CARE OF CHILDREN AFFECTED AND INFECTED BY HIV/AIDS AT KHAYELIHLE CHILDRENS HOME. CATO RIDGE, SOUTH AFRICA.

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University of Zululand

Supervisor: Prof. TAP Gumbi

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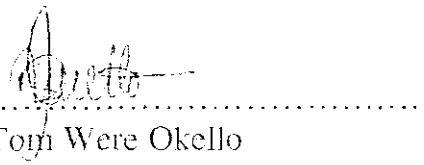
DECLARATION

I, Tom Were Okello, hereby declare that this dissertation is my original work and has not been presented for any other degree in any university. All sources quoted have been acknowledged and a complete list of references given. No part of this dissertation may be reproduced without prior permission of the author and /or University of Zululand.



Tom Were Okello

08/04/15

Date

DEDICATION

This work is dedicated to the memory of:

My dearly beloved grandparents

Desterio Okello Nengo and Rofina Nekesa;

My friend

The late Mary Odanga;

and

My cousin

The late Agnes Maali Oduor.

ABSTRACT

In this study the researcher investigated care of children affected and infected by HIV/AIDS at Khayelihle Children's Home. The principal aim of the study was to offer a diagnostic, evaluative assessment of the care for children at Khayelihle Children's Home.

Survey methodology was adopted for this research. Stratified sampling technique was used in selecting a sample of the respondents to participate in the study. Three strata of: children: aunts/grandmothers: and the international volunteers were selected from the total population at Khayelihle children's home. Sixty people drawn from the stratas participated in the study.

Data was collected by use of structured interviews. Documentary sources and observations were utilised as complementary methods to data collection. Data collected was analysed using descriptive analysis. Tables and pie - charts were used to enter specific types of data and show relationships between variables.

The findings from the study indicated that the care of children at Khayelihle Children's Home was not effective. Several reasons are advanced for this phenomenon. These include: inability to protect children from exploitation, abuse, and neglect: inability of fostering the development of a close and secure relationship with caregivers as well as allowing a close relationship with the remaining family members. Other reasons include: little emphasis in helping children understand the imminent death of a parent: their identity: uniqueness and a sense of personal continuity especially in the maintenance of a close link with the cultural community: and failure in encouraging children expression of emotions a prerequisite for psychosocial development.

It was concluded that the care for children at Khayelihle children's needed to promote psychosocial development and resilience in children for them to be able to deal with the imminent challenges of life as orphans in the face of HIV/AIDS epidemic.

The study recommends that, the care for children at Khayelihle should put in perspective the underlying values advocated by the Convention on the Rights of the Child, which should serve as a constant reference for the implementing and monitoring all efforts to care, promote, fulfil and protect children's rights.

ISIFINYEZO

Kulo msebenzi umcwaningi ucwaninge ngendlela yokunakekela abantwana abahlaselwe yigciwane lesandulelangculaza kanye nengculaza ekhaya labantwana laseKhayelihle .

Inhloso ngqangi yalolu cwaningo bekuwukuthola indlela eqondile engalandelwa ekunakekeleni abantwana basekhaya labantwana laseKhayelihle.

Indlela yokuthola ulwazi mayelana nezimvo zabantu yiyona esetshenzisiwe kulo lI1sebenzi . Kulandelwe indlela yokwehlukanisa ngamazinga okukanye ngokwemikhakha ekukhetheni nasekutholeni imibono kudlanzana labantu elikwazile ukuba libe ingxenye yalolu cwaningo. Zintathu izinhla ezitholakele : Abantwana , obabekazi (0 - anti) nogogo, kanye nabazinikele ekusizeni , amavolontiya avela emhlabeni wonke . Yizona zinhlaka ezikhethiwe kwathathelwa kuzo ikakhulukazi kuwo wonke umphakathi wabantu bakulo muzi wabantwana waseKhayelihle. Sebebonke babe ngamashumi ayisithupha uma kuhlanganiswa zonke izinhlaka ezikwazile ukuba zizibandakanye kulo cwaningo .

Ulwazi luqoqwe ngendlela yemibuzo . Kwafundwa nezincwadi eziwumyombo wakho konke, kwaphindwe kwazibonelwa ngamehlo, lokhu kwenzelwe ukuze kwazeke ukuba kutholakale yonke imininingwane edingekayo mayelana nocwaningo. Imininingwane ibe isihlaziywa kusetshenziswa indlela yokuchaza. Kuphinde kwasetshenziswa imifanekiso midwebo eyizikwele okukanye amatheyibuli kanye nezilinganiso mdwebo eziyizindilinga mashadi ezisaphaya ukufaka nokugqamisa nokuqhathanisa ubudlelwano bemininingwane ngqo yolwazi olutholakele.

Ucwaningo olukutholile mayelana nalo msebenzi . kutshengise ukuthi indlela elandelwayo ekunakekeleni abantwana basemzini wabantwana waseKhayelihle ayinazithelo / okukanye ayisebenzi.Ziningi zizathu ezenza ukuthi lolu hlelo lungasebenzi. Lokhu kubandakanya Ukungakwazi ukuvikela abantwana ekuxhashazweni nasekunyukubezweni , ukunganakwa , ukungaqikeleleni ekwakheni ubudlelwano obuyibo phakathi kwezlsebenzi ezinakekela laba bantwana kanye nasekuqikelweni kokwakha ubudlelwano namalungu omndeni asekhona. Ezinye izizathu yilezi : Ukungachazeleki kwabantwana mayelana nembangela eyaholela ekulahlekeni nasekushoneni kwabazali babo, ukwazi ngemvelo yabo, nobunjalo babo kanjal0 nokuqhubekela phambili nempilo kube kunobudlelwano obukhulu obakhelwe ekuxhumaneni

nendlela yokuphila emphakathini.; ukwehluleka ukugqugquzela ukuthi abantwana bekwazi ukugonyuluka bebeke ubunjalo bemizwa yabo lokhu okuyisona sisekelo ngqangi sokukhula ngokomqondo.

Kuphothulwe ngokuthi unakekelo lwabantwana lwaseKhayelihle kumele lukwazi ukuthi lugqugquzele ukukhula ngokomqondo kanye nokuzimela kwabantwana ukuze labantwana bakwazi ukubhekana nezinselelo zempilo njengezintandane nezinkedama zegciwane lesandulela ngculaza kanye negculaza.

Ucwaningo luphakamisa ukuthi , unakekelo lwabantwana lwaseKhayelihle kumele lube nendlela yokwazi ukubeka phambili imigomo - nqangi eqhakanjiswa umphakathi mayelana namalungelo omntwana , okungukuthi iyohlala yazeka futhi ilandelwa mayelana nemizamo yonke ekhona ethinta unakekelo lwabantwana, nogququzelo oluphokophele ekuvikelweni kwamalungelo abantwana.

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I wouldn't wish to forget my girlfriend Saneliso. Thank you for your understanding and support. I have not been the boyfriend I had hoped to be. But wait. We are not through yet. This is just but the beginning.

TABLE OF CONTENTS

Declaration ii

Dedication iii

Abstract iv

Isifinyezo v

Acknowledgement vii

Table of contents viii

List of Tables xii

List of Figures xiii

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 Introduction 1

1.2 Background information. 2

1.3 Statement of the problem 3

1.4 General aim of the study 4

1.5 Specific objectives 4

1.6 Research questions 5

1.7 Assumptions of the study 7

1.8 Motivation of the study. 7

1.9 Research method and procedures 7

1.9.1 Research methodology 8

1.9.2 Research design 8

1.9.3 Population and sampling 9

1.9.4 Sample size 10

1.9.5 Research instruments. 11

1.9.6 Presentation and analysis of data 11
1.10 Definition of terms 11
1.11 The significance of the study 12
1.12 Organisation of the study 13

CHAPTER 2

LITERATURE REVIEW:

THE IMPACT OF AIDS ON CHILDREN IN SOUTHERN AFRICA

2.1 Introduction 14
2.2 The Impact of HIV/AIDS on children 15
2.3 The Scale of orphanhood 22
2.4 Summary 24

CHAPTER 3

LITERATURE REVIEW:

CARE OF CHILDREN AFFECTED AND INFECTED BY HIV/AIDS

3.1 Introduction 25
3.2 Caring for orphaned children 25
3.3 Community care 28
3.4 Organised community fostering and formal adoption 31
3.5 Institutional care 34
3.6 Summary 38

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction 40
4.2 Research design 40

4.2.1	Reliability and validity	42
4.2.2	Threats to validity.	44
4.3	Sampling procedure	44
4.3.1	The population	45
4.3.2	The sampling strategy	45
4.3.3	Sampling frame	46
4.3.4	Stratified sampling	46
4.4	Research instruments	48
4.4.1	Structured interview	48
4.4.2	Pilot study	49
4.4.2.1	Results of the pilot study	49
4.4.2.2	Results from the volunteers	50
4.5	Data quality checks	50
4.6	Data analysis	51
4.7	Limitations of the study	51
4.7.1	Design and analysis limitations	52
4.8	Summary	53

CHAPTER 5

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

5.1	Introduction	54
5.2	Analysis of the study population	55
5.3	Provision of a safe, nurturing environment in which the child's needs are met.	58
5.4	Protection from exploitation, abuse and neglect	60

5.5 Availability and maintenance of long-term consistent, caring and affectionate Caregivers..... 64

5.5.1 Development of a close and secure relationship with care givers. 65

5.5.2 Maintenance of a close relationship with the remaining family members 67

5.6 Understanding of the imminent death of a parent future plans and who will take care of the children after the home..... 69

5.7 Maintenance of a good autobiographical memory 72

5.7.1 Children expression of emotions 74

5.7.2 A sense of belonging 76

5.8 Summary 78

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction 79

6.1.1 Restatement of the objectives of the study 79

6.1.2 Restatement of the assumptions of the study 80

6.2 Summary of the findings of the study. 81

6.3 Conclusion 85

6.4 Recommendations 87

6.5 Recommendations for further research 90

References 91

Appendix I 96

LIST OF TABLES

Table 5.1: Cluster/category of the study sample 56

Table 5.2: Provision of food, shelter, clothing and access to health care at Khayelihle children's Home. 58

Table 5.3: Protection of children from exploitation, abuse and neglect of children at Khayelihle children's Home 60

Table 5.4: Variables necessary in ensuring the availability of long-term care giving staff 64

Table 5.5: Incentives for Care giving staff 65

Table 5.6: To Whom the children have a close and secure relationship 66

Table 5.7: Maintenance of a close relationship with the remaining family members ..... .67

Table 5.8: Understanding the imminent death of parent future plans and who will take care of the children after the home 69

Table 5.9: Maintenance of a good autobiographical memory..... 72

Table 5.10: Children expression of emotions 74

Table 5.11: Children's sense of belonging 76

LIST OF FIGURES

Figure 5.1: Cluster/Category of the study Sample 56

Figure 5.2: Provision of food, shelter, clothing and access to health care at Khayelihle children's Home. 59

Figure 5.3: Average assessment on the protection of children from exploitation, abuse and neglect 63

Figure 5.4: Maintenance of a close relationship with family members..... 68

Figure 5.5: Incentives for Care giving staff 73

Figure 5.6: Various ways through which children express their emotions 75

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

As HIV/AIDS continues to spread and affect the lives of millions of people, a growing sense of urgency has developed about the imperative need to stop the epidemic. Throughout the world, national HIV/AIDS programs, along with countless non-governmental organizations (NGOs) and community–based organizations (CBOs), have initiated programs to expand the response to the epidemic. The goal of these efforts is to prevent the transmission of HIV and to mitigate the consequences of AIDS through care, support, and treatment. The programs range from very large national efforts to very small local efforts. Fischer et al (2000:1) points out that, whatever their size, the programs almost always involve some elements of planning, coordination, service delivery, and involvement of communities and people affected or infected with HIV/AIDS (People living with HIV/AIDS)

One measure of the devastative massive social change because of the global HIV/AIDS epidemic, is the number of orphans; children affected by HIV/AIDS and other vulnerable children. According to revised 2003 estimates by Family Health International, there are 34.7 million children under age of 15 years in 34 countries who have lost their mother, father, or both parents to HIV/AIDS and other causes of death. By 2010, that number is expected to rise to 44 million. Without AIDS, the total number of children orphaned would have declined to fewer than 15 million. In 2010, 20 percent to 30 percent of all children under age 15 are expected to be orphaned in 11 sub–Saharan African countries – even if all new infections are prevented and

some form of treatment provided to slow the onset of AIDS in those infected with HIV (www.fhi.org/NR/Shared/enFHI/).

The Impact of HIV/AIDS on children and their families is not a simple problem with an easy solution. The current situation is complex, interrelated on all levels of life, and cuts across all sectors of development. State-of-the-art components for the care and support of orphans and other vulnerable children have evolved from lessons learned in various countries and experiences from development, child survival, children of war, and other HIV/AIDS-related programs. These lessons include: policy and law, medical care, socio-economic support, psychological support, education, human rights and community-based programs to mention but a few.

1.2 BACKGROUND INFORMATION.

Children who have lost one or both parents need a lot of support. They have to deal with grief as well as survival. Most orphans are supported by relatives, who are usually older women and are often unemployed or on pension. A large number of orphans stay on alone in the family home when their parents die and in most cases, older children look after young ones and try to find ways to survive. UNICEF 2003 report on HIV/AIDS indicates that, thousands of children are living in desperate poverty in this child-headed homes and many of them drop out of school turning out to sex work or crime to survive. The report further adds that, some children are taken in as foster children are whilst others go to orphanages or other institutions.

Jackson, (2002:285) points out that, when concerned agencies and individuals consider the devastating impact of AIDS on impoverished children a common aim is to build residential care centers(Children Homes). She adds that, a well-resourced residential home can guarantee

clothing, food, education, companionship and induction into a set of moral or religious codes. Furthermore, institutions often have an appeal to donors because they can see how their money is spent, and it is obvious how the children are benefiting from the expenditure.

Khayelihle Children's Home is an orphanage situated on Highland Resort Farm in a rural setting approximately 10-km off N3 Highway at Cato Ridge. Khayelihle is a Christian - based organization and a home for ninety-seven children affected by HIV/AIDS (and other vulnerable children). The home aims at raising these children on a strong Christian foundation with a focus of maintaining a connection to their social and traditional connections.

Ninety-nine percent of the caregivers at Khayelihle are international volunteers (professionals /non-professionals) from Europe, Asia and America (long–term and short–term) who work at different areas of Khayelihle. These various areas include; nursery, crèche, pre-primary school, school, building projects, taking children for medical appointments/treatment and organizing sporting and holiday activities for children. The remaining one- percent of the caregivers at Khayelihle is the management staff, the grandmothers (*gogos'*), and the aunts. The grandmothers (*gogos'*)and aunties offer the supportive services of cooking and cleaning for the children.

1.3 STATEMENT OF THE PROBLEM

Long term institutionalization of children in a home and other facility is not a desirable solution to the impact of HIV/AIDS. An orphanage is costly in terms of staff, resources, and management. An orphanage is impersonal with little children's contact with adults. Many children are in a danger of being abused by older children and caregivers in children's homes.

Thus, the institutionalization of children separates them from families and communities and may affect the normal childhood development.

The purpose of this study is, therefore to offer a diagnostic, evaluative assessment of the care for children affected and infected by HIV/AIDS at Khayelihle children's' home.

1.4 GENERAL AIM OF THE STUDY

The principal aim of this study was to offer a diagnostic, evaluative assessment of the care for children affected and infected by HIV/Aids at Khayelihle Children's Home.

1.5 SPECIFIC OBJECTIVES

The specific objectives of this study were to:

(a) To assess the effectiveness of the care for children at Khayelihle Children's Home in regard to provision of sufficient subsistence (food, clothing, shelter, medical service and education).

(b) To establish the extend to which children are protected from exploitation, abuse and neglect at Khayelihle Children's Home.

(c) To assess the effectiveness of the care at Khayelihle children's home in fostering the development of a close and secure relationship with caregivers as well as allowing a close relationship with the remaining family members.

(d) To determine whether or not the care of children at Khayelihle Children's Home helped children understand the imminent death of a parent, their identity, uniqueness and sense of personal continuity especially in the maintenance of a close link with the cultural community.

(e) To establish whether or not the care at Khayelihle Children's Home offers children a sense of belonging through maintenance of a good autobiographical memory, and encouragement of expression of emotions a prerequisite for psychosocial development.

1.6 RESEARCH QUESTIONS

The following research questions were addressed:

(a) Does the care for children at Khayelihle ensure a sustained provision of subsistence for survival as a human being?

(b) Does the care for children at Khayelihle ensure protection from exploitation, abuse and neglect?

(c) How does care for children at Khayelihle Children's Home ensure maintenance and availability of a long-term caring, consistent, affectionate professional caregivers?

(d) Does care for children at Khayelihle Children's Home ensure development of a close and secure relationship with caregivers?

(e) Are children under care of Khayelihle Children's Home encouraged to maintain a close relationship with the remaining family members?

(f) Are children at Khayelihle Children's Home helped to understand the imminent death of a parent, future plans and who will take care of them after the home?

(g) Does the care of children at Khayelihle Children's Home ensure maintenance of a close link to cultural community?

(h) Are children at Khayelihle Children's Home encouraged to express their emotions?

(i) Does the care for children at Khayelihle Children's Home give children a sense of belonging?

1.7 ASSUMPTIONS OF THE STUDY

The study was based on the following assumptions:

(a) The effectiveness of the care for children at Khayelihle Children's home depends on the availability of long-term care giving staff and the resources to provide subsistence (food, clothing and shelter).

(b) Development of resilience in children depends on the following capabilities: the capability to understand an adverse event (e.g. death of a parent); the capability to believe that they can

cope with crises because they have some control over what happens; and the capability to give deeper meaning to an adverse event.

(c) Proper institutional care promotes, close links to cultural community, a good autobiographical memory, a value and belief system and room for creativity innovation and curiosity through the recognition of children's uniqueness and their participation in decisions.

1.8 MOTIVATION OF THE STUDY.

Care provided in institutional settings often fails to meet the developmental needs of children. This research was prompted by the researchers' two years of involvement as a development instructor/worker in the psychosocial care of orphans and vulnerable children in South Africa. Through this involvement, the researcher encountered issues such like, children raised in orphanages often had difficulty re-entering society once they reached adulthood because many are poorly equipped to fend for themselves in the outside world. Therefore the researcher felt that in communities under severe economic stress, increasing the numbers of children homes may result in the removal of children from households and the community.

1.9 RESEARCH METHOD AND PROCEDURES.

The research methodology and procedure is discussed as follows:

1.9.1 RESEARCH METHODOLOGY

The study adopted both quantitative and qualitative research methods. Among methods given priority was the survey method to measure variables and produce statistical information (Neuman, 2000: 247). Similarly, historical comparative method were used to combine data and theory by using existing statistics, documents, the Internet, newspapers and interviews. By combining probability with non-probability techniques, the study did not only concern itself with issues of measurement and sampling, but also, issues of texture and feeling prior to data collection and analysis.

1.9.2 RESEARCH DESIGN

This study used a non-experimental study design. Fisher et al (2000:54), points out that this type of study design is most appropriate for collecting descriptive information or for conducting small case studies. The study design was also thought useful by the researcher as a diagnostic study to determine the reason why a problem exists.

Hence a post-test-only study design used in the study is herewith represented as follows:

Experimental group Time ⟶

X O_1

Where

⟶ = *Is the passage of time. The extreme left of a design is the beginning of the study. The Extreme right is the end.*

X = *Is a programme intervention, an experimental intervention (e.g. care of Children at Khayelihle home).*

O_1 = *An observation measurement. The subscript is used to distinguish one observation measurement from another e.g.* O_1, O_2, O_3, O_4.

In this design, a program intervention (X) = care has been introduced, and after its introduction, a measurement observation (O_1) is made. Since there is no control group, there is no possibility of comparing the O_1 measurement to any other measurement. The design was appropriate since the researcher wanted to assess the impact and characteristics of the care for children affected and infected by HIV/AIDS at Khayelihle children's home.

1.9.3 POPULATION AND SAMPLING

The research population comprised of children affected by HIV/Aids under residential care of Khayelihle Children's home and their caregivers that included: the International volunteers, the grandmothers and the aunts. The study was on the care for the children affected and infected by HIV/Aids and who were under the care of Khayelihle Children's home.

This study employed probability sampling as a technique to maximize external validity or generalizability of the results of the study. Three factors in determining how accurate the sample was a description of the population of Khayelihle Children's home were considered as stated below and as adopted from Fisher, et al (2000:65)

1.9.4 SAMPLE SIZE

The population of Khayelihle children's home consisted of stratas (groups), that is; the grandmothers, the volunteers, the aunts and the children that are different from each other.

To ensure that all relevant strata of the populations were represented in the study sample, the researcher used a stratified sampling technique. The sample frame was arranged by strata and then a systematic sample was drawn from each by selecting every $n^{th.}$ Case, starting with a randomly selected number between 1 and n

Thus n was calculated as follows:

The desired sample size was 60 respondents

Total population was equal to 127 people

$$n = 127/60 = 2.1$$

$$n = 2$$

A proportionate stratified sample was drawn from the stratified population. It was important that the designation of the elements of study at Khayelihle (that is, the children, aunts, grandmothers and the international volunteers) be the same as the composition distribution of the population of study. Thus, the sample included every $2^{nd.}$ Child, every $2^{nd.}$ Volunteer, every $2^{nd.}$ Grandmother and every $2^{nd.}$ Aunt.

1.9.5 RESEARCH INSTRUMENTS.

Given that the sample for this study was large enough to permit statistical analysis, it was convenient to use a structured interview rather than un-structured one, since according to Fisher, et al (2000:22) the former lend itself better to quantitative analysis and the latter would create serious data processing difficulties, particularly if the sample was large.

In this study, a structured interview using a researcher-administered questionnaire was used. This ensured that, respondents were asked exactly the same set of questions in the same sequence. The research questions comprised of both closed and open-ended questions.

1.9.6 PRESENTATION AND ANALYSIS OF DATA

Responses received from open-ended interview questions were analyzed using the content analysis method that grouped data into relevant categories, (Kerlinger, 1986:111).

1.10. DEFINITION OF TERMS

The following terms as defined below formed the basis of the study and were used throughout the study:

Children : In South Africa, the term generally refers to persons under the age of 18 years.

Orphans and OVC : OVC Stands for Orphans and vulnerable Children, a term used to describe children under the age of 18 who have lost one or both parents and or/ their primary caregiver due to death, or who are in need of care.

Resilience : The human capacity to face, overcome and be strengthened by or even transformed by the adversities of life. Alternatively, resilience is the ability to "bounce back" after stressful and potentially traumatizing events.

Operation Research : A process, way of identifying and solving program problems, a continuous process with five basic steps namely: Problem identification and diagnosis; strategy selection & testing, evaluation, information dissemination and information utilization. (Fisher et al, 2000:5).

1.11 THE SIGNIFICANCE OF THE STUDY.

One of the destructive social impacts of HIV/AIDS is the increasing numbers of young parents who die and leave small children orphaned. The crises has led to a situation where the protection of the rights of orphaned and vulnerable children in many communities in Southern Africa are unable to effectively function without outside assistance. As a result more community – based initiatives have and are being established to address the plight of children who are affected by HIV/AIDS.

The ultimate aim of the South African government is to support, strengthen and mobilize children, families and communities to combat many of the effects of the HIV/AIDS pandemic. One way of supporting organizations and others in assisting children is to provide them with information on the services and other options available in government to meet the needs of children. Hence, the publication of the National Guidelines for Social Services to children infected and affected by HIV/AIDS by the Department of Social Development in 2000.

This study forms part of the basis for identifying successful approaches on existing sustainable programmes aimed at designing interventions to address the physical and psychosocial needs of children affected by HIV/AIDS and other vulnerable children. This study is a key instrument for advocating effective interventions beyond health issues to a broad range of child and family needs aimed at helping parents and families plan and care for their children's future.

1.12 ORGANIZATION OF THE STUDY

This study was presented as follows:

Chapter 1	:	Orientation to the Study
Chapter 2	:	Care For Children Affected and Infected by HIV/AIDS in Sub-Saharan Africa
Chapter 3	:	Care For Children Affected and Infected by HIV/AIDS at Khayelihle Children's Home
Chapter 4	:	Research Methodology
Chapter 5	:	Data Presentation, Analysis and Interpretation.
Chapter 6	:	Summary, Conclusions and Recommendations.
		References.
		Appendices.

CHAPTER 2

LITERATURE REVIEW:

THE IMPACT OF AIDS ON CHILDREN IN SOUTHERN AFRICA

2.1 INTRODUCTION

This chapter examines existing literature as part of the research process. According to Neuman (1997:88), reviewing the accumulated knowledge about a question is an essential early step in the research process. The author advises that, as in other areas of life, it is best to find out what is already known about a question before trying to answer it yourself.

This study is just a tiny part of the overall process of creating knowledge and it is hoped that, building on the past studies through comparison, replication or criticism for weaknesses, it would be stronger in fulfilling one or another of the four goals of literature review stated as follows:

- To demonstrate a familiarity with a body of knowledge and establish credibility. This chapter aims at establishing knowledge and major issues concerning HIV/AIDS in Sub-Saharan Africa with special reference to Southern Africa ;
- To show the path of prior research and how this study is linked to it. This chapter on literature review aims at outlining the direction of the research on the question whilst showing the development of knowledge;
- To integrate and summarize what is known in the area, pulling together and synthesizing different results, by pointing out areas where prior studies agree, disagree and where major questions remain i.e. the review aims at collecting what is known up to the year 2004 and

hopes to be able to indicate a direction for research as regards the care for children affected and infected by HIV/AIDS; and

- To learn from others and stimulate new ideas. This review of literature aims at telling what others have found so that the researcher may benefit from the efforts of others. In doing so, the literature review aims at identifying blind alleys, divulge procedures, techniques, and research designs worth replicating so that the researcher can better focus assumption of the study and gain new insights.

2.2 THE IMPACT OF AIDS ON CHILDREN

The HIV/AIDS epidemic in Sub-Saharan Africa and especially in Southern Africa has already orphaned a generation of children – and now seems set to orphan generations more. Today, over 11 million children under the age of 15 living in sub-Saharan Africa have been robbed of one or both parents by HIV/AIDS. Seven years from now, the number is expected to have grown to 20 million. At that point, anywhere from 15 per cent to over 25 per cent of the children in a dozen sub-Saharan African countries will be orphans – the vast majority of them will have been orphaned by HIV/AIDS (UNAIDS: 2003).

In Southern Africa, millions of children are experiencing deepening poverty, enormous mental stress from witnessing illness and death of their loved ones and a profound sense of insecurity. The immediate concerns are the fundamental human rights and needs for these children and the urgent requirement to ameliorate their physical and psychosocial distress and suffering. The situation also is likely to create a huge risk for these children as they grow up, both for themselves and for the society, poorly educated, with poor social skills and minimal life chances to pull themselves out of poverty, have a little chance to become productive, self-sufficient

citizens and parents. They will instead be likely to increase instability, crime and other problems in the society at large, perpetuating the human rights abuses they have suffered. We can expect to see rising crime and homelessness, growing number of street children, increasing sex work, and worsening exploitation of girls and women with a further generation of ill-cared for children born to these impoverished parents. The cycle of deprivation and high HIV risk will repeat itself, but at greater intensity as the cushion of a relatively uninfected elderly generation will no longer be there.

Recent studies on HIV/AIDS in Africa as documented by Jackson, et al (2002: 258), "HIV infection levels are likely to rise significantly as people in desperate circumstances have to concentrate on immediate survival needs, not on protecting themselves from a long term health problem. Lack of sufficient care now is a recipe for increased spread of HIV infection in the future and for increased social instability".

In sub – Saharan Africa more than anywhere else, children may be affected by HIV and AIDS through:

Personal Infection:

- In the uterus, during birth or during breast – feeding.
- Through sexual abuse.
- Through contact with infected blood or for instance, traditional circumcision with an infected blade, or unscreened blood transfusion.

By far the commonest route is infection before or during birth; or through breast-feeding. Many children born with HIV fail to thrive as babies and die before they are five, but in others, signs of infection may take years longer to show. Thus, even where new infections are fairly low in the age range 5 to 13, children infected from birth may live long enough to enter this age group.

Infection in the Family:

- Seeing their parents or guardians become ill or die of AIDS.
- Having to take on care roles in the family.
- Being withdrawn from school and losing their opportunity for long term self – reliance.
- Becoming orphaned.
- Increasing poverty and the need to engage in productive labour from a young age.
- Stigma and discrimination.
- Risks of sexual abuse and /or neglect and overwork.
- Losing not just their immediate family but sometimes their second and third families too, as AIDS continues to kill those caring for them.
- Growing up increasing at the risk of HIV infection themselves. (Jackson, et al., 2002: 262).

Children may also be affected by living in a household that takes in orphaned children increasing demands on household resources, and creating the potential for material deprivations and conflicts, jealousy and resentment.

Orphanhood is not necessarily the critical point of escalating need. Long before being orphaned, many children suffer the long time decline in health of their parents or guardians, reduced family income, and the psychological and material consequences of both. Many have to start productive work and undertake extensive subsistence and household chores far younger than the norm, because their parents can no longer cope. Many girls, especially, may enter sex work to survive and support their family. Given adult HIV prevalence ranging up to 35% in mainland South Africa perhaps, one-quarter of all children must be living in a household where at least one parent or guardian already has HIV, although most are not yet sick. Almost all these children are

likely to be orphaned once or more than once in the next decade and they may be increasingly vulnerable with each year that passes.

Some children are taken in by extended family members who are able to look after them well. This may be the beginning of the resumption of a normal life, when they gradually overcome their grief at bereavement and can stop bearing the brunt of coping for the family. The trauma of watching a loved parent or guardian suffer and die, while striving to cope materially, may be by far the most stressful period. For others, life only gets worse after parents die, as they may be evicted by the unscrupulous relatives, siblings may split up, and their lives may suddenly be devoid of any continuity, security, regular food or shelter. When other relatives or community members do not step in to help, the child risks falling through the social safety net and ending up homeless on urban streets or destitute in rural areas. It is completely unrealistic to think that the state sponsored welfare or private and NGO run projects can identify and support all these children by any means other than directly through communities themselves.

Foster (2001a: 126) cautions against assuming that orphaned children are always worse off than others in the community. He cites conflicting evidence from Dar-Es-Salaam in Tanzania, for instance, where orphaned children felt they ate less, worked harder and were beaten more than the non-orphans. A case control study, however, found no difference in these measures. HIV/AIDS certainly adds to individual, family and community problems, but in generality, deprived communities other factors may even be more significant in reducing the quality of life.

The problem of HIV and AIDS is occurring in situations where many children are already undernourished and impoverished. UNICEF (1998) notes that nutritional indicators in children (such as stunted growth and upper arm circumference that measures wasting) reflect their overall

well being in developing countries, their exposure to infectious diseases, food consumption and general care. Hence, signs of under-nutrition reflect a breakdown in the most basic care needs.

On the other hand, Piwoz and Preble (2000: 6) comment that, " recent Data suggest that little or no progress has been made in reducing the prevalence of malnutrition amongst children in sub-Saharan Africa in the last 20 years, and in several countries, malnutrition is increasing as a result of armed conflicts, deteriorating health systems, shrinking economies, and HIV/AIDS. Much of Africa's child diseases are related to malnutrition.

The COPE programme of the save the Children Federation (USA) illustrates the extend of the problems on the ground for orphaned children in a poor area of Malawi: The village Aids Committee (VAC) identified the following main problems facing orphaned children, listed in order of Importance.

- Food insecurity; 60% of orphans are malnourished, with seasonal variation of food supply.
- Lack of clothes and blankets; most orphans wear rags.
- Inadequate shelter.
- Reduced access to education; orphaned children are reported to start education later; and to be less likely to attend secondary school (Primary education is free).
- Abuse by guardians; - Physical and verbal. Orphaned children tend to have poorer clothes, are less well fed, and undertake more household cores than biological children in the household.
- Lack of health care, linked to neglect by the guardians, high malnutrition, and higher infant mortality and less breast-feeding.

- Lack of social interaction; worst for young children. This is a combination of a withdrawal by orphans themselves after bereavement, and neglect by the guardians and isolation from other children.
- Verbal abuse by other children, teasing leading to stress and isolation

(Adapted from COPE field notes reported in Web & Elliot 2000:54-55).

In such impoverished conditions, the risk arises that the child's psychological distress is overlooked because of the primacy of the basic survival needs (Poulter, et al 1997:26). Research in Zambia found significantly more signs of psychological disturbance among children of sick parents. Nonetheless, many children experience little closeness to their fathers in particular, who are often employed away from home for long periods, and they may not experience deep emotional loss if a little known father (Mother) dies. Even before orphanhood the children may live with various extended family members for considerable periods. For some, this may reduce the sense of bereavement when parents die, but if children are close to many relatives or guardians in the extended family who are also dying, their experience may be one of multiple painful bereavements overtime. Research in Malawi by Maleika Little in the middle 1990s (Mutangadura and Jackson: 1998) found such poverty among rural adolescents, and such overwhelming experiences of HIV/AIDS in the community, that most had little hope at all for the future. They presumed they would soon be dead. This level of desperation and hopelessness calls for a massively increased response to their development needs overall as well as for HIV prevention care.

Given the depth of problems facing impoverished communities caring for orphaned children, some argue against the provision of Anti-retroviral treatment to HIV- Positive pregnant women on the ground that saving babies lives will create more orphans. This is a dangerously blinkered

view of both HIV prevention and of human development in the context of HIV/AIDS, apart from the inherent denial of human right to life.

In the first place, several analysts do not think that preventing infection in babies will significantly increase the numbers of orphans. Foster (2001b) estimates that if one half of all HIV-positive mothers were enrolled in HIV prevention programmes to protect their babies, and vertical transmission were reduced by 50%, the total orphans in the country with 30% maternal HIV prevalence would increase by under 5% in the first 10 years and by 15 % in 20 years. If maternal care improves for instance, through good nutrition and access to health care, the number of orphans would be substantially lower.

Second, caring for Children, particularly orphans, may be the most effective route to community-owned HIV prevention strategies. For instance, Lee (1999) describes the impact of HIV prevention among youth involved in the FOCUS community child-support programme in Zimbabwe. "The youth became aware of HIV and the meaning of AIDS through the care work with children. The RED CROSS is also increasingly involving young people in HIV care and prevention efforts in many different countries, knowing that this helps them to keep safe while expanding support and care to others."

Many faith organizations take the same approach; UNAIDS and UNICEF (1999) documented a wide range of responses in eastern and South Africa, showing both their achievements and the challenges they face.

2.3 THE SCALE OF ORPHANHOOD

HIV/AIDS affects children through increased morbidity and mortality as well as through increased impoverishment and orphanhood as parents die. The numbers of children becoming orphans is increasing sharply in many countries and children tend to be orphaned by AIDS at a younger age than from other causes of parental death. UNAIDS estimated that, (by mid 2000) in Africa 13.2 million children aged under 15 has (d) lost their mother or both parents to AIDS. (UNAIDS 2000a; 13).

According to Foster 2000a; the projected orphans in nine South African countries between 1990 – 2010; shows that the numbers of maternal (loss of mother) or paternal (loss of father) orphans are projected to double; the number of double (loss of both parents) orphans are projected to increase 17-fold, from 0.2 million to 3.4 million. Based on the United States of America census Bureau projections, by 2010, 28% of all children in South Africa will have lost one or both parents. The most affected will be Botswana (37%), Zimbabwe (34%), Swaziland and Namibia (32%) and South Africa (31%). In Zambia, the central board of health (1997) estimated that the country will have a half a million children under 15 orphaned by AIDS (mother or both parents) by 2000 and double that number by 2010. This is a country that is beginning to show a decline in urban HIV incidence in young people. According to UNAID (2000b), of all children orphaned by AIDS worldwide 95 % live in Sub –Saharan Africa.

Most Children Orphaned by AIDS do not have HIV (Foster, 2000a, estimates only 1:24 based on the analysis by Hunter, 2000). This is because few children born with HIV outlive their parents. As the rate of transmission from mother to child is reduced, even fewer children who are orphaned will be infected. They may become at a higher risk of infection as they grow up,

however, if they are sexually abused, at risk of unprotected casual sex, or forced to sell (unprotected) sex to survive.

According to Foster (2000a: 132), children from these households must be cared for by other households, normally in the extended family, or by other relatives moving into the initial household. The main carers in most societies are aunts and uncles but, with increasing ill health and deaths amongst them too, elderly grandmothers and older siblings are increasingly also becoming the main carers. In Zambia for instance, more than one quarter of all children under 15 are already orphaned, and an estimated two-thirds of rural households already look after one or more orphaned children. To be in a household containing orphans has become the norm, not the exception.

Urban households have fewer orphans, according to UNICEF Zambia (1999) because they prefer to send the children to other relatives in the rural areas where the cost of living is lower. The irony is that the burden of care is falling predominantly on the less well – resourced households, not the richer ones, echoing an earlier finding in Kenya (Saoke et al, 1996:54). In the Kenyan study, majority of families accepting orphans were living below the poverty line, while wealthier, often urban relatives did not keep up much contact.

A 1996 UNICEF study in four heavily affected communities in Kitwe and Choma districts in southern Province of Zambia found that, over 50% of surveyed children had lost one or both parents and 71.5% of all households were caring for at least one orphan. The study also found that 98% of all orphans were being cared for by a surviving parent, the extended family, or grandparents (Project Concern International, 1999: 1).

2.4 SUMMARY

This chapter set out the theoretical background of the impact of HIV/AIDS on children in Southern African. The chapter also highlighted the scale of orphan -hood in Southern Africa. The outstanding highlight of the chapter is that, among the most devastating effects of HIV/AIDS epidemic in Southern Africa is that it is orphaning generations of children- jeopardizing their rights and well-being, as well as compromising the overall development prospects of their countries.

CHAPTER 3

LITERATURE REVIEW:

CARE OF CHILDREN AFFECTED AND INFECTED BY HIV/AIDS

3.1 INTRODUCTION

Children who have lost one or both parents need a lot of support. They have to deal with grief as well as survival. Most orphaned children are supported by relatives who are usually older women, often unemployed or on pension. The family eventually becomes poorer and in need of food and financial support. A large number of orphans stay on alone in the family home when their parents die. Older children look after young ones and try to find ways to survive. Thousands of children are living in desperate poverty in these child-headed homes. Many of them drop out of school and some turn to sex work or crime to survive (UNICEF: 2003: 13). Some children are taken in as foster children while others go to orphanages or institutions.

This chapter looks at the different options to the care of children affected and infected by HIV/AIDS. The chapter lays a theoretical background that will serve as a frame of reference for the research.

3.2 CARING FOR ORPHANED CHILDREN

Paradoxically, the effectiveness of the African extended family in absorbing millions of vulnerable children has contributed to the complacency of external agencies concerning the emerging orphans' crisis (Foster and Germann, 2003: Unpublished).

According to AIDS AFRICA: *Continent in Crisis* (2002:273), long before the emergency of the HIV/AIDS epidemic, the extended family in Africa has been taking care of the vulnerable children. Today development agencies are increasingly recognizing the need to assist children affected by AIDS, and several broad responses are emerging; these are:

- Identifying all children in exceptional need and promoting support for their well-being in the community;
- Identifying children specifically affected by AIDS and targeting community support to them in particular (although not all children affected by AIDS are in need);
- Identifying abandoned orphaned or mistreated children and placing them in foster homes or for adoption; and
- Placing abandoned, orphaned, neglected or mistreated children in residential care.

However, in different countries, the combinations vary, partly along urban-rural divides, but with by far the greatest number of children remaining in the community cared for by extended family. Foster and Germann (2003: Unpublished) contend that, care and coping strategies must be sustainable over time, be able to assist large and rapidly increasing numbers of children orphaned and / or in exceptional need be culturally acceptable and take into account the multiple developmental needs of children, not just their basic physical needs. This means that support efforts must be primarily community supported with external assistance.

According to the UNICEF Namibia in UNICEF (2001:43) "....the child support initiative in Namibia...where the number of children orphaned by AIDS increased five-fold between 1994 and 1999, the Government and UNICEF offer equipment , supplies and materials to day care centers that provide free services to orphans. A center receives pit latrines, tarps, crayons and

paper to be used by all children, and the orphans are assured much needed care. And families are more likely to adopt children orphaned by AIDS because they are guaranteed free day care".

Further support for children must be seen in a wider development context, not in isolation. Care for children may be an entry point into the community for other development programmes, including off-course, HIV prevention. As Kerkhoven and Harnmeijer (1998:14) notes, "maintaining that orphan care as a care issue alone focuses on the short-term and ignores the long-term need for adequate orphan care as an effective prevention strategy.

According to recent research, strongly felt concerns about orphans and other vulnerable children (OVC) can be the issue that brings the community together and prepares them to address other shared concerns as well. The OVC project has potential as a cost effective way of mobilizing communities around shared community concerns about orphans, and it can also be the starting point of community problem solving around other issues such as health, sanitation, nutrition, support for home-based care and HIV/AIDS education and prevention activities. There is growing interest in ways that orphan activities and other kinds of care activities can be the entry point of promoting HIV prevention (Project Concern International, 1999: 13).

It is essential to focus on the basic needs and human rights of all children, and to concentrate where possible on those in particular need, rather than select for special treatment those whose parents die of AIDS. "Children in especially difficult circumstances" (CEDC) is a common term to reflect this focus or, as project Concern International and some others prefer, 'Orphans and other Vulnerable children' (OVC), or simply VC (Vulnerable Children). The point is to help meet children's unmet needs, not to label them as orphans, let alone, "AIDS orphans"- Meaning children whose parents have died of AIDS. Also potentially stigmatizing is the term "CABA"

(Children Affected by Aids) although this is increasingly used in literature. [AIDS AFRICA: *continent in crisis,* 2002:278].

In many African cultures the term "orphan" has little meaning, as parents' brothers and sisters are also considered to be mothers and fathers rather than the western concept of uncles and aunts. Provided an aunt or uncle remains alive, and can care for the child, the child is not an orphan. However, with the gradual breakdown of extended families in many countries, the escalation of poverty and the sheer numbers of children now being orphaned by AIDS, orphanhood has taken a new meaning and child-headed households have emerged for the first time on a wide scale.

3.3 COMMUNITY CARE

The first response to problems caused by HIV/AIDS comes from the affected children, families and communities themselves, not from government agencies, NGOS or donors. However, given the scale of problems and the fact that those hardest hit are often the most disadvantaged, this first response will be insufficient on its own. Additional assistance from Governments, NGOS and donors is crucial (Hunter & Williamson, 1998:4)

The impact of Aids is experienced first at individual household and family levels, and gradually more widely in the community. Hunter and Williamson (1998:5) note that, the first responses also take place at this level. They suggest five broad responses crucial to ensure that the individual local responses have the greatest chance of success. These are based on the concept of different levels of safety net described by Foster (2000a: 2) as follows;

- *Strengthening family capacity to cope*, in particular with immediate material problems and the extra burden faced by women. Valuable inputs include Labour-saving initiatives

(e.g. piped water if women are going long distances to access water: micro –credit schemes especially targeting women; and services that protect widows and children's inheritance rights. Support is also needed for vulnerable children and adults physical and psychological health.

- *Stimulating and strengthening community responses* to identify, support and monitor the neediest households on the assumption that those in greatest need are often those least able to seek help themselves. In different communities, various traditional mechanisms may exist to assist needy families. For example, in parts of Zimbabwe, local chiefs would set aside certain area of land to be cultivated communally and the produce distributed to those in need (Zunde Ramambo). Many other examples of community coping strategies exist in different countries to meet special needs during a drought, food shortage or other recurrent events that stress routine coping mechanisms (UNAIDS, 1999). Faith communities in many countries also provide care and support more effectively. The priority is to built on the existing traditions and structures rather than introducing totally new concepts that have less chance of being sustained: and to explore with the community how the current resources can be developed, supported and restructured to address new needs. Communities do adapt, cultures are dynamic, and their innate strengths need to be built on. What locally driven and locally acceptable innovations could help transform the capacity of the traditional responses, rather than replacing them with foreign and external approaches. The communities have not before met the long-term challenge and disaster of widespread double orphan-hood and should not be left to cope alone.
- *Direct government support for the most vulnerable children* may be needed when children fall through the community safety nets, when they are abused, neglected or exploited for Labour. This requires appropriate legislation and commitment to human

rights and its effective implementation through government, NGOs, community mobilization, and other efforts. Where governments are not democratic; and community empowerment is in effect a threat, the role of non-governmental sector is particularly crucial. In most countries in Sub-Saharan Africa, too, State welfare provisions are extremely limited and declining. Facing the reality that they are unlikely to improve in declining economies, they need to refocus their roles and develop strategic partnerships with other development agencies within a clear policy framework. Communities will remain in the forefront of identifying needy children and need of access to external support to provide effective care through their existing and new structures. Direct government support may supplement provisions in a few extreme cases, but the roles of policy development, monitoring and coordinating support jointly and democratically with others are central.

- *Building that capacity of children to support themselves.* This is both a short-term and a long-term need. ' Even while AIDS is removing highly educated and skilled workers from the labor force , it is forcing the children and young adults who could replace them to leave school, increasing their poverty, frustration, and social disaffection' (Hunter and Williamson, 2000:12).

According to 'Mama Mkubwa' (The Big Mama Model - Rufigi Coastal region, Tanzania) in this remote region of Tanzania, with a population of around one million, an estimated 35,000 children had lost one or both parents by the mid-1990s. DANIDA supported the local branch of the society of women and AIDS in Africa, Tanzania (SWAAT) and the National AIDS control programme. (NACP) to establish a support programme for orphaned children being cared for within extended families. In this programme, SWAAT members selected big Mamas 'women who are retired civil servants or unemployed who have sufficient education,

skills and motivation for the role. They also attend various workshops to build their capacity ...the benefit and limitations of the programme are being monitored so that it can be adapted and initiated elsewhere. Two key benefits noted are that, the programme helps make the existing community care stronger and more sustainable; and that, it taps into the underutilized community resources; the many educated but unemployed women available in the area (which does not off-course imply that uneducated and illiterate women cannot contribute too) (NACP, 1997: 6).

Finally, NGOs, governments and other development agencies have to take some risks to achieve the goal of community –led orphan-support programmes. They must genuinely support communities to take the lead in identifying children in need and channeling support to them, and trust intermediary organizations, including NGOs and CBOs (Community Based Organizations), to control and disburse funds. NGOs, government departments and other agencies, where appropriate, need to provide back-up monitoring, liaison between donors and recipients, support accounting and management processes with the community, and ensure effective evaluation.

3.4 ORGANIZED COMMUNITY FOSTERING AND FORMAL ADOPTION.

Foster and Germann (2001: 8) observe that the extended family is not a social sponge with an infinite capacity to soak up orphans. Accordingly the traditional safety net is becoming saturated, overwhelmed and weakened by a combination of three detrimental factors i.e.

- Orphan prevalence is increasing dramatically.
- The number of prime-age caregivers is being reduced.
- The safety net is unraveling as a result of social change.

According to Foster, et al (2001:8), crises occur when children are abandoned, or parents die and nobody steps in immediately to care for them. A young child abandoned or bereft today does not just need help in a week's time, but at once. If no relatives are available, able or willing to help, should these children be placed in residential care? The deal is not residential institutions, but rather the availability of foster homes in the community on a temporary or long-term basis, registered and available to take in children in crisis. In the absence of sufficient foster homes, then residential institutions can play a valuable crisis role as long as the commitment remains to getting the children back into community care as soon as possible. The risk is that the institution becomes an easy dumping ground and the next stage, resettlement in the community, gradually declines. The presence of a network of supervised foster homes could avert this outcome.

South Africa is a country with highly urbanized population (over 50% live in urban areas); the need for short-term and possibly long-term residential child-care facilities may increase. This will be particularly true if extended family networks have broken down or, as Foster and Germann (2001:11) observe, the extended family becomes 'saturated'.

Nonetheless research has proved that fostering in the community will be a more sustainable and appropriate option if the cultural taboos against fostering can be overcome and if families or single families are supported to undertake this role. Supported foster care could be a valid form of income generation, meeting the needs of far more orphaned children than could be met through an institutional response, and providing foster parents with a source of income that could assist women to avoid for example, sex work to survive. Appropriate monitoring and support services would need to be established to ensure a basic quality of care.

In many countries, taboos about adoption pose a further barrier to effective care in the community. Many African individuals or couples who are childless are unwilling to adopt children because of fears that this will anger ancestral spirits. Other relatives may in future blame any misfortunes in the family on the presence of children with the wrong totem or from the wrong clan. Yet, this is beginning to change. In Zimbabwe, for instance, increasing number of women and couples whose own children have grown up and left home are willing to foster or adopt young children (Orphaned) from residential homes. Powel (2002:32), suggests that, the cultural barriers are slowly being overcome in the country. Predominantly, these parents have a strong religious faith. Foreigners also adopt a few orphans if they can overcome the legal barriers.

Siamwiza (1998:8) describes legal barriers arising in Zambia around formal fostering and adoption, with civil and customary law often in conflict. She comments on the need for legislation to change in the context of massive number of children needing foster or adoptive homes, and for the formal mechanisms, including the role of the state and of the NGO'S, to adapt to meet the new realities of AIDS. The existing realities cannot cope. Normalizing informal fostering may be more workable and adoptive than trying to apply rigorous legislation to formal fostering and adoption.

Various specific problematic issues also arise that need to be resolved, for instance over property inheritance, and whether fostering and adoptive parents have the right to demand an HIV test on the child and the obligation to undergo an HIV test themselves. Siamwiza's view on the latter is that, "prospective parents who agree to foster or adopt an HIV-positive child should know the child's HIV status and be assisted to cope with the child's and their own needs.

Siamwiza however, does not comment on whether prospective parents should also be tested- and, if so, should HIV-positive couples be denied the right to foster or adopt a child? The international standards is that the rights of the child comes first, and the fear is that a fostered or adopted child, apart from facing likely bereavement again, might be used as cheap labour in the home as the parents become sick. As people survive longer with good health care and, potentially, anti-retroviral, the arguments become more complex. Ideally, each situation should be assessed on a case-by-case basis, although in reality the human resources are not in place for in-depth assessments in many countries.

3.5 INSTITUTIONAL CARE

When concerned agencies and individuals consider the devastating impact of AIDS on impoverished children, a common aim is to build residential care –centers. A well-resourced residential home can guarantee clothing, food, education, companionship and induction into a set of moral or religious codes. Institutions always have an appeal to donors because they can see how their money is spent, and it is obvious how the children are benefiting from the expenditure. Several critical concerns, however, argue overwhelmingly against the development of the residential children's homes as the key response to the epidemic. One, is the full impact of residential care on the children; second, is the economic cost of residential compared to community care and related issues of sustainability; third, is the negative impact on community care and on communities providing alternative child care in institutions.

According to AIDS AFRICA: *Continent in Crises (2002:286)*, at first, these negative outcomes are not merely risks in residential care, but some, such as, sexual abuse, or major risks of orphaned, neglected and deprived children in the community also. In both settings, children at

risk need identifying and provided with sensitive long-term support. In community care, however, the risks of loss of cultural identity and dislocation are much lower, and the dramatic transition from institution to community is avoided.

Secondly, children taken into well-resourced residential care do gain certain benefits materially and with regard to education. For the most part, they emerge well dressed, well, fed, healthy and well educated. Nevertheless, what they loose is considerable and may cause severe psychological and social damage. As well as often being an insignificant member of a large institutional group, Children in residential care may well not know their totem, essential in various cultures with regard to seeking acceptable marriage partners. They will have lost a substantial part of their sense of belonging to a particular community or area, especially if the home is far from where they were born. As siblings may not be kept together, bereaved children may lose the last possibility of family togetherness. They may be separated on the basis of age or gender or both. For, instance, in Harare, abandoned or orphaned babies may spend their first two or three years in one institution before being send to another institution for a further few years after which they may be allocated according to gender to another institution for their teenage years. Each transition is major separation, akin to bereavement.

The burning questions are; what *chances do children with such experiences have as adults to enter with full confidence into a trusting marriage? How will they dare to love another human being too deeply, if they have an underlying fear of inevitable loss based on repeated personal experience?* According to Okello (2003/2004) field experience as a development worker: the assumption is they may have a desperate need for love and acceptance that they tolerate all forms of abuse for fear of driving the partner away, or their unmet needs from their childhood surface in other ways. Some become excessively demanding, some become alcoholics, and some take

out their underlying anger and frustrations on others, including sexual and physical abuse. People who had emotionally deprived childhood's react differently, but common to all is, emotional baggage of one sort or another that makes successful adulthood harder to achieve.

According to AIDS AFRICA: *Continent in Crises (2002) ed.*, when children reach a certain age they have to leave the residential home and start to fend for themselves. They may well have an advantage because of their education but they may have no obvious home or community to go to. and be isolated at a young age in a difficult environment. They may not have the psychological resilience let alone the skills to cope effectively, and they may eventually embark on crime, turn to alcohol and other drugs, engage in sex work and other actions that marginalize them further.

Sexual abuse is a widespread problem, particularly for girls, in many communities, with orphaned children often at increased risk. The occurrence of sexual and other abuse in residential care is also a far wider problem than once realized. Severe cases of abuse have been identified in children's homes in numerous countries in both the developed and developing world. Often, the children who are abused have nobody to whom they can, or dare report the abuse, even more so than the abused children in the community. Worse, those who do report abuse may not be believed and the abuse may be covered up. Often the perpetrators are those in authority in the home, even men in the priesthood or who have status that makes society unwilling to doubt them. (Jackson, H: 287)

When a priest running a boy's home in Harare committed suicide in early 1980s, a search of his rooms found a range of implements he had used to assault the boys. Medical examinations of many of the boys in hi 'care' revealed sexual and physical abuse. Today, the risk is not merely physical and emotional trauma, but HIV infection too. Boys brutalized in this way are a risk of

assaulting others weaker than themselves and acquiring or transmitting infection. Girls (and boys) who have experienced early sexual assault may invite further assault when they grow up, or enter sex work because of their low self-esteem, and hence also expose themselves to HIV risk. They do not want to be assaulted but have lost too much self-esteem and confidence to behave in ways that would keep them safe. (Jackson, H: 287)

A further argument against residential care is that, in many instances, homes are not actually well resourced in the first place, and it may be difficult to attract and keep qualified, appropriate staff. If resources dry up, the children may be at a high risk of severe poverty. Yet, welfare departments may be unable to keep up with the numbers of unregistered residential centers setting up let alone monitor or take action on those they know about. A survey of registered children Homes in Zimbabwe in the 1980s (Powel, 2002) found high death rates in some homes caring for young children (this was prior to high AIDS-Related mortality) and was related to poor nutrition, poor sanitation, and little access to health services. The costs of providing quality residential care are extremely high. The main costs of any sizeable institution include:

- Capital costs of the buildings and facilities themselves, and maintenance and running costs;
- staff training in social work, child care and community liaison;
- direct food, clothing, health, recreational, welfare and educational costs for the children;
- staff salaries, which includes the care staff, administrative staff and others; and
- transport.

Ironically, higher standards in some residential homes can lead to further problems as children grow up. If for instance, they live in modern, attractive home, children may look down on the much poorer communities around them and find it difficult to adapt to the outside world when

they leave the home. Further, the higher the standard of care and material provision in a residential center, the more attractive the center may appear as a resource to take over the care of the abandoned or orphaned children. The result is that extended family members and the community at large may become less willing to undertake care roles themselves, particularly if they are poor and receive little support compared with the money going into the residential care. Thus, the impact of residential care provision may be directly to undermine community willingness and capacity care for these children themselves. As a strategy it is dependency creating (Kluckow: 2001:23).

According to Kluckow, (2001:25), the world –renowned SOS villages that provide family style care for orphaned and abandoned children are aware of these difficulties, and are still struggling with how to resolve them. One suggestion is to increase integration with the community by supporting orphaned families in special houses built outside the SOS village.

3.6 SUMMARY

This chapter examined different options to the care of children affected and infected by HIV/AIDS. The chapter laid a theoretical background that will serve as a frame of reference for the research.

The chapter established that, children in Southern Africa orphaned by HIV/AIDS or otherwise affected by the epidemic:

- First, need help to recover as much as normality and security as they can, emotionally, physically, educationally;

- Second, only strengthened communities are tipped to provide the best opportunity for this to occur : and
- Lastly. Since from the start of the epidemic, communities have quietly adapted to care for these children, albeit with varying resources and degrees of success; they now need support to expand their care, commensurate with the rising numbers of orphans and needy children in their midst.

In the review of literature it was also, established that, orphanages are a new phenomena to the African set-up and that there are very few orphanages available for the thousands of the children who need care. More so, orphanages are a very expensive way of looking after children since the building, staff and services are costly. Thus a need for further research on the effectiveness of institutional (orphanage) care for children affected and infected by HIV/AIDS.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Neuman (2000:190) defines methodology as a research plan of action to measure variables of interest. The aim of this study was to establish whether care of children affected and infected by HIV/AIDS at Khayelihle Children's Home is sufficient and has had any considerable impact. This chapter discusses the major components of the methodology of the study. These include; the research design, the sampling procedure, tools of data collection, the research instruments and the methods of data analysis.

4.2 RESEARCH DESIGN

A study design is the researcher's plan of action for answering the research questions. According to Fischer, et al (2000:45), the objective in selecting a study design is to minimize possible errors and bias by maximizing the reliability and validity of data. This study used a non-experimental study design commonly used in HIV/AIDS operational research studies.

Fischer, et al (2000:54), points out that this type of study design is most appropriate for collecting descriptive information or for conducting small case studies. The study design was also regarded useful by the researcher as a diagnostic study to determine the reason why a problem exists. Hence a post-test-only study design used is herewith represented as follows:

Time

Experimental group ⟶

X O_1

Where

⟶ = Is the passage of time. The extreme left of a design is the beginning of the study. The Extreme right is the end.

X = Is a programme intervention, an experimental intervention (e.g. care of Children at Khayelihle home).

O_1 = An observation measurement. The subscript is used to distinguish one observation measurement from another e.g. O_1, O_2, O_3, O_4.

In this design, a program intervention (X) = care has been introduced, and after its introduction, a measurement observation (O_1) is made. Since there is no control group, there is no possibility of comparing the O_1 measurement to any other measurement.

Raymond (1996:158), advocates for this kind of research design adding that, as a plan, the research design specifies the sequencing and arrangement of independent and dependent variables in operational research studies.

The threats to validity of history, maturation, selection, and mortality are not controlled and were factors considered by the researcher before choosing this design. The design was appropriate since the researcher wanted to assess the impact and characteristics of the care for children affected and infected by HIV/AIDS at Khayelihle children's home.

4.2.1 RELIABILITY AND VALIDITY

Reliability refers to the consistency, stability, or dependability of the data. According to Fischer, et al (2000:44), whenever a researcher measures a variable, he or she wants to be sure that the measurement provides dependable and consistent results that is, a reliable measurement is one that, if repeated the second time will give the same results as it did the first time. Neuman (1997:139), is in agreement adding that, what is meant by reliability is that, the information provided by indicators (i.e. a questionnaire) does not vary as a result of characteristics of the indicator, instrument, or measurement devise it self.

In this kind of survey study, reliability problems commonly result when the respondents do not understand the question, are asked about something they do not clearly recall, or are asked about something of little relevance to them. Neuman (1997:140) is in agreement with Fischer and suggests four principles of which he contends, when followed will increase the reliability of measures. These principles are:

- Clear conceptualization of constructs, i.e. developing unambiguous, clear theoretical definitions in order to eliminate 'noise' (distracting or interfering information) from other constructs;
- Use of precise level of measurement, i.e. indicators at higher or more precise levels of measurement are more likely to be reliable than precise measures because the latter pick up less detailed information;
- Use of multiple indicators of a variable, i.e. two or more indicators of the same construct are better than one; and

- Use of pretests, Pilot studies, and Replication, i.e. developing one or more draft or preliminary versions of a measure and trying them out before applying the final version in a hypothesis-testing situation may take more time and effort, but it is likely to produce reliable measures.

Validity on the hand refers to data that is not only reliable but also true and accurate. Put another way, according to Fischer, et al (2000:45), validity is the extend to which a measurement does what it is supposed to do. Thus, if a measurement is valid, it is also reliable. But if it is reliable it may not necessarily be valid. Neuman (1997:141), on the one hand points out that validity is an overused term and is often confused with related ideas i.e. it is sometimes used to mean 'true' or 'correct'. The author advises that, when a researcher says that an indicator is valid, it is only valid for a particular purpose and decision. He adds that, the same indicator can be valid for one purpose (i.e., a research question with units of analysis and universe) but less valid or invalid for others.

According to Fischer, et al (2000:46), most operational researchers distinguish between two types of validity namely, internal and external. 'Internal validity refers to situations in which you find that your measurements are true and accurate and you can answer with confidence that a particular experimental intervention actually made or did not make a difference in a particular geographical setting with a particular population group at a particular time in history'.

Cook and Campbell (1979:89) are of the opinion that, internal validity means there are no errors internal to the research design. They differentiate between high internal validity which means there are few such errors and low internal validity which means that such errors are likely.

There exists however an argument that, a study with high internal validity may not necessarily have high external validity. Fischer, et al (2000:46) and Neuman (1997:145), are in agreement that, "external validity refers to the extent to which results of a study can be generalized to other settings or groups." They argue that, if something happens to among a particular group of subjects (e.g. college students), can the findings be generalized to the general public. Neuman is of the opinion that high external validity means that the results can be generalized to many situations and many groups of people while low external validity means that the results apply only to a very specific setting.

4.2.2 THREATS TO VALIDITY.

In selecting the research design for this study, the criterion used was the extend to which the design would control the threats to validity. In other words, the researcher wanted a design that would give true and accurate information whilst avoiding confounding factors that might invalidate the study.

At a minimum, the researcher wanted a design that would allow him the findings of whether the care for children infected and affected by HIV/AIDS at Khayelihle children's home really made a difference, that is, the researcher wanted a design with high internal validity.

4.3 SAMPLING PROCEDURE

As an operational research study, this study depended on data that was obtained from samples. According to Fischer, et al (2000:62)," a sample can be thought of as a model of a larger

population... and it consists of a relatively small number of individuals or other units that are selected from a larger population according to a set of rules".

4.3.1 THE POPULATION

The research population comprised of children affected by HIV/Aids under residential care of Khayelihle children's home and their caregivers that included, the international volunteers, the grandmothers and the aunts. The study was on the care for the children affected and affected by HIV/AIDS and who were under the care of Khayelihle children's home.

4.3.2 THE SAMPLING STRATEGY.

According to Raymond (1996:106), there are two general types of samples: probability (or random) and non-probability samples and that the nature of the operational research study determines which type of sampling to use. This study employed a probability sampling as a technique to maximize external validity or generalizability of the results of the study. Three factors were considered in determining how accurate the sample was a description of the population of Khayelihle children's home they are stated below:

i. the methods used to select the elements must not bias the sample, that is, the sample must be truly a representative of the larger universe;
ii. the characteristics of a sample must be consistent with the characteristics of the population of interest: and
iii. the numerical estimates provided by the sample should accurately represent the values of the population. (Fischer, et al., 2000:65)

Thus, the essence of employing probability sampling in this study is that each element of the larger population (i.e. each child, each volunteer, each grandmother and each aunt) had a known, non-zero probability of being selected. This was achieved through a random selection of units for the sample from a list (sampling frame).

4.3.3 SAMPLING FRAME

By definition, a sampling frame is a list of the population from which the sampling units are drawn. For the purposes of this study, the sampling frame' consisted of 25 volunteers, 18 caregivers and 97 children.

The completeness of the sample frame was critical to the "representative ness" of the sample chosen from the frame. Finally the sample size was made to be moderately large enough to deliver the level of accuracy or precision required in the estimate of the value of the total population.

4.3.4 STRATIFIED SAMPLING.

The population of Khayelihle children's home consisted of stratas (groups), that is; the grandmothers, the volunteers, the aunts and the children that are different from each other and consisted of very different sizes.

To ensure that all-relevant stratum of the populations were represented in the study sample, the researcher used a stratified sampling technique.

Stratification was used in conjunction with systematic sampling (a modification of simple random sampling which was ordinarily less time consuming and easier to implement) whereby, the estimated number of elements in the larger population was divided by desired sample size, yielding a sampling interval ***n***. Upon Stratification, each strata was treated as a separate population.

The sample frame was arranged by strata and then a systematic sample was drawn from each by selecting every $n^{th.}$ case, starting with a randomly selected number between ***1*** and ***n***

Thus ***n*** was calculated as follows:

The desired sample size was 60 respondents

Total population was equal to 127 people

$$n = 127/60 = 2.1$$

$$n = 2$$

A proportionate stratified sample was drawn from the stratified population. It was important that the designation of the elements of study at Khayelihle (that is, the children, aunts, grandmothers and the international volunteers) be the same as the composition distribution of the population of study, thus a proportionate sample by use of same or unified sampling fraction was drawn from each group (that is, the strata that composed of the children, or the volunteers or the aunts etc).

The sample included every $2^{nd.}$ Child, every $2^{nd.}$ Volunteer, every $2^{nd.}$ Grandmother, and every $2^{nd.}$ Aunt.

4.4 RESEARCH INSTRUMENTS

One of the most common ways to collect quantitative data on people is to use a standard questionnaire that is administered by a trained interviewer. Fischer, et al (2000:46) points out that there are two ways of collecting data, these include; self–administered questionnaires, service statistics, or such secondary sources as the census, vital records, an HIV/Aids sentinel surveillance system or other existing records and samples.

4.4.1 STRUCTURED INTERVIEW.

Raymond (1996:242) and Fischer, et al (2000:74), are in agreement that, "...studies which obtain data by interviewing people are called surveys, and if the people interviewed are a representative of a sample of a larger population, such studies are called sample surveys".

Raymond (1996:404), defines a structured interview as one in which the specific wording and order of questions is predetermined and standardized for all interviewees.

Given that the sample for this study was large enough to permit statistical analysis, it was convenient to use a structured interview. A structured interview was used to ensure that respondents were asked exactly the same set of questions in the same sequence. The exact wording of each question was specified in advance, and the researcher merely read each question to the respondents.

4.4.2 PILOT STUDY

A pilot study is the one that allows a researcher do the pre – testing of questions asked to the respondents thus, doing away with ambiguity and that validity is concerned with the soundness and the effectiveness of measuring instruments (Leedy, 1993:32).

A pilot study was carried out using respondents from Khayelihle Children's Home in April 2004 with twenty children, five aunts, five grandmothers and five international volunteers. This was done in order to gain insight and familiarity with the environment of the study and improve on the research instruments and on the premise that a preliminary of a questionnaire is useful to determine if items were yielding the required information.

The questionnaires were administered to the five volunteers, whilst informed and guided structured interviews were conducted with twenty children on the first day, five aunts and five grandmothers on the second day making a total of thirty – five respondents.

4.4.2.1 RESULTS OF THE PILOT STUDY

Preliminary results from the children, aunts and grandmothers revealed that; all children, aunts and grandmothers respondents (100%) were residents of the children Home; the majority (80%) indicated that they were not happy with the care for children at the children's Home; all the children respondents reported that nobody gives them personalized attention as regards their psychological development; all the aunts indicated dissatisfactions with their job as caregivers; lastly, all the respondents indicated that they were not appreciated by the home management.

4.4.2.2 RESULTS FROM THE VOLUNTEERS

The preliminary responses from the volunteers indicated that: all the Volunteer respondents felt that their time at the home was too short to form a bond with the children; 90% indicated that they were confused of the care given at the home since there were no clear guidelines prescribed to them; 100% were dissatisfied with the care being offered indicating their concerns that the care was not directed towards child development.

The purpose of the pilot study was to test the research design and the methodology. It emerged that certain questions needed clarity, and the researcher was required to add some information specifically in the category of children. Instruments were then adjusted where respondents indicated a problem of understanding. Some items were corrected for clarification such as instances where they could use "yes or no". Though the respondents indicated some problems in understanding the proper guidelines as regards the care for children affected by HIV/AIDS, this was not removed but, "Yes" or "No" response was the option to use.

4.5 DATA QUALITY CHECKS

The researcher used several ways to check the quality of data obtained from the structured interview. These are as outlined below:

- The researcher asked two to three questions that yielded the same type of information. The first questions were asked at the beginning of the interview whilst the other similar questions were asked towards the end of the interview. Similar questions were then examined for consistency of response; and

- For difficult questions or sensitive questions of which the researcher wanted to be sure the information was correct, probing was applied, i.e., the researcher repeated the question in a slightly different form or repeated the respondents answer and then asked if the information was correct or not.

4.6 DATA ANALYSIS

According to Raymond (1996:300), data analysis is the process by which large sets of numbers are reduced to smaller sets to make it more understandable. Raymond is in agreement with Fischer, et al (2002:92) that, the purpose of data analysis is to provide answers to the research questions being studied. Both authors are of the view that the research questions dictates the type of data to be collected during the study and the type of the analysis to be performed.

For the purposes of this study, analysis was seen as an ongoing process that commenced at the beginning of the survey study. Each stage of the study provided valuable data that influenced the progress of the study. However, information gathered during the field survey was analyzed in the form of statistics, tables, graphs, pie charts and coding of data.

4.7 LIMITATIONS OF THE STUDY.

According to Fischer, et al (2002: 117), one of the most important responsibilities of a researcher is to report on the limitations and problems of their study. Gumbi (2004) (unpublished) warns that '*....when you know of problems and limitations before starting a study, you should discuss them in the operations research proposal...*" Accordingly, he adds that, " *.....you should report these and any additional problems that occur during research in the write-up of the study.*"

Gumbi (2004) warns against concealment and misinterpretation of the limitations or problems of the study.

4.7.1 DESIGN AND ANALYSIS LIMITATIONS

The main problem was with the reliability and validity of the data, the size of the sample, the questionnaire design, and the analysis plan.

This study attempted to keep these problems to a minimum, but some problems remained. These include:

- Overall, language barrier was the greatest limitation. The research relied on the interpreters for the interview schedule since all the aunts and grandmothers did not communicate in English;
- It was difficult to organize the interview schedule for children, since most of them were involved in various activities around the home and had to be forced to come for the interview;
- Transport and weather were a major limitation, by the fact that the area of study is in a rural setting, accessibility by road is not very easy. The researcher had to walk a distance of fifteen kilometers from the nearest taxi rank to the home; and
- Lastly, it took long for the Management of Khayelihle children's home to grant permission for the survey study which was eventually issued after the researcher explained to them the purpose and benefit of the survey study to the children and the home.

4.8 SUMMARY

This chapter dwelt on the discussions of the methods employed in the collection and analysis of data. This is an operational, survey, diagnostic study and as discussed in the chapter, data was analyzed both qualitatively and quantitatively. Structured interviews were employed for the collection of data.

CHAPTER 5

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

According to Mugenda (1999:115), data obtained from the field in raw form posses challenges when interpreting. Such data must be cleaned, coded, key punched into a computer and analyzed. It is from the results of such analysis that researchers are able to make sense of the data.

This chapter presents data, analyses and interprets the findings of the study. The first section of the chapter provides an analysis of the population studied as well as information on Khayelihle children's home.

The second section focuses on the effectiveness of the care for children at Khayelihle children's home in regard to developing resilience in children. It discusses the views of the children and the caregivers in regard to the provision of welfare services i.e. food, clothing, shelter, education and access to health care.

The third section focuses on the assessment of the care in regard to protection of children from exploitation, abuse and neglect. Also discussed are the views of the caregivers in ensuring there availability and maintenance of a long term caring consistent, affectionate and skilled care giving staff.

The fourth section analyses the effectiveness of the care at Khayelihle Children's Home in fostering the development of a close and secure relationship with caregivers as well as allowing a close relationship with the remaining family members.

The fifth section focuses on the care for children at Khayelihle Children's Home in regard to the imminent death of parents, identity, uniqueness and a sense of personal continuity especially in the maintenance of a close link with the cultural community.

The sixth and the last section of the chapter analyses the effectiveness of care at Khayelihle Children's Home in regard to maintenance of a good autobiographical memory, promotion of children's emotional expressions and a sense of belonging.

Questions are analyzed individually and findings tabulated and recorded as frequencies and percentages and by use of graphical representations e.g. Histograms, bar graphs and pie charts etc.

5.2 ANALYSIS OF THE STUDY POPULATION

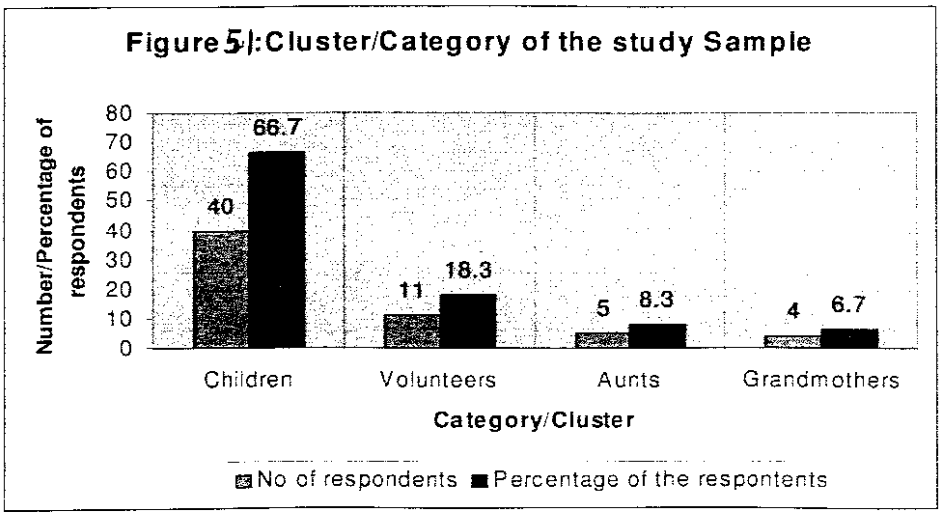
The total population at Khayelihle Children's home is approximated at 127 people excluding the management staff (Khayelihle staff database: 2004). This population is clustered into five categories depending on the functional role at the home. The clusters are the children, the volunteers, the aunts, the grandmothers and the management staff. A total of sixty people took part in the study.

The table 5.1: Shows the cluster/category of the study sample:

Cluster/Category	N	Percentage (%)
Children	40	66.7
Volunteers	11	18.3
Aunts	5	8.3
Grandmothers	4	6.7
Total	**60**	**100**

As tabulated in table 5.1, the study sample comprised of, 40 (66.7%) children who were the majority, 11 (18.3%) volunteers, 5 (8.3%) aunts and 4 (6.7%) grandmothers who formed the minority of the total population of study at Khayelihle Children's Home. The findings in table 5.1 are also presented in figure 5.1.

Figure 5.1 :Cluster/Category of the study Sample



From the findings as represented in figure 5.1, it can be deduced that children were the majority of the respondents, thus the evidence that the larger population at Khayelihle Children's Home are the children under care hence the name Children's Home. Volunteers made up 18.3 %.

Khayelihle Children`s Home predominantly relies on the services of international volunteers for the care of children and its operations. The volunteers originate from various countries in Europe and the United Stated of America. They stay on at Khayelihle Children`s Home for a period ranging between two to six months. They are involved in the day to day care of the children at the home.

The aunt's percentage of 8.3 % can be explained by the fact that, they make significant part of the care giving staff. They form an interface between the grandmothers, the children and the volunteers. Most aunts have basic formal education and therefore can read and write. Volunteers cannot communicate in the local IsiZulu language so in most times aunts act as internediaries. The aunts are also utilized in the socialization of the children especially in blending of Zulu and western cultures.

Only 6.7 % of the grandmothers were interviewed. This is explained by the fact that most of them are not considered in the care giving staff category, however some function as housemothers for the children whilst others are predominantly utilized in subordinate roles as cleaners, cooks and launders.

The findings on gender disparities indicated that out of 60 respondents, 25 (41.2%) were males whilst 35 (58.3%) were females. This finding indicates that the majority of the respondents were females. An indication that males were not fully involved in the care of children at Khayelihle and that most vulnerable of the children in care were female

5.3 PROVISION OF A SAFE, NURTURING ENVIRONMENT IN WHICH THE CHILDS NEEDS ARE MET.

Resilience should be encouraged and developed in all children. According to Silke-Andrea (2002:5), all children are born with the potential to be resilient, but resilience has to be developed, just like other skills and capabilities. Provision of sustained subsistence in terms of welfare services, access to health care, and education is one way in which children in care are helped to develop resilience. Silke-Andrea (2002:3), points out that provision of enough food, clothing and access to health care forms part of the external resources that help build resilience in children.

Questions in regard to provision of food, clothing, shelter, and health care were asked to establish whether the care for children at Khayelihle children's home ensured a sustained provision of subsistence for survival as a human being. The results are as summarized in table 5.2 as follows:

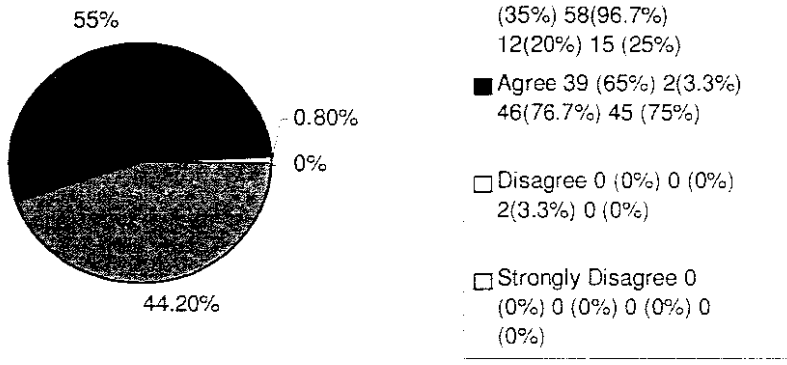
Table 5.2: Shows responses in regard to provision of food, shelter, clothing and access to health care at Khayelihle children's Home.

Variable	Strongly Agree	Agree	Disagree	Strongly Disagree	Total
Food	21 (35%)	39 (65%)	0 (0%)	0 (0%)	**60(100%)**
Shelter	58(96.7%)	2(3.3%)	0 (0%)	0 (0%)	**60(100%)**
Clothes	12(20%)	46(76.7%)	2(3.3%)	0 (0%)	**60(100%)**
Health care	15 (25%)	45 (75%)	0 (0%)	0 (0%)	**60(100%)**
Mean	**44.2%**	**55%**	**0.8%**	**0%**	

The findings as tabulated indicate that on average 44.2 % of the respondents strongly agreed that the care at Khayelihle children's home ensured a sustained provision of subsistence in terms of food, clothing, shelter and health care. Fifty-five percent on average indicated that they agreed whilst only 0.8 % of the respondents on average indicated their disagreement of whether the home provided sufficient subsistence necessary for survival.

The findings can be presented graphically as follows in figure 5.2:

Figure 5.2: Provision of food, shelter, clothing and access to health care (on Average)



The findings as represented in figure 5.2 indicates that the majority of the respondents either strongly agreed (44.2%) to, or agreed (55%) to the questions on whether at Khayelihle children's home their was a sustained provision of subsistence.

These findings concurs with studies across sub-Saharan Africa by Jackson, et al (2002:285), whose findings shows that, '...when concerned agencies and individuals consider the devastating impact of AIDS on impoverished children, a common aim is to build residential care homes...a well – resourced residential home can guarantee clothing, food, education and access to health

care.'. They further argue that, institutions often have an appeal to donors and a sustained provision of subsistence level is an indicator to them (donors) on how their money is being spent which is an obvious case on how children are benefiting from the expenditure.

5.4 PROTECTION FROM EXPLOITATION, ABUSE AND NEGLECT.

Studies across Sub-Saharan Africa as documented by Jackson, et al (2002:287) indicate that, "...sexual abuse is a widespread problem, particularly for girls, in many communities, with orphaned children often at increased risk". The study findings further revealed that, "... the occurrence of sexual and other abuse in residential care is also a far wider problem than once realized and severe cases of abuse, neglect and exploitation have been identified in children's homes in numerous countries in both the developed and developing world". The study concluded that, "often children who are abused have nobody to whom they can or dare report the abuse, even more so than abused children in the community..... worse , those who do report abuse may not be believed and the abuse may be covered up since often the perpetrators are the caregivers".

This study endeavored to establish whether the care for children at Khayelihle children's home ensured protection from exploitation, abuse and neglect of children. The results are as presented in table 5.3.

Table 5.3: Shows responses in regard to protection from exploitation, abuse and neglect of children at Khayelihle children's Home

Indicators	Yes	Sometimes	Occasionally	No
Knowledge of children Whereabouts	21(35%)	39(65%)	0(0%)	0(0%)
Protection of children Rights	9(15%)	21(35%)	21(35%)	9(15%)
Consistent Healthy Discipline	33(55%)	15(25%)	12 (20%)	0(0%)
Explanation of Discipline	24(40%)	9(15%)	27 (45%)	0(0%)
Mean	**36.2%**	**35%**	**25%**	**3.8%**

The findings as tabulated in table 5.3 revealed that only 35% of the respondents always had knowledge of the children whereabouts, whilst 65 % of the respondents indicated that they were only sometimes aware of the children's whereabouts. The findings indicated an existence of a risk factor, since children, especially girls, are vulnerable and at a high risk of sexual abuse and exploitation. An around the clock knowledge of the whereabouts of children is essential in ensuring protection of children from abuse and neglect.

Fifteen percent of the respondents indicated the knowledge of children's rights and enforced them; 35 % indicated that they sometimes protected children rights and enforced them, the other 35 % of the respondents indicated that they occasionally protected children rights and enforced them, whilst 15 % of the respondents indicated that they were unaware of the children's rights and therefore they did not enforce them.

Human rights of children are an ethical imperative. The United Nations Convention on the Rights of the Child (UNCRC) enshrines guidelines within which countries should develop national laws and policies that affect children. Key provisions of the UNCRC relevant national responses to the AIDS epidemic (among other concerns) as cited in Jackson, et al (2002:260) include:

- *Article 3: includes the provision that the best interests of the child shall be a primary consideration in matters concerning the children; and*
- *Article 19: Concerns the protection of children from abuse, neglect, maltreatment or exploitation.*

These guidelines according to UNCRC should assist advocates for child rights, policy makers, service providers and communities in their efforts to ensure that children's needs and rights are not neglected.

On whether the care at Khayelihle Children's Home ensured a consistent healthy discipline, the findings showed that 55% of the respondents' said yes to the question indicating that discipline was consistent, 25 % of the respondents indicated that the discipline was sometimes consistent, whilst 20 % of the respondents indicated that discipline administered was occasionally.

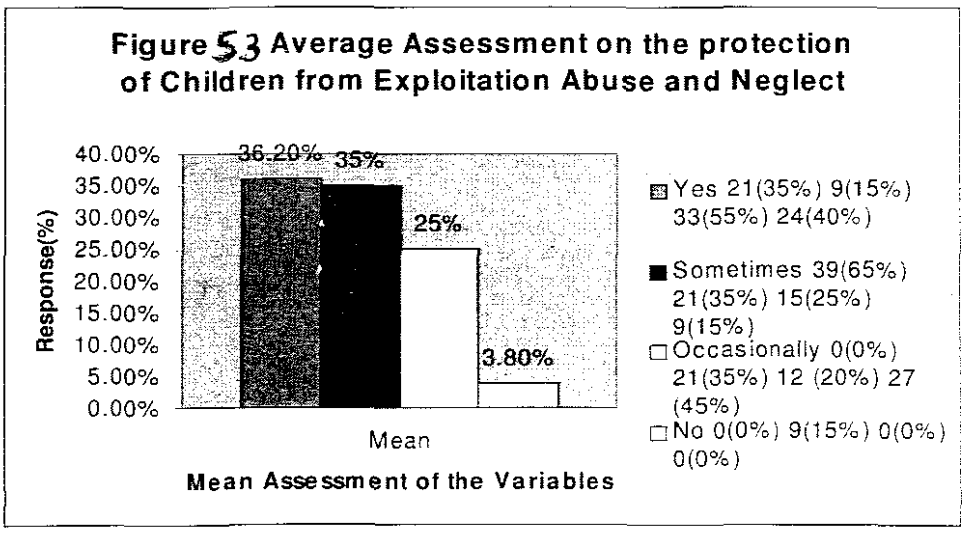
On the question of whether the caregivers explained to children why some form of discipline was necessary; 40% of the respondents indicated that the care givers actually explained to children why some form of discipline was necessary, 15% of the respondents indicated that sometimes a form of discipline was explained to the children, whilst 45 % of the respondents indicated that it was only occasionally that children were explained to some why some form of discipline was necessary.

A study carried out after a priest running a boys' home in Harare committed suicide in the early 1990s, revealed that a search of his rooms found a range of implements he had used to assault the boys. The study findings adds that, medical examinations of many of the boys in his "care" revealed sexual and physical abuse (Jackson, 2002:287).

In as much as *Article 19* of the United Nations Convention on the Rights of the Child (UNCRC) provides for *Concerns about the protection of children from abuse, neglect, maltreatment or exploitation:* Today, the risk is not merely physical and emotional trauma, but HIV infection too. Boys traumatized as in the case of the Home in Harare are at risk of assaulting others weaker than themselves and acquiring or transmitting infection (Jackson, et al, and 2002:270).

The findings are represented graphically in figure 5.3 as an average assessment with regard to protection, exploitation and abuse of children at Khayelihle Children's Home.

Figure 5.3: Average Assessment on the protection of Children from Exploitation Abuse and Neglect



Collating the findings from the four variables an average assessment as represented in figure 5.3 above indicates that out of 60 respondents, 36.2% indicated that the care at the home ensured protection of children from exploitation, abuse and neglect, 35 % indicated that this was sometimes ensured but not always, 25 % indicated that the ensurance was occasionally whilst 3.8% indicated that never were children at the home protected from abuse, neglect, and exploitation.

5.5 AVAILABILITY AND MAINTENANCE OF LONG-TERM CONSISTENT, CARING AND AFFECTIONATE CAREGIVERS

Availability of and maintenance of long-term, caring consistent and affectionate care-giving staff is necessary for the care of children in an orphanage. Table 5.4 gives the suggested variables in

relation to the care at Khayelihle Children's Home in ensuring the availability of long-term care giving staff.

Table 5.4: Suggested variables necessary in ensuring the availability of long-term care giving staff.

Indicators	**Respondents**	**Percentage (%)**
Give Incentives	30	50
Give Good Remuneration	3	5
Training for Care Givers	12	20
I Don't Know	15	25
Total	**60**	**100**

From table 5.4, the findings indicate that 50 % thought that by giving incentives the availability and maintenance of long term care givers will be ensured; 5 % indicated that good remuneration were necessary in the form of salaries etc. 20 % indicated that it was necessary to organize training for care givers in relation to care for children in orphanages since most of them had minimal knowledge on the care of children affected or infected by HIV/AIDS in an orphanage. 15 % were not aware on what could be done to ensure the availability of long term care giving staff members.

On whether or not the incentives given to the care givers were enough, the findings were as tabulated in table 5.5:

Table 5.5: Indication of whether the incentives for Care giving staff were sufficient.

Response	N	Percentage (%)
Yes	0	0
Sometimes	9	15
Occasionally	30	50
No	20	35
Total	**60**	**100**

None (0%) of the respondents indicated whether the incentives were sufficient. 15% indicated that sometimes incentives were enough for them. 50 % indicated that occasionally incentives were sufficient whilst 35 % indicated that the incentives were never sufficient for them.

The findings indicate that on average, what the caregivers require in order to remain and provide their care service is incentives of which as established in figure 5 above were not sufficient in the case of Khayelihle children's home. These findings conquer with the argument by Helen Jackson et al (2002) that "...usually it may be difficult for a poorly resourced orphanage to attract and keep qualified, appropriate staff".

5.5.1 DEVELOPMENT OF A CLOSE AND SECURE RELATIONSHIP WITH CARE GIVERS.

Related questions in relation to who amongst the caregivers children considered to be friendly; who treated them well and to whom they preferred to have a close, secure and trusting relationship with were asked to establish whether the care at Khayelihle children's home encouraged development of a close and secure relationship between children and care givers. The results were as tabulated below in table 5.6.

Table 5.6: Responses on whom the children have a close and secure relationship

Variables	Close Relationship	Treated children well	Friendly	Mean
Volunteers	6(10%)	11(18.3%)	12(20%)	**10(16.7%)**
Aunts	3(5%)	12(20%)	6(10%)	**7(11.7%)**
Grand mothers	0(0%)	0(0%)	0(0%)	**0(0%)**
House mothers	0(0%)	11(18.3%)	3(5%)	**5(8.3 %)**
Other Children	51(85%)	24(40%)	39(65%)	**38(63.3%)**
Total	**60(100%)**	**60(100%)**	**60(100%)**	

The findings as tabulated in table 5.6 indicate that, 10 % of the children interviewed preferred a close relationship with the volunteers. 5% would prefer a close relationship with the aunts. None of the children indicated preference for a close relationship with the housemothers nor the grandmothers, the majority of the children (85%) preferred a close relationship with other children.

On who treated children well, i.e. showed interest in them, the results reveals that 18.3% of the respondents indicated that the Volunteers treated them well, 20 % indicated that the Aunts treated them well, none indicated of good treatment from the grandmothers 18.3% indicated that they were treated well by the Housemothers whilst 40 % indicated that they were always treated well by other children.

On average the majority (63.3%) preferred to have a close relationship with other children. 16.7% preferred volunteers, whilst 11.7% and 8.3% preferred to have a close relationship with the Aunts and House Mothers respectively.

5.5.2 MAINTENANCE OF A CLOSE RELATIONSHIP WITH THE REMAINING FAMILY MEMBERS

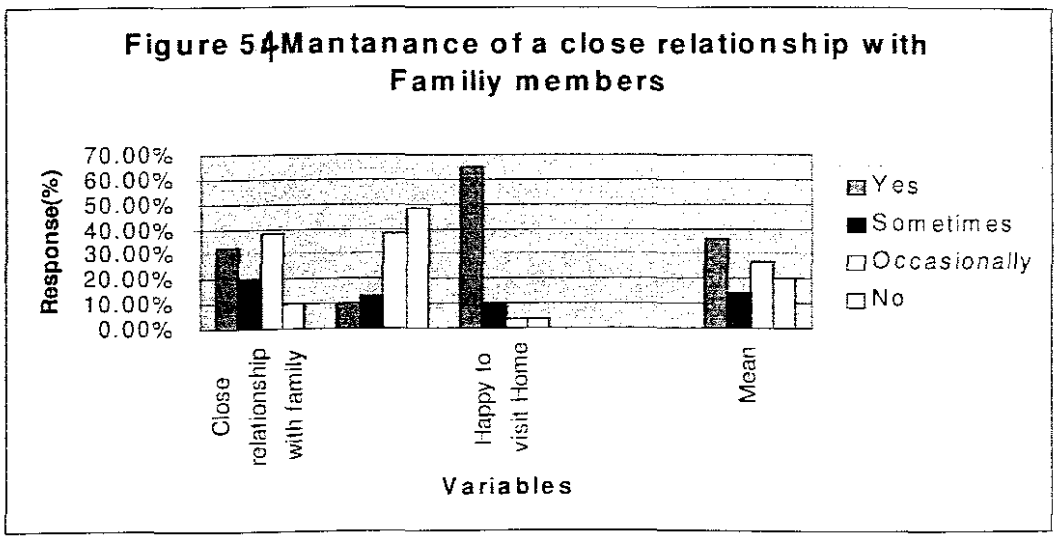
The family is the first environment in which a child experiences love and affection it provides a basic framework for a child's development and has an enormous impact on child's life (Silke-Andrea, 2002:5). This study aimed at establishing whether the care at Khayelihle children's home promoted maintenance of a link with the remaining family members after death of parents and subsequent adoption to an orphanage. The results are as tabulated in table 5.7:

Table 5.7: Responses on the maintenance of a close relationship with the remaining family members

Indicators	Yes	Sometimes	Occasionally	No
Close relationship with family	20(32.5%)	12(20%)	23(38.3%)	6(10%)
Relatives Visited	6(10%)	8(13.3%)	23(38.3%)	29(48.3%)
Happy to visit Home	39(65%)	6(10%)	2(3.3%)	2(3.3%)
Total	**51(107.5%)**	**26(43.3%)**	**48(79.9%)**	**37(61.6%)**
Mean	**17(35.8%)**	**9(14.4%)**	**16(26.6%)**	**12.3(20.5%)**

The findings in table 5.7 are represented graphically as in figure 5.5.

Figure 5.4: Maintenance of a close relationship with family members.



The graphical representation of the findings in figure 5.5 indicated that 32.5 % of the respondents indicated that children maintained a close relationship with their family members, 20% indicated that maintenance of a close relationship with family members was sometimes not always, 38.8 % indicated that this was occasionally whilst 10% of the respondents indicated that children never maintained a close relationship with the family members.

On whether relatives were encouraged to visit the children at the home, 10% respondents indicated that that this was true, 13.3% indicated that sometimes relatives visited, whereas the results from 23(38.3%) respondents indicated that relatives only visited occasionally, whilst results from 29(48.3%) respondents indicated that relatives never visited the children at the home.

Results from 65% respondents indicated that children were happy to visit their homes, 10% indicated that they were sometimes happy, 3.3% of the respondents indicated that they were occasionally happy to visit their homes, whilst 3.3% indicated that they were never happy to visit their homes whilst, 18.4 % of the children did not respond to this question since they were permanently at the children's home and never visited their homes.

A follow up question on how many times during the year a child was allowed to visit their homes revealed that 75% of the respondents visited their homes once in a year, 6.6% indicated that they visited their homes thrice in a year while 18.4% indicated that they never visited their home at all.

The implication of this findings is that, the care for children at Khayelihle Children's Home did not encourage maintenance of close relationship with family members. The findings are in agreement with Silke-Andrea (2002:20), who warns that the importance of family members is easy to overlook. The author advises that, in many societies, the impact of disasters is shared rather than experienced alone and the HIV/AIDS pandemic was not an exception. According to the author, families and relatives in communities have their own resources and traditional ways of coping with adversity and their contribution to the care of children was vital. For this reason, it is important for the maintenance of close family relationships in the care and support of orphans.

5.6 UNDERSTANDING OF THE DEATH OF A PARENT, FUTURE PLANS AND WHO WILL TAKE CARE OF THE CHILDREN AFTER THE HOME.

This study aimed at establishing whether or not, the care for children at Khayelihle children's home helped children in understanding the death of their parents; whether or not, the children were helped to understand the implications of HIV/AIDS, and if children were involved in plans regarding their future. The results are as tabulated below are as presented in table 5.8

Table 5.8: Responses in regard to understanding the death of a parent, future plans and who will take care of the children after the home

Indicators	Yes	Sometimes	Occasionally	No	Total
Understanding of imminent parental Death and future plans	0(0%)	3(5%)	24(40%)	33(55%)	**60(100%)**
Understanding of the HIV/AIDS implications	9(15%)	21(35%)	30(50%)	0(0%)	**60(100%)**
Involved children in Plans regarding their care	0(0%)	0(0%)	30(50%)	30(50%)	**60(100%)**
Total	**9**	**25**	**84**	**63**	
Mean	**3(5%)**	**8(13.3%)**	**28(46.7%)**	**21(35%)**	

The findings on whether or not children were helped to understand the death of a parent, future plans and who will take care of them after the home shows that, 5% of the respondents indicated that they were only sometimes helped to, 40% indicated that they were occasionally helped whilst 55% indicated that they were never helped to understand the imminent death of parent and future plans.

These findings reveals that children at Khayelihle Children's Home were hardly helped to understand the death of a parent and the circumstances that led to their being in a children's home.

The findings on whether or not children were helped to understand the implications of HIV/AIDS and how they could look after themselves indicates that, 15% of the respondents answered yes, 35% indicated that this was only done sometimes, whilst 50% indicated that they were occasionally helped to understand the implications of HIV/AIDS. These findings indicate that children at Khayelihle children's home were hardly helped to understand the implications of HIV/AIDS and how they could look after themselves.

Studies in Southern Africa as documented by Jackson, et al (2002:273) reveals that, children are affected by HIV/AIDS long before they are actually orphaned. The emotional suffering of children when parents become sick and die may never be recognized nor responded to. Thus, involving children in plans regarding their future is necessary for their development and especially in the ownership of the growth process.

Study findings showed that 50% of the respondents as presented in table 5.8 indicated that only on occasion were children involved in plans regarding their care, whilst 50% indicated that children were never involved in plans regarding their care.

Silke-Andrea (2002:13), argues that, children that have been prepared for the death of their parent (either by the parent or by other caregivers) generally cope better with the death because they understand what is happening. The author adds that, parents who prepare for their own deaths by arranging with relatives to take care of their children go a long way towards helping their children accept their deaths and preparing for them for the future. Silke-Andrea (2002: 3), warns that, as for the case of Khayelihle children's Home, without such preparation, the death of a parent can be extremely traumatic for a child. The child may be overwhelmed by the sudden loss and may react with shock and confusion. This, she warns might take longer for the child to understand what happened, making the grieving process more complicated, sometimes causing severe nightmares, hyperactivity or outbursts of anger.

UNAIDS (2001) discusses the psycho-social support needed by children affected by AIDS in understanding of the imminent death of a parent's future plans and who will take care of the children after the home. The report emphasizes the importance of recognizing and responding to their emotional needs. The report advises that, it was important to recognize and understand what children are going through in order to be able to help them understand what is happening. UNAIDS (2001) concludes that, information should not be forced on children before they are ready, but sensitive responses to the questions they ask, and opening up opportunities for them to ask questions, can help a great deal.

5.7 MAINTENANCE OF A GOOD AUTOBIOGRAPHICAL MEMORY

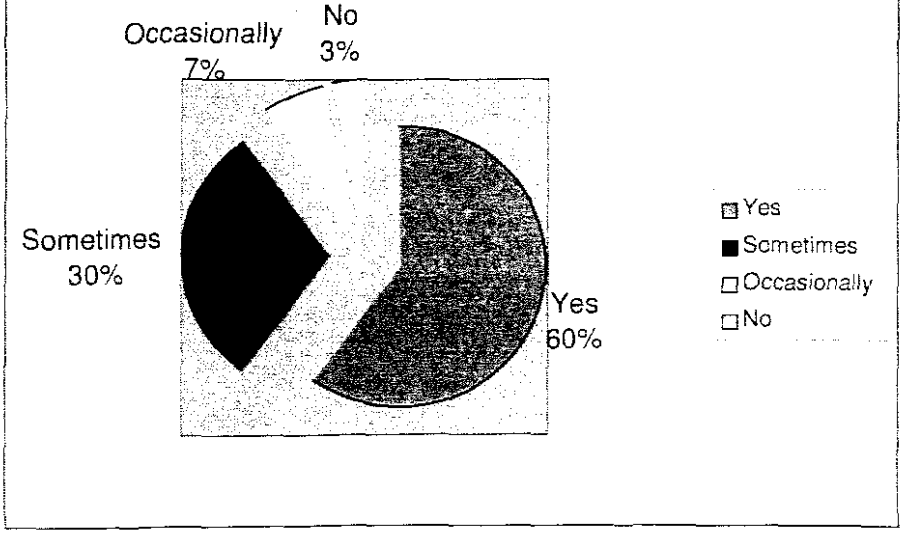
The autobiographical memory is the memory in which personal memories about our lives and histories are saved or stored. Findings on whether or not care at Khayelihle children's home help children in maintenance of a good autobiographical memory is as presented in table 5.9

Table 5.9: Findings in regard to maintenance of a good autobiographical memory.

Response	Respondents	Percentage (%)
Yes	36	60
Sometimes	18	30
Occasionally	4	6.7
No	2	3.3
Total	**60**	**100**

The above findings are represented in the figure 5.5:

Figure 5.5: Findings in regard to maintenance of a good autobiographical memory.



The findings from figure 5.5 indicates that 60% of the respondents indicated that children were helped to maintain a good autobiographical memory, 30% indicated that this was sometimes, 7% indicated that only occasionally were the children helped to maintain a good autobiographical memory whilst 3% of the respondents indicated that children were never helped to maintain a good autobiographical memory. The implication of these findings shows that children in care at Khayelihle were helped to maintain a good autobiographical memory.

Silke-Andrea (2002:4) argues that, a resilient child can usually recall positive relationships, moments of kindness, role models (for example, parents , caregivers or teachers) as well as personal achievements from the past.

5.7.1 CHILDREN EXPRESSION OF EMOTIONS

Asked whether or not children were encouraged to express their emotions the findings are as represented in the table 5.10 .

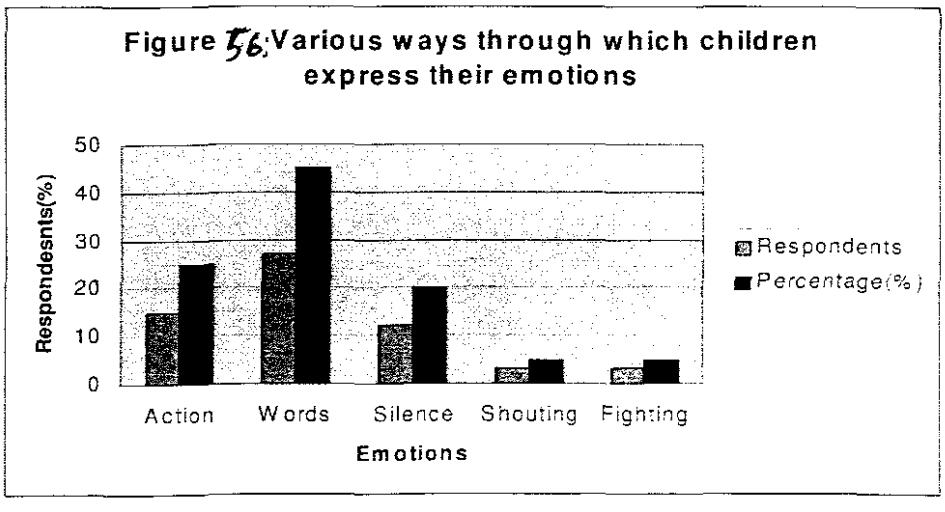
Table 5.10: Responses in regard to children whether children were encouraged to express their emotions.

Response	Respondents	Percentage (%)
Yes	16	26.7
Sometimes	36	60
Occasionally	8	13.3
No	0	0
Total	60	100

The findings as tabulated shows that 26.7% of the respondents indicated that children were encouraged to express their emotions, 60% of the respondents indicated that this was sometimes whilst 13.3% indicated that children were occasionally encouraged to express their emotions. The findings reveal that on average children were not always encouraged to express their emotions but only sometimes.

Asked how children expressed their emotions, the findings are as presented in figure 5.6.

Figure 5.6 : Various ways through which children express their emotions



The findings in the figure 5.6 show that children mainly expressed their emotions verbally (45%) that is, by words, however some reported to show their emotions through actions.

Poulter (1997:20) observes that, the emotional suffering of children when parents become sick and die may be neither recognized nor responded to. Children often become withdrawn (20% of the study findings in figure 5.6) and some will show antisocial behavior (5% - shouting and 5% -

fighting) for which they are likely to be punished. Poulter further observes that, particularly in societies and cultures that devalue children's needs and rights, children are more likely to internalize their pain. Their hidden distress may have long-lasting consequences and, even if they appear to be coping well on the surface, they should have opportunities to explore their fears and anxieties, and to express their feelings. Children may feel, in turn, angry, betrayed, guilty, anxious and despairing. This observation by Poulter concurs with the findings in figure 5.6.

Thus, this finding establishes the fact that the care for children at Khayelihle is not keen on the promotion of children's emotional expression.

5.7.2 A SENSE OF BELONGING

This study endeavored to establish whether or not the care for children at Khayelihle offered children a sense of belonging. The results are as presented in table 5.11:

Table 5.11: Children's sense of belonging

Indicators	Strongly agree	Agree	Disagree	Strongly Disagree	Total
Children fit well with others	31(51.7%)	29(48.3%)	0(0%)	0(0%)	60 (100%)
Happy to be with other children	34(56.6%)	22(36.7%)	0(0%)	4(6.7%)	60 (100%)
Happy with Self	24(40%)	36(60%)	0(0%)	0(0%)	60 (100%)
Happy to be helped by other children	46(76.7%)	14(23.3%)	0(0%)	0(0%)	60 (100%)
Happy to help Others	49(81.7%)	11(18.3%)	0(0%)	0(0%)	60 (100%)
Mean	37(61.4%)	22(37.3%)	0(0%)	1(1.3%)	60 (100%)

The findings in table 5.11 reveals that 51.7% of the respondents indicated that children fitted well with others at Khayelihle Children's Home whilst, 48.3% also indicated that they agreed that children fitted well with others. This finding establishes the fact that children fitted well with others at the home.

Fifty -six percent of the respondents indicated that they strongly agreed that children were always happy to be with other children at the home; 36.7% indicated that they agreed that children were always happy to be with others, whilst a negligent 6.7% of the respondents indicated that they strongly disagreed with the fact of children being happy with others. These findings establish that children were contented to be with others.

Forty percent of the respondents indicated that they strongly agreed with the fact that children at Khayelihle children's home were happy with themselves, the majority (60%) of the respondents showed their agreement that indeed children were happy with themselves. These findings establish the fact that children at Khayelihle were happy with themselves.

The majority (76.7%) of the respondents indicated that they strongly agreed with the fact that children were always happy to be helped by other children in any way possible, whilst 23.3% of the respondents indicated that they agreed. These findings show that indeed children at Khayelihle children's home were happy to be helped by other children.

Eighty one percent of the respondents strongly indicated that children were always happy and keen to help others; whilst 18.3% indicated that they agreed. The implication of these findings is that children had feelings for others.

On average the findings indicate that, 61.4% of the respondents strongly agreed that Khayelihle Children's Home provided a sense of belonging for the children; whilst 37.3% of the respondents indicated that they agreed. However 1.3% of the respondents were strongly in disagreement as to whether or not the home gave children a sense of belonging.

Silke-Andrea (2002: 4) from her studies of orphans and vulnerable children in Masiye Camp, Zimbabwe advises that, resilient children know where they belong. According to Silke-Andrea, such children are detained at home, in the community and have a sense of their own culture whether in the present or the past....understand how they fit into a family, a small group of friends, the school, the community or the church.....are able to look for and find emotional support from other people and are self-confident and also confident of the support of peers and caregivers. However, Silke-Andrea warns that, this support may change from time to time and; it may not be provided by the same person over an extended period of time but may change, as the child's needs change.

5.8 SUMMARY

This study has established that, Khayelihle Children's Home is a well resourced residential care home for children affected and infected by HIV/AIDS and Children in care do gain certain benefits materially and with regard to education. For the most part, the study established that in as much as children emerge well dressed, well fed and healthy, nevertheless what they lose is considerable and may cause severe psychological and social damage.

The study further established that siblings do not live in the same house and that bereaved children face a danger of losing the last possibility of family togetherness. They are separated on

the basis of age or gender or sometimes both. Overall, this study established that care at Khayelihle Children's home was not sufficient in meeting the developmental needs of the children. It was established that children were not given personal attention and social connections the families and communities can provide.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter summarizes the major findings arising from the study, gives conclusions and suggested recommendations for improvement of the care for children affected and infected by HIV/Aids at Khayelihle Children's Home. The chapter is presented in two major headings: The first part gives the summary of the findings or conclusions of the study, while the second part gives the recommendations of the study.

6.1.1 RESTATEMENT OF THE OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

- To assess the effectiveness of the care for children at Khayelihle Children's Home in regard to provision of sufficient subsistence (food, clothing, shelter, medical service and education).
- To establish whether or not children are protected from exploitation abuse and neglect at Khayelihle Children's Home.
- To assess the effectiveness of the care at Khayelihle children's home in fostering the development of a close and secure relationship with caregivers as well as allowing a close relationship with the remaining family members.

- To determine whether or not the care of children at Khayelihle Children's Home helped children understand the death of a parent, their identity, uniqueness and sense of personal continuity especially in the maintenance of a close link with the cultural community.
- To establish whether or not the care at Khayelihle Children's Home offers children a sense of belonging through maintenance of a good autobiographical memory, and encouragement of expression of emotions which is a prerequisite for psychosocial development.

6.1.2 RESTATEMENT OF THE ASSUMPTIONS OF THE STUDY

The following were the assumptions of the study:

- The effectiveness of the care for children at Khayelihle Children's home depends on the availability of long-term care giving staff and the resources to provide subsistence (food, clothing and shelter).
- Development of resilience in children depends on the following capabilities: the capability to understand an adverse event (e.g. death of a parent); the capability to believe that they can cope with crises because they have some control over what happens; and the capability to give deeper meaning to an adverse event.
- Proper institutional care promotes, close links to cultural community, a good autobiographical memory, a value and belief system and room for creativity, innovation and curiosity through the recognition of children's uniqueness and their participation in decisions.

6.2 SUMMARY OF THE FINDINGS.

For each of the major areas of the study, the results have been summarized in the paragraphs that follow. These summaries are based on the research questions that were used to guide the study.

Question 1: Care for children at Khayelihle in ensuring a sustained provision of subsistence for survival as a human being.

Care at Khayelihle children's Home ensures a sustained provision of subsistence in the form of food, clothing and shelter (Table 5.2 in Chapter Five summarizes the indicators as concerns provision of food, clothing, shelter and health care.). The study established that care at Khayelihle Children's Home ensured a sustained provision of food, clothing and shelter. Children were accorded enough food, good shelter and enough clothing. It was also established that Khayelihle Children's Home maintained a hospice, which ensure provision of health care for the children. It was further established that children according to gender and age groups lived in four houses under the care of housemothers who were the day to day guardians for the children.

It was however, established that although the care for children at Khayelihle ensured a sustained provision of subsistence for the children, it was difficult for the care to maintain provision of a balanced diet due to the cost of food.

Question 2: Care for children at Khayelihle in ensuring protection from exploitation, abuse and neglect.

The study established that on average, the caregivers and the children themselves had little knowledge of children's rights and that they were unaware as to whether children had additional rights besides rights to basic subsistence. Thus, from the study findings, (Table 5.3, chapter five) it was established that, rarely were children's rights promoted as per the White Paper for Social Welfare (1997:60).

The study further established that, care at Khayelihle children's home ensured consistent healthy discipline for children in the form of punishment by detention at a corner or sometimes denial of play or food (Table 5.3, chapter five). In addition, the study established that, in most cases, the caregivers were not obliged to explain to children why some form of discipline was necessary or administered.

Question 3: Care for children at Khayelihle Children's Home in ensuring maintenance and availability of a long-term caring, consistent, affectionate professional care-giving.

The findings established that maintenance of a consistent, caring care-giving staff, depended on provision of a good remuneration in the form of salaries and incentives, which was not sufficient for the grandmothers and the aunts (Table 5.4, Chapter 5). The study also established that, Khayelihle Children's Home was not keen on maintaining a consistent and long term care staff since it relied predominantly on the services of international volunteers who worked free for short-term periods of between one to three months in a year.

Question 4: Care for children at Khayelihle Children's Home in ensuring development of a close and secure relationship with caregivers.

The study established that children preferred to have a close relationship with other children since the main care givers who were the volunteers only stayed for short-periods of one to three months at the home (Table 5.6, Chapter 5). The study however established that the volunteers were friendly to children and in most cases they treated children well as compared to the aunts and grandmothers who were impersonal.

Question 5: Encouragement of Children under care of Khayelihle Children's Home to maintain a close relationship with the remaining family members.

The study established that, rarely were children encouraged to maintain a close relationship with the remaining family members, and that relatives rarely visited children at the home (Table 5.7, Chapter five). The study further established that, as a rule of the home, siblings were not kept together as such, hence it was established that children at Khayelihle were denied the last chance of close family relationships. In addition, the study established that some children were allowed to visit their relatives only once in a year for two weeks while the rest of the children were mainly at the home.

Question 6: Helping of children at Khayelihle Children's Home to understand the death of a parent, future plans and who will take care of them after the home.

The study established that children rarely helped to understand the death of a parent, future plans and who will take care of them after the home (Table 5.8 chapter five). The study established further that, children were rarely involved in plans regarding their care, and that, they were never helped to understand the implications of HIV/AIDS and how they would look after themselves.

Question 7: Care of children at Khayelihle Children's Home in ensuring maintenance of a close link to cultural community.

The study findings established that, children at Khayelihle Children's Home were helped to maintain a good autobiographical memory,(Table 5.9, chapter five) through story telling about their families, whereas some children were provided with own place to keep possessions from family, while some had the memory box from deceased parents kept for them.

Question 8: Encouragement of children at Khayelihle Children's Home to express their emotions.

The study established that, children were not encouraged to express their emotions freely and that on occasions children were punished when they expressed how they felt (Table 5.10, chapter five).

The study however, established that, majority of the children expressed their emotions through actions, crying and fighting while some preferred to keep to themselves (Quite) or refuse to eat food (figure 5.6, chapter five).

Question 9: Care for children at Khayelihle Children's Home offering children a sense of belonging.

On average, the study established that most of the children were happy to be with, help and be helped with other children and that, children were always happy to be with others. In addition, the study established that the care for children at the home provided a sense of belonging for the children (table 5.11, chapter five).

6.3 CONCLUSION

The above discussion cannot be complete until one very important question has been satisfactorily answered: Firstly, is the care for children at Khayelihle Children's Home effective? This actually is what the study was aimed at. Based on the findings of the study, the researcher hopes that a fair diagnostic evaluation has been made of the extend to which the care for children affected and infected by HIV/AIDS at Khayelihle Children's Home could be said to be effective.

The care for children at Khayelihle Children's Home was found to be effective in ensuring a sustained provision of sufficiency subsistence for children's' survival as human beings in terms of food, clothing, shelter, medical service and education.

However, it was established that the care for children at Khayelihle Children's Home did not always meet children's rights and that children were prone to exploitation, abuse and neglect by the care givers or other children. This was evidenced by the fact that discipline for the children was sometimes not properly never explained.

Second, the care at Khayelihle children's home was found to be not effective in fostering a close and secure relationship with caregivers as well as allowing a close relationship with the remaining family members. Children were not encouraged to have a close relationship with care givers, rather the time at which the international volunteers spent with the children at the Home was not sufficient for any bonding to take place. Siblings were not kept together, and children were allowed only a two week holiday with their relatives in a year. this completely cut them off from maintaining a close relationship with the remaining family members.

Third, the care of children at Khayelihle children's Home, rarely helped children understand the death of a parent, their identity, uniqueness and sense of personal continuity especially in the maintenance of a close link with the cultural community. Further, children were not involved in plans regarding their care. Decisions affecting children's life at the home were arrived at without them being involved.

Lastly, in as much as the care for children at Khayelihle Children's Home offered children a sense of belonging through maintenance of a good autobiographical memory, it denied children an essential ingredient for psychosocial development, 'the emotional expression'. Children need to be encouraged to express how they felt in whatever form for them to develop psychosocially and resilient to deal with the imminent challenges of life as orphans in the face of HIV/AIDS epidemic.

6.4 RECOMMENDATIONS

From the results of the study, a number of recommendations are made in an effort to improve the care of children affected and infected by HIV/AIDS at Khayelihle children's home, and in our communities and in Sub-Saharan Africa as a whole.

(a) Provision of subsistence for survival as a human being.

This study recommends that care for children at Khayelihle Children's Home should ensure, provision of a safe, nurturing environment in which the child's needs are met. This includes access to health care, education and welfare services.

(b) Protection from exploitation, abuse and neglect.

The study recommends that the care for children at Khayelihle Children's Home should ensure that caregivers spend time with the children, listen to them instead of talking about them, and show interest in them, in what they do, think and feel and even play. Further the study recommends that, children should be allowed to make mistakes. Children should be helped to recognize and understand their mistakes, be encouraged to correct what they did wrong; and be supported to deal with negative thoughts, feelings and behavior.

(c) **Maintenance of long-term caring, consistent, affectionate professional caregivers.**

The study recommends that Khayelihle Children's Home should recognize the role played by the grandmothers and the aunts in care giving. They should be well remunerated and appreciated for their work as primary caregivers of the children in care.

Further, the study recommends that, Khayelihle Children's Home should aim at recruiting long-term volunteers other than short-term volunteers in the care for children, and that all volunteers should be well inducted in the care for children before being entrusted with the care giving role for children.

(d) **Development of a close and secure relationship with caregivers.**

The study recommends that, care for children at Khayelihle Children's Home should encourage development of a close and secure relationship between the children and the caregivers. Volunteers who leave the home for their countries should be encouraged to maintain long-term contact with children at the home through letters, telephone etc.

(e) **Maintenance of a close relationship with the remaining family members.**

The study recommends that, care for children at Khayelihle Children's Home should encourage maintenance of a close relationship with the remaining family members through allowing children to visit their relatives during the year and also encouraging relatives and family members to visit children at the home on a regular basis. Further, the study recommends that children and relatives should be encouraged to maintain contact through the mail and telephones

and that siblings should be kept together in one house under a single housemother where possible.

(f) **Children understanding of the death of a parent, future plans and who will take care of them after the home.**

The study recommends that, care for children at Khayelihle Children's Home should help children understand the death of their parents, future plans and plans after the children's home by:

- Encouraging children participation in decisions affecting them where, the best interests of the child must be a primary consideration. (This is relevant to orphans and vulnerable children where decisions are being made regarding caretakers, property and futures, but extends much further to all matters that concern children, including development policies and programs and allocation of public resources);
- Respecting views of the children. Their views must be given due weight in accordance with their age and maturity.

(g) **Maintenance of a close link to cultural community**

The study recommends that, children should be involved in the day-to-day activities as well as family rituals, cultural rituals, religious rituals and festivals. Children should be taught family routines i.e. caregivers should be encouraged to provide clear routines for the day and to expect the children to stick to the routine.

(h) **Children's expression of emotions**

The study recommends that children should be taught how to communicate with other people. They should be taught how to express their emotions, ideas and how to solve problems and conflicts and in most cases they should be encouraged to express their emotions in whatever way they feel comfortable to without fear of being punished.

6.5 RECOMMENDATIONS FOR FURTHER RESEARCH

It is recommended that more research to conducted to establish the effectiveness of care for children affected and infected by HIV/AIDS involving the community as an alternative to institutional and foster care in relation to the following programming guidance:

i. Focus on the most vulnerable children and communities, not only those orphaned by HIV/AIDS.
ii. Definition of community -specific problems and vulnerabilities at the outset and pursue of locally determined intervention strategies.
iii. Inclusion of young people as active participants in the response.
iv. Giving particular attention to the roles of boys and girls, men and women, and addressing gender discrimination.
v. Strengthening of partners and partnerships at all levels and building of coalitions among key stakeholders.
vi. Link of HIV/AIDS prevention, activities, care and support for people living with HIV/AIDS, and support for orphans and other vulnerable children.
vii. Use of external support to strengthen community initiative and motivation.

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Appendix I

SURVEY OF THE CARE FOR CHILDREN AFFECTED INFECTED BY HIV/AIDS AT KHAYELIHLE CHILDRENS HOME, CATO RIDGE SOUTH AFRICA

QUESTIONNAIRE

PART 1: PERSONAL DATA.

1. **Sex:** Male[ ] Female [ ]

2. **Age group:**

Below 5 years [ ]

5 – 8 years [ ]

3. **Designation:**

Children [ ]

Volunteer [ ]

Aunt [ ]

Gogo [ ]

PART II: PROVISION OF A SAFE, NURTURING ENVIRONMENT IN WHICH THE CHILDS NEEDS ARE MET.

4. Do you provide enough and nutritious food to the children?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

5. Do you provide a secure shelter and dwelling place for the children?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

6. Do you provide children with appropriate and enough to clothes?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

7. Do you provide ensure children's access to healthcare and medical services? the children?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

PART III: PROTECTION FROM EXPLOITATION, ABUSE AND NEGLECT

8. Are you always aware of the children whereabouts?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

9. Do you always protect the children rights and enforce them?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

10. Do you always ensure consistent and healthy discipline i.e. familiar place and known routine?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

11. Do you explain to the children why certain form of discipline is necessary?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

PART IV-a: AVAILABILITY AND MAINTENANCE OF LONG-TERM CONSISTENT, CARING AND AFFECTIONATE CAREGIVERS.

12. How do you ensure availability of long-term caring, consistent, affectionate, considerable and available caregiver?

Give Incentives [ ]

Give Good Remunerations [ ]

Training for Care Givers [ ]

I Don't Know [ ]

13. Are the incentives given to the caregivers and volunteers sufficient?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

PART IV-b : DEVELOPMENT OF A CLOSE AND SECURE RELATIONSHIP WITH CAREGIVERS.

14 . To whom does children have a close/secure relationship with?

Volunteers [ ] Aunts [ ] Grandmothers [ ]

Housemothers [ ] Other Children [ ]

15. Who always treated children well?

Volunteers	[ ]	Aunts	[ ]	Grandmothers	[ ]
Housemothers	[ ]	Other Children		[ ]	

16. To whom do children prefer to make friends with?

volunteers	[ ]	Aunts	[ ]	Grandmothers	[ ]
Housemothers	[ ]	Other Children		[ ]	

PART IV-c: MAINTENANCE OF A CLOSE RELATIONSHIP WITH THE REMAINING FAMILY MEMBERS.

17. Are children encouraged/helped to maintain a close relationship with the remaining members of your family?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

18. Are relatives' allowed/encouraged to visit children at the home?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

19. Are children always happy to visit their relatives at home?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

PART V: UNDERSTANDING OF THE IMMINENT DEATH OF A PARENT FUTURE PLANS AND WHO WILL TAKE CARE OF THE CHILDREN AFTER THE HOME.

20. Do help children understand the imminent death of a parent, future plans and who will take care of them after the home?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

21. Do you help children understand implications of HIV/aids? And how they can look after themselves?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

22. Do you involve the children in plans regarding their care?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

PART VI : MAINTENANCE OF A GOOD AUTOBIOGRAPHICAL MEMORY

23. Are children encouraged/ helped maintain a good autobiographical memory?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

PART VII: CHILDREN EXPRESSION OF EMOTIONS

24. Are children encouraged to express their emotions?

Yes [ ] Sometimes [ ] Occasionally [ ] No [ ]

25. How does children express their emotions?

Action [ ] Words [ ] Silence [ ] Shouting [ ] Fighting [ ]

PART VIII: A SENSE OF BELONGING

26. Does children fit well with others at the home?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

27. Does children feel happy to be with other children at the home?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

28. Are children happy with themselves ?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]

29. Are children happy to help others and be helped?

Strongly Agree[ ] Agree [ ] Disagree [ ] strongly Disagree [ ]