The experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in the Free State

by

MELANIA GONO

submitted in accordance with the requirements for
the degree of

MASTER OF SOCIAL WORK

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF L I QALINGE

JANUARY 2015

DECLARATION

STUDENT NUMBER: 47195339

I, MELANIA GONO, declare that **THE EXPERIENCES, CHALLENGES AND COPING RESOURCES OF AIDS-ORPHANS HEADING HOUSEHOLDS IN AN URBAN AREA IN THE FREE STATE** 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

Melania Gono — 15 December 2014

DEDICATIONS

This thesis is dedicated to my late parents, Mr. and Mrs. Gono for their belief in me since I was a child. They taught me that education is important for women to enable them to live independent and self-reliant lives. Their motivating words have inspired and boosted me to accomplish all my educational successes.

The thesis is also dedicated to my loving husband and our two lovely boys, for consistently supporting me throughout my studies.

ACKNOWLEDGEMENTS

I wish to express my deepest appreciation and gratitude to the following people and organisations for their invaluable contributions and support towards the completion of this thesis:

- Almighty God (God the Father, Jesus Christ my Lord and Saviour and the Holy Spirit) for giving me strength and wisdom to do this work.
- Prof Lulama Qalinge my supervisor, for providing professional and astute guidance, encouragement and shared expertise in qualitative methods. Her prompt and prudent comments expedited the completion of this thesis.
- Ms Talana Erasmus, Personal Librarian at UNISA, for assistance in retrieving required literature from the shelves.
- Ms Margaret Grobbelaar who independently coded and edited the thesis.
- My family and especially my husband Morris, for their continued support, endurance, patience and understanding whilst I was occupied and engrossed in this study.
- All my friends and colleagues for providing a platform for debriefing and for facilitating access to literature relevant to this study.
- Mr. R Makube (former Social Work Director at Child Welfare South Africa, Sasolburg), for granting permission to conduct this research.
- The orphaned children who participated in this study and allowed me into their painful world by sharing their emotional stories. Without their contributions, this study would not have been possible.
- The UNISA postgraduate bursary Programme for the bursary awarded to me for the purpose of this study. Without their financial support this study would not have been possible.

ABSTRACT

HIV and AIDS related deaths have left numerous children heading households as the number of adults dying from this pandemic increased significantly. The goal of this study was to gain an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in Free State using a qualitative study. The research revealed that the level of suffering faced by these children began with their parents' illness. This was further worsened by the death of the parents. These children are in most instances not absorbed by their extended families as the traditional safety nets are stretched to their limits. Children heading households were forced to take up adult responsibilities prematurely and as such encounter challenges on daily basis. The study concluded that the child headed families are a reality in South Africa and need lots of support from the government and local communities.

KEY WORDS

HIV and AIDS, Orphan, child headed household, family, urban area, experiences, challenges, coping, resources and child.

LIST OF ABBREVIATIONS

AIDS	Acquired immuno-deficiency syndrome
CBO	Community-based organisation
CDG	Care dependency grant
CRC	Convention on the Rights of the Child
CSG	Child support grant
FBO	Faith-based organisation
FCG	Foster care grant
HCBC	Home and community based care
HIV	Human immuno-deficiency virus
NACCA	National action committee for children affected by HIV and AIDS
NGO	Non-governmental organisation
NPO	Non-profit organisation
OVC	Orphans and vulnerable children
PPC	Positive peer culture
RDP	Reconstruction and development programme
SSA	Sub Saharan Africa
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
USA	United States of America
USAID	United States Agency for International Development
WCC	World Council of Churches

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ADDENDUMS 132

CHAPTER ONE
INTRODUCTION AND GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Children are the future of any nation or any family. For these children to grow and become responsible members of the community, they must be guided, loved, respected, nurtured, supported and directed accordingly. It is every nation's primary goal to raise a responsible generation. In the African context, as stated in "The African Child Policy Forum" discussion paper by Tsegaye (2007:2), there is a saying that "It takes a village to raise a child". In other words, it is every community's primary goal to ensure that its children are well protected from harm and that their basic needs are met. UNICEF/UNAIDS/USAID (2004:13) stress that, in order to survive and thrive, orphaned children and adolescents need to grow up in a family and community environment that provide for their changing needs. However, as a result of the impact of poverty, armed conflict, family disintegration and, most importantly, the HIV and AIDS pandemic, this safety net is stretched to its limits writes Foster (2004:77). This is confirmed by a large number of orphans left alone to care for themselves. As indicated by Van Dyk (2008:343), the existing pool of community-based support has become flooded. Therefore, these children now have to fend for themselves. They are forced to become heads of households and breadwinners.

Traditional safety nets are unravelling as increasing numbers of adults die from HIV-related illnesses (Foster, 2004:77). Families and communities struggle to fend for themselves, let alone take care of orphans (UNICEF/UNAIDS/USAID, 2004:13). Typically, half of all people with HIV become infected before they are aged 25, developing AIDS and dying by the time they are 35, leaving behind a generation of children to be raised by their grandparents, other adult relatives or left on their own in child headed households (Subbarao, Mattimore & Plangermann, 2001:65). This eventually leads to the phenomenon of child headed households as these orphans, who witnessed their parents' death, face the challenge of continuing to fend for their family's sustenance (Tsegaye, 2007:2).

Studies of child headed households deal primarily with children's rights and the accessibility of social grants for children infected and affected by HIV and AIDS,

child headed households and other vulnerable children (Rosa & Lehnert, 2003; Sloth-Nielsen, 2004; Rosa, 2004). Because of an increasing number of children who have lost both parents to AIDS, the number of child headed households is also growing. Although not much is available statistically, for the purpose of this study the researcher identified households headed by AIDS-orphans between the ages of 16-18 years. The researcher investigated their challenges, experiences and coping resources as heads of households. Books (1998:48) states that research has shown that HIV-affected children and youths are a population at risk. They are prone to developmental, behavioural and mental health problems, teenage pregnancy and becoming infected by HIV themselves. In this study, the researcher investigated the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, an urban area in the Free State province.

Although the HIV and AIDS epidemic started relatively late in Southern Africa, it has been volatile, reaching prevalence rates of over 30% in some countries such as Botswana and Swaziland. In 1998, a study by the South African Ministry of Health suggested that by 2005 between 197 000 and 250 000 children would be orphaned in the province of KwaZulu Natal alone. These figures are expected to grow if appropriate steps are not taken. Yet, HIV and AIDS have done great harm to families and their children. It has ruined the lives of many people and affected individuals, families, and communities (WCC Study Document, 1997:1). At the end of 2001, 11 million of children in sub-Saharan Africa were orphaned due to HIV and AIDS, nearly 80% of the world total (UNICEF, 2003). This figure was expected to grow to 20 million by 2010. In South Africa, for example, based on the data given in Children on the Brink (UNAIDS, UNICEF & USAID 2004), the estimated number of child headed households represents 7% of orphans but doubles to 14% of AIDS-orphans. In Rwanda, the 4% of estimated child headed households makes up 8% of orphans, but 41% of AIDS-orphans.

Foster (cited in Tsegaye, 2007) asserts that children start carrying the burden of heading households even before the death of their parents. The emptiness created by the mother's illness spurs the eldest child to take over all household chores. Therefore, the child prepares him/herself for the duty of looking after the other siblings and running the household. A great number of these children who became

the heads of households, were forced to look after themselves, dropped out of school, became vulnerable to many forms of abuse and had to look for work in order to care for their siblings (Van Dyk, 2008:343). Hence, the researcher wanted to study the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela.

The government, business, the media, academics, international donors, non-governmental organisations (NGOs), non-profit organisations (NPOs), community-based organisations (CBOs) and faith-based organisations (FBOs) continue to strive to halt the effects of HIV and AIDS where children end up in child headed households but with little success (Bojer, Lamont, Janitsch, Dlamini, & Hassan, 2007:15). This situation creates a need for support to children who are left alone to fend for themselves. More seriously, and a cause for concern is support for AIDS-orphans compelled by circumstances to head families in the absence of an adult family member. The researcher, therefore, considered it worthwhile to study the experiences, challenges and coping resources of AIDS-orphans heading households in urban areas of the Free State province.

1.2 PROBLEM STATEMENT

Children start carrying the burden of heading households even before the death of their parents, argues Foster (cited in Tsegaye 2007). The emptiness created in the home by the mother's illness results in the eldest child taking over all household chores. Therefore, the child prepares him/herself for the duty of looking after the other siblings and running the household. A great number of the children who had become the heads of households, were forced to look after themselves, drop out of school, became vulnerable to many forms of abuse and had to look for work in order to care for their siblings (Van Dyk, 2008:343; Bray 2003:45). Van Dyk and Bray's findings confirm that the child headed household phenomenon is an emerging type of family and is growing rapidly. Tsegaye (2007) comments that the first reports of large numbers of child headed households appeared in the early nineteen nineties in Uganda and later on in Tanzania, Zambia and Zimbabwe, where HIV and AIDS epidemics started to emerge. The problem later seemed to permeate nearly all countries of the continent, including South Africa. Below are the estimates indicating the rapid increase in the child headed household phenomenon, as stated by Tsegaye (2007):

- In Eritrea, there were some 3 000 street children counted as child headed households in 2001.
- Burundi reported an estimated number of 20 500 unaccompanied children in 2001.
- A 2005 Food Security and Livelihoods Survey in the central highlands of Angola found 2% of households headed by children
- In 1997, 3% of households in Zimbabwe were headed by children who were 18 years and below.
- In Zambia, 7% of households were headed by children in 1998.

According to a survey by UNAIDS (2006, the following numbers of orphans were reported:

- South Africa – 1 200 000 estimated number of orphans
- Tanzania – 1 100 000 estimated number of orphans.
- Zimbabwe – 1 100 000 estimated number or orphans.
- Kenya – 1 100 000 estimated number or orphans.
- Uganda – 1 000 000 estimated number of orphans.
- Nigeria – 930 000 estimated number of orphans.
- Zambia – 710 estimated number of orphans.
- Democratic Republic of Congo – 680 000 estimated number of orphans.
- Malawi – 550 000 estimated number of orphans.

(UNAIDS, 2006).

In 2012 the Global Report (UNAIDS, 2012) notes that "sub-Saharan Africa remains the most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide" (UNAIDS, 2012:8). In South Africa, for example, based on the data given in Children on the Brink (UNAIDS, UNICEF & USAID, 2004), the estimated number of child headed households represents 7% of orphans but doubles to 14% of AIDS-orphans. These

statistics indicate the seriousness of the problem and pose a number of questions as to how these children cope, the challenges they face, and what resources they have at their disposal to deal with the vulnerable position in which they find themselves.

The extent of vulnerability faced by AIDS-orphans depends on many factors: whether they have been infected themselves, whether they have relatives willing to foster them, whether these relatives have the resources to care for them, whether they are allowed to go to school, how they are treated within the home and community, what degree of psychosocial trauma they have suffered and what responsibilities they are left with, to mention a few (Subbarao et al., 2001:3). In addition to this, UNICEF (2003b: 26) states that AIDS-orphans are likely to suffer damage to their cognitive and emotional development, have less access to education and are subjected to the worst forms of child labour. Hence, the researcher's desire to understand their experiences, challenges and coping resources.

Generally, children who lose their mothers suffer massive grief over the loss of love and nurturing that mothers normally give. Children who lose their fathers also suffer particularly from a decline in their standard of living, as the death of a father typically entails the loss of income for the household, especially if the father was the only breadwinner (Subbarao et al., 2001:3). In other words, AIDS-orphans heading households will at times end up suffering from fear, depression, stress, anxiety, stigmatization, discrimination, isolation, and disrespect from peers (Salaam, 2005:15).

When children have to assume the tasks of acting as parents and looking after siblings, they often experience pain and trauma because they have to perform duties for which they have not been prepared (Moutona, 2001:191). Moutona further describes the role of parenting as being composed of tasks, roles, rules, communication, resources, and relationships, and confirms that AIDS-orphans heading households lack these parenting skills. Parenting is not about being in a particular family structure, but rather refers to a process of guiding children from conception and birth through development challenges until adulthood. This, to AIDS-orphans, becomes an unfulfilled dream as they are the ones who have to provide this guidance for their younger siblings.

Hepburn (2002:89) asserts that poverty is the primary barrier to caring for orphans locally and nationally. She explains that without adequate resources to feed, clothe, and offer counselling the basic needs of such children will continue to go unmet. For example, children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes (Salaam, 2005:16). Salaam (2005:18) furthers asserts that property grabbing, a practice where relatives of the deceased come and claim the land and other property, is reportedly a serious problem for child headed households. Traditional law in many rural areas dictates that women and children cannot inherit property and consequently property grabbing has a many negative consequences, particularly for girls. Girls may experience sexual abuse and exploitation from their new caretakers; they may be forced into the sex trade in exchange for shelter and protection, further increasing the risk of contracting HIV.

Based on the above, although there has been some research on the experiences and challenges of AIDS-orphans heading households, this topic has not been researched in the context of Zamdela, an urban area in the Free State. This motivated the researcher to carry out this study in the context of Zamdela which proved to have a graet number of child headed households.

1.2.1 Rationale for research

The researcher is a senior social worker and the project manager of Asibavikele (Let's protect them) project that focuses on the care of orphans and vulnerable children (OVC). This research project is intended to help social workers and the social work profession redress the challenges and experiences and build the coping resources of AIDS-orphans heading household in Zamdela and South Africa as a whole. As a social worker, the researcher has a caseload of children living in child headed households. Observation and consultation with them revealed that they are not happy, need food and other important resources. For example, food that they are given at the project is normally taken home to share with other siblings because no-one is working to maintain them. At times they come in on Monday's with unwashed uniforms and not properly bathed. This motivated the researcher to investigate the challenges faced by these AIDS-orphans and their experiences on a personal level.

1.3 RESEARCH QUESTION

The research question acts as the primary signpost for explaining the purpose of the study and guiding the research (Mouton, 2006:101). The researcher was guided by the research question throughout her study. In other words, a research question must be a reformulation of the research title into a question. In this case, the research question for this study was formulated as follows:

- What are the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State?

1.3.1 Research goal and objectives

Research goal, according to Fouché and De Vos (in De Vos, Strydom, Fouché & Delport, 2005:104), is described as a "dream while an objective involves the steps one has to take, one by one, realistically at grassroots level, within a certain time span, in order to attain the dream". In other words, the dream is the main purpose of the research study and the objectives are like the signposts guiding the researcher to attain the purpose of the study. This is confirmed by Mouton (1996:101) when indicating that a goal gives a broad indication of what researchers wish to achieve in their research whilst an objective presents a more systematic picture of different kinds of research objectives.

The research goal or aim for this study was:

To gain an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State.

In order to realise the aforementioned goal, the following objectives were formulated:

- To explore and describe the experiences of AIDS-orphans heading households
- To explore and describe the challenges faced by AIDS-orphans heading households.
- To explore and describe the coping resources of AIDS-orphans heading households
- To draw conclusions and make recommendations on how to improve the welfare of AIDS-orphans heading households.

These research objectives were then broken down into the following task objectives:

- To obtain a sample of AIDS-orphans heading households in Zamdela, Free State.
- To conduct in-depth semi-structured interviews to explore the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State.
- To sift, sort and analyse the data obtained according to the eight steps of qualitative data analysis as stated by Tesch (in Creswell, 2009:189).
- To subsequently describe the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State.
- To interpret and analyse the data and conduct a literature control in order to verify the data.
- To draw conclusions and make recommendations on the findings

1.4 THE RESEARCH METHODOLOGY

According to Babbie and Mouton (2001:75), research methodology focuses on the kinds of tools and procedures used in a study. These tools and procedures include the design, sampling, data collection and data analysis methods that the researcher employs in the study. Henning, Van Rensburg and Smit (2004:36) argue that methodology refers to the rational group of methods that complement each other in order to deliver data and findings that will reflect the research question and suit the research purpose. The research methodology applied in this study constituted the following:

1.4.1 Qualitative research approach

A qualitative research approach can best be used when some kinds of information cannot be adequately recorded using quantitative data (Bless, Higson-Smith & Kagee, 2006:44). They further argue that language provides a far more sensitive and meaningful way of recording human experiences. In this case the researcher investigated the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela. As compared to the quantitative approach that gives a step-by-step plan or a fixed recipe to follow, qualitative approach is more flexible wherein the researcher's choices and actions determines the strategy, as argued by

Fouché (in De Vos et al., 2005:269). This assisted the researcher during the research process to create the strategy best suited for this study.

Qualitative research concerns itself with the study of people in their natural environment as they go about their daily lives (Creswell, 2009:175) and by trying to understand how people live, the researcher concluded that this approach was well suited to realize the goal of the study.

From this qualitative stance, the researcher wanted to come to an understanding of the challenges, experiences and coping resources of AIDS-orphans heading households in Zamdela. Within the qualitative approach, the following research designs were used:

1.4.2 Research design

A research design entails the researcher's overall plan in conducting the research (Babbie & Mouton, 2001:74). Burns and Grove (2001:223) assert that, for a researcher to attain the intended goal, one must be guided by the design in planning and implementing the study. This overall plan entails what the research question should be, what data will be required to answer it, from whom the data will be obtained and how best to gather the data. The research design for this study incorporated exploratory, descriptive and contextual designs.

Exploratory research design was considered since little is known on the phenomenon to be studied (Babbie & Mouton, 2001: 79). Yegidis and Weinbach (1996:92) also support this idea by indicating that exploratory research is appropriate when problems have been identified, but understanding of them is fairly limited. This design is used to begin the process of building knowledge about the problem. More specifically, this design was used to explore the experiences, challenges and coping resources of AIDS-orphans heading household in Zamdela. The purpose of this exploration will hopefully lead to the development of hypotheses which can be investigated and tested later with more precise and more complex designs and data gathering techniques (Neuman, 1997:19).

Descriptive design was considered in order to gain an understanding on the experiences and challenges faced by AIDS-orphans heading households in Zamdela

an urban area in Free State. The researcher used descriptive design because she looked with intense accuracy at the phenomenon of the moment and then described what she had observed (Babbie & Mouton, 2001:80; Leedy, 1997:191).

Contextual design was considerd by the researcher since it seeks to avoid the separation of participants from the large context to which they may be related (Schruink in De Vos et al., 1998:281). The researcher wanted to explore and describe the challenges, experiences and coping resources of AIDS-orphans heading households in the comfort of their own homes. In view of the fact that the researcher sought to explore and describe the experiences, challenges and coping resources related specifically to the context of AIDS-orphans heading households in Zamdela an urban area in the Free State, a contextual research design was employed.

1.4.3 Population and sampling methods

A study population is any group of individuals that has one or more characteristics in common, and is of interest to the researcher (Best & Kahn, 1993:32). The study population for this research would be AIDS-orphans heading households residing in the urban area of Zamdela, Free State. Since the researcher cannot always study the whole population, it was necessary to select a sample. A sample is a small portion of objects, events or persons which represents to various degrees, the study subjects (De Vos 1998:191; Bless et al., 2006:100). The characteristics and attributes of the population are used to select a sample, which is "a subset of measurements drawn from a population", according to Strydom (in De Vos et al., 2005:194). The targeted participants for this study included AIDS-orphans heading households in Zamdela, Free State.

The researcher considered non-probability sampling method to select a sample. Non-probability sampling is used in cases when the researcher does not know the population size (Strydom in De Vos et al., 2005:201). In this case, the researcher did not know the total number of AIDS-orphans heading households in Zamdela. It is for this reason that snowball sampling, as a technique of non-probability sampling method, was applied. Snowball sampling is whereby the researcher gets to know other participants through a few that she has identified. These then lead her to others until data is saturated, as stated by Strydom and Delport (in De Vos et al., 2005:330).

The researcher also deliberated on purposive sampling technique which is defined by Neuman (2006:222) as a non-random sampling method in which the researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult-to-reach population. Neuman (2006:222) adds that in purposive sampling, qualitative researchers use their own judgement as experts on the topic to select participants. In this case, the sample included seven AIDS-orphans who are heading families in an urban area which included both males and females and orphans attending and not attending school.

The criteria for inclusion of participants in the sample were therefore as follows:

- All children (boys and girls) whose parents died of AIDS-related diseases;
- Who live in Zamdela;
- Who are between the ages of 16 and18 years;
- Willing to participate in this study; and
- Whose guardians consented to their participation in this research study.

The area of Zamdela was considered because the researcher is working in the area as a social worker and is conversant with the social characteristics of the area and the large number of child headed households.

1.4.4 Method of data collection

Data collection, according to Neuman (2006:15), relates to the fourth step of the qualitative research process. Creswell (2007:118) argues that the purpose of data collection is to gather information in order to answer the emerging research question. Data collection is the process of gathering information in the field by the researcher. The research question guided the researcher on what data to collect. The researcher looked at the necessity of conducting a pilot study to test her interview guide and the research methods for the study in order to enable her to gather appropreate information.

- *Pilot study*

A pilot study is a specific pre-testing of research instruments, such as an interview guide which is done in preparation for full-scale use to see if the envisaged methods are valid in the practical research environment (Van Teijlingen & Hundley, 2001:1). It was important to carry out the pilot study in Zamdela where the researcher was to conduct the actual study.

- *Preparation for data collection*

In preparing participants for data collection, contact with the participants in their homes was considered. The purpose of this was to request the participants to take part in the research study. It is important for a researcher to ensure that participants feel comfortable to share their stories if a researcher is to create and maintain a relationship with the participants (Nziyane, 2010:26). The criteria for inclusion in this study were explained to the participants and it was necessary to point out to them that their participation would be voluntary and that they could withdraw at any time during the process if they so wished (Strydom in De Vos et al., 2005:59). Emphasis not to have have rights endangered was fully considered. The contents of the preamble to the consent form were explained to participants who agreed to take part in the study. A request to sign the consent form to indicate that they understood the contents of the letter was taken into consideration. Consent in cases where the participants who could not give permission because of their ages was obtained from their elder relatives, educators and or church leaders.

- *Method used for the purpose of data collection*

The researcher interviewed the AIDS-orphans heading households on a one-on-one basis in their homes in order to get a full understanding of their world. The first technique of the data collecting tool used in this study was interviews. Interviews, according to Greeff (in De Vos et al., 2005:287), are face-to-face conversations with the aim of understanding the world from the participants' point of view and to unfold their experiences. This was the direct way of obtaining information. Since the study was conducted with exploratory research in mind, semi-structured interviews were used.

Semi-structured interviews are structured in the sense that a list of pertinent issues for investigation is drawn up prior to the interview. Denzin and Lincoln (2000:649) state that the list of issues contains some precise questions and their alternates or sub-questions, depending on the answer to the main question. These authors continue by stating that semi-structured interviews help to clarify concepts and problems. They help to establish a list of possible answers or solutions which in turn, facilitates the construction of more highly, structured interviews. The researcher used an interview guide to ask her participants to broadly define their experiences and challenges in heading households in the urban area of Zamdela in the Free State (Bless et al., 2006:116). The following questions would be used in the interview guide:

1. When did you become head of the household?
2. How did you become head of the household? /What were the reason(s) for you becoming head of the household?
3. How has your life changed since you become head of the household?
4. How does it feel to be the head of the household at this stage?
5. How is it for you to be head of the household?
6. What are your responsibilities as head of the household?
7. What are the challenges that you experience in your role as the head of the household? /What makes it difficult for you to head the household?
8. How do you cope with/or address these challenges?
9. What support do you get as head of the household?
10. Who supports you?
11. What support do you think children who head households should get?
12. Who should support them?

The researcher considered the use of the following techniques and tips, as laid out by Greeff (in De Vos et al., 2005:288-289) and Creswell (1994:71-74):

- Let the participants do most of the talking, about 90%. The point is for the participants to tell their story.
- During all the interviews, purposively try to establish trust and build a rapport, and only ask questions related to the study.
- Carefully use listening skills through use of verbal cues to demonstrate her interest.
- Asked clear, brief questions and avoid leading questions.
- Conclude interviews with general questions such as “Is there anything further you feel is important?” to help the participants to express anything in their minds that was not included in the interview guide.
- Ende interviews at a reasonable time before the participants became bored.

1.4.5 Method of data analysis

Data analysis is a way of bringing order, structure and meaning to the data that the researcher has gathered in the field (De Vos in De Vos et al., 2005:333). The purpose of data analysis is to reduce data to a legible and interpretable form so that the relationships of the research problems can be studied and conclusions drawn. Qualitative data analysis would take place throughout the data collection process (Henning et al., 2006:127). After and during each interview session, the researcher would go through the interview guide and the recoded interviews and make further notes. The data will be presented as direct quotations.

For purposes of this study the eight steps for qualitative data analysis proposed by Tesch (in Creswell, 2009:189) will be considered.

1.5 CLARIFICATION OF KEY CONCEPTS

The following terms are diversely defined in the literature, but for the purpose of this study, the following definitions are used.

*Orphan***:** According to the Children’s Act, (Act No. 38) of 2005 (2006:18), an orphan is a child who has no surviving parent caring for him or her. UNAIDS (2002) estimates that 660 000 children in South Africa have become orphans due to HIV and AIDS. They define an AIDS orphan as a child, aged between 0 and 14 years of age

who has lost one or both parents to HIV and AIDS. Woldeyohannes (2010:16) refers to an orphan as a child under 18 years of age without parents. For the purpose of this study, an orphan is a child under the age of eighteen without any surviving parent due to having died from HIV and AIDS.

*Vulnerable children***:** All children who are at risk of neglect, abuse, extreme hunger or homelessness. This may apply to children who are already or who might soon become orphaned. It also includes children heading households because both parents have died due to AIDS or other causes. According to the policy and practice guidelines on protecting and supporting vulnerable children and orphans in their families and communities in South Africa by the Child and youth care agency for development (2004:4), vulnerable children are those children and young people between the ages of 0 and 21 years whose well-being and safety is affected by HIV and AIDS and poverty.

*Urban areas***:** Hornby (2006:1626) defines an urban area as connected to the town or city. There were anecdotal reports of urban child- or adolescent-headed households breaking up, with boys becoming street children or leaving to work on rural farms and girls taking up low-paid domestic work (Foster et al. in Tsegaye, 2007:9). This was due to the shortage of accommodation in urban areas, for instance in Zimbabwe. In this study, the researcher conducted her study in Zamdela an urban area connected to Sasolburg.

*Experience***:** According to Hornby (2006:513), experience is the knowledge and skill that is gain through doing something for a period of time. In this regard, the researcher investigated the know-how and the adjustments made or coping mechanisms of the AIDS-orphans had attained pertaining to their daily living.

*Challenge***:** This is a new or difficult task that tests one's ability and skill (Hornby, 2006:231). The researcher investigated the challenges or tasks that the AIDS-orphans had been faced with when becoming the head of the household.

*Coping***:** According to Hornby (2006:324), coping is dealing successfully with something difficult. The researcher sought to investigate how well the AIDSorphans had dealt with the burden of caring for their siblings and other household chores.

Resources: Hornby (2006:1244) defines resources as personal qualities such as courage and imagination. In this study resources are what helped AIDS-orphans heading households to deal with difficult situations in their day-to-day living.

AIDS: is an abbreviation for Acquired Immune Deficiency Syndrome which is a disease caused by the HIV virus. Mkhize (2006:18) argues that the AIDS pandemic is a major challenge that threatens the family unit. The loss of parents as a result of HIV and AIDS-related diseases has a negative effect on children, hence the establishment of child headed households. Maqoko (2006:5) argues that, prior to the AIDS epidemic, orphans were a common phenomenon. However, in the past, satisfactory solutions were found by society for the majority of the children. The difference now is that there is a great increase in the number of orphans because of HIV and AIDS (Ng'weshume, Boerma, Bennett & Schapink, 1997:347).

Child headed household: Nziyane (2010:63) defines a child headed household as a household in which a child under the age of eighteen years assumes the role of an adult caregiver in respect of the household and the siblings. Nziyane further asserts that this child is responsible for day-to-day decisions and there is no surviving parent to take care of them or an adult caregiver to give them guidance. Children heading households are not considered as children by their peers and other community members because they are playing the roles of adults, they are also not taken seriously by older community members because of their tender age (ACORD, 2001). Under these circumstances, where the biological age of the children conflicts with their social roles, they feel some sort of identity crisis and a sense of communal alienation (Tsegaye, 2007:15).

1.6 STRUCTURE OF THE REPORT

- *Chapter 1:*

This chapter serves as an introduction and general orientation to the research report. Specific focus is on the following: introduction and problem formulation, problem statement, rationale for the study, research question, goal and objectives, research approach and design, ethical considerations, clarification of key concepts and the content plan of the research.

- *Chapter 2:*

This chapter gives a detailed account of previous research and the literature used to motivate the study. It gives an insight into the theoretical framework that guided this research project.

- *Chapter 3:*

In this chapter the reader is given an insight into the methods and methodology used to gather data and how the collected data has been analyzed.

- *Chapter 4:*

The research findings are presented, discussed and compared and contrasted with existing literature related to the topic. .

- *Chapter 5:*

This chapter provides a summary of the research report, and outlines the overall conclusions and recommendations.

1.7 DISSEMINATION OF RESEARCH RESULTS

The research findings will be presented primarily in the form of a treatise. The findings will be presented in the form of a typed report to the participants in the research project. Other copies will be presented to the organisations which render services to AIDS-orphans in urban areas. And finally, an academic article will be prepared and submitted for review and possible publication in a professional journal.

1.8 CONCLUSION

The chapter above outlined the details of the study undertaken and how the study was carried out. This chapter looked at the rationale of the study, the problem statement, the objective of the study, the outline of the methodology used in the study, ethical considerations, clarification of key concepts and the chapter outline. The next chapter looked at the literature that was consulted in this study.

CHAPTER TWO
LITERATURE REVIEW ON THE CHILD HEADED FAMILIES AS A RESULT OF AIDS DEATHS

2.1 INTRODUCTION

In this chapter, the researcher reviews the literature on AIDS-orphans' experiences, challenges and coping resources in heading a household. In addition to this, literature written by other scholars on the subject of the experiences, challenges and coping resources of AIDS-orphans heading households is considered. In this context, AIDS-orphans refer to children between the age of sixteen and eighteen years heading households as a result of parental death due to HIV and AIDS-related illnesses. In most scenarios, these children may well have experienced the illness of a parent or parents due to HIV and AIDS in the process of their becoming responsible for the households.

Children are the future of any nation or any family. For these children to grow and become responsible members of the community, they must be guided, loved, respected, nurtured, supported and directed accordingly. Society decrees that children are to be raised in a family, either nuclear or extended, with adults in these families providing for the children's physical, physiological, psychological, social and emotional needs and ensuring that their rights are recognised, as stipulated in the South African Constitution. This is endorsed by the White Paper for Social Welfare (1997:15), which describes a family as "the basic unit of society that provides services to its members, especially those that need care, for example, the children". For that reason, society has put in place societal mechanisms, norms and standards that safeguard this institution (White Paper for Social Welfare, 1997). Therefore, it is every nation's primary goal to raise a responsible generation.

This literature review provides an extensive framework within which findings regarding the experiences, challenges and coping resources of AIDS-orphans heading households can be presented and discussed.

The following are covered in the literature review:

- The impact of HIV and AIDS on the community,

- The extent of child headed households,
- The experiences and challenges of children heading households,
- The rights of children, their needs and coping resources.

These factors will be reviewed as yardsticks in the research topic under study.

2.2 THE IMPACT OF HIV AND AIDS ON THE COMMUNITY

HIV has a major impact on individuals and on community structures such as the family, and the illness and death of an individual impact on these structures (Frohlich, 2010:373; Gow & Desmond, 2002:111). HIV infects the individual but the individual seldom lives as an island to him/herself. This individual dwells in a family and in a community of people. In the context of this study, the individual is a parent or the primary caregiver. In many African and Asian countries, the AIDS pandemic has changed the social structure of society with AIDS-orphans and children infected and affected by HIV and AIDS becoming more common (Lachman, Poblete, Ebigba, Nyandiya-Bundy, Bundy, Killian & Doek, 2002:590). Among the most devastating effects of the AIDS epidemic in Sub-Saharan Africa (SSA) is that it is orphaning generations of children, thereby jeopardising their rights and well-being as well as compromising the overall development prospects of their countries (UNICEF, 2010). In addition to this, instead of the country focusing on its economic growth, it is forced to look after its orphans' socio-economic needs and therefore its development prospects will be put on halt or slowed down.

In South Africa, the negative impact of HIV and AIDS has caused even more children not to receive proper care and attention from their parents. When these parents are frail, they are unable to give their children proper care and attention because they themselves are in dire need of such care and attention. At the end of the day, children and especially the elder siblings will be forced to play this role if there is no adult family member to fill the gap created by a sick and frail parent. Children always need parental love and guidance. Lack of parental love and guidance can result in children being disadvantaged, as in many cases; they will be harmed or damaged by neglect (National Action Committee for Children Affected by HIV and AIDS, 2007:19).

In the African context, as stated in The African Child Policy Forum discussion paper by Tsegaye (2007:2; NACCA, 2007:19; Germann, 2005:55), there is a saying that "It takes a village to raise a child" or "every child is my child". In other words, it is every community's primary goal to see to it that its children are well protected from harm and that it meets their basic needs. In the past, there was also no such thing as an orphan in Africa since children were always absorbed by the extended family or by the village community in cases where the extended family was unavailable (Germann, 2005:55; NACCA, 2007:19; Frohlich, 2010:384). This means that the community members would come together for the sake of protecting their children. This culture is currently diminishing as communities gradually move away from the sense of collectiveness and mutual aid. In contemporary communities, this role is taken over by welfare organisations which assist in looking after the rights of children. For instance, the home and community based care (HCBC) programme rendered by Child Welfare South Africa and funded by the Department of Social Development caters for the needs of the orphans and vulnerable children (OVC) and vulnerable households. The community caregivers do home visits to these vulnerable groups and render psychosocial support services and in worst scenarios immediately refer the case to the social worker who is in charge of the programme, who then further refers the matter to the relevant departments or stakeholders for appropriate interventions.

In order to survive and thrive, orphaned children and adolescents need to grow up in a family and community environment that provides for their changing needs (UNICEF/UNAIDS/USAID, 2004:13). Children need to be looked after, loved and protected in order to grow up healthy and with a healthy self-esteem. The nuclear and the extended family safety nets are responsible for the well-being of its members, especially the children and the elderly. However, as a result of the impact of poverty, armed conflict, family disintegration and most importantly the HIV and AIDS pandemic, this safety net is stretched to its limits (Foster, 2004:77). As a result of this, many children are orphaned because of the epidemic and so many are left at a young age and need alternative care, but fewer relatives are available due to the financial burden attached to adding a new member. This is confirmed by a large number of orphans left alone to care for themselves. As indicated by Van Dyk (2008:343), the existing pool of community-based support has become flooded as the number of children in need of care and protection becomes larger than the available number of

social workers and resources, thus leaving children to fend for themselves and to grow up overnight to become heads of households and breadwinners.

As indicated above, the family has traditionally been the fundamental unit of any society. It has been the most important institution of any society and ideally the primary point of provision to its members for care, nurturing and socialisation, affording them physical, economic, emotional, social, cultural and spiritual security. But, as the AIDS epidemic progresses, this structure is being steadily eroded (Frohlich, 2010:373-375; Foster, 2004:77; Foster, Makufa, Drew & Kralove 1997:156; Amber, 2005:202). The traditional absorption of orphans into the extended family is no longer possible, as already strained communities struggle to cope with the burden of the epidemic. These days, there are so many orphaned children and many able-bodied people have died who could have assisted them. Therefore, orphanhood becomes a common phenomenon which is no longer strange. This can be articulated to the life expectancy in many African countries which has decreased as a result of this AIDS pandemic, causing a reduction in the number of caregivers of optimum age (Germann, 2005:67). Therefore, the fewer who are alive cannot support them (UNICEF, 2003). This is confirmed by Freeman and Nkomo (2006:212) when alluding to the fact that there is emerging evidence that the capacity of the extended family to provide such care is experiencing strain and there is concern that the extended family cannot continue to absorb the full social, economic and psychological impacts of the epidemic.

In addition to this, UNICEF (2010) argues that, with the number of children who require protection and support soaring and an even larger number of adults falling sick with HIV and AIDS, many extended family networks have simply been weighed down. This has led to the development of a new household structure, which is the child headed household. Frohlich (2010:374) concurs with UNICEF by indicating that the impact of HIV and AIDS on society, family and community is complex. Thurman, Snider, Boris, Kalisa, Nyirazinyaye and Brown (2008:5) agree with this complexity and assert that the economic resources of extended families have been depleted to such an extent that they are unable to care for additional children, and as such, the role of household head in particular is undergoing a radical change. These burdens are

worsened by the stigma attached to this pandemic disease, which among others, prevents the affected from openly grieving the loss of their loved ones.

Frohlich (2010:373) estimates that there will be a rise to over five million AIDS-related deaths by 2014 in South Africa, making effective community response to this pandemic essential. Typically, half of all people with HIV become infected before they are aged 25, develop AIDS and die by the time they are 35, leaving behind a generation of children to be raised by their grandparents, other adult relatives or left on their own in child headed households (Subbarao, Mattimore & Plangermann, 2001:65). This eventually leads to the phenomenon of child headed households, as these orphans who witnessed their parents' death face the challenge of continuing with having to ensure their family sustenance (Tsegaye, 2007:2). In the process of striving to continue with family sustenance, the remaining children face a magnitude of challenges, for example the presence of disputes in the family before the death of the parent/s, (Germann, 2005:4), the trauma of witnessing their parent's health deteriorate in front of their eyes, watching them die and eventually being left alone with no visible means of support. This may be aggravated by the poverty situation they live in, resulting in damage to their cognitive and emotional development.

2.3 THE EXTENT OF CHILD HEADED HOUSEHOLDS

The HIV and AIDS epidemic, although it started relatively late in Southern Africa, has been volatile, reaching prevalence rates of above 30% in some countries such as Botswana and Swaziland. In 1998, a study by the South African Ministry of Health suggested that by 2005 between 197 000 and 250 000 children would be orphaned in KwaZulu Natal alone. These figures were expected to grow if something is not done. At the end of 2001, 11 million of children in Sub-Saharan Africa were orphaned due to HIV and AIDS, nearly 80% of the world's total population (UNICEF, 2003). The figure was expected to grow to 20 million by 2010. In South Africa, for example, based on the calculation of data given in Children on the Brink (UNAIDS, UNICEF & USAID 2004), the estimated number of child headed households represents 7% of orphans but doubles to 14% of AIDS-orphans. In Rwanda, the 4% of estimated child headed households make up 8% of orphans but 41% of AIDS-orphans.

Tsegaye (2007) comments that the first reports of large numbers of child headed households appeared in the early nineties in Uganda and later on in Tanzania, Zambia and Zimbabwe, where HIV and AIDS epidemics started to develop. The problem later seemed to permeate nearly all countries of the continent, including South Africa. Below are the global estimates indicating the rapid increase in the child headed household phenomenon, as stated by Tsegaye (2007):

- In Eritrea, there were some 3 000 street children counted as child headed households in 2001.
- Burundi counted an estimated number of 20 500 unaccompanied children in 2001.
- A 2005 Food Security and Livelihoods Survey in the central highlands of Angola found 2% of households headed by children
- In 1997, 3% of households in Zimbabwe were headed by children who were 18 years and below.
- In Zambia, 7% of households in 1998 were headed by children.
- An estimated number of 2.5 million children were AIDS orphaned in South Africa in 2012 (UNAIDS, 2013)

According to UNAIDS (2006) survey the following number of orphans were reported in Africa:

- South Africa – 1 200 000 estimated number of orphans
- Tanzania – 1 100 000 estimated number of orphans.
- Zimbabwe – 1 100 000 estimated number or orphans.
- Kenya – 1 100 000 estimated number or orphans.
- Uganda – 1 000 000 estimated number of orphans.
- Nigeria – 930 000 estimated number of orphans.
- Zambia – 710 estimated number of orphans.
- Democratic Republic of Congo – 680 000 estimated number of orphans.
- Malawi – 550 000 estimated number of orphans.

(UNAIDS, 2006).

In 2012, the Global Report (UNAIDS, 2012) notes that “Sub-Saharan Africa remains the most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV

and accounting for 69% of the people living with HIV worldwide" (UNAIDS, 2012:8). On the other hand, the 2013 UNAIDS report estimated that, in 2012, 35.3 million people globally were living with HIV, with 2.3 million people becoming newly infected with HIV and 1.6 million people dying from AIDS-related illness (UNAIDS, 2013). In addition to this, in Sub-Saharan African in 2012 a total of 25 million people were living with HIV and AIDS of which 2.9 million were children.

An estimated number of 2.5 million children were AIDS orphaned in South Africa in 2012 (UNAIDS, 2013). According to Walker, Reid and Cornell (cited in Dlungwana, 2007:13) it is estimated that by 2015 almost 12% of South African children will be orphaned as a result of HIV and AIDS-related deaths. They further argue that South Africa is seeing increasing numbers of children in distress, a situation made worse by the collapse of the traditional models of child care such as the extended family. In research conducted by UNISA's Department of Health Studies, Department of Development Studies, Department of Social Work, Bureau of Market Research and Unit of Social Behaviour Studies: HIV and AIDS and Health (2008:22-23), the following was reported:

- Many of the child headed households were found in the deep rural areas and urban informal areas.
- Many (66.0%) of the households conducted were headed by females who had dropped out of school, who were unemployed and had a child of their own.
- The youth (20-34 years) comprised of the majority (52.1%) of children heading households.
- On average, each household had four members, mostly siblings and own children (21.3%).

These figures are supported by Law (2009:1-2) in his briefing paper 209 on child headed households when he states that the available data suggests that 52% of child headed households are headed by youth over the age of 17, 36% by children aged 15-17, 11% by children between the ages of 10 and 14 and 9% by children under the age of 10. However, Law argues that there are no reliable statistics as to the number of child headed households in South Africa. He adds that such households are primarily headed by female children, 13% of these children obtained a grade 12 or matric

certificate and 49%, at the time of the study, were attending school whilst the remainder was not attending school.

The above statistics indicate the seriousness of the problem and pose a number of questions as to how these children cope, the challenges they face, and what resources they have at their disposal to deal with the vulnerable position in which they find themselves. The extent of vulnerability faced by AIDS-orphans depends on many factors: whether they have been infected themselves, whether they have relatives willing to foster them, whether these relatives have the resources to care for them, whether they are allowed to go to school, how they are treated within the home and community, what degree of psychosocial trauma they have suffered and what responsibilities they are left with, to mention but a few (Subbarao et al., 2001:3).

2.4 EXPERIENCES AND CHALLENGES FACED BY AIDS-ORPHANS HEADING HOUSEHOLDS

Child headed households are a reality in Sub-Saharan Africa. Children live in poverty, without enough food, families are falling apart and many parents are absent, if not dead. Most children live with grandparents or even on their own. These children head a household and have to do the chores that adults do while they are still young (NACCA, 2007:47; Foster, 2004:70). In many instances, when parents are sick for a long time before dying due to AIDS related illness, children feel sad and confused and are under stress, knowing that they may have to become responsible for running the house, cooking and cleaning and bathing their siblings. Therefore, children often have to fill this gap created by their sick parents (Gow & Desmond, 2002:113). Because of this responsibility, their childhood is stolen from them early in their lives. Safety nets are stretched to their limits with some children slipping through the extended family safety net and ending up in a variety of extremely vulnerable situations. These include living and working on the streets, substance abuse, working for others in low-paid domestic or agricultural settings, or living by themselves with their brothers and sisters in child headed households (Foster, 2004:70).

Foster (cited in Tsegaye, 2007) asserts that children start carrying the burden of heading households even before the death of their parents. Therefore, the child prepares him/herself for the duty of looking after the other siblings and running the

household. Woldeyohannes (2010:29) alludes to the emptiness created by the parent's death which swiftens the eldest child taking over the responsibility of all household chores and the task of earning an income. Such children undoubtedly are forced to look after themselves, drop out of school, becoming vulnerable to many forms of abuse and having to look for work in order to care for their siblings (Van Dyk, 2008:343). These elder children will be left with no choice but to head the family since no other older family member is available to look after them or their sick parent.

Generally, children who lose their mothers suffer massive grief over the loss of love and nurturing that mothers normally give, and children who lose their fathers suffer from a decline in their standard of living, as the death of a father typically entails the loss of income for the household, especially if the father was the only breadwinner (Subbarao et al., 2001:3). For example, in the past, men were the only ones who were allowed to work and would temporarily migrate to cities for work leaving their wives and children in the villages and therefore they were the sole breadwinners. Economic deprivation forces the head of the household to look for a low paying job or resorting to criminal activities to generate income to sustain such households. In other words, AIDS-orphans heading households will at times end up suffering from fear, depression, stress, anxiety, stigmatization, discrimination, isolation, and disrespect from peers (Salaam 2005:15). Children need motherly love and affection and this is compromised when it comes to AIDS-orphans who are heading households who in turn provide love and affection to their younger siblings. The question is who will provide such motherly love and nurturing to them and how do they cope with this need?

Apart from the loss of love and affection, Hepburn (2002:89) asserts that poverty is the primary barrier to caring for orphans, locally and nationally. She explains that without adequate resources to feed, clothe, and offer counselling the basic needs of such children will continue to be unmet. For example, children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes (Salaam, 2005:16). Salaam (2005:18) furthers asserts that property grabbing, a practice where relatives of the deceased come and claim the land and other property is reportedly a serious problem for child headed households, especially in poor communities where the parents rarely draw up a will before they die or fail to

assign a guardian to look after their children if they die. This practice is still prevalent in some parts of the rural areas in Zimbabwe, whereby when a relative dies, extended family members soon after burying him/her will distribute his/her wealth and possessions, including livestock and property amongst themselves. This practice is commonly known as *"kugova nhaka"* in Shona. This is commonly done instead of the *"kugara nhaka"* which is to remarry the deceased's surviving partner which is seemingly now no longer practised for fear of the AIDS pandemic.

Traditional law in many rural areas dictates that women and children cannot inherit property and property grabbing has a number of negative consequences, particularly for girls (UNISA research report, 2008:33). Girls may, as a result of this, experience sexual abuse and exploitation from their new caretakers; they may be forced into the sex trade in exchange for shelter and protection, further increasing the risk of contracting HIV.

The economic and social effects of HIV infection and AIDS on children include malnutrition, migration, homelessness and reduced access to education and health care. The situation of children living in child headed households is often perilous in that they are exposed to the mentioned factors. Child heads often drop out of school for lack of school fees, money to buy books and uniforms and, sometimes stigma. Many must work hard to feed and educate their younger siblings, while younger children may be forced to labour in domestic or agricultural chores once carried out by adults. Girls may feel their family's situation might improve if they were married, which may result in teenage motherhood and being forced to choose between their family and their husband if he rejects their younger siblings.

Children living in child headed households thus face problems that are common to other vulnerable children living in destitute households, such as role adjustment, migration, emotional and social distress, lack of education, food insecurity, socio-economic deprivation and property deprivation. In the next section these experiences and challenges faced by children living in child headed households and how these impact on their lives in terms of literature review are discussed.

2.4.1 Role adjustment

Heading a household is generally the responsibility of parents or mature adult caregivers. In the HIV and AIDS generation, this role is now being performed by children below the age of eighteen. This is so because of the AIDS pandemic which is robbing children of their childhood. These children are being deprived of their childhood and forced to take on adult roles (NACCA, 2007:47). Following the death of their parents, the eldest sibling in the family must make the adjustment of being a child to being the head of a household (Van Dyk, 2012:359). Such adjustments carry many challenges, such as the feeling of having lost one's childhood and a sense of self accompanied by feelings of deprivation, of responsibility towards younger siblings and the obligation to take the place of the deceased parents.

Masondo (2006:44) alludes to the fact that orphaned heads of households are often faced with the situation where they have to take decisions on behalf of their siblings. For instance, they are challenged with the decision of what to eat daily. The younger siblings at times look up to the elder sibling heading the household for solutions when problems arise. They also have to deal with the management of conflict, especially between siblings. This poses a serious challenge for them.

2.4.2 Migration

Human migration involves the movement of people between two places for a certain period of time (Conway, 2010:1891). Parry (2007:566) alludes to migration asbeing the process by which individuals, families and groups of people move from one country of residence to work or settle in another. Migration in general is the movement of people from one place or state to another in search of a better life. AIDS-orphans might find themselves in the predicament of moving from one household or community to another, particularly in the absence of another capable adult in the household, due to financial constraints (Nkomo, 2006:28). This type of migration is described by Conway (2010:1893) as involuntary migration as the decision is not their choice. Nkomo further asserts that, when the new environment is unsupportive, unaccommodating and uncomfortable for these children it complicates their grieving and adjustment process. At times, conditions force them to move from one area to another in search of family to care for them. This places them in strange or non-supportive environments where they may need to adjust to the host family, make

new friends, and learn the culture and norms of a new community in a new geographic area. In other instances, they may migrate to other areas because they fear being separated from each other, and therefore prefer to live in a child headed household for fear of being treated as a second class family in the extended family (Nkomo, 2006:28: Frohlich, 2010:376). Foster et al. (1997:164) state that at times, children wish to stay as one family rather than being split up among different relatives or desire to stay at their own residence in familiar surroundings.

2.4.3 Emotional and social distress

Heading a household at a tender age comes with pain and sorrow as these children will be still grieving their lost parents and at times in so doing isolate themselves from their peers. AIDS-orphans are exposed to a number of stressors which may compound and complicate the grieving process. The stigma attached to HIV and AIDS is a major obstruction to people affected, in this case the AIDS-orphans, and the infected to be able to speak openly without limitations about the multitude of feelings, fears and concerns the disease provokes (Frohlich, 2010:388). They may have cared for and witnessed the death of parent/s with a debilitating illness, loss of bodily functions, and sometimes AIDS-related mental illness. The impact of witnessing these stressors gives rise to psychological trauma which, in turn, results in the loss of self and emotional balance. Emotional pain among children affected by HIV and AIDS may be at its climax during the periods of intense parental illness. The household at this stage is still struggling with the meaning and consequences of a parent's HIV status. A significant adjustment, both psychologically and physically, is required when it comes to the parent's HIV diagnosis which is very stressful for the affected children (Nkomo, 2006:19).

In addition to this, children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer emotional neglect long before they are orphaned. Ultimately, they may suffer the death of their parents and the resultant emotional trauma. They are forced to adjust to the new situation in this case, at times with little or no support and may at times suffer exploitation and abuse. Therefore, the parent's illness coupled with being forced to take over household responsibilities, affects the children's mental well-being in one way or the other. Moffett (2007:7) confirms this when stating that children heading households

experience various psychological stressors related to the environments in which they live, illness or death of their parents, whilst other impacts are directly related to being the head of the household.

2.4.4 Education

Education is valued around the world as a means of promoting individual advancement and well-being; for its potential to encourage economic growth and employment; empowering women and minority groups; and reducing infant and child mortality rates (Blum, 2007:543). Basic education for AIDS-orphans may become a dream at times when they are forced to drop out of school and become heads of households. Children, after witnessing the illness of their parents, are at times forced to drop out of school if there is no other adult family member taking care of their sick parents or taking care of them after the death of a parent (Frohlich, 2010:374). A higher number of school dropouts was found amongst girls because it is normally the girl child who is expected to take over the household responsibility and accountability of caring for her siblings and sick parents (Maqoko, 2006:36). If they remain in school, they are bound to neglect their homework and are at times forced to skip extracurricular activities, so important to their stage of development. Over time, they eventually drop out of school thereby missing the opportunity for tertiary education. (Van Dyk, 2012:349; Gow & Desmond, 2002:112). This might be the beginning of further misery in that the girl child may seek solace in early marriage with the hope that the husband will take up their burden.

At times, children drop out of school because of the stigma attached to their parents' cause of death. For those who manage to stay in school, they often have to endure the stigma and ostracism resulting from the rumour or suspicion on the part of both pupils and/or staff that their parents are or were HIV positive or indeed have died of AIDS. The plight is even worse for those children who are themselves HIV-positive. Therefore, AIDS-orphans are less likely to have proper schooling (Barnett & Whiteside, 2006:220; Van Dyk, 2012:359).

2.4.5 Food security

Food is the most important and immediate basic need for survival. Food security, as defined by the World Food Summit of 1996, is "when people at all times have access

to sufficient, safe, nutritious food to maintain a healthy and active life." Usually, the concept of food security includes both physical and economic access to food that meets people's dietary needs and preferences (Grover, 2011:188). AIDS-orphans experience hardships when it comes to food security because they may be unable to meet their minimum food requirements over a sustained period of time. This is related to issues of low income and continuing poverty (Grover, 2011:188). Most of the AIDS-orphans experience food insecurities on a daily basis because of insufficient funds. At all levels, from family to government, lack of funds, in its worst form, poverty, makes the economic burden of caring for orphans frequently close to unbearable and at other times impossible. In fact, it has been observed that poverty and HIV and AIDS reinforce each other (Maeda in Lachman et al., 2002:599). Nkomo (2006:23) elaborates that the reduced access to food manifests in a number of ways such as lack of proper and nutritious diet and also insufficient daily meals.

According to the Nelson Mandela Children's Fund Report (2001: 26), many of the children are helpless and unable to think of ways of fending for themselves or coping with the uncertainty of where the next meal will come from. Young siblings tend to look up to the child heading the household "to make a plan", especially in respect of providing the meals. This puts a great deal of pressure on the child heading the family.

Children's essential needs include food, clothing, a safe home environment, basic household amenities and cleanliness (Smart, 2003:182-183; Masondo, 2006:45). In the case of OVC, children are deprived of a family home, the buying and production of food, monetary income, basic clothing, and physical health (Van Dyk, 2005:274). This may compel children to resort to begging from their neighbours or in the streets.

2.4.6 Socio-economic deprivation

As a result of the HIV and AIDS impact on the household economy, poverty is likely to deepen as the epidemic takes its course. The AIDS-orphans are at most economically disadvantaged and may be incapacitated for life. As the epidemic cheats families and communities of members of the working age group, in a context marked by weak or non-existent social safety nets, large networks of dependants may lose economic support (De Jong, 2003:5). Children usually drop out of school as they

become involved in income-generation activities (Nkomo, 2006:16). They are at times forced to sell their belongings to pay the medical bills of the sick parent and by the time the parent dies, they are left with close to nothing to economically sustain themselves. Loss of parental income and changes in the family economy often spiral down into poverty and deprivation (Van Dyk, 2012:360). This creates a vicious cycle of poverty. In some instances, girls will be forced into prostitution in order to earn a living for the younger siblings. Others may be left with no option but to take up low paying jobs, such as domestic work. Equally, boys also may drop out of school to take up low paying odd jobs, since they are unqualified for better paying jobs.

In support of the above statements, Simfukwe (2003:22) asserts that when the parent or caregiver becomes ill, the situation may be so serious that they are forced to renounce their jobs and this negatively impacts on the household income. Thereby, this marks the beginning of the vicious cycle of poverty.

2.4.7 Property deprivation

Shelter is referred to by Nekundi (2007:23) as a home where children feel comfortable, happy and safe and is one of the most imperative factors in the development of a child. It is a basic necessity for all humans. Children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes which their parents left for them. Van Dyk (2012:356) argues that, children often lose their rights to the family land or property after the death of their biological parents. Insufficient legal protection may result in unjust property rights, thus depriving them of the inheritance to which they are entitled (De Jong, 2003:6). Children generally have a right to own possessions or money left to them by their dead relatives. However, in some cultures, children's inheritances are taken away from them (NACCA, 2007:20). Relatives may move in and often take advantage of the vulnerable children by taking their possessions and property and at the same time failing to provide any form of support for them. This act eventually exacerbates their vulnerability. Children in urban areas who live in rented property may face eviction from the property they grew up in. They may subsequently relocate to rural areas or informal settlement (*mokhukhu)* areas where they find dodgy means of survival such as stealing, living on the streets, abuse of drugs, etcetera.

2.5 THE RIGHTS OF CHILDREN

A discussion of children's rights in an HIV and AIDS-dominated era is presented next, proving that notwithstanding the said rights, vulnerable children's rights are sometimes violated.

Children's rights are of paramount importance. A child is a full and complete person like any adult person, but a potentially vulnerable one whose personhood is special and who is entitled to special protections because of the fact that he or she is a child. According to Mkhize (2006), it is asserted that children's rights are important in the sense that they aim at ensuring that, through provision of services, children's needs are met and they therefore do not fall through the cracks.

In 1989, a decade after the international Year of the Child, the United Nations General Assembly adopted the Convention on the Rights of the Child (CRC) which sets out the political, civil, cultural, economic and social rights of children. All of the countries in the world, except for the United States of America (USA) and Somalia ratified it a decade later (Smart, 2003:178). The South African government became a signatory to the CRC in 1995, therefore it is legally bound to comply with the rules as set out by the convention (Van Dyk, 2012:357). The CRC guarantees the rights of the children to the following:

- Non-discrimination. Children should be treated equally and unconditionally no matter what their current situation is. Children from child headed households must not be ostracized because of their parents' cause of death. All children, irrespective of their race, gender, age and culture must receive equal and fair services from government and institutions. They are all entitled to equal access of services.

- The best interest of the child. In all policies and decisions regarding children, the well-being of the child should be the primary consideration. If children, especially those in child headed households, decide to stay together in the child headed household, whoever is willing to assist them must respect their decision as long as it is in their best interest. Some of them prefer to stick together in order to maintain their deceased parents' house and for fear

of separation. At times it is very challenging to decide what a child's best interests are, as one often has to weigh up various issues very carefully. These may include the child's right to socialise, to live a normal life, to be healthy, to develop with other children and also to consider what the child wants or prefers.

- The right to life, survival and development. All children have an inherent right to life, survival and development. The government must assist children in child headed households who are struggling to meet their basic needs especially food, shelter, clothing, education and health, to mention but a few. Children must grow up in an environment that enables their survival and development. This environment must be sufficiently conducive to meet all their basic needs for survival and growth. This, in the world of AIDS-orphans heading households is often impossible.

- Respect for the views of the child. The views of children should be respected and taken into account in all decisions concerning them. People must respect the decisions of children heading households and guide them in a constructive way if they are wrong.

Looking at the above challenges faced by orphaned children, it seemingly becomes evident that children's rights are not taken seriously in South Africa.

2.6 CHILDREN'S NEEDS

Children have needs like any adult person. They deserve the best possible start in life, to be raised in a conducive environment, listened to and heard and to be given every opportunity to achieve and develop to their full potential. For children to enjoy life, develop to their full potential, develop into participating and contributing adults, their physical, emotional, social and intellectual needs must be met (Smart, 2003:180; Van Dyk, 2012:358; Save the Children, 2007). If these needs are not met, this might hinder children's development and these needs are the key to realizing children's rights. In addition to this, Smart (2003:180-181) asserts that the needs of orphans go further than physical and material needs. Their needs include food security, housing,

clothing and bedding, health care, education and income generation, parenting, friends and recreation, non-discrimination and legal protection.

Children's needs can be classified into different categories namely, subsistence, protection, affection, understanding, participation, leisure, creation, identity, freedom and transcendence (Van Dyk, 2012:358). Van Dyk further states that in all of these categories, each need occurs at four different levels of activity that is, of being, having, doing and interacting.

2.6.1 Protection

Children need to be protected against discrimination, stigmatization, abuse and neglect. Child headed households are exposed to all forms of abuse mainly because the family environment that used to protect them as a safety net has been eroded. At times, when AIDS-orphans are placed in the care of other extended family members, they do not feel the same as they used to with their own biological parents. These extended family members may utilize everything to their advantage and not in the best interest of the orphaned children. However, these orphaned children also need parental control, social security and protection from stigmatization. The AIDS impact deprives children of this right (Van Dyk, 2005:274; Van Dyk, 2012:316).

2.6.2 Affection

Children need a caring, constant and reliable adult presence who offers security and continuity and with whom the child can communicate openly. They also need a stable, dependable and loving adult caregiver with a positive communication style, which includes being there for the child, taking time to listen and communicate at the child's level (Smart, 2003:183). Children also need the extended family and familial support and love, unconditional love, friendship and peer intimacy and safe space for experimentation with expression of emotions (Van Dyk, 2005:274; Van Dyk, 2012:361). As a result of the AIDS epidemic, the extended family safety nets are stretched to their limit. Extended family members are failing to cope with the number of orphans who need their affection and therefore they will be left alone to provide affection on their own. The absence of parental affection in child headed households may foster feelings of isolation, expressions of resentment and aggression, low self-

esteem and anti-social and risk behaviors. Children may well tend to turn to the wrong people or places to seek this need for affection.

2.6.3 Participation and Freedom

Children have a right to experience and express freedom as long as it does not infringe the freedom of others. Article 12 of the (CRC) states that children have the right to participate in decision-making processes that may be relevant to their lives and to influence decisions taken in their regard within the family, the school or the community. This principle affirms that children are fully-fledged persons who have the right to express their views in all matters affecting them and requires that those views be heard and given due consideration, in accordance with the child's age and maturity. Therefore, the government must honour this right by granting children their appropriate status in their families, schools and communities. In the context of AIDS-orphans, the children heading a household should be recognized as citizens and actors of change. In addition to this, the government must allow children to experience and express their independence (Van Dyk, 2005:275; Van Dyk, 2012:362). Children heading households should not feel that they are coerced or constrained in ways that might prevent them from freely expressing their opinions or leave them feeling manipulated. Children need time and opportunities to question and discuss values, ethics and morals and to be able to freely seek information and express their ideas

2.7 COPING RESOURCES OF AIDS-ORPHANS HEADING HOUSEHOLDS

The first line of support for vulnerable children is their family, including the extended family, while households that struggle to meet the needs of vulnerable children may be assisted by members of their community. These informal safety net mechanisms are responsible for the care and support of the majority of vulnerable children in Southern Africa. Formal mechanisms, such as those provided by government and civil society, also provide services, especially for children living in situations of extreme vulnerability (Foster, 2004:65).

Where family and community networks fail, become overburdened, or require supplementing, the state is often the final port of call. In this regard, there are many mechanisms by which governments can improve the situation of children made vulnerable by HIV and AIDS. These include supporting families through the

provision of access to basic services such as free basic education, good health care and community development programmes, as well as direct support initiatives such as feeding schemes and the provision of grants (Foster, 2004:79).

South Africa has one of the most well-developed statutory social support schemes in Africa. The Social Assistance Act (Act No. 13) of 2004 serves to provide the rendering of social assistance to persons who are unable to support themselves and their dependants. Family and child benefits in South Africa currently include the following:

- *Child Support Grant (CSG)* which currently targets children under the age of 18. The grant is paid to the primary caregiver of the child in order to provide for the concerned child's basic needs (NACCA, 2007:78). The grant is means tested and caregivers are eligible for a grant of R290 per month. Child heads are eligible to apply for this grant but only for their younger siblings. They are disadvantaged themselves because in temrs of the Social Assistance Act (Act No. 13) of 2004, the child head cannot receive a grant for him/herself.

- *Foster Care Grant (FCG)* for children placed in foster care. This grant amounts to R800 per month and only children placed in foster care by a court of law are eligible to receive it. When a child is orphaned, abandoned, at risk, abused or neglected, he or she can be regarded as a child in need of care and protection according to Section 150 of the Children's Act (Act No. 38) of 2005 and will be placed in foster care by a court order. Anyone who is not a biological parent of the concerned child can apply to be a foster parent (NACCA, 2007:80). The researcher once placed children in foster care with their biological brother who had just turned eighteen years old, a month before the finalization of the children's court inquiry. This placement was a child headed household as described in Section 137(1) of the Children's Act (Act No. 38) of 2005.

- *Care Dependency Grant (CDG)* for children with severe mental or physical disabilities who require permanent home care. Parents, foster parents or

caregivers appointed as such in terms of a court order can apply for this grant. The grant is means tested and amounts to a sum of R1 260 per month. There is no specific provision for children with chronic illnesses such as HIV and AIDS and relatively few children in the terminal stages of the virus have managed to access this care dependency grant.

In addition to these grants, the South African government has put in place Social Relief of Distress measures, which take the form of temporary assistance — in cash or food — for people in need of immediate help to survive. The monetary amount or equivalent of such relief is less than the monthly value of the grants received by the household and is only given to households for a period of up to three months (Foster, 2004:80).

Many eligible children and households do not receive grants, either because they are unaware of their entitlement or lack the documentation, time and resources necessary to access the social support system. Administrative delays in processing grant applications, as well as the poor attitude of some administrative personnel, also often deny families the grants to which they are entitled under South African law.

Foster (2005:19) describes that in Malawi, children deployed a range of coping strategies, including dropping out of school, seeking paid work to meet their basic needs, and seeking help and support from their own peer networks, neighbours and other families outside of their household for specific needs. When hungry, children wandered from house to house throughout the community in the hope that someone would take pity on them and give them food. Others shared tasks in the household with supportive or kind children in order to reduce their workload.

According to Simfukwe (2003:40), it is argued that some households came up with strategies aimed at improving food security by reducing their food consumption; substituting their food with cheaper alternatives, relying on wild foods and, when the worst comes to the worst, resorting to begging. In addition to this, the family may relocate to cheaper accommodation in order to survive or migrate from rural areas to urban areas in search of jobs. In Uganda, family members will opt to migrate to the

rural areas where most of the extended members are. This situation is also seemingly similar in Zimbabwe.

2.8 CONCLUSION

In this Chapter, the relevant literature was reviewed to provide in-depth information regarding the topic under investigation, namely the experiences, challenges and coping resources of AIDS-orphans heading households. The literature reviewed the impact of HIV and AIDS on the community, the extent of child headed households, the experiences and, challenges of children heading households, the rights of children, their needs and coping resources. In the following chapter, the researcher discusses the methodology of the research used in this particular study.

CHAPTER THREE

APPLICATION OF THE QUALITATIVE RESEARCH PROCESS

3.1 INTRODUCTION

This chapter deals basically with the methodological requirements of the research. It covers how the research was undertaken in a bid to investigate the experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in the Free State province. The research instruments for data collection are discussed in this chapter. Research procedures: sampling, the pilot study, data collection, data analysis, data verification and ethical procedures are discussed in detail. .

According to Babbie and Mouton (2001:75), research methodology focuses on the kinds of tools and procedures used in a study. These tools and procedures include the design, sampling, data collection and data analysis methods. Henning, Van Rensburg and Smit (2004:36) argue that, methodology refers to the rational group of methods that complement each other in order to deliver data and findings that reflect the research question and suit the research purpose. The research methodology that the researcher applied in this study is discussed next.

3.2 QUALITATIVE RESEARCH APPROACH

A qualitative research approach can best be used when some kinds of information cannot be adequately recorded using quantitative data (Bless et al., 2006:44). These authors further argue that language provides a far more sensitive and meaningful way of recording human experiences. In this study, the researcher investigated the experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in the Free State province. As compared to the quantitative research approach that has a step-by-step plan or a fixed recipe to follow, the qualitative approach is more flexible wherein the researcher's choices and actions determine the strategy (Fouché in De Vos, Strydom, Fouché & Delport, 2005:269). This assisted the researcher during the research process to create the strategy best suited for her study. The researcher concluded that the qualitative research approach was appropriate for

the study because of the following characteristics of the approach as spelled out by Creswell (2009: 176):

- Qualitative research takes place in a natural setting. Therefore, the researcher collected data in the field where the participants under study experience their challenges and coping resources in heading households. The researcher went to her participants' homes in Zamdela and collected data from them in their own homes.
- In qualitative research, the researcher is the instrument in the process of data collection. The researcher carried out the interviews herself. In addition to this, the researcher was involved in field work where she had physical contact with her participants in their homes for the purpose of data collection.
- Multiple sources of data are employed for the purpose of data collection. Qualitative researchers typically gather multiple forms of data, such as interviews, observations, and documents, rather than rely on single data sources. The researcher, during her field work process, used face-to-face interviews with her participants. She also took note of the non-verbal cues that she observed during the interview sessions and at times probed for more information. She had a notebook in which she recorded her interviews since most of her participants refused to be tape recorded as it made them feel uncomfortable.
- An inductive approach to data analysis is followed in qualitative research. Researchers build their patterns, categories, and themes from the bottom up, by organizing the data into increasingly more abstract units of information. This inductive process entails working back and forth between the themes and database until the researchers have established a comprehensive set of themes. It may involve collaborating with the participants interactively, so that participants have a chance to shape the theme or abstractions that emerge from the process.
- Participants' meanings are central in qualitative research. Therefore, the researcher in this case kept her focus on learning the meaning that the participants hold about their experiences, challenges and coping resources as

heads of households, not the meaning the researcher brought to the research or that writers express in the literature.

- In qualitative research an emergent design is preferred. This means that the initial plan for the research cannot be tightly prescribed, and all phases of the process may change or shift after the researcher enters the field and begins to collect data. For instance, the questions at times changed the form of data collection as time shifted, and the individuals studied and sites visited were sometimes modified. The key idea behind qualitative research is to learn about the problem or issue from participants and to address the research to obtain that information.
- Qualitative researchers often use a lens to view their studies, such as the concept of culture, central to ethnography, or gendered, racial, or class differences from the theoretical orientations discussed. This study was organized around identifying the social, political, and historical context of the problem under study.
- Qualitative research is interpretive: a form of interpretive inquiry in which researchers make an interpretation based on what they saw, heard and understood. Their interpretation cannot be separated from their own backgrounds, history, contexts and prior understanding. After a research report is issued, the readers make an interpretation as well as the participants, offering yet other interpretations of the study. With the readers, the participants, and the researchers all making interpretations, it is apparent how multiple views of the problem can emerge.
- Qualitative research provides a holistic account of the topic investigated. The researcher tried try to develop a complex picture of the problem under study. This involved reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges.

In view of the aforementioned characteristics inherent in the qualitative approach and the fact that qualitative research concerns itself with the study of people in their natural environment as they go about their daily lives and by trying to understand how people live, the researcher concluded that this approach was well suited to realize the g oal of the study.

3.3 RESEARCH DESIGN

From this qualitative stance, the researcher worked towards an understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in Free State. Within the qualitative approach, the research designs used are explained.

A research design entails the researcher's overall plan or logical structure that guides the investigator to address research problems and answer research questions (Babbie & Mouton, 2001:74; DeForge, 2010:1253). Burns and Grove (2001:223) assert that, for a researcher to attain the intended goal, one must be guided by the design in planning and implementing the study. This overall plan entails what the research question should be, what data will be required to answer it, from whom the data will be obtained and how best to gather the data. From another perspective, Babbie and Mouton (2001:74) attest that research design is a plan or a blueprint of how one intends conducting the research. Bless and Higson-Smith (1999:63) are of the opinion that a research design can be regarded as the preparation to guide the researcher in collecting, analyzing and interpreting observed and collected data. For the purposes of this study, exploratory, descriptive and contextual designs were used.

The essence of using the qualitative phase which embodies an exploratory, descriptive and contextual design is "the idea of acquiring an 'inside understanding of the actors definitions of the situation", which according to Schwart (2001:102) is the central concept for understanding the purpose of qualitative inquiry. In the following section, each of the designs is explained in detail:

3.3.1. Exploratory research design

Babbie (2007:88-89) explains that an exploratory design is appropriate when a researcher examines a new phenomenon about which little is known in order to generate a foundation of general ideas which can be explored in greater depth at a later stage. This opinion is also supported by Neuman (2006:33-34) who indicates that exploratory design is when researchers seek to examine a new topic or phenomenon about which little is known in order to generate more precise research questions for future research. The need for such a study could arise out of a lack of basic information on a new area of interest or in order to become acquainted with a

situation in order to formulate a problem or hypothesis. Brink (2006: 202) states that exploratory research is conducted when little is known about the phenomenon that is being studied. In view of the fact that not much is known about the research topic, the researcher envisaged using the explorative design for the purpose of exploring the experiences, and coping resources of children heading households. Mkhize (2006:26) acknowledges that the child headed household (CHH) phenomenon is relatively new, particularly in South Africa. However, various studies have been conducted on the subject of CHH but no empirical evidence on the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela is available. Therefore, it is at this juncture that this study sought to explore and understand the life experiences, challenges and coping resources of AIDS-orphans who are heading households in Zamdela in an attempt to inform future planning, policies and interventions in this regard.

3.3.2 Descriptive research design

This type of design presents a picture of specific details of a situation, social setting or relationship, and focuses on why and how things happen. Descriptive research design is used in studies where information is required in a particular field through the provision of a picture of the phenomenon as it occurs naturally (Brink, 2006: 102). Yegidis and Weinbach (2002:109) state that descriptive designs usually follow exploratory designs in the sense that they aim at measuring and describing the variables that were identified through exploratory research. Descriptive designs enable researchers to gain a better understanding of the phenomenon under investigation. Through this design, the researcher was able to look at and describe intensely and accurately the experiences and coping resources of AIDS-orphans heading households. In addition to this, the descriptive design was also employed in order to describe and present a word picture with specific details portraying the lived realities of AIDS-orphans who are heading households.

3.3.3 Contextual research design

Contextual research design seeks to gather evidence of participant's perceptions according to the larger context in which they occur (Kayrooz & Trevitt, 2005: 10). According to Babbie and Mouton (2001:272), the contextual design is referred to as the understanding of events against the background of the whole context and how

such a context gives meaning to the events concerned. Neuman (2006:92) argues that evidence about a person's social world cannot be secluded from the context in which it occurs or the meanings assigned to it by the person involved. Therefore, qualitative researchers can assign appropriate meaning to an act or statement only if they take into account the social context within which the act or statement occurs because the same event or action can have different meanings in different contexts. In this research, the researcher's intention was to understand, explore and describe the experiences and coping resources of AIDS-orphans heading households in their own homes.

3.4 POPULATION, SAMPLE AND SAMPLING METHODS

A study population is any group of individuals that has one or more characteristics in common, and is of interest to the researcher (Best & Kahn, 1993:32). According to Given and Saumure (2008:645), a population refers to every individual who fits the criteria, either broad or narrow, that the researcher has laid out for research participants. The study population for this research was defined as AIDS-orphans heading households residing in the urban area in Zamdela Free State Province of South Africa. Since the researcher could not study the whole population, it was necessary to select a sample.

A sample is a small portion of objects, events or persons who represent to various degrees, the study subjects (Bless et al., 2006:100). At the same time, Bloor and Wood (2006:154) define a sample as representative of the population from which it is selected, if the characteristics of the sample approximate to the characteristics in the population. The targeted participants for this study included AIDS-orphans heading households in Zamdela, an urban area in the Free State.

Since the study was qualitative in nature, purposive sampling which is a form of non-probability sampling was used. The purposive sampling technique is defined by Neuman (2006:222) as a non-random sampling method in which the researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult-to-reach population. In this instance, qualitative researchers use their own judgement as experts on the topic to select participants. Non-probability sampling was used because the researcher was not aware of the total number of AIDS-orphans heading

households. Non-probability sampling is a form of sampling that does not adhere to probability methods where every member of the population does not have an equal chance of selection (Jupp: 2006:197). In addition to this, non-probability sampling is very useful and justifiable when the researcher is seeking information on a new or under-researched area and targets subjects or cases who typify the issue to be studied (Alston & Bowles, 2003:87).

It was for this reason that purposive and snowball sampling were applied as techniques of non-probability sampling method. Cramer and Howitt (2004:155) describe snowball sampling as a method of obtaining a sample in which the researcher asks a participant if they know of other people who might be willing to take part in the study who are then approached and asked the same question. Through snowball sampling the researcher got to know other participants through a few that she had first identified. This technique is particularly useful when trying to obtain people with a particular characteristic or experience which may be unusual and who are likely to know one another.

The criteria for inclusion of participants in the sample were therefore as follows:

- All children (boys and girls) whose parents died of AIDS-related diseases, and who are heading the household
- Who stay in Zamdela,
- Boys or girls attending or not attending school.
- Who are between the ages of 16-18 years,
- Willing to participate in the study, and
- Whose guardians consented to their participation in the research study.

The area of Zamdela was chosen because the researcher is working in the area and is conversant with the social aspects of the area.

3.5 METHOD OF DATA COLLECTION

Data collection, according to the framework of Neuman (2006:15), relates to the fourth step of the qualitative research process after acknowledging social self, adopting a perspective and designing the study. Creswell (2007:118) argues that the

purpose of data collection is to gather information to answer emerging research questions. Data collection is a process whereby the researcher goes into the field for the purpose of gathering information for the research topic under study. According to Cynthia, Clamp, Gough and Land (2004:197), data collection refers to ways in which information can be obtained from the real world, recorded in a systematic way, quantified and/or explained. The research question guided the researcher on what data to collect. Data was collected by means of an interview schedule which was a guide used by the researcher in her semi-structured interview (Floyd & Fowler, 2004:519). The researcher used a tape recorder with some of her participants during the interviews after permission was given by participants to do so. Also, notes were taken of the responses of the participants during the interviews. Soon after each interview the researcher transcribed the responses of the participants into text word for word.

In order for the researcher to gather quality information for her study, she first conducted a pilot study to test her interview guide and the research methods for her study. This is described in the following sub-section. After the pilot study had been conducted, the researcher embarked on the process of preparing her participants for the interviews. An account of the preparation for data collection and the methods of data collection are presented in the following sub-sections. .

- *Pilot study*

A pilot study is a specific pre-testing or trial run of research instruments, in this case, an interview guide, which is done in preparation for the full-scale use to see if the envisaged methods are valid in the practical research environment (Van Teijlingen & Hundley, 2001:1; Persaud, 2010:1033). In other words, Schreiber (2005:625) states that a pilot study can be used to simply examine the potential barriers before full implementation of the research study. In short, it is a feasibility study.

The pilot study was conducted in Zamdela where the researcher conducted the actual study as it was important to use the same geographical area of the study in order to obtain accurate feedback on the adequacy of the interview guide as informed by individuals who had a similar background to the actual participants. The researcher included two participants in her pilot study, a boy and a girl who closely resembled the targeted population (Persaud, 2010:1033). One of the participants used in the pilot

study dropped out of school and the other one was in Grade 11 during the period of data collection. The researcher did not include these participants again in the final data collection because she had already interviewed them. She also did not analyse the data she gathered during the pilot study in her final data analysis stage. This was done in order to avoid the contamination of the sample. As indicated by Van Teijlingen and Hundley (2004:824), participants who have already been exposed in the pilot may respond differently from those who have not previously experienced it. The importance of and reason for conducting a pilot study is that it provides the opportunity to examine amendments, substitutions and assess the feasibility of the full-scale study (Schreiber, 2005:626; Van Teijlingen & Hundley, 2004:824). A pilot study was important to the researcher in an attempt to develop and test the adequacy of her instruments in order to obtain reliable and valid data to answer her research questions or hypothesis (Persaud, 2010:1033; Van Teijlingen & Hundley, 2004:824). It was of paramount importance to the researcher to test her instruments prior to her actual study to avoid failure. In addition, a pilot study saved the researcher both time and money because logistical problems and other design deficiencies were identified prior to the actual study and corrections and adjustments were made before the main study was executed (Persaud, 2010:1033; Van Teijlingen & Hundley, 2004:824).

The researcher undertook the pilot study in an attempt to answer the following questions proposed by Schreiber (2008:625):

- How many times will interaction or contact with the participants be needed?
- How long will these interactions take if they run smoothly or if they do not?
- How many interviews or observations appear to be realistic?
- What are the issues regarding ethics, anonymity and so on of these interactions?
- Are multiple data collectors needed and will they all need to be trained and then examined to see if they can collect the data properly?

All in all, the pilot study helped the researcher to examine her research instruments before she conducted her full-scale study. It also assisted her in identifying possible threats and hindrances in her research study.

- *Preparation for data collection*

The researcher began the process of data collection by making contact with the participants in their homes. The purpose of this visit was to request the participants to take part in the research study. It is important for a researcher to ensure that participants feel comfortable to share their stories and therefore the researcher created and maintained a relationship with her participants (Nziyane, 2010:26). It is also of vital importance that the researcher prepares her participants to establish a relationship with them that will improve the participants' willingness and ability to co-operate. Rapport building is primary to this process and there must be a level of trust between the interviewer and the interviewee. Before starting the interview, the researcher explained the purpose of the study and the need to interview participants. The researcher also explained to her participants that everything that was discussed during the interview would remain confidential. It was also explained that their rights would not be endangered. The contents of the preamble to the consent form were explained to those participants who agreed to take part in the study.

All the AIDS-orphans selected to participate in the study voluntarily agreed to participate in the study. After verbal consent was given by these children, the researcher discussed the consent forms and requested all children to sign them (see Addendum A). It was also explained to the children that their church pastors, educators or extended families (legal guardian) had signed these consent forms for them to participate in the study only because it is required by law as they are below the legal age. However, their legal guardians' consent was not imposed on the children, and therefore their voluntary participation was sought. Appointments to conduct interviews to collect data were made with each child, emphasizing the date, venue, the time and the length of the interview. The researcher told her participants before she began her interviews that they could express themselves in any language with which they felt comfortable. She also asked for their permission to record the interviews and take notes during the interview. It was for these reasons that the researcher first held interviews with all of her research participants to establish working relationships with them for the sake of this research endeavour and to prepare them for the process of how the data would be collected.

- *Method used for the purpose of data collection*

Qualitative methods of data collection were used. In this study, semi-structured individual interviews were held with participants. Interviews were held in the AIDS-orphans' homes in order to get a full understanding of their world and also to make them feel as comfortable as possible. The other purpose of using interviews in this research was to discover the reality of the experiences, challenges and coping resources of AIDS-orphans as heads of households and wanting to become part of the circumstances in which they are living. Interviews, according to Lavrakas (2008:260), are often used to solicit information in projects that can be considered to be very sensitive. This was a direct way of obtaining information. Since the study was conducted with exploratory research in mind, semi-structured interviews were used. Semi-structured interviews are structured in the sense that a list of pertinent issues for investigation is drawn up prior to the interview. Denzin and Lincoln (2005:649) state that such a list contains some precise questions and their alternates or sub-questions, depending on the answer to the main question. They continue by stating that semi-structured interviews help to clarify concepts and problems. They help to establish a list of possible answers or solutions, which in turn, facilitates the construction of more highly, structured interviews. The researcher used an interview guide to ask her participants to broadly define their experiences and challenges in heading households in Zamdela (Bless et al., 2006:116). An interview guide is explained by Vogt (2005:161) as a list of questions and spaces to write down the answers. It is used by interviewers to record respondents' answers.

The interviews were recorded using a Nokia asha 311 phone and were stored on the researcher's personal laptop, the interviewer sat adjacent to her participants. She switched on the phone to record her interview as soon as the first question was asked and kept it on until the last question was answered. The researcher held the interview guide in her left hand and on the right hand was the pen and a notebook on her lap to write down the responses as well. The phone was placed near the participant. The recorder was switched off in cases where the participants became emotional in order to allow them to regain their composure. Note taking was used minimally to capture important aspects, for example issues that required further exploration or recording non-verbal communication since voice recorders are not able to capture this kind of communication. The use of a digital voice recorder facilitated the smooth flow of the

interview as the researcher was able to maintain eye contact with the participants and this encouraged them to talk, knowing that the researcher was interested in what they were saying. It also helped in instances when some of the participants cried because the researcher was able to put her hands on the participant's back as a sign of comfort. The researcher also debriefed the participants who were emotional after the interview and arranged for a review session with them afterwards. Appropriate interviewing skills were important to enable the researcher to enter into the participants' experiential world and encourage them to give accounts of their life experiences regarding the phenomenon studied.

The following techniques and tips, as laid out by De Vos et al. (2005:288-289) and Creswell (1994:71-74), were used during the interviews:

- The researcher let the participant do most of the talking, about 90%. The point was for the participants to tell their stories.
- The researcher tried her best to establish trust, build rapport and tried only to ask questions related to the study.
- She also demonstrated that she was listening carefully by using verbal cues to show interest.
- The researcher asked clear, brief questions and avoided leading questions.
- The researcher concluded interviews with a general question such as "Is there anything further you feel is important?" which helped the participants to say something in their minds that was not included in the guide.
- The researcher ended the interview at a reasonable time before the participants became bored.

3.6 DATA ANALYSIS

Data analysis is a way of bringing order, structure and meaning to the data that the researcher has gathered in the field (Brewer, 2000:105; De Vos et al., 2005:333). The purpose of data analysis is to reduce data to a legible and interpretable form so that the relationships of the research problems can be studied and conclusions drawn. Qualitative data analysis took place throughout the data collection process (Henning, et al., 2006:127). After and or during each interview session, the researcher went through the interview guide and made further notes. Data were collected from the

participants in the form of words, since the research study was qualitative in nature. Denzin and Lincoln (2005:647) support this, by pointing out that qualitative researchers study spoken words and written records of people's experiences. As is common in qualitative studies, data is presented as direct quotations.

Data was analysed using the eight steps for qualitative data analysis by Tesch (in Creswell, 2009:189). This entailed the following:

- The researcher read through all the transcripts carefully in order to get a sense of the whole, while at the same time writing down along the margin some ideas as they came to mind in connection with each topic.
- The researcher chose the transcript on top of the pile of transcribed interviews and read through it, asking herself what it is that she is reading. In this step, the researcher thought about the underlying meaning of the information and not the substance.
- The researcher repeated this process until a list of all the topics was acquired. She then clustered similar topics together into columns that were labelled as major topics, unique topics and left-overs.
- She revisited her data with this list at hand. An abbreviation for each of the topics was made in the form of codes and she wrote these codes next to the appropriate segments of the text. This preliminary organizing scheme was used to see if new categories and codes emerged.
- The researcher found the most descriptive wording for the topics and turned them into categories. Grouping together topics that were related to each other was done in an effort to reduce the total list of categories and lines were drawn between categories to show interrelationships.
- The researcher made a final decision on the abbreviation for each category and alphabetised the codes.
- The researcher assembled the data material belonging to each category in one place and a preliminary analysis was performed.
- She then recoded her existing data where necessary and started to write the research report.

3.7 METHOD OF DATA VERIFICATION

Babbie and Mouton (2001:275-278) assert that data verification denotes the: 'trustworthiness, credibility, transferability, dependability and conformability of data gathered in the field'. Data verification helps to determine whether data was accurately translated, is complete and it supports processes of the new system. Creswell (2003:196, 1994:157) supports the above by stating that data verification in qualitative research means a process of checking the accuracy and credibility of research findings from the standpoint of the researcher, the research participants or the readers of the account. The researcher verified her data according to the model of Guba (in Krefting, 1991:214-222) of ensuring the trustworthiness of qualitative data. The four characteristics to ensure trustworthiness are truth-value, applicability, consistency and neutrality. A discussion of these four characteristics follows.

- *Truth-value*

Truth-value asks how confident the researcher is with the truth of her findings based on the research design, informants and the context in which the study was undertaken. It is also concerned with whether the findings of the study are a true reflection of the challenges, experiences and coping resources of AIDS-orphans heading households in Zamdela under study. Truth-value is established by the strategy of credibility and for the purpose of this study, the researcher used the following criteria:

- Interviewing techniques: During the interview, the researcher made use of various interviewing techniques such as probing, verbal and non-verbal expressions, restating and summarising in order to enhance the credibility of the study.
- Triangulation: This is described as the comparison of multiple perspectives by using different methods of data collection (Krefting, 1991:219). In this study, triangulation of data sources was employed by means of interviews and observation. Since this was a very sensitive study, observation was used to observe participants' emotions and feelings during the interview. This gave the researcher a view of how participants felt and responded to the questions. It also gave an indication of whether participants needed debriefing or intensive counselling.

- Peer examination: The researcher sought input from her colleagues who are well-versed qualitative researchers and who were capable of clarifying the study by asking her questions and generally shedding light and making suggestions.
- Authority of the researcher: The researcher is a registered senior social worker working for Child Welfare South Africa, Sasolburg and the project manager for the Asibavikele project working with orphans and vulnerable children (OVC) and also running After Care Centres and food gardens. This requires of her to have a sound knowledge of the services available for AIDS-orphans heading households as well as the available community resources.

- *Applicability*

Applicability refers to the degree to which the findings can be applied to other contexts and settings or to other groups (Krefting, 1991:216). Applicability is established through the strategy of transferability. In order to achieve transferability, the researcher provided a dense description of the research methodology employed.

- *Consistency*

Consistency of data refers to whether the research findings would be consistent if the enquiry was replicated with the same subjects or in a similar context (Guba in Krefting, 1991:216). This is established through the strategy of dependability and was achieved using an independent coder. The researcher and the independent coder separately coded the data and subsequently had a consensus discussion with the study leader on the themes, sub-themes and categories to be presented as research findings.

- *Neutrality*

Neutrality refers to the extent to which the study findings are free from bias. Neutrality in qualitative research should consider the neutrality of data rather than that of the researcher, which suggests confirmability as the strategy to achieve neutrality (Guba in Krefting, 1991:216-217). The aim was to establish neutrality through the criterion of triangulation which is described as the comparison of multiple perspectives by using different methods of data collection (Krefting, 1991:219).

3.8 ETHICAL CONSIDERATIONS

Ethics according to Denzin and Lincoln (2005:144) are viewed as a set of considerations which determines what researchers ought morally to do. Neuman (2006:129) emphasises that researchers have a moral and professional obligation to be ethical, even if research participants are not aware or not concerned about these ethics. Since the researcher undertook her study using human beings as her subjects, she had to conform and adhere to some of the ethical guidelines discussed below in order not to harm her subjects:

- *Confidentiality, non-violation of privacy and Anonymity*

Confidentiality is described by Denzin and Lincoln (2005:145) as safeguards to protect participants' identities. As a researcher and a social worker, the researcher had to ensure confidentiality of the participants by guarding jealously the information that was confided to her. The researcher maintained confidentiality in this study as a primary safeguard against unwanted exposure.. Information was gathered from children heading households, therefore the researcher never divulged information to anyone without her participants' prior consent. From the onset of her study, the researcher informed and assured her participants that she would not divulge their information to anyone except her supervisor as well as the independent coder. The researcher ensured that confidentiality and anonymity was maintained by adhering to the following as outlined by Mark (1996:48):

- By keeping all information about participants confidential, unless where participants gave consent to reveal the information
- By soliciting and recording only personal information that was necessary for the study to achieve its purpose.
- By storing all study information that could reveal a participant's identity in a safe, closed place. This information was only accessible to the researcher, the independent coder and the study supervisor.
- By removing all the participants' identifying information after coding each participant. After all the analysis, original data was kept in a safe place and on completion of the study destroyed.

- *Avoidance of harm*

This is a situation whereby the ethical obligation rests with the researcher to protect her participants, within reasonable limits, from any form of harm that may emerge from the research project. Participants were thoroughly informed beforehand about the potential impact of the investigation. Such information offered participants the opportunity to withdraw from the study, if they so wished. The researcher was also in a position to identify and avoid participants who proved to be vulnerable in the study before harm was done. During the interview, the researcher never interrupted her participants, she listened very attentively as a sign of respect for them. The researcher also empathized with the participants who broke down during the interview. She held them their hands and rubbed their backs as a sign of support. She was also sitting on the same level with her participants so that they would feel comfortable to share their stories. At the end of the interview, the researcher debriefed the affected participants.

- *Informed consent*

The principle of informed consent is at the core of social science research and is aimed at ensuring that all participation is truly voluntary Therefore, emphasis was placed on accurate and complete information so that participants fully understood the investigation and consequently made a voluntary, thoroughly reasoned decision about their possible participation in order to give their informed consent. All participants in this study were fully informed about the research project and their role in the study. Based on this information, they made an informed decision to participate in the study. During her initial contact with each of the participants, the researcher engaged them in a discussion during which she introduced herself, the goal of the research and the need for and value of the research. Furthermore, she outlined the process of the research project and their right to withdraw their participation at any time. In cases where the participant could not give consent due to their being under the age 0f 18 years, the researcher sought consent from their elder relatives, church leaders or their educators. The consent forms were given to the participants once they were provided with all the information pertaining to the research and expressed their willingness to voluntarily participate in the research study and another consent form was given to elder relatives, church leaders and educators in case of those participants who could not give consent. (A copy of the informed consent forms is attached in Addendum A).

- *Deception of subjects*

Deception of participants involves withholding information or offering incorrect information in order to ensure participation of participants. The participants were informed by the researcher that the collected information would be used specifically for this study and not for any other purpose.

- *Debriefing*

The interviews aroused intense emotions as participants shared their real life difficult experiences and challenges of the phenomenon under study. Some of the participants had very difficult and traumatic experiences such as losing their loved ones who used to be the sole breadwinner and rejection by their own family members, which were all re-lived during the interviews. Therefore, with the aim of minimising emotional or psychological harm, debriefing of research participants was done by the researcher immediately after each interview with each participant to enable them to work through the experiences of the interview and the emotions that had surfaced as a result. Some of the participants were too emotional and the researcher, as a social worker, planned a follow up counselling session with them.

- *Management of information*

Neuman (2006:140) suggests that participants' information should be seen as private property because like other 'intellectual' property it continues to have value after it is exchanged. Therefore, participants should have rights over the information to ensure that it is not used in ways they would disapprove. The researcher sought permission from all research participants to use a digital voice recorder and notes to capture the data. She explained to them that the audiotapes, notes and transcripts would be coded to disguise their identifying particulars and also that information would be used only for the purpose of the study. In order to safeguard participants' information, the researcher kept the voice recorder, notes and transcripts in a locked cupboard in the researcher's house where only the researcher had access to the information. The researcher destroyed the real names of participants once data had been coded and alphabetical references assigned. The researcher will erase all recordings on her phone and laptop once the study and report are completed.

3.8 SUMMARY OF THE CHAPTER

This chapter sought to outline the methodology applied in the study. The researcher opted to approach the research project with a qualitative approach as it sought to discover and describe an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela. The researcher conducted the methodology process for this study according to the systematic planning as discussed in this chapter. This Chapter discussed the type of study and research techniques that were employed. The population was identified and the sampling methods explained. Data collection was gathered, as anticipated. The chapter concluded by explaining the ethical considerations for the study and how the researcher's moral and professional obligation to protect participants was achieved. The findings from these interviews will be discussed in the next chapter. The responses given by the participants during the interviews and observations will be analysed in full and conclusions will be drawn.

CHAPTER FOUR
PRESENTATION OF THE FINDINGS AND LITERATURE VERIFICATION

4.1 INTRODUCTION

The aim of this research study was to gain an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State. In order for the researcher to realise this aim, a qualitative research approach was followed, whereby semi-structured interviews were used to collect data from the AIDS-orphans in child headed household (CHH) in Zamdela. Data were analysed using Tesch's eight steps of data analysis, as cited in Creswell (2003:192-193).

The findings are presented first by providing the biographical profile of the participants, followed by their educational level, household size, and secondly by presenting their experiences, challenges and coping resources as heads of households.

4.2 RESPONSE RATE/PROFILE OF PARTICIPANTS

4.2.1 Demographic data of participants

The researcher purposively selected nine participants to take part in the study and conducted her research with only seven participants. Two of the participants were used in the pilot testing, and therefore not included in the main study. Of the seven participants included in the final study, participant number 1 is an eighteen year old African male. He was attending school and was in Grade 12. He is looking after his two younger siblings, both are boys. He is receiving a foster care grant on their behalf. Their parents both passed on because of HIV and AIDS-related illnesses. He reported that, he and his younger brothers sell sweets and nik-nak chips in order to make extra cash in the house since no other relatives are available to help them out financially. He reported that they do not have a healthy relationship with their maternal family. The paternal family stay far away from them and have their own families to run.

Participant number 2 is a seventeen year old African male. He is staying in a backyard shack because he rented out the main house to tenants in order to sustain himself since no-one in his family is ready to help him out. He does not attend school. He dropped out, due to financial constraints. His older brother left him for another town in search

of a better living when he was fifteen years old and never returned back home. No-one in his family wants to be his foster parent. His biological mother passed on when he was only three years old with a HIV and AIDS-related illness and his biological father's identity and whereabouts are allegedly unknown.

Participant number 3 is an eighteen year old African female staying with her younger sister. At the time of the interview she was in Grade 12. Her younger sister's paternal family tried to split them as they were only prepared to support her alone since they have different biological fathers and the participant's biological father's identity and whereabouts are allegedly unknown. The younger sister was in Grade 7. The younger sister pulled out of the paternal family since she refused to abandon her elder sister. Their maternal relatives are in the Eastern Cape and do not communicate with them regularly. Their biological mother passed on from an HIV and AIDS-related illness.

Participant number 4 is a sixteen year old African male staying with a terminally ill paternal grandmother. He is currently in Grade 8 and his attendance is disrupted with his grandmother's illness. Both of his parents passed on with HIV and AIDS- related illnesses when he was young and he grew up with his paternal grandmother. His paternal family is in the Eastern Cape and his father was the only child to his paternal grandmother. His maternal family is from Lesotho and he has never had any contact with them since his mother passed on when he was very young

Participant 5 is an eighteen year old African female. She is staying with her two younger brothers and one child of her own. She dropped out of school when she was in Grade 10. She is unemployed and depends on a foster care grant for her two younger brothers and a child support grant for her son. She added that she sometimes plaits people's hair in order to make extra cash for the household. She resides in a shack with her brothers because their stepbrother chased them out of the RDP house they used to stay in with their maternal grandmother before she passed on. Their biological mother passed on from an HIV and AIDS related illness.

Participant 6 is a 17 year old African female currently in Grade 10. They are two in the household, herself and her younger sister who is in Grade 9. Their biological

father passed on first and shortly after his passing, their biological mother followed, both with an HIV-related illness. Their parents were in the process of extending their four-roomed house but unfortunately the house was left unfinished almost at roof level. One of their church elders is receiving a foster care grant on their behalf. Both the paternal and the maternal families are not supporting them in any way whatsoever. Their maternal family lives in a nearby town in Odendaalsrus and their paternal family is from Lesotho and they do not have contact with them. These children are regular church goers.

Participant 7 is a 17 year old African male who used to stay with his 12 year old sister who has Down syndrome. His sister was placed in a facility in Sebokeng for children with severe disabilities by the social worker working in that area when she was informed by the researcher about the matter. Their biological father is allegedly unknown and their biological mother passed on due to an HIV-related illness. His maternal aunt used to help him take care of his younger sister until he knew her motive. She wanted to repossess her late sister's house and he went to the ward councillor who helped him secure his late mother's house. He then chased the aunt away. He dropped out of school in Grade 10 when his biological mother was terminally ill. During that time he used to take care of both his biological mother and his severely disabled sister. He mentioned that it was too much for him and decided to quit school. He is a regular church goer and sells fruits and vegetables with his wheelbarrow in order to earn a living.

4.2.1.1 Ages of participants

Table 4.1 below illustrates the ages of the AIDS-orphans heading households and the age at which they commenced heading the household:

TABLE 4.1 AGES OF CHILDREN HEADING HOUSEHOLDS

Participant	**Age**	**Age of commencement as head of the household**
1	18	15
2	17	15
3	18	17
4	16	11

5	18	16
6	17	16
7	17	17

The above table indicates that the ages of participants ranged between 16 and 18 years old. According to the Children's Act (Act No. 38) of 2005 (2006: section 137(1)(c)), a child headed household is recognised when a child over the age of 16 years has assumed the role of a caregiver in respect of the children in the household. Therefore, according to this section, these children bear the rights and responsibilities as heads of households. It is evident from the ages of the children who participated in the study that they were within the age limit for being heads of these households according to the said Act.

Table 4.1 also indicates the ages when these children began heading households. Three of the participants began heading the households below the accepted age in terms of the Children Act (Act No. 38) of 2005 (2006: section 137(1)(c)) which recognises a child headed household when a child is over 16 years old. Of these three children, one was 11 years old when he began heading the household and the other two were 15 years old. This clearly shows that participants were exposed to the role of heading a household at a very tender age. However, at the time when the researcher conducted her study, all the children who participated in her study fell within the accepted age range of child headed households.

4.2.1.2 Gender of AIDS-orphans heading households

The total number of participants who took part in this study was seven. Of these, four were males and three were females. This unequal distribution between the genders in respect of being the head in a child headed household indicates that there has been a shift in the patterns of gender and family care. Germann (2005:90) highlights that in most African countries before the onset of HIV and AIDS, most girl children provided care to their younger siblings whereas boys were less likely to provide care to their siblings. This was attributed to the gender stereotypes that women were perceived as the caretakers of the family. Women were mainly responsible for cleaning, cooking, and taking care of the sick, whereas men were seen as the breadwinners of their

families. In this research context, both girls and boys were heading their households and were responsible for performing all household chores, including taking care of their younger siblings.

4.2.1.3 Educational status of participants

Table 4.2 below illustrates the highest educational level of the children heading the households at the time when this study was conducted

TABLE 4. 2 EDUCATIONAL LEVELS OF PARTICIPANTS

Participant	**Grade**
1	12
2	Dropped out – at Level 2 ABET
3	12
4	8
5	Dropped out – at Grade 10
6	10
7	Dropped out – at Grade 10

From this table, it is evident that four of the participants were attending school. Three of the participants dropped out of school due to financial constraints. It is interesting to note that none of the participants dropped out of school below the compulsory school-going age as set down by the South African Schools Act (Act No. 84) of 1996 (1996: section 3(1)), which stipulates that a child is expected to attend school from the first school day of the year in which such learner reaches the age of seven years until the last school day of the year in which such learner reaches the age of fifteen years or the ninth grade. This means that all the participants attended school until Grade 9 as well as those who dropped out. None dropped out before reaching the age of fifteen. One of the participants, although still in school, does not attend regularly because he has to take care of his terminally ill paternal grandmother. A terminally ill parent takes a lot out of a young child. Watching a terminally ill parent degrading into a helpless state is enough to affect any child's schooling. In such a situation, a child cannot concentrate at school and after school does not have adequate opportunity to do school work. Such children are trapped between helping their only surviving

parent and keeping up at school (Nkomo, 2006:64). Another child dropped out of school in order to take care of her sick grandmother and never returned to school after she passed on. Smart (2003: 7) and Foster (2004:5) state that the human and social costs of HIV and AIDS are enormous for children as some children, especially girls, are forced to drop out of school in order to provide care and support to their sick parents. Though the study is qualitative, the researcher deemed it necessary to use the two tables above to give a clear picture of some of the biographical data.

4.2.1.4 The household size of the child headed household

The total number of children residing in each child headed household is discussed here. The number of people residing in each participant's household ranges from one to four. As a result of HIV and AIDS, an increased number of orphaned children will grow up in households headed by adolescent caregivers as they lose their parents to the HIV and AIDS pandemic (Germann, 2005:67). One of the participants had a child of her own and also had to raise her two siblings. Two of the participants are now staying alone and three are taking care of one sibling and one had two siblings under his care. Mkhize (2006:96) adds that these children are forced to become primary caregivers for their younger siblings while they themselves are still children with an equal right to parental care.

4.3 THEMES AND SUB-THEMES

The following is the discussion of the themes and the sub-themes that emerged from the study.

4.3.1 Themes

In South Africa the negative impact of HIV and AIDS has caused some children not to receive proper care and attention from their parents and or caregivers. When these parents and or caregivers are frail, they are not able to give their children proper care and attention because they themselves are in dire need of such care and attention. At the end of the day children, especially elder siblings are forced to play this role if there is no family member to fill the gap that has been created by a sick and frail parent. These elder siblings take up the role of looking after their frail parents and their younger siblings. Below is a discussion of themes and sub-themes as they emerged from the analysis of data covering the challenges, experiences and the

coping resources applied by the AIDS-orphans heading households without adult supervision:

4.3.1.1 Reasons leading to heading the household (When and why)

In many of the countries in Sub-Saharan Africa, children have often assumed parental responsibilities during the terminal illness stage of their parents and they continue with this role after their death. (Woldeyohannes, 2010:57-58). All the AIDS-orphans who participated in this study were heads of households. The study revealed that the eldest child, before and after the death of their parents and regardless of gender, assumed parental responsibilities for the younger siblings. Furthermore, there is also an indication that children could make the choice to establish their own households as they did not want to be separated from their siblings for fear of mistreatment and abuse by relatives. In support of this statement, from the interviews carried out by the researcher with her participants, it is clear that the heads of the households started taking care of their siblings during the terminal illness stage of their parents. They continued with this after the death of their parents seeing that there was no adult family member available to look after them. Here are some of the direct quotations from the participants' stories:

"… I started assuming it in 2011 because that is when my mom was so sick, like very very sick and I saw that since I and my mother's family don't get along, obviously I am the oldest child so if should something happen to her or she passes away I will be the one who will be responsible for my siblings…".

: "When my mother was very sick, sometimes I would dodge school to come and cook for her, do the washing for her".

"… when my grandmother was terminally ill I had to take over".

From the above extracts it is clear that most of the children started heading the household when their parents or caregivers were terminally ill. Children often have to fill this gap created by their sick parents (Gow & Desmond, 2002:113). These children were forced by circumstances to nurse their sick parents and caregivers and at the same time take care of their younger siblings. They even continued to care for

their siblings after the death of their parents. Foster (cited in Tsegaye, 2007) asserts that children start carrying the burden of heading households even before the death of their parents. Therefore, the child prepares him/herself for the duty of looking after the other siblings and running the house. Woldeyohannes (2010:29) alludes to the emptiness created by the parent's death that swiftens the eldest child to take over the responsibility for all household chores and the task of bread winning. Therefore, the child prepares him/herself for the duty of looking after the other siblings and running the house before and after the death of their parents. All of the participants in this study were the eldest siblings and they felt obligated to assume the head of household responsibility when their parents or caregivers were terminally ill.

4.3.1.2. Feelings about parent/s' death

The loss of a very significant person, especially when it is a parent, is one of the most painful experiences for any human being (Germann, 2005:240). The experience is even far deeper for children who care for their sick parents since they have to watch their parents' health deteriorate until eventual death. This creates a sense of loss accompanied by anxiety, fear and depression (Subbarao, Mattimore & Plangemann, 2001:4). Subbarao et al. (2001:4) affirm that children who lose their mothers suffer massive grief over the loss of motherly love and nurturing while the death of a father entails the loss of income for the household if the father was the sole breadwinner. Every child needs motherly nurturing and tender love. The need in this context becomes an unfulfilled dream to the AIDS-orphans heading households at a tender age. After the death of the parent, children are further traumatised as they may be forced to take on the responsibilities of heading the household and providing care to their younger siblings (Subbarao et al., 2001:4; Mkhize, 2006:82). This, to a child, is a most painful and devastating experience. In this study, the participants felt robbed of their childhood due to their parents' death. The following storylines attest to this:

"Yhooo (closing his face with both of his hands) ssssshh my father died first, … so it was like the world is facing upside down for me and I felt like there is nothing for me left… the way I loved him yhooo I always used to say to myself if it does happen that he passes away I want to be buried with him if it is possible. That's how I much I loved him. As for my mother yhoooo now she was the only one who was helping us who was there for us. When she passed away yhuu … now I said, ooh my God what

have I done to deserve such horrible thing. I felt again that there is nothing again left for me to live for."

"It was a terrible bad feeling".

"It was so painful and I wished it was me who died instead".

"I was devastated when my parents passed away…"

"… I felt bad because no one helped us…"

From the above extracts, it is clear that the sense and feeling of loss differ from participant to participant. Those that witnessed their parents' death are more affected by their loss as compared to the other ones who were left by their parents while they were very young because they did not witness their parents' sickness. On the other hand, those who witnessed their parents' terminal illness stage are somewhat more at ease, although they still feel the gap of losing their parents, compared to those who did not witness the final stages of their illness. Grief can be defined as the affective reaction to stressful life events (Stroebe, Hansson, Stroebe, & Schut, 2001:1). Bereaved people are more likely to have a wide range of physical as well as psychological health problems (Stroebe, Schut, & Stroebe, 2007:1). In addition, there is a risk of more intense grieving when the cause of death is stigmatized, as is commonly reported for AIDS-related deaths (Aranda & Milne, 2000:1).

These children view their lives without their parents as hard-hitting and other participants remarked that they sometimes wish they were dead like their parents. Children need parental love, a sense of security and need help to handle grief. Most of them feel that life was better when their parents or caregivers were alive because they met their basic needs for survival. Foster (2004:4) asserts that although children living in child headed households experience problems that are common to other vulnerable children living in destitute households, their experiences are extreme and unrelenting because they face such problems without the assistance of an adult. Nziyane (2010:143) highlights that the suffering which these children experience unfolds gradually and in many directions starting from the time when the parent is infected

with HIV and ultimately culminates in a situation where children live alone without adult care due to the death of the parent. Now that they are no longer there it is now their duty to think about what they should eat for the day.

Children are understandably one of the most vulnerable groups during the illness and after the loss of a parent or both parents. The cumulative losses suffered by children orphaned by AIDS goes to poverty, poor nutrition and increased workload, beginning with the onset of a parental illness; they experience the loss of love, socialisation, and skills transfer by their parents, who often die in quick succession. Children who are forced through the death of both parents to become the sole provider for younger siblings are seemingly common in South Africa. Living alone without adult supervision, high poverty levels and hunger points to the fact that grief may be seen as a luxury in the face of survival. This, in turn may lead to the development of complicated grief when emotional, social and psychological aspects of grief are not adequately addressed.

Shock and disbelief are the most likely immediate responses by any individual experiencing the loss or death of a loved one. This is more so because more often than not, death usually finds people unprepared and as a result, not really sure how to react or behave (Giddens & Giddens 2000:63; Ward & Associates, 2000:17; Edwards, 2011:4) the quotations from the participants attest to the fact that losing a loved one through death is a very painful experience. The participants were expressing how much pain they endured when they got the news of their parents' death. This confirms the assertion by Ward and Associates (2000:17) that the death or separation from a loved one is the most obvious and most painful sort of loss. Edwards (2011:12) supports this assertion when he states that "research shows that 40% of bereaved people will suffer from some form of anxiety disorder in the first year after the death of a loved one". Anger is the other emotional reaction experienced by some of the participants after the death of their loved ones. The anger was directed at the perceived perpetrators of the loss of a loved one. Some of it was directed to God for not preventing the death.

4.3.1.3. Family relations

In the past there was no such a thing as an orphan in Africa since children were always absorbed into the extended family or the village community in cases where the

extended family was unavailable in the form of a child care forum (Germann, 2005:55; Frohlich, 2010:384). This means that the community members would come together for the sake of protecting the children. Unfortunately this culture is currently diminishing as communities gradually move away from the sense of collectiveness and mutual aid to individualism. In contemporary communities, this role is taken over by welfare organisations which assist in looking after the rights of children. This is an indication that communities are now abdicating their responsibility to the hands of the government, thus taking away the core of *Ubuntu* so characteristic to the black African communities. Ubuntu within the African context is often interpreted as humanness in English, it is about becoming and striving to help people in the spirit of service and to show respect to others and to be honest and trustworthy (Mkhize, 2004:5). It is further explained as a spirit of kinship across both race and creed which unites mankind in a common purpose.

It is greatly concerning that Ubuntu and this community safety net is stretched to its limits due to the large numbers of AIDS-orphans left alone resulting from the HIV and AIDS pandemic (Foster 2004:77). As a result of this, many children orphaned by the epidemic and so many others are left young and needy as fewer relatives are available to step in due to the financial burden attached to adding a new member. This is confirmed by Van Dyk (2008:343) when indicating that the existing pool of community-based support has become flooded as the number of children in need of care and protection gets larger and larger than the available resources , thus leaving children to fend for themselves and to grow overnight to becoming heads of households and breadwinners. The extracts from the interviews below illustrate the relationships between these children and their families:

"…we do not get along with my mother's family. …as for my father's family, they are living far and most of them have got their own families that they have to take care of. So it's hard for them to care for us. "

"they stay afar and they cannot afford to come and help me…"
"…they have their own families to run"

"It is only me and my aged grandmother in Sasolburg, the rest of the family is in Eastern Cape and grandmother does not want to go back to Eastern Cape because she is getting her treatment here as well as mine"

"Because they are not here. They are in the Eastern Cape"

As indicated previously, the family has traditionally been the fundamental unit of any society. It has been the most important institution in any society and ideally the primary point of provision to its members for care, nurturing and socialisation, affording the physical, economic, emotional, social, cultural and spiritual security. But as the epidemic progresses, this structure is being steadily eroded (Frohlich, 2010:373-375; Foster 2004:77; Foster, Makufa, Drew and Kralovec, 1997:156; Amber, 2005:202). The traditional absorption of orphans into the extended family is no longer possible, as already strained communities struggle to cope with the burden of the epidemic. This is confirmed by Kidman, Petrow, and Heymann (2007:326) who contend that extended families struggle to meet the needs of orphaned children under their care which results in many orphans living on their own. These days there are many orphaned children and many able-bodied people have died who could have assisted them, and therefore orphanhood becomes a common phenomenon which is no longer strange.

As illustrated by the above extracts, the extended family members are either far away and taking care of their own families with meagre resources or they are no longer there. As such, these AIDS-orphans feel disconnected from their extended families. They feel that their extended families do not care about their welfare since they live far away and are taking care of their own families. Edwards (2011:5) states that while the painful aspects of dealing with death are clear, bereavement sometimes also leads to enhanced personal development. Hence, these participants learnt to live their own lives in child headed households, independent from their extended families' support. From the excerpts, it is evident that the participants experienced some personal growth and developed some resilience after the passing away of their parents in terms of emotional development, a new identity, new skills and assertiveness. After losing their external coping resources, that is, their supportive parents, the participants learnt to search internally for coping resources. This accorded them opportunities to explore,

discover and utilise their reservoirs of coping resources and strengths that had been lying idle.

4.3.1.4. Experiences as the head of the household

Under normal circumstances, children are cared for by their parents but since the advent of HIV and AIDS this role has been reversed whereby children now act as caretakers to their sick parents and as caregivers to their younger siblings. This is confirmation that children are robbed of their childhood and forced to grow over night and became parents to their own parents and their younger siblings. Barnett and Whiteside (2006:223) support this notion when saying that children are forced into becoming primary caregivers to their sick parents. This overwhelms them as they witness their parents' health deteriorating until they die. Germann (2005:238 & 240) concurs that the continued parental illness creates an emotional desolation for the children as it exposes them to high levels of unease and sadness as they watch their parents die. This, to any human being, can be traumatic let alone when it happens to a child. Parental death exposes a child to a feeling of loss, loneliness and a loss of hope. The fact of watching a dying parent dents the emotions and feelings of security. The following expressions bear testimony:

"…taking care of my brothers… everything that's happening there and everything that has to happen there, I'm the main source of it, I have to take care of everything…"

"…I am the breadwinner and provide for my younger sister. I am also the caregiver and I have to be a mother to my younger sister…"

"It is difficult for me especially when I have to bath my grandmother or lift her up to the toilet when she is too weak"

"It is difficult because we do not have a decent place to stay"

"We experience difficulty in getting day to day food on the table"

The above extracts show that these children act as the breadwinner for they need to put bread every day on the table for their younger siblings. They also need to provide school uniforms and stationery for their siblings and themselves as well. As the financial providers, they have to pay for all the household expenses. These children also act as carers to their sick parent/caregivers as well as to their younger siblings and it is not an easy job, especially when you do not have a stable place to stay and a strong financial support system in place. In addition to this, these children are also acting as the housekeepers as they are responsible for the day-to-day running of the household. They do the household chores and financial budgeting on their own. They also act as conflict resolvers when younger siblings fight one another. From the above theme, the following sub-themes emerged:

- Growing up after parental death

The reflections below demonstrate that life for most children in this study changed since the death of their parents. They experienced the lack of having their basic human needs met since the death of their parents. The decline in the standard of living in their households after the death of their parents was also demonstrated repeatedly by the participants in the study. It was also interesting to see that beyond the limited access to basic needs, children in the child headed households were all aware of their need for parental love and affection after the death of their parents (Woldeyohannes, 2010:77)**.** The extracts below bear witness to this:

"***…****I don't have anything or anyone to ask or help me …"*

"My family is in Pretoria and I am staying alone"

"…I am being deprived of my spare time with my friends…"

"…It is only me and grandmother in Sasolburg the rest of the family is in Eastern Cape…"

"We do not have another family here in Sasolburg close to us"

The participants demonstrated a sense of growth, maturity and independence by indicating that there is no one from their extended families available to help them. They miss being around their families and friends. They feel like the world has closed around them since the death of their parents. Some indicated that their extended families had deserted them and they are left alone to fend for their younger siblings. They feel that there is no one to assist them and they are like an island with no access to their extended families. Despite not having an adult person assisting these children in running the households on a daily basis or regular basis, they are managing independently to keep the house running through thick and thin.

- Depression

AIDS-orphans are exposed to a number of stressors which may compound and complicate the grieving process. The stigma attached to parents having died of HIV and AIDS becomes a major barrier to how these AIDS-orphans being able to speak openly and without restraint about the multitude of feelings, fears and concerns the disease provokes (Frohlich, 2010:388). They may have cared for and witnessed the death of parent/s with a debilitating illness, loss of bodily functions, and sometimes AIDS-related mental illness. This creates a sense of loss, accompanied by anxiety, fear and depression (Subbarao et al., 2001:4). Children suffer psychological trauma through witnessing the parents' illness, of dealing with death, the absence of adult guidance and mentoring and the unmet need for love and security (Sloth-Nielsen, 2004:3; Cluver & Gardner, 2006:1; Van Dyk, 2012:359). Emotional pain among children affected by HIV and AIDS may be at its climax during the periods of intense parental illness. The household at this stage is still struggling with the meaning and consequences of a parent's HIV status. A significant adjustment, both psychologically and physically, is required when it comes to the parent's HIV diagnosis which is very stressful and plunges dependents into a state of depression (Nkomo, 2006:19). In addition to this, children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer neglect especially emotional neglect long before they are orphaned. This may expose them to a higher risk of suffering from depression. Ultimately, they suffer the death of their parents and the emotional trauma that results. They are forced to adjust to the new situation in this case, at times with little or no support and may at times suffer exploitation and abuse.

Therefore, the parent's illness affects the children's mental well-being in one way or another. Here are some of the direct quotations from the participants' stories:

"…I felt again that there is nothing again left for me to live for…"

"…it is difficult to concentrate because you will be thinking what will happen to my mother…"
"…I am exhausted and depressed most of the times"

"…I felt depressed because no one was there for us…"

"…is the depression that kills me"

These extracts indicate that the AIDS-orphans are depressed about the death of the parents and the absence of the extended families to offer psychosocial support in their time of need. Another participant indicated that she feels exhausted most of the time. Her mind is drained by the situation she is in and she also sees no light ahead for her. On the other hand, these children are more likely to suffer damage to their cognitive and emotional development (UNICEF, 2010). Depression is common in adolescence, especially amongst AIDS-orphans heading households without any adult supervision and assistance, for they are exposed to too many pressures almost every day of their life. This pressure encompasses being a teenager and having friends, who do not understand them, pressure of having to take care of themselves and others, and of being ostracized by peers and isolated from family and community due to the cause of their parents' death. In the case of HIV and AIDS-orphans who become heads of households, depression is triggered by the loss of parents through the debilitating disease of AIDS. Furthermore, they have to take on a role far above their abilities and they have to do so in circumstances of poverty, worrying every day about finding something to eat (Maqoko: 2006:56).

In research done by Moffett (2007:7), a child head is said to experience various psychological stressors, of which several will be related to the environments in which they live; several will be related to the illness or death of their parents; whilst the impacts of other i will be directly related to being the head of the household. The

ability of both traditional and modern institutions to adapt to the needs of the orphans in the HIV and AIDS context is severely constrained by the stigma attached to the disease. Indeed, this includes the suspicion of the disease, which reduces what little help might be available by a significant amount (Lachman et al., 2002:599). Therefore children's socio-emotional needs may go unmet and this creates depression and psychological disorders in their development.

- Feeling out of control

Children heading households are overwhelmed by taking over the responsibilities of caring and running the household at a tender age. Instead of enjoying their youth, they are caught in the web of parenting their younger siblings. These responsibilities place a heavy burden on their shoulders and at the end they feel that it is all out of their own control. Here are some of the direct quotations from the participants' stories:

"…I said ooh my God what have I done to deserve such horrible thing…"

"…Since I have to run the house and do the dishes and sometimes I will be tired and I end up going to bed without finishing my homework…"

"…At times I miss classes to check up on my grandmother or will be late at school in the morning because I have to cook her food before I leave for school. I wake up very early in the morning and clean the house and sleep very late at night…"

"…I was forced to drop off school because our grandmother was terminally ill now I am no longer attending school and I miss school a lot…"

Above excerpts illustrate that despite trying to be strong for their siblings, AIDS-orphans feel overwhelmed by their new role and responsibilities of being the head of the household and end up making decisions under pressure, some of which affect or compromise their future. Some of these decisions include dropping out of school, missing classes or not finishing their school work and feeling out of control. These choices extend a long way as they eventually may become unemployed adults due to the lack of education and professional skills. As they feel out of control, education becomes the last thought in their minds and ultimately they miss the opportunity for

tertiary education, so important to their survival (Van Dyk, 2012:349; Gow & Desmond, 2002:112).

4.3.1.5. Challenges encountered in heading the household

Challenges encountered by AIDS-orphans heading households range from dropping out of school, lack of adequate finances, poor housing facilities, food insecurity to poor decision making, to mention but a few. Without any adult support, these children are confronted with these challenges on their own on a daily basis. One can say these challenges are inevitable and can expose these children to being even more vulnerable. Below is a discussion of the challenges faced by the children in their own words according to sub-themes.

- Poor housing facilities

The researcher observed that most of the participants lived in formal RDP houses registered in the names of their deceased parents and the others in backyard shacks. One of the participants lived in a shack with her brothers and her child because their relative chased them out of the house soon after their grandmother's death. Another one stayed in a backyard shack because he is renting out the main house in order to earn cash at the end of the month. The participants highlighted that they all do not have access to proper amenities such as toilets, electricity and running water.

"…We do not have our own place to stay…."

"… I am staying in the backyard room because I am renting out the main house.."

Van Dyk (2012:356) argues that children often lose their rights to the family land or property after the death of their biological parents. Insufficient legal protection results in unjust property rights, thus depriving them of the inheritance to which they are entitled (DeJong, 2003:6). Children generally have a right to own possessions or money left to them by their dead relatives. However, in some cultures, children's inheritances are taken away from them (NACCA, 2007:20). Relatives may move in and often take advantage of the vulnerable children by taking their possessions and property and, at the same time, fail to provide any form of support for them. This act eventually exacerbates their vulnerability. Children in urban areas who live in rented

property may face eviction from the property they grew up in. They may subsequently relocate to rural areas or informal settlement (*mokhukhu)* areas where they find a dodgy means of survival such as stealing, living on the streets, abuse of drugs, etcetera.

- Poor decision making

Children need parental and adult supervision especial when it comes to decision making that affects their lives. Children in child headed households are comfronted with this role on a daily basis and end up failing to make informed decision. Below extracts attest to this:

"I had to drop out of school to look after my sick mother and my younger disabled sister as there was no one helping us…"

"Almost everyday, I dodge school during break time and check up on my grandmother and at times I won't go back…"

"At times we sleep with empty stomachs because there will be no food in the house…"

From the above extract, these children are confronted with the role of decision making on a daily basis. For instance, maintaining peace in the family, deciding on the household duties and what to eat on that day. At times, some of the decisions children make pose a serious threat with regards to their future like dodging school in order to take care of their sick parents and others dropping out of school which will make them unskilled and unqualified for formal work, thus becoming victims of cheap labour. The most painful part is to make a decision to sleep with an empty stomach and go to school in an old school uniform. These children are faced with so many challenges ranging from food insecurity, lack of a stable home, poor conflict resolution skills and financial constraints. However, due to their resilience, they manage their lives in such difficult times.

- Family wanting to take over parental property

Poverty is the primary barrier to caring for orphans locally and nationally (Hepburn, 2002:89). Hepburn explains that without adequate resources to feed, clothe, and offer counselling the basic needs of such children will continue to go unmet. For example, children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes (Salaam, 2005:16). Salaam (2005:18) furthers asserts that property grabbing, a practice where relatives of the deceased come and claim the land and other property, is reportedly a serious problem for child headed households. Traditional law in many rural areas dictates that women and children cannot inherit property and as a result property grabbing has a number of negative consequences, particularly for girls. Girls may experience sexual abuse and exploitation from their new caretakers; they may be forced into the sex trade in exchange for shelter and protection, further increasing the risk of contracting HIV. The following excerpts confirm this:

"…our step-brother chased us from what we believed was our home…"

"… our maternal aunt was only helping me because she wanted to get hold of my late mother's title deeds of this house so that she can repossess it…"

Shelter is referred to by Nekundi (2007:23) as a home where children feel comfortable, happy and safe and is one of the most imperative factors in the development of a child. Children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes which their parents left for them. Few people in poorer communities in sub-Saharan Africa make official wills, increasing the risk that a deceased person's property will simply be grabbed by other family members, or, in some cases, by other members of the community (UNICEF, 2010:20).

- Difficulty controlling younger siblings

Conflict, according to Mkhize (2006:83), is inevitable in any relationship, and the situation is worse when children are staying alone without any adult supervision and continue to live and interact as a unit. At times they are likely to differ in opinions and

this will result in conflict. Children affected by HIV and AIDS, especially those living in child headed households, in most instances lack the capacity to deal with conflict because of poor care and supervision (Richter, 2004:11). Since it is the role of parents to provide supervision and discipline to the children as they grow, lack of parental supervision deprives the children of the virtue of understanding conflict resolution within the family system. . The eldest child may feel inadequate to instil discipline amongst the younger siblings, thus resulting in a lack of discipline within the entire family. Germann, (2005; 261) confirms that this role is compromised by a lack of knowledge and results in failing to instil discipline and control of younger siblings. Some of the children heading households confess having used different strategies, including advice and the involvement of neighbours, boyfriends or church members, which they believed to be appropriate in resolving the conflict. . Mkhize (2006:83) found that in the child headed households she studied, conflict was inevitable as siblings interacted as a unit. She found that sibling rivalry was a result of difference of opinions among children on the allocation of household chores.

"…My boyfriend is helping me to discipline my brothers…"

"…"I don't like it when my brothers fight each other... When our step-brother chased us from his father's RDP house we were forced to go and stay with my boyfriend the four of us and my other siblings did not approve of it."

When children have to assume the tasks of acting as parents and looking after siblings, they often experience pain and trauma because they have to perform duties for which they have not been prepared. The role of parenting is composed of tasks, roles, rules, communication, resources, and relationships, and it can be confirmed that AIDS-orphans heading households lack these parenting skills. Parenting is not about being in a particular family structure, but rather refers to a process of guiding children from conception and birth through development challenges until adulthood. This, to AIDS-orphans, becomes an unfulfilled dream as they are the ones who have to provide this guidance for their younger siblings. Instilling and maintaining discipline with regard to their younger siblings is one of the challenges confronted by these child heads on a daily basis as they do not have sufficient skills and knowledge to do so.

- Not coping at school

Taking care of a sick parent and younger siblings is not an easy task, especially for young adolescents who are themselves still in need of parental care, guidance and protection. The AIDS-orphans who participated in this study demonstrated how challenging it was for them to concentrate in class and at the same time thinking of the situation at home. Though schooling is important to children affected by HIV and AIDS (Foster, Levine & Williamson. 2005:70-72), the possibility of completing their education is minimal. This is greatly regretted because since these children are exposed to a life of suffering, pain, confusion and anxiety, schooling can help them develop a renewed sense of efficacy in relation to life and its circumstances and can restore some lost confidence. Studies by Mkhize (2006), Kelly (in Foster et al., 2005:72), and Smart (2003:22) show that dropping out of school may have a serious impact on the children's future as school also offers an environment in which children can develop socially and emotionally and gain knowledge and skills that will enable them to progress through adolescence to adult life.

It is a clear fact that orphaned children are at risk of not being able to cope at school due to continuous disruptions experienced when their parents fall ill and when they eventually die. The trauma experienced as a result of loss of parents, loss of income and security affects their performance at school which results in repeated failure that leads to dropping out completely (Masondo, 2006:37). Nziyane (2010:137) also states that this role of heading the household at a tender age compromises the children's schooling in a negative way. The children need psychosocial support and, according to Smart (2003:22), the school as a system plays this fundamental role for the orphaned children in providing this psychosocial support service which is neglected in favour of other needs such as economic, nutritional and physical. Education is an important key to success as it equips these children to be literate and productive members of the society (Subbarao et al., 2001:9). However, in the absence of parental care and support, orphans end up not coping with school due to financial constraints and not meeting the demand for school fees, stationery and school uniform. The excerpts below highlight this:

"…I was forced to drop off school because our grandmother was terminally ill now I am no longer attending school and I miss school a lot…"

"…At times I miss classes to check up on my grandmother or will be late at school in the morning…"

"…sometimes I would dodge school…"

'I am certainly not coping with my school work. It is very difficult to focus in school.'

These extracts indicate how the AIDS-orphans heading households struggled to balance their school work and their new roles of being the head of the household. They find it difficulty to balance the two and at times find themselves out of the school because of pressure from home.

- Lack of finances to maintain the family

AIDS-orphans heading households face the most crucial challenge of securing enough funds to run the household. Being a child, the AIDS-orphans by law cannot be formally employed and this poses a huge threat to their household finances. Even though some of the participants sell sweets, fruit and vegetables and do people's hair, the income they get is not sufficient enough to run the household throughout the whole month. At the end of the day, they at times sleep with empty stomachs or ask food from their neighbours for survival. The quotations below attest to this:

"…we don't have money to buy food. We don't have money to buy clothes, uniforms and stationery…"

"…it's hard for them because at times they would struggle to get normal shoes and normal jersey when it's cold and that thing is difficult for me to see because I could not bear the fact that they are feeling helpless…"

"…that time we will want something to eat or maybe they need school clothes or shoes and at that time I don't have anything or anyone to ask or help me…"

These story lines indicate that without adequate finances, AIDS-orphans are struggling to provide for their younger siblings with proper school uniforms, clothes and other basic needs. The role of being a breadwinner is not that simple for the

children. As a result of the impact of HIV and AIDS on the household economy, poverty is likely to deepen as the epidemic takes its course. As the epidemic cheats families and communities of members of the working age group, in a context marked by weak or non-existent social safety nets, large networks of dependants may lose economic support (DeJong, 2003:5). Children usually drop out of school and are involved in income-generating activities (Nkomo, 2006:16). On the other hand, they at times start selling their belongings to foot the medical bills of the sick parent and by the time the parent dies, they will be left with close to nothing to economically sustain themselves. Loss of parental income and changes in the family economy often spiral down into poverty and deprivation (Van Dyk, 2012:360). This creates a vicious cycle of poverty. In support of the above statements, Simfukwe (2003:22) asserts that when the household member becomes ill they are forced to renounce their jobs and this negatively impacts on the household income and subsequently affects the children when the parents die.

- Food insecurity

Food is the most important and immediate basic need for survival. Food security, as defined by the World Food Summit of 1996, is "when people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life." Usually, the concept of food security includes both physical and economic access to food that meets people's dietary needs and preferences (Grover, 2011:188). AIDS-orphans experience hardships when it comes to food security because they may be unable to meet their minimum food requirements over a sustained period of time. This is related to issues of low income and continuing poverty (Grover, 2011:188). Most of the AIDS-orphans experience food insecurities on a daily basis because of insufficient funds. The majority, if not all of the AIDS-orphans are confronted with the challenges of securing a balanced diet throughout the month. They are therefore likely to face a greater risk of malnutrition than any other children (Barnett & Whiteside, 2006:229). This is as a result of the impact of HIV and AIDS which puts economic stress on the affected households, for example children end up selling their parents' property to meet the economic needs of the family, especially as these children are often left with nothing after the death of their parents (Smart, 2003:8). This lessens the household income even further which will therefore result in a worsening of their diet and nutrition (Greenberg, 2007:13). The excerpts below attest to this:

"… it happens that some other days we don't have something to eat…"

"…because we don't have enough money to buy food…"

"…at times I go to bed without eating enough…"

Although some of the extended family members, neighbours and church members seem to be aware of the children's challenges regarding the lack of food. Their own financial circumstances prevent them from offering appropriate assistance to the children. These findings are confirmed by Foster (2004:5) who states that "seeking relief from relatives, friends and neighbours is a common response to economic crises". Relatives, friends and neighbours provide moral and material support to vulnerable individuals on the assumption of future reciprocation. The participants highlighted that from the amount of money they get, they buy basic commodities and as a result they do not eat a balanced diet throughout the entire month. According to Barnett and Whiteside (2006:229), Greenberg (2007:13), and Subbarao et al. (2001:3), orphaned children are at a greater risk of malnutrition than any other children. According to the Nelson Mandela Children's Fund Report (2001: 26) many of the children are helpless and unable to think of ways of fending for themselves or coping with the uncertainty regarding where the next meal will come from. Young siblings tend to look up to the child heading the household "to make a plan", especially in respect of providing the meals – this puts a great deal of pressure on the child heading the family.

4.3.1.6. Coping mechanisms

Children from child headed households, though plagued by numerous challenges, sometimes emerge stronger as they tap deeply into their coping mechanisms to survive. Their resilience is admirable as some of them are able to continue living on social grants and make better lives for themselves. Some of them do menial jobs and exert themselves in different ways to put food on the table. It can be said that they do their best to cope within their own context. The following story lines attest to coping mechanisms they use to keep their heads above water:

"We sell sweets and nik-naks with my brothers in order to supplement our foster care grant..."

"I sometimes plait people's hair to make more money…"

"I moved to the backyard shack and I have rented out the main house so that I will have some money at the end of every month…"
"I am selling fruits and vegetables here in the location…"

From the information gathered during the interviews, it was clear that all participants possess different skills of sourcing money for their survival as well as resilience and the energy to survive, despite all the odds. The following sub-themes emerged emphasising the coping mechanisms that participants use to survive:

- Friends

Friendship is formed based on mutual understanding and the idea that friends help each other during times of hardship. Friendship can also extend beyond school-based encouragement and work. Some friends, because of their shared love and respect, might be able to assist one another through a difficult time, by providing each other with both practical and emotional support through home visits. The positive peer culture (PPC) is often viewed only as a liability, too seldom has it been seen as a resource. Just as peer group influence can foster problems, so also can the peer process be used to solve problems (Vorrath & Brendtro, 1985:1). These children also benefit from aspects of PPC such as belonging, mastery, independence and generosity (Laursen 2010: 39-40). All youths have an innate need to belong with others, master real life problems and challenges as opportunities for learning and use such events to explore their behaviour and feelings; in a way to develop autonomy by involving themselves in decisions that influence their lives and in so doing also care for one another. During the teenage years they are increasingly drawn to the influence of other young people. Thus, peer pressure is omnipresent, whether positive or negative. PPC works to intentionally shape peer group values into positive values of care and concern. This also works out well for AIDS-orphans heading households in this regard as they will regain a sense of belonging through PPC. PPC is a peer-helping model designed to improve social competence and cultivate strengths in troubled and

troubling youth. PPC is designed to convert otherwise negative peer influence into care and concern for others. Developing social interest is the defining element of PPC and requires leadership and guidance from trained adults. Rather than demanding obedience to authority or peers, PPC demands responsibility, empowering youth to discover their greatness.

"I at times enjoy being with my friends who are also orphans as they understand me and do not judge me…"

"My friends at times come home and help me with some of the household chores before we go to out to play…"

From the above extracts it can be said that some of the participants reported that being with friends and especially orphaned children like themselves and being away from the home environment provided them with the space and time to forget about their pain and problems. The participants said that they also have friends of their age and they do have time to play with them but not more often. One of the participants said that he has older Christian friends.

- Religion and prayer

Faith-based organisations have strength, credibility and are grounded in communities. This offers them the opportunity to make a real difference in combating HIV and AIDS. To respond to this challenge, faith-based organisations need to be transformed in the face of the HIV and AIDS crisis in order that they may become a force for transformation, bringing healing, hope and accompaniment to the AIDS-orphans (UNICEF, 2003:7). Prayer and going to church have played an important part in the lives of many of the participants in this study. Religion and praying served to meet the spiritual needs of AIDS-orphans heading households and other individuals in general. Almost all participants felt that only praying could answer their problems, especially in the difficult situation in which they find themselves. In other words, it can be viewed as a healing process (Mkhize, 2006:90). One participant confirmed that one of the church members helped with the application for a foster care grant and is subsequently receiving foster care grant for two sisters on their behalf since none of their extended family members was willing and available to assist. These sisters also

receive food parcels and clothes from their church. The following quotations bear witness to this:

"…above everything, the support that am expecting is from God and God alone from above…"

"… our pastor at church is always there for us…"

"…I also pray to God to help me to be a strong person for my brothers and my child…"

"…I always pray to God to give me strength and to heal my grandmother…"

Religion played a greater role in some of the participants' lives and they believe that only God can help them, especially in this context of being AIDS-orphans who are heads of households and undergoing many traumatic experiences and receiving little if any support. In the absence of parents and the support of family, Christian communities play a vital role in loving and supporting these children and guiding, training and teaching them in the knowledge and fear of God. In search for their identity, teenagers find it important to integrate faith in their life (Maqoko: 2006:72). This helps them to find some positive answers to their many questions. Within the circles of faith communities, they meet some positive people who show them positive ways of coping with life.

Religious leaders are distinctly poised to break the cultural silence which surrounds HIV and AIDS, by acknowledging suffering and reaching out with compassion to the excluded and rejected AIDS-orphans through their sermons and teachings. In addition to this, they have the power to end guilt, denial, stigma and discrimination and open the way to reconciliation and hope, knowledge and healing, prevention and care for the AIDS-orphans (UNICEF, 2003:8). Other activities aimed at mitigating the impact of HIV and AIDS in communities include, mentioning but a few, provision of clinical care, home-based care, spiritual and pastoral support, psychological care, counselling, nutritional and material support, income-generating activities and support groups (Parker & Birdsall, 2005:18-19). Therefore, the church acts as a spiritual home

for the AIDS-orphans and as a source of strength, support and hope (Parker & Birdsall, 2005:12).

- Home and community-based caregivers

The government, business, the media, academics, international donors, non-governmental organisations (NGOs), non-profit organisations (NPOs), community-based organisations (CBOs) and faith-based organisations (FBOs) continue to strive to halt the effects of the devastating HIV and AIDS, though with little success (Bojer, Lamont, Janitsch, Dlamini, & Hassan, 2007:15). This situation creates a need for support to children who are left alone to fend for themselves. More serious is the concern of support for AIDS-orphans, compelled by circumstances to head families, in the absence of an adult family member. When families cannot adequately provide for the basic needs of their children, the community is the next safety net for essential support (UNICEF, 2012:39). The home and community-based caregivers help to minimize the trauma of having lost their parents by visiting them regularly, checking how they live as well as offering them psychosocial support services. They assess issues such as whether the children in child headed households are attending school regularly or not, whether they are immunized and whether the children have time to play (Van Dyk, 2008:334). They also help them buy uniforms and check if they have the necessary documents. They make sure that the children benefit from the food parcels supplied by the Department of Social Development and other welfare organisations. Therefore, the home and community-based caregivers make sure that these children's rights are protected at all times (Maqoko, 2006:87). The following storylines from participants bear witness to this:

"…I am also in the aftercare at school and the community caregivers help me as well…"

"…My younger brother is in the aftercare and his community caregivers come and even check us up at home…"

These storylines demonstrate how communities in Zamdela, Free State are responding to the AIDS orphan crisis in their communities. Child Welfare South Africa, Sasolburg is running two successful aftercare centres for orphans and children made

vulnerable by HIV and AIDS, where they provide psychosocial support services, school work assistance, memory work, spiritual care and on top of that provide these children with nutritional meals during week days. These aftercare centres operate throughout the year except on public holidays and during the festive season. In the case of the festive season, these children are well taken care of as they are provided with food parcels which will last for four weeks for a family of four. Also, the community caregivers visit these children's families to offer psychosocial support and to make referrals to relevant stakeholders.

On the other hand, in Malawi, the village committees undertake a range of activities, including regular visits to households with the most vulnerable children, develop community food gardens and distribute improved crop varieties in order to assist the children in CHH. They also work to ensure that children continue to go to school by convincing foster parents of the importance of continued schooling, and encouraging schools to waive fees for orphans and other vulnerable children (UNICEF, 2012:39). UNICEF (2012:39) also includes another example in the United Republic of Tanzania, where villagers have set up 'Most Vulnerable Children Committees' that mobilize and distribute villagers' donations of food and funds and also organize income-generating activities and other forms of support. Likewise, in Swaziland, local people established Orphans and Vulnerable Children Committees to pool resources and organize community support.

4.3.1.7. Support needed

Deriving from Nuget and Masuke's (2007:1) psychosocial support definition, support can be described as the efforts to meet the on-going emotional, social and spiritual needs of AIDS-orphans as they face life's challenges, especially the household heads. A healthy child development pivots greatly on the continuity of social relationships (PEPFAR, 2008:16). AIDS-orphans suffer anxiety and fear during the years of parental illness, which is then followed by grief and trauma with the death of a parent. Therefore, these children need love and emotional support and also the opportunity to express their feelings without fear of stigma and discrimination. The participants indicated that somewhere, somehow they receive material support from mainly neighbours in the form of food and from their social workers. In terms of frequency of

getting material support, participants revealed that the support is not predictable. The support needed by these children will be discussed as follows hereunder:

- Social work intervention

The role of the social worker in cases like these is to advocate for the rights of children and also to ensure that their basic needs are met (Mkhize, 2006:231). Also, as advocates, social workers should act as intermediaries between children and other social systems with a view to protecting the rights of the children. The support AIDS-orphans receive from their neighbours does not sustain them for a long time therefore, they live without help from neighbours and relatives most of the time. This is where social workers are needed to bridge the gap. Social work intervention can come in different forms, depending on the needs of the vulnerable children. This can include securing an unrelated foster parent in the event of unavailability of extended family members to foster these children; involving them in income-generating projects; involving them in a peer education support group; offering psychosocial support services; and material support, to mention but a few. For example, the participants stated that:

"…I want the social worker to assist us to get ourselves our own stand and also to assist me with parenting skills…"

"…the community caregivers to continue visiting and helping my grandmother…"
"…Parental guidance from the social worker…"

The excerpts indicate that these children, although they are heading the households on their own, feel they need outside support in the form of parental skills since they do not have sufficient skills. As a profession, social work advocates for the poor and the disadvantaged and in this case, the AIDS-orphans heading households. Their main purpose as social workers is to restore and enhance social functioning from dysfuntioning (Mkhize, 2006:80). In addition, social workers as advocates must offer support, advice and represent these child headed households in their dealings with the various social institutions within the households' social environment.

Social work services differ from agency to agency. Some social work agencies provide services to child headed households in the form of material support, such as buying school uniforms and stationery, providing food parcels and they can also advocate for exemption of school fees and being declared indigent by the municipality. There are also some organisations running aftercare centres for orphans and vulnerable children, where these children are provided with meals, psychosocial support services and school work assistance while their elder siblings concentrate on their own school work. However, most of the non-governmental organisations face the challenge of lack of sufficient funding to constantly render such services to vulnerable groups.

- Counselling

Counselling, according to Van Dyk (2008:219), is a facilitative process wherein the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self-knowledge, emotional acceptance, emotional growth and personal resources. All the participants who partook in this study were not happy with the situation they find themselves in and the researcher saw a need to offer them counselling, particularly to those who were very emotional during the research interviews. Some of the research questions opened up old wounds and the participants became emotional. Through counselling, AIDS-orphans heading households are given an opportunity to explore and discover ways of living more fully, despite their challenges, as counselling assists them with addressing and solving these challenges and making an informed decision (Van Dyk, 2008:219). Below extracts indicated the need for counselling for these AIDS-orphans:

"Our social worker only provides us with food parcels and not counselling…"
"At times a feel so down and need maybe counselling…"

"My church pastor provides me with counselling at church and at home at times…"

Therefore, counselling as a coping tool, helped AIDS-orphans to manage their unresolved emotional problems more effectively and they may develop unused or underused opportunities to cope more effectively, writes Van Dyk (2008:219). Through counselling, AIDS-orphans heading households without any adult support

will be assisted and empowered so as to become more effective self-helpers in their everyday lives. Some of the participants, on the other hand, revealed that their area social workers are only concentrating on assisting them with material needs and neglecting their emotional needs. This study however helped them as the researcher referred them to Methodist counsellors for counselling. Some of the participants also mentioned that their churches are also providing them with spiritual counselling.

- Family and community support

Most of the participants perceived that people in their communities (especially neighbours and friends) had sympathy for the orphaned children. Participants reported that they have often been supported with food and other educational material such as exercise books by neighbours and friends. This indicates that the community's response to the needs of orphaned children is not only promising but also reflects a level of acceptance of the children after the death of their parents (Woldeyohaness, 2010:75)

Families are regarded by Schor (2003:218) as the most central and enduring influence in the lives of children. Schor further asserts that families transmit and interpret values to their children and prepare children to interact with the larger world. In addition to this, a family is therefore seen as the first point of provision for socialization. This is of crucial importance especially to growing children. Yet this, to AIDS-orphans heading households, becomes an unfulfilled dream. On the other hand, Schor (2003:219) emphasises that although schools provide formal education, families teach children how to become socially acceptable adults. The family is the first unit in society to teach children the difference between right and wrong. Due to the HIV and AIDS pandemic, this family unity is disrupted and consequently so is the socialisation process of the child (Dalen, 2009:70). As a result, children may develop behaviour which is unwanted or different from what is expected in a particular society. The following excerpts indicate the participants' desire to have support in the form of community or family intervention:

"…parenting support more especially from my extended family…"

"…I want one of my relatives to come stay with us especially when grandmother is too weak or the community caregivers to continue visiting and helping my grandmother…"

The above indicate that these children wish to have support from their extended families. Some also wish that their family members would come to their aid in cases when the grandmother is terminally ill or to foster them since one of the participants is seventeen and cannot foster himself or apply for a child support grant for himself. The well-being of children depends on the ability of families to function effectively, according to the South African White Paper on Social Welfare. It is further asserted that, because children are vulnerable, they need to grow up in a nurturing and secure family that can ensure their survival, development, protection and participation in a family and in social life. Special attention needs to be granted to children in child headed households who are far more vulnerable than children growing up within a secure and stable family unit. Not only do families give their members a sense of belonging, they are also responsible for imparting values and life skills. In the case of children growing up alone in a child headed house, this sense of belonging is not as strong as in those children growing up within the protection of their families. Furthermore, the South African White Paper on Social Welfare (1997) asserts that families create security; they set limits on behaviour; and together with the spiritual foundation they provide they instil notions of discipline. All these factors are essential for the healthy development of the family and of any society.

Children grow up in a wide range of family forms and structures, with different needs, role divisions, functions and values. However, for children growing up on their own in child headed households this becomes a dream which will never be fulfilled.

- Relationship with neighbours

Some of the children who participated in this study had a good relationship with their neighbours, even though they did not go to them for material support and others depend on their neighbours when they need help. Some neighbours in this study are of assistance to these children as they are helping them with material and emotional support and play the role of the extended families who are unavailable. The following storylines indicate these children's relationship with their neighbours:

"… it was fine… am not the type of person who will go and ask something from the neighbours…"

"Good. They also help me with food"

"It is good because they are the ones who always assist us"

"Our relationship with our neighbours is good even though they are busy with their lives"

"Good. Although we don't go to them asking for food or anything because they will gossip us around. We just keep our problems to ourselves'

Although the relationships are good, some participants indicated that they do not go to their neighbours and ask for help for fear of being gossiped about or for reasons of pride. Some of the children indicated that their neighbours assist them with food, although not on a daily basis. The neighbours can be viewed as a support system to the children since their extended families are not available to play this role.

4.4 SUMMARY OF THE CHAPTER

This chapter has been mainly concerned with data presentation and analysis gathered in the field amongst the selected child-household heads participants by using the interview guide. The analysis was undertaken in order to understand and answer the research question of this study which was "What are the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, an urban area in the Free State?"

This study managed to identify the experiences, challenges and coping resources of AIDS-orphans heading households. These AIDS-orphans face a number of challenges at an economic, social and emotional level.

The reporting method used by the researcher is supported by Neuman (2006:181) who asserts that data for qualitative research are mostly presented in the form of written words or spoken words from the participants. The identified themes and sub-themes

from the transcripts were compared and contrasted with existing theory and previous literature in a bid to establish the credibility and the trustworthiness of the study (Creswell, 2003:196). In the following chapter, the summary, conclusions and recommendations on this topic will be discussed.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this final chapter, the researcher deliberates on the conclusions, summarises the research findings, and makes recommendations. The foregoing chapter presented the findings of this qualitative study in accordance with themes and sub-themes that emerged during the process of data analysis and these findings were accentuated by narratives from the transcribed interviews. The findings, illuminated by supportive storylines, were either correlated and/or complemented by a literature control, that is, the findings were compared and confirmed with the existing body of knowledge. In addition to this, the chapter also demonstrates how the goal of the study was achieved.

5.2 RE-STATING THE RESEARCH QUESTION, GOALS AND OBJECTIVES OF THE STUDY

The researcher was guided by the research question throughout her study. It is imperative to restate the research question, goal and the objectives of the study formulated at the outset of this study (See Chapter 1, section 1.3) before concluding this qualitative study. In this case, the research question for this study was articulated as follows:

- What are the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State?

The aforementioned research question dictated the goal of the study which was formulated as follows: *To gain an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdela, Free State.*

In order to realise the aforementioned goal, the following objectives were formulated**:**

- To explore and describe the experiences of AIDS-orphans heading households
- To explore and describe the challenges faced by AIDS-orphans heading households

- To explore and describe the coping resources of AIDS-orphans heading households.
- To draw conclusions and make recommendations on how to improve the welfare of AIDS-orphans heading households.

Looking at the above goal and objectives, the researcher can comfortably conclude that the study was able to answer the research question which was articulated in the goal and objectives as given above. In the next sections of this chapter, the researcher demonstrates how these were achieved.

5.3 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS ON THE QUALITATIVE RESEARCH PROCESS APPLIED TO INVESTIGATE THE RESEARCH TOPIC UNDER DISCUSSION

In this section, the summary and conclusions of the qualitative research methodology, which was followed for the purpose of this study are presented to demonstrate the usefulness and the appropriateness of the qualitative approach.

5.3.1 Research approach

Whereas some kinds of information cannot be adequately recorded using quantitative data, Bless et al. (2006:44) assert that a qualitative research approach is best used. They further argue that language provides a far more sensitive and meaningful way of recording human experiences. In this case, the researcher was investigating the experiences, challenges and coping resources of AIDS-orphans heading households in Zamdele. As compared to the quantitative approach that has a step-by-step plan or a fixed recipe to follow, qualitative approach is more flexible wherein the researcher's choices and actions determine the strategy (Fouché in De Vos et al., 2005:269). This helped the researcher during her research process to create the strategy best suited for her study.

As stated by Creswell (2009:175-176), some of the main characteristics of the qualitative approach are as follows:

- Qualitative research takes place in a natural setting, therefore the researcher collected data in the field where the selected participants experienced their challenges, experiences and coping resources in heading households.
- In qualitative research, the researcher is the instrument in the process of data collection. The researcher carried out the interviews herself. In addition to this, the researcher was involved in field work that is, she went physically to her participants in their homes and conducted interviews with them.
- Multiple sources of data are employed for the purpose of data collection. Qualitative researchers typically gather multiple forms of data, such as interviews, observations, and documents, rather than rely on a single data sources. Then the researcher reviewed all of the data, make sense of it, and organize it into categories or themes that cut across all of data sources.
- An inductive approach to data analysis is followed in qualitative research. The researcher builds her patterns, categories, and themes from the bottom up, by organizing the data into increasingly more abstract units of information. This inductive process illustrates working back and forth between the themes and database until the researcher had established a comprehensive set of themes. It may involve collaborating with the participants interactively, so that participants have a chance to shape the theme or abstractions that emerge from the process.
- Participants' meanings are central in qualitative research. Therefore, the researcher focused on learning the meaning that the participants held about their experiences, challenges and coping resources as heads of households and not the meaning the researcher brought to the research or what writers express in the literature.
- In qualitative research, an emergent design is preferred. This means that the initial plan for the research cannot be tightly prescribed, and all phases of the process may change or shift after the researcher enters the field and begins to collect data. For instance, the questions may change, the form of data collection may shift, and the individuals studied and sites visited may be modified. The key idea behind qualitative research is to learn about the problem or issue from participants and to address the research to obtain that information.

- Qualitative researchers often use a lens to view their studies, such as the concept of culture, central to ethnography, or gendered, racial, or class differences from the theoretical orientations discussed. Sometimes the study may be organized around identifying the social, political, or historical context of the problem under study.
- Qualitative research is interpretive. It is a form of interpretive inquiry in which researchers make an interpretation based on what they saw, heard and understood. Their interpretation cannot be separated from their own backgrounds, history, contexts and prior understanding. After a research report is issued, the readers make an interpretation as well as the participants, offering yet other interpretations of the study. With the readers, the participants, and the researcher all making interpretations, it is apparent how multiple views of the problem can emerge.
- Qualitative research provides a holistic account of the topic investigated. Qualitative researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges.

In view of the aforementioned characteristics inherent in the qualitative approach and the fact that qualitative research concerns itself with the study of people in their natural environment as they go about their daily lives and by trying to understand how people live (Neuman, 2006:92), the researcher concluded that this approach was well suited to realize the goal of this study.

From this qualitative stance, the researcher wanted to come to an understanding of the experiences, challenges and coping resources of AIDS-orphans heading households. Within the qualitative approach, the research designs used are explained in the next sub-section.

5.3.2 Research design

A research design entails the researcher's overall plan on conducting the research (Babbie & Mouton, 2001:74). Burns and Grove (2001:223) assert that, for a

researcher to attain the intended goal, one must be guided by the design in planning and implementing the study. This overall plan entails what the research question should be, what data will be required to answer it, from whom the data will be obtained and how best to gather the data. The research design for this study incorporated exploratory, descriptive and contextual designs.

5.3.3 Population and sampling methods

The study population for this research was defined as AIDS-orphans heading households residing in the urban area of Zamdela, Free State. Snowball and purposive non-probability sampling techniques were used to obtain a sample from the stated population. Non-probability sampling was used in this case because the researcher did not know the population size (Strydom in De Vos et al., 2005:201). The researcher chose Zamdela as the area for her study because of easy accessibility and knowledge of the area.

5.3.4 Aspects of data collection

Data for the study was collected by means of face-to-face individual interviews. The purpose of data collection is to gather information to answer the emerging research question (Creswell, 2007:118). The research question guided the researcher on what data to collect. After data collection, data was analysed. The purpose of the analysis was to reduce data to a legible and interpretable form so that the relationships of the research problems could be studied and conclusions drawn. Qualitative data analysis took place throughout the data collection process (Henning et al., 2006:127).

5.4 SUMMARY AND CONCLUSIONS ARISING FROM THE RESEARCH FINDINGS

This section focuses on the summary and conclusions of the research findings based on the themes and sub-themes that emerged during the data analysis process.

5.4.1 Themes and Sub-themes

5.4.1.1. Reasons for heading household, feelings about the death of a parent/guardian and family relations

It became evident from the study that children are drawn into the role of heading households long before the death of the parent/s or guardian. All the participants

revealed that their parents/guardians died as a result of AIDS. Because AIDS presents itself through opportunistic diseases, parents started by getting sick and gradually progressed to a terminal stage where they could not take care of themselves. This is when the eldest child in the family feels the responsibility of taking over from the ailing parent.

At this stage they were forced by circumstances to act as caregivers to their sick parents as well as to look after their younger siblings. As the parent's sickness prolonged, this evoked feelings of despair in the children. According to them, the most painful feeling was to watch their parents' life deteriorate in front of their eyes and seeing them lose control over their bodily functions. This induced feelings of helplessness and hopelessness as they could not do anything to better the situation. All they could do was to watch in despair as they waited for the final moment to come.

A general feeling of sadness and confusion was evident, and of course they were under stress knowing that they would have to become responsible for running the household, cooking, cleaning and bathing their siblings as they had to fill the gap created by their sick or terminally ill parents. (Gow & Desmond, 2002:113). Woldeyohannes (2010:29) alludes to the emptiness created by the parent's death which swiftenss the eldest child to take over the responsibility of all household chores and the task of earning an income. Because of these responsibilities, their childhood was stolen from them early in their lives.

The fact that children end up heading households at a very tender stage of their lives is an indication that family support is non-existent. It would seem that the old African saying that a child is raised not only by the family, but by the whole community does not hold anymore. Several reasons can be attributed to this, such as high levels of poverty, lack of financial muscle, and inadequate resources where relatives feel adding an extra mouth to feed is beyond their abilities.

On the other side of the coin is family greed where the extended family instead of giving support, uses the opportunity to grab and deprive children of the little inheritance they may have. Land grabbing and children chased out of their parents' home is a great concern.

5.4.1.2 Challenges and experiences

The assumption of parental responsibilities by the children heading households proved to be a challenge and a close to desperate experience that changed the orphan's life forever.

The most challenging experiences for children was to find themselves bogged down by household management, taking care of younger siblings, financial management, decision making and providing for the economic needs of the household. This is also attested to by Mkhize (2006:74-82). Performing these roles was demanding, heavy, difficult, challenging, stressful and wearisome, especially when there were younger children in the family. This ultimately meant that the children's schooling was interfered with and their play compromised thus missing out on the most important components of childhood. Children generally grow and learn through play. The study concluded that children who live in child headed households without adult care face unbearable problems such as:

- Food insecurity due to lack of finances to maintain the family
- Education-related challenges such as interrupted schooling, poor academic performance, lack of a proper school uniform, stationery and bus fare, the worst being dropping out of school.
- Poor housing facilities which exposed them to unsafe health conditions, harm and danger.
- Lack of proper guidance, which eventually results in ill-discipline and lack of self-control. Executing proper discipline to younger siblings proved to be a high mountain to climb due to a lack of skills and knowledge on how to discipline them.

With all the challenges confronting children heading households on a daily basis, the end product is a tremendous amount of stress which leads to depression and post-traumatic stress disorder.

5.4.1.3 Coping resources

Notwithstanding all these experiences and challenges they encounter, AIDS-orphans heading households demonstrated an element of coping on a daily basis. One of the

reassuring findings and conclusions of this study relates to the resilience and remarkable resourcefulness of all children in dealing with the challenges they experience in heading the households. Some participants resolved to find comfort in the hands of their friends, in religion and prayer as well as the home and community-based caregivers. They see these people as their pillars of strength after God. The home and community-based care programme by Child Welfare South Africa, Sasolburg as well as the community caregivers from the Department of Social Development proved to be supportive resources. Aftercare programmes for younger siblings where they receive psychosocial support services, educational support as well as a balanced meal every weekday are of great assistance. Faith-based organisations also play a pivotal role in assisting the orphans to cope with the different challenges, although they mainly focus on those who belong to their denomination.

5.4.1.4 Support from community and from social workers

Despite their coping resources, as mentioned above, orphans heading households reported a need for support from professional social workers. They expressed a need for counselling, family and community support as well as trusting and lasting relationships with their neighbours. A common need for training in parenting skills was mentioned and social workers were indicated as being able to provide such training. The training was important to the children as it was considered to help them in their parenting role and improve communication and discipline techniques towards their younger siblings.

5.5 OVERALL CONCLUSION ON THE RESEARCH FINDINGS

The study concluded that child headed families are a reality in South Africa. This is a phenomenon that is here to stay as children continue to lose parents through HIV and AIDS. Although it has been discussed on different platforms that the HIV infection rate is going down, the fact remains that parents still die and leave children unattended. The impact of children growing up alone cannot be understated as it has far-reaching consequences on the growing child. It is a fact that such children's future is compromised, and will thus remain a liability to the state for the rest of their lives. This situation has a tendency to replicate, because lack of parental supervision results in unbecoming behaviour where girls display promiscuous behaviour in order to make money to feed the family. This directly or indirectly results in early pregnancies.

Children born in such circumstances will also live the way their parents lived. This can be referred to as the cycle of poverty.

Psychologically, the children have to deal with the stigma of their parents having died as a result of HIV. This is compounded by the fact that adult relatives are not always available or willing to take over the responsibility of taking care of the HIV orphans. This makes children feel like outcasts and they end up blaming themselves or hating the fact that their parents died of HIV which is associated with promiscuity. As such, stress, depression and feelings of helplessness become characteristics of child headed households.

It has also been evident through the study that young children heading households are deprived of the opportunity to apply for Child Support Grant on behalf of their younger siblings because of age restriction. This is a disadvantage that affects food security for the children.

5.6 RECOMMENDATIONS

5.6.1 Recommendations pertaining to the qualitative research process

The researcher recommends that workshops in which researchers keep increasing their knowledge and understanding of the qualitative research approach are necessary. This would help maximise the chances of making sure that research is done effectively, efficiently and ethically at all times. She also recommends that researchers consult with their peers especially during data analysis. As two hands are always better than one, this would help in ensuring a thorough analysis of the data, eliminating or at least reducing the chances of major themes being missed or over-looked during data analysis. The researcher also recommends that upcoming researchers gain access to previous research reports before they can report on their own research endeavours. This may increase their awareness of what is expected of them, helping them to come up with a better product. Placing lots of emphasis on the researcher's personality can also increase the success of many research projects as the researcher is the main tool of the qualitative research approach. .

5.6.2 Recommendations related to the research findings

Based on the findings, the following recommendations are made:

- Since the law does not always allow young children to receive a grant on behalf of their younger siblings, there is a great need to have a special grant designed to accommodate child headed households and this grant must not be age bound but situation determined. This can be monitored by the area social worker.
- All the organisations working with children should have a special fund for child headed households so that the needs of children can be addressed more effectively and ethically under the constant supervision of the funding body. This is based on the fact that NGOs working with children are unable to help since funding is gradually drying up. NGOs are community based and are therefore rightfully placed to assist with vulnerable children. Enhancing their financial status would benefit the child headed households.
- There is a need to revisit legislation relating to foster parenting where the child head could be allowed to act as a foster parent to siblings, regardless of age as long as it is in the best interest of the children concerned. The current legislation allows the child who is sixteen years and above to act as a foster parent to his/her younger siblings. However, s/he is not allowed to apply for a foster care grant on his or her own behalf.
- The government must keep an updated database of child headed households separate from that of orphans and vulnerable children (OVC) so that this phenomenon can be closely monitored, especially by the Department of Education. It was proven by the schools in the area where the researcher did her research that the schools failed to differentiate between the two. The Department of Social Development should therefore work hand in hand with the Department of Education in compiling and updating a child headed household database.
- The government should legislate and enforce collaboration among various major departments working closely with children such as the Departments of Social Development, Education, Health, Human Settlements, and Home Affairs, to mention but a few, to ensure that they complement each other's programmes and initiatives in a meaningful manner. On the other hand, the government must increase support to non-governmental organisations in terms of funding and human resources. In addition to this, the policy framework for

orphans and other children made vulnerable by HIV and AIDS should be made available to all organisations working with children.

- Support for education should be extended to children from child headed households who are in high school. For instance, the after care programmes in Sasolburg only focus on Primary school learners who are assisted with school work and also benefit from cooked balanced meals.
- Consistent issuing of food parcels to identified child headed households and emergent relief funding to families in distress should be always available on request. The Department of Social Development is biased in this regard as when they have excess food parcels they only recruit those who do not have identity books and those who are not receiving any form of government grant, and forget that child headed households do not have other sources of income to supplement their grants as they are unemployable due to their age.
- Increased incentives to caregivers are needed, such as appreciating them for the work they are doing and providing them with additional food parcels whenever the Department of Social Development has extras in their budget.
- There is a need for more social workers to be allocated to work with these children to minimise feelings of apathy. These social workers need to advocate for these children's rights and link them with relevant stakeholders for further assistance. They also need to offer continuous and consistent monitoring and supervision of such households.
- Home and Community-Based Care (HCBC) programmes to be absolutely funded by the government for them to be able to carry out their duties to the maximum. For instance, in Sasolburg the Department of Social Development is only funding 5 caregivers from Child Welfare out of its 15 members.
- Child headed households should be exempted from paying school fees , for instance some private schools only exempt learners who became orphans when they were in their school and do not accommodate new orphans joining their schools.
- There is also a great need for extensive psychosocial support service and trauma debriefing by experienced social workers to offer such services to the children as they are traumatised by witnessing their parents' death and running the household at a tender age.

5.6.3 Recommendations for future and further research

The researcher's recommendation pertaining to future and further research is a challenge to all scholars to produce more literature that focuses on the experiences, challenges and coping resources of AIDS orphan households in general in the African context. This comes after the researcher realised that there is barely any literature relating to how to deal with the experiences and challenges of AIDS-orphans heading households. After realising the value of this research study, the researcher recommends that more similar research be carried out in other African societies for comparison and learning from each other. It is also recommended that similar research be conducted in other parts of South Africa since this study only covered a portion of the Free State Province. They are challenged to explore more on how children in child headed heading households in African societies.

5.7 SUMMARY OF THE CHAPTER

In this chapter, the researcher has presented the conclusions arrived at in gaining an in-depth understanding of the experiences, challenges and coping strategies of AIDS-orphans heading households. It provided conclusions about the qualitative research process as well as the research findings. Recommendations pertaining to the qualitative research process, the research findings and further and future research were also presented.

BIBLIOGRAPHY

Abdool Karim, S.S. & Abdool Karim, Q. (eds.) 2010. *HIV AND AIDS in South Africa,* 2nd ed. Cape Town: Cambridge University Press

ActionAID. 2005. *A study on the impact of "Operation Murambatsvina"*.

ACORD (Agency for Cooperation and Research in Development) 2001. *Research into the living conditions of children who are heads of household in Rwanda*. London

Alston, M. & Bowles, W. 2003. *Research for social workers: an introduction to methods,* 2nd ed. London: Routledge.

Amber, J. 2005. Stolen childhood. *Essence,* 35(7): 202-206.

Aranda, S. & Milne, D. (2000). *Guidelines for the complicated bereavement risk in family members of people receiving palliative care.* Melbourne: Centre for Palliative Care.

Babbie, E. & Mouton, J. 2001. *The practice of social research.* Cape Town: Oxford University Press, Southern Africa.

Babbie, E. 2007. The practice of social research**,** 11th ed. Belmont, CA: Thomson/Wadsworth.

Barnett, T. & Whiteside, A. 2006. *AIDS in the Twenty-first century. Disease and Globalisation,* 2nd ed. New York: Palgrave MacMillan.

Best, J.W. & Kahn, J.V. 1993. *Research in Education,* 7th ed. Boston: Prentice-Hall.

Bless, C., Higson-Smith C. & Kagee, A. 2006. *Fundamentals of social research methods: An African perspective*, 4th ed. Cape Town: Juta

Bloor, M., & Wood, F. 2006. Sampling. In *Keywords in Qualitative Methods.* London: Sage. 154-158. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781849209403.n50 (Accessed: 2014/03/15)

Blum, N. 2007. Education. In P. Robbins (ed.). *Encyclopedia of environment and society*. Thousand Oaks, CA: Sage. 543-547. . [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412953924.n341 (Accessed: 2014/05/11)

Bojer, M., Lamont, A., Janitsch, C., Dlamini, B. & Hassan, Z. 2007. *Orphans and vulnerable children in South Africa-Problems, perceptions, players… and possibilities for change*. Africa: Leadership Initiative

Book, S. 1998. *Invisible children in the society and its schools*. Mahwah, NJ: Lawrence Erlbaum Associates.

Bray, R, 2003. Predicting the social consequences of orphan-hood in South Africa**,** *African Journal of AIDS Research*, 2(1): 39–55.

Burns, N. & Grove, S. 2001. Understanding nursing research. Philadelphia: W. B. Saunders.

Children's Act (Act No 38) of 2005, see South Africa, 2006

Cluver L & Gardner, F. 2007. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children and caregivers' perspectives, AIDS Care 19(3):318-325

Constitution, see South Africa, 1996.

Conway, D. 2010. Migration. In B. Warf (ed.), Encyclopedia of geography. Thousand Oaks, CA: Sage. 1891-1897. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412939591.n767 (Accessed: 2014:05/11)

Creswell, J.W. 1994. *Research design: qualitative and quantitative approaches*. Thousand Oaks, Calif: Sage .

Creswell, J.W. 2003. *Research design: qualitative, quantitative, and mixed methods approaches*, 2nd ed. Thousand Oaks, Calif: Sage.

Creswell, J.W. 2007. *Research design: qualitative inquiry & research design: choosing among five approaches*. Thousand Oaks, Calif: Sage

Creswell, J.W. 2009. *Research design: qualitative, quantitative and mixed method approaches*, 3rd ed. Thousand Oaks, Calif: Sage.

Cynthia GL. Clamp, Gough, S. & Land, L. (2004). Data Collection. In *Resources for Nursing Research*, 4th ed.London, England: Sage. 196-198. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9780857024633.d87 (Accessed: 2014/03/15)

Dalen, N. 2009. *Challenges for orphans in sibling headed households: assessment of interventions to reduce stigma in Rakai District, Uganda* [Online]. Available: http://www.dnms.no/filer/Michael2-09_nett.pdf#page=65 (Accessed 2013/05/17).

Davidson, J. (2006). Non-probability (non-random) sampling. In V. Jupp (Ed.), *The Sage Dictionary of Social Research Methods*, London, England: Sage. 197-198. [Online]. From http://0-srmo.sagepub.com.oasis.unisa.ac.za/view/the-sage-dictionary-of-social-research-methods/SAGE.xml (Accessed: 2014/03/15)

De Forge, B. 2010. Research Design Principles. In Salkind, N.J. (ed.). *Encyclopedia of Research Design*, Thousand Oaks, CA: Sage. 1253-1260. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412961288.n381. (Accessed: 2014/03/17)

De Jong, J. 2003. *Making an impact in HIV and AIDS: NGO experiences of scaling up*. London, UK: ITDG Publishing..

Denzin, N.K. & Lincoln, Y. 2000. *Handbook of qualitative research*, 2nd ed. Thousand Oaks, Calif: Sage.

Department of Health. *National HIV and Syphilis antenatal prevalence survey 2001-2007 in South Africa*. See South Africa, 2001.

Department of Social Development, 2007. National Action Committee for Children Affected by HIV AND AIDS, see South Africa, 2007.

Descriptive Research. 2005. In Vogt, W P. (ed.). Dictionary of Statistics & Methodology, 3rd ed. Thousand Oaks, CA: Sage. 88. . [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412983907.n529 (Accessed: 2014/03/15)

Dlungwana, N.E. 2007. *The experiences of children who are heads of households in Hammarsdale.* Unpublished MSW Dissertation. Durban: University of KwaZulu-Natal.

De Vos, A.S. 1998. *Research at grassroots: a primer for the caring professions,* 1st ed. Pretoria: Van Schaik.

De Vos, A.S. 2005. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouchè, CB. & Delport, C.S.L. (eds.), *Research at grass roots for the social sciences and human service professions,* 3rd ed. Pretoria: Van Schaik 333-349.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (eds.). 2005. *Research at grassroots for the social science and human service professions.* Pretoria: Van Schaik.

Dialsingh, I. (2008). Face-to-Face Interviewing. In Lavrakas, P.J. (ed.). *Encyclopedia of Survey Research Methods.* 260-262. Thousand Oaks, CA: Sage. 260-262. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412963947.n174. (Accessed: 2014/03/20)

Drenth C.M., Herbst A.G. & Strydom, H. 2013. Complicated Grief in the South African Context: A Social Work Perspective. *British Journal of Social Work,* 43(2): 355-372

Edwards R.D. 2011. Grief, loss of a loved one. [Online]. From: http://www.medicinenet.com/loss_grif_and_bereavement/article.htm (Accessed: 2014/08/23).

Freeman, M. & Nkomo, N. 2006. Assistance needed for the integration of orphaned and vulnerable children: Views of South African family and community members. SAHARA. *Journal of the Social Aspects of HIV AND AIDS*, 3(3), 503-509.

Foster, G., Makufa, C., Drew, R. & Kralovec, E. 1997. Factors leading to the establishment of child headed households: the case of Zimbabwe. Family AIDS Caring Trust, Mutare, *Zimbabwe Health Transition Review*, 2(7):155-168.

Foster, G. 2004. *A generation at risk.* [Online]. From: http://www.hsrc.ac.za/Documents-1650.phtml. (Accessed: 2010/08/15).

Geldard, K. & Geldard, D. 2002. *Counseling children: A practical introduction*, 2nd. Thousand Oaks: Sage.

Foster, G., Levine, C., & Williamson, J. (eds). 200). *A generation at risk: The global impact of HIV AND AIDS on orphans and vulnerable children.* USA: Cambridge University Press.

Frohlich, J. 2010 The impact of AIDS on the community. In Abdool Karim, S.S. & Abdool Karim, Q. (eds.).. *HIV AND AIDS in South Africa*, 2nd ed. Cape Town: Cambridge University Press. 352-370

Germann, S. 2005. *An exploratory study of the quality of life and coping strategies of orphans living in child headed households in the high HIV AND AIDS prevalent city of Bulawayo, Zimbabwe.* Unpublished PhD Development Studiesdissertation, Pretoria: University of South Africa, Pretoria.

Giddens O & Giddens S. 2000. *Coping with grieving and loss.* New York: The Rosen publishing group.

Greenberg, A. 2007. *Enhanced protection for children affected by AIDS: a companion paper to the framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS.* New York: UNICEF.

Gow, J. & Desmond, C. (eds.). 2002. *Impacts and interventions: The HIV AND AIDS epidemic and the children of South Africa.* Pietermaritzburg: University of Natal Press.

Greeff, M. 2005. Information collection: Interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (eds.), *Research at grass roots for the social sciences and human service professions,* 3rd ed. Pretoria: Van Schaik 286-313.

Grover, V. 2011. Food security. In Cohen, N. & Robbins, P. (eds.), Green cities: An A-to-Z guide. 188-193. Thousand Oaks, CA: Sage. 188-193. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412973816.n61 (Accessed: 2013/11/11)

Guiding Goals, Principles, Objectives, and Outcomes of Youth-Led Research. 2006. In M. Delgado, M. (ed.), *Designs and Methods for Youth-led Research.* 77-109. Thousand Oaks, CA: Sage. 77-109. [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412983884.n3. (Accessed: 2014/05/11)

Henning, E., Van Rensburg, W. & Smit, B. 2004. *Finding your way in qualitative research,* 1st ed. Pretoria: Van Schaik.

Hepburn, A. 2002. Increasing primary education access for children in AIDS affected areas. *Perspectives in Education*, 20(2):87-98.

Hornby, A.S. 2006. *Oxford Advanced Learner's Dictionary: International student's edition,* 7th ed. Oxford: Oxford University Press

Hermien, B., Robert A.C.R., Shegs, J., van den Borne, B., Eka W. & Priscilla, R. 2010. *Correlates of Grief Among Older Adults Caring for Children and Grandchildren as a Consequence of HIV and AIDS in South Africa.* J Aging Health. 2010 Feb;22(1):48-67. doi: 10.1177/0898264309349165. Epub 2009 Nov 18.

Interview Schedule. 2005. In Vogt, W.P. (ed.), *Dictionary of Statistics & Methodology*, 3rd ed. Thousand Oaks, CA: Sage. 161.[Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412983907.n982 (Accessed: 2014/03/17)

Kidman, R., Petrow, S.E. & Heymann, S.J. 2007. Africa's orphan crisis: two community-based models of care. *AIDS Care*, 19(3): 326-329.

Krefting, L. 1991. Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45(3): 214-222.

Lachman, P., Poblete, X., Ebigbo, P.O., Nyandiya-Bundy, S., Bundy, R.P., Killian, B., Doek, J. 2002. Challenges facing child protection. *Child Abuse & Neglect*, 26: 587-617.

Laursen, E.K. 2010. *Positive peer culture – The evidence base for positive peer culture*. Vol 19 (2). [Online]. From: http://reclaimingjournal.com/sites/default/files/journals-articles-pdfs/192%20Laursen.pdf (Accessed: 2014/11/03).

Lavrakas, P. 2008. Research Question. In. Lavrakas, P. J. (ed.), Encyclopedia of Survey Research Methods. Thousand Oaks, CA: Sage. 737[Online]. From http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412963947.n474 (Accessed: 2014/03/16)

Leedy, P.D. 1997. *Practical research: planning and design*, 6th ed. Columbus, Ohio: Prentice-Hall Inc.

Malinga, A.P. 2002. *Gender and Psychological implications of HIV AND AIDS for orphaned children and adolescents*. A draft paper for Women's World Conference. 2012, Uganda. [Online]. From: htt://www.makerere.ac.ug/womenstudies/full%20papers/Apila%20Helen%20Malinga.htm (Accessed: 2014/03/11).

Mark, R. 1996. *Research made simple: a handbook for social workers*. London: Sage.

Masondo, G. 2006. *The lived-experiences of orphans in child headed households in the Bronkhorstspruit area: A psycho-educational approach.* Unpublished Degree of Education mini-dissertation, Johannesburg, University of Johannesburg.

Maqoko, Z. 2006. *HIV AND AIDS-orphans as heads of households: A challenge to pastoral care.* Unpublished MA Dissertation, Pretoria, University of Pretoria.

Mkhize, Z.M. 2006. Social functioning of a child headed household and the role of social work. Unpublished D.Phil Dissertation, Pretoria, University of South Africa.

Moffett, B. 2007.*Parentification in child headed households within the context of HIV and AIDS.* Unpublished MA Dissertation, Johannesburg, University of the Witwatersrand.

Moutona, J, 2001. *How to succeed in your master's and doctoral studies: A South African guide and resource book.* Pretoria: Van Schaik.

Nekundi, L.M. 2007. *A comparative study of orphans and vulnerable children (OVC) support in Oshakati district, Oshana Region, Namibia.* Unpublished MDS Dissertation, Bloemfontein, University of the Free State.

Nelson Mandela Children's Fund. 2001. *Report on a study into the situation and special needs of children in child headed households.* Johannesburg: Nelson Mandela Children's Fund.

Nkomo, N. 2006. *The experiences of children carrying responsibility for child headed households as a result of parental death due to HIV AND AIDS.* Unpublished Degree PSY Dissertation, Pretoria, University of South Africa.

Neuman, WL. 1997. *Social research methods: qualitative and quantitative approaches,* 3rd ed. Boston: Allyn and Bacon.

Neuman, W.L. 2006. *Social research methods: qualitative and quantitative approaches*, 6th ed.). Boston: Pearson Education Inc

Ng'weshume, J., Boerma, T., Bennett, J. & Schapink, D. (eds.). 1997. *HIV prevention and AIDS care in Africa: a district level approach*. Amsterdam: Royal Tropical Institute.

Nziyane, L.F. 2010. *Practice guidelines for the integration of child headed households into extended families*. Unpublished D.Phil Dissertation, Pretoria: University of South Africa, Pretoria.

Parry, S. 2007. Migration. In Bevir, M. (ed.), Encyclopedia of governance. 566-567. Thousand Oaks, CA: Sage. 566-567. [Online] From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412952613.n323 (Accessed: 2014/05/16)

Rosa, S. 2004. *Counting on children: Realizing the right to social assistance for child headed households in South Africa*. Children's Institute Working paper, No. 3. University of Cape Town.

Rosa, S. & Lehnert, W. 2003. *Children without adult caregivers and access to social assistance*. Hosted by the Children's Institute. University of Cape Town and the Alliance for Children's Entitlement to Social Security. 20-21 August 2003.

Salaam, T. 2005. *CRS Report for Congress: AIDS-orphans and vulnerable children (OVC), Progress, Responses and Issues for Congress*. Congressional Research Service. The Library of Congress

Saumure, K. & Given, L. (2008). Population. In Given, L (ed.), *The SAGE Encyclopedia of Qualitative Research Methods*. Thousand Oaks, CA: Sage. 644-645. , . [Online]. From: http://0-dx.doi.org.oasis.unisa.ac.za/10.4135/9781412963909.n327 (Accessed: 2014/03/11)

Schurink, E.M. 1998. The methodology of unstructured face-to-face interviewing, In

De Vos, A.S., Strydom, H., Fouché, C.B., Poggenpoel, M. & Schurink, E.W., *Research at grassroots: a primer for the caring professions.* .

Semkiwa, H.H., Tweve, J., Mnenge, A., Mwaituka, Y., Mlawa, H.M. & Kawala, E. 2003. *HIV AND AIDS and Child Labour in the United Republic of Tanzania: A Rapid Assessment – A Case Study of Dar es Salaam and Arusha*. Geneva: International Labour Organization, International Programme on the Elimination of Child Labour.

Simfukwe, WC. 2003. *Assessment of the impact of HIV AND AIDS on rural livelihoods.* Unpublished MDS Dissertation. Bloemfontein: University of the Free State.

Sloth-Nielsen, J. 2004. *Realizing the rights of children growing up in child headed households: a guide to laws, policies and social advocacy.* Cape Town: Creda Communications.

Smart, R. 2003. Planning for orphans and HIV AND AIDS affected children. In Uys, L. & Cameron, S. (eds.), *Home-based HIV AND AIDS care*. Southern Africa: Oxford University Press 174-190.

Snowball sampling. 2004. In Cramer, D. and Howitt, D. (eds.), *The SAGE Dictionary of Statistics.* London, England: Sage. 155. [Online]. From: http://0-srmo.sagepub.com.oasis.unisa.ac.za/view/the-sage-dictionary-of-statistics/SAGE.xml (Accessed: 2014/03/13)

Social Assistance Act (Act No, 13) of 2004, See South Africa, 2004.

South Africa. 1996. The Constitution of the Republic of South Africa as adopted by the Constitutional Assembly on 8 May 1996 and as amended on 11 October 1996. Pretoria. Pretoria: Government Printer (B34B-96)

South Africa: Department of Welfare. 1997. White Paper for Social Welfare: principles, guidelines, recommendations, proposed policies and programmes for developmental social welfare in South Africa. [Online]. From: http://www.info.gov.za/view/DownloadFileAction?id=127937. (Accessed: 2014/02/05)

South Africa. Department of Health. 2001. *National HIV and Syphilis antenatal prevalence survey 2001-2007 in South Africa*. Pretoria: Department of Health.

South Africa. 2004. Social Assistance Act (Act No 13) of 2004. *Government Gazette*, 714 (26446). 10 June 2004.

South Africa. 2006. Children's Act (Act No 38) of 2005. *Government Gazette*, 492(28944). June 19:1-217

South Africa, 2007. Department of Social Development. *National Action Committee for Children Affected by HIV AND AIDS*. Pretoria: Government Printer.

South African Schools Act (Act No. 84) of 1996, see South Africa

Stroebe, M., Schut, H. & Stroebe, W. 2007. Health outcomes of bereavement. *The Lancet*, 370: 1960-1973.

Stroebe, M. S., Hansson, R. O., Stroebe, W. & Schut, H. 2001. Introduction: Concepts and issues in contemporary research on bereavement. In Stroebe, M.S, Hansson, R.O, Stroebe, W. & Schut, H. (eds.), *Handbook of bereavement research: Consequences, coping and care*, 517-544.

Strydom, H. 2005. Ethical aspects of research in the social sciences and human service professions, in De Vos, AS., Strydom, H., Fouché, CB. & Delport, CSL. (eds), *Research at grass roots for the social sciences and human service professions*, 3rd ed 56-70.

Strydom, H. 2005. Sampling and sampling methods, in De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (eds.), *Research at grass roots for the social sciences and human service professions*, 3rd ed 192-204.

Strydom, H. & Delport, C.S.L. 2005. Sampling and pilot study in qualitative research, In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (eds), *Research at grass roots for the social sciences and human service professions*, 3rd ed 327-332.

Subbarao, K., Mattimore, A. & Plangemann, K. 2001. *Social Protection of Africa's Orphans and other Vulnerable Children: Issues and Good practice Program Options. Human development sector, Africa region.* Washington DC. USA: World Bank.

Thurman, T.R., Snider, L.A., Boris, N.W., Kalisa, E., Nyirazinyonye, L. & Brown, L. 2008. Barriers to the community support of orphans and vulnerable youth in Rwanda. *Social Science & Medicine*, 66:1557-1567

Tsegaye, S. 2007. *HIV AND AIDS and the emerging challenge of children heading households: Discussion paper.* The African child policy forum: In-house document.

UNAIDS, UNICEF, & USAID. 2004. *Children on the Brink : A Joint Report of New Orphans. Estimates and a Framework for Action.* New York City. 3.

UNAIDS. 2002. *Report on the Global HIV AND AIDS Epidemic*. Geneva: UNAIDS.

UNICEF. 2003. *Africa's Orphaned Generations*. New York: UNICEF.

UNICEF. 2003b. *Fighting HIV AND AIDS: Strategies for success 2002 – 2005*. New York: UNICEF

UNICEF. 2006. *Collecting Data for National Indicators on Children Orphaned and Made Vulnerable by AIDS: A Methodological Report.* New York: United Nations Children's Fund.

UNICEF. 2012. *Statistics and Monitoring, Country Statistics.* New York: UNICEF.

United Nations. 1989. *Convention on the Rights of the Child*. New York: United Nations.

Van Dyk, A. 2005. *HIVAIDS Care & counselling: A multidisciplinary approach.* 3rd ed. Cape Town: Pearson Education.

Van Dyk, A. 2008. *HIVAIDS Care & counselling. A multidisciplinary approach*, 4th ed. Cape Town: Pearson Education.

Van Dyk, A. 2012. *HIV and AIDS Education, care and counselling. A multidisciplinary approach,* 5th ed, Cape Town: Pearson Education.

Van Teijlingen, E.R. & Hundley, V. 2001. The importance of pilot studies, *Social Research Update*, (35):1-9.

Vorrath, H.H & Brendtro, L.K. 1985. *Positive peer culture*. [ebook] Library of Congress Catalog number: 84-21570. Aldine Transaction Publishers, Rutgers – The State University: New Jersey USA. [Online] from: http://books.google.co.za/books?id=CVdJo1-FUO4C&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false (Accessed: 2014/05/11)
+
Ward, B & Associates. 2000. *Good grief: exploring feelings, loss and death with over elevens and adults.* London & Bristol: Jessica Kingsley publishers.

White Paper for Social Welfare, see South Africa. Department of Welfare. 1997

WCC Study Document 1997. *Facing AIDS: The challenge, the churches' response.* Geneva: World Council of Churches

Woldeyohannes, M.J. 2010. *The roles and challenges of household care giving in child headed households affected by HIV AND AIDS: the case of 10 child household heads in Addis Ababa.* Unpublished MA Dissertation, Pretoria: University of South Africa.

Yegidis, B.L. & Weinbach, R.W. 1996. *Research methods for social workers.* London. Allyn & Bacon.

ADDENDUM A

LETTER REQUESTING PARTICIPANTS' PARTICIPATION IN THE RESEARCH, INFORMED CONSENT FORM AND LEGAL GUARDIAN'S CONSENT FORM

University of South Africa

Researcher: Melania Gono

Department of Social Work

Title of study: The experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in Free State Province.

I am Melania Gono a post-graduate student at UNISA. As part of the requirements for the master's degree, I am expected to conduct research with a view to adding to international knowledge on the subject.

INVITATION TO PARTICIPATE

You are being asked to participate in this research study because the researcher wants to explore your experiences, challenges and coping resources as an AIDS orphan heading a household.

PURPOSE

The purpose of this study is to develop an in-depth understanding of the experiences, challenges and coping resources of AIDS-orphans heading households.

PROCEDURES

As a participant, you will be enrolled in this study and you will be interviewed in the comfort of your home. You will be asked questions relating to your experiences, challenges and coping resources as an AIDS orphan heading a household in Zamdela (Free State Province). You are expected to honestly answer the questions without prejudice.

RISKS Some of the questions in the interview guide may touch on sensitive areas of your life. However, every effort will be made by the researcher to minimize your

discomfort. You are encouraged to discuss with the researcher and her supervisor any negative or difficult feelings or experiences you have as a result of participating in this research project. If at any time you feel you would like to terminate your participation in the research study, you will be free to do so.

COSTS AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project. Services from the researcher or her supervisor are provided at no cost to you.

BENEFITS

There is no guarantee that you will benefit directly from the study. However, the researcher believes that it is likely that participants may benefit indirectly.

COMPENSATION

You will not receive any form of compensation for participating in this study.

ALTERNATIVES

Participation in this project is entirely voluntary and you may choose not to participate.

CONFIDENTIALITY

Every attempt will be made by the researcher to keep all information collected in this study strictly confidential, except as may be required by court order or by law. If any publication results from this research, you will not be identified by name.

ADDITIONAL INFORMATION

Your participation in this study is entirely voluntary; you are free to refuse participation. You may discontinue your participation at any time without prejudice or without jeopardising the future care either of yourself or your family members. If you discontinue participation in the project, you may request that we not use the information already given to us. You are encouraged to ask questions concerning the study at any time as they occur to you during the programme. Any concerns or issues not included in this interview schedule raised by other participants during the course

of the study that may relate to your willingness to continue participation will be provided to you.

SUBJECT RIGHTS

If you have any questions pertaining to your participation in this research study, you may contact my supervisor, Professor Qalinge by telephoning 012 429 8759.

CONCLUSION

By signing below, you are indicating that you have read and understood the planned research and agree to participate in this study.

…….	**…….**
Participant's signature	**Date**
…….	**…….**
Legal guardian's signature	**Date**
…….	**…….**
Interviewer's signature	**Date**
……	**……**
Witness's signature	**Date**

ADDENDUM B

INTERVIEW GUIDE

1. How old are you?
2. Are you attending school?
3. If yes, what grade are you doing?
4. How many are you in the household?
5. Does being in charge of the household affect your schooling?
6. Can you share with me how this affects your schooling?
7. Would you please tell me about your family?
8. How is your relationship with your extended family?
9. Why is there no adult member of extended family taking over as head of household?
10. What are your experiences as the head of the household?
11. What challenges do you face as being the head of the household?
12. What do you do to cope with these challenges?
13. Can you tell me the feelings that you had when your parents died?
14. When did you assume the responsibility as head of household?
15. Why did you assume responsibility for the household?
16. Would please tell me about your experience at school or at home?
17. How is your relationship with your neighbors?
18. Can you tell me how it feels to take the role of a caretaker at this age?
19. To whom do you turn to when you need support?
20. What support would you prefer to get and from whom?
21. What are your future expectations? How do you see your future?

Addendum C

TRANSCRIPT

PARTICIPANT 3

1. How old are you?

   Ans: Am 17

2. Are you attending school?

   Ans: Yes

3. If yes, what grade are you doing?

   Ans: Am in Grade 12

4. How many are you in the household?

   Ans: We are two and I am the eldest one

5. Does being in charge of the household affect your schooling?

   Ans: Yes

6. Can you share with me how this affects your schooling?

   Ans: Since I have to run the house and do the dishes and sometimes I will be tired and I end up going to bed without finishing my homework. In the morning I have to wake up early prepare myself and my younger sister.

7. Would you please tell me about your family?

   Ans: We are two, me and my younger sister who is in Grade 7.

8. How is your relationship with your extended family?

   Ans: Aah we don't have much. Me and my sister we have different fathers. And from my mother's side they are from Eastern Cape and we don't communicate that much.

9. Why is there no adult member of extended family taking over as head of household?

   Ans: Before our mother passed away we did not have a good relationship with our extended families they have their own families to run.

10. What are your experiences as the head of the household?

    Ans: Being the head of the household, I am the breadwinner and provide for my younger sister. I am also the caregiver and I have to be a mother to my younger sister.

11. What challenges do you face as being the head of the household?

    Ans: Being the head of the household, I have to make decisions, considering my age someone has to make decision for me and I am being deprived of my spare time and my friends and sometimes we live without anything because we don't have money to buy food. We don't have money to buy clothes, uniforms and stationery.

12. What do you do to cope with these challenges?

    Ans: Sometimes we get help from our neighbours and sometimes we talk to our social worker.

13. Can you tell me the feelings that you had when your parents died?
    Ans: It was so painful and I wished if it was me who died instead.

14. When did you assume the responsibility as head of household?
    Ans: When my mother was very sick, sometimes I would dodge school to come and cook for her, do the washing for her.

15. Why did you assume responsibility for the household?
    Ans: I have to because there was on one to run the household for us.

16. Would you please tell me about your experience at school or at home?

    Ans: At school it is difficult to concentrate because you will be thinking what will happen to my mother and she would need all the assistance from me.

17. How is your relationship with your neighbors?

    Ans: It is good because they are the ones who always assist us.

18. Can you tell me how it feels to take the role of a caretaker at this age?

    Ans: It is so challenging because I am a child I also needs someone to take care of me instead I am looking after my younger sister so I need parental guidance.

19. To whom do you turn to when you need support?

    Ans: To my neighbors, the social worker and our pastor at church.

20. What support would you prefer to get and from whom?

    Ans: Parental guidance from the social worker and foster parent to help me.

21. What are your future expectations? How do you see your future?

    Ans: I see my future as bright one day I want to see myself as someone successful and this life I had and have to work extra harder so that I will be able to look after my younger sister.

ADDENDUM D
LETTER FROM CHILD WELFARE SOUTH AFRICA, SASOLBURG GIVING THE RESEARCHER PERMISSION TO CONDUCT RESEARCH

CHILD WELFARE
SOUTH AFRICA
Sasolburg

ENQ: Makube RR
TEL: 016 976 2368
DATE: 09-02-2012

RE: PERMISSION TO CONDUCT RESEARCH – MELANIA GONO

The organisation is hereby granting you permission to conduct your research in Zamdela only for the purpose of your study. We will highly appreciate it if your research findings are going to assist our organisation in improving our service rendering for the benefit of the community.

Good luck with your studies.

Regards

RR Makube
Director

1

Affiliated to:
CHILD WELFARE
SOUTH AFRICA

Tel.: +2716 976 0682 OR +2716 976 2368 • Fax: +2716 976 1124
Physical Address: Finlay Street • Van Riebeeck Community Centre • Sasolburg
Postal Address: P.O. Box 397 • Sasolburg • 1947
Email: ksvsasolburg@absamail.co.za • cwsas@telkomsa.net
www.childwelfaressa.org.za
NPO Reg No: 001/829