

**THE PSYCHOSOCIAL WELL-BEING OF TEENAGED ORPHANS
IN A RURAL COMMUNITY, KWAZULU-NATAL**

by

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CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION

“Psychosocial well-being” is the term used to denote a positive age- and stage-appropriate outcome of children's physical, social, and psychological development; it is determined by a combination of the child's natural capacities, and his/her social and material environment (Richter, Foster & Sherr 2006). This implies living in an environment that promotes the emotional, physical, and social well-being of an orphan. It must be acknowledged that the loss of one or both parents often compromises this psychosocial well-being; some orphans are taken to extended families and looked after by carers who are unskilled/unwilling to assume the role (being too young/too old to assume this formidable task (Davids, Nkomo, Mfecane, Skinner & Ratele 2006)).

Despite the loss experienced by orphans, it is still possible to live well, as long as the extended families, community, community-based organisations (CBOs), faith-based organisations (FBOs), non-government organisations (NGOs) and the government are playing their role in supporting the psychosocial well-being of orphans. This psychosocial well-being depends on to what extent the orphans adjust to and cope with the loss and changes they experience, and it is in this area that the roles of extended families, the community and it's CBOs, FBOs, NGOs and the government become critical.

Different causes of parental-death are responsible for the orphans that, if disregarded, become a burden to the societies they inhabit. These causes range from “intentional” injuries (like homicide) to “unintentional” injuries (like road accidents), and include non-communicable diseases (like deaths from heart disease); communicable diseases (like tuberculosis); nutrition-related

causes of death; and AIDS, which, though a communicable disease, is considered separately, due to its magnitude as a cause of mortality (Muhwava & Nyirenda 2008).

While it is difficult to differentiate HIV/AIDS-related orphanhood from other types, it can be inferred that, since HIV/AIDS is the leading cause of death, it is also the largest cause of orphanhood (Muhwava & Nyirenda 2008). The United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United States President's Emergency Plan for AIDS Relief (US PEPFAR) (2006) indicate that sub-Saharan Africa has the highest number of orphans in the world, with an estimate of 48.3 million (from all causes of death) at the end of the year 2005.

It is further reported that about 12% (12 million) of all orphans in sub-Saharan Africa are due to AIDS (UNICEF, UNAIDS & US PEPFAR 2006), identifying AIDS as the leading cause of orphanhood in sub-Saharan Africa. The study therefore assumed that HIV/AIDS somehow affected most participants, and, so, the psychosocial well-being of orphans affected by HIV and AIDS was assessed.

This study sought to understand the psychosocial well-being of the teenaged orphans aged 13- to 15-years-old, with the intention of scaling-up the psychosocial support available to them in the rural area of KwaZulu-Natal (KZN). Although "teenagers" include children aged 13 to *nineteen*, for the purpose of this study the age band was narrowed to 15, because it is assumed that the needs of the children older than 15 will be qualitatively different from the needs of younger teenagers.

1.2 AIM OF THE STUDY

The study aim was to explore and attain an in-depth understanding of the psychosocial well-being of the orphans aged 13- to 15-years-old, with the intention of scaling-up the psychosocial support available to them.

1.3 OBJECTIVES OF THE STUDY

The objectives of this study were threefold:

1. To describe the psychosocial needs of teenaged orphans aged between 13- and 15-years-old
2. To describe the coping mechanisms of the same
3. To describe the types of psychosocial support available to the same

1.4 RESEARCH QUESTIONS

The research questions of the study were:

1. How did the death of a parent/parents change the research participant's life?
2. How do the research participants cope with the realities of HIV/AIDS?
3. What kind of psychosocial support is available to the research participants in dealing with HIV/AIDS?
4. Where do the research participants go for help in coping with HIV/AIDS?
5. What are the needs of the research participants that are not addressed by current interventions?

1.5 SIGNIFICANCE OF THE STUDY

Child-development passes through the adolescent stage, and it is during this stage that most children start to behave differently from the way they behaved prior to this stage (Huberman 2002). “adolescent stage” is referred to as a “teenage stage”, and it brings the fear of a loss of a good relationship with their children to the majority of parents (Elium 1999). Behaviour change is caused by the physical and biological growth in children, and it is a natural process in human development (Huberman 2002). Parents sometimes try to protect their children by giving them extra attention, support, and guidance during this stage, all of which are factors in the psychosocial well-being of the child.

However, not all teenaged orphans are fortunate enough to experience this extra guidance and support and, in the absence of parents to provide these, their psychosocial well-being may be compromised. About 40% of orphans develop post-traumatic stress as a result of losing their parents, symptoms of which can include withdrawal from society as a whole; feelings of guilt; depression; aggression; as well as eating, sleeping and learning disturbances (Gilborn, Nyonyitono, Jagwe-Wadda & Kabumbuli. 2001). These children are often not only experiencing the death of their parents, but also being confronted with domestic violence in their foster families (Chipungu, Tricia & Bent-Goodley 2004). The society, government, NGOs, FBOs, and CBOs inherit the role of guardian to orphans, and they have to meet huge challenges when attempting to ensure the psychosocial well-being of the orphans.

Although these institutions are willing to assume the guardian-role, efficiently addressing the psychosocial well-being of the orphans without clearly understanding their psychosocial needs and the coping mechanisms, as well as the types of psychosocial support available to them, is high impossible.

Insufficient information creates a gap in the provision of proper psychosocial support to orphans.

This study attempted an in-depth understanding of the psychosocial well-being of these orphans, and resulted in findings that may help the Aid agencies, government departments and society in general on the path to a better understanding of the support needed to attain desirable levels of psychosocial well-being.

1.6 PROBLEM STATEMENT

In sub-Saharan Africa, nearly 12 million children under the age of 18 years have lost one or both parents due to AIDS-related causes (UNAIDS 2008). South Africa alone housed a total number of 3 360 505 orphans due to different causes of death in 2005, and 1 417 918 were between the age of 13- and 17- years old (Statistics South Africa 2006). About 23% (864 643) of the total number of orphans in South Africa are from KZN (Statistics South Africa 2006). These figures indicate that KZN has a huge number of orphans, yet there is insufficient evidence regarding the extent to which the psychosocial well-being of these orphans is addressed.

Children are not always told the truth about their parents' diagnosis, and this fact creates different thoughts, feelings and actions (Nasaba, Defilippi, Marston & Musisi 2006), and the psychosocial well-being of these orphans tends to be ignored by society (USAID 2004). It is acknowledged that family members, generally the children's biological grandparents, often take orphans in and look after them, but they do not understand the various psychosocial effects that need to be addressed (CINDI 2007).

Case *et al* (2003) and Nyamukapa *et al* (2003) cited in USAID (2004) indicated that orphans who have lost a father live in poorer households than non-orphaned children, however widows do provide the emotional and practical support that sustains these paternal orphans and protects them from the danger of educational disadvantages.

On the other hand, although children who have lost their mother do *not* appear to live in the poorest households, they do tend to experience more detrimental effects on their educational attainment and enrolment (Bicego *et al* 2003 and Nyamukapa *et al* 2003 cited in USAID 2004).

Orphans who lose both parents suffer the most detrimental impact on school enrolments and educational attainment (Bicego *et al* 2003, cited in USAID 2004).

This study assumes that the “teenage stage” is the most important stage in human development, with the most dramatic developments taking place, including the initiation of the lifelong processes of physical, behavioural, cognitive, and emotional growth and change. Throughout these processes, each teenager develops the attitudes and values that guide their choices, relationships, and understanding of certain things. It is assumed that if the psychosocial well-being is addressed satisfactorily, teenagers will be able to view life positively, and be able to take decisions that will not jeopardise their future.

1.7 STUDY SETTING

The study area selected is located near the market town of Mtubatuba, in the Umkhanyakude district Municipality of the KZN province (see figure 1). The population is almost exclusively Zulu-speaking, and the area is peri-urban, with settlements in a village known as the Indlovu village, which comprises of about 970 new housing units within the Mtubatuba Municipality.

1.8 OPERATIONAL DEFINITIONS

1.8.1 HIV/AIDS Orphans

Chitiyo, Changara and Chitiyo (2008:384) define an “AIDS orphan” as *“a child who has lost one or both parents to HIV/AIDS”*.

1.8.2 Orphan

“Orphan” is defined by The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (2004:7) as *“a child less than 18 years of age whose mother; father or both parents have died from any cause of death”*. Orphans from all causes can be more specifically described as follows:

Single orphan	– a child who has lost one parent.
Double orphan	– a child who has lost both parents.
Maternal orphan	– a child whose mother has died double (includes double orphans)
Paternal orphan	– a child whose father has died (includes double orphans).

1.8.3 Psychosocial well-being

Richter, Foster and Sherr (2006:15) define “psychosocial well-being” as *“the positive age- and stage-appropriate outcome of children’s physical, social, and psychological development”*. It is determined by a combination of children’s capacities and their social and material environment. Psychosocial well-being is essential for children’s survival and development, especially in chronically difficult circumstances.

1.8.4 Psychosocial support

Philippi Namibia, cited in Van Den Berg (2006:17), defines *“psychosocial support”* as *“an ongoing process of meeting physical, emotional, social, mental, and spiritual needs of a child”*, all of which are essential elements for meaningful and positive human development.

1.8.5 Poverty

“Poverty” is defined as *“the inability of individuals, households, or communities to command sufficient resources to satisfy a socially acceptable minimum standard of living”* (Committee of Inquiry 2002 cited in Abrahams 2006:15).

1.9 CONCLUSION

In this chapter the researcher has described the problem under study and its aim and objectives, as well as discussing the research question, the significance of the study, its problem statement, study setting, and operational definitions, and ends with an outline of the study. The next chapter is a presentation of the literature review.

1.10 OUTLINE OF THE DISSERTATION

In Chapter 1 the researcher introduces the study, its aim and objectives, states the research question; describes the significance of the study; gives the problem statement; describes the study setting; and lists operational definitions.

In Chapter 2 the researcher focuses on a review of the relevant literature.

In Chapter 3 the research methodology, namely, the design of the study, the study sample; data collection; data analysis, reliability and validity the ethical considerations and the limitations of the study are discussed.

Chapter 4 details the findings and the interpretation of the results.

Chapter 5 is a summary of findings; recommendations; and conclusions.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, literature on the psychosocial situations of orphans is examined, and theoretical perspectives on the psychosocial development of adolescents are given. This is followed by a discussion of studies on the psychosocial, social and economic needs of orphans as affected by HIV/AIDS, the support available to them, and the coping mechanisms of the same.

2.2 THEORETICAL PERSPECTIVES ON ADOLESCENCE

Different theorists view adolescence differently; however, they all agree that adolescence is a very important stage, one that needs to be handled with care. Therefore a clear understanding of adolescence is important, since it provides a picture of the role-expectations of adolescents.

Hall's storm and stress model of adolescence describes adolescence as a stage in life that is characterised by a high level of emotional turmoil and stress, due to the hormonal disruption associated with puberty (Hall 1904). He views adolescence as a time of sexual confusion, great emotional stress, and self-doubt.

It can be concluded, based on Hall's model, that adolescence is a stage wherein teenagers are not entirely in control of their lives, and as a result become vulnerable to health-risk behaviours because of the ensuing confusion and self-doubt. During this stage, teenagers are expected to simply deal with the emotional stress caused by the biological changes taking place (an example being menarche).

Hall (1904) suggests that good parenting is vital during this stage of human development if the teenagers are to adequately adjust to these new processes.

On the other hand, Erikson's (1950) psychosocial theory of development argues that human beings pass through eight stages of development, and each of these stages must be resolved successfully before the individual can progress to the next. Stage five of his psychosocial theory denotes the adolescent stage, described as "*personal identify versus role confusion*" (Erikson 1950). Erikson views adolescence as a major stage in human development, one in which teenagers construct the roles they will occupy as adults. During this stage, teenagers re-examine their inherited identity and attempt to define one of their own making, sexually and occupationally. Like Hall, Erikson sees this stage as a very confusing and dangerous one in human development, since it determines how a teenager sees himself/herself in relation to his/her family and society.

Jessor's (1991) problem-behaviour theory emphasises the importance of adolescence, arguing that it is in this critical period that teenagers become vulnerable to risk behaviours. These risk behaviours may have negative health outcomes because this it is in this crucial stage that risk-related learning takes place.

All these theories highlight the importance of adolescence, and these insights are applicable to adolescent orphans affected by HIV/AIDS. Although this stage tends to coincide with conflict between teenagers and parents, the role that parents play in providing guidance for teenagers should not be underestimated.

2.3 THE SITUATION OF HIV/AIDS ORPHANS WORLDWIDE

Globally in 2007, 145 million children under the age of 18 years had lost one or both parents due to all causes of death, whereas 15 million children had lost at least one parent to an AIDS-related death (WHO/UNAIDS/UNICEF/UNFPA 2008).

The projections for 2010 indicate that the total number of orphans under the age of 18 due to all causes of death will decline to 132.2 million, whilst the number of orphans due to AIDS-related mortality will rise to 20.2 million (UNICEF/UNAIDS/PEPFAR 2006). AIDS-related illnesses have been responsible for approximately 25 million deaths worldwide, and have generated profound demographic changes in the areas most heavily affected, examples ranging from dramatic decreases in life expectancy; increases in the number of orphans and increases in the number of child-headed households (UNAIDS/WHO 2008).

UNAIDS/WHO (2008) indicate that in 2007, two million people died due to AIDS-related illnesses. Simbayi, Meintjes, Ngomane, Tabane, Mfecane and Davids (2006) attribute orphanhood and its impact on households and communities to the premature deaths of parents due to AIDS-related causes in sub-Saharan Africa -if adults were not dying in large numbers due to AIDS, the world would not be experiencing such large numbers of orphans. Given the above statistics, it can be argued that HIV/AIDS is a threat to children and their families globally, and that it will continue to be a threat for many years to come.

2.4 THE SITUATION OF HIV/AIDS ORPHANS IN SUB-SAHARAN AFRICA

WHO/UNAIDS/UNICEF/UNFPA (2008) indicate that, in 2007, sub-Saharan Africa had the highest number of orphans under the age of 18, with an estimate of 47.5 million from all causes of death globally. About a quarter of all orphans, 11.6 million, aged up to 17-years had lost one or both parents to AIDS-related deaths by the end of 2007. As the table below shows, the number of orphans in some sub-Saharan African countries exceeds half a million, and, in others, children who have been orphaned by AIDS comprise half or more of all orphans nationally (UNAIDS/WHO 2008).

Table 1: Number of children in selected sub-Saharan Countries orphaned by AIDS

South Africa	1,400,000
Uganda	1,200,000
Nigeria	1,200,000
Zimbabwe	1,000,000
Tanzania	970,000
Ethiopia	650,000
Zambia	600,000
Malawi	560,000
Côte d'Ivoire	420,000

Source: UNAIDS/WHO (2008)

UNAIDS/WHO (2008) report that 22 million adults (15 to 49-years of age) were living with HIV in sub-Saharan Africa in 2007, which implies that this region will continue to have a high adult mortality rate due to AIDS. As long as this status remains unchanged, sub-Saharan Africa will continue to have high numbers of orphans.

It is estimated that by 2010 the number of orphans will rise to 53 million from all causes death, whilst 12 million of those orphans will be due to AIDS related death (UNICEF/ UNAIDS/ PEPFAR 2006).

The significance of orphanhood is demonstrated by the drastic increase of orphans, from 330 thousand (1%) in 1990 to 12 million (35%) in 2005 (UNICEF/UNAIDS/PEPFAR 2006). UNICEF/UNAIDS/USAID (2004) point out that the proportion of children who are orphans generally increases with the age of the child, since 12% of orphans are in the 0- to 5-year-old age-group; 33% are in the 6- to eleven-year-old age group, and 55% are in the 12- to 17-year-old age group. It is evident that older orphans greatly out-number younger orphans and, therefore, one could conclude that adolescents make up the majority of orphans in the sub-Saharan Africa.

2.5 THE SITUATION OF HIV/AIDS ORPHANS IN SOUTH AFRICA

There were 18.3 million children in South Africa in July 2007, which means that children constitute nearly 40% of the population total (Meintjes & Hall 2009). WHO/UNAIDS/UNICEF/UNFPA (2008) indicate that South Africa has a total number of two-and-a-half million orphans due to all causes of death, while just under one-and-a-half million of those were due to AIDS in 2007. The projections indicate that, the above figures will reach 3.2 million by 2010 (UNICEF/UNAIDS/PEPFAR 2006). According to WHO/UNAIDS/UNICEF/UNFPA (2008), South Africa houses the highest number of orphans in the Southern African continent. This suggests that South Africa has the highest rate of adult mortality, resulting in the largest number of AIDS orphans in sub-Saharan Africa.

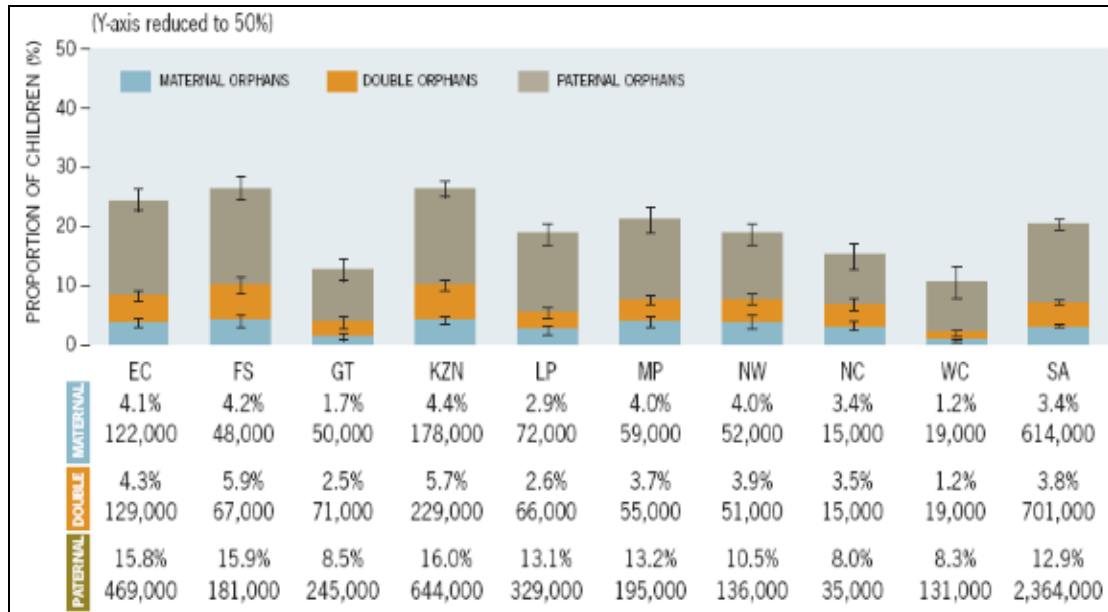
UNICEF/UNAIDS/PEPFAR (2006) indicate that 19% of the orphans in South Africa fall between the ages of 12- and 17-years, which suggests that

adolescents make up the majority of orphans in South Africa. These orphans have to deal with the different types of psychosocial problems caused by losing parents to AIDS or by having an HIV-infected parent (Nasaba, Defilippi, Marston & Musisi 2006).

2.6 THE SITUATION OF HIV/AIDS ORPHANS IN KWAZULU- NATAL

A national-household study conducted by the National Department of Health (NDH), found that in South Africa, KZN has the highest HIV-prevalence (26%) of all the provinces (NDH 2008). It is therefore not surprising that KZN has the highest number of orphans within the age group two- to 18-years. In this population segment, over four percent have lost a mother only; 16% have lost a father only; and over five and a half percent have lost both parents (Meintjes & Hall 2009). Figure 2 below indicate the number of all orphans per province in South Africa in 2007.

Figure 2: Number of orphans per province



Source: Meintjes & Hall (2009) citing Statistics South Africa (2008)

Another study that was conducted in several communities in the province of KZN found that one out of five children aged 18-years or younger had lost one or both parents, while one out of four households was home to at least one orphan (Horizons 2004). In 2007, about 37.4% of the pregnant women attending public health clinics tested HIV-positive, which indicates a significant decline from the 2006 survey, which was at 39.1% (NDH 2008).

2.7 THE PSYCHOSOCIAL WELL-BEING OF HIV/AIDS ORPHANS

Richter, Foster and Sherr (2006:15) define “psychosocial well-being” as *“the positive age- and stage-appropriate outcome of children’s physical, social, and psychological development”*.

This refers to a child’s intrapersonal (internal) emotional and mental state (psycho-) and his/her interpersonal network of human relationships and social connections and functioning (social) (Gilborn, Apicella, Brakarsh, Dube, Jemison, Kluckow, Smith & Snider 2006)

The teenagers' well-being is so important because adolescence is such a significant stage in psychological development, and vulnerable adolescents, especially those affected by HIV/AIDS, face unique responsibilities and challenges, such as earning wages, managing households, and caring for younger children and sick adults (Gilborn *et al* 2006). It is therefore important to understand the limits of their psychosocial well-being and psychosocial distress in the context of socio-cultural and developmental stage of the child.

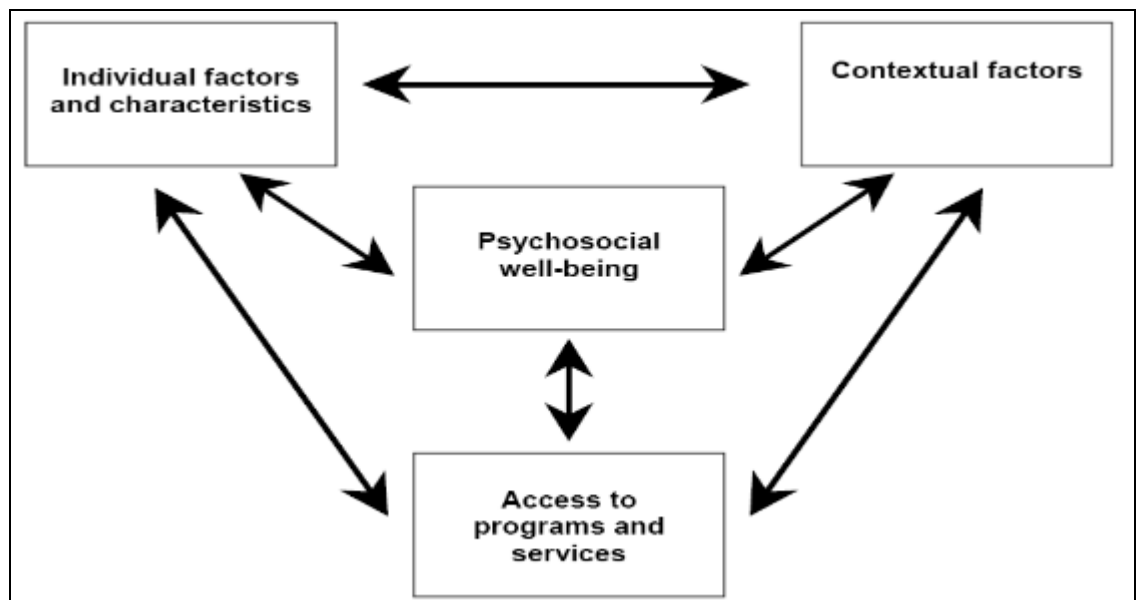
Gilborn *et al* (2006) defines a good (or high) psychosocial well-being as a period in which one's mental/emotional state and social relationships are predominantly positive, healthy, and adaptive, whilst a poor psychosocial well-being (or psychosocial distress) is when these are mostly negative, unhealthy, or maladaptive.

Activities that support and promote the psychosocial wellbeing of children and families are critical because children are able to bear and recover from significant levels of suffering when they are surrounded by people who love and care for them (Richter, Foster & Sherr 2006). The sense of belonging and hope that is nurtured by these relationships enables children to cope better with hardships like hunger, general discomfort, and the other privations of poverty and loss. These efforts are "key investments" in "human capital" - children who receive affection, stimulation, and support in early childhood have a good foundation for growth and development, are more able to cope with challenges, are better at overcoming disadvantages, and making positive contributions to the society (Richter, Foster & Sherr 2006).

Gilborn *et al* (2006: 9) hypothesised that “*psychosocial well-being is influenced by*

1. *Individual factors and experiences (such as age, sex, innate personality characteristics, family or household structure, personal exposure to stress and trauma, and socioeconomic status),*
2. *Contextual factors (e.g., community cohesiveness and support, presence of AIDS-related stigma, the socio-political environment, and availability of educational and employment opportunities), and*
3. *Access to programs and services, including psychosocial support programs” (as illustrated in figure 3 below)*

Figure 3: Psychosocial Well-being Framework



Source: Gilborn *et al* (2006: 10)

Gilborn *et al* (2006) report high levels of psychosocial distress, like feeling guilty for bad things that have occurred/feeling worried or stressed/feeling irritable or sad/difficulty in concentrating/feeling overwhelmed and hopeless about the future. In addition, despite adverse circumstances and feelings of

distress, there are signs of psychosocial well-being among teenagers -peer relationships emerge as an important source of social support and coping. Some teenagers report that they feel they can do things to help themselves/feel confident in themselves/feel hopeful about the future/feel able to cope with difficulties in life (Gilborn *et al* 2006). This suggests some level of resilience amongst the vulnerable group of teenagers.

2.8 PSYCHOSOCIAL NEEDS OF HIV/AIDS ORPHANS

The psychosocial impact of HIV/AIDS on orphans is a neglected topic, due to the shocking financial crisis that confronts them; programmes tend to focus on providing for material needs rather than counselling and other forms of psychosocial support (Foster & Williamson 2000). This section focuses on the psychosocial needs HIV/AIDS orphans experience in relation to parenting with a terminal illness; witnessing an AIDS-related death; the psychological impact of death; psychosocial stressors; and stigma.

Chapter two, section 28(1) of the South African Constitution (1996) states that every child has the right to

- a name and a nationality from birth
- family/parental care (or appropriate alternative care when removed from the family environment)
- basic nutrition, shelter, basic health care services and social services
- Be protected from maltreatment, neglect, abuse, or degradation (Statistics South Africa 2006).

Therefore, psychosocial well-being is a constitutional right for orphans.

Research evidence shows that orphans face many psychosocial challenges that involve the lack of parental guidance, love, care, and acceptance in the new families they join (Nasaba, Defilippi, Marston & Musisi 2006). They also face social problems, which include the lack of supportive peer groups and

role models, stigma and other risks in their immediate environment (Skinner, Davids, Matlhaku, Phakedi, Mohapeloa, Romao, Mdwaba, Kazi & Mundondo 2006).

PEPFAR (2006) adds that HIV/AIDS affects orphans in a number of ways, including:

- Living with a high risk of becoming infected themselves
- Being required to work and/or put their education on hold as they take on the household/care-giving responsibilities of a chronically ill parent/s
- Experiencing greater poverty because of the disease
- Being subjected to stigma and discrimination because of their association with a person living with HIV.

When the health of HIV-infected parents begins to fail, the basic needs of the children may be compromised, as the parent possibly loses his/her job due to bad health and/or the household income is redirected towards caring for the sick parent (Population Council 2004). At times, the normal parental-child role may be reversed, as older children may have to take care of the ill parent and assume household and childcare responsibilities (Smart 1999).

Stein (2003) argues that some terminally ill parents may become overprotective of their children, and may begin to distance themselves from their children in the hopes of reducing the impact of the future loss. This overprotection might have a negative impact in children since they might feel that their parent is neglecting them. After the traumatic experience of witnessing the death of a parent, orphans are often sent to different households, separated from their siblings, and relocated away from schools and friends (UNAIDS 2002).

Cluver (2003) indicates that children with parents infected with HIV are likely to experience more disrupted routines, and more periods of informal fostering than other children who have parents with other terminal illnesses. A study conducted in Zimbabwe by Nemapare and Tang (2003) reports that the loss of a father (who is the symbol of financial security) results in untold worries about the future, and the loss of a mother, who loves, nurtures, and guides the child is the most difficult thing for any child to handle.

Orphans suffer emotional stress; higher levels of anxiety, depression, and anger, along with the associated inactivity induced by depression; feelings of hopelessness and thoughts of suicide due to the hardships they face after a parent dies (UNICEF 2006). Hunter and Williamson, cited in Gilborn *et al*, (2001) found that orphans who witness the prolonged illness and death of one or more family members suffer effects like

- Mental distress
- Depression
- Increased malnutrition
- Lack of health care and proper schooling
- Early entry into paid (or unpaid) labour
- Loss of inheritance through “property-grabbing”
- Homelessness
- Early marriage
- Exposure to abuse
- An increased risk of HIV/AIDS

Orphans and vulnerable children who are affected by HIV/AIDS have the additional burden of becoming the victims of the stigma associated with the AIDS pandemic (Economic Commission for Africa 2004). Bray (2003) argues that this stigma causes varying levels of additional trauma, which is then

added to the traditional long-term effects experienced by non-HIV/AIDS orphans.

Children whose parents are presumed to have died because of AIDS are often thought to be HIV-positive themselves, and are consequently stigmatised, which manifests as being excluded from school and denied treatment when they are sick (Richer, Foster & Sherr 2006). Children have powerful emotions regarding death, and may exhibit these emotions for extended periods of time at random intervals (Kristin, Close, Andrea & Rigamonti [sa]). Table 2 below shows the children's developmental stages of grief.

Table 2: The developmental stages of grief in children

Age	Thoughts	Feelings	Actions
3-5 years	<ul style="list-style-type: none"> •Loved one will return. •Loved one is just away. 	<ul style="list-style-type: none"> •Fearful of separation • Anxious • Confused 	<ul style="list-style-type: none"> •Crying •Temper tantrums •Nightmares •Regressive/clingy behaviour
6-8 years	<ul style="list-style-type: none"> •Wonder if loved one can return •Deceased can still function •Magical thinking 	<ul style="list-style-type: none"> •Confused or anxious •Fearful of separation • Fearful they might die, too 	<ul style="list-style-type: none"> •Temper tantrums •Nightmares •Regressive/clingy behaviour •Difficulty concentrating
9-12 years	<ul style="list-style-type: none"> •Understand finality and irreversibility of death • Magical thinking 	<ul style="list-style-type: none"> • Sad • Confused • Anxious • Withdrawn • Lonely 	<ul style="list-style-type: none"> •Aggressive/impulsive behaviour •Engagement in risky behaviour •Decline in school performance
13-18 years	<ul style="list-style-type: none"> •Understand finality of death •Begin to look beyond physical death •Magical thinking 	<ul style="list-style-type: none"> • Sad • Confused • Anxious • Withdrawn • Lonely • Guilty 	<ul style="list-style-type: none"> •Aggressive/impulsive behaviour • Engagement in risky behaviour •Decline in school performance •Difficulty concentrating •Exhibition of powerful emotional outbursts

Source: O'Neill *et al*, 2003 cited in Close & Rigamonti

Nasaba *et al* (2006: 6) summarise the psychosocial problems that affect HIV/AIDS orphans, starting from the illness until to death of the parent, which includes the following:

- *“Children are not always told the truth about their parents’ diagnosis. This doubt causes anxiety.*
- *Children start worrying about what will happen to them when their parent dies.*
- *Illness and death of parents create traumatic feelings in children.*
- *After the death of a parent, the child may be required to head the family.*
- *Children may be “distributed” to different relatives after their parents die, resulting in a breakdown of the original family unity.*
- *Often children who lose their parents lack parental guidance, love, care, and acceptance in the new families that take them in. It takes a long time to adjust to the new an environment without their parents.*
- *In some instances, children fail to be taken in by relatives and they end up heading their own families. Others opt to move to town and start working as “house girls”, or even commercial sex workers.*
- *At school, children affected by HIV/AIDS face stigma and discrimination”.*

2.9 THE SOCIAL NEEDS OF HIV/AIDS ORPHANS

The fulfilment of the orphans' social needs is very important to the processes of human development. Muller, Sen and Nsubuga (1999) report that the increased risk of malnutrition, inadequate shelter, lack of clothing and interrupted schooling are commonly cited as the consequences of the death of wage-earning adults in AIDS-affected households. Other common impacts include deepening poverty and the ensuing

- Pressure to drop out of school to begin working
- Food-insecurity
- Reduced access to health services
- Deteriorating housing conditions
- General worsening material conditions
- And the loss of access to land and other productive assets

(Simbayi, Meintjes, Ngomane, Tabane, Mfecane & Davids 2006)

Research shows that in households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for other survival activities. For example, a study in Zambia indicates 75% of non-orphaned children in urban areas were enrolled in school, compared to 68% of orphaned children (Richter 2004). Another study conducted by Patterson (2003) reveals that orphans affected by HIV/AIDS do not *want* to participate in school or youth activities because they are rejected by their friends and schoolmates or relatives.

These orphans experience financial deprivation, which begins during the prolonged HIV/AIDS-related illness of the parents and is compounded when the adult breadwinner dies (Muchiru 1998). Orphans are vulnerable to financial exploitation, which includes the use of children as cheap labour, the siphoning off of childcare grants, and the misappropriation of inheritance

monies, as well as homes and property, by surviving adult relatives (Foster 1997).

Such exploitation and abuse contributes to an increased likelihood of anti-social behaviour and criminality, which might even include commercial sex work (Schonteich 1999). Loening-Voysey (2002) argues that, whilst welfare provision in the form of financial grants for fostering orphans affected by HIV/AIDS is a vital way to address the needs of these orphans, grants do not necessarily reach them. Furthermore, it is argued that, due to welfare provision, orphans are being viewed as an economic asset, to be cared for nominally and as a means of providing financially stressed households with an additional income (Loening-Voysey 2002).

According to Richter (2004) children affected by HIV/AIDS may receive poorer care and supervision at home; suffer from malnutrition and may not have access to health services. Stein (2003) notes that comparative studies of orphans and non-orphans suggest that orphans suffer more hunger than non-orphans, since a nutrition surveillance study in Zimbabwe indicates that the proportion of children who are underweight are higher among orphans than among non-orphans (22% versus 17% respectively).

Simbayi *et al* (2006) emphasise that children may also suffer the loss of their home, through the sale of livestock and land, and asset stripping by relatives. Gilborn, Nyonyitono, Kabumbuli and Jagwe-Wadda (2001) indicate that this “property grabbing” undermines the livelihood of orphans, already weakened by the death of parents. They further point out that the overcrowding caused by households taking in orphans can lead to increased psychosocial stress and the larger risk of abuse, especially if adults and teenage girls and boys are sleeping in the same room.

2.10 PSYCHOSOCIAL SUPPORT AVAILABLE TO HIV/AIDS ORPHANS

Philippi Namibia, cited in Van Den Berg (2006:17), defines “*psychosocial support*” (PSS) as “*an ongoing process of meeting the physical, emotional, social, mental, and spiritual needs of a child*”, all of which are essential elements for meaningful and positive human development. It includes “*formal and informal services that address psychosocial well-being either*

1. *Directly and specifically (e.g., through interpersonal moral support, counselling, spiritual support, creation of memory books, etc.) Or*
2. *Indirectly (e.g., school and nutritional support programs that may alleviate stress and worry)”* Gilborn et al (2006: 9).

Duncan and Arnston, cited in Gilborn *et al* (2006), argue that social connectedness, such as having supportive relationships with primary caregivers and members of one’s cultural or faith groups, and access to community resources are widely recognised as protective factors that buffer the consequences of negative experiences on children. Gilborn *et al* (2006: 9) indicate that, although teenagers report that they feel very well supported by the adults in their lives and their religious communities, many youth do not receive the social support needed from peers and adults to effectively mitigate the impacts of the stressful and traumatic events in their lives. Orphans experience many challenges, including unmet psychosocial needs due to the lack of guidance and psychosocial support, and meeting these adequately is very important for a child’s development (Giese, Meintjes, Croke & Chamberlain 2003).

Since the onset of the AIDS pandemic, numerous individuals, groups, and organisations have come forward to offer help to children orphaned by HIV/AIDS. Germann (2004) criticises the approaches used to support orphans, because they undermine children’s own coping capacity, which

creates and reinforces a dependency syndrome that may have serious long-term consequences. He further indicates that such approaches tend to be biased towards children's' material and formal educational needs and often fail to address the less obvious social, mental, and emotional needs that children have.

2.10.1 The psychosocial support model

The Family Health International (FHI) (2001) recommends a model of psychosocial support in order to provide a better understanding of the different needs, since meeting these is essential in the development of children. It is envisaged that the understanding of these needs by the communities, aid agencies, NGO and the government will assist in better meeting them, and so eventually improve the orphans' psychosocial well-being. This model supports Maslow's theory of needs, since it emphasises the importance of balance in acquiring the basic skills needed for survival. This model states that these skills form a wheel comprising five elements, but asserts that none of the five elements would be adequate if provided for without input from the others.

At the centre of the model is the awareness of cultural practices, beliefs, and rituals, which informs one about the manner in which all of the other needs are met, since culture serves as a storage of knowledge, values, connectedness, belonging and traditional practice. The first element of the wheel represents the physical needs of a child, which incorporates financial needs such as food, shelter, clothing, school uniforms, school fees, and basic health care. Most of these economic needs of children are combined with educational needs. The simple provision of financial assistance is not the only need children have, from a psychosocial perspective, but their needs for financial support must be met in an on-going and reliable fashion.

The second element is the emotional needs of children. This includes the need for love, security, encouragement, motivation, care, self-esteem, confidence, trust and security, a sense of belonging, guidance, and understanding. Children need to be heard, and need to learn to express their feelings in an appropriate manner. At times, children's emotional needs may include assisting them to cope with especially difficult circumstances, like bereavement and loss.

The third element is the mental needs of the child, incorporating three aspects, namely

1. Formal education (schooling),
2. Informal education (opportunities for acquiring observational knowledge and adaptation skills, which would support the child in their ability to exercise an appropriate amount of control over their environment and access positive reinforcement), and
3. General skills (life skills, general knowledge, etc) combined with the motivation to succeed.

The fourth element is the children's social needs. It is essential that these needs be met for proper integration into a community without feelings of stigmatisation, and in developing a sense of belonging. These needs being met fosters the ability to form friendships and community ties, which promotes self-acceptance and a healthy sense of personal identity, and elicits acknowledgement from peers and more opportunities for social interaction, from which orphans learn socially acceptable behaviour (through feedback from others).

The last element is the children's spiritual needs. Children need a belief that enables them to develop hope for, and a belief in their future, they need to develop a sense of trust in the security of their survival.

This enables them to keep trying when facing obstacles, and facilitates a sense of connectedness to deceased parents and ancestors.

2.10.2 Family and community responses

Support at the community level, whether initiated by individuals or groups, offer material and non-material assistance to children and households affected by HIV/AIDS. This assistance includes food and nutritional support, educational support, psychosocial support, household visits and home-based care-giving, treatment-support, and child-fostering (Mathambo & Richter 2007).

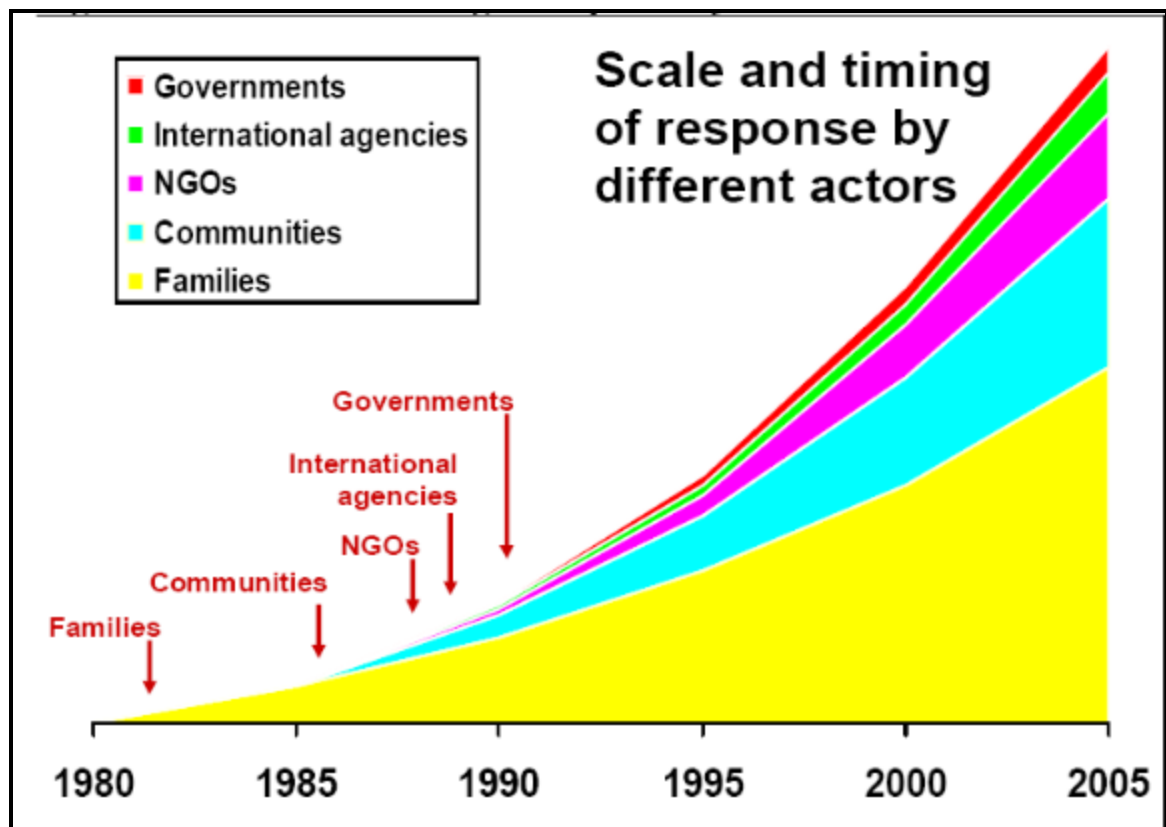
Prior to the AIDS pandemic, orphans were traditionally incorporated into the extended family. According to Matshalaga (2004), the definitions for “mother” and “father” are very broad in the traditional African extended family, including both the mother’s sisters, and father's brothers. “Kin” (or blood relationships) make up the extended family network of people connected to the orphans. When a parent dies, the traditional system provides an elaborate framework for arranging for the provision of the surviving spouse and children.

There are opposing views in the available literature regarding the capacity of extended families to care for and support orphans. Foster *et al*, 2000 cited in Mathambo and Richter (2007), argue that extended families are actively responding and coping with the growing demand of orphans, whereas, Ntozi *et al*, (1999), cited in Mathambo and Richter (2007), suggest that the extended family’s ability to cope is starting to fail, buckling under the increased strain, and leading to its collapse. Mutangadura *et al*, cited in Mathambo and Richter (2007), shows that the major share, 90%, of assistance to orphans is provided by extended families and community groups, with only 10% being supplied by the government/NGOs.

Figure four below indicates the increasing support provided by the government, international agencies, NGOs, communities, and families over time (1980 to 2005). It shows the proportion of reinforcement received from these support structures. The importance of family help, as the primary support structure, is clearly demonstrated in figure three, representing a bigger proportion than any other.

It is the first type of assistance that was available, before the implementation of any of the other support structures (community, NGOs, international agencies and government).

Figure 4: Scale and timing of response by different actors



Source: Foster & Williamson cited in Mathambo & Richter (2007)

2.10.3 NGOs and government responses

According to the KZN office of the Premier (2006), although not evenly represented throughout the KZN province (they tend to be concentrated in urban areas), there are a wide range of NGOs and community-based organisations (CBOs) that provide support to HIV/AIDS orphans in that province. NGOs and CBOs are involved in almost every area of the HIV/AIDS response (HIV prevention and treatment, as well as AIDS care and support). Although many of these were formed specifically as responses to AIDS, there are others which, although the result of different social development and support functions, have become involved as a response to the changing needs of the communities they serve. The provision of standard services, including voluntary counselling and testing (VCT); home-based care, orphan-support; and community mobilisation and education have performed an important function in this respect. They have been found to act as an intermediary between communities and the government, and, sometimes, international funders (KZN office of the Premier .2006).

Governments and childcare experts have developed policies and strategies to ensure that the available resources are used effectively to benefit the largest number of orphans. They promote the understanding that orphans need a life that provides love; warmth; security; the experience of family; and that they have the right to an education.

Three different welfare grants that are available to children in South Africa:

1. The child-support grant
2. The care-dependency grant
3. The foster-care grant

Provincial social-development departments, through their social-security budgets, pay for these. The foster-care grant is aimed at protecting and

improving the general welfare of orphans. The increasing number of orphans in South Africa has raised the number of foster-care grant-recipients from 85 910 in April 2001 to 256 325 in April 2005 (South Africa, Department of Treasury, 2005: 57, cited in Statistics South Africa 2006). In other African countries, like Zimbabwe, only 2% of needy households received the government support that they were entitled to (Drew *et al.*, 1996 in Foster, 2005 cited in Mathambo & Richter, 2007). Leatt, Meintjes and Berry (2005), estimate that 67% of the over eight million children eligible to receive the child-support grant in South Africa have access to this financial assistance. The South African government is experiencing severe challenges in identifying orphans and other vulnerable children and planning accordingly (Skweyiya, 2006 quoted in Statistics South Africa 2006), and so it is found to be extremely difficult to develop a relevant social policy without a real understanding of the magnitude of the problem (Statistics South Africa 2006).

2.11 CONCLUSION

This chapter discussed the theoretical perspectives of adolescence as an important stage in human development. It gave a general overview of how orphans are affected by HIV/AIDS worldwide, as well as how they are affected in sub-Saharan Africa, South Africa, and the province of KZN. It further considered previous research conducted on the psychosocial well-being and support; as well as the social needs of orphans affected by HIV/AIDS.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

An exploratory, qualitative research approach was used, to enable the researcher to explore and obtain an in-depth understanding of the effects of HIV and AIDS on the psychosocial well-being of teenaged orphans (aged between 13 and 15-years). The main research aim of this study was finding out how the death of a parent (or both parents in some cases) changed the research participants' lives. This discovery also intended to explore these teenagers' coping mechanisms, the kinds of psychosocial support they obtained and the psychosocial needs *not* addressed by the current interventions.

According to WHO/UNAIDS/UNICEF/UNFPA (2008), South Africa has the highest number of orphans in the Southern African region, which suggests that South Africa has a large number of children that are affected by HIV and AIDS. This study focused on psychosocial well-being as an indicator regarding understanding the impact of HIV and AIDS on teenaged orphans. In this chapter, the researcher describes the study design; selection of the research participants; the process of data collection, data management, data analysis and data validity; as well as ethical considerations.

3.2 RESEARCH DESIGN

This exploratory study used a qualitative approach in the form of narrative work in particular oral history. Qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings, A

"real world setting where the researcher does not attempt to manipulate the phenomenon of interest" (Golafshani 2003:600, citing Patton).

An oral history approach was chosen, as it is a good method to elicit personal testimonies as evidence. Oral history allows an in-depth exploration of the research topic with people who have had the relevant experiences (Charmaz 2006). Following this research approach in this study enabled the recording of the orphans' memories of their unique life experiences before and after the death of their parent(s), using the power of verbal communication.

Life histories are also called "the biographical method" (Denzin & Lincoln 2003), and they are used to present an insider's view of culture and daily life. Denzin and Lincoln (2003: 295), citing Watson and Watson-Franke, define "life history" as any retrospective account of an individual's life, in whole or in part, in written or verbal form, that has been elicited or prompted by another person. This method enabled the researcher to gain insights into the broader human condition by coming to know and understand the relationships, the complexity of interactions and the experience of teenaged orphans (Cole & Knowles 2001), through exploring and obtaining an in-depth understanding of the effects of HIV and AIDS on their psychosocial well-being. The direct talk between the researcher and the research participants allowed the participants to tell their stories without any fears of misinterpretation. Creswell (2007) suggests that this approach empowers individuals to share their stories by conveying those stories in a flexible manner.

Drawing on Creswell's understanding of oral history as empowering, the researcher attempted to level the inherent power differential between himself and his teenaged research participants in the following ways:

- Firstly, all recruited participants willingly and freely participated in this study. The researcher attributes their willingness to participate to an initial visit paid to the potential participants during the recruitment process. Their caregiver introduced the researcher to potential participants, and this resulted in establishing an immediate trust, because they knew their caregivers well.
- Secondly, during the initial visit the researcher spent time explaining the goals of the study and building a rapport with the potential participants, which alleviated any fears from the participants' side because they had a chance to ask questions.
- Thirdly, before commencing with the interviews the researcher warned the research participants that retelling their stories might be a painful experience. They were reassured that help in dealing with these distressing feelings and memories would be at hand, and that the information given the researcher would be treated with utmost confidentiality.
- Fourthly, the researcher listened with sensitivity, and encouraged the participants to respond to the open-ended questions used by the researcher to guide the telling of their stories. The researcher had to consider his insider and outsider roles in the data-collection process. In this regard, maintaining composure after hearing painful recollections was a very challenging experience for the researcher.

A qualitative study by Wood, Chase, and Aggleton (2006), which focuses on the narratives of older children in their teens, who have experienced parental AIDS-related illness and death in six sites in Zimbabwe, used a similar method to obtain information from orphans. They remark: *"Spending several hours in each household enabled the team to make important observations throughout the day, as well as hold in-depth discussions with different members of the family in relation to family composition, everyday lives,*

survival strategies and sources of support, roles and responsibilities of different family members, experiences of illness and bereavement in the family, views of childhood and child labour, and particular challenges faced by orphans (Wood, Chase & Aggleton 2006:1926).

3.3 SAMPLING TECHNIQUE

The study site was a small village called Indlovu at the Mtubatuba Municipality, which comprises approximately 970 new housing units. This study area is located near the market town of Mtubatuba, which falls within the boundaries of the Umkhanyakude District Municipality in the northern part of the KZN province. The population is almost exclusively Zulu-speaking.

The research site was purposefully selected because most deaths (73%) occurring in the 15 to 44-year age group in Mtubatuba were due to AIDS in 2000 (Tanser *et al* 2007), which is an indication that there are many orphans in Mtubatuba, and the greater percentage of these is a result of AIDS. Research participants were recruited with the assistance of Inkanyezi Yokusa Mina Nawe, an NGO that supports orphans affected by HIV and AIDS in the municipal area.

Prior to commencing the research, written permission and approval to conduct the study was granted by the Research Ethic Committee of the University of South Africa (UNISA); the Department of Social Development: Hlabisa Region and Inkanyezi Yokusa Mina Nawe respectively. Purposive sampling was employed to include orphans affected by HIV and AIDS who were being cared for and supported by Inkanyezi Yokusa Mina Nawe; who were resident at Indlovu Village and those who were between the ages of 13 and 15-years. Orphans not residing at Indlovu Village and those orphans below 13-years old and above 15-years old were excluded from the study.

The research participants were recruited through the assistance of the Inkanyezi Yokusa Mina Nawe NGO, which renders assistance to orphans and vulnerable children at Mtubatuba. Inkanyezi Yokusa Mina Nawe allocated three volunteers to assist the researcher during the recruitment process. The researcher was provided with a list of the orphans affected by HIV and AIDS who were being cared for by Inkanyezi Yokusa Mina Nawe, and the researcher used this list to identify participants born between 1993 and 1995 and residing at Indlovu Village. The researcher and the volunteers visited the potential participants in their homes for the recruitment exercise.

The recruitment process offered the researcher an opportunity to build a rapport with the potential research participants prior to the interview-process. In order to conduct the interviews, the researcher revisited the research participants who consented to participate in the study.

3.4 DATA COLLECTION

This section describes the data collection method, and the related tools used for analysing the well-being of orphans affected by HIV and AIDS. After obtaining the permission to conduct the study from the Research Ethics Committee (UNISA); the Department of Social Development (Hlabisa District); and Inkanyezi Yokusa Mina Nawe, the researcher arranged the dates for the recruitment of the research participants. This was done in collaboration with the assigned volunteers.

During the recruitment process, orphans affected by HIV/AIDS were visited at their homes, and the researcher was introduced to the potential participants. The background and ethical considerations of the study were explained to the orphans and their guardians, and the potential participants were then asked if they were interested in participating in the study. Research participants who

showed an interest in participating in the study were revisited within one week by the researcher, in order to conduct the interviews. Data collection took place during the month of August 2008.

During the interview process, the researcher reintroduced the study, and asked the potential participants and their guardians if they were still interested in participating in the study. An informed-consent statement was read to both the guardians and the research participants, who reaffirmed their interest in participating in the study. Both the guardians and the research participants signed the informed-consent forms, which contained information about the purpose of the study; the nature of voluntary participation; the potential risks and benefits of participation; the confidentiality policy; and the relative information of the researcher and research supervisor, prior to the commencement of the interviews.

Five research participants were interviewed in this study. Although the number of the participants may appear small, the focus of the oral history is not on the *number* of participants, but rather on the richness of data obtained from these participants. Therefore, participants were able to give sufficient information for the purpose of this study.

In-depth interviews were conducted in order to elicit the various perspectives, reflections, and observations from HIV/AIDS orphans. Data was gathered by means of a semi-structured interview schedule (interview guide), used in conjunction with audio-recorded, personal, face-to-face interviews between the researcher and each participant. In addition, the non-verbal clues were observed during the interview process. The interviewer used probes in order to elicit a deeper understanding necessary for this study, because “when probing, an interviewer encourages a respondent to produce more

information on a particular topic, without injecting his or her own ideas into the discussion” (FHI/ IMPACT/ USAID 2005: 53).

All interviews were conducted at the dwellings of the research participants, in a quiet environment where there were no disturbances. Interviews were conducted in the home language of the research participants (Zulu). Prior to the commencement of the interview, the researcher reminded the participant of his/her right to withdraw from the project if it became too strenuous, however all participants who consented to participate in the study were able to complete their interviews. The interviews took an average of 30 minutes to complete.

3.5 THE RESEARCH INSTRUMENT

A data collection tool, in the form of a semi-structured interview schedule, was adopted from a framework and resource guide compiled by FHI, IMPACT, and USAID (2005) (Appendix 4). Although a semi-structured questionnaire was used to collect data from focus group discussions in this resource guide, the researcher found it possible to adopt it for the oral histories used in his study because of its focus on the psychosocial well-being of orphans affected by HIV/AIDS. Some areas of the in-depth interview guide were changed to suit the purpose of this study.

The in-depth interview guide was pre-tested with a group of teenagers outside Indlovu Village a week prior to the commencement of the interview in order to check the appropriateness and relevance of the interview guide, the selection criteria, and the feasibility of completing interviews with selected participants.

An audiotape recorder (the Olympus Digital Wave Player) was used to tape-record the interviews, in order to provide the details that even the most careful field notes cannot. This enabled the researcher to replay each recording several times, improving the veracity of the verbatim transcriptions.

The researcher obtained permission to use the audio recorder from each participant, since the quality of the recorded interview depends on the comfort level of the research participant (FHI/ IMPACT/ USAID 2005). In order to avoid having to change disks in the middle of an interview, an audio recorder that had an internal storage disk with a recording capacity of 12 hours was purchased.

3.6 DATA MANAGEMENT

The researcher transcribed the audiotapes on the same day as the completion of the interviews, enabling the researcher to capture the observations of the non-verbal points of the interview (by linking the audio recorded interviews, field notes, and the researcher's memory of the event).

Field notes contained information that was observed during the interviews by the researcher. Non-verbal clues for each participant were recorded as separate field notes as they occurred during the interview process, without interfering with the conversation, and the notes were clearly marked with the name of the research participant. The researcher safely stored the audiotapes and field notes so that their confidentiality was ensured.

Two transcriptions were done each day, as the researcher conducted only two interviews per day. Transcriptions were done in an undisturbed environment, at the hotel room where the researcher was staying during the

data collection process. The researcher transcribed each interview by listening to the recorder and typing the words spoken and recorded during the exchange. The written field notes, identifying the non-verbal clues recorded during the interview process were added to each individual's computer file. Each interview transcription took an average of two hours to be completed.

The researcher embarked on the following steps:

- Each recorded interview was downloaded using the Olympus Digital Wave Programme into the researcher's personal computer (laptop). Only the researcher had an access to the downloaded interviews, as it was secured with an access code
- Each folder was allocated a unique file name, containing the date of the interview, for identification purposes
- Recorded interviews were downloaded to disks, creating a backup copy
- A verbatim translation of the transcripts (from Zulu into English) was done by the researcher. Listening to the recorded interviews again whilst reading the computer files checked the translation
- after completing the transcriptions, copies of transcripts and downloaded disks were locked up, to ensure confidentiality.

3.7 DATA ANALYSIS AND INTERPRETATION

In-depth individual interviews with five orphans were conducted, using a narrative inquiry process. Narrative analysis was selected as the primary analytic framework for this study, since it emphasises the stories that people tell, in the course of interviews and other interactions with the qualitative researcher (Bryman 2004). Richmond (2002) notes that narrative inquiry follows a structuring borrowed from literature, such as:

- The plot, (in the case of this study, the focus on psychosocial needs and coping mechanisms was the underlying theme or plot)
- The thoughts and actions by the actors (in the case of this study, this refers to the cognitive reflections and understanding of traumatic life events by the research participants), and
- Events (in the case of this study, this refers to the actions and outcomes of these actions as narrated by the research participants).

The narrative enquiry process is important for both the research participants and the researcher. According to the narrator's point of view, the narrative's importance lies in its being one of the main forms through which the interviewee perceives, experiences, and judges his or her actions, and how he/she makes sense of the social world (Hydén 1997: 49; Somers 1994).

Rossmann and Marshall (1995) note that data analysis is the process of bringing order, structure, and meaning to the mass of collected data. Narratives create frameworks for understanding and judgement, and link them to the everyday reality of the narrator's life (Hydén 1997:49). In analysing narratives, the researcher works to actively find the voice of the participants in a particular time, place or setting (Connelly & Clandinin 1990).

All audio taped interviews were transcribed into Zulu, the original language the interviews were conducted in. The Zulu transcripts were then translated into English by the researcher. The researcher analysed the research participants' words to reveal past, present and potential psychosocial experiences; meanwhile the researcher was reading and searching for connections between psychosocial well-being and the loss of a parent or parents.

A 3-dimensional approach to narrative analysis was employed to analyse the stories gathered from the research participants. The analysis of data was done for three elements:

1. Interactions (personal and social)
2. Continuity (past, present and future)
3. Situation (physical space or story teller's space).

Stories were re-written to form chronological sequence. The narrative segments and categories within the story were isolated to determine larger patterns and meanings or themes.

3.8 VALIDITY

The researcher subscribed to the notion of Stenbacka (quoted in Golafshani 2003), that reliability-issues concern measurements, and therefore these had little relevance in this qualitative study. Part of the method of checking the authenticity of this study was using semi-structured interviews, audio taped, so that the researcher was able to go back to the original data for clarity. The *flow* of the interview, rather than the order of the questions in the guide, determined when and how a question was asked, depending on how each interview progressed (Bailey 2007).

As an example, most research participants were answering question 2 ("What has changed for you since the death of your parent(s)?") and question 7 ("Please describe to me what happened after the passing of your parent until you were placed with your current care-giver.") concurrently. The researcher therefore did not need to repeat question 7, as the research participant had already answered it.

Flick, (1998) citing Hopf, warns against applying the interview guide too rigidly, since that may restrict the benefit of openness and contextual information. Neuman (1997) argues that measurement must be more flexible when using qualitative methods. In addition, using semi-structured interviews, an interview guide, as well as a tape recording (dual methodologies) during the interviews with the orphans excluded the personal biases that could have emanated from the application of a single methodology.

3.9 ETHICAL CONSIDERATIONS

This study adhered to ethical principles throughout, to protect the right of the participants. Neuman (1997) mentions that the rights of the participants include

- The right not to be harmed
- The right to self-determination
- The right to privacy
- The right to obtain services.

He further mentions that these rights are related to

- The rights to maintain self-respect and dignity
- The right to remain anonymous
- The right to have confidential material remain confidential

(Neuman 1997)

Prior to the data collection, process the researcher submitted an ethical application for approval and the UNISA Research Committee granted the approval. The researcher maintained the rights outlined below.

3.9.1 Protection of privacy

The researcher observed a strict ethical adherence to protect the participants' confidentiality, meaning that all information provided was not made available to anyone who was not directly involved in the study. For example, no information was given to Inkanyezi Yokusa Mina Nawe about the participants.

An explanation on how data was going to be collected, analysed and stored was given to participants. The researcher ensured that interviews were conducted in a private place. In the case of interruptions, the researcher paused the interview until the cause of the disturbance was seen to, and only then would the interview resume. Although quotations in participants' own words are given to illustrate the findings (with translations in English), this is done in a manner that protects the identities of the research participants.

3.9.2 Informed consent

The guardian, or remaining parent, were asked to read and sign the informed-consent form, and all participants were also asked to sign an informed-consent form, confirming that they voluntarily participated in this study after they had been advised about its purpose; the type of information being collected; and how that information would be used. Both the remaining parent/guardian and participants retained signed copies of the forms.

3.9.3 Voluntary participation

Participants were informed that participation in the study was voluntary, and that failure to participate in the study or a withdrawal of consent at any stage was not going to result in any penalty or loss of the benefits to which the

participants were entitled to, either from the researcher or Inkanyezi Yokusa Mina Nawe. To ensure voluntary participation, the researcher did not give the names of the participants to Inkanyezi Yokusa Mina Nawe –the NGO knows only the number of recruited participants, not who did or did not take part. Participants were told that they were not compelled to answer any questions they did not wish to.

3.9.4 Avoidance of harm

The study did not place any participant in a potentially harmful situation, whether physically, emotionally, socially, politically, economically, and/or psychologically. Every issue discussed was done with sensitivity. The times and localities of the interviews was taken into consideration in order to ensure confidentiality. Guardians and participants were given the researcher's contact details and were instructed to call if they felt the need to debrief after the interview had taken place.

3.10 CONCLUSION

This chapter dealt with the research methodology. The nature of the qualitative approach chosen for this study was explored, and the ethical principles discussed. The next chapter presents a detailed description of the findings of this study, as well as an exploration of the main patterns and themes that emerged.

CHAPTER 4: FINDINGS AND INTERPRETATION

4.1 INTRODUCTION

This chapter presents a brief profile of each research participant, as well as the analysis and interpretation of the data. . The data is presented as themes that emerged from the analysis of the transcribed interviews and the field notes taken during the interviews. This study aimed to explore and possibly attain an in-depth understanding of the psychosocial well-being of orphans aged 13- to 15-years. To achieve this aim, the researcher opted for a qualitative approach, the objectives being to identify the psychosocial needs of the research participants, uncovering their methods of coping and testing their perceptions of the types of psychosocial support available to them, and others like them.

This study used a narrative analysis approach to gauge and analyse the life histories of the research participants. Narration enabled the creation of a framework for relating experiences, as well as a model for ascribing meaning, understanding, and judgments to these experiences, linking them to situations typical of the narrator's life (Hydén 1997:49). Narrative analysis allowed the researcher to formulate broad themes and sub-themes to analyse the voices of the research participants and through his interpretation brought meaning and insight to their words, actions, and experiences (Neuman 1997).

4.2 BRIEF PROFILES OF THE RESEARCH PARTICIPANTS

Working on the principles of constant comparison, saturation of themes and simultaneous collection and analysis of data, the researcher collected narratives from five teenaged children affected by HIV and AIDS. These

research participants were all orphans and their ages ranged from 13- to 15-years. Three of the participants were female.

By building a relationship of trust with the interviewees, the researcher created an environment that encouraged all the participants to communicate their own interpretation of what life as a teenage orphaned by HIV and AIDS in South Africa today is like. What struck the researcher was the lack of excitement about their youthfulness expressed by each of the interviewees.

Although all of them were able to express a future career aspiration, none of the interviewees gave concrete examples of things that they really liked about their lives, or things that they were looking forward to. Instead, the narrations were beset with reflections on the harshness of a life characterised by mourning and bereavement. To help contextualise these findings, a brief biographical profile of each research participant is presented below, in the order in which they were recruited for participation in the study.

4.2.1 Participant #1

The first participant is a 13-year-old boy who lives with his maternal aunt, younger sister, and 2 cousins at Indlovu Village. He attends Grade 5 at the local primary school, and aspires to be a policeman when he grows up. This choice may be affected by the fact that he is from a rural background, and there are not many options in this setting that allow for a variety of career-choices.

He used to live at Ingwavuma, in the far northern part of KZN, with his aunt, whilst his mother stayed at Mtubatuba. When his mother's health deteriorated, he and his aunt joined her there, and he then stayed with his

mother until her death two years later. His parents were not married and did not stay together, although they both died the same year.

This respondent proved difficult to interview because he was very reserved. Most of the information was obtained after some probing. He appeared to be introverted by nature.

4.2.2 Participant #2

The second participant is a 15-year-old boy who lives with his aunt and four female cousins at Indlovu Village. He is enrolled for Grade 8 at the nearby secondary school. Previously he stayed with his father at Sokhulu, near Richards Bay. His mother died when he was very young, before starting his primary education, his father died when he was ten years old. He went to stay with his aunt at Mtubatuba because of the difficulties he faced when his father died; exacerbated by the sour relationship he has with his grandmother.

Unlike the first interviewee, he spoke freely and openly about his life. However there were instances where he displayed some emotional distress, when he remembered his lost inheritance and when he spoke about his father's illness.

4.2.3 Participant #3

The third participant is a 13-year old girl who lives with her 2 sisters and brother in Mtubatuba. She stayed in a homestead that belonged to her grandmother, who had died in 2008. Her guardian is her older sister, who was still a minor at the time of the interview. Her parents were not married; she used to stay with her mother, siblings, and grandmother before her mother and grandmother died. Her mother died in 2007.

This young woman does not know her father and he has never been part of her life, although she has been told that he is alive. This interviewee was talkative, frank, very forthcoming, and very easy to converse with, however she displayed some emotion when talking about her aunt. She seemed angry about the treatment she received from her aunt. Halfway through the interview, the aunt walked into the house (where the interview took place) and seemed upset, stating that she had not been told about the visit. She claimed that she was the participant's guardian, yet the interviewee insisted that she was not -consent for the interview had been negotiated with the elder sister, the interviewee's legal guardian, and the interviewee. The interviewee was crying with fury and exchanged harsh words with her aunt. The researcher calmed them down and repeated the consent process with the aunt, the interviewee, and her sister. After this, all parties agreed that the interview could continue.

It is important to note here that the ethical requirements were met, the consent signed and the research procedure explained to the legal guardian. However, the actions of this particular adult demonstrated some of the pressure felt by teenagers who have to share dwellings with members of their extended family after the death of a parent.

Reflecting on her dreams about the future, this participant expressed a desire to be a nurse when she finished her basic education. She was doing Grade 8 at the local secondary school.

4.2.4 Participant #4

The 4th participant is a 15-year old girl who stays with her grandmother, 2 siblings, and cousins at Mtubatuba. She was in Grade 9 in one of the local secondary schools, and wants to study to become a journalist after

completing school. Her mother died in 2002 and her father two years later. Since her mother's death, her maternal grandmother has been her primary care giver. Her mother was not married to her father, and he did not pay child-support or offer any form of sustenance to her or her siblings when he was still alive. Her grandmother supports her and her siblings with the aid of social grants.

This interviewee is a soft-spoken teenager who appeared relaxed and comfortable during the interview, not displaying any visible signs of emotional distress. Upon reflection, the researcher ascribes some of this composure to the fact that, by all accounts, this girl feels loved and cared for by her aunt.

4.2.5 Participant #5

The 5th participant is a 13-year old girl staying with her grandmother, aunt, and twin sister at Mtubatuba. Since birth, she and her sister lived with their mother, a single parent, who died in 2007. Although her father was still alive and living with her stepmother in a close-by dwelling, her mother never encouraged the girls to visit their father, or to build any type of relationship with him. Although the father never paid maintenance for his twin daughters while their mother was alive, he did support them after her death. At various points during the interview, the interviewee broke down in tears as she related instances of her aunt's ill treatment of her and her twin sister. The interviewee was given time to calm down before the interview continued.

The research participants included three double orphans and two maternal orphans. Female relatives (aunts, grandmothers or older female siblings) became the primary care takers of these children during their parents' illnesses and after their deaths. Many of the participants did not have sound

relationships with their fathers even before HIV/AIDS affected their households.

4.3 THEMES THAT EMERGED FROM THE COLLECTION AND ANALYSIS OF DATA

In the section below, 4 broad themes that emerged from the narrative analysis and their sub-themes are discussed. The four broad themes are:

1. Description of the psychosocial needs
2. Coping with orphanhood and future aspirations
3. Psychosocial support available to orphans
4. Changes experienced by orphans when the parent died

4.3.1 The Psychosocial Needs of Teenaged Orphans

The psychosocial needs as narrated by the research participants emerged as needs related to the disclosure about HIV in the family; the social and physical needs experienced by the research participants; needs arising from relocation and changed household living arrangements; and emotional trauma and abuse. This situation presented a multifaceted context where respondents expressed the fact that they were exposed to different levels of traumatic experiences at a very young age, essentially robbing them of a carefree childhood. They were faced early on with the multiple losses of very significant members of their families, and were pushed from different households, in need of care, which contributed to their feelings of being uprooted from their original families. The fact that they participated in the activities of local organisations demonstrated further challenges with regards to fulfilling the psychosocial needs in their lives as teenagers. Each of these sub-themes is discussed in turn below.

4.3.1.1 Disclosure about the parents' HIV-statuses

All of the research participants reported that their parents did not disclose any information about their illnesses, and all of them expressed a deep regret that they were not allowed the opportunity to discuss their parents' health with them before they passed away. They felt that such openness would have enabled them to better deal with their parents' illness and death. They also reported that they harboured unanswered questions about the deaths of their parents. Participant #1 gave the following response to the question of what he knows about the illness of his parents:

I did not have any information about my father's sickness (pause)... except that I was told by my aunt that he was sick. I was young and I could not probe further because my father was not staying with me... I would have loved to know more about his sickness but nobody said anything about it. As for my mother...I only know that she was suffering from headache and my aunt took care of her when she was sick.

This participant emphasised that even though he felt that he needed to know more about his mother's condition, he was too young to ask his mother or aunt those kinds of questions. In traditional Zulu households, young children are not supposed to confront elders, even if the matter at hand may impact negatively on the child.

Like Participant #1, Participant #2 also had very little information about his parents' illness He stated:

Although my father did not say anything about his sickness, I knew that he was suffering from stomach-ache because I was the one who was taking care of him. Few days before he died, he told me was that I must inherit all his belongings when he died. It became clear to me that my father will die

but I did not have guts to ask more about his illness even though I wanted to know

Just after his father death, he enquired about his mother's death from his aunt. She told him that his mother suffered from stomach-ache. That triggered some questions in his mind, he stated:

I asked myself...why my parent suffered a similar condition. I started asking myself that, could it be HIV related death? I answered myself.... no, it can't, answering myself in denial. I asked all these questions with no answers and who was going to give me those answers? I guess those are the questions I will always have throughout the rest of my life without getting answers for (he displayed some emotional distress)

At first, Participant #3 did not know what her mother was suffering from; although her mother told her that she was sick she but did not explain the cause of her ill health. She narrated her mother's experiences during her illness:

My mother consulted the local traditional healer who told her that she was suffering from a traditional condition called "Idliso". Later she went to Hlabisa hospital because she was not getting better when using traditional remedies. She was diagnosed with tuberculosis (TB at the hospital). She was given tablets and she came back home. She was fine for a short while after started TB treatment and then later TB got worse. She went back to hospital and that was the time I last saw my mom. She died in hospital.

During the interview, it was apparent that Participant #3 had been very close to her mother. At first her mother only told her that she was ill, without any explanation because she did not know herself what was she suffering from. After the traditional healer had made the diagnosis that she had "Idliso", she

communicated that, and further informed her after being diagnosed with TB. It appeared that although this mother communicated with her daughter about her illness, Participant #3 was still left with some questions. She stated:

I trusted my mother a lot but I wonder if she told me everything about her illness. Since TB is curable if you treat it, why did my mother die? Unfortunately I can't ask anyone but this question is always coming up in my mind.

Although Participant #3 trusted her mother, she suspected that her mother did not tell her everything. This demonstrated how accurate information about the deceased parent's illness is a need experienced by some young orphans. Participant #4 also did not know what her mother was suffering from. She narrated:

I do not know what my mother was suffering from before my mother died; I only know that my mother was bedridden. When I think about my mother I sometimes speculate that maybe she was suffering from AIDS since she was bed bound and my father also died. I also did not know anything about my father's sickness and I feel that it would have been better if I was told what was my parent suffering from before he died.

Her mother did not tell participant #5 formally that she was HIV-positive, but could relate memories of her mother suffering from TB and chest sores. She mentioned that during that time she did not know what AIDS was. She argued:

I know I am not supposed to diagnose my mother with this disease but from what I was taught about the symptoms of AIDS, I think my mother was suffering from it. I did not think like this when she was sick because I did not know about the symptoms then but now I do.

In all of these cases, painful memories surfaced in the narrations of parents suffering from obscure symptoms that seemed to persist over time without having a clear diagnosis or label for what they were suffering from. Some parents tried to talk about their illness, but none of them disclosed his/her status to these teenagers. These teenagers were therefore left with many questions that they were afraid to pose to their relatives. This inability to discuss their parents' condition caused feelings of fear and isolation in these young people. The silence about HIV and AIDS persisted for most of them even after the death of their parents. Therefore, the non-disclosure of the parental status remained an unfulfilled need that must be addressed (see Gilborn, Nyonyintono, Kabumbuli & Jagwe-Wadda 2001 for a more detailed discussion on parental HIV disclosure)

4.3.1.2 Social and physical needs

All of the research participants spoke with longing of things that they had when their parent/s were still alive which they now have to do without. This longing for material things indicated that these teenagers have internalised the loss of their parents, but these feelings of grief have not been dealt with directly. At the same time, however, the participants were appreciative of the efforts by their extended/foster families to provide for them, even though this was not enough.

Participant #1 lamented the fact that he did not have toys to play with, despite the fact that he was a 13-year old boy, and that he did not have a complete set of school uniform like other children at school. When asked about his feelings about failing to get things he liked, he responded:

It is very painful that other children are getting everything they like and I am not. My aunt is trying everything to provide what I need but the gap still remains... (a long pause with no eye contact to the interviewer) it would have been better if my mother was still alive because my aunt would not be struggling to raise me.... As much as my aunt loves me, she cannot replace my biological mother, I was very happy when my mother was still alive because she used to love me so much and provided everything I asked from her.

Despite these feelings, Participant #1 attached meaning to the minimal provision of his needs; he knew that his aunt was struggling to make ends meet because she had taken on the additional burden of raising him. The fact that some of his social and physical needs were not fulfilled did not affect his values and aspirations, however, which included to live a happy life, to be respectful, to show affection towards his aunt, and to complete school so that he can become a policeman. He emphasised that he dislikes crime because criminals beat people”, and that he feared becoming a victim of violent crime. Although the problem of his incomplete school uniform affected him, making him stand out among the other school children (which, for him, underscored his orphanhood), in his narration he made it clear that he was content enough with life. He spoke with pride of the fact that he had never been ill enough to visit a medical doctor and that the minor ailments he suffered were treated with traditional medicine and spiritual healing from church.

Participant #2 told of how, just before his father passed away, his father had told him that he would inherit all his father's belongings. On his father's death, however, his grandmother took all his father's goods, and stored them in her house. After some time, she even sold some of the items. Participant #2 was deeply saddened about this, as he felt that in addition to losing his father, he had also lost his inheritance. Although these items could eventually have been of some financial value to him, he felt the loss of sentimental things

more keenly. He felt unable to express these feelings to his grandmother, or to openly defy her.

He reported that he used to like playing soccer, but had stopped after his father's death because he did not have soccer boots. In any society, sport is an integral part of youth development, but since his aunt could not afford to buy the soccer boots, Participant #2 had stopped playing soccer, compromising a vital part of youth development.

After the difficulties Participant #3 experienced in her early life she lost hope for the future, and doubted that it had anything positive in store for her. She reported:

I was living a good life when my mother was alive but now, life is no longer the same as before. I was getting everything I needed; she was buying me the full set of uniforms, which I don't have now. Now I have one skirt instead of two; I don't have a school tie; I have old shoes.

The biggest challenge Participant #3 had to face was the complete absence of anyone to provide in her needs -Participant #1 and Participant #2 had their extended families to provide for them although they could only afford the most essential items. Participant #4 told of how she not only felt ashamed that she was supported by a governmental social grant, this grant was not enough to meet her needs. In addition, her current dwelling was not big enough to accommodate all of the household members: she had to share one small bedroom with 3 other children. This loss of privacy and straightened income was difficult to bear for a 15-year old girl used to her own bedroom and many different clothes to wear.

Erikson (1950) termed adolescence as a stage of burgeoning independence, describing it as a stage characterised by less interest in parental activities, increased daydream activity (adolescents often seeming to live in a “fantasy world”), and a heightened need for privacy.

Despite having unfulfilled needs, Participant #4 was very aware of the fact that her grandmother provided for her basic needs. What differentiated her from Participants 1, 2 and 3 was that she did not display any emotional attachment toward her deceased parents, happy instead that her grandmother was “always there”, supporting her. When asked about the feelings she had regarding the loss of her parents, she responded:

I did not feel any change due the death of my father because I had never felt how good or bad it is to have a father. Mind you, my father has never showed love to me since he was not supporting me. I however felt the change about my mother but I am grateful that my grandmother is always there for me.

It is not surprising that Participant #4 complains about sharing a bedroom with other children, as this is the loss of her privacy, the need for which is compounded by the stage of human development she is in. Participant #5 reported that, although she had a full school uniform she did not have enough clothes. This participant had had no relationship with her father until her mother died, after which he began to provide for physical needs, like clothes, although Participant #5 was not residing with him, but living with her grandmother and aunt. Although her physical needs were being met to a degree, her social needs were not, as she felt mistreated by her aunt.

4.3.1.3 Relocation and changed living arrangements

The narrations revealed that after the death of their primary caregivers radical changes took place in the lives of the teenaged orphans. Some were taken in by foster or extended families and this compelled them to relocate from their original dwelling places to a new area of residence. Such changes included a change of school. UNAIDS (2002) reports that this re-distribution of orphans to different households, involving relocation away from schools and friends, is a common occurrence, obligating the teenagers to cultivate new friendships, and learn to deal with different teachers in a new setting.

Participants reported that they were forced to migrate from their original dwelling places to either join households where their ill/dying parent(s) were cared for, or to new foster or extended households. In some cases, this meant more than one move in a short period. This uprooting, to new, unfamiliar places was reported as a traumatic experience. Participant #1 told how he moved from Ingwavuma to join his ill mother in Mtubatuba, where he stayed in a 1-bedroom house with his younger sister, two cousins, and aunt. This dwelling was much smaller than the one his family owned in Ingwavuma.

It is important to note that during all of these changes, the children are experiencing several painful events -the relocation of the household is directly attributable to the death or serious illness of a parent. Their receiving environments (new homes) may not be ready to deal with these children's' stress and trauma. Participant #1 reported:

Unfortunately, I did not have a choice to stay at Ingwavuma because my mother was sick here (Mtubatuba) so I had to come. At Ingwavuma, I was sharing a big house with my cousin but here I am very squashed and it is unusual to me. I cannot say much; at least my aunt loves me.

Participant #2 first relocated from his father's house to his grandmother's house in the same area (Sokhulu), but then eventually volunteered to move much further away in order to join a foster household in Mtubatuba. Participant #2 reported that:

During December holidays, I visited my aunt at Mtubatuba and I realised that the conditions of living were far better than at Sokhulu where I was staying with my grandmother. I then asked to go to school at Mtubatuba from both my aunt and my grandmother, and they both agreed. I registered and enrolled in Grade 7.

Life was very difficult for Participant #2 after his father passed away because he had no one to look after him. Although the standard of living at Mtubatuba was far better than at Sokhulu, the fact that he was living in a 1-bedroom house with his aunt and 3 cousin sisters meant that he suffered from the lack of privacy. Participant #3 used to stay with her mother at her grandmother's house before her mother's death 2007. After this, she moved from her grandmother's house to that of her aunt's, where she stayed for only 1 year before returning to her grandmother's house. This move was precipitated by her aunt's ill treatment of her. However, her grandmother also passed away in 2008. Participant #3 reported:

After my mother's funeral, the family had a meeting in our absence (the children's absence) and decided that I should go and stay with my aunt since I was the youngest. This was difficult for me because I was not consulted, I was just forced to go and stay with her... if I was consulted I would have preferred to stay here where my mother was staying (grandmother's house) before she died.

It was clear that, although Participant #3 did not initiate, or favour, the move to her aunt's house she felt obliged to do so, because the family had decided to distribute the children in that way. It is common practice in rural areas for children to be redistributed in this way, so that the care-burden of orphans and vulnerable children is distributed across various households. However, in the case of Participant # 3, this arrangement did not work. At the time of the interview, she was living in her deceased grandmother's house with her 2 sisters and brother, who were minors as well, forming part of a child-headed household; fending for themselves seemed a better alternative to staying with relatives who, they felt, treated them poorly.

Participant #4 had lived with her mother and maternal grandmother since she was born, and did not, therefore, need to relocate after her mother's death. However, the living arrangement nonetheless changed drastically for her, since, before her mother died, she was used to being provided with everything but now was being supported by a social grant, insufficient to address all her material needs teenagers long for the consumer items that make them "fit in" with their peer-groups.

Participant 4 was used to sharing a bedroom with her mother, but was now sharing one with other children. She was not comfortable with this living arrangement; sorely feeling the lack of privacy this enforced communal living resulted in.

As Participant 5's parents had not been married, she had never stayed with her father or been supported by him. Her sole caretaker since birth had been her maternal grandmother. Although Participant #5 was staying approximately 5 kilometres from her father's house, her mother discouraged her from visiting her father, which in itself was a painful experience for this young girl. This was likely caused by the fact that her father was not

contributing to her upkeep, and her mother felt this lack of financial assistance keenly, resulting in feelings of anger and resentment toward him. The situation worsened after her mother died because her aunt was “always shouting at her”, telling her that she did not belong in that household. Statements like these made Participant 5 realise the importance of initiating a relationship with her father. Her desire to foster a relationship with her father resulted in him beginning to contribute to her physical needs. Healing, or initiating, a father-daughter/son relationship is a difficult task, and Participant 5’s bravery in taking this first step should be commended. During the time that the interview was taking place, Participant 5 reported that she visited her father regularly.

The impact of moving from one’s original home to a foster family situation presented challenges to these young people, which included leaving behind the memories of a place where they grown up; leaving friends behind; sometimes even dropping out of school. These children became strangers in their new households and the new areas they were forced to move to, sometimes resulting in a situation where some of them felt they were ill-treated by members of their extended/foster families, and most had to share bedrooms with children of different sexes, which compromised their privacy.

4.3.1.4 Emotional trauma and abuse

Losing a parent is emotionally taxing, but some of the research participants suffered the additional ordeal of emotional trauma or abuse by some of their new caretakers. Participant #2 told of the emotional trauma he suffered at the hands of his grandmother when he visited with her during school-holidays and she took great pleasure in telling him how his father’s house had been dismantled because the local *Inkosi* (chief) wanted to give the premises to

other people. As explained earlier on, this grandmother had removed all the goods from the house and stored them at her dwelling, eventually selling off the items bit by bit to passers' by. These actions, along with her retelling the story of how his father's house has been broken up deeply angered the young man and he said:

My relationship with my grandmother is not good because she did not take good care of my father's belongings, that is. She did not give me the money she got from selling my father's belongings, and the money that came from my father's employer.

Moreover, the grandmother took all useful documents, including the father's identity document and death certificate and hid them so that Participant #2 could not get them. Foster (1997) found that orphans are vulnerable to financial exploitation, which includes the misappropriation of inheritance monies, homes, and property by surviving adult relatives. This "property grabbing" undermines the livelihood of orphans already severely compromised by the death of parents (Gilborn *et al* 2001).

This interviewee eventually decided to go and stay with his aunt, who was doing her level best to provide good parental guidance to him. Participant #2 reported:

My aunt has tried her best to register me for the social grants but they need my parent's document, which she does not have. I have asked for these documents from my grandmother twice already. The last time I asked for them, she told me that she cannot give me these documents because my aunt will misuse my social grant.

The grandmother's reactions as narrated by Participant #2 seem to indicate spite, or, possibly, confusion. Nevertheless, whatever the reason for her

seemingly irrational behaviour, it holds real consequences for him, as it made it impossible for him or his aunt, as primary caregiver, to access sorely-needed state assistance.

The claims of emotional abuse made by Participant 3 were supported by the fact that the aunt in question interrupted the participant's interview by shouting abuse at the interviewee in the presence of the researcher. The aunt did not reside with the interviewee, was not her legal guardian, yet seemed to want to assume a care-giver role as it suited her. In her child-headed household, this young girl received little guidance, love, or care - psychosocial challenges like these were found in a study by Nasaba *et al* (2006).

The story told by Participant #5 was one of actual verbal and emotional abuse at the hands of her aunt. The aunt's frequent emotional outbursts against her and her sister were a source of deep pain for this young woman, and she cried when she related the following:

My aunt shouts at us (Participant #5 and her twin sister) and she tells us that she will chase us to go where we belong. When we tell our grandmother, she just keeps quiet and when we tell our father, he normally tells us that he will take us so that we could stay with him. Sometimes my father asks my aunt about this matter and she says we are lying... I am very confused, I do not know what to do now because I always wanted to go and stay with my father but I know that my mother did not want me to stay with my father.

Not only did this respondent suffer the ill effects of the aunt's reported emotional and verbal abuse, she felt isolated because none of the other adults believed that this was even happening. Moreover, the poor

relationship her sister and her had with their father existed before her mother's death, and the fact that her mother insisted that she and her sister should not have contact with their father further deepened her isolation after her mother's death. This young woman did not entirely trust her father, yet longed to believe that his repeated promises of rescue would eventually happen. This repeated cycle of verbal abuse, being told by their caregiver that she and her sister did not really belong with her, were unwanted, and then this fact further not being acknowledged or rectified by their grandmother or father can, potentially, hinder these young women's ability to trust others.

In this case, the acutely felt emotions were grief, trauma, and an overriding sense of loss. Although not always explicitly articulated, it was evident in a number of the interviews. On a number of occasions during the interview, Participant # 3 cried when she spoke about the trauma of losing her mother. With her mother gone, she felt there was no one left to provide for her, despite her father still being alive. She termed her father as person who is dead: "I would have been better if my father died instead of my mother because he is "dead-alive", so there is no meaningful reason for his existence in my life".

The above extract points out that Participant 3 regarded her father as not being able to take on the role of a father figure and that he did not contribute in any significant way to her life. Instead of seeking further help when her mother died, Participant 3 discontinued the child maintenance grant her mother had been receiving, resulting in added trauma. The loss of her mother was a devastating blow for Participant 3 as she had lost a provider.

A common theme in these narrations is the grief of losing one's parent and guardian. Having a full set of clothes for the prescribed school uniform was shown to be something to covet, and the absence of one impacted the

orphans (having dissimilar clothing meant that some of the research participants stopped participating in healthy leisure-time activities such as sport). This self-imposed isolation should be seen as a form of self-stigmatisation related to orphanhood. These teenagers did not openly sulk or complain about their lack of worldly belongings, for fear of offending their current caretakers. This can thus be regarded as an unmet psychological need.

Maslow's (1970) hierarchy of need indicates that physical needs are vital to survival, and that these include the need for clean water, air, food, and sleep - the most basic and instinctive needs in the hierarchy. He cited social needs as equally important and stressed the importance of loving and being loved, these include the desire for affection and a sense of belonging. These young people were deprived of basic physical and social needs by the premature death of their parents. The summary of the psychosocial needs presented in this study is similar to those uncovered by Nasaba (2006) which includes, among other needs,

- (1) The lack of disclosure of parental HIV status, which causes anxiety
- (2) Distribution of children to different relatives after their parents die, resulting in a breakdown of the original family unit
- (3) The lack of parental guidance, love, care, and acceptance in the new families that take them in
- (4) The lack of the kind of support that would help orphans to quickly adjust to the new environment without their parents.

4.4 COPING WITH ORPHANHOOD, AND FUTURE ASPIRATIONS

A major theme that emerged from the analysis of the transcribed interviews related to what the research participants considered as the things that helped them to cope with orphanhood. Participant 1 recounted that sport; holidays: and excelling at school made him happy, and helped him cope with orphanhood. In addition, positive reinforcement from his caretaker was a source of great pride for him. This young man aspired to be a policeman after completing Grade Twelve.

Participant 2, in contrast, was still locked in the memory of the great emotional pain of having to take care of his dying father. Paradoxically, this pain was also the source of his coping mechanism -he felt that coming to terms with the inevitability of his father's death helped him steel against the hardships of life, he stated:

It was fine caring for my father though it was painful, but it came to a stage whereby it became apparent that my father was going to die soon. I had to prepare myself for his death. I therefore waited for his death because he had suffered for a long time and I was hurting to see my father feeling such pain. This prepared me for the hardships ahead of me.

Participant #2 spent many hours in a day riding on his bicycle. This, he told the researcher, helped him to cope when he missed his father. His future aspiration was to be a soldier after completion of his secondary school education.

Participant 3 related how the fact that she was attending school, like other children in the community, despite being an orphan was a great source of pride for her. She liked going to school and enjoyed playing and doing her

homework with friends. She aspired to be a nurse when she completes Grade Twelve.

Participant 4 reported that her source of strength was her religion. She actively participated in the activities of her Christian church, which gave her a strong sense of fulfilment and consolation. She credited her religion with enabling her to survive in times of difficulty, helping her to cultivate a forward-looking orientation. She enjoyed playing volleyball with her friends at school. Her only regret was not having someone to talk to when she felt sad at home, but she reportedly felt comfortable talking to her friends at school. She aspired to be a journalist one day.

In the narrations of Participant 5, the recurrent theme of conflicting emotions about her father surfaced many times. She told the researcher how her father started to provide financial support to her after her mother's death, which was not something he had done before. She interpreted this change in her father's attitude as proof of his love for her. Like the previous research participant, the emotional support at her home was almost non-existent, poor but she was able to draw strength from her acceptance in her church and in participation in church-based activities. This young woman wanted to be a nurse in the future.

Most participants reported faith and religion as a coping strategy that helped them to conquer difficult situations. Interviewee # 4 stated that: "Whenever I start feeling bad about things that happen I go to church for a prayer and I feel relieved after that...God is always great and assist me to cope with my situation [orphanhood]"

Participant 1 was very excited when he mentioned that he had never fallen ill in such a way that he would need to visit the medical doctor. He attributed

this to traditional healing, more importantly to the spiritual healing he was receiving from his church. The fact that he was being healed in church when he was ill meant that there was nothing to worry about when it comes to his health and physical well-being. Participant 3 and 5 also cited the importance of the church as a coping strategy, stating that it often gave them relief from the problems in their lives.

This sub-theme indicates that religion provided participants with a belief that helped them develop a positive outlook and attitude. This includes instances where these participants displayed a positive view of themselves and determination to survive against whatever eventuality they would confront. This is apparent from the sort of careers that the participants wanted to pursue after finishing school. Participant 1, for example, sees himself becoming a policeman, participant 4 imagines herself obtaining a Journalism qualification in one of South Africa's universities; Participant 3 wanted to become a nurse. This confirms the positive role that Inkanyezi Yokusa Mina Nawe and churches are playing in cultivating self-belief in these participants.

4.5 PSYCHOSOCIAL SUPPORT AVAILABLE TO ORPHANS

Although the research participants experienced severe challenges and radical changes, they nonetheless reported elements of support from community members and organisations. This theme has the following sub-themes:

- (1) Support from family and friends
- (2) Support from Institutions.

4.5.1 Support from family

All of the research participants were able to report some moral, spiritual, and social support from families and friends. This kind of support was narrated as

vital to help them cope with orphanhood. Support in this sense took on the form of care-giving; taking care of specific needs (such as health, food, shelter, clothing and school fees); treating the teenager as a member of the family (as opposed to treating them like an interloper); listening to the teenager; and helping him or her keep the memories of their deceased parents alive.

Participant 1 told how his mother had showered him with love, and that these memories of her kept her alive in his thoughts. He also related that he felt a different kind of love from his aunt's - when retelling his story, Participant 1 revealed that there were many occasions where he missed his mother terribly, and it was then that he had a burning desire to tell stories of "the good times" he had enjoyed when his mother was still alive. He felt that these stories would connect him to her again, and make his plight more bearable. At the same time however, he felt that these reminiscences could not be shared with just anybody -in this respect, his cousin was the one person who was always willing to listen to him. He voiced his deep appreciation for the support he received from his aunt and for the fact that she made every effort to treat him like a son.

Participant 2 told the researcher how he had felt loved and wanted when his aunt invited him to come and stay with her. He felt that his aunt treated him like her own child, and his fondest memory was when she gave him money to buy his bicycle. In his account of support, Participant #2 noted that he felt "at home" with her, and "well taken care of" and, as a result, he did not have plans to go back to stay with his grandmother at Sokhulu. He felt comfortable talking to his uncle and aunt about his late mother and father, the loss of his inheritance and any other issues that worried him. Over the course of the fieldwork, this respondent's uncle also died and his aunt was the only person left that he felt he could talk to. Part of the loving care he received from his

aunt was the fact that she sent him to a local clinic for medical attention when he was ill and paid his school fees.

Participant 4 told the researcher that, since her grandmother has always assumed full responsibility for her care, she felt deeply loved and completely at home with her, praising her grandmother for taking such good care of her. Participant 3 told the researcher how her father used to pay maintenance support while her mother was still alive, but that soon after her mother's death this support ceased. Her uncle stepped in to help her with material needs like food and clothes, her emotional and psychological needs remain unmet, and this is where Inkanyezi Yokusa Mina Nawe; the church; and friends stepped in to meet these unfulfilled needs. Participant 3 narrated:

Even though it was difficult to live in a household I used to share with my mother and my grandmother, who both died...but staying here made me believe that I am still connected with them, therefore I am safe despite all odds. I cannot imagine myself staying in any other household than this one and that is why I could not resist coming back home when my aunt started humiliating me.

Participant 3 could not stand the ill treatment from her aunt because she wanted to go back to the home she felt she belonged. This sense of belonging was so vital to her that she preferred living in a household where there were little more than minimal provisions for basic needs. To her, nothing mattered more than feeling a continued sense of connection with her beloved mother and grandmother, enabling her to happily stay in this household. Apart from feeling that she did not have enough clothes and longing for her own bedroom, Participant 4 was happy to live with her grandmother, a woman who tried everything in her power to continue to provide for this young girl.

Contrary to the above-mentioned participants, Participant 5 found herself in a very confusing situation: she did not know whether she belonged with her grandmother or with her father. This was caused, in part, by the ill treatment they (Participant 5 and her twin sister) reportedly received from their aunt. Participant 5 wanted to go and stay with her father and her father repeatedly made promises that he failed to fulfil. Not only did this create stress for this girl, but she experienced feelings of guilt that leaving her grandmother would mean betraying her current caregiver. She felt certain that her grandmother loved her, but her aunt's angry outbursts and emotional abuse made it unbearable for her to develop a sense of belonging at her grandmother's household. Moreover, she was still haunted by her late mother's instructions that she should not stay with her father, or have any type of relationship with him. This emotional turmoil created distress in this participant and, as she narrated this during the interview, she broke down in tears, saying that she did not know how to solve this problem. In the end, she connected her current situation with the loss of a parent due to death and the potential loss of another due to a poor relationship and said through her tears: "It would have been better if my mother did not die".

In this sub-theme on familial support, most participants voiced their appreciation for having supportive family members. Their foster families, with the exception of one child who did not enjoy staying with her aunt, treated these teenagers well. The support they received from family members enabled the participants to bear their plight, and to recover from their bereavement. Richter, Foster, and Sherr (2006) attribute this to the fact that children are likely to develop resilience in order to face challenges if they are surrounded by people love and care for them.

4.5.2 Support from institutions

An overwhelming number of respondents described how, through the association that they have developed with Inkanyezi Yokusa Mina Nawe; they were able to fulfil their basic needs. They considered the role played by this organisation as a vital one in helping them restore their sense of purpose and confidence in life. Participant 1 narrated how this community organisation has helped him to find hope:

I feel so different ever since I started associating with Inkanyezi Yokusa Mina Nawe. They give us food, clothes, and life lessons. When I visit that place, I meet other children who are in the same situation as I am, and we talk and share common issues with one another. This has really helped me a lot and I think other children feel the same way as me.

Participant 2 appreciates the availability of the services Inkanyezi Yokusa Mina Nawe provides and remarked:

Apart from the support I get from my aunt, Inkanyezi Yokusa has done wonders in my life. Here (home) I get food and clothes but Inkanyezi Yokusa has given me, among other things, the life orientation training and life skills that I would never have received.

According to Participant 2 this organisation has given him more than just the basic needs –it has given him the social skills that he needs in order to cope with his orphanhood. This NGO does as much to assist orphans as institutions like the church and local schools. Participant 3 remarked how she received support from friends and from the church:

When I am feeling sad about something, I confide to my school friends, but if I miss my mother I do not talk to my friends but I prefer going to church for prayers... [Pause and a vibration of the voice] I am afraid of talking

about my mother with my friends because they would ask me questions that I am not ready to answer about my mother.

This participant enjoyed the support she received from friends at school when she was feeling bad about something, which suggests that the role played by the schools is as vital, and should not be underestimated. Although it was clear that Participant 3 avoided talking about her mother she unfortunately did not provide details as to why she did not want to do so. This could be attributed to two possibilities:

1. A after having seen her mother progressing through all the stages of illness, she was probably hurt, and not ready to face any questions around this issue.
2. She might have thought that if she informed her friends about her mother's illness they might stigmatise her.

It was noted however that Participant 3 was well aware of the support structures available to her, and the different roles they played in her life. For example, friends and the churches complemented each other when this young girl faced difficult times.

Three issues emerged from this sub-theme.

1. Inkanyezi Yokusa Mina Nawe was the only organisation that provided support services to these young persons in the area. Support from the other institutions, such as churches and schools, was either informally harnessed by the teenagers themselves, or elicited through the intervention of Inkanyezi Yokusa Mina Nawe. The presence of that organisation made a difference to the lives of all the participants because they claimed that it provided them with the needs that were not fulfilled by their foster families. Therefore, the existence of this

organisation played a crucial role in shaping the lives of these teenagers.

2. Schools played a vital role in connecting these teenagers with friends and peers. School friends provided them with social support, which encouraged and motivated them when they were on the verge of giving-up due to seemingly overwhelming challenges.
3. Churches were reported as the main source of spiritual support to participants. They found comfort in the prayers from the church members in dealing with issues that were deemed too sensitive to talk about.

Her grandmother had cared for participant 4 since her mother's death; her father did not support her and she and her grandmother relied totally on the government's social grant. She valued the role played by the church in her life, as she reported that she felt reassured and comforted when attending church services. The importance of the spiritual support was mentioned by many of the participants.

From this sub-theme, it emerged that participants appreciated the institutional support from this NGO (Inkanyezi Yokusa Mina Nawe), their schools, and churches. The finding that only one NGO provided support to the children in the area is disconcerting, as there is a great need if one takes into account that in 2000 about 73% of all deaths occurring among the 15– to 44-years age group in Mtubatuba were due to AIDS-related causes (Tanser *et al* 2007). It is expected that such an area would enjoy higher priority in receiving support, especially since the KZN office of the Premier (2006), indicates that there is a wide range of NGOs and CBOs in the province that provide support to AIDS orphans. It is unfortunate that such organisations

tend to be concentrated in urban areas, leaving rural areas unattended (KZN office of the Premier 2006).

Another unsettling finding was that so few of the orphans received the grants paid by provincial social development departments to qualifying children. In April 2005 only 256 325 out of 3 360 505 orphans received foster care grants (South Africa, Department of Treasury, 2005: 57 cited in Statistics South Africa 2006). This means that only 8% of all orphans were recipients of foster grants in South Africa. Therefore, apart from the scarcity of NGOs in this area, the government itself is not providing adequate support. This could be due to the unavailability of information about these grants, or due to poor service provision on the side of the government.

4.6 CHANGES EXPERIENCED BY ORPHANS AFTER THE DEATH OF THEIR PARENTS

The dramatic changes brought about by parental death were reported by all of the research participants as the culmination of smaller changes that took place well before their parents' deaths. The two sub-themes that form part of this retelling of changes are

1. Changes in school attendance and academic performance
2. Living with an ill parent.

4.6.1 School attendance and academic performance

All the research participants were attending either primary or secondary school at the time of the interviews. They were all in different grades, ranging from Grade 5 to Grade 9. However, some

of the research participants were forced to drop out of school for a while when their parents were ill or immediately after their deaths. Participant 1 reported: I am doing Grade 5 in the local primary school, but I am supposed to be doing Grade 6. Unfortunately for me, I had to break from school for a year when I moved to join my mother at Mtubatuba.

This extract indicates that Participant 1 was not happy about the fact that his move from Ingwavuma to Mtubatuba occurred in the middle of the year and that, as a result, his school education was interrupted. Participant 2 was in Grade 8 at a nearby secondary school, but he too had drop out of school in Grade 6, in order to take care of his father. He rejoined in the same grade after the death of his father and successfully completed the academic year, showing his ability to manage changes, and he told the interviewer:

At the age of 10 (years) I had to break from school so that I can take care of my father since no one from my family was willing to help my father when he got sick, including my grandmother. I thank my friends for helping me during those difficult times, even though God decided to take him from me. However, I will always remember and value my friends for what they did for us.

Participant 2 was very appreciative of his friends for the assistance they gave him; however he seemed agitated when he mentioned that he did not get any help from his family. It was clear that he had had expectations that he was going to receive support from his family; but did not receive any.

Participant #3 had to go to a new school after her mother died, but this did not interrupt her schooling or force her to repeat a grade, despite the fact that she had not willingly changed schools. It was heartening to witness that, despite the hardships they experienced, all of the research participants reported that they enjoyed school and were determined to complete their schooling in order

to prepare for the job market. It is also a tribute to their caretakers and the schools involved that these children did not suffer severe setbacks in their schooling. It was thus found that these research participants were fully involved in youth activities and they enjoyed the company of their friends. They were able to participate in youth and school activities, which are contrary to the findings reported by Richer, Foster, and Sherr (2006). Patterson (2003) reports that children affected by HIV and AIDS do not want to participate in school or youth activities. Credit should be given to the schoolteachers, friends, and caretakers from the foster families for uplifting the esteem of these teenagers -this enabled them to mingle with other children at school without any fears, or negative self-judgment and labelling.

4.6.2 Living with an ill parent

The research participants retold painful experiences of having to witness the slow but dramatic declines in the health of a parent. Most of them did not really understand the causes of their parents' illness and some of the research participants found it very difficult to put into words the suffering they witnessed, instead turning the discussion to a retelling of who took care of the parent before their death.

Participant 1 moved from Ingwavuma to Mtubatuba to stay with his mother, who was by then already seriously ill. For 2 years, this young man witnessed the slow deterioration in her condition, without fully comprehending what was happening to her. The retelling of this experience was very harrowing for this respondent, and he took several long pauses before continuing with his narration to compose himself. Eventually he ended with: "My aunt took care of my mother when my mother was sick...she...she just gave her tablets when necessary".

Participant 3 also restricted her retelling of her mother's illness to the care given to her by grandmother and her aunt. In contrast, Participant 2 experienced living with a terminally ill parent as having to adjust to the reversal of parental and child roles:

When my father became sick, I took care of him in such a way that I stopped going to school and I even stopped playing soccer. I was cooking for him, bathing him, fetching water and wood to make fire, cleaning the house, and giving him everything he wanted. I was only 10 year old and had to take care of my father since nobody from my family was helping me, except my friends.

One of the significant issues that emerged from the texts for Participant 2 relates to lost childhood. This issue captures feelings around having to assume the responsibilities of an adult whilst still a child. It also includes a sense of deprivation and exclusion from the normal human developmental stage, like participating in activities that other children of their age are involved in, like playing soccer with his peers. This was uncovered by Gilborn *et al* (2006) when they found that vulnerable adolescents, especially those affected by HIV and AIDS, face unique responsibilities and challenges, such as managing households, and caring for ill parents.

One of the experiences reported is having to adjust to the reversal of parental and child roles when a parent becomes ill and subsequently dies. This experience presents drastic challenges. Under this sub-theme, the narrations revealed a range of emotions, including pain and hurt as well as depression due to their experiences. Participant 5 illustrates these emotions in the following extract: "Apart from the reversal of roles, the effects of living with a sick parent are very traumatic and I do not wish my worst enemy to experience it".

What is apparent from the above extract is the amount of anxiety Participant 5 experienced during this period. She expected that her mother would survive, since she had sacrificed her time to take care of her. She narrated:

My mother was taken care of by my grandmother. My grandmother was very old and could not do other things since she also needed to be taken care of. My sister and I had to assist our grandmother in taking care for my mother... anyway, she was our mother; we were obliged to help her even if it meant suspending our childhood activities. After all that effort trying to help our mother, she still died and that was a blow to me.

This reversal of the normal parental-child role, where orphans took care of parents and assume household and childcare responsibilities was also reported by Smart (1999) and PEPFAR (2006). The memories of their parents' disease progression and deaths were traumatic, especially because most of them had lost their mothers who were not only the primary source of love but the main caregiver to the participants (Nemapare & Tang 2003). In most cases, however, new caretakers in foster or extended families took adequate care of the orphans. This study therefore did not uncover the same extent of high psychosocial distress as reported in the study by Gilborn *et al* (2006).

4.7 CONCLUSION

Erikson's (1950) psychosocial theory of development argues that all human beings pass through 8 stages of development, and that each of these stages must be resolved successfully before the individual can progress to the next. It can be argued that teenaged orphans whom HIV/AIDS affects do not get a

chance to resolve stage 5 because they assume parental roles. This may deprive orphans of the opportunity to find their identities (Erikson 1950).

It was found that the research participants coped with orphanhood; despite the challenges and hardships they were confronted with, all of them verbalised future aspirations. Things like sport, celebrating Christmas and passing at school were very important to these interviewees. They drew strength from these things, and they added meaning to their lives.

It was found that caretakers in foster or extended families provided shelter and clothing, but that this was often insufficient. Problems that were reported were insufficient space and the resulting lack of privacy, not having new clothes, not having a full school uniform, and not having sport clothes. Muller, Sen, and Nsubuga (1999) found similar challenges where shelter, lack of clothing and interrupted schooling were identified as the challenges that were inadequately addressed. One of the research participants added the problem of being deprived of his inheritance. Simbayi *et al* (2006) also reported that children might even suffer the loss of their home, through the sale of livestock and land, and asset-stripping by relatives.

The final unmet need expressed by the research participants was the lack of a formal and clear support system to assist them with their feelings of sadness and grief for their parents. This is consistent with the study conducted by Foster and Williamson (2000), who found that the psychosocial impact of HIV and AIDS in orphans is neglected due to the shocking financial crisis that orphans confront; therefore the programmes tend to focus on providing for their material needs whilst neglecting counselling and other forms of psychosocial support.

This study found that there was a lack of formal psychosocial support, however it was noted that ad hoc psychosocial support was available to orphans. The kind of support given included the provision of shelter; food; paying for the school fees and giving love. Churches provided spiritual support to some of the research participants, which helped them cope with orphanhood. The study further found that the government's social grants help the orphans and their caretakers to fulfil in some of their material needs. The availability of these grants helps orphans affected by HIV and AIDS to contribute financially towards needs of the extended or foster families.

Many of the interviewees expressed their appreciation for the affection and support they received from their caretakers, regarding this as a major contribution to their personal growth and development. This finding is similar to that of Richter, Foster, and Sherr (2006) who report that the sense of belonging and hope that is nurtured in these relationships enables children to cope better with hardship, including hunger, discomfort, and other privations of poverty and loss. This suggests that orphans are in a position to bear and recover from suffering when they are surrounded by people that love and care for them

The findings presented in this chapter describe the type of challenges and psychosocial needs that the research participants in this study confronted. These challenges include social, economic, and emotional challenges.

The findings also describe the coping mechanism that the participants employed in their day-to-day life in order to ensure psychosocial adjustment and adaptation. Furthermore, a description of the psychosocial support available to orphans was presented.

CHAPTER 5: CONCLUSION

5.1 INTRODUCTION

Adolescence is a period of transition, in which young people reconsider their identities, roles, and feel the pressures of social expectations acutely. If this transition phase is further complicated by a traumatic event such as the death of a parent, the development of adaptive coping strategies may be hampered.

In this study, both the review of related literature and evidence stemming from the analysis of narrations provided by teenaged orphans showed that the loss experienced by these teenagers represents a progression of experiences. These range the gamut of emotions, from the onset of a parent's illness, through the physical and emotional impact of their deaths, and into the aftermath of their dying, including having to relocate to a different area and facing that ensuing uncertainty. The findings from this study clearly demonstrate that orphanhood brings great challenges for the teenagers concerned. However, their inherent ability to cope with those challenges (mediated by social, spiritual and cultural factors) cannot be undervalued.

This study aimed to explore and attain an in-depth understanding of the psychosocial well-being of teenaged orphans aged 13- to 15-years old, with an intention of scaling-up the psychosocial support to orphans. The objectives of the study were to describe the psychosocial needs of teenaged orphans aged between 13- to 15-years. Here the study revealed that teenaged orphans have to face harsh and shocking realities. The longer the spread of HIV-infections and AIDS-related mortality in South Africa are left unchecked, the heavier the impact on children will be; not only in terms of orphanhood, but also in terms of the psychosocial needs left unmet. Such circumstances are likely to be aggravated by an ever-changing environment, characterised

by deepening poverty. The grief of the loss of parents and significant others is made more difficult by multifaceted challenges, as children are uprooted to seek care in foster homes or the homes of relatives. In some cases, children whose parents have died due to AIDS-related causes are labelled as 'AIDS Orphans' and stigmatised.

The study explored areas of vulnerability facing orphans in the context of HIV/AIDS. Particular attention was paid to an evaluation of the *kinds* of support available to children whose parents died of AIDS-related causes. Stigma; discrimination; cultural bias against divulging important information to children (and withholding the truth in an attempt to protect the children) prove to be factors very negatively experienced by children.

The second objective was to describe the coping mechanisms of the teenaged orphans. In this regard, the study explored the practical ways that teenagers use to cope with trauma on a daily life basis. The study learned that teenaged orphans are coping with the challenges they confront, despite the lack of concrete or formal support structures to enhance resiliency. For example, playing favourite sports; going to holidays and excelling at school are all factors which bring joy to teenaged orphans, and as a result assist them to cope with the realities of orphanhood. The support they receive from extended or foster families instils a sense of belonging in the teenaged orphans, enabling them to accept their new situation as orphans. The fact that most foster families treated teenagers as members of the family made them realise that they still have bright future ahead of them, even though their biological parents had died.

The restoration of this sense of purpose was evident from the nature of career options that research participants wanted to explore after finishing school. The pattern observed from their career choices was one of

community-service oriented careers, e.g. policing, journalism, and nursing. These choices might have been influenced by the fact that the community is contributing towards their upbringing, instilling in them the desire to “give something back” to society. Support from churches and from Inkanyezi Yokusa Mina Nawe helped teenaged orphans develop a positive outlook and attitude about themselves. This study has ascertained that teenaged orphans utilise the support offered by various stakeholders, unstructured or not, as their primary coping mechanism, enabling them to acquire a positive view of themselves, and a determination to survive against all odds.

The third objective was to describe types of psychosocial support available to the teenaged orphans. The study revealed that teenaged orphans obtained psychosocial support at a family and institutional level. At the family level, foster families are providing support in a form of “care-giving”, taking care of specific needs such as those of health, food, shelter, and clothing and, more specifically, things like school fees. Proper management of the integration process of the teenaged orphan into the new (foster) family (treating these orphans as members of the family) brings solace, and makes them feel loved and wanted. The study also reveal that teenaged orphans are enjoying the presence of at least 1 family member who is always willing to listen to them when they want to share their memories about the deceased parents, helping them to keep the memories of their deceased parents alive as well as to cope with orphanhood.

Since foster families are able to send orphans to school, orphans further enjoyed social support from friends at school that they would otherwise not have received. Friends at school offer support by offering their time for listening to the orphans when they feel badly about something that they do not want to discuss with the foster-family members. Such support encouraged and motivated them when they were confronted with challenges at home.

Teenaged orphans receive spiritual support from churches, which assist them in dealing with issues that were deemed too sensitive to talk about at all. They found comfort in the prayers from church members. Inkanyezi Yokusa Mina Nawe is the only organisation that provided support services to these young persons in the area. The support from this organisation has made a huge impact in shaping the lives of these teenagers, since it fulfils those needs not addressed within their foster families. This study revealed that, although they were not structured, the orphans enjoyed familial and institutional support.

5.2. LIMITATIONS OF THE STUDY

Any study has limitations, and in this study, two types of limitations came to the fore, namely

1. Limitations related to the research design, and
2. Limitations related to the selection and recruitment of interviewees.

These limitations are discussed in turn below.

5.2.1. Limitations inherent to the chosen research design

The desire to fulfil the objectives of the study led the researcher to choose a qualitative, narrative approach. Since the focus was on re-telling, and so gaining an in-depth understanding of what it is like to be a teenager orphaned by HIV and AIDS in South Africa today, the study elicited vivid narrations of personal experiences, but not general results. The results of this study should not be seen as representative of the experiences of *all* teenaged orphans. Moreover, the time commitment required to recruit the interviewees and to gain their trust made it impossible for the researcher to work with a larger

number of participants. It also required skills and patience from the researcher to develop a rapport with participants.

The interpretation of the results required recognition of the constructed nature of the narrations. This challenged the researcher to keep the voices of the participants' central in the presentation of the extracts, whilst searching for common themes. Moreover, the stories were taken at face value as the experiences of the young people, and not all the details could be verified as objective truth by the researcher. It was difficult to retell the stories and place them as themes into a larger narrative of teenage experiences without imposing meaning of these lived experiences. The researcher tried to guard the authenticity of the narrations by

- (1) transcribing the interviews immediately after the events, to maintain the originality;
- (2) listening to the tape recordings attentively; and
- (3) Presenting extracts of the transcriptions and translations to his supervisors.

The research participants were teenaged orphans with ages between 13- and 15-years. These children are very young, and unable to remember all the series of the events that had taken place during the course of their lives. Therefore, there is a possibility that the information obtained from the research participants was limited or, rather, not as rich as was initially supposed. However, it must be noted that the researcher used his skills to ensure that probing was vigorous in such a way that he managed to obtain sufficient information from all the research participants.

One of the ethical challenges central to this study was the emotive aspect to asking young people to narrate such inherently painful experiences. The researcher worked hard at gaining the trust of the participants, and

exchanging stories was regarded as something that happened within the boundaries of a reliable relationship. In this regard, the researcher found it hard to disengage after each interview. This was used as strength in the transcription of the interviews in which the researcher, because of the impact of hearing these stories, tried to represent the stories as truthfully as possible.

5.2.2. Limitations related to the recruitment of the sample

Recruiting young people as research participants can be a significant challenge (Alderson & Goodey 1996). Since the research participants were minors, the researcher had to observe particular ethical guidelines in the recruitment of these interviewees.

Research participants were recruited through a three-part process.

1. The assistance of Inkanyezi Yokusa Mina Nawe was required to identify teenagers eligible for recruitment. This poses some level of bias because there is the possibility that orphans who were not linked to this NGO were excluded. It should be noted that the recruitment of the research participants for this study without the assistance of Inkanyezi Yokusa Mina Nawe, would have been impossible however, since these households are not always visible to an outsider. It must be kept in mind that recruiting participants through Inkanyezi Yokusa Mina Nawe executed a protective role against the violations of the ethical rights in the research process. For example, the study was first presented to Inkanyezi Yokusa Mina Nawe and the approval of the study had to be obtained before the study could continue.
2. Fully briefing both the legal guardians and the interviewees on the details of the study was the next step, and

3. Signing informed consent forms the final one. Such safeguards are based on the assumptions that young people are too vulnerable to be competent in making decisions about matters that affect them (Morrow & Richards 1996). These assumptions about young people's vulnerability and decision-making abilities emerged in the findings as the interviewees narrated how they were not informed of the causes of their parents' illnesses, or how they were not consulted about where they should move to or whom their legal guardians would be after the death of their parents. Landsdown (1994:38) points out that these assumptions mean that a culture of listening to children has not been established. The researcher endeavoured to listen and to represent in this study.

It should be pointed out that in one case the informed consent process was renegotiated to include an aunt who was *not* the legal guardian of the interviewee, but who acted as an important gatekeeper. This shows how pragmatics of research in the field sometimes presents the researcher with new challenges.

5.3. SUGGESTIONS FOR FURTHER RESEARCH

This study has exposed the reality that the concept of "family" need to be re-evaluated in the light of the present reality that as we are losing conventional family units, and children are often left with minimal care, or none at all. This challenges future researches to explore/create workable innovative and holistic approaches at a community-level towards caring for vulnerable youth and children. Since orphans are residing within the community, there is a need to investigate the involvement of the local community in the provision of

psychosocial support services to orphans. The study revealed that the volunteers and caregivers are doing a commendable job in providing support to orphans; however, the level of their knowledge on what “psychosocial support” entails is not known. Thus, it is not known whether volunteers and caregivers are aware of what is expected of them as far as this psychosocial support is concerned. There is a need to study the level of knowledge and understanding that volunteers and caregivers have of the psychosocial support needs of teenaged orphans.

5.4. CONTRIBUTION AND RECOMMENDATIONS

This study has amassed a body of information that will assist in better understanding the coping mechanisms, psychosocial needs, and the psychosocial support available to meet those needs, of teenaged orphans residing in the rural setting of Mtubatuba. Based on the contribution of this study to the body of knowledge, the recommendations to assist teenaged orphans in achieving or maintaining their psychosocial well-being are discussed below. It is important to note that this study has discovered that the duties of caring for the orphans which is often taken for granted need to be looked at seriously in that the concept of ‘extended families’ is no longer as viable as it used to be in the past. In some cases, the uprooting of children to their next of kin can bring more harm than good in their lives.

The current high rate of unemployment means that more and more families are struggling to survive in these straightened economic times, and this impacts a great deal on the ability of already overstretched families to cope with the additional demand of caring for HIV/AIDS orphans. It is clear that the mushrooming of CBOs and Non-Profit Organizations (NPOs) seem to be replacing the role of the family in communities ravaged by the scourge of HIV/AIDS, but even these initiatives need to be monitored and supported so

that children may benefit positively as they look for alternatives and a second chance in life.

5.4.1. Contribution

The findings of this study highlight some of the psychosocial challenges that teenaged orphans face because of parental death due to HIV. These challenges take root at different stages, starting from the period prior to bereavement through to post-bereavement adjustment. This information provides service providers (the government, professionals and other stakeholders) with information that could inform and renegotiate the support they provide to teenaged orphans. Teenaged orphans are faced either with the task of looking after a very ill parent or dealing with a parent's death, sometimes both. This could be the beginning of a psychosocial challenge whose ramifications, if left unaddressed, could affect these teenaged orphans for the rest of their lives.

The formal management of changes that take place in any environment is very important for the sustainability of that environment. Orphans are experiencing a number of changes before and after their parents die, and change management then becomes very critical to them. It is clear that foster families are doing everything in their power to provide support to these teenagers; however, there are no formal systems to help manage these. The absence of these systems could create a vacuum that may undermine the efforts of the members of the foster families in supporting teenaged orphans. Consequently, foster families may think that they are taking good care of the teenaged orphans, yet the orphans feel that their psychosocial well-being is being compromised.

This study highlights the strength showed by the teenaged orphans to overcome the hardships they are experiencing in their everyday life. Teenaged orphans develop coping mechanisms that allow them to stay positive about life and to aspire to greater things, like other children who are not orphans. The efforts and support of their foster families does not go unnoticed, the orphans rely on these at times. Therefore, things that foster-families do to support orphans may appear as relatively minor to them, but mean a lot to orphans. For example, celebrating Christmas is normal for most of us, but to an orphan it could mean much more than that -it could mean that even though they are orphans, they are still entitled to be happy, and this sense of a right to happiness might keep them going when the odds against them seem overwhelming.

The foundation of psychosocial well-being in the rural areas is cultural obligations, whereby the members of the community or extended families are *obligated* by their culture to ensure that they absorb orphans into their families. The absorption of these orphans comes with responsibilities to provide for needs, such as paying for their education. This is emphasised by idiomatic expressions that say: 'Umuntu ngumuntu ngabantu' ("a person exists through other people"), a Zulu expression which means that the community members must help others as they themselves may one day need the same support. These are good values that create a strong bond amongst members of communities rooted in "Ubuntu" values, but the present context of a weak economic climate compromises the pillars that support the admirable attributes of this "Ubuntu", and there is a need to search for alternatives to affirm ourselves, and move towards a holistic and transformative future.

Although the support from the extended or foster families is the primary source of support, the support from churches, school, peers, and institutions

(NGOs and government) play a great role in assisting orphans. The collective support from foster families, churches, schools, and institutions can be regarded as the pillars that provide teenagers with the strength to successfully negotiate the challenges that confront them. These “pillars” provide an ongoing support that help orphans in meeting their physical, emotional, social, mental and spiritual needs, all of which are essential elements for meaningful and positive human development. Coping strategies, a sense of purpose and future aspirations assist in the development of a positive sense of security, belonging, happiness, capability, and respect. This contributes to the establishment of the psychosocial well-being of the orphan.

5.4.2. Recommendations

Three recommendations emerge from this study.

1. It is clear that drastic changes take place in the lives of teenaged orphans who have lost parents due to HIV/AIDS. Inter-sectoral collaboration could mitigate the impact of the ensuing changes and challenges, and so it is very important for the government, NGOs, and other aid agencies to establish formal structures where foster families can be trained as to how to manage the changes and challenges that confront the orphans. Such training might enable the members of the community to understand the psychosocial needs and the changes that take place when children lost their parent to HIV and AIDS.
2. Inkanyezi Yokusa Mina Nawe is a small NGO that provides services to about 200 orphans. This willingness to support orphans is, however, paralysed by the non-availability of operational funding as well as the lack of other resources. The government and other intervention agencies should provide grants and various forms of aid packages to Inkanyezi Yokusa Mina Nawe, so that it can provide for basic needs such as food, clothing, and access to health care and education. The

personnel of this organisation need to be trained in fundraising strategies, to be able to write proposals and raise funds to run the organisation. Inkanyezi Yokusa Mina Nawe should be empowered to be self-sufficient by making financial and technical assistance to run income-generating projects for sustainability purposes available.

3. The caregivers visit households to support orphans in the Mtubatuba area. This study values the contribution made by the caregivers and recommends that caregivers be capacitated in the programmes and legislation that protect children's rights. If caregivers are knowledgeable about these programmes, they can identify issues that need referral. This will in its own right promote inter-sectoral collaboration, which is vital for all stakeholders who work with orphans.

5.5. CONCLUSION

The impact of HIV and AIDS on the family unit, and the destruction and the pain that it leaves behind will be felt for decades to come. The increasing number of orphaned and vulnerable children is a serious social problem that requires urgent attention from *all* stakeholders, including families; communities; schools; churches; NGOs; local government; and the international community. Due to the nature of the spread of HIV-infections, if one parent is infected there is a high probability that the other parent will also be infected. Consequently, children are at risk of losing both parents within a short period.

The increasing orphan crisis due to HIV /AIDS stretches the capabilities of the extended family system in Africa, resulting in children slipping through the extended family safety net (Foster 2000). It is therefore vital to study the experiences of orphans, in order to attain an in-depth understanding of the psychosocial well-being with an intention of contributing to the body of

knowledge that will assist stakeholders in scaling-up the psychosocial support they provide to orphans. The present study has managed to explore and attain the experiences of teenaged orphans before and after their parent died. This study provides the description of the psychosocial needs, coping mechanisms and psychosocial support provided to teenaged orphans of the ages between 13- and 15-years residing in Mtubatuba.

This study found that shelter and clothes (including sports attire) were needs that were provided for by foster or extended families, but that they were often inadequately provided for. The unavailability of toys to play with; the lack of protection of their inheritance; the lack of a formal (and clear) support system to assist the orphans in handling their grief; and the failure to seek medical help from doctors and clinics in favour of traditional remedies (like inducing vomiting) are needs that remain unfulfilled.

Despite the challenges and hardships orphans are confronted with, they are coping. They believe that their future is promising, and all the interviewees aspired to improved circumstances (as a direct result of their ability to cope with their current straightened circumstances). Foster/extended families are taking good care for the orphans and that helps orphans in coping. The ad hoc psychosocial support available to orphans from friends; peers; churches; NGOs; and foster/extended families is providing a firm base that promotes coping with orphanhood, although this study has noted that the lack of formal psychosocial support is undermining these good efforts. One would therefore lobby for a more coordinated approach and the formalisation of the psychosocial support system.

"There can be no keener revelation of a society's soul than the way in which it treats its children" -

Nelson Mandela

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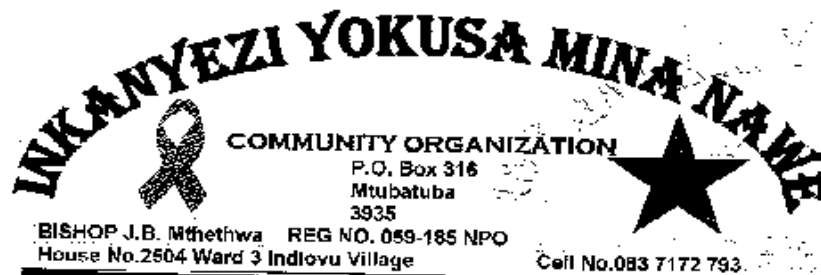
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Annexure A: Approval from Inkanyezi Yokusa Mina Nawe

FEB 26 2008 08:21 C355531526

YASISTATANE MTUBATUBA

#0079 2.001 0001



P.O. Box 316
Mtubatuba
3935
26 February 2008

Dear Sir

I'm very glad to write this letter to you as we are hoping that will a pressure to you to get it.

Mr. P.R. Gumede I write this letter on behalf of Inkanyezi Yokusa Mina Nawe Community Organization to accept your approach to work with us in orphans and OVC children programme so Mr. Gumede you are welcome.

Thanks God bless you.

Yours Truly

Miss S.S. Gumede
Miss S.S. Gumede (Secretary)

Annexure B: In-depth Interview Guide

In-Depth Interview Guide

1. What is it like to be a young person growing up in South Africa today?
Probes:
 - 1.1 What are some positive things about being a teenager today?
 - 1.2 What are some negative things about being a teenager today?
 - 1.3 What do you like most about your life?
 - 1.4 What do you like least about your life?
2. What has changed for you since the death of your parent(s)?
Probes:
 - 2.1 Domestic arrangements and care. Who is the child's current guardian? How many people in the household?
 - 2.2 School interruptions: dropped out, changed schools, etc.
 - 2.3 Still with siblings/contact with siblings and friends
 - 2.4 Career prospects
 - 2.5 Psychosocial needs:
 - 2.5.1 How often to you feel happy?
 - 2.5.2 How often do you feel unhappy?
 - 2.5.3 What makes you feel happy?
 - 2.5.4 What makes you feel unhappy?
 - 2.5.5 Do you ever feel worried?
 - 2.5.6 What makes you feel worried?
 - 2.5.7 Did you ever feel like running away?
3. What was discussed with you concerning what would become of you after your parent(s) passed away?
Probes:
 - 3.1 Which plans were adhered to and which were not?
 - 3.2 If there was no discussion, what would you have wanted to happen?
4. Although this might be painful, for you, could you please tell me what happened at home prior to your mother's/father's passing?
Probes:
 - 4.1 What did he/she tell you with regard to his/her health condition?
Did anyone else discuss this with you?
 - 4.2 When did you become aware that he/she was ill?
 - 4.3 Who helped with the physical care of your mother/father?
 - 4.4 Did you stay with (the ill parent)?
5. During your mother's/father's illness:
Probes:
 - 5.1 Did your role in the household change?
 - 5.2 Whom did you talk to about what you were going through?
 - 5.3 Probe for all kinds of social support offered

- 5.4 What did you learn about HIV and AIDS during your parent's illness?
- 6. What kind of support was available to you to deal with the death of your parent?
- 7. Please describe to me what happened after the passing of your parent until you were placed with your current caregiver.
- 8. How did HIV and AIDS change your life?
- 9. Probe for current needs being met:
 - 9.1 Room (shelter), bed, place to study, privacy
 - 9.2 Health needs, Medical and dental care
 - 9.3 Clothing, school fees, books, school uniforms, tuition, school supplies
 - 9.4 Transportation
 - 9.5 Recreational/sport clothes/activities
 - 9.6 Emotional needs/spiritual needs

Annexure C: Consent Form

Oral Informed Consent for OVCs

Introduction:

My name is Siphiwe Gumede. I am studying towards the MA (Social Behaviour Studies in HIV/AIDS) at UNISA. We are interviewing children between the ages of 13 and 15 years here in Mtubatuba, who are orphans and vulnerable children in order to find out what the effects of HIV and AIDS are on the psychosocial well-being of teenagers. I understand that you have lost a parent or both parents and that is why you are considered in this study.

Confidentiality and Consent:

I am going to ask you some personal questions that some people may find difficult to answer. Your answers are completely confidential, which means I am not going to talk to anyone about what you tell me. Your name will not be written on this form and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want. However, your honest answers to these questions will help us better understand the effects of HIV and AIDS on the psychosocial well-being of teenaged orphans and vulnerable children. We would greatly appreciate your help in responding to this interview. Due to the nature of this study, the interviewer might come several times if there is information required. Some of the things we are going to talk about in the interview might make you feel sad, but through the *Inkanyezi Yokusa Mina Nawe* Programme, we can offer you psychosocial support to help you with these feelings.

Would you be willing to participate?

If you want to contact the researcher and /or research supervisor during office hours, please call these numbers:

Researcher Supervisor: **012429 6587**

Researcher: **031 373 2807**

Signature of Interviewee _____ Date _____

(Certifying that informed consent has been given verbally by respondent)

Signature of Interviewer _____ Date _____

(Certifying that informed consent has been given verbally by respondent)

Annexure D: In-depth Interview Guide

Oral Informed Assent for Guardians

Introduction:

My name is Sipiwe Gumede. I am studying towards the MA (Social Behaviour Studies in HIV/AIDS) at UNISA. We're interviewing children between the ages of 13 and 15 years here in Mtubatuba, who are orphans and vulnerable children in order to find out what are the effects of HIV and AIDS on the psychosocial well-being of teenaged orphans and vulnerable children. I understand that you are living with a child in this household who has lost a parent of both parents.

Confidentiality and Assent:

I am going to ask the child some personal questions that some people may find difficult to answer. The answers are completely confidential, and the name of the child will not be written on this form and will never be used in connection with any of the information provided. The child does not have to answer any questions that he or she does not want to answer, and may end this interview at any time he or she wants. We would greatly appreciate your help to allow the child to participate to this study. Would you be willing to let the child participate?

If you want to contact the researcher and /or research supervisor during office hours, please call these numbers:

Researcher Supervisor: **012 429 6587**

Researcher: **031 373 2807**

Signature of Guardian/Parent/Social Worker _____
Date _____

(Certifying that informed assent has been given verbally by guardian/parent/social worker)

Signature of Interviewer _____ Date _____

(Certifying that informed assent has been given verbally by guardian/parent/social worker)

DECLARATION

I declare that: *The psychosocial well-being of teenaged orphans in a rural community, KwaZulu-Natal* 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.

Phiwayinkosi Richmond Gumede

3315-311-6

Signature

Date

ACKNOWLEDGEMENTS

First and foremost, God has embraced me with His power, and it is His Spirit that gave me the strength to prevail until the completion of this dissertation, let the glory be unto Him. Although this project has been a challenging one, the support I received made it possible and my sincere gratitude goes to the following individuals, groups, and institutions:

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- the research participants, for offering their valuable time and sharing their very emotional narratives –I value that so much.
- Inkanyezi Yokusa Mina Nawe, for providing assistance during the recruitment process.
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- my loving wife, Dumile “Ndondo” Gumede, for being my research advisor, as well as primary motivator and friend for life. You have been my source of strength throughout the course of this project, and I would not have made it without your support. Thank you, mama.
- my daughters Dwe and Nokwanda, for your support and for understanding my hectic schedule
- my little Ntombinkulu, whose presence motivated me when writer’s block was taking its toll – thanks, girl, for being my best friend, and always providing me with the laughter and joy that refreshed my mind and helped me re-focus.

SUMMARY

Dealing with HIV and AIDS and parental illness and death are realities many teenagers have to face, yet little is known about their psychosocial well-being. This study gauged the psychosocial well-being of teenaged orphans in a rural area in KwaZulu-Natal. Using a narrative approach, data were collected by means of interviews. The study examined the nature of social support available to teenaged orphans and their subjective experiences of well-being. Findings suggest that these teenagers were confronted with drastic changes before and after the deaths of their parents. The ramifications of these and the different ways of coping with orphanhood were explored. Foster parents and other care-givers were found to provide differentially in the needs of the teenagers and this impacted on their well-being and coping. This study extends the literature on children made vulnerable by HIV and AIDS by considering the specific experiences of teenagers.

KEY WORDS: coping; HIV status; HIV/AIDS; orphan; psychosocial needs; psychosocial support; psychosocial well-being; social support; teenagers; trauma

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
CBOs:	Community-based Organisations
CINDI:	Children in Distress
FBOs:	Faith-based Organisations
FHI:	Family Health International
HIV:	Human Immunodeficiency Virus
HSRC:	Human Sciences Research Council
IMPACT:	Implementing AIDS Prevention and Care Project
KZN:	KwaZulu-Natal
MRC:	Medical Research Council
NDH:	National Department of Health
NGO:	Non-Government Organisation
NPOs:	Non-Profit Organisations
PSS:	Psychosocial Support
STATSSA:	Statistics South Africa
TB:	Tuberculosis
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNDP:	United Nations Development Programme
UNFPA:	United Nations
UNICEF:	United Nations Children's Fund
UNISA:	University of South Africa
USAID:	U States Agency for International Development
US PEPFAR:	United States President's Emergency Plan for AIDS Relief
VCT:	Volunteer-Counselling Training
WH O:	World Health Organisation