FACTORS INFLUENCING THE CAPACITY OF EXTENDED FAMILIES TO PROVIDE PSYCHOSOCIAL SUPPORT TO AIDS ORPHANS

by

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STATEMENT

I declare that **FACTORS INFLUENCING THE CAPACITY OF EXTENDED FAMILIES TO PROVIDE PSYCHOSOCIAL SUPPORT TO AIDS ORPHANS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signed:_____ Date:_____.

SUMMARY

Statistics on HIV/AIDS are alarming. Very little is known about how communities are actually coping with this disease and what methods seem to be working to empower them to deal with it.

Psychosocial distress is one of the dimensions of the impact of AIDS on children and families, and stresses the necessity to enhance the capacities of extended families and friends to be able to deal with these psychosocial issues.

Using qualitative research and a case study as the strategy of inquiry, this dissertation of limited scope explores and describes the factors influencing the capacity of extended families in providing psychosocial support to AIDS orphans.

A literature study was done to give a theoretical overview on the following aspects:

- AIDS orphans
- The extended family and HIV/AIDS

To reach the first objective of this study, an empirical study was done and semi-structured interviews were used to obtain information from four extended families in the Mukwe area of the Kavango Region in Namibia.

The literature study and the empirical study enabled the researcher to draw conclusions on the factors which influence the capacity of extended families to provide psychosocial support to AIDS orphans.

The information was analysed, interpreted and published in this research report so as to reach the other objectives of this study.

OPSOMMING

Statistieke rondom MIV/VIGS is kommerwekkend. Weinig is bekend oor die wyse waarop gemeenskappe die impak van die siekte hanteer, en op watter maniere hulle bemagtig kan word om meer daaraan te doen.

Psigososiale nood is een van die dimensies van die impak wat VIGS op kinders en families het, en benadruk die noodsaaklikheid om die kapasiteit van uitgebreide families en vriende te vergroot, om hulle sodoende in staat te stel om hierdie psigososiale probleme te kan hanteer.

Deur gebruik te maak van kwalitatiewe navorsing en 'n gevallestudie as strategie, verken en beskryf hierdie navorsing van beperkte omvang die faktore wat 'n invloed het op die kapasiteit van uitgebreide families om psigososiale ondersteuning aan VIGSwese te voorsien.

'n Literatuurstudie is gedoen om 'n teoretiese perspektief te bied op die volgende aspekte:

- VIGSwese
- Die uitgebreide familie en MIV/VIGS

Om die eerste doelwit van die studie te bereik is 'n empiriese studie gedoen en semi-gestruktureerde onderhoudskedules is gebruik om inligting van vier uitgebreide families in die Mukwe streek van die Kavango regio in Namibië te verkry.

Die literatuurstudie en die empiriese studie het die navorser in staat gestel om gevolgtrekkings te maak ten opsigte van die faktore wat 'n invloed het op die kapasiteit van uitgebreide families om psigososiale ondersteuning aan VIGSwese te voorsien.

Die inligting is verwerk, geïnterpreteer en in die navorsingsverslag gedokumenteer om sodoende die ander doelwitte van die studie te bereik.

KEY TERMS

Extended family

AIDS orphan

Psychosocial support

Capacity of extended family

HIV/AIDS

Factors influencing capacity

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CHAPTER 1 – INTRODUCTION AND OUTLINE OF THE STUDY

1.1 INTRODUCTION

For many African people, illness and death are parts of the fabric of life; crises which are dealt with by existing coping mechanisms. Past experience allows adaptation to take place, and rehearsed response strategies to be used. The Acquired Immuno Deficiency Syndrome (AIDS) pandemic, however, is different. There are usually no rehearsed coping responses because of the limited experience of this relatively new disease with its widespread, rapid and cumulative effects. The Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS) pandemic creates a situation of growing uncertainty and instability at global, family and individual levels (Ledward in Madorin, 1999: 11).

HIV/AIDS is a pandemic, threatening lives of people all over the world and confronting them with a full range of developmental issues. In Namibia an estimated 22.3% of all adults are HIV positive, or some quarter million Namibians, and this will continue to climb to a figure just under 25%. In 2001 there were an estimated 82,671 orphans in Namibia, of which more than half were AIDS orphans. As the pandemic worsens, AIDS orphans are projected to comprise three quarters of all orphans in 2006. By the year 2021 there will be an estimated 251,054 orphans, almost 200,000 of them AIDS orphans (Ministry of Health and Social Services, 2002: 1-2).

The number of orphaned children supported by organisations, aside from family members, appears to be quite low. Instead, extended family members and close neighbours/friends are meeting most of, if not all the needs, with only some receiving Government support (Ministry of Health and Social Services, 2002: 5). However, the emergence of orphan households headed by siblings is an indication that the extended family is under stress (Foster, 1995: 2). Over 80% of families affected by HIV are from poor communities, and are already burdened by poverty, discrimination and often limited support systems. These families and children develop profound psychosocial problems. Most of the time, these

families are without savings, employment, income, insurance, legal counsel and medical or social support – all of which antedate infection with HIV.

Psychosocial distress is one of the dimensions of the impact of AIDS on children and families, and includes anxiety, loss of parental love and nurture, depression, grief and separation of siblings among economically strapped relatives. Fears associated with the stigma that surrounds the disease bring about even more problems. (Compare Wiener, 1998: 315; Williamson, 1999: 1; World Bank, 1999: 37.) It is therefore necessary to enhance the capacities of extended families and friends, for them to be able to deal with these psychosocial issues.

In recent years, many articles and books have pointed out that the AIDS pandemic has an impact on different levels such as economic and social levels, etc. They have also expressed a growing awareness about one specific impact, which is not so visible: the psychological impact on children whose parents are terminally ill or have already died. There is often a lack of understanding among adults for the emotional turmoil of these children. At the same time children are sometimes unable to express their grief in a way that adults can understand. More accurate information is therefore needed to understand children and to assist them in this difficult period (Madorin, 1999: 4).

In Chapter 1 a literature overview is given regarding the motivation, as well as the aim and objectives of the study. On the basis of a pilot study that was done, the feasibility, the ethical aspects and the possible limitations of the study are outlined. The research approach and methodology, as well as an overview of concepts, are also discussed.

1.2 MOTIVATION FOR THE STUDY

The main reason for choosing the subject of the study lies in the researcher's involvement in a programme in the proposed geographical area where information for this study has been collected, namely the Kavango Region of Namibia. Part of the programme focuses on strengthening community abilities to cope with the orphan problem resulting from parents dying of AIDS. The proposed study provided the necessary knowledge needed for planning this component of the programme, as the extended families on which this study focused were an integral part of the overall community. The study determined the most important factors on which the programme had to focus.

The researcher has a long-standing interest in the impact of the HIV/AIDS pandemic and its effect on children. Seen together with a passion for being involved in improving the lives of children who are vulnerable because they live in very difficult circumstances, this study was an opportunity to be an instrument in the enhancement of knowledge on the subject.

1.3 PROBLEM FORMULATION

Problem formulation is related to a number of factors, of which the research motivation is a very important one. Other factors of importance are the unit of analysis, the research goals and the research strategy (Mouton & Marais, 1996: 37-51).

Despite the alarming statistics on HIV/AIDS, very little is known about how communities are actually coping with this disease and what methods seem to work to empower them to handle it. Even less has been discussed regarding how to scale up effective community mobilisation approaches to benefit more children and families suffering of this pandemic.

While studying literature on the subject, the researcher found many books, reports and other material on the impact of AIDS and support that is needed. They all recognise the

importance of the extended family in orphan care, and many see the importance of psychosocial care and support. (Compare Barnett & Whiteside, 2002: 207; Van Dyk, 2001: 334-335; Hunter, 2001: 206-215.) However, very little is written on how extended families can provide this psychosocial support to the orphans they care for and what influences their capacity to be or not be able to do so. The researcher is of the opinion that this study makes a contribution to filling this gap, providing important information that can be used by several project managers and programming officers.

1.4 RESEARCH QUESTIONS

The following research questions were formulated to guide this study:

- What is the nature of factors that influence the capacity of extended families to provide psychosocial support to AIDS orphans?
- To what extent does this nature influence the capacity of extended families to provide psychosocial support to AIDS orphans?

1.5 GOAL SETTING

1.5.1 Aim of the research

The goal or objective of a study can be defined as the end toward which the effort or ambition is directed (Fouché, 2002: 107). The aim of this study can be formulated as follows:

To study the factors influencing the capacity of extended families in providing psychosocial support to AIDS orphans and capture experiences of the extended families providing this support.

1.5.2 Objectives of the research

In order to be able to reach the aim of this study, the following objectives were formulated:

- Collection of information through a literature study; the completion of semi-structured interview schedules with extended family members, AIDS orphans and key persons; and observation with the objective to capture experiences of the extended families providing this support.
- Qualitative information analysis to transform the collected information on the most important factors influencing the capacity of extended families in providing psychosocial support and captured experiences into findings with the objective to make a contribution to filling the existing knowledge gap.
- Publishing of findings in a research report, which can be of future assistance to students studying this subject as well as to people working in the field of AIDS orphans and community capacity building.

1.6 RESEARCH METHODOLOGY

1.6.1 Research approach

In this study the approach was qualitative which, according to Fouche and Delport (2002: 79), aims mainly to understand daily life and the meaning people give to their lives, thus making it relevant to the study. The focus was not on producing statistical answers as would be done in a quantitative study, but on understanding the experiences of extended families in caring for AIDS orphans and these families' perceptions of factors that influence their capacity to provide the necessary support to these children.

Patton (2002: 39) describes qualitative approaches or designs to be naturalistic to the extent that the research takes place in real-world settings and the researcher does not

attempt to manipulate the phenomenon that is studied. In this study the real-world settings which were studied were the extended families in which orphans live, without manipulating any of their circumstances.

1.6.2 Type of research

In his explanation of the goals of research, Fouché (2002: 108-109) explains that the aim of social research can be either basic or applied research. This study will have applied research as aim as it is aimed at solving specific problems and assisting practitioners to accomplish tasks (Fouché , 2002: 108).

According to Babbie and Mouton (2001: 79) and Fouché (2002: 108-109) social research serves many purposes. They single out three of the most common and useful objectives of social research, namely exploration, description and explanation. Exploratory research is typically done when the researcher examines a new interest or when the subject of study is relatively new (Babbie & Mouton, 2001: 79-81). Besides exploratory research, the researcher will make use of descriptive research. Exploratory and descriptive research have some similarities according to Fouché (2002: 109), although descriptive research presents a picture of the specific details of the social setting and focuses on the "how" and "why", where exploratory research focuses more on the "what" question.

Although the field of the proposed study is not new, little has been written about the specific factors that are involved where the extended families of AIDS orphans are to provide psychosocial support. The nature of these factors was therefore explored and their influence on the extended families' capacity was described in an applied research study.

1.6.3 Research strategy

The proposed research embarked on an empirical study and methods of data collection, and the case study approach was the strategy of inquiry. In an empirical study we are able to make use of existing data and collect real-life data (Babbie & Mouton, 2001: 75). Both these strategies were used in this study. Creswell (in Fouché, 2002: 275) describes the case study approach as an exploration or in-depth analysis of a "bounded system". In this study the collective case study as explained by Fouché (2002: 276) was used, with the aim to make comparisons between the cases and concepts so that theories as described in the literature study could be extended and validated. The "bounded system" in this study consisted of four extended families caring for AIDS orphans in the Mukwe district of the Kavango Region of Namibia.

Fouché (2002: 275) continues by explaining that the exploration and the description of the cases take place through detailed, in-depth data collection methods. For this study existing literature, semi-structured interview schedules and observations were used to collect data on the capacity of the extended family to provide psychosocial support to the AIDS orphans they care for and the meaning that these families give to their experience of those factors.

1.7 FEASIBILITY OF THE STUDY

The following aspects highlight the feasibility of the study:

1.7.1 Sampling

Sampling is described as taking any portion of a population or universe as representative of that population or universe (Kerlinger in Strydom & Venter, 2002: 198). A sample comprises the elements of the population considered for actual inclusion in the study (Arkava & Lane in Strydom & Venter, 2002: 199).

According to Patton (2002: 230), qualitative inquiry typically focuses in depth on relatively small samples, selected purposefully. He goes further by saying that in qualitative inquiry there are no rules for a sample size. The size of the sample depends amongst others on what you want to know, the purpose of the inquiry, what will be useful and what can be done with available time and resources (Patton, 2002: 242-246).
Sampling types include probability sampling and non-probability sampling. The researcher chose to use the combined purposive and snowball sampling techniques of the non-probability sampling type.

Purposive sampling is based entirely on the judgment of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population (Strydom & Venter, 2002: 207). Snowballing involves approaching a single case that is involved in the phenomenon to be investigated, in order to gain information on other similar persons. In turn, this person is requested to identify further people who could make up the sample (Strydom & Venter, 2002: 208).

The purposive and snowball sampling methods were chosen due to the sensitive nature of the study. The stigmatisation and general beliefs surrounding AIDS make it difficult for people involved to come forward and offer inside information. Another reason for this choice was that the research was done in an area where cultural traditions required the researcher to follow certain rules of etiquette to approach people who could be involved in the information collection.

The researcher was not allowed to approach any person in the community on her own, but had to make use of contacts like traditional leaders, social workers, church leaders and school principals to single out cases that could be approached for information collection. For this study the headman of the Mukwe constituency and a church leader were approached for singling out cases through the snowball sampling methods.

This study was conducted in the Mukwe constituency of the Kavango Region of Namibia. Therefore the target population included the inhabitants of that constituency. The units of observation were the main caregivers of extended families caring for AIDS orphans and the AIDS orphans living with them. This sample consisted of four different extended families and several key persons like school principals, church leaders and traditional leaders in the constituency.

1.7.2 Literature review

The Children on the Brink report compiled by UNAIDS, UNICEF and USAID (2002), analyses the toll of the AIDS pandemic on orphaned children. The report contains statistics on children orphaned by HIV/AIDS from 88 countries, analyses of the trends found in those statistics, and strategies and principles for helping the children. The report also stresses that the growing psychosocial needs of children made vulnerable by HIV/AIDS must be met, and gives strategies for meeting these needs. The report tries to convey critical points that can help develop well-coordinated and compassionate responses from families, communities, governments and others.

Madorin (1999) gives an overview on the psychosocial needs of orphans and discusses the reasons for psychosocial support to AIDS orphans. His manual is used to train teachers in schools, day care centres and Non-Governmental Organisations (NGOs). According to him, there is an obvious lack of teaching materials enabling teachers and other adults to counsel orphans or children of terminally ill parents. The objective of the manual is to enhance the capacity of any adult to listen and to talk to orphans or children of terminally ill parents and to have a better understanding of their situation and their needs. In this way, the community improves its capacity to cope with some consequences of AIDS.

Barnett & Whiteside (2002) give a detailed perspective of the impact of AIDS on households, communities and nations. They write that the pandemic increases morbidity and mortality in populations at precisely those ages where normal levels of morbidity and

mortality are low. It is from these unusual events that other impacts flow. These impacts may be felt as an immediate and severe shock, or they may be more complex, gradual and long-term changes. They discuss in detail the impact of AIDS on orphans, as well as on older people, usually the people who care for orphans.

Jackson (2002) aims to provide up to date information on the HIV/AIDS pandemic in sub-Saharan Africa and particularly southern Africa, and on responses and gaps. The publication includes broad development impacts as well as challenges that must be addressed at different levels. The emphasis falls on holistic care that includes medical treatment, nutrition and psychosocial care.

Van Dyk (2001) writes from a counselling perspective. The book is multidisciplinary in its approach and provides professionals as well as caregivers and volunteers with the necessary skills and knowledge to counsel people about every aspect of life and practice that is relevant to HIV/AIDS. In her book, which is written from a South African perspective, Van Dyk pays special attention to women's and children's issues, community care and African beliefs and customs.

For the purpose of this study additional literature in the form of books, internet articles, professional magazines, reports and theses were studied to identify the different factors that influence the capacity of extended families to provide psychosocial support to AIDS orphans.

1.7.3 Additional information collection

Additional information collection in this study was done by using one-to-one interviewing. The purpose of interviewing according to Patton (2002: 342) is to allow us to enter into the other person's perspective. There are different approaches to collecting qualitative information through open-ended questions, and in this study a semi-structured interview

schedule was used where certain key questions were specified exactly as they had to be asked.

Semi-structured interviews were conducted with caregivers in extended families, key persons like school principals, local headmen and social workers, and with AIDS orphans.

The semi-structured interview schedules were chosen as it enabled the researcher to record the context of the interview, as well as observe the non-verbal responses of the respondents. The non-verbal information in this study was important because of the sensitive nature of the topic. Respondents had difficulty verbalising their answers and the observation of non-verbal responses was valuable in understanding what the respondent was saying. Due to the sensitive nature of the topic, there was a need to use the semi-structured interview schedules to secure the cooperation of the respondents and maintain rapport with them.

1.7.4 Information (data) analysis

Qualitative analysis transforms information into findings, and was guided by the purpose of the study. Information analysis already begins when the researcher collects the information, implying that collected information has to be stored in a way that will make it possible to track information easily when the processing begins. Because the research was done from a case study perspective, the analysis was done from the same perspective. (Compare Patton, 2002: 482-487.)

1.7.5 Pilot study

1.7.5.1 Discussion of the pilot study

The pilot study was undertaken in the area where the research was conducted. It was a difficult task to do a pilot study, mainly because of cultural traditions in the community.

The headman of the community had to be contacted for permission for the study and to ask for possible candidates for interviewing.
In this specific community it also seemed very important that a trusting relationship be built before conducting a sensitive study like this. For that reason, only one interview was conducted in each of the three categories.

During the pilot study, the research was discussed with two communities in the proposed area, as well as with their headmen. During the meetings it was clear that people were positive about the necessity of the study and were willing to give their support. It was mentioned that the orphan problem in the communities was becoming a major problem that had to be addressed.

1.7.6 Limitations of the study

The limitations of the study can be listed as follows:

- The language barrier and the use of an interpreter had an effect on the study, as it was not possible for the researcher to verify responses.

- The fact that the study was carried out in the Mukwe district of the Kavango Region, made it difficult to generalise the findings for the whole of Namibia.

- Respondents might not have been very open, because of the sensitive nature of the study.

- The nature of tradition and community involvement where people are seldom left to discuss or talk in private, may have influenced confidentiality.

- Relevant literature was not readily available to the researcher, as the researcher lives in the area of the study, far from library services.

- The absence of electricity and effective telecommunication services had a delaying effect on the progress of the study.

- Supervision was done by e-mail contact and telephone conversations. These contacts were very irregular due to the lack of availability of these services. This resulted in misunderstandings and delay from time to time.

Despite the limitations of the study, the research process was scientific.

1.8 ETHICAL ASPECTS

Ethics, according to Strydom (2002: 63-74), are a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students.

The following generally accepted ethical issues, which have also been applied to this study, can be outlined:

1.8.1 Informed consent

No respondent was forced to cooperate in the study, and when a respondent voluntarily gave his cooperation, informed consent was obtained from him. This implies that all possible or adequate information on the goal of the investigation as well as the possible advantages and disadvantages to which the respondent was exposed, were rendered to the respondents and, in case of children, to their parents or caregivers.

1.8.2 Prevention of harm to respondents

Respondents can be harmed emotionally or psychologically, especially in view of the sensitive nature of the subject of study. The researcher took all possible measures to prevent such harm, by ensuring as much as possible privacy during interviews.

1.8.3 Debriefing of respondents

To minimise eventual emotional or psychological harm, debriefing of respondents was done, where necessary, directly after the interviews, in which they could work through the experience of the interview and emotions that surfaced as a result of the investigation.

1.8.4 Deception of respondents

Deception involves withholding information, or offering incorrect information in order to ensure participation of subjects who otherwise might have refused (Strydom, 2002: 66-67). The researcher took care, as far as possible, that no form of deception was inflicted on respondents, by instructing the interview assistant to give correct information on the research for which the information was used.

1.8.5 Violation of privacy, anonymity and confidentiality

The researcher had to safeguard the privacy of respondents as well as anonymity where respondents requested so, and confidentiality of information was maintained by storing the information in a safe place. The research was conducted in an area where a native language is spoken, which is not understood by the researcher. Therefore the researcher made use of an assistant. Confidentiality was taken into account by signing a contract of confidentiality with the assistant.

1.8.6 Cultural and gender bias and insensitivity

Several local leaders were consulted to ensure that cultural beliefs and traditions were taken into account and respected in the investigation and that gender equality was maintained.

1.8.7 Publication of findings

The research report has been compiled as objectively and accurately as possible, so that the report will be clear and will contain all the information necessary for the readers to understand what has been written.

1.9 DEFINITION OF KEY CONCEPTS

The term concept is described by Babbie and Mouton (2001: 109) as the result of the process of coming to an agreement, which is called conceptualisation. Conceptualisation is, in other words, the process through which we specify in our research what we mean when we use a particular term. Concepts further have dimensions and indicators, which enable us to measure them, a specifiable aspect or facet of a concept.

The following main concepts involved in this study can be identified:

1.9.1 Capacity of extended families

Hunter (2001: 70) defines extended family as a group of people of many generations who consider themselves related for various purposes and who may or may not be resident together or even close by. It includes grandparents, aunts, uncles, nieces, nephews, step-relatives and in-laws. She distinguishes between a household and a family, when she says that families are biologically related groups, which may or may not be resident together,

while households are resident groups, people not necessarily biologically related, but sharing living quarters and other resources (Hunter, 2001: 103).

For the purpose of this study, the terms household and extended family will be used alternatively and can be defined as a group of people that can consist of many generations and who consider themselves related because of family ties, and who reside together and care for one or more orphaned children that are part of this extended family or household. This extended family or household can include grandparents, aunts, uncles, nieces, nephews, step-relatives and in-laws.

When referring to the capacity of the extended family in this study, it emphasises the mental power, psychological and social competencies, and social status in the community of the member(s) of the extended family who takes care of AIDS orphans.
The following dimensions are considered when referring to the capacity of extended families:

- number of people in household
- number of orphans in household
- social stratification in community
- economic status/income
- age of main caregiver
- culture/traditions
- relationship with deceased parents of orphan
- health, mental and physical
- support systems
- social skills
- relationship with orphan before death of parents
- educational level
- knowledge of childcare

1.9.2 AIDS orphan

The internationally accepted definition of an AIDS orphan is a child under the age of 15 who has lost his mother or both parents due to AIDS (UNAIDS in Jackson, 2002: 267).

In Namibia, the definition has been expanded to include those who have only lost their fathers and are under the age of 18. It should be noted that Namibia now defines orphans as part of an overall population of vulnerable children (orphans and other vulnerable children, or OVC), and this definition reads as follows: *"OVC are children up to the age of 18 whose mother, father or both parents have died; who are affected by HIV/AIDS; who are in need of care including those disadvantaged, in conflict with the law, or who are subject to abuse and violence"(Ministry of Health and Social Services, 2002: 52).*

The following definition of an AIDS orphan will be used in this study: an AIDS orphan is a child under the age of 18 who has lost his mother and/or father due to AIDS.

The following dimensions are considered when referring to AIDS orphans:
- age of the child
- type of orphan (maternal, paternal, double)
- parents died of AIDS-related illness

1.9.3 Psychosocial support

Philippi Namibia (2003: 22) defines psychosocial support as an ongoing process of meeting the physical, emotional, social, mental and spiritual needs of children, all of which are essential elements for meaningful and positive human development.

The above definition will be used for the purpose of this research.

The following sub-concepts and dimensions are considered when referring to the essential elements of psychosocial support:

- physical needs (appearance)
- emotional needs (depression)
- mental needs (school progress)
- spiritual needs (father image of God)

The following dimensions are considered when referring to psychosocial support:

- kind of support from extended family
- communication between orphan and caretaker
- quality of relationship

1.10 OUTLINE OF CHAPTERS

Chapter 1 : Introduction and outline of the study
In this chapter a literature overview is given regarding the motivation of the study, as well as the aim and objectives of the study. The problem is formulated and the research methodology is outlined in general.

Chapter 2 : AIDS orphans
The focus of Chapter 2 will be on children orphaned by AIDS. The special focus will be on the impact of HIV/AIDS on children, the needs of these children orphaned by AIDS and the forms of care available.

Chapter 3 : The extended family and HIV/AIDS
In Chapter 3 the main focus will be on the traditional, African form of care for orphans, namely the extended family, and especially on their capacity to provide psychosocial support to AIDS orphans.

Chapter 4 : Analysis and interpretation of findings

The aim of Chapter 4 is to reflect findings of the empirical study that was done and to interpret these findings.

Chapter 5 : Conclusions and recommendations

In this last chapter, aims and objectives of this study are evaluated. Conclusions and recommendations are made as a result of the study.

1.11 SUMMARY

In this first chapter, the motivation for this study was given and the problem on which the study focuses was formulated. The aim and objectives of the study, as well as the research methodology were described.

The next chapter will start with the literature study and focuses on children orphaned by AIDS. The special focus will be on the impact of HIV/AIDS on children, the needs of children orphaned by AIDS and the forms of care available.

CHAPTER 2 – AIDS ORPHANS

2.1 INTRODUCTION

As on the whole continent of Africa, thousands of children in Namibia are experiencing deepening poverty, enormous mental stress from witnessing the illness and death of their loved ones and a profound sense of insecurity. It is difficult to overstate the trauma and hardship that the increase in AIDS-related morbidity and mortality has brought upon children. Denied the basic closeness of family life, children lack love, attention and affection. They are pressed into service to care for ill and dying parents, removed from school to help with farm or household chores, or pressured into sex work to help pay for necessities their household can no longer afford. They receive less access to health care and are often treated harshly, or are abused by step- or foster parents. The extended family or neighbours charged with caring for children frequently take the children's property or inheritance, leaving them more vulnerable to mortality, illness and exploitation. The immediate concerns are the fundamental human rights and needs of these children and the urgent requirements to relieve their physical and psychosocial distress and suffering (Jackson, 2002: 257-261).

In spite of all the hardships and stigma, these children also have a right to education, affection and cultural identity, as well as to services for the care of children. They have a right to be heard and to be protected from abuse, neglect, maltreatment and exploitation. They have the usual needs of children, including economic, social, educational, medical and psychosocial needs (Fox, 2001: 7).

In this chapter the researcher is going to focus on children orphaned by AIDS. The special focus will be on the impact of HIV/AIDS on children, the needs of these children and the forms of care available for them. In Chapter 3 the main focus will be on the traditional African form of care for orphans, namely the extended family, and especially on their

capacity to provide psychosocial support to AIDS orphans. It is therefore important that in this chapter these needs are discussed, to provide a knowledge base for the next chapter.

2.2 AIDS ORPHANS DEFINED

UNAIDS and UNICEF (Jackson, 2002: 267) define AIDS orphans as children who lose their mother to AIDS before reaching the age of 15 years. Some of these children have also lost, or will later lose, their father to AIDS. In some assessments, paternal orphans – those who have lost only their father to AIDS – are included in estimates of children orphaned by AIDS. A child whose father dies typically experiences serious psychological, emotional, social and economic loss. However, because reliable data on the number of paternal orphans are not available in many countries, the orphan statistics used by UNAIDS and UNICEF do not include children who have lost only their fathers.

USAID, UNICEF & UNAIDS (2002: 8) define three types of orphans namely:

Maternal orphans who are children under age 15 whose mothers, and perhaps fathers, have died (including double orphans).
Paternal orphans who are children under age 15 whose fathers, and perhaps mothers, have died (including double orphans).
Double or total orphans who are children under age 15 whose mothers and fathers have both died.

The Namibian definition includes children under the age of 18 who lost either one parent, mother or father, or both parents due to AIDS (Ministry of Health and Social Services, 2002: 52).

According to Philippi Namibia (2003: 15) the use of the term "AIDS orphan" is inappropriate and can contribute to the stigma and discrimination against vulnerable

children. They suggest that children who have lost their parents to AIDS should simply be described as orphans.

Although the researcher agrees with the suggestion made by Philippi Namibia, the term AIDS orphan will be used for the purpose of this research, because the research aims at gathering specific data on the psychosocial needs of children orphaned by AIDS, which differ from the psychosocial needs of children orphaned by other causes, as indicated by Philippi Namibia (2003: 18). They explain this by saying that children affected by AIDS already suffer greatly as a result of their parents' status, when they are still alive. They experience distress and social isolation, both before and after the death of their parents, which are strongly exacerbated by the shame, fear and rejection that often surround people affected by HIV/AIDS.

2.3 IMPLICATIONS OF AIDS FOR ORPHAN PREVALENCE

The AIDS pandemic is the world's most deadly undeclared war, and Africa has so far borne its brunt. Because those dying from AIDS are mainly people in the prime of their lives who are often parents, a less well-known and calamitous effect of AIDS is the vast numbers of children orphaned by the disease (UNAIDS, 2000: 2).

From 1990 to 2010, the numbers of maternal and paternal orphans are projected to double and the numbers of double orphans are projected to increase 17-fold, according to Jackson (2002: 267). She mentions that, according to the US Census Bureau projections, 32% of all children in Namibia will have lost one or both parents by 2010.

In 2002, the AIDS pandemic had already left behind 13.2 million orphans worldwide, children in this case, who lost father, mother or both parents to AIDS before the age of 15. More or less 95% of these orphans live in sub-Saharan Africa. These children endure overwhelming and largely unmitigated losses, living as they do in societies already weakened by underdevelopment, poverty and the AIDS pandemic itself. And the worst is

yet to come, in numbers both of deaths and of children left behind. The lives already claimed by the pandemic are just a fraction of those that lie ahead, in sub-Saharan Africa and many other countries of the world. Estimates by the joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) indicate that 12.2 million women and 10.1 million men were living with HIV in sub-Saharan Africa at the end of 1999, with infected women actually outnumbering infected men (UNAIDS, 2000: 2; Barnett & Whiteside, 2002: 198-199).

Where the Namibian situation is concerned the following statistics apply: in 2001, an estimated 22.3% of all Namibian adults were HIV positive, or a quarter million Namibians, and this will continue to climb to a figure of just under 25%. According to the health information system, in 1999 about 2,823 people died of diseases associated with AIDS, representing 26% of all reported deaths and 47% of all deaths in the age group 15-49. However, most AIDS-related deaths have not been recorded in the health information system. Indeed, model projections indicate that some 50,000 Namibians have already died of AIDS, and by the year 2021 there will be a cumulative death total of over half a million. The total population by 2021 is estimated at 2.7 million, compared to an estimate of 3.6 million without AIDS (Ministry of Health and Social Services, 2002: 1).

There are numerous problems to project the number of orphans in the population. Specifically, there are no estimates of non-AIDS orphans, and AIDS orphans estimates are only as good as the data they are based on. What is of interest is that the population results yielded by the model used, differ from the provisional results of the 2001 census by only 16,000 people. Findings therefore suggest that the model is an accurate reflection of reality, and that the zero-prevalence data form a good basis for modelling. In 2001 there were an estimated 82,671 total orphans, of whom more than half were AIDS orphans. As the epidemic worsens, AIDS orphans are projected to comprise three quarters of all orphans from 2006. By the year 2021, there will be an estimated 251,054 orphans, with almost 200,000 of them being AIDS orphans (Ministry of Health and Social Services, 2002: 1-2).

2.4 IMPACT OF HIV/AIDS ON ORPHANED CHILDREN

HIV/AIDS affects children profoundly by its impact on their parents and communities in addition to their own infection risk. 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 crises and insecurity by their parents' death and struggling without services or support systems in impoverished communities. Extended families taking over the care of these orphaned children come across the same problems, as the HIV/AIDS pandemic not only affects the children, but families and communities as a whole. These new caretakers are confronted with dealing with the impact AIDS has on orphans, as the orphans come into their households with their specific problems. Their capacity to do so and the factors that influence this capacity will be discussed in Chapter 3. UNAIDS (2000: 3) discusses the following impacts that make these orphans' crises especially acute:

2.4.1 Economic impact

As those dying are usually in their most productive years, many schools, hospitals, private industries and civil services are short-staffed. In the private sector, AIDS-related costs – including those connected to absenteeism from work, insurance and the recruitment and retraining of replacement workers – are estimated to consume as much as one fifth of all profits. Economists at the World Bank conservatively estimate the impact on countries with high HIV rates at a loss of 1% of gross domestic product growth each year (UNAIDS, 2000: 3).

The effects also reach deeply into the daily lives of families caring for someone with the disease, where resources quickly evaporate. Savings are depleted and people often go into debt to care for their sick. Food consumption has been found to drop by 41%. The drain on virtually all segments of communities and nations means that very few resources or services remain and fewer can be produced or provided to those on the front line of

orphan care. This again creates the potential for material deprivation and conflicts, jealousy and resentment. Once a parent dies, children, particularly in the case of girls, may also be denied their inheritance and property. Girls in particular face the possibility of both physical abuse and the exploitation of their labour. If a family cannot pay school fees or there is a sick person who needs caring for, it is the girl child who is usually the first to drop out of school or to be given additional responsibilities. Moreover, as the rights of children are inextricably linked to those of their surviving parent, laws and practices that deny widows their rights and property have devastating consequences for children after their father's death (UNAIDS, 2000: 3-5; Jackson, 2002: 262-263; Fox, 2001: 19-20).

For the extended family that takes the child into their care, this often means that the child comes to the family with no inheritance or other support left by the parents, cannot contribute to the income, and is an extra economic burden on the family.

2.4.2 Social impact

Barnett and Whiteside (2002: 200) stress the fact that whatever the number of orphans in a household or community, they run great risks of many kinds, of which the social effects are a serious part. Three of these social effects will be emphasised:

2.4.2.1 Social exclusion

In households which are AIDS affected, whether they are infected with the virus or affected through sickness and death of relatives or orphan care, the available resources decrease for a number of reasons: productive members of the family die, expenses on medicine and food become higher, orphan care increases the number of children to be cared for, time needed for caring increases. AIDS-affected households tend to be poorer, they have less food for consumption and a smaller disposable income. The results of these circumstances are that orphans in these households are usually less well nourished and have a greater chance of being stunted or wasted. Orphans endure the grave social isolation

that often accompanies AIDS when it strikes a family and are at far greater risk than most of their peers of eventually becoming infected with HIV (Barnett & Whiteside, 2002: 200-201; UNAIDS, 2000: 3-5).

In his study, Foster (1995: 16-17) found that community members witnessing orphan care in extended families gave consistent testimony to the occurrence of discrimination and stigmatisation against orphaned children. Some examples of discrimination may be the result of poverty; as one community member in this study stated, most caregivers want to do as much for orphaned children as for their own, but because of financial constraints, they give first preference to their own biological children. Cases of discrimination and stigmatisation need to be interpreted in the light of the economic deprivation of a large number of families caring for orphans.

2.4.2.2 Taking adult roles

The AIDS pandemic disrupts social roles, rights and obligations. For the orphaned child there is often a premature entrance to the burdens of adulthood, all without the rights and privileges and obviously the strengths associated with adult status. Becoming an orphan of the pandemic is rarely a sudden switch in roles. It is slow and painful, and the slowness and pain have to do not only with the loss of a parent, but also with the long-term care which that parent's failing health may require. Young children may become responsible for the care of younger siblings, and are unprepared for this. When the children become orphans this taking on of adult roles continues. In the extended family into which they are taken, a family member may become ill, a grandparent may die, and the orphan may lose his second and sometimes even third family too; and the same process repeats itself time after time (Barnett & Whiteside, 2002: 206; Jackson, 2002: 262).

As a result of too many children in the extended family household where the orphan lives, or frailty of the caring grandmother, orphaned children often have no choice than to take up adult roles.

2.4.2.3 Weakened societies

Another impact of AIDS-related deaths in a society is that social support for children is diminishing in heavily affected communities. The remaining proportion of children, affected or "not affected" live in societies with vastly poorer infrastructure and human resources. Access to health, education and social services is decreasing as wage earners fall sick and the disease draws off more skilled personnel and resources. As a consequence of these threats to their well-being, children face increased risks of death, illness and starvation due to family food shortages, reduced protection as their family members and guardians die, vulnerability to neglect, abuse and exploitation, including sexual abuse, physical and emotional abuse and exploitation of their labour, as well as reduced opportunities to education and increased risk of HIV infection (Hunter 2001: 146-147).

2.4.3 Educational impact

According to the World Bank (in Barnett & Whiteside, 2002: 202), as well as UNAIDS (2000: 3-5) and Jackson (2002: 262), orphans are less likely to have proper schooling. The authors agree that the death of a prime-age adult in the household will reduce the child's attendance at school. The primary caregiver of an extended family caring for the AIDS orphan may be less able to pay for schooling and school necessities. An orphaned child may have to take on household or income-earning work. When an orphaned child lives in another household, like an extended family household, the obstacles become even greater as the child is not their own, and the number of children to attend school in the household rises. Girls carry a larger burden of domestic responsibility than boys and are more likely to be kept out of school, losing their opportunity for long-term self-reliance.

As Barnett & Whiteside (2002: 204) state, impacts of the HIV/AIDS pandemic on orphaned children are interrelated: poor nutrition, poor care and poor or little schooling affect orphaned children in many ways, and often their school attendance is less consistent, their progression rates more erratic and their academic attainment and results poorer.

In agreement with Barnett and Whiteside, Fox (2001: 20) states that the presence of AIDS or an AIDS orphan in a household, and the additional responsibilities and burden it brings on the family, may cause children to drop out of school. Due to unresolved psychological trauma, the school performance of children is negatively affected by HIV/AIDS. Traditional skills, passed through the generations, die with the parent before being taught to the children. Orphans also face stigmatisation by other children, at school and elsewhere.

2.4.4 Developmental impact

The situation in which many children find themselves as a result of the HIV/AIDS pandemic, creates huge risks for their overall development into well-balanced adults. Children grow up with low self-esteem and little sense of security, poor education, poor social skills and minimal life chances to pull themselves out of poverty. This can severely reduce their chances to become productive and self-sufficient adults, parents and citizens. They will be likely to increase instability, crime and other problems in society, perpetuating the human rights abuses they have suffered (Jackson, 2002: 257).

Hunter (2001: 192) mentions that many orphaned children are traumatised permanently by the loss of care and protection. Even when taken into extended family care, these children often lack love, attention and affection, have to eat separately, and suffer harsh treatment and abuse from step- or foster parents. Less attention and care are provided to orphans when they are sick and they have a higher mortality rate than biologically related children. Their malnutrition rates are higher, even in financially stronger extended families, and they are less likely to be immunised. The health and well-being of AIDS orphans are lower than those of non-orphans. Finally, when extended families have exhausted their resources and coping capacity, orphaned children end up living on their own or on the street. All of these are factors that can hamper orphaned children's overall development into responsible and balanced adults.

Another factor that influences the development of the child affected or orphaned by AIDS is the loss of consistent nurturing, which can lead to serious emotional developmental problems and loss of guidance, which makes it more difficult for the child to reach maturity and to be integrated into society (Fox, 2001: 20).

2.4.5 Psychological impact

Children in households with HIV-positive members suffer the trauma of caring for ill family members. The trauma of seeing their parents or caregivers become ill and die, while striving to cope materially, may be the most stressful period by far, often leading to psychosocial stress, which is aggravated by the stigma so often associated with HIV/AIDS. The distress and social isolation experienced by children, both before and after the death of their parent, are strongly exacerbated by the shame, fear and rejection that often surround people affected by HIV/AIDS. Because of this stigma and the often irrational fear surrounding AIDS, children may be denied access to schooling and health care, which can cause feelings of low self-worth. Since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, the children are far more at risk to lose the remaining parent. Children thus find themselves thrust into the role of mother or father or both – doing the household chores, looking after siblings, farming, and caring for the ill or dying parent or parents, bringing on psychological stress that would exhaust even adults (Jackson, 2002: 262-263; UNAIDS, 2000: 3-5; Van Dyk, 2001: 145-146; Fox, 2001: 19-20).

Some orphaned children are taken in by extended family members who are able to look after them well. This may be the beginning of the resumption of normal life, when they gradually overcome their grief at bereavement and can stop bearing the load of coping on behalf of their family. For others, life only gets worse after their parents have died, as they may be evicted by unscrupulous relatives, siblings may be split up, and their life may suddenly be devoid of any continuity, security, regular food and shelter. Children may not

understand the situation and therefore cannot express their grief effectively. Even if they want to express their feelings, there is often no one to listen, as extended family members are not always interested in the orphan. Many children lose everything that once offered them comfort, security and hope for the future. Often the extended family member that takes care of the orphan does not have proper knowledge on how to provide psychosocial support to the orphan. (Jackson, 2002: 262-263; UNAIDS, 2000: 3-5; Van Dyk, 2001: 145-146; Fox, 2001: 19-20).

2.5 NEEDS OF AIDS ORPHANS

When considering the basic needs of a child one is inclined to think in terms of food, shelter, clothing, love and security, a combination of the material and psychological needs. Children affected and/or orphaned by HIV/AIDS have similar needs, except that the fulfilment of these needs is potentially in jeopardy when a parent or caretaker becomes ill and eventually dies. Meeting these needs is important for the growth and ability of a child to succeed in life. According to the United Nations Convention on the Rights of the Child, it is not a privilege but the right of every child to have his psychosocial needs attended to (Fox, 2001: 13).

The needs of a child are summarised very well by UNICEF (2004: 13), when they say that to survive and thrive, children need to grow up in a family and community environment that provides for their changing needs, thereby promoting their healthy and sound development.

When the child becomes orphaned and is taken up in the extended family, these needs have to be provided for by the new caretaker. Mostly, extended families try to allocate orphaned children to families with sufficient resources to provide in their needs. However, when there have been a large number of adult deaths in a family, children are sometimes in the care of relatives with inadequate resources, often elderly grandparents, who are not able to provide satisfactorily in the needs of the orphans (Hunter, 2001: 192).

For the purpose of this study, it is of importance that these needs are discussed, as Chapter 3 will discuss in detail the factors that influence the capacity of the extended family in providing these needs.

In their research report, Loening-Voysey and Wilson (2001: 13-15) use Manfred Max-Neef's theory on human scale development as a framework for understanding children's fundamental needs, which are seen as a basis for understanding the needs of AIDS orphans. In terms of this theory, human needs are seen as an interactive and interrelated system and not as a hierarchy. Needs, which are identified as subsistence, protection, affection, creation, idleness, identity, participation and understanding are best met synergistically by satisfiers that respond to more than one need at a time. They give some examples: active feeding, whereby bonding relationships are nurtured whilst children are being fed, community-building activities that satisfy the need for participation, identity, understanding and leisure simultaneously.

Needs and rights of AIDS orphans are clustered by Loening-Voysey and Wilson (2001: 13) into the following broad categories:

Survival - food, clothing, shelter and health care
Security - love, affection, protection against abuse, neglect and exploitation
Socialisation – understanding, identity, participation and basic psychosocial services
Self-actualisation – recreation, leisure and freedom of expression

Although survival needs and rights are recognised as a priority, it must be noted that without affection, protection and understanding, children are less likely to grow up into well-functioning adults. The categories of needs and rights may appear to be in a hierarchy, but this is not intended. In terms of the human scale development theory and the rights-based approach to meeting needs, all needs are of equal importance and are non-negotiable (Loening-Voysey & Wilson, 2001: 13).

The needs of AIDS orphans will be discussed according to these categories as suggested by Loening-Voysey and Wilson (2001: 13).

2.5.1 Survival needs

Survival implicates subsistence and survival as a human being. Children need adequate nutritious food, secure dwelling, appropriate clothes, accessible health care and social security. AIDS orphans often face malnutrition and stunted growth, high mortality and morbidity rates and common disabilities, as a result of a lack of resources from the side of the extended family caring for them.

2.5.2 Security needs

Security includes protection from exploitation, stigmatisation, abuse and neglect. To be and feel secure, a child needs a caregiver who knows his whereabouts and protects his rights. This especially refers to the orphan's right to protection of home and inheritance. Another important part of security for a child is consistent and healthy discipline as well as a familiar place and routine. His caretaker should protect him and see to it that law enforcement is carried out. AIDS orphans often lack most of this protection and stand a chance to become troubled and disturbed children. A major threat is that they come to live in dysfunctional families or become homeless and live in harmful environments.

Security also includes love and affection, given to the child in stable, continuous, dependable and loving relationships. These relationships should give the child unconditional love, friendship and intimacy.

As AIDS orphans are often cared for by overburdened, unstable extended family members, this security is not given to them. The need for love and nurturing was raised many times in their research, according to Loening-Voysey and Wilson (2001: 14). They further state

that the lack of concern for others and lack of conscience are probable reactions to being unloved and rejected. Vandalism, violence and delinquency are frequently an outward expression of these feelings and of the need for love.

2.5.3 Socialisation needs

The need for socialisation involves different aspects. The first aspect can be described as identity, meaning uniqueness as a person and a sense of personal continuity. This identity includes a name and kinship, as well as being part of cultural customs and traditions. Memories and knowledge of personal and family origin are also an important part of forming a unique identity. This gives a child a sense of future and direction. If this socialisation need of an AIDS orphan is not met, he may experience a sense of alienation and become apathetic, with a low self-esteem and lack of direction (Loening-Voysey & Wilson, 2001: 14-17).

The second aspect of socialisation is the need for understanding, insight, direction and knowledge. This need is met by giving the child access to information, which includes schooling/education, positive communication, cultural guidance and mentoring. Many AIDS orphans face illiteracy, because they are not able to start or continue their schooling and therefore have poor employment prospects. They are often ill informed, even about the imminent death of their parent or family member, which disempowers them and creates a lack of self-direction (Loening-Voysey & Wilson, 2001: 15-17).

The last part of socialisation that Loening-Voysey and Wilson (2001: 14) mention is participation, where a child is valued as a contributor to society, considered a person with own rights. For a child's development it is important to be involved in community, neighbourhood and cultural activities. Positive communication, which includes discussions involving the child, gives him opportunities to exercise responsibility. When an AIDS orphan is isolated, it can create a lack of concern and respect for communal goods like

traditions and possessions, lack of confidence to tackle new situations, tasks or relationships and lack of a sense of responsibility for himself, others and material objects.

2.5.4 Self-actualisation needs

The fourth category of needs and rights of AIDS orphans mentioned by Loening-Voysey and Wilson (2001: 14-17, 80-83) is self-actualisation. The realisation of this need is closely related to the protection of the child against exploitation and abuse.

Self-actualisation includes the need for recreation/leisure and new experiences. To develop and come to self-actualisation the child needs time and space to play, stimulation and recreational facilities. When the AIDS orphan lacks these rights there is a risk that he will become inert and apathetic and will have a low morale. He is at risk of becoming unresponsive to environmental stimuli.

Another need in this fourth category is the need for freedom of expression and expression as an individual. Children need the flexibility/space for exploration and expression of different views, and the opportunities to exercise independence and to explore thoughts, views, ways of doing things and philosophies. When the AIDS orphan's need for this part of self-actualisation is not met, he faces the risk of experiencing disempowerment, voicelessness and apathy and can develop stereotypical views on life (Loening-Voysey & Wilson, 2001: 14-17, 80-83).

Most often, according to Hunter (2001: 192), when children live with extended family members, they miss the love, motivation and encouragement of their parents and family. Many are traumatised permanently by the loss of care and protection and are now denied the basic closeness, attention and affection of family life, altering the fulfilment of their self-actualisation needs.

2.5.5 The need for psychosocial support

The HIV/AIDS pandemic affects children either directly through their own infection or indirectly through infection of those close to them, especially their parents, guardians or siblings. Children are affected by the pandemic long before they are actually orphaned. They may witness the recurring suffering and illness of a brother, sister or parent (or guardian or family members), ending with their death. After one parent has died, they are likely to witness the sickness and death of the second parent too, if the family is still together. In a study done in 1997 in Zambia by Poulter et al. (in Jackson, 2002: 273), it was found that most families did not talk to their children about any aspect of their illness, partly out of fear of causing distress. Yet the children were already distressed, and the fact that their parents did not talk to them left them without the opportunity to discuss and cope with their fears (Jackson, 2002: 269-271; Mallmann, 2002: 9-10).

Often, after the death of the mother, children live with other relatives rather than with their father alone. Household income and security usually decline, school may be an unaffordable luxury and girls, in particular, are drawn in to undertake care and subsistence activities and other household tasks at far too early an age. Loss of schooling means that they will grow up with reduced chances of securing work and, for girls, an increased risk to entering sex work to survive (Jackson, 2002: 269-273).

The emotional suffering of children when parents become sick and die may neither be recognised nor responded to. Children often become withdrawn and some show antisocial behaviour for which they are likely to be punished. Particularly in societies and cultures that devalue children's needs and rights, children are more likely to internalise their pain. They may not be able to describe their thoughts and feelings easily, but this does not mean the illness or death of a parent does not affect them. Their hidden distress may have long-lasting consequences and, even if they appear to be coping well on the surface, they should have the opportunity to explore their fears and anxieties, and to express their feelings. They may feel, by turns, angry, betrayed, guilty, anxious and despairing, a process similar to the

mourning process, although they may express feelings in different ways. Although in situations of extreme poverty the psychological distress of children may appear secondary in importance to meeting basic material needs, it should not be ignored or considered unimportant (Jackson, 2002: 273-274; Fox, 2001: 65).

Philippi Namibia (2003: 18-19) adds that children affected by HIV/AIDS suffer greatly as a result of their parents' status. They say that failure to support children affected or orphaned by AIDS to overcome such trauma, will have a very negative impact on society and might cause dysfunctional societies, jeopardising years of investment in national development.

Hunter (2001: 169) also stresses the importance of psychosocial support to help children cope with their grief and anger because of the deaths of family and friends. To encourage normal responses in children, Mallmann (2002: 46) states that the attitude of caregivers plays a very important role. The extended family member, with whom the child is living now, has to recognise the orphan's creativity, initiative and coping capacity. If the caregiver is able to do this and can ask the child what kind of assistance he needs, he will provide the best possible assistance and will encourage the orphaned child to cope better and become more resilient.

2.6 FORMS OF CARE FOR AIDS ORPHANS

Long before the emergence of the HIV/AIDS pandemic, the extended family in Africa had been taking care of vulnerable children, many of whom were orphaned children. Today, development agencies are increasingly recognising the need to assist children affected by AIDS, and several broad responses are emerging (Jackson, 2002: 276). These responses include:

- Identifying all children in exceptional need and promoting support for their well-being in the community.

- Identifying children specifically affected by AIDS and targeting community support for them in particular.

- Identifying abandoned, orphaned or mistreated children and placing them in foster homes or naming them for adoption.

- Placing abandoned, orphaned, neglected or mistreated children in residential care (Jackson, 2002: 276).

Jackson (2002: 276-277) mentions a number of requirements that care and coping strategies have to comply with, in order to be effective. She says they have to be sustainable over time, be able to assist large and rapidly increasing numbers of children orphaned and/or in exceptional need, be culturally acceptable and take into account the multiple development needs of children, not just their basic physical needs. Such care should not only involve basic physical care but also ensure the emotional, social, educational and material well-being of children. According to Jackson this means that support efforts must be primarily community driven and owned, or at least be community supported with external assistance.

Several forms of care can be identified and will be discussed briefly, to emphasise the importance of the extended family as caretakers:

2.6.1 Traditional forms of care

2.6.1.1 Extended family or community care

Loening-Voysey and Wilson (2001: 25) discuss community care strategies as informal, indigenous and traditional ways of caring for children in need of care, most commonly by extended family or kinship members, usually a granny or an aunt. They argue that this

form of informal care is widespread and a practice acceptable in most cultures, but that the capacity of families to take in extended family orphans is diminishing increasingly. The assumption of community care is that communities have families or capable women, who are willing and able to provide care, but, according to these writers, this assumption is questionable. They argue that "*while community care can certainly give individuals a better quality of life than they would have in an institution, community care can equally be a convenient cover for the neglect by the state*".

Hunter and Williamson (in Jackson, 2002: 279) agree with Loening-Voysey and Wilson that the forms of informal family care, which they call the first response to the problems caused by HIV/AIDS, come from the affected children, families and communities themselves. They say, however, that given the scale of the problems and the fact that those hardest hit are often the most disadvantaged, this first response is becoming insufficient on its own. Additional assistance is becoming crucial.

The importance of care by extended family members is also stressed by Mallmann (2002: 6), as the family is usually the first environment in which a child experiences love and affection. The family provides the child with a sense of belonging and an identity, because they have common roots and the same ancestors.

The role and importance of extended family support will be further discussed in Chapter 3.

2.6.1.2 Formal foster care placements

Crises occur when children are abandoned, or parents die and nobody steps in immediately to care for the children. A young child does not need help in a week's time, but at once. If no relatives are available, able or willing to help, alternative arrangements are to be made. The ideal is not residential institutions, but rather the availability of foster homes in the community on a temporary or long-term basis, registered and available to

take in children in crisis. This need for foster homes will increase, as extended family networks break down in urban areas, or become saturated, overwhelmed and weakened (Jackson, 2002: 282-283).

Supported foster care could be a valid form of income generating, meeting the needs of far more orphaned children than could be met through an institution response, and providing foster parents with a source of income, provided that appropriate monitoring and support services be established to ensure a basic quality of care (Jackson, 2002: 283-284).

2.6.1.3 Adoption

Many writers (compare Jackson, 2002: 284; Van Dyk, 2002: 336; Hunter 2001: 113-114) argue that in many African countries taboos about adoption pose a barrier to effective care in the community. Many African individuals or couples who are childless are unwilling to adopt children because of the fear that this will anger ancestral spirits. Other relatives may in future blame any misfortune in the family on the presence of children with the wrong totem or from the wrong clan. Where strong religious faith appears, this begins to change, and parents become more willing to adopt children. Another problem arising is poverty. With the adoption of a child, no grants and other income are available for the adoptive parents and the maintenance of the adopted child becomes a burden to the already impoverished family.

2.6.1.4 Institutional care

When concerned agencies and individuals consider the devastating impact of AIDS on impoverished children, a common aim is to build residential care centres. A well-resourced children's home can guarantee clothing, food, education, companionship and induction into a moral or religious code. Several critical concerns, however, argue overwhelmingly against the development of residential children's homes as the key response to the pandemic. One of these concerns is the full impact of residential care on the children; a

second is the economic cost of residential against community care and related issues of sustainability; a third is the negative impact on community care and on communities providing alternative child care in institutions (Jackson, 2002: 285-286).

Children taken into well-resourced children's homes do gain certain benefits materially and with regard to education, as they usually have a better chance to complete their secondary school education. Nevertheless, what they lose is considerable and may cause severe psychological and social damage. Being an insignificant part of a large institutional group, children in a children's home may not know the important aspects of their own culture, which are essential for their future. They will have lost a substantial part of their sense of belonging to a particular community or area, especially if the home is far from where they were born. As siblings might not be kept together, bereaved children might lose the last possibility of family togetherness. They might be separated on the base of gender or age or both (Jackson, 2002: 286).

When children reach a certain age they have to leave the children's home and start fending for themselves. They might well have an advantage because of their education, but they might have no obvious home or community to go to, and be isolated at a young age in a difficult environment. They might not have the psychological resilience, let alone skills, to cope effectively and could embark on crime, turn to substance abuse, engage in sex work or other actions that will marginalise them further. Low self-esteem, lack of cultural identity and values and other factors can increase sexual risk taking, making them vulnerable to contract HIV/AIDS themselves (Jackson, 2002: 287).

UNAIDS (2000: 28-29) agrees with Jackson and states that countries that have relied on institutions to care for their orphans have learned that children's homes or orphanages are not the answer. Expensive to build and maintain, with the problem to attract qualified and appropriate staff, orphanages remove children from their communities and extended families. They also say that these and other institutions set up to care for children can have catastrophic consequences on children's emotional lives and development. When

institutions are no longer able to absorb growing numbers of orphans who have no other support systems, some children end up homeless and hungry on the street.

Another difficulty that Jackson (2002: 288) discusses is that higher standards in some children's homes can lead to further problems as children grow up. If children live in a modern, attractive home, they may look down on the much poorer communities around them and find it difficult to adapt to the outside world once they leave the home. Further, the higher the standard of care and material provision in a residential centre, the more attractive the centre may appear as a resource to take over the care of abandoned and orphaned children. The result is that extended family members and the community at large may become less and less willing to undertake care roles themselves, particularly if they are poor and receive little support compared with the money going into residential care. Thus the impact of provision by institutional care facilities may directly be undermining community willingness and capacity to care for these children themselves. As a strategy for orphan care, institutional care therefore seems to create dependency.

2.6.2 Alternative and new forms of care

Besides the traditional forms of care Barnett and Whiteside (2002: 188) recognise several new forms of households and alternative care that are developing as a response to the impact of HIV/AIDS. They include:

- Elderly household heads with young children, also called grandparent-headed households. This option will not be sustainable on the long run, as the grandparents of tomorrow are dying today.
- Large households taking care of unrelated fostered or orphaned children, also called community-based foster care. This is based on the premises that orphans and foster parents should be actively supported by each other and the community.
- Child-headed households, consisting of children 'parented' by an elder sibling.
- Single-parent, mother- or father-headed household.

- Cluster foster care, where AIDS orphans are cared for formally or informally by neighbouring adult households. These family-type groups usually comprise of orphaned children living together in a family unit and being cared for by a carefully selected, usually paid, caregiver.
- Children in subservient, exploited or abusive fostering relationships.
- Neglected, displaced children in groups or gangs (Barnett and Whiteside, 2002: 188-189, UNAIDS, 2000: 31, Van Dyk, 2002: 334-337).

Several forms of care for children orphaned by AIDS were discussed. The importance of the extended family as option for orphan care will be further discussed in Chapter 3, as well as the factors that influence the capacity of the extended family to provide the necessary care.

2.7 CONCLUSION

The vast number of children in sub-Saharan Africa, orphaned by AIDS or otherwise affected by the pandemic, need help to recover as much normality and security as they can, emotionally, physically and educationally. Strengthened communities provide the best opportunity for this to occur. From the start of the pandemic, communities have been quietly adapted to care for these children, albeit with varying resources and degrees of success. They now need support to expand their care, commensurate with the rising number of orphans and needy children in their midst. Society at large needs to see the broad picture of children in the community and societal context and adopt approaches that will support communities to care for their own children, rather than strategies to address community limitations by removing children from them (Jackson, 2002: 292).

Chapter 3 will emphasise the important role of the extended family in providing this community-based support, as well as the factors that influence the capacity of these extended families to do so and to provide the necessary psychosocial support to the orphaned children.

CHAPTER 3 – THE EXTENDED FAMILY AND HIV/AIDS

3.1 INTRODUCTION

Despite poverty, children benefit from a wide variety of support mechanisms in Africa that may provide a wider safety net than found in other regions of the world. This safety net includes multigenerational, extended families where single mothers reside in small households that are subunits of a larger one, and where exchange of children and sharing of child support and child rearing among kin take place so children are already known to relatives when a death occurs. Many features of African social life are not found in Asia or Latin America, including the numerous kinship- and community-based networks (Hunter, 2001: 209-210).

In this chapter the researcher is going to discuss the impact of HIV/AIDS and the resulting orphan care on the extended family. The role of the extended family will be discussed and special focus will be on the factors that influence the capacity of the extended family to provide psychosocial support to the orphans in their care.

3.2 TRADITIONS AND THE EXTENDED FAMILY IN AFRICA

The community plays a very important role in the lives of traditional Africans. Traditional African beliefs are predicated on principles such as the value of the collective interest of the group, the survival of the community or tribe, and the union with nature. The traditional African person cannot exist alone: his identity is totally embedded in his collective existence. This collective existence of traditional Africans gives rise to values such as communality, group orientation, cooperation, interdependence and collective responsibility (Van Dyk, 2002: 124).

Helen Jackson (2002: 212-213) agrees with Van Dyk (2002: 126) when she writes that the involvement of traditional sources of community support, such as traditional healers,

chiefs, headmen and others, is very valuable. All traditional communities have support mechanisms for dealing with death and crises, as well as certain cultural traditions for handling major life events. Traditional healers, for example, function as psychologists, marriage and family counsellors, physicians, priests, tribal historians and legal and political advisers.

The previous authors are joined by Seeley and Kajura (1993: 117), according to whom in rural Africa, traditionally, the extended family and clan assume the responsibility for all services to their members, whether social or economic. People live in closely organised groups and willingly accept communal obligations for mutual support. The sick, the aged and children are all cared for by the extended family. The care of AIDS patients and orphans is seen as falling within the sphere of extended family care.

Relating with Seeley and Kajura, Foster (2000: 56) says that in the past, the sense of duty and responsibility of extended families towards other members was almost without limits. Traditional life was characterised by brotherhood, a sense of belonging to a large family, and by groups, rather than individuals. The extended family gave security and support and the members shared many assets. Even though a family did not have sufficient resources to care for existing members, orphaned children were taken in. This was the basis of the assertion that traditionally, "*there is no such thing as an orphan in Africa* ".

According to Barnett and Whiteside (2002: 197) in most African countries families routinely took in children from the wider family. They also state, however, that the scale of AIDS orphaning is such that this coping mechanism is collapsing. This is becoming a major problem as is evidenced by the growing number of street children around the developing world.

The weakening of the extended family safety net as coping mechanism is also described by Foster (2000: 56-57) where he states that in recent years, changes such as labour migration, the cash economy, demographic change, formal education and westernisation have

occurred, which have weakened extended families. Labour migration and urbanisation have led to a reduction in the frequency of contact with relatives and encouraged social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family. Increased life expectancy and family size mean that it is now impossible for an extended family of three or four generations to reside together; the diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture. The breaking up of the traditional extended family system has resulted in the fact that education about social values occurs through schools and interaction of children with their peers, rather than through traditional mechanisms, which has lessened the ability of older people to exert social control over children.

Jackson (2002: 212-213) agrees with Barnett and Whiteside and Foster, but comments that although these support systems, like extended families, may now be severely stretched and have lost some of their traditional influence, power and strength, they remain a crucial part of their local social scene. They can influence attitude and behaviour change, help mobilise and distribute resources, give respected advice and create a sense of social unity and mutual support.

The researcher is of the opinion that in the rural areas of Namibia, the extended family is still the primary support system for orphans. When parents pass away, children are almost automatically taken up into part of the extended family. However, in urban areas the influence of western tradition and the cash economy, as mentioned above by Foster, is becoming more and more visible. Many orphaned children become so-called street children, as nuclear families wish to stay in their nuclear family unit and are no longer willing to take orphans into their care. In rural areas the extended family is still a very important source of support, although the increasing adult death rate is weakening the capacity of extended families to take care of orphans.

The opinion of the researcher was tested and verified in the empirical chapter, Chapter 4 of this study.

3.3 THE ROLE OF THE EXTENDED FAMILY

The extended family is not only socio-cultural, it is also psychosocial in nature, role and functions. In a subtle, yet powerful manner, it controls, moderates and regulates the behaviour of its members. It orients members towards affiliation and conciliation, arbitrating when and where necessary, thus minimising interpersonal abrasiveness and emphasising interpersonal harmony, encouraging as much as possible the sacrifice of personal gain for the maximisation of interpersonal harmony. As an agent of social insurance, the extended family provides for and supports the individual, not only psychologically, but also financially by means of direct contributions, help on the farm or with one's trade (Evans, 1994: ii).

When taking the aforementioned traditions of extended families into consideration, death in individual households has implications for other households because of their interdependence. Barnett and Whiteside (2002: 187-189) state that the coping mechanism of extended families becomes increasingly weakened as more households in a community are affected and communal support networks are less and less able to cope. Although Van Dyk (2002: 334-335) agrees on the emerging problems in extended family care, she argues that every reasonable attempt should be made to trace relatives of children orphaned by AIDS. Relatives who cannot afford to look after orphaned children should be helped financially so that they can care for these children.

Hunter (2001: 210) relates to Barnett and Whiteside by stating that not only has the coping mechanism of extended families become increasingly weakened, but that in private, some guardians express dismay at having to restart families late in their lives, both in terms of their loss of personal freedom and in their anxiety about meeting the needs of small children financially, emotionally and physically. They are also frustrated by the behavioural

problems of children who have been traumatised by the sequence of events surrounding their parents' deaths. The adults may be traumatised themselves by repeated deaths within their families. In some areas, fostering by extended family members has become less common than before AIDS, and families feel they are returning to a more traditional – and less advantageous – way of life.

The arguments of different writers are compared by Madhavan (2003: 15-17). According to her, Foster (in Madhavan, 2003: 15) takes on a pessimistic outlook on the potential of the extended family to care for AIDS orphans. He argues that the management of crisis fostering by extended families might be more successful if a certain level of voluntary fostering already exists. Ankrah (in Madhavan, 2003: 16) has not given up on the extended family and clan system, as is made clear in her synthesis of the resilience of the clan in African societies. She points out that AIDS-affected or -infected orphans are not without some extended family support. Even the so-called child-headed families are often linked to the larger clan. Her main point is that while HIV/AIDS has forced a reorganisation of the family and clan structure, there is every reason to be optimistic that new arrangements can succeed. She goes further to criticise intervention efforts that have neglected the clan structure and warns of the possible negative consequences of such a strategy. She uses the example of institutional care for orphans, who have no links to traditional family and clan organisation.

In the same vein, Hunter (in Madhavan, 2003: 16-17) offers a tempered analysis of the orphan issue in Uganda. She warns against premature conclusions about the capacity of the extended family to care for orphans, and suggests that we continue to regard the extended family as the most important source of support. She says:

> In Uganda, traditional fostering systems have been able to bear the additional burdens created by AIDS and it is our bias that they continue to do so if at all possible so that premature social change is not promoted by a panicked reaction to an imaginary present or future.

Neither Ankrah nor Hunter disputes the extraordinary pressures faced by these institutions as a result of HIV/AIDS, but they argue that families and clans can and will adapt as they have done for centuries.

The researcher is of the opinion that the extended family is the most important source of support for orphans, as they know where the child's roots are and what the habits of the child's family were. In the traditional African society, the extended family members usually stayed nearby the family of the orphan, and extended family members were known to each other, long before they came to stay with each other. In some clans in Namibia, the mutual responsibility for each other is so much part of the culture, that the language of the clan does not have words for aunt and uncle and cousin. These persons are respectively also called the child's fathers and mothers, brothers and sisters, implying the mutual responsibility and support. Programmes targeting HIV/AIDS and orphans should therefore, in the opinion of the researcher, focus on the strengthening of the capacity of extended families to provide support for the orphans of their family. These efforts should be encouraged by governments and foster families should have fast and effective access to material or financial assistance to care for orphans.

3.4 IMPACT OF HIV/AIDS ON THE EXTENDED FAMILY

The major impact of the HIV/AIDS pandemic is described by Barnett and Whiteside (2002: 160-161) as being the morbidity and mortality in populations at precisely those ages where normal levels of morbidity and mortality are low. Arising from these unusual events are several other impacts such as a higher frequency of other opportunistic diseases and additional pressure on health personnel, resulting in an overall reduction of people's health status. These impacts may be felt as an immediate and severe shock or they may be more complex and cause long-term changes. These changes affect households and communities and circle out to the whole nation.

The effects of the pandemic on the affected households, as well as on extended families involved in caring for AIDS orphans, are of an emotional and financial nature, depending often on the socio-economic status of the family and gender (Barnett & Whiteside, 2002: 162).

An important concept mentioned by Barnett and Whiteside (2002: 166-167) in connection with the impact of the pandemic is vulnerability. They say that vulnerability describes those features of a society or social institution such as an extended family, that make it more or less likely that excess morbidity and mortality associated with HIV/AIDS will have negative impacts. For example, a household with only one small income and five children is more vulnerable than a household with two incomes and three children.

The deep-rooted kinship systems that exist in Africa, extended family networks of aunts and uncles, cousins and grandparents, are an age-old social safety net for such children that has long proved itself resilient even to major social changes. This safety net is now unravelling rapidly under the strain of AIDS and soaring numbers of orphans in the most affected countries. Whereas before AIDS, approximately 2% of children in developing countries were orphaned, in 1997 rates in some countries were 7, 9 and even 11%. Capacity and resources are stretched to break point. Those providing the necessary care are in many cases already impoverished, often elderly and might themselves have depended financially and physically on the support of the very son or daughter who has died (UNAIDS, 2000: 3-5).

As a result of rising AIDS mortality, families are forced to alter cultural rules according to which orphaned children are taken in by family members, as the traditional system according to which orphans are cared for, like the maternal grandmother or aunt, no longer exists. More importantly, they have to redefine their roles and positions completely. And although all members of the family unit stand to lose in the process, female children, mothers and grandmothers bear the bulk of the personal, social and economic costs, as in

most African cultures orphans are cared for by the maternal grandmother or aunt. (Hunter, 2001: 208).

Paradoxically, the effectiveness of the African extended family in absorbing millions of vulnerable children has contributed to the complacency of external agencies concerning the emerging orphan crisis (Foster & Germann in Jackson, 2002: 276).

3.4.1 Impact of HIV/AIDS on older people

The HIV/AIDS pandemic is altering the demographic structure of societies. It is cutting away the middle generation of society, which leaves children orphaned and elderly people to bear the burden of care (Barnett & Whiteside, 2002: 196).

Currently, the main problem confronting the elderly in societies affected by HIV/AIDS is poverty. A second problem is grief over lost children. Those two problems go hand in hand, as the failing powers of the elderly make it more difficult for them to work and earn a living. This poverty and frailty are then made worse by the loss of adult children in two respects: the loss of financial and other support that older people could have expected and might have received, and the unexpected burden of orphaned grandchildren who come to live with them (Barnett & Whiteside, 2002: -216).

The suggestion is made by Williams (in Barnett & Whiteside, 2002: 218-219) that elderly people are affected by the HIV/AIDS pandemic more through the fulfilling of their parental obligations than the loss of their children's support. First they care for their children who are sick, then they bury them; after this, they care for their grandchildren. Lack of energy and strength to work in the fields means that the income and the range of food available to them and their dependants become smaller and the nutritional status of both elderly and orphans becomes worse.

On the other hand, Barnett and Whiteside (2002: 219) mention that older grandchildren may provide practical and emotional care for the grandparents. But sometimes it is the sheer numbers of orphans that come to stay with the grandparents' household which overwhelm their capacity to offer material and emotional care and support.

3.5 IMPACT OF ORPHAN CARE ON THE EXTENDED FAMILY

According to Barnett and Whiteside (2002: 186-187) it has been argued by some that the entity called '*the extended family*' will absorb the orphans and the destitute created through AIDS-related mortality. This view has been heard from people ranging from senior policy makers in national agencies to politicians and people in local African communities. It is, however, now heard less as the full effects of the pandemic become apparent. As pointed out by Barnett and Whiteside (2002: -187), the extended family:

- is a variable, it is dynamic and can become more or less extended depending on resource availability;
- is ideological, it is something people want to believe, because it validates their traditions;
- is ideological because belief in it relieves politicians of responsibility for thinking through the implications of the pandemic;
- reaches a point where it can no longer cope.

In rural Africa, traditionally, the extended family and clan assume the responsibility for all services for their members, socially or economically. When a child's parents die, the extended family members, where available and willing, take care of the children left orphaned. The effect of this tradition of caring for family orphans on the extended families is described by the International HIV/AIDS Alliance (2003: 5-6) as extended families becoming larger, as orphans move in with relatives who may already be living in difficult circumstances. Many extended families do not have enough resources to provide economic support to the ever-increasing numbers of orphaned and affected households. These poor households struggle without support to meet their children's basic needs for food, clothing,

education, housing and medical care while poverty increases. They start spending savings, seeking wage labour, switching to lower maintenance subsistence crops, selling possessions, livestock and land, borrowing and begging food and money, reducing consumption and expenditure on food, resorting to cheaper medication and withdrawing children from school. Children may also resort to paid labour to assist with household income.

The result of becoming poorer and poorer is that it is difficult to obtain credit for income-generating activities because they have nothing to offer as security. Poor households may already have debts or are wary of borrowing money that they may not be able to pay back. Institutions that offer loans are usually far from rural areas and do not consider providing credit to grandparents, sick people or adolescents (International HIV/AIDS Alliance, 2003: 6).

3.6 COPING MECHANISMS OF EXTENDED FAMILIES

Extended families in Africa are trying to adapt to the growing number of children orphaned by AIDS. One way in which they do this is by changing their composition. Three key points on changing of traditional structures are listed by Barnett and Whiteside (2002: 188) in this regard:

Societies where extended families are the rule or where clusters of households operate together to pursue a common livelihood strategy may be more robust in the face of adult death, as there are more adults available to care for the orphans.

Sending children to stay with relatives means that the effect of the adult death will be felt beyond the family who sent the children. Whoever takes care of the children can expect to expend resources.

Orphans need care, either in other families or through some form of public support. They increasingly do not receive this support as the number of orphaned children grows beyond the coping mechanism of changing compositions.

Adaptations such as these depend on people's receptiveness to the idea that the traditional extended family system is still appropriate and that care of AIDS orphans remains their responsibility.

Coping mechanisms regarding orphans are complex and vary according to differing cultural, geographic, economic and social settings. In general, where traditional values are maintained, such as in rural communities, the extended family safety net is better preserved. Where countries are more urbanised, extended family safety nets are weakened. As the traditional practice of orphan inheritance by uncles and aunts has lessened, it has been replaced by alternate safety nets with care provided by grandparents or other relatives. Children who slip through this safety net may end up in a variety of vulnerable situations (Foster, 2000: 58).

Hunter (2001: 103, 206) joins Foster when she discusses the fact that family structures worldwide have been changing rapidly over the past several decades to respond to global and local economic and social changes. Such changes come about as the family attempts to maximise access to resources. Families evolve coping strategies of which household reorganisation is a part. Household reorganisation includes change in membership and roles, and reallocation of labour among members. These household living arrangements are the outcome of family survival strategies, an expression of the family coping with underlying economic and social circumstances.

Another coping strategy of extended families is to ally themselves in cooperative groups to form community-based organisations. These organisations might begin within other organisations, such as religious, financial or governmental groups (Hunter, 2001: 207).

Some responses on the orphan problem by extended families are summarised by Hunter (2001: 210) as follows:

- Families continue to absorb orphans;
- Children are frequently shifted between relatives, or shift themselves when economic conditions dictate;
- Family member roles and responsibilities change, and children must assume adult roles;
- Children participate as adults;
- Children provide much of the care-giving for younger siblings;
- Extended family members try to work harder and more productively to support more dependants;
- Orphans and foster children are not treated as well as biological children, even when resources are available.

3.7 THE CAPACITY EXTENDED FAMILIES NEED FOR ORPHAN CARE

Families provide the best environment for bringing up children and if adequately supported they will be best able to provide the care that AIDS orphans require. This support must encompass improved access to basic services, including health care, safe water and sanitation, education, as well as assistance with childcare (Jackson, 2002: 279).

Strengthening the capacity of the community to identify and support those needy households will add to the quality of care for orphaned children in the households. Jackson (2002: 279) stresses the fact that in building the capacity of extended families it is the priority to build on existing traditions and structures rather than introducing totally new concepts that have less chance of being sustained. An important factor here is to include the community in exploring how the current resources can be developed, supported and restructured to address new needs.

The same fact is stressed by Hunter (2001: 212) when she says that when considering interventions to improve capacities of extended families to care for orphans, it is important

to recognise that their composition and vulnerability differ, and their capacities to make use of inputs vary and change over time.
Different capacities that are needed are discussed in the following categories:

3.7.1 Material resources

A recurring theme throughout the study done by Loening-Voysey and Wilson (2001: 57-58) in South Africa, shows how poverty, specifically lack of access to resources, weakens the capacity of the extended families to care for AIDS orphans. Many of these families do not have access to the necessary financial or human resources to enable them to provide adequate care for their own children, let alone the AIDS orphans in their care. This results, in many instances, in inadequate, poor quality care for the orphans and threatens their survival and security needs.

According to Jackson (2002: 279-282) extended families that take care of children orphaned by AIDS need strengthening of the family capacity, in particular with immediate material problems and the extra burden faced especially by women. Valuable inputs include labour-saving initiatives. An example of this is piped water if women have to go long distances to access water, micro-credit schemes especially targeting women as well as services that protect widows' and children's inheritance rights. Other inputs may entail support for income-generating activities, small business cooperatives, vocational training and micro-credit schemes.

3.7.2 Access to basic health care services

Support is also needed for the physical and psychological health of the orphaned children and the caring family member. The assumption is made here that those in the greatest need are often those least able to seek help themselves. In this matter, they need the capacity to seek support and know where to find it, otherwise the survival needs of the orphaned children are threatened (Jackson, 2002: 279).

3.7.3 Childcare and education

The exclusion of children from schools often occurs because of lack of funds for school fees and uniforms, which again has to do with a lack of material resources. Education is an important socialisation need of orphans, as well as a self-actualisation need as discussed in Chapter 2. Keeping orphans in school is especially crucial in breaking the poverty cycle. Information and education on childcare, the importance of schooling and practical skills are also required by many of the caring families, as well as education to enable them to prepare nutritious food, apply basic hygiene and infection control measures, use healthy discipline practices and respond appropriately to the psychosocial concerns of orphans (Loening-Voysey & Wilson, 2001: 57).

3.7.4 Psychosocial support

Another important need for the families caring for AIDS orphans, is receiving emotional support and encouragement that will help them deal with current problems and plan for the future. This important part of the psychosocial support to extended families can be provided by other family members, friends, community members or organisations and is an essential part of home-based care. Other forms of psychosocial support to caring families are grief and family counselling, which can assist extended family members in dealing with behavioural problems in fostered and adopted children and the provision of day care for the children of respite and working women. Families receiving this support are in a better position to cater for the orphans' socialisation and self-actualisation needs (UNAIDS, 2000: 28-29; Hunter, 2001: 169-170, 215).

3.8 PROVIDING PSYCHOSOCIAL SUPPORT TO AIDS ORPHANS

Philippi Namibia (2003: 22-24) gives an overview of how the extended family, communities and friends can provide psychosocial support to AIDS orphans. They divide the term into three elements, from where they discuss the provision of the support:

3.8.1 Psycho

Any psychosocial support must create the possibility that the person who receives it will be able to tell the reality of his or her life story. This implicates listening to the child when he expresses facts and feelings about what happened to him, how he then felt about this and feels about it now, as well as listening when the child expresses his needs and fears. The extended family member caring for the child needs the capacity to listen to and communicate with the child, without judging the child or making him feel that his feelings are not important.

3.8.2 Social

Children need to hear that it is normal to react the way they do under their circumstances. The extended family member caring for the orphans needs to make sure that the orphans' social environment is influenced to ensure that children belong to and feel connected to their community.

3.8.3 Support

This element involves building children's resilience and looking into and working on the building up of resources or tools in support of the child. It further involves the providing of material resources, education and time set apart for listening to the orphans' needs.

Psychosocial support recognises that providing physical or material support in the form of clothes, food, shelter and money is not enough if the emotional and psychological well-being, as well as the social setting in which one lives, is unhealthy. The mere provision of material and the knowledge on processing the material are inadequate and will not yield

required results unless the motivation and emotional intelligence aspects on how to apply this material and knowledge are considered (Philippi Namibia, 2003: 24).

Provision of psychosocial support may require input of money. Money, however, does not play the central role, but rather the people or community involved. By referring to "community" Philippi Namibia (2003: 23) recognises every individual that constitutes that community. That means from the high ranking, rich and well-to-do individuals to the poor and unemployed members of society. Here it includes the extended family member caring for the orphan. They continue by saying that every member of a community has the ability to offer psychosocial support to the needy child. When dealing with issues of love, security, guidance, provision of identity, care, listening, etc. no expert or level of competency is required. The capacity that the extended family needs to provide psychosocial support to AIDS orphans is described by Philippi Namibia (2003: 23) as:

> the eyes to see and the ears to listen to a child's problems, the mouth to speak words of comfort and wisdom, the heart to feel and understand the plight of the orphaned children and the time and willingness to listen and share.

Fox (2001: 64) differs slightly from Philippi Namibia and is of the opinion that a certain level of knowledge is necessary for the provision of psychosocial support. He states that another important capacity needed by the extended family members caring for the AIDS orphan, is knowledge of the needs of children affected and orphaned by AIDS. This knowledge increases their understanding of the situation and lets them respond positively. The discussion and education about needs of children affected and orphaned by AIDS also add to breaking down stigmatisation of AIDS orphans.

The researcher agrees with Philippi Namibia about the fact that love and nurturing can be provided by every caretaker without expert knowledge, providing that they are willing to provide such support. The researcher agrees, however, with Fox on the importance of

knowledge about providing this kind of support to orphaned children. If the impact of a lack of psychosocial support to a child is known to the extended family member caring for the orphan, there is a reason for this family member to go to a further extent to provide this support. The importance of this knowledge for the provision of psychosocial support will be elaborated on in Chapter 4 of this study.

The principle of holistic care is advocated by Philippi Namibia (2003: 23) when they say that any support that lacks the components of holistic support (meaning physical care, transfer of knowledge and skills, psychosocial care and support) is unlikely to yield the desired results, which are to reach out to the orphaned child in his difficult circumstances, helping him to deal with negative feelings such as anger, self-pity, hopelessness and suicide, and helping him to acquire the drive to move on with his life and become a productive member of society.

3.9 THE NATURE OF FACTORS INFLUENCING CAPACITIES OF EXTENDED FAMILIES TO CARE FOR ORPHANS AND PROVIDE PSYCHOSOCIAL SUPPORT

In his article, Foster (2000: 57) writes that of all children orphaned by AIDS throughout the world, 95% have occurred in Africa. In severely affected communities, an increase in the number of orphans throughout the next decade is inevitable as a consequence of increased parental mortality rates. Increasing numbers of orphans only become a major sociological concern when the numbers of children living in especially difficult circumstances increase. Enumeration of orphans, as well as the monitoring of the capacity of extended families to care for orphans, is important.

Some of the factors that influence the capacity of the extended family to provide overall care, of which psychosocial care is an important part, were discussed in point 3.7 of this chapter.

According to Foster (2000: 57-61) there are various other factors that influence the capacity of the extended family to function as a safety net providing psychosocial support for AIDS orphans, and the nature of these factors will be discussed:

3.9.1 Widow remarriage

In many African communities, widows are inherited through remarriage to a brother of the deceased husband. In Tanzania, 65% of about 2,000 widows had a sexual relationship with in-laws, though 84% disliked the relationship, but were persuaded because of cultural and economic factors. In Zimbabwe, the practice of widow inheritance is rare and many women now refuse traditional remarriage. However, widow inheritance may have been replaced by a practice whereby male relatives maintain sexual access to widows without formally inheriting them. Where traditional widow inheritance is prevalent as in Tanzania, orphan inheritance is also likely to be stronger. This means that the widow and the orphans are taken up into another part of the extended family, responsibilities are shared with other extended family members and the capacity needed by the widow to care for her orphans is lower (Foster, 2000: 57-58).

3.9.2 Purposive fostering

In most African communities, the western concept of adoption does not exist. Children are fostered, a culturally sanctioned procedure whereby natal parents allow their children to be reared by adults other than the biological mother or father. Child fostering is a reciprocal arrangement, based on political and economic considerations and contributes to mutually recognised benefits for both natal and foster families (Foster, 2000: 58-59).

Madhavan (2003: 5) adds that in this way, the bond between parents and their children is lessened and children become more independent and, in some cases, better disciplined. In addition, child fostering provides an opportunity for both natal and foster households to strengthen social and kinship ties through short- and long-term benefits to both parties,

including reciprocity obligations, social security, access to resources (e.g. land), and investments in both households by sharing the costs of child rearing.

The prevalence of purposive fostering varies. In a study done by Hunter (in Foster, 2000: 57) in Tanzania, where fostering of non-orphaned children is common, 34% of children under 15 were living without one or both parents though only 8% were orphans. The prevalence of fostering throughout the country bore no obvious relationship to orphaning or AIDS mortality. Crisis fostering of orphans occurs following the death of a parent. In cultures where purposive fostering is practised, those same relatives who have a right to claim a child when its natal parents are alive, have an obligation in times of crisis, as is the case where the child becomes orphaned, to foster the child. The prevalence of purposive fostering of children within a community may thus serve as an indicator of the strength of the extended family safety net and influence their capacity to do so.

3.9.3 Contact with relatives

Children who belong to families which have little or irregular contact with relatives are at risk of being abandoned if they are orphaned. In certain cultures, relatives are less likely to visit families in which unions between a man and woman were established without the payment of a bride price. Children from households headed by single mothers or commercial sex workers are particularly likely to slip through the extended family safety net. Migrant workers are another group likely to have limited contact with relatives. In Zimbabwe, for example, some two million people live in commercial farm communities which have limited access to traditional extended family systems. Families which have little contact with their extended families have a greater likelihood of orphans being abandoned should the current caregiver die (Foster, 2000: 60-61).

Madhavan (2003: 8) adds here that the treatment a child receives often reflects the type of relationship that existed between foster and biological parents, rather than the existence of kinship links.

3.9.4 Changes in relative support practices

Safety net mechanisms include care for sick or dependent relatives and the provision of material relief, labour and emotional support to destitute or bereaved families. According to Foster (2000: 59) studies suggest that material support provided by relatives to orphan households is limited. In his example from Tanzania, he mentions that less than a quarter of orphans received support from the surviving parent and under 10% received support from other relatives or elsewhere. Changes in the ratio of paternal : maternal caregivers may reflect a weakening of the extended family safety net. As the number of orphaned children in a community increases and uncles and aunts, the traditional first choice as substitute caregivers, become unavailable, grandparents are recruited into childcare. Grandparents are often a last resort as caregivers and agree to take orphans because other relatives refuse. In some cases, what is viewed as a situation in which the elderly provide childcare is actually more akin to a situation of mutual support with increasingly frail grandparents becoming the care recipients of grandchildren (Foster, 2000: 57 – 61).

An interesting outcome of the study done by UNICEF (1998: 18-19) in Zimbabwe was their finding that psychosocial treatment of orphans was distinctly different in the two types of kinship systems: matrilineal and patrilineal. Orphans were rarely isolated or stigmatised in matrilineal groups. Adults and children tended to make special efforts to try to make the orphans feel included. Orphans in patrilineal groups could be cruelly stigmatised and subjected to psychological traumatisation and separation from their mother (where they were paternal orphans) with subsequent harassment and punishment should they try to re-establish contact with her.

This study outcome of UNICEF, as well as the above factors that influence the capacity of the extended family in providing psychosocial support to the AIDS orphan will be emphasised and elaborated on in Chapter 4 of this study.

3.10 CONCLUSION

The researcher can identify with Foster (2000: 61) when he says that despite its weakening, the extended family continues to remain the predominant caring unit for sick relatives and orphans throughout Africa. Communities and families are changing their systems of caring for orphans to cope with changes taking place within the society. This illustrates the strength, resilience and adaptability of extended family coping mechanisms.

The consequence of increasing numbers of orphans and weakening of the extended family safety net is that increasing numbers of orphans are now living in especially difficult circumstances leading to physical, social, economic and psychological morbidity and increased vulnerability to HIV infection. Community-based orphan support initiatives have a demonstrable ability to target support to large numbers of orphan households in greatest need and children in difficult circumstances. There is a growing recognition that strengthening spontaneous community-based initiatives such as caring for the sick and orphans are as urgent as preventing the further spread of HIV. Such initiatives should be provided, especially in AIDS-affected communities where coping mechanisms have been weakened most.

Another important conclusion according to the researcher, is that this strengthening of capacities of extended families to absorb the growing number of orphans has to be supported by government institutions. Good cooperation and coordinating of programmes implemented by government and non-governmental institutions to assist communities and extended families in their effort to care for the orphans are of paramount importance in the building of the resilience of extended families in Namibia.

Mallmann (2002: 19) concludes that a loving extended family that provides security and care can offer an orphaned child a sense of identity and a sense of belonging. Members of a family share the same roots, the same history and generally have similar values and beliefs. This familiarity provides warmth and protection. However, a family divided by conflict or

with problems like alcohol dependency, domestic violence, severe poverty and an absence of strong values and beliefs can be an additional stressor for the mourning child. A dysfunctional family structure may thus have a negative effect on the coping process and encourage poorly adapted behaviour.

CHAPTER 4 – ANALYSIS AND INTERPRETATION OF FINDINGS

4.1 INTRODUCTION

In her chapter on qualitative data analysis and interpretation, De Vos (2002: 339) states that data analysis is the process of bringing order, structure and meaning to the collected data. This statement is a summary of the aim of this chapter, where findings of the empirical study that was done will be reflected.

The purposive and snowball sampling methods were chosen for this study due to its sensitive nature. The stigmatisation and general beliefs surrounding AIDS made it difficult for people involved to come forward and offer inside information. Another reason for these specific sampling methods was that the research was done in an area where cultural traditions required the researcher to follow certain rules of etiquette to approach people who could be involved in the information collection. The village in which this study was conducted is part of a traditional community, living by subsistence farming. This is a poverty stricken community, as very little formal job opportunities exist. The researcher was not allowed to approach any person in the community on her own, but had to make use of contacts like traditional leaders, social workers, church leaders and school principals to single out cases that could be approached for information collection. For this study the headman of Mukwe and a church leader were approached for singling out cases through the snowball sampling method.

This study was conducted in the Mukwe constituency of the Kavango Region of Namibia. Therefore the target population included the inhabitants of that constituency. The units of observation were the main caregivers of extended families caring for aids orphans and the AIDS orphans living with them. This sample consisted of four different extended families and six key persons including a school principal, a head of department in a school, a church leader, a traditional leader and a member of an Aids Awareness Committee in the constituency.

4.2 DESCRIPTION OF FINDINGS FROM INTERVIEWED EXTENDED FAMILIES (UNITS OF OBSERVATION)

For this study fifteen semi-structured interviews were conducted. Four caregivers in extended families, five AIDS orphans living in these extended families and six key persons from the same communities were interviewed. The extended families were visited two or three times for observation purposes and to build trust.

Findings based on observation and completion of interview schedules will be explained by a detailed description of each of the four extended families.

4.2.1 Ouma Mukana's household

Ouma Mukana lives in a traditional housing setup and is the maternal grandmother of the two AIDS orphans she cares for. She is an 81-year-old widow, never had any formal schooling and is a pensioner.

The household consists of four adults and five children. The adults are Ouma Mukana herself, her son and daughter-in-law and her other son living with severe mental disability.

The children in the household comprise of the three children of her son and daughter-in-law, and the two AIDS orphans, a girl and a boy aged 10 and 12.

4.2.1.1 AIDS orphans in the household

The orphans in the household are a 12-year-old boy and a 10-year-old girl, Betty, who was interviewed. The father of the orphans did not live in the household as he had died long ago. Their mother passed away in 2000. She and the children had been born in the household and the children stayed there with their mother until she passed away. Betty was sent to her paternal family, but was treated very badly and almost died of famine. Her grandmother then took her back into her household. Both orphans attend school.

4.2.1.2 Income generation in the household

Ouma Mukana receives a monthly government pension of N$300. The household has mahango fields (a local grain pounded for porridge), which they plough in season. The household also has some chickens, but no other livestock. Ouma Mukana's son works at a school as a labourer, earning a small salary. Sometimes he assists in the financial care of the orphans.

4.2.1.3 Psychosocial needs, adjustment and support system of the household and orphans

In terms of the subconcepts of the definition of psychosocial support as defined in Chapter 1, paragraph 1.7.3, the psychosocial needs of the orphans that Ouma Mukana describes are in the first place physical needs. She mentions that her monthly pension is not enough to provide for all the food, clothes, toiletries and school necessities of the children.
Ouma Mukana mentions that in terms of the children's emotional and mental needs, she talks to them and they talk as friends. But she explains that she cannot go to the school or see what happens in the community, as she is not able to walk any more. She says: *"The children need someone to talk to and who can teach them everything in life."*

According to Ouma Mukana, the orphans did not have adjustment problems in the household, as they were born and raised in the household before the mother passed away. To the question how they were treated by other community members, Ouma Mukana says that she cannot tell that, because she never gets out of the household any more to see. She cannot talk about the school progress either as she cannot attend meetings. The children do not receive school reports, as they are not able to pay the school fees.

In the interview with Betty she says: *"People treat me not well. They talk about that I have no mother, they talk badly, they chase me away and beat me. They do not want to help me. It happens many times and makes me feel bad. When it happens, I can do nothing. I can just stand there alone."*

The feelings that Betty experiences regularly as a result of being an orphan are confusion, loneliness, fear, hopelessness and sadness. She summarises her life as follows: *"I do never feel happy. The only time I will feel happy is when people talk nicely with me."*
During observation when visiting the household, the researcher could see that this child is sad, and gave an impression of being depressed. Her brother's appearance seemed the same. To the question if there was someone to talk to when she was feeling bad, Betty declared that she talks to Ouma Mukana and that she feels better then. However, her grandmother does not always listen well, or is too tired.

The orphans have many responsibilities in the household, as Ouma Mukana is not able to wash, cook, pound mahango, fetch water and firewood and clean any more. The daughter-in-law living in the household is sickly and the only other person to assist with all the household tasks is the 14-year-old cousin of the orphans who lives in the household. According to Betty the work she has to do is too much, she cannot keep up, and time for playing is scarce. Betty states that the best thing that could happen to her in life is if she could have food every day when she comes from school.

4.2.1.4 Capacity of the household to provide psychosocial support to the orphans and factors influencing this capacity

According to the interview schedules and observations made during home visits to Ouma Mukana's household, the capacity of this household to provide psychosocial support to the orphans can be summarised as follows:

Physical capacity

Ouma Mukana indicates that her monthly pension is not enough to provide for the basic physical needs of herself and the orphans. The yearly mahango harvest is too small to fulfil the feeding needs of the family, and provide money for clothing, blankets, toiletries and school fees and necessities. She describes her physical capacities as being too low.

The nature of the factors that influence Ouma Mukana's capacity is summarised by herself as follows: *"I am too old, my health is weak. I cannot work for the children's food and I am dependent on the assistance of the government."*

Age, health and finances are the main factors that influence Ouma Mukana's capacity to provide all the necessary support to the children. She can no longer plough the fields as a result of age, can no longer wash laundry, cook food, fetch water and firewood and pound mahango as a result of her health. The government pension is too low to hire people to do this work for her.

Emotional capacity

Ouma Mukana says she has the emotional capacity to provide psychosocial support, but that this capacity is decreasing. She mentions that she can talk with the children, give them psychological support and advice, but that she cannot go to other people and talk to them about their behaviour towards the orphans. She also mentions that she tires easily and cannot listen and advise for long times.

Betty says that her grandma can listen well sometimes, and that she is the first person the orphans go to if there is a problem, but she also says: *"Sometimes grandma is not listening nicely. When people talk bad about me here, grandma does not help me, she says nothing. Grandma should talk to them, but she is too old."*

Here Betty also indicates that the main factors influencing her grandmother's capacity to provide support are her old age and weak health.

Mental capacity

Ouma Mukana never had any formal schooling, and according to her this influences her capacity to assist the children with their schoolwork. She also indicates that she needs assistance to teach the children all the practical things in life, as well as other life skills. To the question how the school progress of the orphans was, Ouma Mukana said that she does not know as she is not able to go to the school any more, and the children do not receive school reports.

Health, age, educational level and economic circumstances are the factors that influence the mental capacity of Ouma Mukana to support the orphans.

Spiritual capacity

Religion is very important in Ouma Mukana's household. She regularly talks with the children about religious issues. She cannot attend church services any more, but the children go to church every Sunday. In this case the wisdom of old age influences her capacity to provide positive spiritual support to the children.

Throughout the interview with Ouma Mukana, as well as with Betty, another important factor arose that has an influence on the provision of support to the orphans, namely the support of relatives. Besides the son of Ouma Mukana living in the household, there is no support network outside the household. Ouma Mukana is alone in caring for the two orphans, and expressed a great fear of what would become of them if she passes away.

4.2.2 Josephine's household

Josephine and her family live in traditional housing. She is a maternal niece of the three AIDS orphans she cares for. She is 22 years old, is married and has an eight-month-old son. She went to school where she finished Grade 9. The other family living in the same homestead are her maternal uncle and his wife with their three children aged 11, 9 and 2. Nobody in the household is formally employed, or receives any pension or grant moneys.

4.2.2.1 AIDS orphans in the household

The three orphaned children in the household are two boys, aged 16 and 9, and a 15-year-old girl, Kushamuna, who was interviewed as well. Two of the orphans are the children of Josephine's maternal aunt and the other orphan is the child of another maternal aunt. The grandmother of the orphans and Josephine assisted in caretaking, as well as her three daughters, the mothers of the orphans and of Josephine. However, one after the other

passed away, and Josephine was the only one left to take care of the orphans. All three the orphans attend school.

4.2.2.2 Income generation in the household

Nobody in the household is formally employed, or receives money from anywhere. Josephine has her mahango field, which provides food for approximately five months of the year. When food supplies are finished everybody in the family fends around for food in the community. Josephine tries to get piecework in the community, and is paid mostly with mahango or maize meal.

4.2.2.3 Psychosocial needs, adjustment and support system of the household and orphans

The first needs that Josephine mentioned and which seemed the most pressing to her, are physical needs. The orphans lack clothes, food, soap, toiletries and money to pay school fees. The other need that was mentioned by Josephine was a need for good health and health services. With respect to support systems, Josephine mentioned that they get no support from anybody, besides sometimes when they go begging for food from neighbours.

Kushamuna, the 15-year-old orphaned girl in the household, was interviewed as well. She also mentioned school fees and necessities, soap and food, as the most urgent physical needs.

Emotionally the orphans are encountering several problems. According to Josephine people in the community have treated the children differently since they became orphans. It seems to her if people just do not care about the children any more.

Kushamuna described this problem more concretely: "*People treat me and my brothers differently now. They do not come to visit us any more, chase us away from their homes, and beat us. They tell me that I am crazy because my mother died. There is nobody to stand up for us now.*"

According to Josephine all three orphans cried a lot more, withdrew and their school progress worsened. She mentioned that they are adapting to the situation now and are doing well.

Kushamuna agreed with the adaptation problems, but indicated that it is just getting worse, not better. She said: "*When we have no food to eat, I think about my mom and get very sad and feel hopeless. Then I feel people are right and I become crazy.*"

4.2.2.4 Capacity of the household to provide psychosocial support to the orphans and factors influencing this capacity

According to the interview schedules and observations made during home visits to Josephine's household, the capacity of this household to provide psychosocial support to the orphans can be summarised as follows:

Physical capacity

According to Josephine she has enough time to care for the orphans, and she is also willing to do so, but she is not financially able to do so. Her economic capacity is too low to care well for the whole household. Kushamuna confirmed this when she said: "*Josephine tries to support us, but it is not the same as our mother. There is no money for school and school necessities, soap and enough food.*"

Emotional and mental capacity

One of the main factors that influences Josephine's capacity to provide emotional and mental support to the three orphans in her household is age. She mentioned that because she is still young herself she does not have the capacity to provide adequate psychological support to the orphans. Her knowledge and experience in childcare are not enough: "*I would like to support them. I am interested and do have the time, but not enough knowledge.*"

A positive influencing factor however, is the fact that Josephine had formal schooling and is able to help the orphans with their schoolwork.

According to Kushamuna, Josephine's emotional capacity is weak, but she can talk to her and express her feelings: "*If I have been alone and crying somewhere I go to Josephine to talk. That helps a lot*."

According to the interviews with Josephine and Kushamuna, the main factors influencing the caretaker's capacity to provide psychosocial support to the orphans are economic factors and age.

4.2.3 Pauline's household

In Pauline's homestead there are a total of thirteen people. Ten of them are children. The three adults are Pauline, her brother and his wife. They have three children living with them. Pauline is divorced, has four children of her own and three orphans for whom she cares. They live in a traditional homestead far from the riverside.

4.2.3.1 AIDS orphans in the household

The three orphans in Pauline's household are 9-year-old twins, a boy, Ndjamba, who was also interviewed, and a girl and their 13-year-old sister Minga, who was interviewed as well. Their mother passed away in 2001. The then 6-year-old twins lived with their mother and their then 10-year-old sister Minga lived with her father's family. She came to live with them a few months before their mother passed away. The reason for that she described as follows: "*I came here because I had to take care of my mother. When I was at school the twins had to look after her.*"

When the mother passed away the children stayed behind alone. Minga, who was ten years old at that stage said: "*I stayed here after my mother passed away, because I wanted to be with my brother and sister. I had to take care of them*."

After some time, Pauline saw that the child-headed household was not coping and she took the three orphans in with her.

4.2.3.2 Income generation in the household

No person in the household or homestead is formally employed or earns any kind of a salary. Pauline ploughs her mahango fields in season and this gives the family food for more or less six months of the year. She asks for work around and works for other people occasionally in exchange for food. She has some chickens that provide meat and eggs.

When the food is finished she goes to the bush to collect wild fruits and vegetables and has to find food in the village: "*When the mahango is finished I have to beg for food from other people, and wait for someone to give us something.*"

4.2.3.3 Psychosocial needs, adjustment and support system of the household and orphans

According to Pauline and the two orphans who were interviewed, their support system is very weak. Pauline has to take care of all seven children by herself, with only sometimes some assistance from her brother. That means that the orphans' psychosocial needs are not met. There is a lack of economic support for physical needs like clothing, school fees, soap, blankets and food.

Emotionally and mentally the orphans are in great need. Minga mentioned that she feels very bad when the school principal asks for school fees and they cannot pay them. The other emotional stressor in her life is the fact that the family cannot cope when it comes to food: "*The thing that makes me feel very bad is when I see how Pauline has to beg and ask around for food everywhere for us. Then I think about my mother and feel very bad.*"
The same psychosocial need was identified by Ndjamba, who mentioned that they were hungry many times, and that the best thing that could happen in his life would be if he could eat every day.

Feelings that were singled out by both Ndjamba and Minga were sadness and hopelessness. According to Pauline these feelings and withdrawing behaviour were improving a lot, but both the children mentioned that the feelings were worsening.

4.2.3.4 Capacity of the household to provide psychosocial support to the orphans and factors influencing this capacity

Physical capacity

The physical capacity of the household to provide psychosocial support to the three orphans is very weak. Pauline tries to provide as well as she can, but the orphans lack the most basic physical needs. The main factor that influences this capacity is their economic status. Other factors are the number of children in the household and a lack of support systems.

Emotional capacity

From the interview schedules it can be concluded that the capacity of the caretaker to provide emotional support leaves room for improvement One of the two orphans gave the following summary of this capacity: "*I can talk with Pauline nicely, and she always has enough time for me. There is no constraint. She works with us the same as her own children, treats us the same.*" *(Minga)*

"*When I feel sad, I run away to the field and cry and stand alone where people cannot see me. But I do not feel better. Afterwards I sometimes go to Pauline and talk. Then I feel a bit better." (Ndjamba)*

However, Pauline herself feels insecure about her capacity to provide emotional and mental support. She mentioned the psychological support as a very important issue. She identified a lack of friendship as one of the constraints on her side. This indicates support systems that she does not have. The other important factor that influences this capacity is her lack of knowledge. She sums it up:

> I feel I do not have all the capacity I need to provide the psychosocial support to the orphans. This is for the material needs, as well as the other psychosocial needs. It is not easy to give the support. It would be better if someone could teach me how to handle the orphans better and if they could show me how to care for them.

Spiritual capacity

In Pauline's household, religion is very important. She mentioned that the three orphaned children showed withdrawing behaviour, cried a lot and they seemed scared to visit other people. To the question about what she thinks made this better she answered: "*We went to the elders of the church and discussed this. They prayed with us and encouraged the children. Now it is going better.*"

Here Pauline indicated that she has the capacity to provide spiritual support to the orphans.

4.2.4 Mahiuwa's household

Mahiuwa is the grandmother of the five orphans living with her. She was widowed long ago. Besides them, there are fourteen people living in the homestead, of whom nine are children. The housing setup is traditional, with the mahango fields around the homestead.

4.2.4.1 AIDS orphans in the household

The five orphans living in the house are all brothers and sisters of ages ranging from 1 to 17. The eldest child is 17-year-old Kaunda, who was also interviewed. The father passed away in 2003, and their mother is in the hospital, terminally ill with AIDS. The two youngest children are with her in the hospital, and one of them is also terminally ill. The grandmother has stayed with her daughter and the two children in the hospital for the past

nine months, to care for them. The other three orphans are at home and have to look after themselves.

4.2.4.2 Income generation in the household

Nobody in the homestead is employed, or brings any money into the household. The way the family survives is by eating their mahango, field food, a few chickens, food from the river garden and when one of the grownups works for food. Mahiuwa has a lot of knowledge about traditional field food and spends much of her time searching for this food. When there is no food, she tries to find work in other households, or asks other people for assistance.

4.2.4.3 Psychosocial needs, adjustment and support system of the household and orphans

The most important need that was identified by Mahiuwa is education of the orphans. The eldest one left school due to financial problems. He got assistance from a teacher and could continue his education. Mahiuwa mentioned as one of the main needs of the children the need for clothes and shoes to go to school. She mentioned that the children are not eager to go to school as a result of their physical appearance. Besides education and clothing, food scarcity is a problem.

Kaunda mentioned that the only support system he has, are his friends. He is not able to talk to anybody, and has the feeling of not being accepted. In the community people seem to treat him and his brothers and sister differently, and do not allow them into their houses. This makes him feel sad. Mahiuwa confirmed this emotion of sadness to be present with all the orphans. She indicated that she talks to them, but the problem is worsening.

Kaunda mentioned that the only thing making him happy in life is when he can go to his friends and they accept him.

4.2.4.4 Capacity of the household to provide psychosocial support to the orphans and factors influencing this capacity

To the question to Mahiuwa if she thinks she has the capacity to provide psychosocial support to the orphans in her household, she was positive. She mentioned that especially the psychological support is not a problem. The answer to the question if she can handle the children's sadness is contradictive in this regard. Mahiuwa, as well as Kaunda says that the sadness is worsening and the children feel there is nothing besides their friends that makes them happy in life.

Kaunda mentioned that he does not talk to Mahiuwa or the other adults in the homestead about his feelings, because he feels they are not interested, do not listen and do not understand him.

The physical support also seems to be a problem and the capacity in this regard is very weak. There is no money for paying school fees, or for buying clothes, enough food and other necessities. As Mahiuwa stated: "*I have a lot of love for the children and I am interested in them. I have the time for them. However, the financial difficulties make it very hard to provide for all of them and get them satisfied.*"

Another factor that Mahiuwa mentioned as having an influence on her capacity in a negative way is her age: "*I am getting too old to look after the children. They need assistance and have to learn well, so that they can start caring for me now.*"

Here it can be summed up that the main factors influencing the capacity to provide psychosocial support are economic constraints and age.

Table 1: Summary of the factors having a negative influence on the capacity of extended families to provide psychosocial support to orphans.

Factor	*(Number of extended families experiencing this factor as having a negative influence on their capacity to provide psychosocial support to the AIDS orphans)*	*(Number of orphans identifying this factor as having a negative influence on their caretakers' capacity to provide psychosocial support to them)*
1. Lack of time	0	0
2. Economic status	4	5
3. Old age of the caretaker	3	2
4. Interest in the orphans	0	1
5. Knowledge of caretaking	2	1
6. Health	1	1
7. Number of children	1	0
8. Support network	3	3

4.3 DESCRIPTION OF FINDINGS FROM INTERVIEWED KEY PERSONS

For this study six semi-structured interviews were conducted with key persons in the community. The key persons included two school principals, an HIV/AIDS community group member, a clinic nurse, a teacher and a traditional leader. The results of these interview schedules are reflected in Table 2.

Table 2: Analysis of findings of interview schedules with key persons

1. Situation of orphans in the community	*Number of positive answers*	*Number of negative answers*
1.1 Orphans are treated differently compared to non-orphans	3	3
1.2 Assistance from the community to orphan-families is enough	1	5
2. The psychosocial needs of orphans		
Physical needs are met satisfactorily	0	6
Psychological needs are met satisfactorily	0	6
Emotional needs are met satisfactorily	2	4
Mental needs are met satisfactorily	3	3

3. Factors influencing the capacity of extended families to provide psychosocial support to orphans in their households	Number of respondents seeing this factor as not being a problem	Number of respondents seeing this factor as being a problem
1. Amount of time to spend with the orphan	5	1
2. Economic status	0	6
3. Old age of the caretaker	2	4
4. Interest in the orphans	4	2
5. Knowledge of caretaking	0	6
6. Health of the caretaker	2	4
7. Number of children in the household	5	1
8. Support network	2	4
4. Capacity of the extended family to provide psychosocial support to AIDS orphans	Number of respondents giving positive answers	Number of respondents giving negative answers
1. The capacity of the extended family to provide psychosocial support to AIDS orphans is enough	1	5

4.4 INTERPRETATION OF FINDINGS

From the analysis of findings, certain interpretations can be made.

4.4.1 Psychosocial needs of AIDS orphans living in extended families

All respondents answered to this question that the main need of orphans is their physical needs. In this community, extended families do not have the financial capacity to provide for the basic physical needs of the orphans in their care, like food, clothing, soap and school fees. For the caretakers it seemed difficult to think beyond physical needs, as these needs are overwhelming. On probing, the other most pressing needs they could identify were an emotional support network and education.
The key persons also identified physical needs as most important, but all of them identified psychological support as being a very important need as well.

The orphans themselves identified the lack of food as their greatest need. All of them also indicated the need for emotional support. Feelings of guilt about being a burden to their caretaker, especially financially, were present in all orphans interviewed.

4.4.2 Capacity of extended families to provide psychosocial support to AIDS orphans

Five of six key persons were of the opinion that extended families do not have the capacity they need to provide adequate psychosocial support to AIDS orphans.
Three of the four caretakers were of the opinion that they do not have the capacity to provide psychosocial support. One of the respondents was of the opinion that she does have the capacity, but indicated that her financial situation is a burden and causes a lack of food, clothing and other material things in the household. As the definition of psychosocial support includes material support, it can be concluded that this caretaker does not have the capacity to provide this support to the orphans in her household.

4.4.3 Factors influencing the capacity of extended families to provide psychosocial support to AIDS orphans

A number of factors were identified as having an influence on the capacity of extended families to provide psychosocial support to AIDS orphans and will be discussed.

4.4.3.1 Lack of time

The lack of time for the orphans in their household was not seen as having any influence on their capacity to provide psychosocial support to the orphans by the caretakers that were interviewed. None of the orphans mentioned this as a problem either. Only one key person mentioned this factor as important.

4.4.3.2 Economic status

All respondents mentioned that economic status, lack of money, is the greatest need and factor influencing the capacity to provide psychosocial support. One of the key persons who identified this as being a problem, made the remark that the provision of psychosocial support to orphans would not be any better if the extended families had access to more financial resources, without the knowledge of how to use it. He was of the opinion that extra money would be used to buy alcoholic beverages, if caretakers were not provided with knowledge of how to use the money to look after orphans in their care.

4.4.3.3 Old age of the caretaker

In the cases where the caretaker was aged, this was seen as a factor influencing their capacity to provide psychosocial support. They mentioned that their capacity to provide psychological and emotional support to the orphans was better than the capacity of younger caretakers in this regard, but their physical strength was a definite negative factor. The younger caretakers mentioned that they lacked the wisdom and experience coming

with age to give the orphans optimum support. The answers of the other respondents were in agreement with this.

4.4.3.4 Interest in the orphans

Three respondents were of the opinion that the lack of interest of caretakers in the orphans they cared for was a factor influencing their capacity to provide psychosocial support to AIDS orphans.

4.4.3.5 Knowledge of care taking

The lack of knowledge on how to take care of AIDS orphans was for two caretakers and all the key persons a factor which has a definite influence on the psychosocial support provided to AIDS orphans. Only one of the orphans identified this as a problem.

4.4.3.6 Health of the caretaker

Health was not seen as one of the major factors, with six of 15 respondents giving positive answers. Most respondents coupled health with a lack of food. If food shortages become worse, health deteriorates, which then has a negative influence on the capacity of extended families to provide psychosocial support to the AIDS orphans in their care.

4.4.3.7 Number of children

The number of children was seen as an influencing factor by two respondents.

4.4.3.8 Support network

The lack of a support network was one of the important factors seen as having an influence on the provision of psychosocial support to orphans, with nine of the respondents giving

positive answers. Fellow community members seem not to be much involved with extended families caring for orphans. For the orphaned children, the support network they need consists of friends and family.

There was a contradiction in answers to this question by the adult respondents and the children. Four adults said that the community does not treat orphans differently from non-orphans, one did not know and five saw this as a problem.

However, all the orphans interviewed saw this as a problem.

4.5 CONCLUSION

The analysis of findings in this chapter was based on the information collected during an empirical study, whereby semi-structured interview schedules were used. Several factors that have an influence on the capacity of extended families to provide psychosocial support could be identified and discussed.

In the last chapter conclusions will be made using information from the literature study and the empirical study, whereafter recommendations for further study and for the application of findings will conclude this study.

CHAPTER 5– CONCLUSIONS AND RECOMMENDATIONS

5.1 SUMMARY

More and more children in Namibia are orphaned by AIDS. AIDS orphans are projected to comprise three quarters of all orphans by 2006. The majority of these orphans are taken up by extended family members, putting pressure on households.

There are certain factors that influence the capacity that extended families have for dealing with the psychosocial problems of orphaned children. However, as mentioned earlier, little information exists on the nature of these factors.

A literature study was done on AIDS orphans and on the extended family and HIV/AIDS. To verify and supplement this information, an empirical study was done and results of this study were analysed in Chapter 4.

The focus in this study was not on producing statistical answers as would be done in a quantitative study, but on understanding the experiences of extended families in caring for AIDS orphans and these families' perceptions of factors that influence their capacity to provide the necessary support to these children.

The nature of these factors was therefore explored and their influence on the extended families' capacity was described in an applied research study.

In this chapter, the aims and objectives of the study are evaluated. Conclusions and recommendations will be made as a result of the study.

5.2 ADDRESSED RESEARCH QUESTION WITHIN THE RESEARCH PROCESS

This study was guided by the research questions formulated in point 1.4, namely to explore the nature of factors that influence the capacity of extended families to provide psychosocial support to AIDS orphans and to what extent this nature influences their capacity to provide psychosocial support to AIDS orphans.

A literature study was done to determine these factors, as well as to provide a knowledge base on the impact of HIV/AIDS on children and the phenomenon of the extended family, from where the empirical study could be done.

As was explained in Chapter 1 point 1.6.2, this study is described as applied research. The research strategy, which followed in Chapter 1 point 1.6.3, was explorative and descriptive, in that it explored the factors influencing the capacity and described these factors.

5.3 ACHIEVEMENT OF AIM

The aim of the study was to study the factors influencing the capacity of extended families in providing psychosocial support to AIDS orphans and capture experiences of the extended families providing this support.

The aim was achieved through four case studies which were done where semi-structured interview schedules were used to obtain information. The information obtained from the semi-structured interview schedules was analysed and interpreted in Chapter 4 and conclusions and recommendations are made in this chapter.

5.4 ACHIEVEMENT OF OBJECTIVES

In order to be able to reach the aim of this study, the following objectives were formulated and were carried out in Chapters 2,3,4 and 5:

- Collection of information was done through a literature study, the completion of semi-structured interview schedules with extended family members, AIDS orphans and key persons. Observation with the objective to capture experiences of the extended families providing this support took place.
- Qualitative information analysis was used to transform the collected information on the most important factors influencing the capacity of extended families in providing psychosocial support and captured experiences into findings with the objective to make a contribution to filling the existing knowledge gap.
- Findings were published in a research report, which can be of future assistance to students studying this subject as well as to people working in the field of AIDS orphans and community capacity building.

The researcher is of the opinion that this study made a contribution to filling this gap, providing important information that can be used by several project managers and programming officers. Certain factors that have a definite influence on the capacity of caretakers to provide psychosocial support to AIDS orphans, like the economic status of the extended family, the lack of knowledge that exists on orphan care and the lack of a support network were identified. These can be used as a basis for assisting programmes.

5.5 PROBLEM FORMULATION

The research problem formulated in Chapter 1 point 1.3 was that according to the researcher there are certain factors that influence the capacity that extended families have for dealing with the psychosocial problems of orphaned children. Little information exists on how to develop and strengthen that capacity.

In Chapter 2 AIDS orphans and the psychosocial problems they experience were discussed and Chapter 3 described the nature of factors influencing the capacity of extended families to provide psychosocial support to AIDS orphans.
In order to be able to address the formulated problem, the empirical study as described in Chapter 4 was done using qualitative analysis.

5.6 CONCLUSIONS

The following conclusions can be made as a result of the study:

5.6.1 AIDS orphans living in extended families have certain psychosocial needs

In the literature study it was noted that although in situations of extreme poverty the psychological needs of children may appear of secondary importance to meeting basic material needs, it should not be ignored or considered as unimportant. In the empirical study all respondents mentioned the material needs of the AIDS orphans first. Only after probing, they recognised other psychosocial needs like emotional support and encouragement that will help them deal with current problems and plan for the future.

5.6.2 The majority of extended families do not have the capacity to provide the necessary psychosocial support to AIDS orphans

During the interviews, the majority of respondents indicated that extended families do not have the necessary capacity to provide psychosocial support. It seems that even the most basic material needs are not met. Emotional and psychological needs were seen as important, but were not mentioned first by any of the respondents. Of the respondents, all key persons, and 3 of 4 caregivers stated that extended families do not have the capacity to provide adequate psychosocial support to AIDS orphans.

5.6.3 The capacity of extended families to provide psychosocial support to AIDS orphans is influenced by a number of factors

There are certain factors that have a positive or a negative influence on the capacity of extended families to provide psychosocial support to AIDS orphans.
In the literature study a number of factors were singled out and the influence of these factors on the case studies was tested in the empirical study. The main factor influencing this capacity is the economic status of the extended family. Secondly the knowledge of childcare and orphan care was mentioned, followed by old age of the caretaker and lack of a support network.

In Chapter 3 point 3.8 Philippi Namibia (2003: 23) mentioned that when dealing with issues of love, security, guidance, provision of identity, care, listening, etc. no expert or level of competency is required. Fox (2001: 64) differed slightly from the Philippi Namibia and was of the opinion that a certain level of knowledge is necessary for providing psychosocial support. He stated that another important capacity needed by the extended family members caring for the AIDS orphan, is knowledge on the needs of children affected and orphaned by AIDS. The researcher agreed with Philippi Namibia about the fact that love and nurturing can be provided by every caretaker without expert knowledge, providing that they are willing to provide such support. The researcher, however, also agreed with Fox on the importance of knowledge about providing this kind of support to orphaned children. When the impact of a lack of psychosocial support to a child is known to the extended family member caring for the orphan, there is a reason for this family member to go to a further extent to provide this support.

In the empirical study it came out that lack of knowledge was seen by all key persons and two of four caretakers as a definite factor influencing the capacity of the extended family to provide psychosocial support negatively.

5.7 RECOMMENDATIONS

Recommendations that can be made from this study are the following:

5.7.1 In some clans in Namibia, the mutual responsibility for each other is so much part of the culture, that the language of the clan does not have words for aunt, uncle and cousin. These persons are respectively also called the child's fathers and mothers, brothers and sisters, implying mutual responsibility and support. It is therefore recommended that programmes targeting HIV/AIDS and orphans should focus on the strengthening of the capacity of extended families to provide support for the orphans of their family.

5.7.2 The strengthening of capacities of extended families to absorb the growing number of orphans has to be supported by government institutions. Foster families should have fast and effective access to material or financial assistance to care for orphans. Good cooperation and coordinating of programmes implemented by government and non-governmental institutions to assist communities and extended families in their effort to care for the orphans are of paramount importance in the building of the resilience of the extended families in Namibia.

5.7.3 Follow-up research where a programme is developed for the strengthening of the capacity of extended families would be a great advantage

5.7.4 Research on the fast and effective scaling up of programmes and access to assistance in Namibia would be beneficial to the capacity building process.

May the findings of this study and the recommendations made, be of great value to every concerned person trying to assist AIDS orphans and their families and caretakers, and be a tool to improve the quality of life for these children.

APPENDIX

Semi-structured Interview Schedule for Main Caregiver in Extended Family

Respondent Name:

Date:

Introductory Question

We would like to begin by asking you to tell us about yourself and the household you live in.

1. Please tell us about yourself.

(Probes):

First name:

Age:

Occupation:

Educational level :

Marital status:

Anything else you would like to add about yourself:

Background Information on the Extended Family

We would like to understand a bit more about the household you live in.

2. Can you tell us how many people currently live on a regular basis in your household? By this we mean all those who are resident here, eat here and sleep here. We are interested in both adults and children.

3. How do these people relate to each other?

4. How is your household making a living?

(Probes):

Formal employment?

Growing crops?

Casual labour?

Life stock?

Any informal business?

Who is doing what?

5. Tell us a bit about your average day during the week. What do you do first when you get up in the morning, what do you do in the morning, afternoon and evening?

6. If weekends are different, how do they differ?

Background information about the orphans living in the household

We now want to try and get a better understanding about the child(ren) who are living in your household.

7. You told us there are … (questions 2) children living in your household. How many of them are orphans and what are their ages?

8. Tell us about how you came to be looking after them?
(Probes):
When was this?
Who were the parents, how were they related to caregiver?
What was the decision making process? Why this household?

9. Who in the household is involved in caring for the children, aside from yourself?

10. If they are of school going age, are they going to school?

11. If they attend school, can you describe their school progress?

12. How would you describe the children's school progress from the time they came to stay with you until now?

13. If they do not attend school, what is the reason?
(Probes):
Do they have to help in the house? (no time)
Financial constraints?
Not seen as necessary?

The Situation of Orphans in the Community and Household

14 . How do the orphans in your household spend a normal weekday?
(Probes):
Are they playing with other children in the village?
Are they usually among other children or alone?
Are they working, e.g. crop farming, household chores etc.

15. If there are other children in the household, how do they get along with the orphans?

(Probes):

Do the children play together?

How is the attitude of non-orphans towards orphans?

16. Do you feel people in the community treat the orphans in your household different than the other children or the same?

17. If different, please explain?

(Probes):

What is different?

What makes you think this is because the children are orphans?

Psychosocial needs, adjustment and support system

We would now like to discuss with you how the orphaned children fit into your household.

18. What, in your opinion, are the needs of orphans?

19. Discuss with us the children's behaviour .....
    a. when they first arrived (after parents passed away).
       OR (If the children already stayed there *with parents*:
    b. after the caregiver changed (when parents passed away).

(Probes):

Behaviour towards adults in the household

Behaviour towards other children in the household

Social behaviour

20. In terms of over time adjustment, have the children had any of the following problems and, if so, please describe:

Trouble sleeping

Crying a lot

Fighting/aggressive

Poor performance in school

Involved in crime

Withdrawing from other people

21. If the children experienced any of the above problems, which, if any, are they still experiencing?

22. If the problems became less or disappeared, what in your opinion, caused the improvement?

23. When the child(ren) are feeling sad, angry or scared to who do they usually go to get comforted?

Capacity to provide psychosocial support

24. Did you get any support or training from anyone to assist you in caring for the orphans in your household?

25. Do you feel you have all the capacity to support the children when they experience abovementioned emotions? Can you elaborate?

26. What do you think makes you able / not able to provide the necessary support that the children need?
(Discuss in depth)

(Probes):
What are the constraints?

Time?	*Interest?*	*Number of children?*
Economical status?	*Intellectual capacity?*	*Acceptance?*
Caretakers age?	*Other factors?*	

27. What should you think could change your capacity to provide the necessary support?

(Probes):
What has to change?
What/who has to change (that)?
How can this change?
Who can change it?
(What will improve the capacity of the extended family in providing the support the orphan needs?)

Closing Question

28. We have come to the end of our interview. Is their anything you feel we should have asked and didn't, anything you would like to tell us?

Semi-structured Interview Schedule for Aids Orphans

Respondent Name:

Date:

Introductory Question

We would like to begin by asking you to tell us about yourself and the household you live in.

1. Please tell us about yourself

(Probes):

First name:

Age:

Where you are from:

How long are you living in the current household?

Anything else you would like to add about yourself:

The Extended Family the Orphan lives in

We would now like to ask you about the household you live in.

2. The household you live in, is it made up of your father's family or your mother's family?

3. How did it happen that you came to live with them, and not with someone else?

4. Tell us about other children in the household you are living in.

(Probes):

Who are they?

How are they related to you?

Are they older or younger then you, or the same age?

Do you sometimes play together?

5. Tell us about the adults in the household you are living in. Who would you say looks after you the most among the adults?

(Probes):

Who helps him/her/them?

Are there any other adults in the household? If yes, how many and who are they?

6. Tell us a bit about your average day during the week. What do you do first when you get up in the morning, what do you do in the morning, afternoon and evening?

Education

7. Are you in school? Grade?

IF NOT IN SCHOOL:

7a. *(If there are other children in the household:)* Are the other children in your household going to school?

7b. Can you tell why you are not going to school?

Social Involvement

The next questions are about your life in the community / village where you live in.

8. How long do you live in this community / village?

9. Tell us about your involvement in the community / village?

(Probes):

Do you play with other children?

Are you involved in sports activities? How?

When there are activities in the community, what is your involvement?

9a. *IF THE CHILD IS INVOLVED*: How did you get to know the community / become involved?

(Probes):

Did you make contact all by yourself?

Did the family you live with now introduce you?

Did people / children from the community come to you?

9b. IF THE CHILD IS NOT INVOLVED: Can you tell the reason(s) why you are not involved?

(Probes):

Did you make not contact all by yourself? For what reason?

Did the family you live with not introduce you? Reason?

Did people / children from the community not come to you? Reason?

10. A child who lost his father, or mother or both parents is called an orphan. You father / mother / both parents died.
Do you feel people in the community treat you the same or different since you are an orphan?

11. If different, please explain?

(Probes):

Where there changes in their behaviour?

Where there changes in the way they look at you, talk with you, treat you?

What makes you think this reaction is because you are an orphan?

12. If people treat you different then other children because you are an orphan, tell us about how that makes you feel?

Psychosocial needs, adjustment and support system

13. We are going to show you some cards with words on it. Each word is a feeling any person can experience. We would like you to look at (listen to/) each word and tell us what comes to your mind?

(Probes):

13a Did you ever experience that feeling? When was that?

13b If yes, do you still sometimes experience that feeling?

13c What do you do when you experience that feeling?

Words / Feelings:

a. Confused
b. Sad /hopeless
c. Happy / glad
d. Scared
e. Lonely

14. Can you mention any other feelings you have (had) since you live in this household?

15. When you are experiencing any of this feelings, who will you normally talk to about the feelings?

(If it is someone else then the primary caregiver go to question 16. If it is the primary caregiver go to question 20).

16. Earlier in the interview you told us that your grandmother / aunt / older sister (whoever is the caretaker), is taking care of you.
We would like to know if you can discuss this feelings with her?

17. If yes, how does that makes you feel?

18. If no, what, in your opinion, makes that you cannot discuss this with your caregiver?

(Probes):

What are the constraints?

Time ?	*Interest?*	*Number of children?*
Economical status?	*Intellectual capacity?*	*Acceptance?*
Kinship?	*Other factors?*	

19. What should you think could change this, and make it possible for you to discuss this kind of feelings with your (primary caregiver)?

(Probes):

What has to change?
What/who has to change (that)?
How can this change?
Who can change it?
(What will improve the capacity of the extended family in providing the support the orphan needs?)

20. When you could change anything in your household to make your life better, what would it be?

Closing Question

21. We have come to the end of our interview. Is their anything you feel we should have asked and didn't, anything you would like to tell us?

Semi-structured Interview Schedule for Key Persons

Respondent Name:

Date:

Introductory Question

1. We would like to begin by asking you to tell us about yourself.

(Probes):

First name:

Age:

How long have you lived in this area:

Occupation:

Employment status:

Educational level :

Position in the community:

Anything else you would like to add about yourself:

The Situation of Orphans in the Community and Households

We would now like to talk to you about orphans in the community.

2 . Can you please tell us what you understand by the word orphan?

3. How are you involved in orphan issues?

4. Tell us what you know about orphans in your community?

(Probes:)

How many orphans do you know of?

With whom do they live?

Do they attend school?

5. Do you feel people in the community treat the orphaned children different than the other children in the community or are they treated the same?

6. If different, please explain?

(Probes):

What is different?

What makes you think it is because the children are orphans?

7. Your community, as with other communities, has ways of coping with difficult as well as emergency situation, as do households, extended families etc.
Please tell us a little about how the extended families who are caring for orphans in your community cope?

(Probes:)
Do other families help?
Do they get assistance from outside?

8. To what extend, if at all, are organisations and individuals in your community involved in providing support services to orphans and the households who care for orphans?

Psychosocial needs, adjustment and support system

We would now like to talk with you about the needs of orphans.

9. What, in your opinion, are the needs of orphans in your community?

(Probes:)
Material:
Psychological:
Social:
Educational:

10. In your community, how can you describe the capacity of the extended families who care for orphans, to cope with these needs of the orphans/to provide in these needs.

11. Is there anyone, and if so, who is this, in the community to assist them in coping with these problems?

We are specifically interested in the psychosocial support that the extended families give the orphaned children.
Children have different needs. Psychosocial support is the process of meeting the physical, emotional, social, spiritual needs of children so that they can positively develop.

12. Do you feel these families have the capacity they need to support the orphaned children in their psychosocial needs? Please elaborate?

13. What factors (positive / negative) are influencing this capacity?

(Probes, only if necessary):

Health of caretaker / children
Age of caretaker / children
Number of people / children in the household
Social status of family in the community
Kinship
Culture / traditions
Support systems
Educational level
Knowledge of childcare

14. How in your opinion, can this capacity of families be strengthened?

Closing Question

15. We have come to the end of our interview. Is their anything you feel we should have asked and didn't, anything you would like to tell us/add?

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