.....

.....

33. My secret ambition in life.....

.....

.....

34. The people (children) who do things for me.....

.....

.....

35. Some day I.....

.....

.....

36. When I see the teacher coming.....

.....

.....

37. I wish I could lose the fear of.....

.....

.....

38. The people I like best.....

.....

.....

39. If I were a little child again.....

.....

.....

40. I believe most women.....

.....

.....

41. If I had a love affair.....

.....

.....

42. Most families I know.....

.....

.....

43. I like working with people.....

.....

.....

44. I think that most mothers.....
.....
.....

45. When I was younger I felt guilty about.....
.....
.....

46. I feel that my father is.....
.....
.....

47. When luck turns against me.....
.....
.....

48. In giving orders to others.....
.....
.....

49. What I want most out of life.....
.....
.....

50. When I am older.....
.....
.....

51. People whom I consider my superiors.....
.....
.....

52. My fears sometimes force me to.....

.....

.....

53. When I am not around, my friends.....

.....

.....

54. The thing I remember best about my childhood.....

.....

.....

55. What I like least about women.....

.....

.....

56. My love life.....

.....

.....

57. When I was a child, my family.....

.....

.....

58. Other children in my class.....

.....

.....

59. I like my mother but.....

.....

.....

60. The worst thing I ever did.....

.....

.....

My three wishes are:

1. .....

   .....

   .....

   .....

   .....

2. .....

   .....

   .....

   .....

   .....

3. .....

   .....

   .....

   .....

   .....

APPENDIX C

SUMMARY OF QUESTIONNAIRES

1. *SACKS SENTENCE COMPLETION TECHNIQUE*

Category I: Family

1. The mother

14. My mother is.....
29. My mother and I.....
44. I think that most mothers.....
59. I like my mother but.....

Interpretation of views of the mother

.....
.....
.....

2. The father

1. I feel that my father seldom.....
16. If my father would only.....
31. I wish my father.....
46. I feel that my father is.....

Interpretation of views of the father

.....
.....
.....

3. Family

12. Compared with most families,.....
27. My family treats me like a.....
42. Most families I know.....
57. When I was a child, my family.....

Interpretation of views of the family

.....
.....
.....

Category II: Sexual

1. Being a woman

10. My idea of a perfect woman.....
25. I think most girls.....
40. I believe most women.....

55. What I like least about women.....

Interpretation of being a woman

.....
.....
.....

2. Heterosexual perceptions

11. When I see a man and a woman together.....
26. My feeling about married life is.....
41. If I had a love affair.....
56. My love life.....

Interpretation of heterosexual perceptions

.....
.....
.....

Category III: Interpersonal relationships

1. Friends and acquaintances

8. I feel that a real friend.....
23. I don't like people who.....
38. The people I like best.....
53. When I'm not around, my friends.....

Interpretation with reference to friends and acquaintances

.....
.....
.....

2. Superiors

6. The male teachers at our school.....
21. I school my teachers.....
36. When I see the teacher coming.....
51. People whom I consider my superiors.....

Interpretation of views of superiors

.....
.....
.....

3. People in charge

4. If I were in charge.....
19. If people work for me.....
34. The people (children) who do things for me.....
48. In giving orders to others.....

Interpretation of views of people in charge

.....
.....
.....

4. Peers

13. At school I get along best with.....
28. Those at school with me.....
43. I like working with people who.....
58. Other children in my class.....

Interpretation with reference to peers

.....
.....
.....

Category IV: Selfconcept

1. Fears

7. I know it is silly but I am afraid of.....
22. Most of my friends don't know that I am afraid of.....
37. I wish I could lose the fear of.....
52. My fears sometimes force me to.....

Interpretation of fears

.....
.....
.....

2. Guilt feelings

15. I would do anything to forget the time I.....
30. My greatest mistake was.....
45. When I was younger, I felt guilty about.....
60. The worst thing I ever did.....

Interpretation of guilt feelings

.....
.....
.....

3. Personal strengths

2. When the odds are against me.....
17. I believe that I have the ability.....
32. My greatest weakness is.....
47. When luck turns against me.....

Interpretation of personal strengths

.....
.....
.....

4. The Past

9. When I was a child.....
24. Before I was at school.....
39. If I were a little girl again.....
54. My most vivid childhood memory.....

Interpretation with reference to the past

.....
.....
.....

5. The future

5. To me the future looks.....
20. I look forward to.....
35. Some day I.....
50. When I am older.....

Interpretation with reference to the future

.....
.....
.....

6. Goals and Ambitions

3.I always wanted to.....
18.I could be perfectly happy if.....
33. My secret ambition in life.....
49. What I want most out of life.....

Interpretation of goals and ambitions

.....
.....
.....

Summary Of Three Wishes

SUMMARY OF QUESTIONNAIRES

1. *SACKS SENTENCE COMPLETION TECHNIQUE*

Category I: Family

1. The mother

16. My mother is.....
30. My mother and I.....
45. I think that most mothers.....
59. I like my mother but.....

Interpretation of views of the mother

.....
.....
.....

2. The father

3. I feel that my father seldom.....
16. If my father would only.....
31. I wish my father.....
46. I feel that my father is.....

Interpretation of views of the father

.....
.....
.....

3. Family

12. Compared with most families,.....
27. My family treats me like a.....
42. Most families I know.....
57. When I was a child, my family.....

Interpretation of views of the family

.....
.....
.....

Category II: Sexual

1. Being a woman

10. My idea of a perfect woman.....
25. I think most girls.....
40. I believe most women.....
55. What I like least about women.....

Interpretation of being a woman

.....
.....
.....

2. Heterosexual perceptions

11. When I see a man and a woman together.....
26. My feeling about married life is.....
41. If I had a love affair.....
56. My love life.....

Interpretation of heterosexual perceptions

.....
.....
.....

Category III: Interpersonal relationships

1. Friends and acquaintances

8. I feel that a real friend.....
23. I don't like people who.....
38. The people I like best.....
53. When I'm not around, my friends.....

Interpretation with reference to friends and acquaintances

.....
.....
.....

2. Superiors

6. The male teachers at our school.....
21. I school my teachers.....
36. When I see the teacher coming.....
51. People whom I consider my superiors.....

Interpretation of views of superiors

.....
.....
.....

3. People in charge

4. If I were in charge.....
19. If people work for me.....
34. The people (children) who do things for me.....
48. In giving orders to others.....

Interpretation of views of people in charge

.....

.....
.....

4. Peers

13. At school I get along best with.....
28. Those at school with me.....
43. I like working with people who.....
58. Other children in my class.....

Interpretation with reference to peers

.....
.....
.....

Category IV: Selfconcept

1. Fears

8. I know it is silly but I am afraid of.....
22. Most of my friends don't know that I am afraid of.....
37. I wish I could lose the fear of.....
52. My fears sometimes force me to.....

Interpretation of fears

.....
.....
.....

2. Guilt feelings

17. I would do anything to forget the time I.....
31. My greatest mistake was.....
46. When I was younger, I felt guilty about.....
60. The worst thing I ever did.....

Interpretation of guilt feelings

.....
.....
.....

3. Personal strengths

4. When the odds are against me.....
18. I believe that I have the ability.....
32. My greatest weakness is.....
47. When luck turns against me.....

Interpretation of personal strengths

.....
.....
.....

4. The Past

9. When I was a child.....
24. Before I was at school.....
39. If I were a little girl again.....
54. My most vivid childhood memory.....

Interpretation with reference to the past

.....
.....
.....

5. The future

6. To me the future looks.....
20. I look forward to.....
35. Some day I.....
50. When I am older.....

Interpretation with reference to the future

.....
.....
.....

6. Goals and Ambitions

3.I always wanted to.....
18.I could be perfectly happy if.....
34. My secret ambition in life.....
49. What I want most out of life.....

Interpretation of goals and ambitions

.....
.....
.....

Summary

NTOMBIFUTHI ZUMA

(5)

IDENTIFICATION DATA

1.1. Introduction: My name is Jyothi Chabilall and I need to interview children between the ages 13-18 here in _____ in order to find out how they live without their parents and how they manage to survive.

1.2. I am going to ask you some very personal questions. I will not discuss any of your answers with anyone else. Your name will not be written on the form and will never be used in connection with any information you give me. You do not have to answer a question if you do not feel comfortable and you can ask me to stop the interview at any time you want. But I want you to understand that if you are able to answer honestly, we will be able to understand what people think, say and do about orphans. Your guardian or caregiver can sit with us if you want him/her to. We will be very grateful if you help us with this interview. The interview should take about 30 minutes.

1.3. Will you answer these questions for me, please?

1.4. I must tell you that some of these questions may cause you to feel very sad and upset, since they describe the very difficult times in your life. The benefit of helping us is that we can arrange for you to be helped by others who are qualified to help you solve your psychological and social problems. We can also give you the addresses of those who can assist you.

J Chabilall

(Signature of interviewer certifying that informed consent has been given verbally by the respondent)

+ D. Ramsid

(Signature of witness certifying that informed consent has been given verbally by respondent)

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE			
INTERVIEWER			
COMMENT			

INTERVIEWER: J Chabilall

DATE OF INTERVIEW: 1/11/2003

Thembelihle Pretty Habede

IDENTIFICATION DATA

1.1. Introduction: My name is Jyothi Chabilall and I need to interview children between the ages 13-18 here in WILLOWFONTEIN in order to find out how they live without their parents and how they manage to survive.

1.2. I am going to ask you some very personal questions. I will not discuss any of your answers with anyone else. Your name will not be written on the form and will never be used in connection with any information you give me. You do not have to answer a question if you do not feel comfortable and you can ask me to stop the interview at any time you want. But I want you to understand that if you are able to answer honestly, we will be able to understand what people think, say and do about orphans. Your guardian or caregiver can sit with us if you want him/her to. We will be very grateful if you help us with this interview. The interview should take about 30 minutes.

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Chabilall

(Signature of interviewer certifying that informed consent has been given verbally by the respondent)

X F.N. Buthelezi

(Signature of witness certifying that informed consent has been given verbally by respondent)

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE		1/11/2003	
INTERVIEWER		JAC	
COMMENT			

INTERVIEWER: Chabilall

DATE OF INTERVIEW: 1/11/2003

6 Brenda

IDENTIFICATION DATA

1.1. Introduction: My name is Jyothi Chabilall and I need to interview children between the ages 13-18 here in WILLOWFONTEIN in order to find out how they live without their parents and how they manage to survive.

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1.3. Will you answer these questions for me, please?

1.4. I must tell you that some of these questions may cause you to feel very sad and upset, since they describe the very difficult times in your life. The benefit of helping us is that we can arrange for you to be helped by others who are qualified to help you solve your psychological and social problems. We can also give you the addresses of those who can assist you.

Chabilall

(Signature of interviewer certifying that informed consent has been given verbally by the respondent)

X F.N. Ratlhaga

(Signature of witness certifying that informed consent has been given verbally by respondent)

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE			
INTERVIEWER			
COMMENT			

INTERVIEWER: Chabilall

DATE OF INTERVIEW: 1/11/2003

JEFFREY SPISO MAGCABA

IDENTIFICATION DATA

1.1. Introduction: My name is Jyothi Chabilall and I need to interview children between the ages 13-18 here in WILLOWFONTEIN in order to find out how they live without their parents and how they manage to survive.

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Chabilall

(Signature of interviewer certifying that informed consent has been given verbally by the respondent)

F. N. Buthelezi

(Signature of witness certifying that informed consent has been given verbally by respondent)

INTERVIEW LOG

	VISIT 1	VISIT 2	VISIT 3
DATE			
INTERVIEWER			
COMMENT			

INTERVIEWER: Chabilall

DATE OF INTERVIEW: 5/11/2003