THE EFFECT OF ORPHANHOOD ON THE PSYCHOSOCIAL DEVELOPMENT OF PRE-PRIMARY AND PRIMARY SCHOOL LEARNERS

by

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DECLARATION

I declare that **THE EFFECT OF ORPHANHOOD ON THE PSYCHOSOCIAL DEVELOPMENT OF PRE-PRIMARY AND PRIMARY SCHOOL LEARNERS** 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.

. . . .

Signature Date

DEDICATION

This thesis is dedicated to my three sons,
Tshegofatso, Ofentse and Kgosimang Moime.

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ABSTRACT

Although the human immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS) is still very much a silent issue in South Africa, the AIDS pandemic has become a public problem which is threatening to a significant proportion of the population of South Africa (Heartbeat 2002:1; Kaseke and Gumbo 2001:53). HIV infections are on the rise and people are dying every day of AIDS related diseases (Msomi, 2000:8). Thus, the overall aim of this research was to determine how the HIV/AIDS orphans'/vulnerable children' psychosocial status is affected by the HIV/AIDS disease.

The study was conducted in the Bojanala Region of the North West Province. A purposeful sampling was used because four (4) schools were suggested by the Department of Social Services in the Rustenburg Area due to their high populace with HIV/AIDS orphans. The other four (4) schools were suggested by the Auxiliary Services Division in the Bojanala Region of Education.

The literature revealed that failure on part of the parent, guardian and/or teachers to meet the psychological needs of the child at a certain stage in his/her development may result in personality disorders, which can become a potential danger and a source of unhappiness to the individual him/herself (cf. 2.5). Furthermore, it was evident from the literature that chronic parental illness may have a traumatic effect on young children because both parents may neglect a child (cf. 4.2). The literature also revealed that children should not be viewed as passive recipients of assistance, but as active participants who play a key role in the development of responses to the HIV/AIDS pandemic. Receiving quality services is a right and a need not only of AIDS orphans, but also of all children (cf. 4.6).

From the quantitative data analysis, the following findings emerged, that HIV/AIDS orphans/vulnerable children are optimistic about their future. Children do not blame themselves for their parents' death.

Arising from this research certain conclusions were drawn, recommendations were made and areas for possible future research were suggested.

KEY TERMS:

HIV/AIDS	Death
Aids orphans	Poverty
Primary school children	Homeless
Child headed families	Stigmatisation
Vulnerable children	Foster care
Psychosocial development	Stress

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CHAPTER ONE

INTRODUCTORY ORIENTATION

1.1. INTRODUCTION

Although the human immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS) is still very much a silent issue in South Africa, the AIDS pandemic has become an acute problem which is threatening to decimate a significant proportion of the population of South Africa (Heartbeat, 2002:1; Kaseke and Gumbo, 2001:53). HIV infections are on the rise and people are dying every day of AIDS-related diseases (Msomi, 2000: 8). People infected with the disease, still carry the brand of stigmatisation and marginalisation from their communities and their societies as a whole (Heartbeat, 2002:1; Mutwa, 2000:14).

It was estimated that by 2005 there will be about 800 000 children under the age of 15 who would have lost one or both parents due to AIDS in South Africa (Strachan, 2000:6; Loening-Voysey, 2002:103). Williams (2000:33) predicts that there will be at least two million AIDS orphans in South Africa by 2010, but with an estimated 600 000 already, the figure may even be much higher. According to Michael (2001:23) 4,2 million people, or about 10 percent of the population, live with HIV in South Africa but Wild (2001:3), says, more than 13 million children under the age of 15 have lost their mothers or both parents to AIDS. He went on to say that currently the vast majority of these AIDS orphans are living in sub-Saharan Africa. The researcher cannot deny the fact that there are already many AIDS orphans in Africa.

In a related HIV/AIDS research, Gilbert (2001:135) found that children from HIV-affected families are very often exposed to major psychological risk factors, including ”stigma, secrecy, exposure to acute and chronic illness, death of parents and/or siblings, separation, losses, orphanhood, and foster home placement”. According to this researcher, although many children are remarkably resilient, some children’s inability to cope with a parent’s HIV infection may manifest severe behavioural and psychological problems, such as destructive acts, suicidal ideation, uncontrolled defiance, running away and withdrawn, noncompliant, or aggressive behaviour. The school is often the first place where the behavioural and emotional problems of HIV-affected children and adolescents are exhibited and experienced (Gilbert, 2001:135).

Beyond the behavioural and emotional problems accounted for by Gilbert (2001:135) different authors and researchers highlight the following stressors as commonly associated with HIV/AIDS orphans both before and after the death of their parents.

1.1.1. Lack of family support

A significant feature of the AIDS pandemic has been emergence of child-headed households and households headed by elderly persons. The existence of child headed households in particular is a reflection of the growing incapacity of the extended family system to provide care and protection to orphaned children. Under such circumstances the eldest child assumes the responsibility for looking after the younger siblings, sometimes with the assistance of relatives or other members of the community. Unfortunately these children rarely have the necessary resources and often find it difficult to access social safety nets because of their minor status. As a result they struggle to meet their basic needs (Kaseke and Gumbo, 2001:54). While many children come from caring and supportive social situations, a significant number of children orphaned by AIDS come from socially disorganised and poorly functioning families. In these

families, social interaction, isolation, drug abuse, mental illness, poor housing, poverty and discrimination have been ongoing aspects of their lives (Dane and Levine, 1994:79).

1.1.2. Lack of social network

In a most inclusive sense, the social network is defined as the set of all others with whom one has social interactions (Naug, 2000:52). According to the researcher, lack of social network in HIV/AIDS orphans is caused by the stigma attached to HIV/AIDS. The society isolates them because they think that orphans will infect their children with AIDS.

1.1.3. Lack of social support

The concept of social support is operationally defined as the ‘intimate psychosocial network’, which is a subset of a larger personal social network (Naug, 2000:53). According to Naug (2000:53) social support is important during childhood, a period of social vulnerability and physical reliance on others, as well as when children acquire a sense of self across multiple settings like family, school and peer groups. According to the researcher, a social network must come from the nuclear family, peer group, the school and the community.

1.1.4. Isolation

Isolation can best be described by Strachan (2000:6), when he anecdotally talked about Khululiwe’s loneliness during his mother’s long illness and how he miss his mother and pray for her and for their schooling. According to the researcher, once the children are called orphans, they become emotionally vulnerable so they draw back in self-pity, self-doubt and lack confidence in themselves.

1.1.5. Coping

The researcher experienced that it is very difficult for HIV/AIDS orphans to cope after the death of their parents as orphans are exposed to major psychological risk factors and are frequently left to fulfill the parental role towards younger siblings.

According to Dane and Levine (1994:1-23), coping with parental loss has always strained the capacity of family members and community institutions, children orphaned by AIDS present new and greater challenges. The orphans, whether HIV- infected or not, are best supported when there are family members willing and able to provide a stable home. Children of parents with HIV/ AIDS can benefit from familiar care.

1.1.6. Effect of death on children

According to Ndebele and Phungula (2001:31) growing incidences/incidents of HIV-positive children in the early 1990s prompted research and ultimately entry into the fields of AIDS care.

When a person dies of AIDS, the process of loss starts long before the death. In some African villages, there are primarily grand parents and children, because the parent generation has died of AIDS (Pequegnat and Szapocznik, 2000: 4). For many children, being orphaned results in a move from home, siblings, school, and friends, frequently older adolescents take on increasing responsibility at home, such as parenting younger siblings without available adults (Dane and Levine, 1994: 24; De La Cruz, 2000: 20; Ewing, 2000:10).

The loss of a cherished and significant relationship can have both overt and inner psychological effects. As with other human behaviour death can be expressed in different ways (Dane and Levine, 1994:13). Although each

surviving orphan had a unique relationship with the deceased parent, he or she will experience death and grief differently (Dane and Levine, 1994:15).

1.1.7. Migration

According to Michael (2001:25) migration is one of the AIDS related courses. Following the death of an adult, children are often sent away to live with extended family members (forced migration). Migrant labourers often return to rural homesteads when they fall ill, thereby stressing and diverting household resources (Michael, 2001:25).

1.1.8. Stigmatisation

Although HIV/AIDS remains an issue shrouded in silence in South Africa, many people are dying of HIV/AIDS related diseases. People infected with the disease are still stigmatised and marginalised from their communities and society as a whole (Heartbeat, 2002:1). According to research done by Cawyer and Smith-Dupre' (1995:243), people with HIV/AIDS and their families often face hostility and ostracism rather than support.

Death from AIDS, like death from suicide, profoundly alters survivor's social relationships as a consequence of real, imagined stigma. A stigma is a mark of shame or discrete (Dane and Levine, 1994:17). Mutwa (2000:14) blames the media, the government, doctors and the community for stigma that attaches to HIV/AIDS. Ndebele and Phungula (2001:29) indicated that the Deputy President Jacob Zuma who is also the chairperson of the South African National Aids Council (SANAC) said "we would like to see more empathy for people living with the disease, and also to create an environment where people feel free to speak up about the disease and disclose their status without fear of stigmatisation". The researcher observed that the HIV/AIDS orphans are used to be labeled by

the community. The HIV/AIDS orphans are also treated as outcasts by the society, hence stigmatisation.

1.1.9. Multiple stressors

Orphans of the HIV epidemic who are subjected to multiple stressors are more likely to be at risk for psychological and physical problems as the number of stressors increases. It is not unusual for families in which an AIDS death has occurred to undergo multiple stressors before and after the death (Dane and Levine, 1994:19). The researcher observed that stressors start when the parents are ill. There is reversal of roles and orphans do household chores.

1.1.10. Human relationships

A relationship so central to the self as that between child and parent does not end with the death of a parent. Attachment theory confirms the importance of human relationships and their consequences for individual development. Beginning in infancy, with the bond between the child and parent figure, attachments are essential to feelings of safety, and security, providing care and protection during times of stress (Njoko, 2000: 3-4). The manner in which parents meet their children's basic strivings for attachment is an important determinant of future mental health (Dane and Levine, 1994:21).

1.1.11. Fear of death

Generally, the death of a parent, especially for young children, creates fears for their own survival. The child who has lost a parent fears that the grandparent or aunt, uncle, or foster care parent may also die (Dane and Levine, 1994:22).

In many situations, surviving children are haunted by fear of contagion. They fear that they could die of AIDS like their parents or young siblings (Ndudane,

1998:6). The quality of the child's relationship to the parent affects his or her success in meeting developmental challenges prior to the death of the types and fantasies that are produced subsequent to the death. In addition to suffering grief, many children experience guilt caused by previous arguments or fights with the dead parent. Youngsters feel in some way responsible for the death because of previous experiences and bad thoughts about their dead parents. Although the impact of parental loss can be overwhelming, it is essential to provide the kind of an atmosphere where children are given support and permission to ask questions and express feelings (Dane and Levine, 1994:22).

1.1.12. Grief responses

It is now appreciated that children are capable of a wide range of grief responses, whose expression is influenced by the child's level of development, personality, and cultural milieu. Grief-stricken children differ in some respects from their adult counter-parts. The capacity of children to sustain sadness or dysphonic affects over time increases with age and ego maturity, because young children have a short attention span, their sadness or pain may go unnoticed (Dane and Levine, 1994:23). According to the researcher, children with such problems need to be identified as soon as possible so that they can receive the necessary assistance. Hargis (1996:8) maintains that the cycle of failure begins early for disadvantaged children thus intervention is necessary.

1.2. AWARENESS OF THE PROBLEM

- The researcher realised that in South Africa a large number of the children have lost their parents as a result of HIV/AIDS. This assumption is supported by orphans who show signs of grief and encounter social as well as psychological problems. Socially orphans seem to be isolated in some aspects of life. They need parental love, support and security (Hargis,1996:8). Psychologically, orphans have a negative self-image and

low self-esteem. They become emotionally affected at the end of the day and they run away from their homes for a better life.

- Due to a high number of adult's death, both fathers and mothers, children are left to be looked after by the extended families, relatives and sometimes by foster parents. Few of them are being looked after in care centers, but many of them are being cared for by their grand parents or by elder brothers and sisters. Sometimes there is nobody who can look after these children. This can be supported by the fact that we have a high number of orphans in South Africa (Hargis,1996:9).

A mother who was diagnosed HIV-positive said these words: "I wondered what would happen to my son after my death (expressed the agony of the effect of HIV/AIDS). I wondered how people would treat him once I had left for the new place… I was thinking' how he is going to face life without me? 'His grandmother would be there but he also needed me" (Njoko, 2000:3). Similar responses were reported in a study by Gogging, Catley, Brisco, Engelson, Rabkin and Kotler (2001:85). They found that women experience feelings of guilt and concern about childcare and care-taking roles.

- According to the researcher, there is a high number of HIV/AIDS orphans with psychosocial problems in schools. The most important people who can easily be aware of these problems are teachers (Hargis,1996:9). In the learning situation, learners show problems like absenteeism, home work not done, a poor self image, a lack of motivation towards learning, scholastic underachievement, they are always emotional, they fight others, they are short tempered, lack concentration, show withdrawal signs and other anti social behaviours. In this case the researcher realised that teachers do play a role in gathering more information about the learners' behaviour. Most of the learners who have displayed this type of behaviour are those without parents. In the case of girls, if they don't

get immediate help they resort to negative behaviour like involving themselves in prostitution, get involved in relationships with the older people while boys fall into gangsterism and criminal behaviour.

1.3. STATEMENT OF THE PROBLEM

Although the phenomenon of HIV/AIDS orphans' plight emanating from their psychosocial effects has been researched extensively, the majority of the research pertains to overseas countries. Even research undertaken in South Africa has focused mainly on HIV/AIDS and how it affects households in South Africa in general. But as yet no study has focused exclusively on the Black rural school population in South Africa. The study of the psychosocial effects facing HIV/AIDS orphans in Black communities in South Africa, where unique conditions such as poor health, school failure, crime and substance abuse prevail has not yet been undertaken, and this is a matter of grave concern. According to Harold, Kaplan, Benjamin, Sadock, Jack, and Grebb (1994:207) poverty is also associated with ethnicity, with about 85 percent of the poor being blacks.

The research questions and problems to be researched in this study are formulated as follows:

- To find out what problems are experienced by HIV/AIDS orphans/vulnerable children.
- How HIV/AIDS orphans/vulnerable children are assisted psycho-socially by members of the community in the Rustenburg Area?

The second part of the problem pertains to the prevention of and intervention with regard to the psychosocial problems encountered by HIV/AIDS orphans in the Rustenburg communities, namely:

- What support systems are available in schools to assist the HIV/AIDS orphans/vulnerable children in the Rustenburg communities?

From the exposition above, it is evident that HIV/AIDS orphans experience problems, which are unique to their situations. This research seeks to highlight the problems orphans could encounter and how those problems can be minimised. With this research, the researcher shall have gathered information that could hopefully be of help in addressing the psychosocial problems encountered by HIV/AIDS orphans. For the sake of this research therefore, the following questions need also to be investigated:

- What should educators, teachers, grandparents, community members and older siblings taking care of AIDS orphans, know to support these children on a psychosocial level?

- Are teachers aware of the presence and problems experienced by HIV/AIDS orphans/vulnerable children in their schools?

- What support systems are needed for HIV/AIDS orphans/vulnerable children?

- Do the teachers understand the needs and or implications of orphan-hood's psychosocial effect?

- Do the teachers accept or reject orphans within the school?

- Are the teachers knowledgeable enough to support orphans on a psychosocial level?

- How does the psychosocial effect of orphans affect their self-concept?

1.4. DEMARCATION OF THE FIELD OF STUDY

The thematic demarcation of the field of study is the focus on HIV/AIDS orphans. Orphans are found in most countries, in all races and cultures, but it is practically impossible to include all of them in this investigation. The main focus will be on HIV/AIDS orphans. The geographical demarcation of the investigation will consequently be confined to the Rustenburg Area.

1.5. THE AIMS AND OBJECTIVES OF THE INVESTIGATION

The aim of the investigation is to ascertain how this disease would affect the orphans' psychosocial status. This will be done by involving children who have parents living with HIV/AIDS, or whose parents have died of the disease. This investigation will also look at the stressors, which commonly face AIDS orphans both before and after the death of their parents and the likely psychological impact of these adversities. Questions like whether AIDS orphans are at risk of experiencing the psychosocial adjustment difficulties would be addressed.

The specific aims of the empirical investigation are to determine:

- How equipped teachers are in handling HIV/AIDS orphans/vulnerable children?
- How could the school support HIV/AIDS orphans/vulnerable children?
- What various important issues regarding norms and values are practiced in the schools?
- How HIV/AIDS orphans/vulnerable children are psycho-socially affected?

- How HIV/AIDS orphans/vulnerable children are treated and handled in different schools?

- If orphans are treated differently from other children?

- How HIV/AIDS orphans/vulnerable children cope psycho-socially?

The ultimate aim of this research is to find out if teachers are able to handle and support HIV/AIDS orphans/vulnerable children. Furthermore, to determine whether teachers have received enough knowledge to support HIV/AIDS orphans/vulnerable children during their initial training and if they are able to provide specialised support to these children.

1.6. THE METHOD OF RESEARCH

A literature study will be undertaken to highlight the psychosocial adjustment of HIV/AIDS orphans in the community. This will then be preceded by an investigation of how HIV/AIDS orphans cope after the death of the beloved one and what they can do to live a normal life after the death of their parents. The literature study will be verified by means of questionnaires testing HIV/AIDS orphans and teachers. A different questionnaire will be issued to some community members such as teachers to answer. The experimental research will be conducted by using HIV/AIDS affected orphans and their teachers.

In the empirical research the overall number of orphans to be used for the investigation will be all-inclusive that is a child orphaned by HIV/AIDS. Primary school children will be used but the main focus will be on learners from the age of six to thirteen. The researcher will formulate simple questionnaires. The method to be used in this research will be a quantitative approach employing a survey design and using questionnaires to collect data. The method of research will be discussed in detail in chapter 5.

1.7. DATA ANALYSIS AND HYPOTHESES

To achieve the central aim and objectives outlined in this research, a quantitative approach employing a survey design will be used for analysis of the data.

The following hypotheses were derived form the literature review and are stated to guide the investigation:

Ho1 The AIDS orphans/vulnerable children lack physical needs

Ho2 The AIDS orphans/vulnerable children need psychological and sociological support services

Ho3 The AIDS orphans/vulnerable children cope with the situation they are in

Ho4 The school have a task to raise awareness of AIDS orphan/vulnerable children

Ho5 The school have a task to support the AIDS orphans/vulnerable children in their psychosocial needs

Ho6 Opinions of teachers on problems of the AIDS orphans/vulnerable children does not depend on the phase they are teaching

Ho7 Teachers who are more aware of the AIDS orphans/vulnerable children's problems are more likely to provide special support

Ho8 The AIDS orphans/vulnerable children are optimistic about their future

Ho8(a) The AIDS orphans/vulnerable children blame themselves for their parents' deaths

Ho9 The AIDS orphans/vulnerable children have good interpersonal relationships

Ho10 The AIDS orphans/vulnerable children grieve about the death of their parents

Ho11 The AIDS orphans/vulnerable children feel uncomfortable about being orphans

Ho12 The degree of optimism of AIDS orphans/vulnerable children depends on their grade

Ho13 Optimism and outlook of the future of the AIDS orphans/vulnerable children varies with grades they are in

Ho14 Optimism and comfort of the AIDS orphans/vulnerable children in the community depends on the family size

Ho15 Optimism of the AIDS orphans/vulnerable children depends on the grant they receive

1.8. ETHICAL CONSIDERATION

In adherence to the ethics of science, as outlined and advocated by Mouton (2001:238-248) the researcher commits to professional ethical values of objectivity and integrity in the execution of the study. This report therefore presents a true reflection and account of what has been investigated.

The final ethical consideration to be made is in relation to the subject of science. In this regard commitment is made to adhere to the right of privacy including the right of one to refuse to participate in the research study and not to be coerced to do so.

The other rights to participating will be those of anonymity and confidentiality if they so wish. It is the researcher's view that adherence to these ethical considerations enhance to the epistemic imperative of the study as observed by Mouton (2001:239).

1.9. DEFINITION AND ELUCIDATION OF CONCEPTS

A number of concepts will be thoroughly explained to avoid ambiguity, misunderstanding and own interpretation of concepts. This is done to remove any conflict of ideas and meanings that might exist and to provide a clear understanding.

1.9.1. Orphans/vulnerable children

There is no consensus on the definition of an orphan. However, an orphan can be defined from two perspectives. According to Baggaley, Sulwe, Chilala and Mashambe (1997:8), and Kaseke and Gumbo (2001:53), orphans are pupils who have lost both parents. (Guest, 2001:2) and (Strachan, 2000:6) define orphans as children who have lost either one or both parents or just those who have lost both. According to Ramsden

(2001:34) orphans are defined as children and young people up to the age of 20 who have lost one or both parents.

According to Whiteside and Sunter (2000: 91) orphans are referred to as children below the age of 15 who have lost either their mother or both their mother and father. Paternal orphans are, according to Kaseke and Gumbo (2001:53), those who have lost their fathers while maternal orphans are those who have lost their mothers. Although in recent years the term ‘orphan’ has been used most commonly to describe a child who has lost both parents, for the sake of this research orphan has been used to define a child who has lost one or both parents. The concepts, ‘orphans’ and ‘vulnerable children’ are used interchangeably because these children are exposed to exploitation by the community, not well cared for and protected (Guest, 2001:5).

1.9.2. AIDS orphans

AIDS orphans are children whose parents died of AIDS. A lack of consensus about the definition of “AIDS orphans” means that samples have varied in terms of their upper age limit (e.g. 15, 18, or 21 years) as well as in the patterns of parental death (both parents died, either one parent died, only mother died, or one parent is terminally ill) (Wild, 2001:7). Foster (1996:6) and Webb (1995:5) talk about ‘double orphans’, as those orphans who have lost both parents. Clearly this has a potential to lead to other associated problems for those orphans who tend to live in abject poverty if they may not get adequate support and care.

In a nutshell, it can be discerned from the above explication at paragraph one that HIV / AIDS orphans are actually children who have lost either one or both of their parents to HIV /AIDS related illnesses. Such children may or may not be infected with HIV (Whiteside and Sunter, 2000: 90). The term AIDS orphans set them apart from other orphans, yet the issues influencing their health and well-being are the same. By distinguishing children as AIDS orphans people further perpetuate stigmatisation and discrimination of these children.

1.9.3. Poverty and its relation with HIV/AIDS

It is not clear that AIDS is simply a disease of poverty, although poverty undoubtedly helps drive the epidemic. What is clear is that AIDS increases poverty (Whiteside and Sunter, 2000: 91).

According to Harold et al. (1994:207) poverty is associated with many long term problems, such as poor health and increased mortality, mental disorder, school failure, crime and substance abuse. Poverty is also associated with ethnicity, with about 85 percent of the poor being blacks.

Africa's poverty has accelerated the spread of AIDS. Many Africans cannot afford to protect themselves. They cannot afford condoms or antibiotics to treat other sexually transmitted diseases, which are rife in Africa. Poor people often have little choice but to undertake dangerous jobs. Too many African women can survive only by prostituting themselves, and clients will sometimes pay double for unprotected sex (Guest, 2001:5).

1.9.4. Community based care structures for orphans

Children are cared for within communities and wider family structures (Michael, 2001: 27). According to Michael (2001:27) the best model of child care is a community based model rather than institutional placements.

1.9.5. Homeless children

It has been estimated that families with children now account for 40% of the population who become homeless (Neff and Davey, 2001:279). There is a potentially damaging effect of homelessness as a stressor upon the social and emotional development of children (Neff and Davey, 2001:279). No provision of shelter is made available to

HIV/AIDS orphans (Guests, 2001: 5). For the sake of this research homeless refers to AIDS orphans without homes.

1.9.6. Caring for HIV/AIDS children

Everybody needs care and love. Most importantly children need our love and care. We need to provide children with food, clothes and shelter (Guest, 2001: 1).

Mutwa (2000:8) believes households and communities should support one another because the greatest challenge facing South Africa is caring for Aids orphans.

1.9.7. Children with HIV/AIDS

All pupils under the age of 18 are referred to as children (Guest, 2000:5). For the sake of this research, the focus will be on the pre-primary and primary school children between the ages of 6 and 13 (six and thirteen years).

1.9.8. Bereavement

According to Dane and Levine (1994:80) bereavement is culturally bound, subjective and personal. There are obvious cross-cultural concerns in bereavement. All societies have customs related to death and mourning. Harold et al (1994:80) agreed that bereavement literally means the state of being deprived of someone by death, and it refers to being in the state of mourning.

1.9.9. Death

With little prospect of a cure, HIV infections are on the rise and people are dying every day of Aids-related diseases (Msomi 2000:8). Stein (2000:23) talks about a bad experience at Cotlands Baby Sanctuary in Johannesburg where the staff had to deal

with an eight-year-old boy with AIDS who knew he was going to die. He would ask, “Is this time?” whenever he was ill.

The death of a parent is thought to be a crisis for any child, as it means losing the love, support, guidance, stability and security that parents ideally provide (Wild 2001:8).

Death can manifest itself in two ways that is timely death or untimely death. Timely death implies that one’s expected survival and actual life span are approximately equal; essentially one dies when one is expected to, and those left to grieve are not surprised by death while on the other hand untimely death implies an unexpected or premature death, and those left to grieve are in shock (Harold et al., 1994:76). The focus of this research is on untimely death because parents die prematurely due to HIV/AIDS related diseases.

1.9.10. Stress

According to Neff and Davey (2001:280) stress is defined as a condition of emotional tension or anxiety arising from unmet needs like lack of food, rest, affection, and sense of security or from environmental events like divorce, parental unemployment, and family moves that is perceived as threatening. Stress can affect children emotionally, socially, physically, and psychologically (Neff and Davey (2001:281).

1.9.11. HIV\AIDS

HIV probably originated in Western Central Africa in the 1920s or 1930s. HIV-1 is known to be a strain of a virus that had existed for many years in chimpanzees, without harming them. Another rarer strain, HIV-2, came from sooty mangabey monkeys. The virus probably crossed from apes to humans when the two species’ blood intermingled, perhaps when someone with a cut on her hand was preparing chimp meat for the pot (Guest, 2001:3).

Mutangadura and Webb (1999: 4) believe that HIV/AIDS is characterized by a long incubation period and a gradual increase in morbidity from opportunistic infections.

According to Marcus (2000:6) and Dixton (1993:44) HIV (Human Immuno-deficiency Virus) is a virus, and AIDS (Acquired Deficiency Syndrome) is a pattern of diseases, which may result from that infection. When the virus gets in to the blood stream, the body responds by producing antibodies to the infection. This forms part of the immune response. Often an infection can be counteracted by the production of anti-bodies. However HIV is a retro- virus, which sets out to destroy the immune system itself. At first the body may respond successfully, but gradually the ability of the body to fight off infection is reduced. This is why people who have been infected with HIV often develop one or more of a whole range of diseases collectively known as AIDS, their immune system is no longer able to resist infection by many other organisms.

According to Desmond, Michael and Gow (2000:39) the AIDS epidemic will cause significant increase in illness and death in prime-age adults, which will manifest itself through negative social, economic, and developmental impact.

Nancy, Andearsen, Donald, and Black (1991:403) and Wild (2001:3) describe AIDS as Acquired Immunodeficiency Syndrome. According to their clinical findings, the initial stage of the infection is represented by HIV seropositivity that is the detectable presence of antibodies to HIV in serum. They continue to say that, although the incubation period from exposure to HIV and development of seropositivity may range from months to years, many, if not most, patients who are seropositive will develop AIDS.

Santrock (2000:543) describes AIDS as a sexually transmitted disease caused by the human immunodeficiency virus (HIV), which destroys the body's immune system. This means that a person who has contracted HIV is vulnerable to germs that a normal immune system could destroy. Although the incidence of HIV/AIDS is a worldwide concern, it is of particular significance in sub-Saharan Africa. Donald, Lazarus and

Lolwana (1997:200) state that: ‘This sexually transmitted disease has devastating effects on individuals, unborn children, families, and society as a whole. “Once a person is infected, the prognosis is likely illness and death.

AIDS is a syndrome where an individual is vulnerable to a number of diseases due to a damaged immune system. AIDS is not a disease. It is an acronym for Acquired Immune Deficiency Syndrome. Using lower case letter is incorrect for acronyms.

1.9.12 To die of AIDS

People do not die of AIDS. They die of diseases such as TB or bronchitis from a damaged immune system because of HIV infection. It is more accurate to describe that someone has died of an AIDS related illness.

1.9.13. Body fluids

Confusion about the body fluid that can transmit HIV is a common cause of fear and misunderstanding about HIV. This continues to cause discrimination against HIV/AIDS children.

1.9.14. Psychosocial development

Psychosocial development refers to cognitive as well as the social and personality development of a child. It includes curiosity, memory, general knowledge, problem solving and it also refers both to what is in the mind (what the child knows) and how the mind works (how the child thinks). Impaired social and personality development occur when there is a poorness-of-fit, or incompatibility, between the child and the environment (Berns, 1994:365 - 376). This study focuses on the effects of orphanhood on the psychosocial development of pre-primary and primary school learners.

1.10. CONCLUSION

Chapter one as presented in this text highlights a summation of the following key issues:

That HIV/AIDS present itself as a pandemic that has become a public problem. That HIV/AIDS orphans tend to be exposed to psychosocial risk factors. Furthermore HIV/AIDS leads to several stressors that compound to reflect on the affected. The chapter further highlights the problem statement, demarcation of the field of study, the aim of the investigation, research methodologies definition and elucidation of concepts.

Children orphaned by AIDS, need to be included rather than excluded and that what is mentionable is manageable. We need to provide a role model for children. Let them know that when someone we love dies, we grieve. When they see a healthy response to loss, it is not only of value to them in the present, but also in the future when they experience other losses. Children's personal boundaries must be respected. Forcing them in to any specific reaction is as unhealthy to emotional and mental health as excluding them from any participation (Dane and Levine 1994:28).

According to Hilton-Barber (2000:37) the State should classify the AIDS pandemic as a war situation and put everything else on hold in order to deal with it. He further urges politicians, businesses, trade unions and any other formal group to put AIDS at the top on every agenda. Thus, AIDS is not a health problem, but a social problem. Therefore, if individuals and communities are not part of the solution, they will surely be part of the problem.

1.11. PROGRAMME OF INVESTIGATION

This research will comprise the following chapters:

Chapter one:

This chapter deals with introduction, awareness of the problem, problem statement, demarcation of the field of study, the aims of the investigation, the method of research, definition and elucidation of concepts and the program of investigation.

Chapter two:

This chapter focuses on the psychosocial development of HIV/AIDS orphans.

Chapter three:

This chapter focuses on the role of the parents on the becoming of HIV/AIDS orphaned children. The following are also outlined: child-rearing, parents as positive role-models and goals of parenting.

Chapter four:

This chapter focuses on the effect of illness and death on HIV/AIDS orphaned children. It also focuses on parental illness, children's concept of death and helping young children cope with death.

Chapter five:

This chapter deals with the research design with specific reference to the research problem, aims of the empirical investigation, research paradigm, research method and the research tools.

Chapter six:

This chapter focuses on the analysis and discussion of results. Biographic information is given in order to give a picture of the demographic characteristics of the respondents

Chapter seven:

This chapter focuses on the findings, interpretations, recommendations and their implications, suggestions for future research and concluding remarks.

The following chapter focuses on psychosocial development of HIV/AIDS orphans/vulnerable children

CHAPTER TWO

PSYCHOSOCIAL DEVELOPMENT OF HIV/AIDS ORPHANS

2.1. INTRODUCTION

In this chapter, the researcher will focus mainly on the psychosocial development of children and how this affects HIV/AIDS orphans whose home milieu, the primary environment of children is teeming with problems. In order to execute this task with a large measure of efficacy, the researcher will address the following issues of significance: The psychosocial theory, development of children, stages of development, the self concept, environment, and fostering psychosocial development through play, relationships and aggressive behaviour.

All developmental support is directly or indirectly aimed at the psychological well-being or mental health of the person. According to Warr (in Sengendo and Nambi, 1997: 108) mental health has five components: affective well being (happiness), competence, internal locus of control, aspiration and integrated functioning or adjustment. Supporting children in reaching psychological well being always takes place in a specific social context. The environment plays a dominant role in the psychosocial development of children. The home serves as the basic environment in which the child's development is enhanced. A healthy atmosphere at home is required for the total development of the child. If the child's home environment is conducive, the child will be able to cope easily in other secondary environments such as school, church and the community.

Dane and Levine (1994:21) stress the importance of human relationships and their consequences for individual development. A good relationship between parents and the children should play a dominant role in the psychosocial development of the

children. It is also important for the parents to provide the children with the basic needs such as food, shelter, and most of all love. At school a positive relationship between the teachers and the learners also play a dominant role in the psychosocial development of learners. Teachers should be able to encourage learners to establish a healthy relationship among them, as such peer relationships should be emphasized. If a positive relationship has been established at home and continued at school it will be transferred further in the community.

Thus, the different components of the environment, namely the home, school and community, play an important role in the psychosocial development of children. The roles played by these components are discussed in detail in this chapter.

2.1.1. Psychosocial theory

Donald et al. (1997:156) define psycho-social as: where individual psychological characteristics and social context are seen in continual interaction." The results of this interaction are that the social context, including socio-economic conditions, ways of life and cultural patterns, have an important influence on how children develop. Conversely, people development also influence the environment. People have different views regarding development and needs in accordance with their social context. The eco-systemic perspective and the constructive perspective contribute to the researcher's understanding of individual people in relation to their social context. According to these theories, the individual person and his or her social context are linked. The way people think, feel, behave and develop as individuals is linked to the social structures, forces and relationships which make up their environment. Development does not just happen to the people but is based on their active engagement with and exploration of their physical and social world (Donald et al., 1997:34 and 47).

Psychosocial theory represents human development as a product of the interaction between individual (psycho) needs and abilities and societal (social) expectations and

demand (Newman and Newman, 1995:39). According to Boy and Pine (1998: 1) psychosocial is a term applied to the behaviours exhibited by an individual, which have a social bearing either in origin or in outcomes. The vital link between the individual and the world is a key mechanism of development (Newman and Newman, 1995: 38). In order to preserve and protect its culture, each society encourages patterns of parenting, provides unique opportunities for education, and communicates values and attitudes towards basic domains of behaviour, including sexuality, intimacy and work (Newman and Newman, 1995: 39).

The family and according to some cultures, the nuclear family plays an important role in the preparation of children for entry into the society. Newman and Newman (1995: 39) regards the family as an important agent because parents love their children without the qualification of good behaviour and an atmosphere of forgiveness and tolerance is embedded in this love. The experience of love protects children against the fear of rejection if they should fail. In the family they feel at home, safe and secured and they are able to be themselves. This implies a very special relationship between parents, who are the primary caregivers, and their children, Parents belong to their children and children belong to their parents and as such form an educational unit.

When the family is referred to as a unit, it is implied that the family consists of a group of people who belong together because they are related and live under the same roof. The family's mutual relations and dealings are inter alia characterized by intimacy, attachment, caring, warmth, understanding, good-humor, happiness, security and satisfaction. Liebenman and Fisher (1995: 101) argue that, although not with the same degree of intimacy as in the nuclear family, this unit can also be an extended family, by attaining common goals and shared participation in efforts to achieve common goals within its parameters. A healthy family life is characterized by its active educational influence, which implies an intimate affective relationship between parents and children and is characterized by the socially oriented goal of preparing the child for adulthood (Du Toit, 2000:14).

Families have always been embedded in networks of relatives, neighbours and friends. These network members have undoubtedly influenced the rearing of children, sometimes directly and often indirectly. The social network is defined as the set of all others with whom one has social interactions (Naug, 2000: 53). According to Naug (2000: 53) social interactions may be used in a more restricted manner to refer only to the set of presently significant others with whom one has social interactions.

Attention can also be paid to the ecology of the individual, particularly with respect to social support. According to Naug (2000: 53) the concept of social support is operationally defined as the 'intimate psychosocial network', which is a subset of a larger personal social network. Social support is important during childhood, a period of social vulnerability and physical reliance on others, as well as when children acquire a sense of self across multiple settings, example family, school and peer groups. Social support for families (that are eroded, or otherwise weakened under circumstances of persistent poverty and social deprivation) can alleviate the effect of stressful life transition for both parents and children. Further, social support also provides parents with inter-personal acceptance, opportunities to exchange valuable information, goods and services (Naug, 2000: 54).

In the African context the extended family was the traditional social security system and its members are responsible for the protection of the vulnerable, care for the poor and sick and the transmission of traditional social values and education. In recent years, social change such as migratory labour, the cash economy, demographic change, formal education and westernization, has occurred and weakened the extended family. It can therefore no longer be seen as the social structure to address the problems caused by HIV\AIDS (Foster, Makufa, Drew and Kralov, 1997:155). In contemporary African society, in the absence of the traditional family education, social values are likely to be acquired at school and during interactions of children with their peers rather than through traditional mechanisms. This has lessened the ability of older people to exert social control over the younger generation (Foster et al., 1997:155).

According to Newman and Newman (1995:45) and Bornholt (2000:416) a psychosocial theory consists of a set of skills and competencies that contribute to increased mastery over one's environment and that define what healthy, normal development at each age is in a particular society. He went on to say that human development is a process in which people attempt to learn the task required of them by society to which they are adapting. Although development emphasizes the guiding role of society in determining which skills need to be acquired at a certain age, it does not totally ignore the role of physical maturation (Newman and Newman, 1995:45).

2.1.2. Development

According to Bukatko and Daehler (1992:3) development means all the physical and psychological changes a human being undergoes in a lifetime, from the moment of conception until death. Development is a process, which concerns the totality of the structure of knowledge (Gauvain and Cole, 1997:20).

2.1.2.1. Stages of development

According to Newman and Newman (1995: 41) development is a period of life that is characterised by a specific underlying organisation. A wide variety of behaviours can be viewed as expressing the underlying structure of each stage. Readers are to be made aware of the fact that different motivations are needed depending on the stages of the childs' development, and children of the same age can certainly be at different developmental stages. What is of utmost importance is that the HIV/AIDS orphans should be made aware of the fact that they are unique and special and that no one else in the world has experienced things exactly in the way they have. Teachers must really see the children as worthwhile human beings loaded with untapped potential.

Figure 2.1 is the chart Erickson produced in childhood and society to describe the stages of psychosocial development (Newman and Newman, 1995: 42). For the sake of this research the researcher will only focus on two stages of development namely

early school age 4 – 6 years and Middle school age 6 – 12 years because Newman and Newman (1995: 43) divides his stages according to different age groups.

The following table represents the psychosocial stages of development:

							Ego integrity vs. Despair
						Generativity vs. Stagnation	
					Intimacy vs. Isolation		
				Identity vs. Role Confusion			
			Industry vs. Inferiority				
		Initiative vs Guilt					
	Autonomy vs. Shame, doubt						
Basic trust vs. Mistrust							
1. Oral sensory	2. Muscular anal	3. Loco Motor genital	4. Latency	5. Puberty and adolescence.	6. Young Adulthood	7. Adulthood	8. Maturity

FIGURE 2.1 Newman and Newman (1995: 42).

- Latency period (4 – 6 years)

According to Lovrin (1995:93) and Papalia, Olds and Feldman (2006:306) the latency period is characterized by ‘the post Oedipal lessening of drive urgency and the transfer of libido from the parental figures to contemporaries, community, and others. This transfer of libido manifests itself through interpersonal relationships with peers. Lovrin (1995:93) referred to the developmental task in the latency period as that of industry versus inferiority. The child needs to concern herself with getting along in the world of school, with her teacher, her peers, and the task of everyday life. The child’s danger, at this stage, lies in a sense of inadequacy and inferiority’. The potential for social isolation at this juncture is ever present. It would seem the loss of a parent or a sibling could seriously exacerbate isolation and loneliness. For not only has the child lost the

significant others, but she also finds herself in a unique situation vis-à-vis the other girls and boys. Lovrin (1995:93) described the developmental task of latency as the completion of concrete operations. He saw the totality of this stage as a unification of cognitive, playful, affective, social and moral reactions into a whole. ”Social exchanges give rise to a process of gradual or socialisation which leads from a state of relative lack of coordination or differentiation between the child’s own point of view and that of others to a state of coordination of points of view and cooperation in action and communication’(Papalia et al., 2006: 307).

- Puberty and adolescence (6 – 12 years)

According to Lovrin (1995:93) most theories view peer relationship as having a positive impact on psychological well being. These relationships help children form meaningful relationships later in life. Lovrin (1995:93) highlighted that Sullivan believed children who were responsive to their friends’ needs and desires showed the same concern later as adolescents and adults. He wrote that during preadolescence, specifically between the ages of 8 and 10, a special bond develops between same sex children, which he called chumship. Papalia et al. (2006: 307) pointed to the fact that the child of this age ‘begins to develop a real sensitivity to what matters to another person. And this is not in the sense of ‘what should I do to get what I want?’ but instead “what should I do to contribute to the happiness or support the prestige and feeling of worth-whileness of my chum?” He went on to write that the developmental marker for this age group is indicated by the development of the manifestation of the need for personal intimacy. ”Intimacy is that type of situation involving two people which permits validation of all components of personal growth”.

Lovrin (1995:93) wrote about interpersonal relationships as the “bedrock of quality of life”. He sees the importance of self-esteem resulting from interpersonal relationships. Writing about the self-system, He defined the self-system as including the following: self-views, self-images, self-worth and self-esteem. ”Self-views are definitions, conceptions of oneself, that are comprised of baseline reflected appraisals, input

originally from caretakers early in life, and incremental additions, elaborations, and revisions resulting from the persons' subsequent life experiences".

When a child loses a parent, the very basic component that makes up this self-view, that is, appraisals originally from caretakers early in life, is disrupted. A child's picture of the world as well as herself is altered if family system collapses after the death of a parent. The interpersonal support children are able to provide for each other helps them build their sense of self-esteem and lessons` feelings of loneliness and isolation. "Interested readers should not forget that an assumption of this and other stage theories is that the psychological development that takes place at each stage will have a significant effect on all subsequent stages, that is the stages are viewed as sequence" (Newman and Newman, 1995: 43).

2.2. SELF CONCEPT

Self-concept can be positive or negative. A child will categorise himself or herself accordingly. Because of that, the child's self concept needs to be developed positively. The background environment of the child is important. Both the parents and the teachers need to be aware and careful of what they utter when they are with the children. Labeling can make a child to lack self-esteem. For the positive development of one's self-concept, the child should be accepted as she / he is. In the following section self concept as a self categorisation, self concept at a personal and social levels are discussed.

2.2.1. Self concept as a self categorisation

Self-categorisation covers a broad range of factors behind the conceptions that people have of themselves in terms of individuality and group affiliations. We are motivated to be both socially distinctive and socially assimilated as an optimal point on the social continuum (Bornholt, 2000: 416).

2.2.2. Categorisation at a social level

In principle, the social basis of self-concepts rests on a sense of belonging to the social group. Social influences such as gender stereotyping in academic self-concepts depend on whether relevant differences are perceived between the self and others, in the shared context (Bornholt, 2000: 416). In the school context, children divide themselves according to different social groups. These groups are in accordance with their common interests and characteristics. Social groups can be peer group members of either sex.

2.2.3. Categorisation at a personal level

Although much of the research examines social identity, categorisation also occurs at a personal level. The personal basis of academic self-concepts rests on a sense of individuality (Bornholt, 2000: 416). Each child will get an opportunity to do self introspection and categorise himself/herself accordingly.

2.3 ENVIRONMENT

The following section outlines the three components of the environment, that is the school, home and community. It also examines other factors influencing the psychosocial development of children.

2.3.1. The school

In the school children are more natural than individual. Children can learn new ways of relating more easily through interaction and feedback in a safe practice with their peers (Akos, 2000: 214). He further states that in a school situation children begin to appreciate the relation between thinking and feeling. According to Wanlass (2000: 513) the school has to perform the following vital roles:

- Schools must devise ways to close the large and unacceptable gap between many learners' actual and potential school success;
- School must capitalise on each learner's strengths, develop his/her unique competencies and foster the necessary affective dispositions in order to help more learners achieve to their fullest potential;
- The school, especially teachers, should be in the position to provide orphans and vulnerable children with specialised support;
- As part of the democratic goals of education, teachers must take responsibility for the success of all learners, not just brightest and most academically adept; and
- The school has to articulate and embrace a richer conception of school competence, one that recognises and values that wide spectrum of skills, competencies, and affective dispositions, in addition to academic achievement, that lead to a successful life.

2.3.1.1 Psychosocial development and values in the school

The teacher's role is influenced by his psychosocial values. The psychosocially stable teachers have self respect and respect for learners (Boy and Pine, 1998: 168). Self-trust is the first secret of success while self-confidence is a feeling of assurance in ones' own judgment, ability, and power (Jenkings, 1980:15 -16).

2.3.1.2 Creating a conducive environment for psychosocial learning and development in the school

The environment that is proper for development and learning is crucial for young children, so teachers should be encouraged to create the learning atmosphere that is welcoming, warm and free of prejudice. Teachers should seek strategies appropriate for fostering healthy social and emotional development in learners. Learners should be equipped with helpful insight to deal with problems they face in the classroom (Herbert and Neumeister, 2002:17).

2.3.1.3 Creating psychosocial experiences for children in the school

Teachers should find out ways to reveal learners' persons. Many of us have learned to hide our feelings, because we fear being rejected or hurt (Boy and Pine, 1998: 170). The researcher is aware of the fact that HIV\AIDS orphans can be treated otherwise in the school, or can be rejected by both the teachers and the peers but the most important thing is that those orphans should be free from pressure and should be treated with respect. The most important thing is that their self-confidence should be strengthened. Teachers should be aware that the child with self-doubt is vulnerable to 'put downs' disparagement.

2.3.1.4 Psychosocial relationships in the school

Through relationships with others one can learn more deeply about the self as a person (Boy and Pine, 1998: 171). Learners can learn to be more real as they interact with each other in helpful ways which are non exploitive (Boy and Pine, 1998: 171). Social conflict techniques can dictate the type of relationship quality children have with their peers (Rinaldi, 2002: 78).

2.3.2 The home

Symons and Clark (2000: 3) state that the family context serves as the basis for the children's understanding of mental states and behaviour of others. They further state that the development of children's understanding of mental states is embedded within the social world of the family and the home. Children from families affected by substance abuse often suffer from abuse and neglect, have poor school performance, low self-esteem, a diminished sense of self-efficacy, and depressed mood (Unger, Parker, Antal and Tressell, 2000: 274).

2.3.3 The community

According to Unger et al. (2000: 274) the following community structures, that is community centres, boys and girls clubs, religious groups, youth clubs, political groupings, and others, are desirable because they are located within the communities where children live and they strive to deliver culturally competent services that address the specific needs of their community. Furthermore, these structures have professionals who work closely with children, are committed to improving the lives of children, and have the expertise to identify children appropriate for a prevention programme.

2.3.4 Other factors influencing the psycho-social development of children

The following are other factors that affect the psychosocial development of children.

2.3.4.1 Maternal victimisation

Most research has examined the direct impact of violence on its victims; with little attention directed to the effect that physical and/or sexual victimisation of women and girls may eventually have on their offspring (Morrel, Dubowitz, Kerr and Black, 2003: 29). They also said that there is evidence suggesting that women who are victimised suffer emotional and behavioural consequences that interfere with effective and nurturing parenting, which then can affect their children's development and behaviour.

- Victimisation and mental health problems

According to Morrel et al. (2003: 29), victimisation can have long-term negative consequences on women's mental health. For instance, prospective studies of children who have been abused have shown that during their adolescent and adult years they are more likely to experience symptoms of posttraumatic stress disorder, be arrested for nonviolent and violent crimes, develop substance abuse and disorders, and

demonstrate lower levels of intellectual ability and academic achievement than children who have not been victimised, even after controlling for other family characteristics often associated with poor outcomes, such as poverty and parental substance abuse and arrest Morrel et al. (2003: 29).

- Victimisation and parenting

According to Morrel et al. (2003: 30), research has also shown that mothers with a history of childhood abuse report greater parenting problems. Much of the research has targeted sexual abuse and has shown that mothers with sexual victimisation histories report less knowledge of parenting skills, such as role support, communication and role image, less satisfaction with themselves as parents, and greater use of physical conflict strategies with their children (Morrel et al., 2003: 30).

- Maternal victimisation and children's outcomes

Morrel et al. (2003: 30) indicated that studies of the effect of domestic violence on children have consistently shown poor outcomes, including increased internalizing and externalizing behaviours and trauma symptoms, lower social competence and an increased risk of being maltreated. Victimised women are at greater risk of abusing their children, and as a result, their children may be at increased risk for behavioural, emotional, and interpersonal problems (Morrel et al., 2003: 30).

- The effect of maternal victimisation on children

Children of mothers with a history of victimisation would show more behaviour problems, less social competence, and lower cognitive abilities than children of mothers who did not experience victimisation (Morrel et al., 2003: 31). Morrel et al. (2003: 31) added that victimised mothers would exhibit more depressive symptoms and report more frequent use of harsh disciplinary practices, such as verbal aggression and minor violence, which would lead to worse child outcomes.

2.4. FOSTERING PSYCHOSOCIAL DEVELOPMENT THROUGH PLAY

Play is important because children will develop in totality. Children will have the opportunity to express themselves, they will talk about their play, about the rules governing their play, about their experiences, what they are able to do and what they cannot do and in so doing, communication skills will be acquired in a more informal way. They will understand to respect others' opinions. Through play, children will also develop their body muscles both fine and gross. Children will also socialise with the others. They will learn to be members of a group. They will learn to respect others in a group.

2.4.1. The power of play

The power of play can be paraphrased as follows according to Boy and Pine (1998: 209 – 210), Gordon and Browne (2007: 328) and Papalia et al. (2006:306-307):

- Play is voluntary activity. It must be spontaneous. The child must participate if she so wishes. A child can choose if she wants to play or not. Children should also be given variety of activities to choose from. Under no circumstances should children be forced to play. It is intensely personal, self-powered, and it embodies a high degree of motivation and achievement.
- Play offers freedom of action. Emphasis is on encouraging creativity. Play is always free in the sense that each act can be performed for its own sake and for its immediate results. In so doing, children are free to increase motor control and eye, hand, and mind coordination (Papalia et al., 2006:306).
- Play provides an imaginary world one can master. Play is a voluntary system that admits both reality and fantasy. It enhances the ability to visualize. Children can also be given the opportunity to create their own stories. They can also act out what they have seen and can also imitate their role models.

- Play has an element of adventure in it. New ideas are learnt in a more spontaneous way and varieties of techniques are encouraged. It has uncertainty and challenge, which can prompt one to be exploratory.
- Play provides a base for language building. While children play, they talk about their experiences, they also communicate ideas and in so doing they can easily acquire new words and vocabulary. The use of prior knowledge is encouraged (Papalia et al., 2006:307). It develops creative thinking. Relevant words are used and encouraged. Words come from a foundation of play experiences.
- Play has unique powers of building interpersonal relations. Play gives children the opportunity to make friends easily. Children consider many ways of developing relationships with others (Boy and Pine, 1998:209). It leads to the integration of the individual. It also develops appreciation for the individuality of others. It provides contacts with others while letting them engage in natural behaviours. Children can talk about their likes and dislikes. They will also learn more about the different emotions and how to handle them. They will also learn strategies to address their concerns. Through play children can experience and produce affective change and promote personality growth and development.
- Play offers opportunities for mastery of the physical self. One can learn body control through active physical play.
- Play is a way to learn about us. Play helps us to learn how we will respond to a certain set of circumstances.
- Play furthers concentration. One's power of concentration in the here and now world is improved through play.
- Play is a way of learning about roles (Cohen et al., 2007:452). Children imitate the behaviour, attitudes, and language of the important adults in their lives.
- Play is always a dynamic way of learning. Play often includes conscious organization of the environment, explorations of physical and social relationships, and levels of fantasy (Gordon and Browne, 2007:328).
- Play refines one's judgment. It is often an accepted vehicle for expressing one's feelings and thoughts.
- Play is vitalising. Play has a neuropsychological effects on us.

Taking into consideration the above facts it is clear that well constructed and well-planned play can help the children to grow creatively, aesthetically, socially, emotionally, physically, and intellectually.

2.5 RELATIONSHIPS

According to the researcher, it is good for the children to form some kind of relationships because they will learn how to socialise with the others and most importantly they can learn some skills in a more spontaneous way. Ferron (1990:172-174) also stresses the importance of considering the individual as the member of the group. Failure to meet the psychological needs of the child at a certain stage in his development may result in personality disorders, which can become a potential danger and a source of unhappiness to the individual himself. Ferron (1990:172-174) also indicated that there is a need to make a contribution to the life of the group and to share in the responsibilities of group living.

2.5.1. Peer relationships

The development of successful peer relationships is a major task of childhood and problematic peer relationships have been identified as a risk factor for both concurrent and long-term difficulties in psychosocial adjustment (Gaylord, Kitzman and Coleman, 2003: 23). Rinaldi (2002: 78) indicated that ineffective management of conflicts between peers has been linked to aggression and peer rejection. He went on to say that children identified as aggressive and isolated by their peers are at a higher risk of experiencing long-term social functioning difficulties, where as children identified as sociable share more favourable social outcomes. To him, the frequency of conflict and behavioural responses in the conflict resolution process or the presence of the conflict *per se* is not that a contributing factor but the type of conflict strategies that are employed. According to Chapman and McBride (in Rinaldi, 2002:79) cite communicative conflict, perspective taking, moral reasoning, and justification as

positive methods of dealing with conflict situation. He is of the opinion that social conflict is an inevitable part of everyday living and mastering the rules and skills of social conflict is an important survival skill. Rinaldi (2002:78) agreed that social conflict techniques can dictate the type of relationship quality children have with their family and peers. According to Huurre and Aro (2000: 625), children with chronic illness and disabilities are at an increased risk of developing psychosocial problems because of their continuous need for medical care, special educational services, and a range of social services.

2.5.2. The influence of parenting on children in their psycho-social development

Parenting does not occur in a vacuum, but within a broader context (Colpin, 2002: 646). Parents can have both direct and indirect influence on children's peer relationships and behaviour in the peer context by intentionally controlling peer related activities and through attempts to enhance children skills with peers and by organizing features of a social environment, providing access to play partners, choosing types of play mates, and by planning and supervising children's interactions with peers (Gaylord et al., 2003: 24 and Simpkins and Parke, 2001: 270).

2.5.3. Children's perceptions of parenting

Children's perceptions of parenting have been shown by Gaylord et al. (2003: 25) and Colpin (2002: 644) to be related to children's psycho-social adjustment with the direction of the association dependent on the dimension of parenting being rated like parental support tend to be associated with more positive child outcomes, and children's perceptions of parental rejection tend to be associated with more negative child outcomes. According to Adams-Webber (2000: 292) some children's evaluation will be those particular characteristics that are attributed to self, but are evaluated negatively. Research has shown that children's perceptions of parenting are related to psycho-social measures such as sociability among peers, internalizing and externalizing problems in the classroom, aggression with peers, and peer rejection and

popularity with peers (Gaylord et al., 2003: 25). Children's perceptions of parental rejection tend to be associated with more negative child outcomes, like for instance aggressive behaviour.

2.6. AGGRESSIVE BEHAVIOUR

According to Hubbard, Dodge, Cillessen, Coie and Schwartz (2001: 268) and Squires (2000: 107) aggression has been considered to be a general characteristic of individuals, because some children are more aggressive than others. According to Hubbard et al. (2001:268) aggression is considered to be an internal, stable, personality like trait. Aggressive behaviour patterns within an individual have been shown to be consistent across settings and stable across time. In addition, Hubbard et al. (2001:268) found that over half of all aggressive behaviour is displayed by just 10% of boys. This formulation implies that certain children can be labeled aggressive and that these children tend to behave aggressively towards all members of the peer.

2.7 CONCLUSION

In this chapter the author dealt with the psychosocial development of HIV/AIDS orphans. The rationale behind this was to illustrate how the HIV/AIDS orphans will miss out in terms of enhancing a full-fledged psychosocial development so that this child can find his or her feet in the country.

In the ensuing chapter, the author will now focus on the role of the parents on the becoming of HIV/AIDS orphaned children.

CHAPTER THREE

THE ROLE OF THE PARENTS ON THE BECOMING OF HIV/AIDS ORPHANED CHILDREN

3.1 INTRODUCTION

In this chapter, the researcher seeks to review the role of the parents on the becoming of HIV/AIDS orphaned children. In order to execute this task with a large measure of efficacy, the researcher will address the following issues of significance: child rearing practices, providing love and food, parents as positive role models for their children, parenting goals, parent-child communication, parental style of discipline, parent and schooling, parents as supporters of the school efforts, parent-teacher relationship, parent-teacher-child relationship and strategies teachers can use to establish a climate conducive to open communication with parents.

It is customary for African families to adhere to the principle of extended families. This practice allows orphaned children to be placed in homes of family members who take them in and raise them as their own. At times members of the community may foster these children, thus raising and rearing them.

For the purpose of the inclusion of the people mentioned above as care-givers to these orphans, the word ‘parent’ in this chapter will be used to espouse such. They shall also be referred to as guardians and or custodians.

3.2 CHILD-REARING

All societies expect parents to take up the primary responsibility for raising their children. Parents are held responsible for their children’s health, safety, and socialisation until the time that they can live without adult supervision (Jaffe,1991: 14).

Raising children to lead independent and fulfilling lives in a complex, technological society is certainly challenging. Parents must compete with other powerful sources of influence, such as their children's friends, siblings, television, and movies (Jaffe,1991: 15). Parenting does not occur in a vacuum. Parents are often preoccupied with the stresses and strains of their own lives. Unfortunately, adults are vulnerable to stress, illness, marital conflict, drug problems and financial pressures.

Child-rearing is a highly creative and imaginative task and, like other creative functions, requires considerable reflection and thought. Obviously, parents anticipate and visualise the kind of person they want their child to become. In a general sense, there are traits that they admire as well as a value system they wish to instill (Firestone, 1990:185). However, rather than forming a set of rigid image that is based on a restrictive view of the child, parents can learn ways of nurturing and guiding their children that facilitate the expression of their natural qualities and personal style of being in the world. This goal implies parents taking a sensitive, empathetic interest in their children's development and perceiving children as human beings quite separate from them (Firestone, 1990:186).

3.3 PROVIDING LOVE AND FOOD

Children have many psychological needs. Small children need to be loved, caressed, kissed and hugged. To provide the infant with proper emotional sustenance, a mother or parental figure must be able to feed and care for her child without arousing undue anxiety in the child. To succeed on this level, she must be sensitive to the child's needs. In addition, in the process of socialization, she must be capable of offering her child control and direction (Firestone,1990:19). A child's basic need for love, control, and direction can hardly be met by basically immature, needy, dependent, hostile parents. When parents are inadequate and immature, that is, when they do not provide sufficient love-food, the infant experiences separation anxiety and lack of love as a threat of annihilation and draws upon its imagination for relief from emotional pain and anxiety (Firestone,1990:20).

3.3.1 Criteria for love

Criteria for love include genuine expressions of warmth, a smile or a friendly look that communicates empathy and good humour, physical affection, respectful, considerate treatment, tenderness, sensitivity to children's wants and needs, companionship, and a willingness to be a real person with the child rather than simply act the role of "mother" or "father"(Firestone, 1990:6).

For children to develop a sense of self-esteem, they need to feel that they are loved. Self-esteem is based on love in the same way that a house is built on a foundation. This is one of the human's basic needs. According to Stenhouse (1994:12), apart from the most basic biological drive for self-preservation for food, shelter and safety; love is also important. Our most important need as humans is to feel that another person cares for us. If we don't grow up feeling that we are loved and wanted, it is much more difficult for us to develop to our full potential as individuals and as contributing members of society. Children who do not experience the security of a loving relationship with their parents may develop an attitude to life of anxious self-doubt rather than one of basic trust in their own abilities and worth (Stenhouse, 1994:13).

3.4 PARENTS AS POSITIVE ROLE MODELS FOR THEIR CHILDREN

More important than specific training or disciplinary measures is the powerful modeling effect derived from the child's living day-in and day-out with parents who themselves consistently behave in a responsible manner (Firestone,1991:189). There is no better method for teaching a child to be considerate. Certain personality characteristics are harmful while others are growth-enhancing in terms of their effect on people. Toxic personality traits in parents not only have a profound destructive effect on children directly, but these negative qualities are passed on to succeeding generations through the process of identification and imitation (Firestone, 1991:189).

People who are paranoid, suspicious, and have a victimised orientation to life, who possess strong self-denying or self-sacrificing tendencies, or who are weak and passively conforming to authority, will have a destructive effect on others, especially their children. These people foster guilt reactions in their offspring when they fail to actively embrace life (Firestone, 1991:189). Parents who themselves lead dishonest, empty lives will fail to provide their children with good role models. Phoniness, status-seeking, and class consciousness can foster vanity and feeling of superiority in children. Rigidity and a need to control would tend to produce a compulsive-obsessional personality structure in the child.

Tightness or lack of generosity, hostility and sarcasm, indifference, intrusiveness, irritability, and over-solicitousness are also toxic personality characteristics (Foster 1996:5). Fathers and mothers who are domineering, overbearing, evaluative, or condescending behave in a manner that is against their child's psychological development. In contrast, the parent who is congenial, non-defensive, non-intrusive, consistent, and generous has a more positive impact on his child's personality. Parents can best help their children not by sacrificing themselves for their children but by attempting to fulfill their own lives and this can be visible through a good parent-child relationship (Foster, 1996:6).

Parents can become good role models by celebrating special occasions such as, birthday parties, weddings and house-warming parties, without using alcohol and other intoxicating substances. During times of difficulties, parents can escape those times without using alcohol, gambling and other drugs. As these are some of good qualities of a good role model, children will take these as a remembrance in to their future as they grow up and learn by their parent's example (Kelly, 2003:3)

3.5 PARENTING GOALS

Roberts (1994: 181), Jaffe (1991:15-16) and Kelly (2003: 118), regards the following as parenting goals:

3.5.1. Good parent-child relationship

According to Roberts (1994:181), parents inhabit a world of people. For most parents, other people provide them with much of the satisfaction life has to offer. Parents must have an understanding of the developing child, provide structure, and increase the complexity of the rules (Roberts, 1994:182). One of the challenges of parenting is teaching children to get along with each other. This is very challenging, because children are very self-centered. Occasionally, children are selfish, impulsive, insensitive, and demanding. These qualities set the stage for parent-child conflict. Good parental judgement often stands in opposition to a child's demand for immediate gratification. The family is a "training ground" for having a relationship. Parents assume that what children learn about relationships from their family life will be reflected in their outside relationships (Jaffe, 1991:15 -16).

The relationship between the parent and child should be warm, inviting and interesting. Children need to have responsive parents to whom they are securely attached. These parents encourage stimulating interaction and share the excitement of exploration and discovery with their children. It is, at this juncture important to state that though the parents discussed in this chapter may be ailing due to ravages of HIV/AIDS, the role they play in their children's life (though compromised) does not change nor deviate from the role played by any other able-bodied parent. They too extend parental sentiments and support to their children. The parent-child relationship thus provides cognitive development (Jaffe, 1991:246). Children who are securely attached as infants subsequently approach cognitive tasks in ways conducive to cognitive development. Their problem-solving style is characterized by more curiosity, persistence and

enthusiasm, and less frustration than less securely attached infants. Surely attached children also appear to use adult-like cognitive and social development. They are more able to benefit from maternal assistance during problem-solving tasks and to interact effectively with teachers (Jaffe, 1991:247).

3.5.2. Good behaviour

Parents enjoy the parenting role more when their children are well behaved. Child rearing is more pleasurable when children cooperate with their parents and siblings instead of behaving defiantly. Hence, it is no surprise that most parents consider good behaviour a high priority (Jaffe, 1991:15). Parents must decide for themselves what constitutes good behaviour. Keep in mind that children benefit when they can please other people too, not just their family members. Once parents can articulate what behaviours they value, they can adopt child-rearing strategies that encourage those behaviours.

Parents must provide for children's education in schools but should also take personal interest in their studies, help them if they can. This gives children a feeling of 'working with the parents' and encourages them in studies. Parents should sacrifice their own comfort and social activities and must spare some time to take interest in children's studies, especially when they are young. Leaving children to the mercy of teachers or tutors is not a wise policy (Kelly, 2003: 118). And of course, parents should not forget or neglect imparting religious/moral training to children. A little sacrifice on part of the parents will save children from moral disasters. Effective moral training comes not from sermons, advice and precepts but from parents' personal examples of good behaviour.

3.5.3. Competence

Parents are expected to teach their children useful behaviour, that is, behaviour that accomplishes something that they or someone else values. One of the major accomplishments of childhood is mastering the physical environment. This often takes

the form of problem-solving skills that allow a child to identify a problem, generate a possible solution, and test it (Jaffe, 1991:15). If an attempt solution fails, competent children learn to persist until they are successful. Competence comprises of cognitive and intellectual abilities, achievement motivation, and self-reliance.

3.5.4. Self-esteem and self confidence

The nucleus of personality is self-esteem, that is, how we evaluate and feel about our selves. People who don't like themselves are prone to anxiety, depression, and self-destructive behaviour pattern (Jaffe, 1991:16). People who like and accept themselves tend to have more satisfying and productive lives and better relationships. The ability to accept and like ourselves is rooted in the feedback we get from other people early in our lives and from our ongoing records of successes and failures.

3.6 PARENT-CHILD COMMUNICATION

Communication is vital and should always be a two way street. Parents should listen to their children, find out what is going on in their lives and if anything is bothering them (Kelly, 2003: 119). Children should know that they can talk to their parents about anything under the sun. It is important for parents to remember that children who have good communication with their parents are more likely to ask for their advice than turn to their peers.

3.7 PARENTAL STYLE OF DISCIPLINE

According to Davidson (2001:127), mental health professionals have tended to ignore the religious dimension of life. There has always been opposition on both sides to the crossing of such disciplinary boundaries, yet it will be incomplete if the teachers ignore and do not explore these religious dimensions of life. Parental style of discipline plays an important role in the promotion of human psychological as well as spiritual growth.

Davidson (2001:133) states that a good parent provides both an experiential role model and supportive nourishment for growth.

Children of parents who practiced the authoritative (democratic) parenting style had better grades than children whose parents were authoritarian (punitive) or permissive. Children of parents who scored highest on authoritative parenting had the best grades. Good parental discipline leads to a child's perfect self which encompasses admiration, respect and self-regard (Davidson, 2001:129).

3.8 PARENT AND SCHOOLING

In years ahead, it is believed that parental participation in school affairs will become increasingly more accepted, pervasive, and effective. More than any other educational movement, the participation of parents, the first and most important teachers of school children, will inevitably produce dramatic changes in the governance of schools and schooling (Angela, Carrasquillo and Clement, 1993:175). In cases where the parent has been debilitated by HIV/AIDS or where the child is already orphaned, the role of the parent is assumed by the individual who, at that point in time, will be taking care of the child (see sec. 3.1). Such a person will play a participatory role in the child's schooling.

Parents are an integral part of schooling. Parents teach their children and through that teaching they influence the extend to which teachers can be effective. They are primarily responsible for the education of their individual child. The parental dimension of schooling is central to professional performance of teachers (MacBeth, 1989:1).

3.9 PARENTS AS SUPPORTERS OF THE SCHOOL EFFORTS

Parents and teachers share responsibility for creating a working relationship that fosters children's learning. This digest examines the cultural context for parent-teacher relationships, suggests some general strategies for creating a climate in which misunderstandings and disagreements between parents and teachers can be minimised through communication, and discusses some general principles for parents and teachers in dealing with misunderstandings or disagreements as they arise (Doner, 1996:47).

It is felt that parents will become equal partners with school professionals in deciding what schools ought to, can, should not and cannot do (Angela et al.,1993:175). Similarly parents will become equally responsible for the failure or success of their children in the school. Whether the parents' function has been exercised fully or minimally, parents have traditionally supported school efforts. They have held certain academic expectations for their children and have performed moral and emotional acts of support which served as reinforces of certain basic skills.

It was not recently, however, that any reasonable, concerted effort was made to legitimise, by recognizing and harnessing, the valuable input of parents in the functions of schools. Now, many appear to recognise the cogent role that families and caregivers play in supporting the school, as well as in instilling moral virtues and values in their children and in instructing and reviewing their children in basic skills; in helping at school with a wide variety of functions and, altogether, in presenting themselves as a critical component of the schools' existence, purpose, and function (Angela et al., 1993:176). There is now much more support for the idea of some parental involvement in formalised in-school participation of their children's education. Such support has gained credence from recent research, which has found, among other things that children basically perform better at school when parents are involved and those children whose parents help them at home and remain in close contact with their

children's school score much higher than children of similar aptitude and family background, but whose parents are not involved (Angela et al., 1993:176).

Parental participation derives impetus when there is genuine demonstration that their presence is needed at school. A warm hand extended is a genuine, initial sigh of welcome for a school unit. Establishing and strengthening links between family, home and school is critical (Angela et al., 1993:177). Reaching out to parents in a genuine way is essential. In this respect, parents can serve several functions, such as keeping a liaison relationship with school and community as voluntary or paid workers, and performing as interested participants, not only as traditional cake sellers.

Schools can create within their physical plants, parent centers with flexible hours that would allow reasonable parental participation at their own time and convenience. It follows therefore, that the school, home, and community must engage in positive interaction.

3.10 PARENT-TEACHER RELATIONSHIP

Parents can keep vigil in two main ways: by reinforcing the mission of the school at home and by monitoring their children's progress (Angela et al., 1993:188). But this effort, this reinforcement, must begin in infancy and be carried throughout, thereby demonstrating a sense of the value of education. Parents should equally work to ensure that their children grow rich in several directions. In the case where the parents of the child are deceased, the responsibility of reinforcing the mission of the school at home and monitoring the children's progress, falls on the shoulders of the guardian or custodian who shall have taken up a parenting role in the child's life. Families hardly count on schools to look after the educational needs of every child; they cannot take anything for granted about the future of their children, including the quality and outcome of schooling, especially given the nature of the society as one that is troubled by drugs, AIDS, violent crime, racism, environmental deterioration, and international competition (Angela et al.,1993:188). Parents must remain vigilant; they must monitor,

and cooperate with, schools for the good of their own children. This is, in a sense, a new dispensation.

According to Angela et al. (1993:189), it is up to parents to take charge of their own responsibility for the education of children. They must now help to build a foundation for their children's language development, to find the best health care, to make the most of the year leading up to school entry and beyond. They must strive to arm themselves with the knowledge they need to ascertain that their children are getting all they should. In addition, these efforts must be extended to include: meeting with teachers; observing classes; and reading the themes, tests, and homework assignments their children take home. As well they must gather information about what their children are studying in each subject throughout the year (Berger, 1991:92). A point of importance in this context is the establishment of a liaison relationship between parent and teacher. A wise parent should get to his or her child's teacher and establish a dialogue, lasting throughout the school year.

3.11 PARENT-TEACHER-CHILD RELATIONSHIP

A good relationship between the parent, teacher and student allows all three parties to have a shared understanding of learning goals, the curriculum and ways they can work together to achieve the most for the children.

Children gain from parents' participation, and teachers, schools, families and communities are strengthened when supportive relations are developed between children, parents and the school.

3.12 STRATEGIES TEACHERS CAN USE TO ESTABLISH A CLIMATE CONDUCIVE TO OPEN COMMUNICATION WITH PARENTS/CUSTODIANS

The foundation for good parent-teacher relationships is frequent and open communication. Both teachers and parents/custodians share the responsibility for

creating such a foundation. Ford (1996:650) and Katz (1996:96) have identified the following strategies for teachers to establish a climate conducive to open communication with parents:

- Let parents/custodians know how and when they can contact the school and the teacher. As early in the school year as possible, teachers can explain that they:
    - can be reached at specific times or in specific ways:
    - can be contacted directly as questions or concerns arise; and
    - have given a lot of thought to their teaching philosophy, class rules and expectations.
- Practise an open door, open-mind policy. Teachers can invite parents/custodians to visit the class at any time that is convenient to the parent/custodians. When they visit, parents/custodians can monitor their child's perceptions of a situation and see for themselves what the teacher is trying to achieve with his or her learners.
- Elicit expressions of parents' concerns and interests in preparation for parent-teacher conferences. Some schools organise parent-teacher meetings to discuss their goals early in the school year. On these occasions, teachers can ask parents/custodians to share their main concerns and goals for their child. Brief questionnaires and interest surveys also provide good bases for meaningful discussions in parent-teacher conferences (Nielsen and Finkelstein, 1993:90).
- Involve parents/custodians in classroom activities. Teachers can let parents/custodians know how they can be helpful and solicit parents' assistance with specific activities. The more involved parents/custodians are in what goes on in the classroom, the more likely they are to understand the teacher's goals and practices.

Parents/custodians also have an important role to play in fostering open communication between themselves and teachers (Katz, 1996: 97). They can:

- Introduce themselves. At the beginning of the school year, parents/custodians can contact teachers and let them know when they can be reached most easily, daytime or evening, to discuss their child's classroom experience, and how they would prefer to be contacted (telephone, cell phone (SMS), e-mail, letter, etc.).

- Be involved in classroom and school activities at whatever level work and family responsibilities allow. If parents/custodians cannot volunteer or go on field trips, they can let the teacher know that they are interested in helping in other ways with a special display or some activity that can be done on an occasional weekend, for example. They can let the teacher know that they have skills that they would be willing to share even if they are not sure how they can be useful in the classroom. Or, they can let the teacher know that special circumstances (an extremely ill parent, or an especially demanding job, for example) prevent them from being formally involved, but that they are always interested in how their child is doing and would welcome communication about their child on a regular basis, not just when there's a problem.

- Initiate regular contact. Parents/custodians need not wait for the teacher to call them; they can contact the teacher at times the teacher has indicated are convenient.

Teachers and parents/custodians share responsibility for the education and socialisation of children. Preventing and resolving the differences that may arise between parents/custodians, teachers, and children with constructive communication, respect, grace, and good humor can help make school a pleasant place.

3.13 CONCLUSION

In this chapter the author dealt with the role of the parents/custodians/guardians on the becoming of HIV/AIDS orphans. The rationale behind this was to illustrate how the HIV/AIDS orphans could be supported to feel good about themselves.

This shows that our behaviour as parents/custodians has a direct influence on our children's self-esteem. Individual parenting style is based on our own upbringing, our personalities, and our values. It is helpful if we can think about our own and clarify our role as parents/custodians so that we can set clear behavioural standards for our children, and avoid having expectations of them that are unreasonable or unrealistic (Stenhouse, 1994:56). It is vital for us to remember that children are not our possessions, they are not ours in the proprietary sense of the word, and rather they belong to themselves and have the right to an independent existence. In the ensuing chapter the author will now focus on the effect of illness and death on HIV/AIDS orphaned children

Chapter 4 deals with the effects of illness and death on HIV/AIDS orphans/vulnerable children

CHAPTER FOUR

THE EFFECTS OF ILLNESS AND DEATH ON HIV/AIDS ORPHANS/VULNERABLE CHILDREN

4.1. INTRODUCTION

In this chapter, the researcher will focus mainly on the effect of illness and death on HIV/AIDS orphaned children. In order to execute this task with a large measure of efficacy, the researcher will address the following issues of significance: Parental illness, children's concept of death, dealing with death, conditions associated with HIV / AIDS orphans and chronic illness, response for all HIV /AIDS affected children not HIV / AIDS orphans only, helping young children cope with death, coping skills of children, the psychological needs, care of orphans, extended family system, parental loss to HIV / AIDS, some factors complicating the mourning of an HIV / AIDS related death, and the impact of HIV / AIDS on the economy.

"Families are the building blocks of society. In the family, couples find intimacy, personal meaning, and identity, while raising children to be competent members of society. How parents develop personal meaning and identity as a couple, and how they deal with changes and challenges as parents with both career and social commitments, may have a significant effect on the development of their children" Johnston, Martin, Martin and Gumaer (1992:225). There is growing evidence that the lack of attention for the emotional, physical and developmental needs of orphaned children may have a lasting impact on society (Loudon, 1998:5). To a child, the death of a parent is the worst thing imaginable (Lovrin, 1995:92). When it happens, the world is turned upside down, security is shaken, and the pain is overwhelming.

Although death of a parent is one of the most stressful life events for children, few empirical studies have investigated children's psychosocial outcomes after parental death (Pfeffer, Karus, Siegel and Jiang, 2000:1-10). The death of a parent is a traumatic event (Moore and Herlihy, 1993: 54). This traumatic event is the one that will affect the child profoundly throughout the rest of his or her life. Yet, a child who is supported through the grieving process can recover and enjoy life once again (Hlophe, 1999:36). Children should be encouraged to talk about death and ask a question about it without feeling it is a taboo subject (Costa and Holiday, 1994:206). According to Ryder, Kamenga, Nkusi, Batter and Heyward (1994:673), children are left parentless by the premature death of their parents from HIV related diseases. Because HIV/AIDS is a universally fatal disease, loss and bereavement are prominent psychosocial issues (Siegel and Gorey, 1997:566 and Hlophe, 1999:36).

4.2. PARENTAL ILLNESS

According to Johnston et al. (1992:225), Miller and Murray (1999:289) and Lovrin (1995:93) parental illness causes major stress on the family system and therefore impacts negatively on the parent relationships, parenting, household management, work responsibilities as well as social relationships. Long-term parental illness as a result, may impose new dynamics of power and control within the family. Thus chronic parental illness may have a traumatic effect on young children because both parents may neglect a child.

Therefore the previously unresolved issues within the family may be exacerbated by continuing stress, leading to dysfunctional family units. Because of stress of an illness, a family may adopt behaviours that may be inappropriate. In the case of parental illness, a strong likelihood of role reversal exists in which the sick parent may become the "child" and the school-age or adolescent child may become the "parent". Botha (1996:16) addressed an example of this situation by outlining a scenario occurring in Uganda where an 18 year old child keeps his dead father's land in production in order to take care of himself and his younger sister and brother. The child said that his father

died of a “slim” disease and their mother went away after his father’s death. He now digs in the banana plantation, grows beans, maize and groundnuts which when ready, his aunt comes and steals them off the trees. Those who would help are very far, stay with their families and are very poor. This then may lead to the child acting-out behaviour, not attending school, miniature adult and social withdrawal (Botha, 1996:16)

According to Miller and Murray (1999:289), Parental HIV illness invariably affects children’s physical and psychological well-being, whether or not children are themselves infected. Parents are also cautious about having conversations about HIV with children, other family members, friends and healthcare workers. According to the researcher this disease will ultimately make the parents die and leave the children alone.

4.3. CHILDREN’S CONCEPT OF DEATH

Todahl, Smith, Barnes and Pereira (1998:96) said that children conceptualise death, first as a temporary and reversible state, and later as an internal and universal biological process that results in the complete cessation of bodily functions. Death is not a singular entity, but a complex concept made up of relatively distinct components such as: universality, irreversibility and non-functionality that are widely identified as elements necessary for an adult perception of death.

4.3.1. Universality

In relationship to death, the concept “universality” asserts that all who are alive must eventually die. Other descriptions include “death as an immediate possibility”, death as a personal event and “necessity” (Todahl et al., 1998:97)

4.3.2. Irreversibility

The concept, “irreversibility’, asserts that once a living thing dies, its physical body cannot be made alive again. It is also defined as “death as final”, “death as irrevocable,” and “death as permanent” (Todahl et al., 1998:96).

4.3.3. Non-functionality

The concept, “non-functionality”, asserts that, with death, all life-defining functions cease. This notion is also termed “dysfunctionality” and “cessation”. The age at which children usually attain a mature understanding of death was examined and this was referred to as “the age of acquisition” or “the age at which at least 50% of the children in a sample show a mature understanding of a given component’. It was found that the age of acquisition across all components varied from a low of 2 to 4 years to a high of 10 to 12 years (Todahl et al., 1998:97).

Todahl et al. (1998:98) further outlined that although professionals often promote the importance of effective communication with children about death, research does not guide professionals and parents in its mechanics. Children benefit when communication and education occur before an actual death experience which can then be expanded to the death of a person. This will lead other members of the family to help orphans deal with death and accept it.

4.4. DEALING WITH DEATH

Managing the fear that HIV means becoming ill and dying, depends largely on the stability of couple relationships and the availability of extended family members to provide support and continuity of family life for the children. Secrets about the cause of illness and death can impact on the bereavement process (Miller and Murray, 1999:289).

4.5. CONDITIONS ASSOCIATED WITH AIDS ORPHANS AND CHRONIC ILLNESS

Conditions associated with HIV/AIDS orphaning are more chronic and arduous, because the death of a parent is preceded by a gradual physical decline and the increasing inability to perform the roles of a protector, bread-winner, guide and caregiver associated with parenting (Loening-Voysey, 2002:105). He continued by making us aware that it is the combination of having to become independent at a pre-mature stage with living through a parent's suffering that makes the load for these children so heavy. Moreover, children are often denied their childhood as they are required to take responsibility in the household of an infected person. In the best cases, the children remain in the care of a family member, usually the maternal grandmother, sometimes an aunt or an uncle. If the deceased person is a single parent the orphans suffer a double loss. Even where there may be another adult, children are expected to perform household chores. According to Loening-Voysey (2002:105) education is frequently denied as children are regularly kept out of school to take on these responsibilities.

According to Denis (2001:23) children do not go to the beach or to a restaurant as they used to when their parents were still alive. Everything becomes so difficult. The family battles financially. The grandmother, for example, is tired. With AIDS the world has been turned upside down. Denis (2001:23) continued to say that at an age when the elderly expect support from their children, they have to bury them instead and are forced to take responsibility for the upbringing of their grandchildren.

4.6 RESPONSE FOR ALL AIDS AFFECTED CHILDREN NOT AIDS ORPHANS ALONE

Morgan (2000:3) indicated that equally, children should not be viewed as passive recipients of assistance, but active participants who play a key role in the development of responses to the pandemic. Receiving quality services is a right and a need not only

of AIDS orphans, but also of all children. According to Morgan (2000:3) a study commissioned by the National HIV/AIDS Care and Support Task Team in South Africa, identified a variety of categories when defining children living with HIV/AIDS. There are children from infected households who are infected in a range of ways, both before and after the deaths of their parents. This includes children and orphans who live in families where parents are still alive but may be periodically ill. These children have to assume similar responsibilities to those of orphans, coupled with the additional burden of caring for their dying parents.

4.7 HELPING YOUNG CHILDREN COPE WITH DEATH

Young children find it hard to accept death. Their understanding of death may be limited. Children should be taught that death is a real and inevitable part of life. Young children who experience loss need comfort and support from the important people around them. However, their reactions to death vary depending upon their ages and stages of development. When adults discuss the topic of death with young children, they must consider the children's level of maturity. Children from about two to seven years are in Piaget's stage of pre-operational thought and view death as contemporary and reversible. They do not recognise it as being permanent. Instead, adults should provide straight forward information and honest answers to children's questions within the range of their understanding. Young children, like adults, do grieve (Wellhousen and Downey, 1992:23).

4.7.1. Stages of grieving

Wellhousen and Downey (1992:23), discussed the five-steps of the grieving process which include denial, anger, bargaining, depression and acceptance. During denial, a child is in shock and refuses to accept that death has taken place. When children move out of denial, they experience anger and may blame others or themselves for the death. After the anger passes, they get into a grieving process, bargaining. They want to strike bargains with themselves, adults, or God. During the fourth stage of grieving,

depression, the child finally experiences what he has been attempting to avoid through denial, anger, and bargaining (Wellhousen and Downey, 1992:25). The child acknowledges what has happened and begins to mourn. The final stage of the grieving process is acceptance. They progress through these stages at different rates and may go forward and backwards before reaching full acceptance. If children are not allowed to grieve, they can experience negative behaviours such as sleep difficulty, bedwetting and temper tantrums.

4.8 COPING SKILLS OF CHILDREN

In processing and coping with parental illness, the child's age can be a significant factor. Young children tend to have primitive thinking and greater nurturance needs. For them, a parental illness can have an unsettling effect because of the disruption of family routines, inability to understand the nature and complexity of illness, and the perception that parental inability seems a personal rejection Johnston et al. (1992: 227).

Within the context of children's family structure and support, resilient boys and girls seem to be affected differently. Girls, because of their early maturity, tend to respond to life events with greater autonomy and competence (Lovrin, 1995:92). In the process of coping, both roles and boundaries between children and parents can become diffused and children's developmental needs may be unmet. Coping with chronic illness is an ongoing process (Johnston et al., 1992: 228).

4.9. THE PSYCHOLOGICAL NEEDS

The psychosocial needs of people dying from HIV/AIDS related diseases should not be overlooked. They sometimes suffer anxiety about what will happen to their children after their death. Most of them become too ill to work and are helpless to provide their children with any kind of insurance for the future. HIV can attack everyone but it tends to concentrate in the poorest and most marginalized sectors. People who are suffering

from HIV/AIDS have already suffered discrimination and they are frightened that the same will happen to their children when they are gone. Although this is true, most people are not aware that the consequences of AIDS begin to impact on children even before their parents die. As a result, many children have to leave school to take care of the ill parents and the siblings (Sherrifs, 1997:83).

4.10 CARE OF ORPHANS

The problem of orphans is as old as society itself and the only difference now is that the problem has become more pronounced due to the AIDS pandemic (Kaseke and Gumbo, 2001:53-58). They continue to say that there have always been care arrangement, both formal and non formal. The responses to the problem of orphans include the use of the extended family system, foster care, adoption, institutional care and community based care. These are looked at in detail in the discussion that follows:

4.10.1 Extended family system

According to Whiteside (1999:14-15), care of orphans has become one of the greatest challenges facing the country. In the past the burden was often picked up by the extended family. Unfortunately, many South Africans no longer have extended families, and those that do exist are often under severe economic pressure. Kaseke and Gumbo (2001:54) and Denis (2001:34) make us aware that orphans were taken in by an aunt (mother/father's sister) or other relatives. However, relatives have been known to channel financial resources left to orphans for their own use, either because of greed or poverty. Many orphans will end up in already stressed households. When orphans are taken in by relatives there is a tendency to separate the siblings, resulting in separation anxiety and unequal opportunities for the orphans (Kaseke and Gumbo, 2001:54). Despite all these problems the arrangement was designed to meet the welfare needs of orphaned children. According to the researcher if problems like this continue the problem of orphans has rendered the extended family system unable to cope (see par. 1.1.1).

4.10.2. Adoption and foster care

Section 2b of the children's Protection and Adoption Act defines a child ''both of whose parents are dead or cannot be traced and who has no legal guardian whereas Section twenty (20) provides for the placement of children in foster care (Kaseke and Gumbo, 2001:55). It is therefore not surprising that few Africans come forward to adopt children. Kaseke and Gumbo (2001:55) continued to say that this problem is also exacerbated by the fact that only those cases referred to the Department of Social Welfare can be processed and these disadvantage rural communities as they do not have easy access to social welfare services (see par. 1.1.7).

4.10.3. Community based care

According to Kaseke and Gumbo (2001:56) the best interest of the child should be paramount in deciding on appropriate intervention and that if children cannot be looked after within their families, then community should care for the orphans. This served to ensure that children are not uprooted from their families unnecessarily. The community based care programme has had some successes in ensuring the care and protection of orphaned children (see par. 1.9.4).

4.10.4. Lack of extended family system

Orphans are less likely to receive adequate nutrition or education, and may be taken out of school while their parents are alive to provide households labour or because the households no longer have the recourse to send them back to school. AIDS orphans face the trauma of losing parents and the stigma of losing them through AIDS. Orphans are also more likely to face sexual abuse and exploitation. Children who grow up without adequate parenting and support are less socialised and less productive members of society. Thus AIDS has inter-generational, long term effects (Whiteside,

1999:14-15). According to the researcher young children don't have enough knowledge about death (see par. 1.1.1).

4.11 PARENTAL LOSS TO AIDS

The stigma and secrecy surrounding AIDS can have many adverse consequences on AIDS orphans. They may not be permitted to talk about the illness and death, either within or outside the family. Children who lose a parent to AIDS may feel guilty and without discussing their feelings, they may blame themselves. The shame these children feel is not only self-imposed, they frequently are the target of ridicule by classmates and peers. When HIV/AIDS orphans are discriminated against by peers and teachers, this can seriously undermine their emotional well-being, social competence, and achievement. It is likely that uninfected children might worry that they have contracted AIDS from an ill parent. These misconceptions often go unnoticed (Siegel and Gorey, 1997:567).

In addition to the above, Wild (2001:11) reminds us that common reaction of children to the terminally ill or death of a parent include depression, hopelessness, and suicidal ideation, loneliness, anger, confusion helplessness, anxiety and a fear of being alone. Children are not given the opportunity to mourn after the death of their parents.

4.12 SOME FACTORS COMPLICATING THE MOURNING OF AN AIDS – RELATED DEATH

The factors outlined below have some adverse complications related to AIDS orphans:

4.12.1 Stigma

The social stigma that has been attached to AIDS is perhaps the most frequently cited factor complicating the period of mourning. Families with AIDS victims are themselves the victims of social stigmatisation and ostracism (Siegel and Gorey, 1997:567).

Because of stigma and discrimination associated with AIDS, the illness and cause of death are often kept secret. Frequently, the children are either not told the true diagnosis or told not to reveal it to anyone outside the family. Even within the family, discussion about family members may be kept uninformed. This secrecy is motivated by both shame and by a fear of social consequence of the parent's HIV status becoming known. In the cases of AIDS, family members may feel particular anger at the deceased for having a self destructive lifestyle and for the potential shame he or she has brought upon the family (IBID).

4.12.2 Poverty

According to Foster (1997:4), HIV infection not only thrives in impoverished environments, the disease is itself a potent cause of poverty. Households where people are sick from HIV/AIDS have higher expenditures due to medical costs, and reduced incomes due to lost earnings, when the breadwinner dies, the family's resources are further depleted as a result of funeral expenses and property removal by the deceased's relatives. Consequently many survivors, indirectly affected by AIDS, are facing increasing poverty, and when poverty increases, children's health deteriorates. Poverty is often associated with increased vulnerability to HIV infection. Orphaned girls are at increased risk of HIV infection as a result of sexual exploitation by relatives or "sugar daddies', or if they become involved in commercial sex in order to make ends meet for their families. Orphaned girls have no one to take care of them when they are dying of AIDS, their orphaned children will have no grandmothers alive who can act as their caregivers. Thus, the AIDS epidemic may be perpetuated by a vicious cycle of orphanhood, poverty and increased vulnerability (Foster, 1997:5).

4.13 PARENT CHILD RELATIONSHIP

Parents' feelings of guilt, shame, remorse and anger can complicate parent-child relationships. Infected mothers are advised to avoid breast-feeding, depriving infants and mothers of this close physical and emotional bond. Two major dilemmas for

parents are disclosure about their own or a child's infection and reluctance to talk about HIV and illness inside the family. Common concerns include uncertainty about the "right" age to tell children; how to explain the diagnosis and the source of infection; and fear of the secret being revealed by children to their friends. For infected adolescents, disclosure by the parent may be precipitated by the onset of their sexual maturity. Some react with resentment towards parents for keeping the secret from them, despite the parents' reasoning that their motives were to protect the child. The second difficulty is parents' reluctance to talk about their infection and illness with their children (Miller and Murray, 1999:289).

There are rarely secrets in a family, as even young children sense tensions and know when adults are worried. Children may have worries, unattended by others, as they watch their parents or siblings become ill and die. In families where one child is infected, other children may be neglected because of the attention required to care for the infected child. Secrets at home, jealousy of the ill sibling or lack of parental attention may be shown at school by poor concentration and misbehaviour (Miller and Murray, 1999:289).

4.14 IMPACT OF HIV/ AIDS ON ECONOMY

It is important to remember that the people who are dying of AIDS are not only parents but, for the most part, are workers, consumers and taxpayers. Their passing not only presents the state with a bill for medical expenses, and another one for child maintenance – but it deprives the state of a source of revenue to meet these costs. Children's homes are too costly, adoptions are culturally fraught, and the foster-grant system will soon collapse under sheer weight of numbers, leaving the care-givers of children under six with a R190-per-month-per-child maintenance grant, and those of older children with nothing. Grandparents will spend their twilight years struggling to raise large numbers of children on state pensions (Loudon, 1998:5).

Worst hit will be those children who lose their parents. Their formative years will be shrouded in uncertainty, they will have fewer brothers and sisters, many will be shunted from one relative to another, many will be raised by strangers, their own children will have no grandparents (Loudon, 1998:5). .

4.15 CONCLUSION

The death of parents affects the whole future of the children involved. Although relatives may be concerned about fostering orphans when they suspect that the parent has died from HIV/AIDS, they may fear contracting HIV infection from the children or fear that bringing such children into their home may lead to stigmatisation and resentment by the community (Foster et al., 1997:163). When a parent, especially a mother, dies of HIV/AIDS orphaned children often go to live with a grandmother, a practice referred to as ‘skip-generation parenting’ with very definite influences on the psycho-socio becoming of the child (Foster et al., 1997:164).

Where the extended family does not take care of the children, it is common for older children to assume parenting roles during prolonged parental illness due to HIV/AIDS. Adolescents learn responsibility, effective coping mechanisms and nurturing skills in the situation (Foster et al., 1997:164).

Like adults, children also need to be attended to due to bereavement when parents pass away. Children may often not feel the full impact of the loss simply because they may not immediately understand the finality of death. This prevents them from going through the grieving process necessary to recover from the loss. Sengendo and Nambi (1997:107) remark that adults sometimes do not seem to realise that children suffer from the death of their parents although they may not have an adult understanding of death. Subsequently little attention is given to children’s emotions. Therefore, children are at risk of growing up with unresolved negative emotions often expressed in anger and depression.

Orphans of the HIV/AIDS epidemic are usually subjected to more stressors than other orphans. Multiple stressors include regular illness of the parents, parents awaiting death, greater responsibility on older siblings to look after the younger ones, poverty due to expensive treatment and lack of employment. Due to these stressors orphans are more likely to be at risk for psychological and physical problems as the number of stressors increase (Dane and Levine, 1994:19).

According to Sengendo and Nambi (1997:107-108), this stress may be shown in symptoms of confusion, anxiety, depression, and behavioural disorders such as disobedience. Perceived lack of control produces a feeling of helplessness and loss of hope and diminishes an individual's will power. The same symptoms may cause learning problems. Children who are frustrated, fearful and depressed may fail to concentrate in class and therefore perform badly (Sengendo and Nambi, 1997:107-108).

Parental long-term illness has an unsettling influence on family life. Adequate economic resources, healthy relationships within the family, effective support systems and coping resources are major tools in developing a coherent and meaningful family life for parents and children (Dane and Levine, 1994:19).

Death is the final dimension of life. It is part of the whole world of children just as it is part of the adult's world (Dane and Levine, 1994:20). Early childhood teachers and care givers have the responsibility to guide young children as they develop their understanding of death. They also must support children who experience the death of a pet, friend, grandparent, sibling, parent, or even fears of their own deaths.

CHAPTER FIVE

RESEARCH DESIGN

5.1. INTRODUCTION

Chapter four focused on the effect of illness and death on HIV/AIDS orphans. The basic aim of this chapter is to outline the rationale behind the methodology used in this study and also how the research was conducted. The previous chapters dealt with the psychosocial development of children, the role of the parents on the becoming of HIV/AIDS orphaned children and how the orphan's psychosocial status would be affected by HIV/AIDS through the literature study. In this chapter the problem is subjected to an empirical investigation. The researcher gives the detailed description of the empirical investigation of this thesis.

As a point of departure the researcher will give a description of the research problem. This will be followed by a discussion of the aim of the empirical investigation, research paradigm, research tools, selection of the sample and the method of investigation used in this study.

Thereafter a description of the procedure followed in the collection of data for the empirical investigation will be discussed including a pilot study. Once data have been gathered, it would be subjected to a statistical analysis and calculations. The discussion of data collection will be followed by data analysis and interpretation.

5.2 THE RESEARCH PROBLEM

Although the phenomenon of HIV/AIDS orphans' plight emanating from their psychosocial effects has been researched extensively, the majority of the research pertains to overseas countries. Even research undertaken in South Africa has focused mainly on HIV/AIDS and how it affects households in South Africa in general. But as

yet no study has focused exclusively on the Black rural school population in South Africa. The study of the psychosocial effects facing HIV/AIDS orphans in Black communities in South Africa, where unique conditions prevail has not yet been undertaken, and this is a matter of grave and concern.

The problem to be researched in this study is formulated as follows:

- Which factors in the Rustenburg communities, according to the teachers, parents and fellow learners contribute to the psychosocial problems faced by HIV/AIDS orphans?

A second part of the problem pertains to the prevention of and intervention with regard to the psychosocial problems encountered by HIV/AIDS orphans in the Rustenburg communities, namely:

- What measures can be taken to prevent the psychosocial problems encountered by HIV/AIDS orphans in the Rustenburg communities?

From the discussion in the previous chapters, it was evident that HIV/AIDS orphans experience problems which are unique to their situation. This research seeks to highlight the problems orphans could encounter and how those problems can be minimised.

5.3 AIMS OF THE EMPIRICAL INVESTIGATION

The specific aims of the empirical investigation were to determine:

- How equipped teachers are in handling HIV/AIDS orphans/vulnerable children?

- How could the school support HIV/AIDS orphans/vulnerable children?

- What various important issues regarding norms and values are practiced in the schools?

- How HIV/AIDS orphans/vulnerable children are psycho-socially affected?

- How HIV/AIDS orphans/vulnerable children are treated and handled in different schools?

- If orphans are treated differently from other children?

- How HIV/AIDS orphans/vulnerable children cope psycho-socially?

5.4. RESEARCH PARADIGM

A quantitative approach was followed. This falls within a positivistic theoretical framework.

5.5 RESEARCH METHOD

The method used in this chapter is a quantitative approach employing a survey design and using questionnaires to collect data.

5.6 RESEARCH TOOLS

Two sets of questionnaires were piloted one for HIV/AIDS orphans and the other for teachers (see Appendix A). The nature of the questions was diverse, ranging from structured to open ended questions. The researcher administered these questionnaires to gain information or collect data about a particular group of AIDS orphans as well as teachers.

5.7 SELECTION OF THE SAMPLE

A sample constitutes part of a target population under a given study, was carefully selected to represent such a population, as long as it may be less than the sum of the total of that targeted population (Sprinthall, 1990: 462). Sampling on the other hand, constitutes a process of choosing the units of a target to be included in a given study (Sarantakos, 1998: 139). It defines a process of selecting a small, but representative subset of the whole population (Floyd and Fowler, 2002:5).The reason being, in a survey study as this one, it is not possible to cover the entire population. The underpinning principle for a process of sampling in a survey study is ensuring that sample units are systematically and objectively chosen. To this end, the proper sampling tends to enhance the validity and reliability of the study (Sarantkos, 1998:139). Following Kotler and Armstrong (1999:122), a sampling plan calls for sampling size and sampling procedure.

A sample is a group, which is selected from a population and thus smaller than the AIDS orphans in the school or the community. The researcher does not intend manipulating the population, while representing the remainder of the population as possible. The sample is selected to give the researcher a manageable group for the purpose of the research. If the sample is representative of the population, results or conclusions from research with the sample will also pertain to the population. What is implied here is thus unless a smaller group which is selected from the population is representative of the population, it cannot be regarded as its sample (Masitsa, 1995:278).

According to De Vos (1998:191) a sample is thus, the element of the population considered for actual inclusion in the study. It can also be viewed as a subset of measurement drawn from a population in which we are interested. We study the sample in an effort to understand the population from which it was drawn. As such, we are interested in describing the sample not primarily as an end in itself, but rather as a means to for helping us to explain some facet of the population. A sample is a small

portion of the total set of objects, event or persons, which together comprise the subject of the study (De Vos, 1998:191).

A purposeful sampling was used because four (4) schools were suggested by the Department of Social Services in the Rustenburg Area due to their high populace with HIV/AIDS orphans. The other four (4) schools were suggested by the Auxiliary Services Division, which I am part of, in the Bojanala Region of Education (cf. Table 5.1).

The researcher administered questionnaires to gain information or collect data about a particular group of HIV/AIDS orphans as well as teachers. In this study, HIV/AIDS orphans aged between 6 and 13 years as well as teachers were the target group. The research sample consisted of a simple random sample of HIV/AIDS orphans and teachers in the Rustenburg Area. HIV/AIDS affected orphans were drawn from different Primary schools. Both males and females HIV/AIDS affected orphans were used.

Table 5.1: Distribution of the sample population

School	**No, of learners**	**No. of educators**
School A	45	16
School B	28	17
School C	38	12
School D	33	10
School E	22	13
School F	27	16
School G	31	19
School H	26	17
Total	**250**	**120**

5.8. ETHICAL ASPECTS

Permission was sought from the Executive Regional Manager of the Bojanala Region and principals of schools to conduct the research (see Appendix B and C).

Participants participated on a voluntary basis. No school or individual was identified in the process and the results of the research will be shared on an anonymous basis with the North-West Department of Education and the schools who participated in the research.

5.9 EX POST FACTO RESEARCH

Ex post facto means from what is done afterwards (Cohen and Manion, 1998:177). An ex post facto research is related to the experimental research non-the less they are not identical. Ex post facto research demonstrates that there exists an independent relationship between the independent and dependent variables. In this research it is important to do an ex post facto research in order to study the causal relationships. In descriptive and correctional designs it is almost always the case that casual relationships are not studied. However there are certain non-experimental designs that are used to investigate causal relationships. These are termed ex post facto designs. In this study the purpose of the research is to examine how an identified independent variable affects the dependent variable, but the circumstances of conducting the research do not allow for an experimental design (Schumacher and McMillan, 1993:284-285).

The purpose of an ex post facto research is to investigate whether one or more pre-existing conditions have possibly caused subsequent differences in the groups of subjects. In other words, the researcher looks to conditions that have already occurred and then collects data to investigate the relationship of these varying conditions to subsequent behaviour. In an ex post facto research, there is no manipulation of conditions because the presumed cause has already occurred before the study is

initiated (Schumacher and McMillan, 1993:285). Thus, the ex post facto research is used in this study because the overall aim of this research was to determine how the HIV/AIDS orphans'/vulnerable children' psychosocial status is affected by the HIV/AIDS disease.

5.10 COLLECTION OF DATA

HIV/AIDS orphans as well as teachers from different schools in the Rustenburg Area completed questionnaires (see Appendix A). As a point of departure, a letter was written to the sample schools and was delivered by the researcher, informing them about the nature and value of the research to be undertaken and also to ask the principal for permission to administer questionnaires in the school. An appointment was made with specific teachers. The questionnaires were distributed to schools on the day on which they were to be completed. All the teachers gathered in a staff room. They took their seats and when they were all seated, the researcher issued questionnaires out. Questions were put upside down on the tables. Each teacher was requested to place the questionnaire in a proper way and read the instructions and start completing it.

The researcher had to ensure that none of them went out with the questionnaire. When all teachers had finished and left, the researcher collected and counted the questionnaires to make sure that she received all of them.

The HIV/AIDS orphans were given the questionnaires on a different date to that of their teachers. HIV/AIDS orphans were given the option of using their first home language in completing the questionnaire. In each school HIV/AIDS orphans were gathered in one classroom. They took their seats and the researcher explained to them on how to complete the questionnaires. Teachers were also invited to assist learners in completing the questionnaire.

5.11 VALIDITY

A research instrument is valid if it measures what it purports to measure. Validity is the degree to which a research instrument is capable of achieving certain aims (Borg and Gall, 1989:254). Validity is a specific job one wants a research instrument to do, thus a research instrument is valid for a specific purpose. Content validity is the degree to which a research instrument samples the content area which is to be measured (Borg and Gall, 1989:250).

The different aspects of validity which should be considered and adhered to are discussed below:

- *content-related validity* – it needs to be closely related to the content of the course presented. One of the most useful ways of determining whether or not a test is capable of providing a valid basis for making content-related inferences about learning is by evaluating the test by a panel of subject experts (Killen, 2003:7);

- *curriculum validity* - there should be a clear idea of expected outcomes and these outcomes need to be justifiable in terms of the instrument (Killen, 2003:7);

- *criterion-related evidence* - educators might be interested to know whether learners' results in an assessment task are good predictors of their future performances (the criterion measure) (Killen, 2003:8);

- *construct-related validity* – when constructing a test, educators need to be sure that it assesses aspects of the construct they have set out to test and not something else.

Reliability is closely related to validity and will be discussed below.

5.12 RELIABILITY

Reliability is the ability of a research instrument to achieve similar results under similar conditions. Reliability of a measuring instrument is the degree of consistency with which it measures whatever it is measuring (Maree and Fraser, 2004: 36). Reliability deals with matters of accuracy. Reliability refers to the consistency with which an instrument produces equivalent scores. An unreliable research instrument gives inconsistent results. A perfect reliable device produces the same results every time it is used for measuring the same thing.

Reliability is the extent to which an assessment activity would render the same results if conducted with the same learners under the same conditions. If a test measures something consistently it can be considered reliable (Nelson Mandela Metropolitan University, 2006:13). Reliability can be enhanced if clear criteria are formulated against which learner performance is measured. Creating and agreeing on sound and usable criteria is thus an important way of improving reliability (Maree and Fraser, 2004:36).

Sieborger and Macintosh (1998:12) made it clear that assessment can never be completely valid and reliable. Some kinds of assessment have much validity, but they do not have much reliability. To be fair in assessment, the assessor must aim at as much validity and reliability as possible.

5.13 THE PILOT STUDY

According to Matshidiso (1999:55) it is impossible to predict how questionnaire items will be interpreted unless the researcher does a pilot study of the questionnaire to a small sample of respondents before starting the main study. Thus, in order to determine any ambiguity and flaws, the questionnaires were piloted using a sample of HIV/AIDS orphans and teachers. The pilot study did not reflect any shortcomings. Consequently, no changes were made when the questionnaires were administered in the main research study.

On the other hand, the research shows that the pilot study is one way in which the prospective researcher can orient him/her to the project he /she has in mind. The pilot study is indeed a prerequisite for the successful execution and completion of a research project. It forms an integral part of the research problem. Its function is the exact formulation of the research problem, and a tentative planning of the investigation (De Vos, 1998:178).

5.14 DATA ANALYSIS

Computer aided statistical analysis was employed. Frequencies and percentages were calculated by means of the Statistical Package of the Social Sciences (SPSS) programme. SPSS version 15.0 was used to summarise the data, perform factor analysis to analyse the items and ANOVA (analysis of variance) to relate the factors to the biographical information.

5.15 CONCLUSION

This chapter has focused on a research procedure and relevant statistical methods used in the analysis of the data in this survey study. A questionnaire was the major instrument used in the collection of data in this study. Furthermore, the methodology of this study has been explained to give an understanding of the procedures that were followed in the collection of data.

CHAPTER SIX

ANALYSIS OF RESULTS AND DISCUSSIONS OF RESULTS

6.1. INTRODUCTION

In the previous chapter, the researcher did a pilot study in which questionnaires were tested. Questionnaires were administered to educators and AIDS orphans/vulnerable children to answer them. In this chapter, the empirical investigation on the psycho-social effect of children orphaned by AIDS in which the research was conducted, are presented, interpreted and analysed. The results will be presented in a table form as follows:

6.2 Hypotheses

To achieve the central aim and objectives outlined in this research, a quantitative approach employing a survey design will be used for analysis of the data.

The following hypotheses were derived form the literature review and are stated to guide the investigation:

Ho1 The AIDS orphans/vulnerable children lack physical needs

Ho2 The AIDS orphans/vulnerable children need psychological and sociological support services

Ho3 The AIDS orphans/vulnerable children cope with the situation they are in

Ho4 The school have a task to raise awareness of AIDS orphan/vulnerable children

Ho5 The school have a task to support the AIDS orphans/vulnerable children in their psychosocial needs

Ho6 Opinions of teachers on problems of the AIDS orphans/vulnerable children do not depend on the phase they are teaching

Ho7 Teachers who are more aware of the AIDS orphans/vulnerable children's problems are more likely to provide special support

Ho8 The AIDS orphans/vulnerable children are optimistic about their future

Ho8(a) The AIDS orphans/vulnerable children blame themselves for their parents' deaths

Ho9 The AIDS orphans/vulnerable children have good interpersonal relationships

Ho10 The AIDS orphans/vulnerable children grieve about the death of their parents

Ho11 The AIDS orphans/vulnerable children feel uncomfortable about being orphans

Ho12 The degree of optimism of AIDS orphans/vulnerable children depends on their grade

Ho13 Optimism and outlook of the future of the AIDS orphans/vulnerable children varies with grades they are in

Ho14 Optimism and comfort of the AIDS orphans/vulnerable children in the community depends on the family size

Ho15 Optimism of the AIDS orphans/vulnerable children depends on the grant they receive

6.3 RESULTS

6.3.1. PART 1. Summary of responses - Teachers

A Biographic information and training support

Question 1: In which phase are you teaching?

The frequencies are shown in Table 6.1 below.

Table 6.1: Teaching phase

Phase	Frequency	Percent
Foundation phase	47	39.2
Intermediate phase	73	60.8
Total	120	100.0

Almost 40% of teachers teach at the foundation phase.

Question 2: Indicate your qualification

The frequencies are shown in Table 6.2.

Table 6.2: Teacher qualifications

	Qualification	Frequency	Percent
	None	2	1.7
	Level 1 SAQA	2	1.7
	3 - 4 yr diploma in JP	20	17.1
	3 - 4 yr diploma in Preprimary	22	18.8
	BprimEd ECD 4 yrs	11	9.4
	HDE pre-primary	17	14.5
	HDE JP	5	4.3
	Other	38	32.5
	Total	117	100.0
Missing		3	
Total		120	

Almost 30% of the teachers have different qualifications other than the ones specified on the above table.

Question 3: Did your training provided for enough knowledge on how to support orphans and vulnerable children?

The frequencies are indicated in Table 6.3.

Table 6.3: Knowledge to orphans

Enough knowledge	Frequency	Percent
Yes	48	40.7
No	70	59.3
Total	118	100.0
Missing	2	
Total	120	

Just over 40% of teachers say their training provided enough knowledge. This implies that the majority of teachers did not receive relevant training in line with this aspect.

Question 4: Do you provide special support to these children?

The frequencies are shown in Table 6.4.

Table 6.4: Special support for orphans

Special support	Frequency	Percent
Yes	82	70.1
No	35	29.9
Total	117	100.0
Missing	3	
Total	120	

About 70% of teachers provide such support. Based on the responses from teachers it is evident that they are aware of the presence and problems experienced by HIV/AIDS orphans/vulnerable children, hence the provision of support.

SECTION B

Statement 5: The HIV/AIDS orphans/vulnerable children experience a lack of food

The frequencies are as follows:

Table 6.5: Lack of food

Lack of food		Frequency	Percent
	Definitely disagree	2	1.7
	Disagree	5	4.2
	Agree	56	47.1
	Definitely agree	56	47.1
	Total	119	100.0
Missing		1	
Total		120	

There is general agreement that lack of food is a problem.

Statement 6: The HIV/AIDS orphans/vulnerable children experience a lack of clothing

The frequencies are shown in Table 6.6.

Table 6.6: Lack of clothing

Lack of clothing		Frequency	Percent
	Definitely disagree	7	5.9
	Disagree	10	8.4
	Agree	48	40.3
	Definitely agree	54	45.4
	Total	119	100.0
Missing		1	
Total		120	

There is general agreement that lack of clothing is a problem.

Statement 7: The HIV/AIDS orphans/vulnerable children experience a lack of personal hygiene

The frequencies are indicated in table 6.7 below.

Table 6.7: Lack of personal hygiene

Lack of personal hygiene		Frequency	Percent
	Definitely disagree	5	4.2
	Disagree	17	14.3
	Agree	66	55.5
	Definitely agree	31	26.1
	Total	119	100.0
Missing		1	
Total		120	

More than 80% of teachers are of the opinion that lack of hygiene is a problem.

Statement 8: The HIV/AIDS orphans/vulnerable children experience a lack of school funds

The frequencies are shown in Table 6.8 below.

Table 6.8: Lack of school funds

Lack of school funds		Frequency	Percent
	Definitely disagree	7	6.0
	Disagree	3	2.6
	Agree	52	44.4
	Definitely agree	55	47.0
	Total	117	100.0
Missing		3	
Total		120	

More than 90% of teachers say that lack of school funds is a problem.

Statement 9: The aids orphans/vulnerable children experience a lack of school material

The frequencies are as indicated in Table 6.9 below.

Table 6.9: Lack of school material

Lack of school material		Frequency	Percent
	Definitely disagree	2	1.7
	Disagree	19	16.0
	Agree	67	56.3
	Definitely agree	31	26.1
	Total	119	100.0
Missing		1	
Total		120	

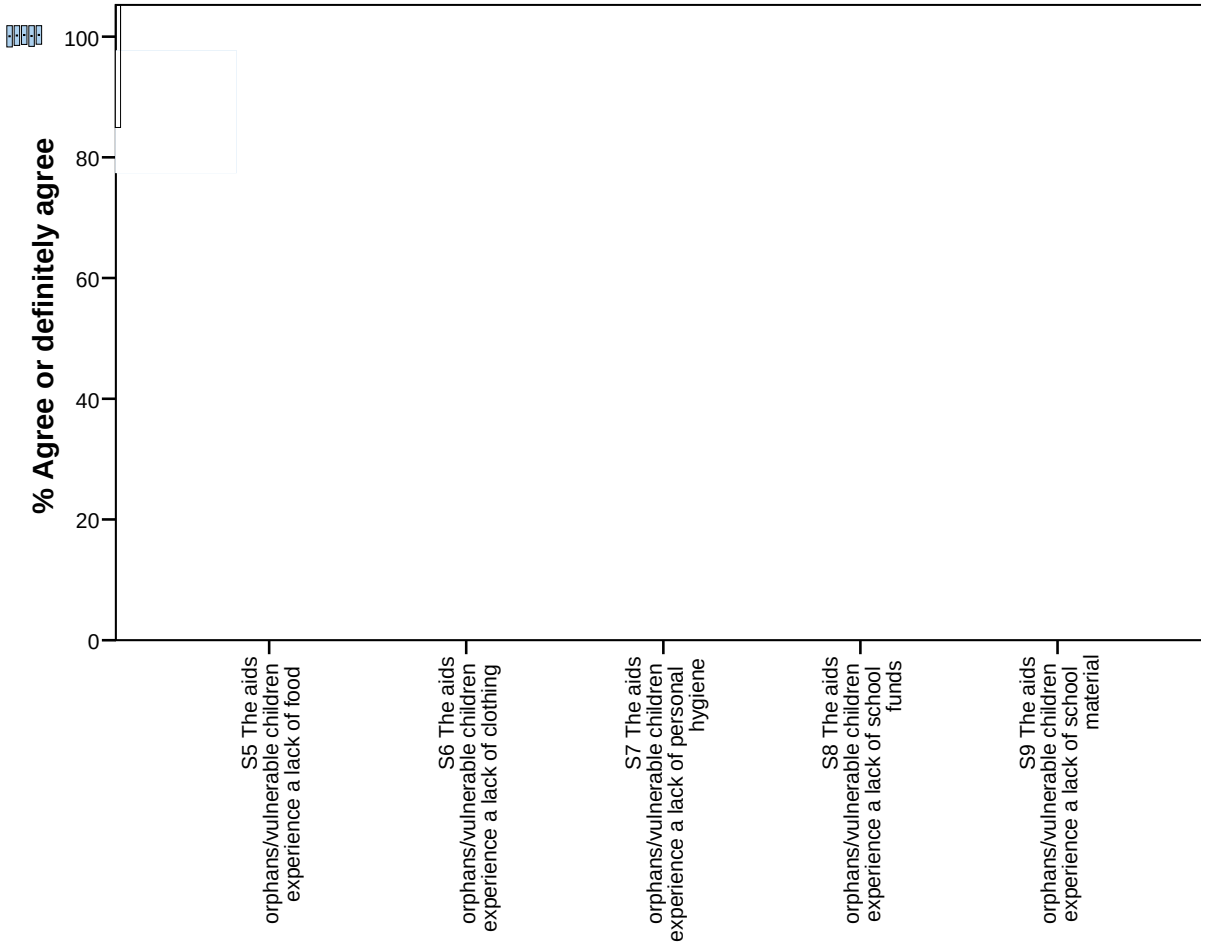
More than 80% of teachers agree that lack of school material is a problem.

It is evident from Tables 6.5, 6.6, 6.7, 6.8 and 6.9 that HIV/AIDS orphans/vulnerable children experience the following problems:

- ✓ Lack of food;
- ✓ Lack of clothing;
- ✓ Lack of personal hygiene;
- ✓ Lack of school fund; and
- ✓ Lack of school materials.

Statements 5 to 9 relate to the children's physical needs, particularly the lack thereof. The responses to the 5 statements are displayed in the following bar chart.

Fig. 6.1: Children's physical needs



Statement 10: The HIV/AIDS orphans/vulnerable children experience a need for psychological support services

The frequencies are as shown in Table 6.10

Table 6.10: Psychological support services

Need for psychological support		Frequency	Percent
Valid	Definitely disagree	1	.8
	Disagree	1	.8
	Agree	37	31.4
	Definitely agree	79	66.9
	Total	118	100.0
Missing		2	
Total		120	

Close on 100% of teachers identify a need for psychological support.

Statement 11: The HIV/AIDS orphans/vulnerable children experience a need for security

The frequencies are shown below.

Table 6.11: Children's security

Need for security		Frequency	Percent
	Definitely disagree	50	42.4
	Disagree	53	44.9
	Agree	13	11.0
	Definitely agree	2	1.7
	Total	118	100.0
Missing		2	
Total		120	

More than 87% of the teachers believe that a need for security is not a problem.

Statement 12: The HIV/AIDS orphans/vulnerable children experience a lack of acceptance by others

The frequencies are shown in Table 6.12.

Table 6.12: Lack of acceptance by others

Lack of acceptance		Frequency	Percent
	Definitely disagree	39	33.3
	Disagree	44	37.6
	Agree	27	23.1
	Definitely agree	7	6.0
	Total	117	100.0
Missing		3	
Total		120	

Only about 30% of teachers believe that there is a lack of acceptance.

Statement 13: The HIV/AIDS orphans/vulnerable children experience a need for dealing with stress

The frequencies are as indicated below.

Table 6.13: Dealing with stress

Dealing with stress		Frequency	Percent
	Definitely disagree	51	44.0
	Disagree	54	46.6
	Agree	10	8.6
	Definitely agree	1	.9
	Total	116	100.0
Missing		4	
Total		120	

This does not seem to be a problem, as more than 90% of the teachers disagree.

Statement 14: The HIV/AIDS orphans/vulnerable children experience a need for managing their fears

The frequencies are indicated in Table 6.14

Table 6.14: Managing fear

Managing fears		Frequency	Percent
	Definitely disagree	43	36.8
	Disagree	66	56.4
	Agree	5	4.3
	Definitely agree	3	2.6
	Total	117	100.0
Missing		3	
Total		120	

More than 93% of the teachers believe this is not a problem.

The responses to Statements 10 to 14 are illustrated in the Fig. 6.2.

Fig.6.2: Psychological needs

Psychological support services appear to be the main need of the children, according to the teachers.

Statement 15: The HIV/AIDS orphans/vulnerable children manifest inability to explore

The frequencies are as follows.

Table 6.15: Inability to explore

Inability to explore		Frequency	Percent
	Definitely disagree	27	23.5
	Disagree	62	53.9
	Agree	25	21.7
	Definitely agree	1	.9
	Total	115	100.0
Missing		5	
Total		120	

Only 22.6% of the teachers see this as a problem.

Statement 16: The HIV/AIDS orphans/vulnerable children manifest an inability to make choices

The frequencies are indicated in the table below.

Table 6.16: Inability to make choices

Inability to make choices		Frequency	Percent
	Definitely disagree	31	26.7
	Disagree	58	50.0
	Agree	27	23.3
	Total	116	100.0
Missing		4	
Total		120	

Only 23.3% of the teachers see this as a problem.

Statement 17: The Psychological needs of HIV/AIDS orphans/vulnerable children manifest excessive stress

The frequencies are indicated in the table below.

Table 6.17: Manifestation of stress

Excessive stress		Frequency	Percent
	Definitely disagree	45	38.8
	Disagree	45	38.8
	Agree	26	22.4
	Total	116	100.0
Missing		4	
Total		120	

Only 22.4% of the teachers see this as a problem.

Statement 18: The HIV/AIDS orphans/vulnerable children experience behavioural problems

The frequencies are as shown in Table 6.18.

Table 6.18: Behavioural problem

Behavioural problems		Frequency	Percent
	Definitely disagree	42	35.6
	Disagree	42	35.6
	Agree	31	26.3
	Definitely agree	3	2.5
	Total	118	100.0
Missing		2	
Total		120	

Slightly more, but still only 28.8% of the teachers experience such problems.

Statement 19: The HIV/AIDS orphans/vulnerable children experience aggression

The frequencies are as shown in Table 6.19

Table 6.19: Aggression

Aggression		Frequency	Percent
	Definitely disagree	45	38.1
	Disagree	44	37.3
	Agree	28	23.7
	Definitely agree	1	.8
	Total	118	100.0
Missing		2	
Total		120	

Only 24.5% of the teachers are of the opinion that these children display aggression.

Statement 20: The HIV/AIDS orphans/vulnerable children experience feelings of helplessness

The frequencies are as indicated in the table below.

Table 6.20: Feelings of helplessness

Feelings of helplessness		Frequency	Percent
	Definitely disagree	48	40.7
	Disagree	59	50.0
	Agree	11	9.3
	Total	118	100.0
Missing		2	
Total		120	

Only 9.3% of the teachers see this as a problem.

Statement 21: The HIV/AIDS orphans/vulnerable children experience feelings of sadness

The frequencies are as indicated below.

Table 6.21: Feelings of sadness

	Feelings of sadness	Frequency	Percent
	Definitely disagree	69	58.5
	Disagree	38	32.2
	Agree	11	9.3
	Total	118	100.0
Missing		2	
Total		120	

Only 9.3% of the teachers have seen this to occur.

Statement 22: The HIV/AIDS orphans/vulnerable children experience feelings of depression

The frequencies are shown in Table 6.22.

Table 6.22: Feelings of depression

Feelings of depression		Frequency	Percent
	Definitely disagree	33	27.7
	Disagree	63	52.9
	Agree	19	16.0
	Definitely agree	4	3.4
	Total	119	100.0
Missing		1	
Total		120	

19.4% of the teachers have observed this.

Statement 23: The HIV/AIDS orphans/vulnerable children experience negative self-concepts

The frequencies are shown in the table below.

Table 6.23: Self-concept

Negative self-concepts		Frequency	Percent
	Definitely disagree	30	25.2
	Disagree	50	42.0
	Agree	35	29.4
	Definitely agree	4	3.4
	Total	119	100.0
Missing		1	
Total		120	

32.8% of the teachers think this is a problem.

Statement 24: The HIV/AIDS orphans/vulnerable children experience disciplinary problems

The frequencies are shown in the table below.

Table 6.24: Disciplinary problems

Disciplinary problems		Frequency	Percent
	Definitely disagree	34	28.8
	Disagree	50	42.4
	Agree	21	17.8
	Definitely agree	13	11.0
	Total	118	100.0
Missing		2	
Total		120	

28.8% of the teachers think disciplinary problems are shown by these children.

Statement 25: The HIV/AIDS orphans/vulnerable children experience stigmatization

The frequencies are indicated below.

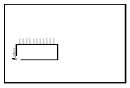
Table 6.25: Stigmatisation

Stigmatization		Frequency	Percent
	Definitely disagree	49	41.5
	Disagree	55	46.6
	Agree	13	11.0
	Definitely agree	1	.8
	Total	118	100.0
Missing		2	
Total		120	

Stigmatization was observed by only 11.8% of the teachers.

The responses to Statements 15 to 25 are illustrated in the following bar chart:

Fig. 6.3: Teachers – psychological needs



Negative self-concepts, disciplinary problems and behavioural problems are most often observed by the teachers; sadness and feelings of sadness are least observed to occur.

SECTION C

Statement 26: It is the task of the school to raise awareness of HIV/AIDS orphans/vulnerable children

The frequencies are as follows:

Table 6.26: The task of the school

School's task to raise awareness		Frequency	Percent
	Definitely disagree	3	2.5
	Disagree	3	2.5
	Agree	54	45.4
	Definitely agree	59	49.6
	Total	119	100.0
Missing		1	
Total		120	

About 95% of the teachers see this as the task of the school.

Statement 27: It is the task of the school to provide a supportive environment for orphans/vulnerable children

The frequencies are as indicated below.

Table 6.27: Supportive environment

School to provide a supportive environment		Frequency	Percent
	Definitely disagree	4	3.4
	Disagree	9	7.6
	Agree	50	42.0
	Definitely agree	56	47.1
	Total	119	100.0
Missing		1	
Total		120	

Almost 90% of the teachers see this as the task of the school.

Statement 28: I am able to fulfil the psychological needs of orphans/vulnerable children

The frequencies are as shown in the table below.

Table 6.28: Fulfilment of psychological needs

Fulfil the psychological needs		Frequency	Percent
	Definitely disagree	11	9.3
	Disagree	21	17.8
	Agree	72	61.0
	Definitely agree	14	11.9
	Total	118	100.0
Missing		2	
Total		120	

About 73% of the teachers believe they are able to fulfil such needs,

Statement 29: The school runs a programme to address the needs of orphans/vulnerable children

The frequencies are as shown in the table below.

Table 6.29: School programme

School programme to address the needs		Frequency	Percent
	Definitely disagree	35	29.9
	Disagree	21	17.9
	Agree	54	46.2
	Definitely agree	7	6.0
	Total	117	100.0
Missing		3	
Total		120	

Just over half (52.2%) of the teachers say that their school runs such a programme.

Statement 30: There is a difference between the socio-cultural needs of my school community and that of other cultural groups

The frequencies are shown in the table below.

Table 6.30: Socio-cultural needs

Difference between socio-cultural needs		Frequency	Percent
	Definitely disagree	2	1.7
	Disagree	24	20.3
	Agree	69	58.5
	Definitely agree	23	19.5
	Total	118	100.0
Missing		2	
Total		120	

78% of the teachers believe there is such a difference.

Statement 31: I take effort to guide orphans/vulnerable children to responsible adulthood (transfer norms and values)

The frequencies are shown in the table below.

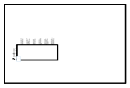
Table 6.31: Transfer of norms and values

Effort to guide		Frequency	Percent
	Definitely disagree	3	2.7
	Disagree	31	27.7
	Agree	50	44.6
	Definitely agree	28	25.0
	Total	112	100.0
Missing		8	
Total		120	

Almost 70% of the teachers claim that they make such an effort.

The responses to Statements 26 to 31 are illustrated in the following bar chart:

Fig. 6.4: Perceptions of teachers on the role of the school



The teachers are of opinion that the most important tasks of the school are to raise awareness and to provide a supportive environment. Just over 50% of teachers believe that their school runs a programme to address the needs of the children.

PART 2. Factor analysis

Factor analysis was performed on the responses to the Statements 5 to 31. The following factors were identified:

FACTOR A: Statements 6, 7 and 8

S6 The aids orphans/vulnerable children experience a lack of clothing

S7 The aids orphans/vulnerable children experience a lack of personal hygiene

S8 The aids orphans/vulnerable children experience a lack of school funds

Reliability

The Cronbach Alpha is a measure of the reliability (internal consistency) of the replies supplied by the teachers.

Reliability Statistics

Cronbach's Alpha	N of Items
.876	3

A value above 0.8 is regarded as very reliable.

FACTOR B: Statements 9 and 10

S9 The aids orphans/vulnerable children experience a lack of school material

S10 The aids orphans/vulnerable children experience a need for psychological support services

It is not usual to calculate Cronbach's Alpha for only two items. The correlation coefficient between Statements 9 and 10 is as follows:

Table 6.32: Pearson Correlation Statement 9 and 10

		S9 The aids orphans/vulnerable children experience a lack of school material	S10 The aids orphans/vulnerable children experience a need for psychological support services
S9 The aids orphans/vulnerable children experience a lack of school material	Pearson Correlation	1	.505(**)
	Sig. (2-tailed)		.000
	N	119	118
S10 The aids orphans/vulnerable children experience a need for psychological support services	Pearson Correlation	.505(**)	1
	Sig. (2-tailed)	.000	
	N	118	118

** Correlation is significant at the 0.01 level (2-tailed).

The correlation coefficient 0f 0.505 is significant at the 1% level of significance.

FACTOR C: Statements 11, 12, 14, 15, 16 and 17

S11 The aids orphans/vulnerable children experience a need for security

S12 The aids orphans/vulnerable children experience a lack of acceptance by others

S14 The aids orphans/vulnerable children experience a need for managing their fears

S15 The aids orphans/vulnerable children manifest inability to explore

S16 The aids orphans/vulnerable children manifest an inability to make choices

S17 The aids orphans/vulnerable children manifest excessive stress

The reliability measure is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.817	6

The Cronbach Alpha, which is larger than 0.8, indicates that Factor C is measured reliably.

FACTOR D: Statements 12, 18, 19, 23 and 24

S12 The aids orphans/vulnerable children experience a lack of acceptance by others

S18 The aids orphans/vulnerable children experience behavioural problems

S19 The aids orphans/vulnerable children experience aggression

S23 The aids orphans/vulnerable children experience negative self-concepts

S24 The aids orphans/vulnerable children experience disciplinary problems

The reliability measure is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.881	5

A Cronbach Alpha of larger than 0.8 indicates that the factor was measured reliably.

FACTOR E: Statements 20, 21, 22, 23 and 25

S20 The aids orphans/vulnerable children experience feelings of helplessness

S21 The aids orphans/vulnerable children experience feelings of sadness

S22 The aids orphans/vulnerable children experience feelings of depression

S23 The aids orphans/vulnerable children experience negative self-concepts

S25 The aids orphans/vulnerable children experience stigmatisation

The reliability measure is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.859	5

The Cronbach Alpha of larger than 0.8 indicated that Factor E was reliably measured.

FACTOR F: Statements 26, 27, 28, 29, 30 and 31

S26 It is the task of the school to raise awareness of orphans/vulnerable children

S27 It is the task of the school to provide a supportive environment for orphans/vulnerable children

S28 I am able to fulfil the psychological needs of orphans/vulnerable children

S29 The school runs a programme to addresss the needs of orphans/vulnerable children

S30 There is a difference between the socio-cultural needs of my school community and that of other cultural groups

S31 I take effort to guide orphans/vulnerable children to responsible adulthood (transfer norms and values)

The reliability measure is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.631	6

At more than 0.6 the Cronbach Alpha indicates reasonable reliability.

Calculation of factors

For each respondent (teacher) the factors A to F were calculated as a mean of the responses to the Statements incorporated into each Factor. A value of 2.5 indicates that the respondent agreed and disagreed equally often with the statements making up the factor. A value of more than 2.5 means agreement more often than disagreement, and a value less than 2.5 indicates disagreement more than agreement.

The overall descriptive statistics are as follows:

Table 6. 33: Descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Factor A	117	1.00	4.00	3.2165	.71293
Factor B	118	1.00	4.00	3.3517	.54030
Factor C	113	1.00	3.33	1.8097	.51170
Factor D	116	1.00	3.60	2.0069	.71259
Factor E	117	1.00	3.20	1.7915	.57559
Factor F	108	1.67	3.83	2.9599	.46857
Valid N (listwise)	101				

In the case of A, B and F there was more agreement than disagreement; in the case of Factors C, D and E there was more disagreement than agreement.

Group comparisons

The next step is to relate the factors to the biographic information.

Question 1: In which phase are you teaching?

The descriptive statistics per group are as follows:

Table 6.34: Teaching phase - Foundation

		N	Mean	Std. Deviation	Minimum	Maximum
Factor A	Foundation phase	45	3.1037	.70289	1.00	4.00
	Intermediate phase	72	3.2870	.71493	1.00	4.00
	Total	117	3.2165	.71293	1.00	4.00
Factor B	Foundation phase	46	3.3696	.58152	1.00	4.00
	Intermediate phase	72	3.3403	.51612	2.50	4.00
	Total	118	3.3517	.54030	1.00	4.00
Factor C	Foundation phase	42	1.8651	.50638	1.00	3.00
	Intermediate phase	71	1.7770	.51559	1.00	3.33
	Total	113	1.8097	.51170	1.00	3.33
Factor D	Foundation phase	45	2.1156	.66945	1.20	3.40
	Intermediate phase	71	1.9380	.73492	1.00	3.60
	Total	116	2.0069	.71259	1.00	3.60
Factor E	Foundation phase	46	1.8522	.63866	1.00	3.20
	Intermediate phase	71	1.7521	.53181	1.00	2.80
	Total	117	1.7915	.57559	1.00	3.20
Factor F	Foundation phase	39	2.9316	.55767	1.67	3.83
	Intermediate phase	69	2.9758	.41349	2.00	3.83
	Total	108	2.9599	.46857	1.67	3.83

The ANOVA showed no significant differences:

Table 6.35: Teaching phase – Intermediate

		Sum of Squares	df	Mean Square	F	P-value
Factor A	Between Groups	.931	1	.931	1.845	.177
	Within Groups	58.028	115	.505		
	Total	58.959	116			
Factor B	Between Groups	.024	1	.024	.082	.775
	Within Groups	34.131	116	.294		
	Total	34.155	117			
Factor C	Between Groups	.205	1	.205	.780	.379
	Within Groups	29.121	111	.262		
	Total	29.326	112			
Factor D	Between Groups	.868	1	.868	1.720	.192
	Within Groups	57.526	114	.505		
	Total	58.394	115			
Factor E	Between Groups	.279	1	.279	.842	.361
	Within Groups	38.152	115	.332		
	Total	38.431	116			
Factor F	Between Groups	.049	1	.049	.220	.640
	Within Groups	23.444	106	.221		
	Total	23.493	107			

All the P-values are larger than 0.1, which means that there are no significant differences between the means of teachers who are teaching at the foundation and intermediate phases.

Question 2: Indicate your qualification

There are too many categories with small frequencies for a sensible ANOVA to be performed.

Question 3: Did your training provided for enough knowledge on how to support orphans and vulnerable children?

The descriptive statistics are as follows:

Table 6.36: Basic training

		N	Mean	Std. Deviation	Minimum	Maximum
Factor A	Yes	48	3.2847	.50524	1.33	4.00
	No	67	3.1642	.83761	1.00	4.00
	Total	115	3.2145	.71763	1.00	4.00
Factor B	Yes	47	3.3617	.42608	2.50	4.00
	No	69	3.3406	.61532	1.00	4.00
	Total	116	3.3491	.54462	1.00	4.00
Factor C	Yes	47	1.9823	.51691	1.17	3.33
	No	65	1.6846	.47792	1.00	2.67
	Total	112	1.8095	.51400	1.00	3.33
Factor D	Yes	47	2.4213	.74277	1.00	3.60
	No	68	1.7000	.49776	1.00	3.00
	Total	115	1.9948	.70361	1.00	3.60
Factor E	Yes	48	2.0958	.59357	1.00	3.20
	No	67	1.5701	.45958	1.00	2.60
	Total	115	1.7896	.57908	1.00	3.20
Factor F	Yes	45	2.9185	.48672	1.67	3.83
	No	62	2.9866	.45996	2.00	3.83
	Total	107	2.9579	.47034	1.67	3.83

The ANOVA results are as follows:

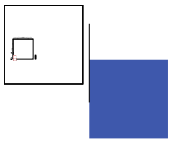
Table 6.37: Basic training – ANOVA

		Sum of Squares	df	Mean Square	F	P-value
Factor A	Between Groups	.406	1	.406	.788	.377
	Within Groups	58.303	113	.516		
	Total	58.709	114			
Factor B	Between Groups	.012	1	.012	.042	.839
	Within Groups	34.097	114	.299		
	Total	34.110	115			
Factor C	Between Groups	2.417	1	2.417	9.879	.002
	Within Groups	26.909	110	.245		
	Total	29.325	111			
Factor D	Between Groups	14.458	1	14.458	38.919	.000
	Within Groups	41.979	113	.371		
	Total	56.437	114			
Factor E	Between Groups	7.728	1	7.728	28.632	.000
	Within Groups	30.499	113	.270		
	Total	38.227	114			
Factor F	Between Groups	.121	1	.121	.543	.463
	Within Groups	23.329	105	.222		
	Total	23.450	106			

In the case of Factors A, B and F the group differences are not significant, because the P-values are larger then 0.1. On the case of Factors C, D and E the differences are significant at the 1% level of significance, since the P-values are less than 0.01. In Factors C, D and E the teachers who said “Yes, my training provided for enough knowledge on how to support orphans and vulnerable children” scored higher means, i.e. the agreed more with the statements making up Factors C, D and E, compared to teachers who said “No, my training did not provide for enough knowledge on how to support orphans and vulnerable children”

The bar chart illustrates this.

Fig. 6.5: Basic training of teachers



Question 4: Do you provide special support to these children?

The descriptive statistics are as follows:

Table 6.38: Provision of special support

		N	Mean	Std. Deviation	Minimum	Maximum
Factor A	Yes	81	3.1770	.75661	1.00	4.00
	No	35	3.2952	.60914	1.00	4.00
	Total	116	3.2126	.71478	1.00	4.00
Factor B	Yes	80	3.4438	.44290	2.00	4.00
	No	35	3.1286	.68966	1.00	4.00
	Total	115	3.3478	.54682	1.00	4.00
Factor C	Yes	76	1.8487	.54309	1.00	3.33
	No	34	1.6814	.41106	1.00	2.33
	Total	110	1.7970	.51003	1.00	3.33
Factor D	Yes	79	2.0759	.74854	1.00	3.60
	No	34	1.7588	.52288	1.00	3.00
	Total	113	1.9805	.70151	1.00	3.60
Factor E	Yes	80	1.8400	.60913	1.00	3.20
	No	34	1.6294	.46484	1.00	2.60
	Total	114	1.7772	.57608	1.00	3.20
Factor F	Yes	75	3.0489	.47755	1.67	3.83
	No	31	2.7473	.38699	2.00	3.50
	Total	106	2.9607	.47171	1.67	3.83

The ANOVA results are as follows:

Table 6.39: Provision of special support – ANOVA

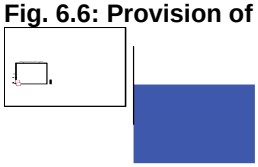
		Sum of Squares	df	Mean Square	F	P-value
Factor A	Between Groups	.342	1	.342	.667	.416
	Within Groups	58.413	114	.512		
	Total	58.755	115			
Factor B	Between Groups	2.419	1	2.419	8.630	.004
	Within Groups	31.668	113	.280		
	Total	34.087	114			
Factor C	Between Groups	.658	1	.658	2.564	.112
	Within Groups	27.697	108	.256		
	Total	28.355	109			
Factor D	Between Groups	2.391	1	2.391	5.032	.027
	Within Groups	52.727	111	.475		
	Total	55.117	112			
Factor E	Between Groups	1.058	1	1.058	3.252	.074
	Within Groups	36.443	112	.325		
	Total	37.501	113			
Factor F	Between Groups	1.995	1	1.995	9.709	.002
	Within Groups	21.369	104	.205		
	Total	23.364	105			

In the case of Factors A and C there is no significant difference between the means. In the case of Factor E the difference is significant at the 10% level (P-value less than 0.1) and in the case of Factors B, D and F the difference is significant at the 5% level of significance (P-values less than 0.05).

In the case of teachers who said “Yes, I provide special support to these children” the mean of Factors B, D, E and F were higher than the means of teachers who said “No, I do not provide special support to these children”. This means that teachers who said “Yes” to this question, agreed more with the statements making up Factors B, D, E and F than teachers who said “No” did.

The bar chart below (Fig. 6.6) illustrates this:

Fig. 6.6: Provision of special support



6.3.2. PART 2. Summary of responses - Orphans

A BIOGRAPHICAL INFORMATION

1 Grade of child

The frequencies are as follows:

Table 6.40: Biographical information

		Frequency	Percent
	Grade 1	23	9.3
	Grade 2	45	18.2
	Grade 3	51	20.6
	Grade 4	52	21.1
	Grade 5	35	14.2
	Grade 6	33	13.4
	Grade 7	8	3.2
	Total	247	100.0
Missing		3	
Total		250	

The highest frequencies are Grades 3 and 4, the lowest in Grade 7 and the next lowest in Grade 1. The pie chart illustrates this.

Fig. 6.7: Biographical information - learners

2 Number of siblings

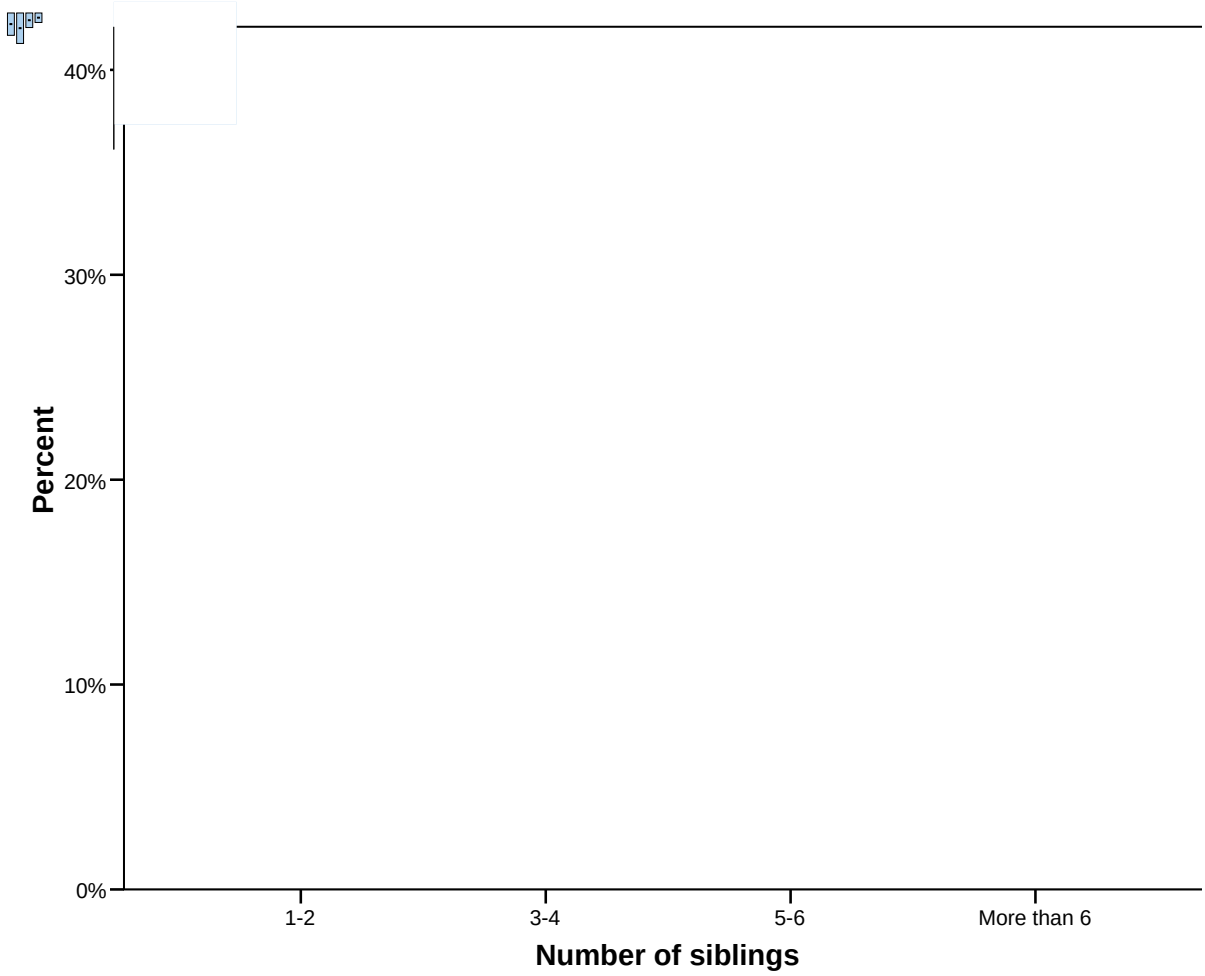
The frequencies are as follows:

Table 6.41: Number of siblings

		Frequency	Percent
	1-2	66	29.1
	3-4	90	39.6
	5-6	43	18.9
	More than 6	28	12.3
	Total	227	100.0
Missing		23	
Total		250	

The highest frequency relates to 3-4 siblings. The bar chart illustrates this.

Fig. 6.8: Number of siblings



3 If child has younger siblings

The frequencies are as follows:

Table 6.42: Younger siblings

		Frequency	Percent
	Yes	128	57.4
	No	95	42.6
	Total	223	100.0
Missing		27	
Total		250	

More than half of the respondents had younger siblings.

4 Does the child have a birth certificate?

The frequencies are as follows:

Table 6.43: Birth certificates

		Frequency	Percent
	Yes	201	90.1
	No	22	9.9
	Total	223	100.0
Missing		27	
Total		250	

Most of the orphans have a birth certificate.

5 Does the child have death certificates for parents?

The frequencies are as follows:

Table 6.43: Death certificates

		Frequency	Percent
	Yes	136	65.1
	No	73	34.9
	Total	209	100.0
Missing		41	
Total		250	

About two-thirds of the orphans have death certificates for their parents.

6 What grant does the child receive?

The frequencies are as follows:

Table 6.44: Child's grant

		Frequency	Percent
	Children's grant - R190 per child per month	122	56.7
	Foster grant - R550 per child per month	20	9.3
	None	73	34.0
	Total	215	100.0
Missing		35	
Total		250	

Most of the orphans receive the children's grant, while about one-third receive no grant. Very few receive a foster grant. The pie chart illustrates this.

Fig. 6.9: Children receiving grant

7 Who is taking care of the child?

The frequencies are as follows:

Table 6.45: Child care

		Frequency	Percent
	Grand parent	114	49.6
	Foster parent/family	83	36.1
	Older brother/sister	32	13.9
	Social worker/community worker	1	0.4
	Total	230	100.0
Missing		20	
Total		250	

Grandparents are most often responsible, followed by foster parents. The pie chart illustrates this.

Fig. 6.10: Child's caretaker

9 Does the child ever visit a clinic?

The frequencies are as follows:

Table 6.46: Clinic visitation

		Frequency	Percent
	Yes	198	85.7
	No	33	14.3
	Total	231	100.0
Missing		19	
Total		250	

The majority of children do visit a clinic.

10 Does the child attend church services?

The frequencies are as follows:

Table 6.47: Church services

		Frequency	Percent
	Every week	130	56.8
	Every two weeks	25	10.9
	Once a month	6	2.6
	Very seldom	45	19.7
	Never	23	10.0
	Total	229	100.0
Missing		21	
Total		250	

The majority of children go to church, most of them every week. The pie chart illustrates this.

Fig. 6.11: Church attendance

SECTION B PSYCHO-SOCIAL WELL BEING

Self perception

11 To what extent do you wish to become a grown up yourself?

The frequencies are as follows:

Table 6.48: I want to become a grown up

		Frequency	Percent
	Definitely disagree	6	2.6
	Disagree	5	2.2
	Agree	36	15.6
	Definitely agree	184	79.7
	Total	231	100.0
Missing		19	
Total		250	

Most of the children want to become grownups.

12 To what extent are you able to complete tasks?

The frequencies are as follows:

Table 6.49: I can complete tasks

		Frequency	Percent
	Definitely disagree	15	6.5
	Disagree	28	12.2
	Agree	124	53.9
	Definitely agree	63	27.4
	Total	230	100.0
Missing		20	
Total		250	

Most children believe that they can complete tasks, but they are more inclined to say "agree" than 'definitely agree".

13 To what extent are you able to cope with your present situation?

The frequencies are as follows:

Table 6.50: I cope with my present situation

		Frequency	Percent
	Definitely disagree	25	10.9
	Disagree	47	20.5
	Agree	112	48.9
	Definitely agree	45	19.7
	Total	229	100.0
Missing		21	
Total		250	

Most children believe that they can cope.

14 To what extent do you blame yourself for your parents' death?
The frequencies are as follows:

Table 6.51: I blame myself for my parents' death

		Frequency	Percent
	Definitely disagree	77	34.7
	Disagree	83	37.4
	Agree	35	15.8
	Definitely agree	27	12.2
	Total	222	100.0
Missing		28	
Total		250	

Most children do not blame themselves (although about 28% do blame themselves).

15 To what extent do you have hope for the future?

The frequencies are as follows:

Table 6.52: I have hope for my future

		Frequency	Percent
	Definitely disagree	9	4.0
	Disagree	11	4.9
	Agree	105	46.7
	Definitely agree	100	44.4
	Total	225	100.0
Missing		25	
Total		250	

The majority (more than 91%) say that they have hope for their future.

16 To what extent do you think you can influence your future?
The frequencies are as follows:

Table 6.53: I can influence my future

		Frequency	Percent
	Definitely disagree	9	4.0
	Disagree	40	17.9
	Agree	106	47.3
	Definitely agree	69	30.8
	Total	224	100.0
Missing		26	
Total		250	

Almost 80% of the children believe they can influence their future.

17 To what extent does the church play a role in your happiness?

The frequencies are as follows:

Table 6.54: The church plays a role in my happiness

		Frequency	Percent
	Definitely disagree	20	8.8
	Disagree	27	11.9
	Agree	97	42.9
	Definitely agree	82	36.3
	Total	226	100.0
Missing		24	
Total		250	

79.2% of children believe the church plays a role in their happiness.

18 To what extent are you happy about the future?

The frequencies are as follows:

Table 6.55: I am happy about the future

		Frequency	Percent
	Definitely disagree	10	4.4
	Disagree	29	12.8
	Agree	107	47.3
	Definitely agree	80	35.4
	Total	226	100.0
Missing		24	
Total		250	

82.7% of the children are happy about the future.

19 To what extent are you afraid in unfamiliar situations?

The frequencies are as follows:

Table 6.56: I am afraid in unfamiliar situations

		Frequency	Percent
	Definitely disagree	22	9.7
	Disagree	60	26.4
	Agree	73	32.2
	Definitely agree	72	31.7
	Total	227	100.0
Missing		23	
Total		250	

Almost one-third of the children say that they are afraid in unfamiliar situations.

20 To what extent are you angry with your situation?

The frequencies are as follows:

Table 6.57: I am angry with my situation

		Frequency	Percent
	Definitely disagree	20	8.8
	Disagree	81	35.7
	Agree	60	26.4
	Definitely agree	66	29.1
	Total	227	100.0
Missing		23	
Total		250	

Just over half of the children (55.5%) say that they are angry about their situation.

21 To what extent do other people understand your feelings?

The frequencies are as follows:

Table 6.58: Other people understand my feelings

		Frequency	Percent
	Definitely disagree	25	10.9
	Disagree	52	22.7
	Agree	94	41.0
	Definitely agree	58	25.3
	Total	229	100.0
Missing		21	
Total		250	

About one-third of the children believe that other people understand their feelings.

22 To what extent do you talk about your grief and sorrow with other people?

The frequencies are as follows:

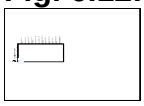
Table 6.59: I talk about my grief and sorrow with other people

		Frequency	Percent
	Definitely disagree	63	28.1
	Disagree	52	23.2
	Agree	63	28.1
	Definitely agree	46	20.5
	Total	224	100.0
Missing		26	
Total		250	

Less than half the children (48.6%) say they talk about it to other people.

The responses to the self-perception statements (11 to 22) are summarized in the following bar chart.

Fig. 6.12: Self-perception



The highest level of agreement was with Statement 11 and the lowest level with Statement 14. This implies that HIV/AIDS orphans/vulnerable children are optimistic about their future. Children do not blame themselves for their parents death.

Values

23 To what extent are you experiencing an inner feeling of satisfaction/happiness (compassionate)?

The frequencies are as follows:

Table 6.60: I experience an inner feeling of happiness

		Frequency	Percent
	Definitely disagree	35	15.2
	Disagree	49	21.3
	Agree	81	35.2
	Definitely agree	65	28.3
	Total	230	100.0
Missing		20	
Total		250	

Almost two-thirds (63.5%) of children say they experience an inner feeling of happiness.

24 To what extent are you taking care of yourself?

The frequencies are as follows:

Table 6.61: I am taking care of myself

		Frequency	Percent
	Definitely disagree	22	9.5
	Disagree	33	14.3
	Agree	100	43.3
	Definitely agree	76	32.9
	Total	231	100.0
Missing		19	
Total		250	

The majority of children (76.2%) say they take care of themselves.

25 To what extent are you caring about others?

The frequencies are as follows:

Table 6.62: I take care of other people

		Frequency	Percent
	Definitely disagree	45	19.5
	Disagree	41	17.7
	Agree	90	39.0
	Definitely agree	55	23.8
	Total	231	100.0
Missing		19	
Total		250	

Almost two-thirds (62.8%) say that they take care of others.

26 To what extent are you sharing love/feelings with other?

The frequencies are as follows:

Table 6.63: I share my feelings with others

		Frequency	Percent
	Definitely disagree	52	22.6
	Disagree	44	19.1
	Agree	94	40.9
	Definitely agree	40	17.4
	Total	230	100.0
Missing		20	
Total		250	

Just over 50% of children share their feelings with others.

27 To what extent do you consider the wishes of others?

The frequencies are as follows:

Table 6.64: I consider the wishes of others

		Frequency	Percent
	Definitely disagree	16	7.0
	Disagree	30	13.0
	Agree	117	50.9
	Definitely agree	67	29.1
	Total	230	100.0
Missing		20	
Total		250	

About 80% of children say they consider the wishes of others.

28 To what extent do you respect others?

The frequencies are as follows:

Table 6.65: I respect other people

		Frequency	Percent
	Definitely disagree	4	1.7
	Disagree	10	4.3
	Agree	137	59.6
	Definitely agree	79	34.3
	Total	230	100.0
Missing		20	
Total		250	

About 90% of children say they respect other people.

29 To what extent do take responsibility for others/the community?

The frequencies are as follows:

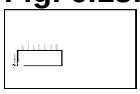
Table 6.66: I take responsibility for other people in the community

		Frequency	Percent
	Definitely disagree	56	24.2
	Disagree	55	23.8
	Agree	91	39.4
	Definitely agree	29	12.6
	Total	231	100.0
Missing		19	
Total		250	

About 52% of children say they take such responsibility.

The responses to the questions about values (Questions 23 to 29) are illustrated in the following graph:

Fig. 6.13: Values



The highest level of agreement was with Statement 28 and the lowest with 29. This implies HIV/AIDS orphans/vulnerable children have good interpersonal relationships. The majority of them indicated that they respect other people

Risk factors

30 To what extent do people think you are different because you don't have parents? The frequencies are as follows.

Table 6. 67: People think I am different because I don't have parents

		Frequency	Percent
Valid	Definitely disagree	41	17.8
	Disagree	74	32.2
	Agree	57	24.8
	Definitely agree	58	25.2
	Total	230	100.0
Missing		20	
Total		250	

About 50% of children say that people think they are different because they do not have parents.

31 To what extent do you want to keep it a secret that you do not have parent? The frequencies are as follows:

Table 6.68: I prefer to keep it secret that I do not have parents

		Frequency	Percent
Valid	Definitely disagree	49	21.5
	Disagree	66	28.9
	Agree	38	16.7
	Definitely agree	75	32.9
	Total	228	100.0
Missing		22	
Total		250	

Close to half (48.6%) of children would prefer to keep it a secret.

32 To what extent do you feel insecure/lost because you do not have parents?

The frequencies are as follows:

Table 6.69: I feel lost because I do not have parents

		Frequency	Percent
	Definitely disagree	27	11.9
	Disagree	92	40.7
	Agree	54	23.9
	Definitely agree	53	23.5
	Total	226	100.0
Missing		24	
Total		250	

Almost half (47.4%) of children say they feel lost.

33 To what extent are you afraid that you will be removed from your home?

The frequencies are as follows:

Table 6.70: I am afraid that I will be removed from my home

		Frequency	Percent
	Definitely disagree	39	17.2
	Disagree	84	37.0
	Agree	42	18.5
	Definitely agree	62	27.3
	Total	227	100.0
Missing		23	
Total		250	

Slightly less than half (45.8%) of children are afraid that they will be removed from their home.

34 To what extent are you still grieving about the death of your parents

The frequencies are as follows:

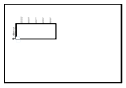
Table 6.71: I am still grieving about the death of my parents

		Frequency	Percent
	Definitely disagree	33	14.6
	Disagree	56	24.8
	Agree	54	23.9
	Definitely agree	83	36.7
	Total	226	100.0
Missing		24	
Total		250	

Over 60% (60.6%) of children are still grieving for their parents.

The responses to the statements about risk factors are illustrated in the bar chart.

Fig. 6.14: Risk factors



The highest level of agreement is with Statement 34. It is evident from Fig. 6.14 that the majority of HIV/AIDS orphans/vulnerable children grief about the death of their parents.

Factor analysis

Factor analysis of the responses to the 34 statements identified two factors:

Factor 1: Statements 12, 15, 16, 18, 21, 22, 23, 24, 25, 26, 27, 28 and 29:

12 To what extent are you able to complete tasks?
15 To what extent do you have hope for the future?
16 To what extent do you think you can influence your future?
18 To what extent are you happy about the future?
21 To what extent do other people understand your feelings?
22 To what extent do you talk about your grief and sorrow with other people?
23 To what extent are you experiencing an inner feeling of satisfaction/happiness (compassionate)?
24 To what extent are you taking care of yourself?
25 To what extent are you caring about others?
26 To what extent are you sharing love/feelings with other?
27 To what extent do you consider the wishes of others?
28 To what extent do you respect others?
29 To what extent do take responsibility for others/the community?

The statements that make up Factor 1 are positive statements, i.e. a child who agrees with these statements is likely to have a positive outlook.

Factor 2: Statements 19, 20, 30, 31, 32, 33 and 34

19 To what extent are you afraid in unfamiliar situations?
20 To what extent are you angry with your situation?
30 To what extent do people think you are different because you don't have parents?
31 To what extent do you want to keep it a secret that you do not have parent?
32 To what extent do you feel insecure/lost because you do not have parents?
33 To what extent are you afraid that you will be removed from your home?
34 To what extent are you still grieving about the death of your parents

A child who agrees with the statements that make up Factor 2 is likely to have a negative outlook.

Reliability analysis

Reliability is a measure of the consistency of the answers of the respondents, i.e. generally respondents who gave a low score (indicating disagreement) for statements included in a factor, also gave mostly low scores for the other statements in the factor and conversely for high scores (indicating agreement with the statements). The Cronbach Alpha is a measure of such consistency. A value of Cronbach's Alpha above 0.8 indicates good reliability of the data, and a value of above 0.6 is still acceptable.

In the case of Factor 1 the reliability is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.865	13

This means that the data relating to the 13 statements making up Factor 1 is reliable.

In the case of Factor 2 the reliability is as follows:

Reliability Statistics

Cronbach's Alpha	N of Items
.702	7

The value of 0.702 is satisfactory.

Subsequently, a score is calculated for each respondent for Factors 1 and 2, namely an average score for the items contained in each factor. A score of 3 or more for a factor indicates that the respondent generally agreed with the statements in that factor, and a score of 2 or less means that the respondent generally disagreed with the statements in the factor. A high score for Factor 1 indicates a positive attitude, and a high score for Factor 2 indicates a negative attitude.

Analysis of Variance

The Analysis of Variance (ANOVA) is a statistical test to test for significant difference between the mean scores of different groups. The means of Factor 1 and Factor 2 are now related to the biographical information (items 1 to 10 of the questionnaire).

1 Grade of child

The descriptive statistics are as follows:

Table 6.72: Grade of child - descriptive

	Grade	N	Mean	Std. Deviation	Minimum	Maximum
FACTOR1	Grade 1	21	2.7473	.47240	1.92	3.62
	Grade 2	28	2.7555	.48427	1.92	3.54
	Grade 3	42	2.7985	.58582	1.62	3.85
	Grade 4	47	2.8560	.54526	1.46	4.00
	Grade 5	33	3.0886	.41697	2.31	3.92
	Grade 6	27	3.1510	.51091	1.62	4.00
	Grade 7	8	2.0385	.50021	1.62	3.15
	Total	206	2.8637	.55340	1.46	4.00
FACTOR2	Grade 1	21	2.5374	.47144	1.43	3.71
	Grade 2	26	2.6923	.60837	1.57	3.71
	Grade 3	46	2.7981	.60277	1.57	4.00
	Grade 4	46	2.5901	.70926	1.43	4.00
	Grade 5	35	2.7020	.51783	1.71	3.86
	Grade 6	31	2.5576	.58129	1.29	3.43
	Grade 7	7	3.7347	.12853	3.57	3.86
	Total	212	2.6941	.62229	1.29	4.00

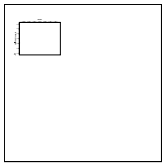
Notice that the children in Grade 7 had the lowest average score of Factor 1 (disagreed more) and the highest average score for Factor 2 (agreed more). The children in Grade 7 thus seem to have a negative attitude with respect to both factors. The ANOVA test outcome is as follows:

Table 6. 73: Grade of child - ANOVA

		Sum of Squares	df	Mean Square	F	P-value
FACTOR1	Between Groups	10.139	6	1.690	6.388	0.000004
	Within Groups	52.643	199	.265		
	Total	62.783	205			
FACTOR2	Between Groups	9.671	6	1.612	4.587	0.000216
	Within Groups	72.038	205	.351		
	Total	81.709	211			

In both cases (Factor 1 and Factor 2) the P-value is less than 0.05, which means that the difference between the means is significant at the 5% level of significance. A plot of the means shows the following:

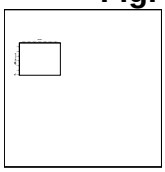
Fig. 6.15: Grade of child



The mean of Factor 1 increases with the grade, but there is a sudden drop, with a very low score for Grade 7. It must be borne in mind, however, that there were only 8 Grade

7 children in the survey. The significance of the ANOVA tests is mainly due to the difference between the mean of Grade 7 against the means of the other grades. Furthermore, this figure indicates that Grade 7 HIV/AIDS orphans/vulnerable children are less optimistic about their future. The degree of optimism of HIV/AIDS orphans/vulnerable children depends on their grades.

Fig. 6.16: Grade comparison



The main difference is the high mean score of Grade 7 compared to the other grades.

2 Number of siblings

The descriptive statistics are as follows:

Table 6.74: Number of siblings - descriptive

	No. of siblings	N	Mean	Std. Deviation	Minimum	Maximum
FACTOR1	1-2	61	2.8071	.49745	1.62	3.85
	3-4	82	2.8396	.52635	1.62	4.00
	5-6	37	2.8441	.73570	1.46	4.00
	More than 6	24	3.1506	.40226	2.31	3.77
	Total	204	2.8673	.55587	1.46	4.00
FACTOR2	1-2	61	2.6534	.65229	1.43	3.86
	3-4	84	2.6224	.57982	1.57	3.86
	5-6	41	2.7944	.69989	1.29	4.00
	More than 6	23	2.8882	.55321	1.71	3.86
	Total	209	2.6945	.62623	1.29	4.00

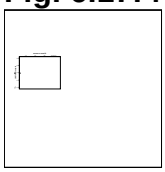
In both factors the highest mean is recorded by children with more than 6 siblings. The outcome of the ANOVA test is as follows:

Table 6.75: Number of siblings - ANOVA

		Sum of Squares	df	Mean Square	F	P-value
FACTOR1	Between Groups	2.231	3	.744	2.459	0.064
	Within Groups	60.495	200	.302		
	Total	62.726	203			
FACTOR2	Between Groups	1.811	3	.604	1.552	0.202
	Within Groups	79.759	205	.389		
	Total	81.571	208			

In the case of Factor 1 the difference is significant at the 10% level of significance (P-value less than 0.10); in the case of Factor 2 the difference is not significant (P-value larger than 0.10). In the case of Factor 1 the main difference is between the mean score of children with more than 6 siblings (who have a positive attitude on Factor 1) compared to all other children.

Fig. 6.17: Number of siblings



3 Does the child have younger siblings?

The descriptive statistics are as follows:

Table 6.76: Number of younger siblings - descriptive

	ounger siblings?	N	Mean	Std. Deviation	Minimum	Maximum
FACTOR1	Yes	115	2.8308	.58487	1.62	3.85
	No	85	2.8959	.50605	1.46	4.00
	Total	200	2.8585	.55236	1.46	4.00
FACTOR2	Yes	117	2.7851	.61463	1.43	4.00
	No	88	2.5860	.61494	1.29	3.86
	Total	205	2.6997	.62116	1.29	4.00

Those with younger siblings have a lower mean score for Factor 1 and a higher mean score for Factor 2 than those who do not have younger siblings. The outcome of the ANOVA test is as follows:

Table 6.77: Number of younger siblings - ANOVA

		Sum of Squares	df	Mean Square	F	P-value
FACTOR1	Between Groups	.208	1	.208	.679	0.411
	Within Groups	60.508	198	.306		
	Total	60.715	199			
FACTOR2	Between Groups	1.990	1	1.990	5.266	0.023
	Within Groups	76.721	203	.378		
	Total	78.711	204			

In the case of Factor 1 the difference between the means is not significant (P-value larger than 0.10) but in the case of Factor 2 the difference is significant (P-value less than 0.05) and on this scale those with younger siblings have a more positive attitude than those without younger siblings.

4 Does the child have a birth certificate?

There were no significant differences in the means of Factor 1 and Factor 2 between children who have a birth certificate and those who don't.

5 Does the child have death certificates for parents?

There were no significant differences in the means of Factor 1 and Factor 2 between children who have such a death certificate and those who don't.

6 What grant does the child receive?

The descriptive statistics are as follows:

Table 6.78: Child grant – descriptive

	Grant received	N	Mean	Std. Deviation	Minimum	Maximum
FACTOR1	Chidren's grant - R190 per child per month	107	2.7829	.57212	1.62	4.00
	Foster grant - R550 per child per month	18	3.1068	.51103	1.46	3.85
	None	66	2.9848	.52419	1.62	4.00
	Total	191	2.8832	.56033	1.46	4.00
FACTOR2	Chidren's grant - R190 per child per month	113	2.6814	.66487	1.29	3.86
	Foster grant - R550 per child per month	18	2.6270	.72038	1.71	4.00
	None	66	2.7619	.54230	1.57	4.00
	Total	197	2.7034	.63017	1.29	4.00

Those children who receive the R190 children's grant have the lowest mean on Factor 1. In Factor 2 the means are very similar.

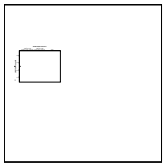
The ANOVA outcome is as follows:

Table 6.79: Child grant – ANOVA

		Sum of Squares	df	Mean Square	F	P-value
FACTOR1	Between Groups	2.659	2	1.329	4.385	0.014
	Within Groups	56.996	188	.303		
	Total	59.655	190			
FACTOR2	Between Groups	.386	2	.193	.483	0.618
	Within Groups	77.448	194	.399		
	Total	77.834	196			

In the case of Factor 1 the difference is significant (P-value less than 0.05) but in the case of Factor 2 the difference is not significant.

Fig. 6.18: Child grant



The children who receive the children' grant have the most negative attitudes, those who receive a foster grant have the most positive attitudes and those who receive none of the two are in between.

7 Who is taking care of the child?

There was no significant difference in the mean scores of factors 1 and 2 depending on who is taking care of the child.

8 Who else is taking care of the child?

No significant differences found.

9 Does the child ever visit a clinic?

The descriptive statistics are as follows:

Table 6.80: Clinic visitation - descriptive

	Visit clinic	N	Mean	Std. Deviation	Minimum	Maximum
FACTOR1	Yes	177	2.8861	.54880	1.46	4.00
	No	31	2.7370	.55781	1.62	3.85
	Total	208	2.8639	.55136	1.46	4.00
FACTOR2	Yes	181	2.6480	.63344	1.29	4.00
	No	32	2.9464	.47967	2.14	3.86
	Total	213	2.6928	.62109	1.29	4.00

The group who do visit a clinic have a higher mean for Factor 1 and a lower mean for Factor 2, i.e. they have a more positive attitude. The outcome of the ANOVA is as follows:

Table 6.81: Clinic visitation - ANOVA

		Sum of Squares	df	Mean Square	F	P-value
FACTOR1	Between Groups	.587	1	.587	1.939	0.165
	Within Groups	62.342	206	.303		
	Total	62.929	207			
FACTOR2	Between Groups	2.422	1	2.422	6.440	0.012
	Within Groups	79.357	211	.376		
	Total	81.779	212			

In the case of Factor 1 the difference is not significant (P-value larger than 0.05) but in the case of Factor 2 the difference is significant (P-value less than 0.05).

10 Does the child attend church services?

In this case there was no significant difference depending on the frequency of going to church.

6.4 CONCLUSION

Teachers as well as learners' responses accentuate that HIV/AIDS orphans/vulnerable children psychosocial status is affected by this diseases (cf. Chapter 4).

According to the researcher's perception of data analysis, teachers agreed that AIDS orphans/vulnerable children experienced lack of food, clothing, personal hygiene,

school material, and a need for psychological support services. The researcher also realised that these children experienced a need for the security, lack of acceptance by others, a need for dealing with stress, a need for managing their fears, behavioural problems, aggression, feelings of helplessness, feelings of sadness, feelings of depression, a negative self-concept, disciplinary problems, stigmatisation, manifest excessive stress, manifest inability to explore and inability to make choices.

Teachers also agreed that it is the task of the school to raise awareness, to provide a supportive environment and to run programmes to address the needs of AIDS orphans/vulnerable children. They also agreed that they are able to fulfill the psychological needs; and take effort to guide AIDS orphans/vulnerable children to responsible adulthood.

AIDS orphans/vulnerable children agree with the values and self perception factors except that they do not talk about their grief and sorrow with other people. AIDS orphans/vulnerable children disagreed with all the risk factors but they agreed that they are still grieving about the death of their parents. Some HIV/AIDS orphans/vulnerable children feel that no one cares and only God can take care of them and no one can replace their parents.

CHAPTER SEVEN

FINDINGS, CONCLUSION, LIMITATIONS, RECOMMENDATIONS, IMPLICATIONS, SUGGESTIONS, FOR FUTURE RESEARCH AND CONCLUDING REMARKS

7.1 INTRODUCTION

The most important aim of this research is to establish how the orphans' psychosocial status would be affected by HIV/AIDS. This was done by involving children who have parents with HIV/AIDS, or have died of this disease. This investigation also looked at the stressors which commonly face AIDS orphans both before and after the death of their parents and the likely psychological impact of these adversities. Questions like whether AIDS orphans are at risk for experiencing the psychosocial adjustment difficulties would be addressed.

The above problem has been investigated in-depth in the previous chapters. The purpose of this chapter was to give a synopsis of the research undertaken. For this reason it was important to recapitulate on the statement of the problem, demarcation of the field of study and the aims and method of this investigation.

The main findings from both the literature survey and the empirical research undertaken were discussed. The conclusions drawn and the limitations of the investigation then followed. Thereafter, the recommendations arising from the findings, the implications of the recommendations and the suggestions for future research are presented. Few observations made by the researcher concluded this study.

7.2 STATEMENT OF THE PROBLEM

In chapter one, the problem that the researcher was confronted with in this study, was mentioned and explained. In short, it comprised of how the orphans psychosocial status would be affected by this disease. This was done by involving children who have parents with HIV/AIDS, or have died of the disease. This investigation also looked at the stressors which commonly face AIDS orphans both before and after the death of their parents and the likely psychological impact of these adversities. Questions like whether AIDS orphans are at risk for experiencing the psychosocial adjustment difficulties were addressed.

Although the phenomenon of HIV/AIDS orphans' plight emanating from their psychosocial effects has been researched extensively, the majority of the research pertains to overseas countries. Even research undertaken in South Africa has focused mainly on HIV/AIDS and how it affects households in South Africa in general. But as yet no study has focused exclusively on the Black rural school population in South Africa. The study of the psychosocial effects facing HIV/AIDS orphans in Black communities in South Africa, where unique conditions prevail has not yet been undertaken, and this is a matter of grave and concern.

The research questions and problems to be researched in this study are formulated as follows:

- To find out what problems are experienced by HIV/AIDS orphans/vulnerable children.
- How HIV/AIDS orphans/vulnerable children are assisted psycho-socially by members of the community in the Rustenburg Area?

The second part of the problem pertains to the prevention of and intervention with regard to the psychosocial problems encountered by HIV/AIDS orphans in the Rustenburg communities, namely:

- What support systems are available in schools to assist the HIV/AIDS orphans/vulnerable children in the Rustenburg communities?

From the exposition above, it is evident that HIV/AIDS orphans experience problems, which are unique to their situations. This research seeks to highlight the problems orphans could encounter and how those problems can be minimised. With this research, the researcher shall have gathered information that could hopefully be of help in addressing the psychosocial problems encountered by HIV/AIDS orphans. For the sake of this research therefore, the following questions need also to be investigated:

- What should educators, teachers, grandparents, community members and older siblings taking care of AIDS orphans, know to support these children on a psychosocial level?

- Are teachers aware of the presence and problems experienced by HIV/AIDS orphans/vulnerable children in their schools?

- What support systems are needed for HIV/AIDS orphans/vulnerable children?

- Do the teachers understand the needs and or implications of orphan-hood's psychosocial effect?

- Do the teachers accept or reject orphans within the school?

- Are the teachers knowledgeable enough to support orphans on a psychosocial level?

- How does the psychosocial effect of orphans affect their self-concept?

7.3 DEMARCATION OF THE FIELD OF STUDY

This research was undertaken on school teachers and HIV/AIDS affected orphans in the Rustenburg area. It was confined to foundation and intermediate phase teachers (grade 1 to 7). The sampled teachers and HIV/AIDS affected orphans were representatives of all teachers and HIV/AIDS affected orphans in South Africa.

7.4 AIMS OF THE INVESTIGATION

This research study has investigated how the HIV/AIDS orphans' psychosocial status would be affected by the HIV/AIDS disease. Finally, recommendations are made to all concerned and interested parties for the improvement of the problematical situation, which could lead to better understanding of the HIV/AIDS orphans' psychosocial status.

7.5 THE METHOD OF RESEARCH

A literature study was undertaken to investigate on how HIV/AIDS orphans psycho-social status would be affected by HIV/AIDS. The psychosocial status of HIV/AIDS orphans was investigated by the means of literature study. Having completed the foregoing, the researcher undertook an empirical study. Questionnaires on how HIV/AIDS orphans psychosocial status would be affected by AIDS were developed and administered to different schools for respondents to answer.

7.6 FINDINGS

The following section discusses the findings from the empirical investigation and literature study.

7.6.1 Findings from empirical investigation

The findings of this empirical research were conducted on 250 AIDS orphans/vulnerable children and 120 teachers from the selected schools, starting from Grade 1 to Grade.7. These findings are based on data analysis from the questionnaires completed by the teachers and AIDS orphans/vulnerable children.

- **Physical appearance and needs**

Teachers agreed that AIDS orphans/vulnerable children experienced lack of food, clothing, personal hygiene, school material, and a need for psychological support services.

- **Psychological needs**

The researcher also realised that these children experienced a need for security, lack of acceptance by others, a need for dealing with stress, a need for managing their fears, behavioural problems, aggression, feelings of helplessness, feelings of sadness, feelings of depression, negative self-concepts, disciplinary problems, stigmatisation, manifest excessive stress, manifest inability to explore and inability to make choices.

- **The role of the school in supporting orphans**

  Teachers also agreed that it is the task of the school to raise awareness, to provide a supportive environment and to run programmes to address the needs of AIDS orphans/vulnerable children.

- **Various issues regarding norms and values**

  They also agreed that they are able to fulfill the psychological needs; and take effort to guide AIDS orphans/vulnerable children to responsible adulthood.

- **Psychosocial well being**

  AIDS orphans/vulnerable children agree with the values and self perception factors except that they do not talk about their grief and sorrow with other people. AIDS orphans/vulnerable children disagreed with all the risk factors but they agreed that they are still grieving about the death of their parents.

- **Responsibility**

  The majority of AIDS orphans/vulnerable children indicated that they would like to be responsible parents. By responsible parent, they meant getting married, staying in beautiful houses, having descent jobs, being part of support services, defense and legal services, human resources and engineering and technical opportunities.

7.6.2 Findings from the literature

The following section discusses the findings from the literature study.

- **Self concept**

It is evident from the literature that AIDS orphans/vulnerable children's self concept need to be developed positively.

- **Environment**

It is evident from the literature that the school plays an important role in developing learners' unique competencies and foster the necessary affective depositions to their fullest potential (see sec 2.3.1 and 3.9).

- **Fostering psychosocial development through play**

It is evident from the literature that children need to be given the opportunities to express themselves for example, talking about their grief and sorrows with other people (see sec 2.4).

- **Relationship**

It is evident from the literature that failure to meet the psychological needs of the child at a certain stage in his development may result in personal disorders (see sec 2.5).

- **Love, food, clothing and security**

It was further found in the literature that children need to be loved and be provided with basic human needs such as food, clothing and security (see sec 3.3.1).

- **Self esteem and self confidence**

It was also found in the literature that people who do not like themselves are prone to anxiety, depression and self destructive behaviour patterns. It is therefore important that teachers need to encourage AIDS orphans/vulnerable children to love themselves (see sec 3.5.4).

- **Parental illness**

It is evident from the literature that chronic parental illness may have a traumatic effect on young children and that a strong likelihood of role reversal exists in which the sick parent may become a ‘child’ and the school-age or adolescent child may become a ‘parent’ (see sec 4.2 and 4.5)

- **Stigma**

It is evident from the literature that families with AIDS victims are themselves the victims of social stigmatisation and ostracism (see sec 4.12.1).

- **Poverty**

Households where people are sick from HIV/AIDS have higher expenditures due to medical costs, and reduced incomes due to lost earnings, when the breadwinner dies, the family’s resources are further depleted as a result of funeral expenses and property removal by the deceased’s relatives (see sec 4.1.2.2).

7.7 CONCLUSION

Within the limits of this research some conclusions based on the literature study and the empirical investigation undertaken can be drawn:

- Hypothesis is true: The AIDS orphans/vulnerable children are severely in need of physical needs.

- The AIDS orphans/vulnerable children are in need of psychological support than sociological support.

- Most teachers agreed that AIDS orphans/vulnerable children are coping with the situation they are in.

- School need to support the AIDS orphans/vulnerable children in their needs but not many schools run a programme to address the needs of these children. It is also the task of the school to raise awareness of these children.

- Teachers are providing support because they are aware of the problems.

- Children are optimistic about their future due to their positive attitude about their lives.
- Hypotheses is not true: children do not blame themselves for their parent's deaths.

- Most children respect people and only few, though more than 50%, take responsibility for other people in the community.

- About 60% of the children are still grieving about their parents.
- About 50% of the children are comfortable about being orphans while another 50% feel uncomfortable.

- The grade 7 learners are less optimistic about their future.

- It is remarkable that children with more than six siblings are more optimistic about their future.

Children who receive children's grant are less optimistic while children who receive foster grant are more.

Of utmost importance here, is whether AIDS affect the psychosocial status of HIV/AIDS orphans in the foundation and intermediate phase.

7.8 RECOMMENDATIONS

The government, especially the Department of Education and Department of Social Services should work together to strengthen the caring and coping capacities of families and communities, with regard to increasing and strengthening community care rather than institutional care. They should also enhance the capacity of families, communities and local organizations to respond to the psychosocial needs of vulnerable children and adolescents.

It is highly recommended that the government should always involve HIV/AIDS affected orphans as part of the solution. All the role-players should encourage the community to reduce stigma and discrimination against HIV/AIDS orphans and vulnerable children. They should also foster linkages between HIV/AIDS prevention activities and efforts to assist HIV/AIDS orphans and vulnerable children and foster linkages between home-based care and support to HIV/AIDS orphans and vulnerable children.

The Department of Education should organise workshops for teachers in order to:

- Accelerate learning and information exchange.
- Promote human rights including the right to education of HIV/AIDS orphans.
- Introduce guidelines for appropriate use of language in HIV/AIDS.
- Foster advocacy at multiple levels to secure commitment to the issues of children and HIV/AIDS.

The government should strengthen partnerships at all levels and build coalitions among key stakeholders to ensure that external assistance does not undermine community initiation and motivation.

All governmental departments should organise local and community capacity building to ensure effective participation and also establish priority needs across the continuum from prevention to care and support by identifying the most vulnerable children and the situation of risk (Smart, 2000:8-9).

7.9 SUGGESTIONS FOR FUTURE RESEARCH

- This research was conducted in the Bojanala Region of the North West Province. The study population included HIV/AIDS orphans and teachers in five schools in this Region. Thus, the findings of the research can neither be generalised to other Regions of the Province, nor to the entire population of South Africa. Therefore, it is recommended, that the study should be replicated on a national sample of HIV/AIDS orphans and vulnerable children.
- There is an abundant need of empirical research on the role of the teachers in handling HIV/AIDS affected orphans in the classes because the literature in this thesis revealed that the number of these children is increasing in schools.
- Researchers need to look into the effect of social stigmatisation on the total development of these children.

7.10 CONCLUDING REMARKS

The community must not lose sight of the right of all children to protection, to care and support, to information, education and health care.

It is our responsibility to find these children, recognizing that those who are most vulnerable might be those who are most invisible. We need to provide appropriate training: training to care for dying parents, training to raise younger siblings, and training in skills to generate an income. We need to establish crisis support such as food, blankets, clothes, seeds for food gardens, or milk for children orphaned at birth and we need creative ways of providing long term psychological support. Finally, we need to support those working with orphans and vulnerable children; grandmothers and grandfathers, young couples setting up house with their ‘inherited’ siblings, and professionals and volunteers who have the opportunity to make ‘the system’ work for and not against the interests of children.

BIBLIOGRAPHY.

Adams-Webber, J. 2000. A further test of a model of self reflection with children ages 10 and 11. *Journal of constructivist Psychology*, 13 (4): 289 – 301

Akos, P. 2000. Building empathic skills in elementary school children through group work. *Journal for specialists in group work*, 25(2): 214 – 223

Angéla, L.,Carrasquillo, D. and Clement, B. G. 1993. Parents and schools. A source Book. London: Garland publishing, INC.

Baggaley, R., Sulwe, J. Chilala, M. and Mashambe, C.1997. HIV Related Stress at School and at Home in Zambia. *AIDS Analysis Africa,* 7(6): 8 – 9

Berger, E. H. 1991. Parents as partners in education. St .Louis, Missouri: The C.V. Mosby Co.

Berns, R. M. 1994. Topical child development. Albany, New York: Delmar

Borg, W. R. and Gall, M. D. 1989.Educational research. An introduction. New York: Longman.

Bornholt L. J. 2000. Social and personal aspects of self-knowledge: a balance of individuality and belonging. *Learning and instruction,* 10 (5): 415 – 429.

Botha N. 1996. AIDS in Uganda. *Farmer's weekly.* 86007:16-18.

Boy, A. V. and Pine, G. J. 1998. Fostering psychosocial development in the classroom. Illinois: Publishers Springfield.

Bukatko, D and Daehler, M. W. 1992. Child development. A topical approach.

New Jersey: Houghton Mifflin.

Cawyer, C. S. and Smith-Dupre', A. 1995. Communicating social support: Identifying supportive episodes in an HIV/AIDS support group. *Communication quarterly,* 43(3): 243 – 358.

Cohen, L. and Manion,L.1989. Research methods in education. London: Routledge.

Cohen, L., Manion, L. and Morrison, K. 2007. Research methods in education. New York: Routledge.

Colpin H. 2002. Parenting and psychosocial development of IVF children: Review of the research literature. *Developmental review.* 22(4): 644-673.

Costa, L. and Holiday, D. 1994. Helping children cope with the death of a parent. *Elementary school guidance and counseling*, 28(3): 206 – 213

Dane B. and Levine C.1994. AIDS and the new Orphans. Coping with death. London: Auburn House.

Davidson, L. 2001. The effects of religious training: implications for counselling and development. *School Psychology Review, 48(3)*: 120 – 136

De La Cruz, M. C. 2000. AIDS Thrives in desperation. *Children First*, 4(30): 20 – 21.

Denis, P. 2001. Children first. Building resilience by remembering: memory boxes. *Children First*, 4(34): 23 – 25.

Desmond, C. Michael, K. and Gow, J. 2000. The hidden Battle: HIV/AIDS in the Household and Community. *South African Journal of International Affairs*, 7(2): 39 – 58.

De Vos, A. S.1998. Research at grass-root. A primer for the caring professions. Pretoria: J.L. Van Schaik.

Dixon, H. 1993. Yes, AIDS again. A Handbook of Teachers. LDA. Duke Street Wisbech. Cambs. P E 13 2AE.

Donald, D. Lazarus, S. and Lolwana, P. 1997. Educational psychology in social context. Challenges of development, social issues, and special need in Southern Africa. Cape Town: Oxford.

Doner, K. 1996. My Teacher Hates Me. *Working Mother 19(9): 46-48*.

Dubois, D. L. and Felner, R. D.1996.The quadripartite model of social competence theory and applications to clinical intervention. Cognitive therapy with children and adolescents. New York: Guilford.

Du Toit, S.J. 2000 Guidelines to help parents achieve their educational goal. In: Parent guidance, Study guide for OSI 441-8. Pretoria: UNISA.

Ewing, D. 2000. Where love is the only therapy. *Children First*, 4(31): 10 – 13.

Ferron, O. M. 1990. Guidelines and counseling for tertiary students. Durban: Butterworth.

Floyed, J. and Fowler Jr, J.F. 2002. Survey Research Methods 3rd ed. Newbury Park: Sage Publishers: California, USA.

Ford, D.1996. Good Parent-Teacher Relationship Benefits Children. Phi DELTA Kappan, (505): 646-652.

Firestone, R. W.1990. Compassionate child- rearing. An in-Depth Approach to optimal Parenting. New York: Plenum Press.

Foster, G. 1996. AIDS and the Orphan Crisis in Zimbabwe. *AIDS Analysis Africa: Southern Africa Edition,* 7(3): 6 – 7.

Foster, G. 1997. Deterioration in child health in countries with severe AIDS epidemics. *AIDS Analysis Africa.* 8(3): 4 – 5.

Foster, G. 1998. Today's children-challenges to child health promotion in countries with severe AIDS epidemics. *AIDS Care,* 10(1): 517 – 523.

Foster, G., Makufa, C., Drew, R. and Kralov, E.1997.Factors leading to the establishment of child headed households: the case of Zimbabwe. *Health Transition Review,* 7(2):155 – 168.

Gaylord, N. K, Kitzman, K. M and Coleman J. K. 2003. Parents and children's perceptions of parental behaviour: Associations with children's psychosocial adjustment in the classroom. *Parenting: Science and practice,* 3(1): 23 – 47.

Gauvain, M and Cole, M 1997. Reading on the development of children. Second Edition. New York : W. H. Freeman and Company.

Gilbert, D. J. 2001. HIV-affected children and Adolescents: What school workers should know. *Children and school*, 23(3):135 – 142.

Gogging, K. Catley, D. Brisco, S. T. Engelson, E. S. Rabkin, J. G. and Kotler, D. P. 2001. A female perspective on living with HIV disease. *Health and Social Work,* 26(2): 80 – 89.

Gordon, A. M. and Browne, K. W. 2007. Beginnings and beyond: Foundations in early childhood education. Singapore: Thomson.

Guest, M. 2001. Children of AIDS Africa's Orphan Crises. London: Pluto Press.

Harber, R. 2001. HIV/AIDS A Professional Vision: AIDS and Architecture. *AIDS Analysis Africa,* 11(6): 14 – 15.

Hargis, B. 1996. Death threat with young adults who have lost a parent to death. *Death Studies, 21(6):*1 – 14

Harold, I., Kaplan, M. D., Benjamin, J., Sadock, M. D., Jack, A. and Grebb, D. 1994. Kaplan and Sadock's Synopsis of psychiatry. Behavioural Problems of sciences in clinical psychiatry. Seventh Edition. Baltimore, Maryland: Freeman and company.

Heartbeat. 2002. Joining Hands. *News letter*. 3: 1 – 8.

Hebert, T. P. and Neumeister, K. L. S.2002. Fostering the social and emotional development of gifted children through guided viewing of film. *Roeper review.* 259(1):12 – 21.

Hilton-Barber, M. 2000. Raising the AIDS generation. *Fairlady, 33(20)*: 34 – 37.

Hlophe, G. 1999. practical hints towards healing book review. *Children first.* 3(26) 36.

Hubbard, J.A., Dodge, K.A., Cillessen, A.H.N., Coie, J.D. and Schwartz, D. 2001. The dyadic nature of social information procecessing in boys' reactive and proactive aggression. *Journal of personality and social psychology,* 80(2): 268-280.

Huurre, T. and Aro, H. 2000. The psychosocial well being of Finnish adolescents with visual impairments versus those with chronic conditions and those with no disabilities. *Journal of visual impairment and blinders*, 94 (10): 625 – 637.

Jaffe, M. L.1991.Understanding parenting. Washington DC: Brown Publishers.

Jenkins, P. D. 1980. Art for the fun of it. A guide for teaching young children. New York : Prentice- Hall, Inc.

Johnston, M., Martin, D., Martin, M. and Gumaer, J. 1992. Long-term parental illness and children: perils and promises. *The school councilor.* 39(3):225-231.

Kaseke, E and Gumbo, P. 2001. The AIDS crisis and orphan care in Zimbabwe. *Social work*, 37(1): 53 – 58.

Katz, L. G. 1996. Building Resilience: Helping Your Child Cope with Frustrations at School. *Instructor 106(3): 95-98*.

Kelly, B. 2003. If you are a parent, you are a role model. *Clearing House, 81: 117 – 121.*

Killen, R. *2003. Validity in outcomes-based assessment. Perspective in education, 21(1):1-14.*

Kotler, P. and Amstrong, G. 1999. Principles of marketing. 8th edition. New Jersey**:** Prentice Hall.

Liebenman, M.A. and Fisher, L. 1995. The impact of chronic illness on the health and well-being of family members. *The Gerotologist*, 35(1): 94 – 102

Loening-Voysey, H. 2002. Caring for vulnerable children. *HIV/AIDS in*

South Africa, 1(2):103 – 110.

Loudon, M. 1998. Raising the orphan generation. *AIDS analysis Africa: Southern Africa edition.* 8(5): 5 – 6.

Lovrin, M. 1995.Interpersonal support among 8-year-old girls who have lost their parents or siblings to AIDS. *Archives of psychiatric nursing,* 9 (2): 92 – 98.

MacBeth, A. 1989. Involving parents: effective parent-teacher relations. Pretoria: Heinemann.

Marcus, T. 2000. AIDS: Understanding the Disinheritances, Organizing Resistances. *Bulletin for Contextual Theology in Africa*, 7(1): 6 – 8.

Maree, J. G and Fraser, W. A. 2004. Outcomes-based assessment. Cape Town: Heinemann

Masitsa, M G.1995.The establishment of a learning culture as prerequisite for academic achievement. Pretoria: UNISA (Doctoral Thesis-Unpublished).

Matshidiso, E.T. 1999. Issues and challenges in the development of a school policy. Mafikeng: University of North West (Unpublished M. Ed Dissertation)

Michael, K. 2001. AIDS Orphans in Africa. Building an Urban response. Centre for Policy Studies. Washington D.C: Woodrow Wilson International Centre for Scholars.

Michael, L., Jaffe, M. L, and Beal, A. V. 1995. Towards more effective parent involvement. *Clearing House, 58: 213 – 215.*

Miller, R and Murray, D. 1999. The impact of HIV illness on parents and children,

with particular reference to African families. *The association for Family therapy and systemic practice.* 21(3):284 – 302.

Moore, J and Herlihy, B. 1993. Grief groups for students who have had a parent die. *On the scene.* 41(1):54 – 59.

Morgan, S. 2000. Response for all AIDS affected children, not AIDS orphans alone. *AIDS Analysis Africa.* 10(6):3.

Morrel, T. M, Dubowitz, H, Kerr, M. A. and Black, M. M. 2003. The effect of maternal victimisation on children: A cross-informant study. *Journal of family violence,* 18(1): 29 – 41.

Mouton, J. 2001. How to succeed in your masters and Doctoral Studies.J.L.Van Schaik Publishers: Hartfield, Pretoria.

Mouton, J. 1996. Understanding Social Research. Pretoria: J. L. Van Schaik Publishers.

Msomi, T. 2000. Evil and Death is in the Air. Credo Mutwa's Latest Vision. *Drum,* 42(1): 8 – 9.

Mutangadura, G. and Webb, D. 1999. The Socio-economic impact of adult mortality and morbidity on urban households in Zambia. *AIDS Analysis Africa,* 9(4): 4 – 6.

Mutwa, C. 2000. Truth, Love and the Sound of flute. *Children First,* 4(31): 14 - 16.

Nancy, C., Andreason, M. D., Donald, W. and Black, M. D. 1991.Introductory

textbook of psychiatry. Washington D.C: American Psychiatry Press. Inc.

Naug, K. 2000. Maternal social network in an urban slum and its impact on cognitive and social development in children. *Journal of personality and clinical studies*.16 (1) 53 – 62.

Ndebele, Z. and Phungula, S. 2001. Business Joins Battle, Zuma Outlines AIDS Strategy, Suffer Little Children. *Enterprise*: 29 – 31.

Ndudane, N. 1998. Accepting death as part of live. *Children First,* 2(21): 6 – 7.

Neff, J. A. and Davey T. L. 2001. A Shelter-Based Stress-Reduction Group Intervention Targeting self-Esteem, Social Competence, and Behaviour Problems among Homeless children. *Journal of social lisbes and the homeless.*10(2): 278 – 291.

Nelson Mandela Metropolitan University (Faculty of Education). *2006. Study guide: outcomes-based assessment. Port Elizabeth: Goshank Litho.*

Newman, B. M. and Newman, P. R. 1995. Development through life. A psychosocial approach. 6th Edition. Ohio State: Brooks\Cole publishing Company.

Nielsen, L. E., and Finkelstein, J, M. 1993. A New Approach to Parent Conferences. *Teaching pre k-8 24(1): 90-92.*

Njoko, M. 2000. How do you say good bye to your child. *Children First,* 4(31): 3-4.

Papalia, D. E., Olds, S. W. and Feldman, R. D. 2006. A child's world: Infancy through adolescence. Boston: McGraw-Hill.

Pequegnat, W. and Szapocznik, J. 2000. Working with families in the era of and HIV\AIDS. New Delhi: Sage Publications, Inc. International Educational Professional.

Pfeffer, C. R,, Karus, D., Siegel, K. and Jiang, H. 2000. Child survivors of parental death from cancer or suicide: depressive and behavioural outcomes. *Psycho-oncology.* 9:1 – 10.

Ramsden, N. 2001. Sharing skills for self help. *Children first,* 5(35): 34 – 37.

Rinaldi, C. M. 2002. Social conflict abilities of children identifies as sociable, aggressive, and isolated: Developmental implications for children at-risk for impaired peer relations. *Developmental disabilities bulletin*, 30 (1): 77 – 94.

Roberts, T. W. 1994. A system perspective of parenting. The individual. The Family and the social network. California: Brooks/Cole Publishing Company.

Ryder, R. W., Kamenga, M., Nkusi, M., Batter, V. and Heyward, W. L. 1994. AIDS orphans in Kinshasa, Zaire: incidence and socioeconomic consequences. *AIDS,* 8(5):673 – 679.

Sarantakos, S. 1998.Social Research, 2nd edition. Johannesburg: MacMillan: Education South Africa.

Santrock, J. 2000. Psychology. 6th edition. New York: McGraw-Hill.

Schonteich, M. 1999. AIDS and age: SA' crime time bomb? *AIDS Analysis Africa,* 10(2): 3 – 4.

Schumacher, S and McMillan, J. H. 1993.Research in education. A conceptual introduction. New York. Longman.

Sengendo, J. and Nambi, J. 1997. The psychological effect of orphanhood. A study of orphans in Rakai district. *Health Transition Review,* 7(1): 105 – 124.

Sherrifs, P. 1997. The orphan generation. *Femina.* 80 – 84.

Sieborger, R. & Macintosh, H. *1998. Transforming assessment - a guide for South African teachers. Cape Town: Juta.*

Siegel, K. and Gorey, E. 1997. Childhood bereavement due to parental death from acquired immunodeficiency syndrome. *Journal of developmental and behavioural pediatrics.* 15(3):566 – 570.

Simpkins, S. D. and Parke, R. D. 2001. The relations between parental friendships and children's friendships: self-report and observational analysis. *Child development.* 72(2): 569 – 582.

Smart, R. 2000. Orphans and vulnerable children: The collateral casualties. *Children and HIV/AIDS.* 11(2):8-9.

Sprinthall, R. C. 1990. Basic Statistical Analysis, 3rd Edition. Englewood Cliff, NJ: Prentice-Hall.

Squires, J. K. 2000. Identifying social/emotional and behavioural problems in infants and toddlers. *The transdisciplinary Journal*, 10(2): 107 - 119

Stein, J. 2000. Talking to HIV-Positive Children about Death and Dying. *AIDS Bulletin,* 9(2): 22 – 23

Stenhouse, G.1994. Confident Children. Developing your child's self-esteem. Melbourne. Oxford University Press

Strachan, K. 2000. AIDS Orphans-Putting Faces to the figures: Policy in progress. *HST Update*, 58: 6 – 10

Symons, D. K. and Clark, S. E. 2000. A longitudinal study of mother-child relationships and theory of mind in the pre-school period. *Social Development*, 9(1): 3 – 23

Todahl, J, Smith, T. E., Barnes, M. and Pereira, M. G. A. 1998. Therapy and perceptions of death by young children. *Journal of Poetry Therapy.* 12(2):95-107.

Unger, D. G., Parker, E. A., Antal, P and Tressell, P. A. 2000. Serving children with special social and emotional needs: a practical approach to evaluating prevention programs in schools and community settings. *Journal of Educational and Psychological consultation,* 11(2): 273 – 296

Wanlass, Y. 2000. Broadening the concept of learning and school competence. *The elementary school Journal*, 100(5): 513 – 527

Webb, D. 1995. Orphans in Zambia. *Southern Africa Edition,* 6(2): 5

Wellhousen, K. and Downey, J. 1992. Helping young children cope with stress. *Dimensions of early childhood.* 21(1):23-25.

Whiteside, A. 1999. The real challenges: The orphan generation and employment creation. *Aids analysis Africa.* 10(4):14-15.

Whiteside, A. and Sunter C. 2000 AIDS. The challenge for South Africa. Tafelberg: Human and Rousseau.

Wild, L. 2001.The Psychosocial Adjustment of Children Orphaned by AIDS. *Southern African Journal of Child and Adolescent Mental Health*, 13(1): 3

Williams, G. 2000. Living in the Shadow of Death. *Leadership,* 23(12): 30 – 35.

APPENDIX A

QUESTIONNAIRE - ORPHANS
Teachers

This is a questionnaire to determine you perception of Aids orphans and vulnerable learners in your school. Besides your personal information, we would appreciate it if you share your view on the physical and psychological state (condition) of Aids orphans and vulnerable learners in your school. Will you please circle the number at the right hand side to indicate your answer.

V1

SECTION A BIOGRAPHICAL INFORMATION

1 In which phase are you teaching?	
Foundation Phase	1
Intermediate Phase	2

V2

2 What qualification/s do you have?	
No teaching qualification	1
Level 1 SAQA	2
Level 4 SAQA	3
3 to 4 year Diploma in JP	4
3 to 4 year Diploma Preprimary	5
BprimEd ECD 4 years	6
HDE preprimary	7
HDE JP	8
Other	9

V3

3	**Did your initial teacher training provide enough knowledge to enable you to support orphans and vulnerable learners?**		V4
	Yes	1	
	No	2	

4	**Do you provide special support to orphans and vulnerable learners?**		V5
	Yes	1	
	No	2	

SECTION B PHYSICAL APPEARANCE AND NEEDS

This section focuses on your perception of various physical and school aspects regarding orphans/vulnerable learners in general. Use the following four point scale for each of the statements below to indicate to what extent you agree with the statements. Circle the number of your choice on the scale at the right side.

Four point scale

1	***2***	***3***	***4***
Definitely disagree	**Disagree**	**Agree**	**Definitely agree**

5	The aids orphans/vulnerable learners experience a lack of food.	1	2	3	4	V6
6	The aids orphans/vulnerable learners experience a lack of clothing.	1	2	3	4	V7
7	The aids orphans/vulnerable learners experience a lack of personal hygiene.	1	2	3	4	V8
8	The aids orphans/vulnerable learners experience a lack of school funds.	1	2	3	4	V9
9	The aids orphans/vulnerable learners experience a lack of school material.	1	2	3	4	V10
10	The aids orphans/vulnerable learners experience a need for psychological support services.	1	2	3	4	V11

SECTION C PSYCHOLOGICAL NEEDS

This section focuses on your perception on the psychological needs of orphans/vulnerable learners in general. Use the following four point scale for each of the statements below to indicate to what extent you agree with the statements. Circle the number of your choice on the scale at the right side.

Four point scale

1	*2*	*3*	*4*
Definitely agree	**Agree**	**Disagree**	**Definitely disagree**

11	The aids orphans/vulnerable learners experience a need for security.	1	2	3	4	V12
12	The aids orphans/vulnerable learners experience a lack of acceptance by others.	1	2	3	4	V13
13	The aids orphans/vulnerable learners experience a need for dealing with stress.	1	2	3	4	V14
14	The aids orphans/vulnerable learners experience a need for managing their fears.	1	2	3	4	V15
15	The aids orphans/vulnerable learners manifest inability to explore.	1	2	3	4	V16
16	The aids orphans/vulnerable learners manifest an inability to make choices.	1	2	3	4	V17
17	The aids orphans/vulnerable learners manifest excessive stress.	1	2	3	4	V18
18	The aids orphans/vulnerable learners experience behavioural problems.	1	2	3	4	V19
19	The aids orphans/vulnerable learners experience aggression.	1	2	3	4	V20
20	The aids orphans/vulnerable learners experience feelings of helplessness.	1	2	3	4	V21
21	The aids orphans/vulnerable learners experience feelings of sadness.	1	2	3	4	V22
22	The aids orphans/vulnerable learners experience feelings of depression.	1	2	3	4	V23
23	The aids orphans/vulnerable learners experience negative self-concepts.	1	2	3	4	V24
24	The aids orphans/vulnerable learners experience disciplinary problems.	1	2	3	4	V25
25	The aids orphans/vulnerable learners experience stigmatisation.	1	2	3	4	V26

SECTION D

This section focuses on the perception of teachers regarding the role of the school in supporting of orphans/vulnerable learners. Use the following four point scale for each of the statements below to indicate to what extent you agree with the statements. Circle the number of your choice on the scale at the right side.

Four point scale

1	*2*	*3*	*4*
Definitely disagree	**Disagree**	**Agree**	**Definitely agree**

26	It is the task of the school to raise awareness of orphans/vulnerable learners	1	2	3	4	V27
27	It is the task of the school to provide a supportive environment for orphans/vulnerable learners.	1	2	3	4	V28
28	I am able to fulfil the psychological needs of orphans/vulnerable learners in my class.	1	2	3	4	V29
29	The school runs a programme to address the needs of orphans/ vulnerable learners.	1	2	3	4	V30
30	There is a difference between the social-cultural needs of my school community and that of other cultural groups.	1	2	3	4	V31
31	I take effort to guide orphans/vulnerable learners to responsible adulthood (transfer norms and values).	1	2	3	4	V32

If you agree or definitely agree to the statement 31, answer the following questions:

a What norms and values exist in your cultural community?

……
……
……
……
……
……

b How do you know what the norms and values of your cultural community are?

……
……
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……
……
……

c What are the most valuable social-cultural aspects appreciated by your community?
……
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……
……

d How should one ‘Live your life’ as member of a specific cultural community?
……
……
……
……
……
……

Thank you for your support and cooperation

QUESTIONNAIRE - ORPHANS

Name of child: ……

Age of child: ……..

V1

A BIOGRAPHICAL INFORMATION

1 Grade

Grade 1	**1**	V2
Grade 2	**2**	
Grade 3	**3**	
Grade 4	**4**	
Grade 5	**5**	
Grade 6	**6**	
Grade 7	**7**	

2 Number of siblings

1-2	1	V3
3-4	2	
5-6	3	
More than six	4	

3 Does the child have siblings younger than him/her?

Yes	1	V4
No	2	

4 Does the child have a birth certificate?

Yes	1	V5
No	2	

5 Does the child have death certificates for parents?

Yes	1	V6
No	2	

6 What grant does the child receive?

Children's grant – R190-00 per child per month	1	V7
The foster grant – R550-00 per child per month	2	
None	3	

7 Who is taking care of the child?

Grand parent	1	V8
Foster parent/family	2	
Older brother/sister	3	
Nobody	4	
Church	5	
Social worker/community worker	6	
Any other organisation	7	

8 Does the child ever visit a clinic?

Yes	1	V9
No	2	

9 Does the child attend church services?

Every week	1	V10
Every two weeks	2	
Once a month	3	
Very seldom	4	
Never	5	

SECTION B PSYCHO-SOCIAL WELL BEING

This section focuses on the psycho-social well being of the orphans/vulnerable children. Teachers have to interpret, explain and complete the questionnaire on behalf of the children. Use the following four point scale for each of the statements below to indicate to what extent the child agree with the statements. Circle the number of the child's choice on the scale on the right hand side of the table.

Four point scale

1	***2***	***3***	***4***
Definitely disagree	**Disagree**	**Agree**	**Definitely agree**

Self perception

11	I want to become a grown up.	1	2	3	4	V11
12	I can complete tasks.	1	2	3	4	V12
13	I cope with my present situation.	1	2	3	4	V13
14	I blame myself for my parents' death.	1	2	3	4	V14
15	I have hope for my future.	1	2	3	4	V15
16	I can influence my future.	1	2	3	4	V16

17	The church plays a role in my happiness.	1	2	3	4	V17
18	I am happy about the future.	1	2	3	4	V18
19	I am afraid in unfamiliar situations.	1	2	3	4	V19
20	I am angry with my situation.	1	2	3	4	V20
21	Other people understand my feelings.	1	2	3	4	V21
22	I talk about my grief and sorrow with other people.	1	2	3	4	V22

Values

23	I experience an inner feeling of happiness.	1	2	3	4	V23
24	I am taking care of myself.	1	2	3	4	V24
25	I take care of other people.	1	2	3	4	V25
26	I share my feelings with others.	1	2	3	4	V26
27	I consider the wishes of others.	1	2	3	4	V27
28	I respect other people.	1	2	3	4	V28
29	I take responsibility for other people in the community.	1	2	3	4	V29

Risk factors

30	People think I am different because I don't have parents.	1	2	3	4	V30
31	I prefer to keep it secret that I do not have parents.	1	2	3	4	V31
32	I feel lost because I do not have parents.	1	2	3	4	V32
33	I am afraid that I will be removed from my home.	1	2	3	4	V33
34	I am still grieving about the death of my parents.	1	2	3	4	V34

Open questions

a How do you see yourself as an adult? Please explain.

……
……
……
……
……

b Who would you want to take the place of your parents to look after you?

……
……
……

c Is there a grown-up who loves you like your parents did? Tell us about him/her.

……
……
……
……

Thank you for your support