

AN EXPLORATORY STUDY OF SOCIAL
PERCEPTION AND ATTITUDES TOWARDS
HIV/AIDS ORPHANS IN ESIKHAWINI
AND ITS SURROUNDINGS

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By

NOMSA MITCHELL MKHATSHWA

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ATTITUDES TOWARDS HIV/AIDS ORPHANS IN
ESIKHAWINI AND ITS SURROUNDING*

BY

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UNIVERSITY OF ZULULAND

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(II)

DECLARATION

I declare that this research project entitled: **AN EXPLORATORY STUDY OF SOCIAL PERCEPTION AND ATTITUDES TOWARDS HIV/AIDS ORPHANS IN ESIKHAWINI AND ITS SURROUNDING** is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this dissertation was not previously submitted by me for a degree at another university.

.....
(N.M. MKHATSHWA)

DEDICATION

I would like to dedicate this dissertation to my grandmother Sibolile Annah Magagula (LaNkala) and my late mother in law Dzeliwe Mkhathshwa (La Ntiwane).

(IV)

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Most of all I thank the Almighty God who helped me to reach this level.

Without Him I was just nothing.

ABSTRACT

This study looks at some important facts about the attitudes and feelings of grand parents of young orphans with HIV/AIDS in Esikhawini and its surrounding. In real life people with AIDS are discriminated by community. This is due to the lack of information about HIV/AIDS more especial in our rural areas, this affects our young children who are born with or who are being raped by the infected people with the wrong idea that says, "if an infected person sleep with a virgin he would be cured".

This study looks at the treatment of orphan with HIV/AIDS in different age groups. It reveals the impact of living with the pandemic in our community. It is found that people who have been diagnosed as HIV positive are being discriminated against very severely in a range of contexts and environment from school, sports and aspects of service and facilities which have a severe impact on their social lives and self image. Much of this discrimination is in fact unjustified and unfair because no one has asked to be infected.

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CHAPTER ONE

1.1 INTRODUCTION

This research is designed to uncover some important facts about the attitudes and feelings of grandparents of children with HIV/AIDS in Esikhawini and its surrounding. The researcher wants to find out what attitudes grandparents of such children have towards them and to examine clearly the experience that are encountered by young orphans with HIV/AIDS while attending school or playing with their class mates or peer groups.

1.2 STATEMENT OF THE PROBLEM

AIDS is undoubtedly the most formidable public health problem facing South Africa today. Perhaps no disease in modern times has created as much fear and panic, as has HIV/AIDS. In recent years the epidemic has rapidly involved the heterosexual community, mainly affecting people from low socio-economic groups. South Africa currently has a high proportion of children who are not continuously cared for by either parent or very high rates of care by grandparents and by other relatives. This is due to the history of displacement the people to implement the racially segregated society envisaged during the years of apartheid, combined with the migrant labour system. The pandemic insert itself into this already fragile family environment, and one of its worst consequences is the creation of AIDS orphans. Whiteside and Sunter asserted that at present, South Africa is witnessing the emergence of child-headed

households and the conversion of facilities designed for early childhood education into *de facto* residential homes. It has been estimated that KwaZulu-Natal will face 65 500 AIDS orphans by 2000. According to South African Red Cross Society there are about 300 000 orphans with HIV/AIDS at KwaZulu-Natal (Gibson 2001). Children who suffer a loss of a parent to AIDS have their loss exacerbated by prejudice and social exclusion. This exclusion can lead to the loss of education and health care. Whiteside, *et al.* (2000) asserts that the growing up without parents, and badly supervised by relatives and welfare organizations, this growing pool of orphans will be at greater than average risk to engage in criminal activity in order to survive. In Whiteside *et al.*, Schonteich assert that the increasing number of AIDS orphans, who grow up without parental support and supervision may turn to crime. Crime will be made worse by the lack of guidance, care and support for HIV-positive people, including children.

According to statistics released by researchers, non-governmental at a conference held in Durban in January 1998. The UNAIDS issued a map showing global infection. In 1999, there were 2,6 million deaths from HIV/AIDS (see table 1.3). In contrast the HIV-positive population still expanding – there were 5,6 million new infections in 1999 (see table 1.1) and 33,6 million people living with HIV/AIDS (see table 1.2) (Whiteside *et al.* 2000:36-37). It is stated that since the beginning of the pandemic there were 3,6 million children under 15 years (see table 1.4). The South African HIV/AIDS projection (HIV Prevalence) estimated that from year 2000 to year 2002 there will be 600 children with HIV (see table 1.5). AIDS death will be 109 from year 2000-2002 children only.

**THE GLOBAL ESTIMATES OF THE HIV/AIDS PANDEMIC AS OF THE YEAR 1999
PROVIDED BY THE UNITED NATIONS AIDS**

GLOBAL ESTIMATES OF THE HIV/AIDS PANDEMIC

TABLE 1.1 PEOPLE NEWLY INFECTED WITH HIV IN 1999

Children < 15 years	570 000 million
Women	2,3 million
Adults	5 million
TOTAL	5,6 MILLION

Whiteside (2002)

TABLE 1.2 NUMBER OF PEOPLE LIVING WITH HIV/AIDS

Children < 15 years	1,2 million
Women	14,8 million
Adults	32,4 million
TOTALS	33,6 MILLION

Whiteside (2002)

TABLE 1.3 AIDS DEATHS IN 1999

Children < 15 years	470 000
Women	1,1 million
Adults	2,1 million
TOTALS	2,6 MILLION

Whiteside (2002)

TABLE 1.4 TOTAL NUMBER OF DEATHS SINCE THE BEGINNING OF THE PANDEMIC

Children < 15 years	3,6 million
Women	6,2 million
Adults	12,7 million
TOTALS	16,3 MILLION

Whiteside (2002)

SOUTH AFRICAN BASIC HIV/AIDS PROJECTION FROM 2000 TO 2002

TABLE 1.5 HIV PREVALENCE (000's)

YEAR	2000	2001	2002
Adults	3475	3871	4235
Children	173	201	226
TOTAL	3648	4072	4461

Whiteside (2002)

TABLE 1.6 AIDS DEATHS (000's) FROM 2000 TO 2002

YEAR	2000	2001	2002
Adults	125	161	203
Children	31	36	42
TOTAL	156	197	245

Whiteside (2002)

KWAZULU-NATAL ESTIMATES OF THE HIV/AIDS PANDEMIC FOR 2000

TABLE 1.7 PROJECTIONS FOR KWAZULU-NATAL

Adults	1 115 000
People living with aids	71 000
Orphans	65 500
Deaths	53 500
TOTAL	1 305 000

Whiteside (2002)

1.3 **EXPLORATORY STUDY**

For the purpose of this research the researcher postulated the following assumption:

This study is an exploratory study into the perceptions, support and treatment of HIV/AIDS orphans by the grand parents, school children schooling with the orphans and teachers. The investigation is not based on assumptions as such, such as whether, for example, there is stigma attached to grand parents who have HIV/AIDS grand children, but rather the investigation seeks to explore the nature and the extended of the hindrances and facilitators in the live of the orphans.

1.4 **AIMS OF THE STUDY**

The aim of this research is to investigate community support and perceptions of HIV/AIDS orphans with particular focus on:

- Grand parents
- School children with whom they are schooling
- Teachers
- Orphans themselves

1.5 **VALUE OF THE STUDY**

This information will hopefully assist non-governmental organization and government organization in facilitating the role of grand parents and other concerned with orphans who are infected with HIV/AIDS, in guiding the orphans towards becoming more mature adults. It is hoped that young orphans with HIV/AIDS and grand parents

of our contemporary society will be assisted to understand one another better through the use of knowledge generated in this research.

1.6 **DEFINITION OF CONCEPTS**

The concepts that will frequently be used in this research are defined below:

1.6.1 **AIDS**

According to Giddens (1994:748) AIDS can be defined as a disease that attacks the autoimmune system of the body. This definition concurs with that of Evian (1991:9) who described AIDS as a new and unique disease. It is caused by the most primitive of all in the microbiological world, a virus, called the human immune deficiency virus, generally shortened to HIV.

AIDS stand for:

- A: Acquired it is passed from person to person, it is not inherited.
- I: Immune to do with the body's defence against disease.
- D: Deficiency not working properly, a break down.
- S: Syndrome a collection of different diseases.

1.6.2 **HIV**

HIV can be defined as a sexually transmitted disease. Like some other sexually transmitted disease, it can also be transmitted through blood and during pregnancy like syphilis or herpes (Berer *et al.* 1993:5).

HIV stands for:

- H: Human this tiny germ is only found in infected humans.
- I: Immune-deficiency this causes the body's protective system against diseases to stop working properly.
- V: Virus HIV is sometimes also called AIDS virus or the virus that causes AIDS. Other examples of viruses are those that cause measles, polio and flu.

1.6.3 **Attitude**

An attitude may be defined as the individual's tendency to react positively or negatively to some person, object, situation institution or event (Nimbi 1988:8). This definition concurs with that of Fishbone and Ajzen (1975:66) who described an attitude as a "learned pre disposition to respond in a consistently favourable or unfavourable manner with respect to a given object".

In this study the concept attitude will be used to the positive or negative reaction of orphans with HIV/AIDS, grandparents and other relatives towards orphans behaviour.

1.6.4 **Grand parent**

The concept grandparent in the present study will be used to refer to any person who has grandchildren.

1.6.5 **Peer group**

According to Newman (in Wolman 1982:526) the concept peer group refers to more especially to the cluster of associates who know each other and who serve as a source of reference or comparison of one another.

Craig (1983:537) defines a peer group as a “stable group of two or more children who interact, share norms and goals and with respect to age level or social status are considered equals”.

A peer group is thus an important source of information for an adolescent. It is in this group where she evaluates the values, norms and goals, which she internalized from parents.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on literature review with particular focus on how orphans with HIV/AIDS infection are cared in our community. It also highlights the evolution of the HIV/AIDS pandemic, modes of transmission, infection control. It looks at the literature, media, articles and dissertations. The literature survey establishes the framework in which to interpret how the community treats children with HIV/AIDS.

2.2 SUMMARY OF EVOLUTION OF THE HIV/AIDS

YEAR	EVOLUTION
1960	No trace of the virus has been found in blood stored for research before the 1960`s
1978	Gay men in America and Sweden and heterosexual. People in Tanzania and Haita show signs of a disease, which will latter be identified as AIDS.
1981	The American center for Disease control becomes aware of an increase of an increase of a rare skin cancer, karpos sarcoma, in otherwise healthy gay men. They call it gay cancer. But changed it to gay related immune deficiency. The center for Disease control warns blood transfusion services that their blood supply may have a problem. The H1-virus is found in the institute Pasteur France.

1984	American researcher, Dr Gallo, indicates that he also found the H1-virus; latter confirms that the French first found the virus.
1985	All blood products in America, Japan, South Africa are now tested for HIV antibodies. The first international conference on AIDS is held in Atlanta. The first found by the French.
1986	HIV-2 is isolated in patients in west Africa.
1987	Glaxo wellcome introduces the first approved anti-HIV drug : AZT
1991	More than 10 million people worldwide are HIV positive; new drugs containing nucleoside reverse transcriptase inhibitors are approved in America.
1997	6,4 million people have already died and 22 million are HIV-positive.
1998	WHO indicates that more than 30 million people are HIV- positive? 11,7 million died of which 83% of them are from Africa. 66% of all HIV positive people live in Africa.
2001	43 MILLION Africans live with HIV/AIDS.

(Gibson 2001).

2.3 SOURCE OF INFECTION

Three modes of human immunodeficiency virus transmission have been identified so far namely:

2.3.1 Sexual Transmission

According to Whiteside and Sunter (2000:10) the vast majority of HIV infections is the result of sexually transmission. HIV is a sexually transmitted

disease, and transmission of the virus can happen when having unprotected sexual intercourse with an infected person, that is when bodily fluids are exchanged during sexual contact vaginal, anal or oral sex.

Those who have more than one partner are especially at risk. Similarly if your partner has sexual partners, both she/ he and you are at great risk. The virus can be passed in this way from woman to man, man to woman and man to man. It is also possible for the virus to pass from woman to woman. Anal sex is particularly risky especially for the receiving partner because the walls of the rectum (the persons "bum" are weaker and more likely to tear than those of the vagina, making it easier for the virus in the seminal fluid to pass directly into the blood stream. Persons with another sexually transmitted disease, for example genital sores are also at greater risk.

Basically, for all types of sex there is a greater risk of transmission where there are abrasions of the skin or mucus membrane for oral and vaginal sex, the risk is reported to be even higher when the woman is menstruating (Beth 1994 & Hubly 1990).

2.3.2 **Mother to Child (MTC)**

According to the world health organization report (2000) an estimated 600,000 children are infected in this way each year accounting for 90 % HIV infection in children. Whiteside and Sunter assert that the child can be infected with HIV pre-natally, at the time of delivery or post-natally, through breast-feeding. The same authors continue highlighting that infection at delivery is the most common mode of transmission. A number of factors influence the

risk of infection, particularly the viral load of the mother at birth the higher the load, the higher the risk. Research shows that woman with more advanced levels of the disease (manifested in lowered c d 4 cell counts) may be more likely to transmit infection. (Broder *et al.* 1994).

Current studies show that using the most widely available test, it is still not possible to tell whether a newborn has already been infected with HIV. World health organization reports (1999) suggest that an infected mother's child may have maternal anti bodies in his or her blood until 18 months of age. Therefore testing cannot be used to help make decisions about whether to breastfeed or not.

2.3.3 **Transfer of Infected Blood**

According to Whiteside and Sunter (2000) blood product is a very effective way of transmitting the virus, since this route introduces the virus directly into the blood stream. Research has proven that an intact skin is an effective barrier against the virus. When pierced by needles, tattooing equipment or other invasive instruments that have been contaminated with blood containing HIV, infection can take place if the dose is large enough.

2.4 **HIV AND OTHER DISEASES**

As HIV depresses the immune system, other diseases will affect HIV positive people (Whiteside *et al.* 2000). The major cell surface receptors for HIV are CD4 differentiation antigens. According to medical research almost all HIV infected people will ultimately develop HIV related disease and eventually AIDS. HIV

progression mainly depends on the type and strain of the median time between initial infection and the development of an AIDS-defining illness is 10-12 years, a few individuals progress to AIDS within 18 months, whereas others remain asymptomatic for more than 18 years (Broder *et al.* 1994).

2.5 **ADVANCED HIV/AIDS DISEASE**

It seems as children appear to develop neuro developmental abnormalities, most frequently manifested as motor deficit, the delayed acquisition or loss of normal developmental milestone for example, walking, speech, self care skills and cognitive deficits (Wiener *et al.* 1996:86). HIV infection represents a multi-system disorder in children, with the potential for repetitive life-threatening event. The researcher suggested that emphasis at this time must on the development of strategies or regimes that will further improve the survival of children with HIV infection. But hope must be tempered by reality, and attention to the dignity of both the life and death of children with HIV infection must be the concern of health care providers.

People with advanced AIDS are reported to have a considerable likelihood of developing a new defining illness or dying within a two-year period. Broder *et al.* (1994) assert that certain opportunistic infections that are associated with more profound immune suppression become prevalent during this stage of disease. Some patients develop HIV-associated dementia during this period. This is characterized by cerebral atrophy and diminished cognitive function. At this particular stage, HIV wasting syndrome is seen with increased frequency. It is generally defined as a voluntary weight loss of greater than 5kg.

2.6 AIDS RELATED DISEASES

Stereotypes and stigmatization have emerged as major variables complicating the experience of AIDS and the process of coping with and dying with AIDS. Lindegger *et al.* (1995:6) asserts that AIDS patients and cancer patients who adopt more positive coping mechanisms are likely to survive longer with the disease. Doyle *et al.* (1991) highlighted that AIDS is separated from other chronic and terminal illnesses by its marginal status in the economy of disease seen in the out right oppositional attitudes of many family members, the general public and even health care workers to HIV-positive people and AIDS patients.

2.7 OPPORTUNISTIC ILLNESSES

Opportunistic illnesses are infections that are manifestations of immune system failure. The following are some of the more common opportunistic infections that occur during early immune failure (Broder *et al.* 1994).

2.7.1 Shingles

Shingles is a painful rash condition, which often occurs on the torso (the main part of the human body, not including the head, arms and legs). This is the virus that causes chicken pox during childhood and is a member of the herpes virus (Oxford, advanced learner's dictionary, eleventh impression (2000:1086). Broder *et al.* (1994) asserts that in AIDS patients the severity of shingles appears to be greater than on non-AIDS patients, most probably due to their compromised immune system.

2.7.2 **Mycobacterium Tuberculosis**

Mycobacterium tuberculosis is reported to be the most common serious HIV related infection worldwide. Statistics show that there is an unbelievable increase in the number of tuberculosis cases world wide, particular in Africa. Tuberculosis has thus become an important opportunistic disease and one of the most common causes of death observed among the HIV positive patients in Africa (AIDS analysis in Africa, Volume 8, No.2, August/September 1997:7).

2.8 **LINKING SCHOOL AND AIDS**

The mere fact that grand parents enroll her child with a particular school places her in a relationship with the school. As a result of the enrolment the grandparent expects something of the school and the grandparent and the child. Probably the most important expectation the grandparent has is that the school will teach the child in preparation for an occupation. In addition grandparent may expect the school to educate the child in respects as well.

Not only does the grandparent expect something from the school, but grandparent may also wish to identify with the school. Possibly unconsciously the grandparent express her desire to establish some degree of communication with the school by taking an interest in the scholastic and other activities of the child at school. Minkler *et al.* asserts that supporting school activities and functions such as sport, concerts, etc. Are the other ways of becoming involved in the affairs of the school, as the paying of school fees.

Parker *et al.* (1998) asserts that however one of the most important instruments to

ensure a sound relationship between the grandparent and the school is either the school committee, the parent–teacher association or the parents advisory committee. These bodies normally consist of parents or grandparents and teachers elected by other parents or grandparents and teachers. Apart from fund raising they can undertake important work to facilitate the educational and socializing function of the school.

2.8.1 **The School as a Social Institution**

Initially the community delegated the task of transmitting knowledge to the younger generation, to the school. The family became dependent upon the school to share the transmission of culture. The school made it possible for communities to no longer depend solely on the spoken word in order to educate and to transmit culture. By means of the written word it became possible to preserve and transmit norms, values, customs and beliefs in a way that the family alone could not do (Pizzo *et al.* 1996).

In addition to the above functions the modern school is further expected to develop character and the personality of the child and special attention is expected to be given to the development of the child's potentialities. Qualities such as vitality, courage, sensitiveness and intelligence are to be developed.

Pizzo *et al.* (1996) continue asserting that another important education function of the school is to assist the child in moving from the known and intimate family to life in the broader and unknown community outside the home. The school introduces the child to a section of unfamiliar community

life where she could feel insecure and unaccepted. The school however offers a very convenient transmittional experience. Since it is instituted for the child and the general atmosphere is one of relative friendliness and acceptance.

Evian (1991) argues that in order to have a better understanding of the school as a social institution it is necessary to further elucidate some of the educational and social objectives and functions of the school and to consider how the school and supplements the functions of the family.

2.8.2 **Objectives and Function of a Physical Nature**

Smith(2001) asserts that the school ensures the physical well being of the child. Physical training usually included in the curriculum, and extra mural activities such as various types of sports and games, are given emphasis for this purpose. An important advantage is that the activities mentioned can be fruitfully continued into adulthood. Moreover such activities and other wholesome living habits are encouraged in the belief that these produce pleasure and enhance productivity.

Rogers (1989) mention that extramural activities also play an important role in the socialization of the school child. Sport and other cultural activities provide and opportunity for more informal social interaction between pupils and teachers and between fellow-pupils. A further advantage of socialization on a more informal basis is that the tension, which may arise between the child and between fellow pupils, is released by means of extramural activities. Moreover the knowledge and experience gained by means of extramural

activities further encourages children to discuss to exchange ideas and to stimulate their schoolmates.

In the process of socialization it is important that the school guides the child in establishing harmonious social relationship with children from different social levels. It is beneficial for children more especial young orphans with HIV/AIDS to feel that they belong to a meaning full group outside their home even if members have their differences. Group feeling or a feeling of belonging is increased by means of school uniform, school badges, school song and participation in sport and cultural activities such as school concerts etc.

In the school the peer group or sub-group serves as a powerful agent to socialize the child. The fact that the child, more especial orphan with HIV/AIDS wishes to be accepted by the group causes her to conform to the norms and values of the groups. If the norms and values of the peer group correspond with these of the school and the wider community the process of socialization is promoted in respect of the particular child.

2.8.3 **How AIDS will change the face of school in the near future**

Smith(2001) asserts that over the next decade AIDS will change every facet of our lives. The traditional school day could disappear with traveling teachers giving focused lessons for a short while before moving on and the community ensuring children do homework and revision. It is further asserted that school could change to become far more work oriented than they are at present.

Smith (2001) maintains that by 2010, there will be 44-million AIDS orphans

worldwide. By that time around 35% of children under the age of 15, in 11 eastern and southern African nations will have lost one or both parents. He writes that the 1999 progress of nations report noted that South Africa, is one of seven countries where the number of children orphaned by HIV/AIDS between 1994 and 1997 increased by more than 400%. In KwaZulu-Natal it is estimated that there are about 300 000 young orphans with HIV/AIDS.

According to Smith (2001) delegates noted that education is the principal weapon against the spread of HIV/AIDS, and the best defense against abuse, neglect and impoverishment. Factors seeing high dropout rates of AIDS orphans are not only related to a lack of parental guidance or money to pay for school costs, but the poor quality of teaching in schools, and perceived irrelevance of schooling in relation to the job market.

Delegates came up with some innovative ideas, which education departments across the region still have to consider. It was suggested that "if children could not get to a school, the school somehow be made accessible to them". Several models were discussed:

- Community schools-run by communities, charging no fees, requiring no uniform, providing almost all educational materials and using teachers from within or close to the community, often on a voluntary basis and with little training.
- Satellite schools-covering a wide geographic area, providing resources to teachers who travel to visit different communities to provide short periods of formal teaching, leaving children with assignments to be

done under supervision by the community.

- Distance learning-using interactive radio (television, or the Internet) teaching materials, under the supervision of members of the community.
- Schools as comprehensive, community-based organizations—teachers are joined by those with a traditional role in society (leaders, healers, birth-attendants, craft-persons) in collectively education children. Children, in turn, could go into the community to support caregivers, engage in pee education, and gather data for community research programs.
- Long-term welfare assistance has a positive and sustainable effect in terms of building educated and healthy national human capacity. Short term and piece meal assistance has little if any long-term benefit.

Smith (2001) asserts that schools should become a focal point for feeding schemes, support to caregivers, or one stop orphan care support centers with free education to needy children. Schools should be providing life skills and vocational training to pupils, to equip them as income earners. The United Nations security council early last year warned that a failure to assist orphans would see them develop as regional security threats as these uneducated, uncared for, desperate children take what they can to survive. To support the above statement UNAIDS argues that children without parental protection lose opportunities for school, health care, development, nutrition, shelter, and even their rights to a decent and humane existence (Smith 2001:3).

2.8.4 **The need for permanence with reference to HIV/AIDS orphans**

The researcher observes that early planning is essential to prevent further chaos and to develop stable home environments for these children who face physical and familial devastation. Pizzo *et al.* (1996) asserts that there are several potential obstacles to the provision of a permanent home for these children, including the emphasis the child welfare field has traditionally made for family cohesion. The underlying argument, Pizzo *et al.* maintain is that children should spend their lives with their biological family. However, illness, drug use, neglect, or abuse may make this impossible or not in the child's best interest.

It is further asserted that there has to be a humane approach to get children freed for permanency so children can grow up in a permanent, stable home. Where bonding can take place, where the child owns one of the family member so when the time comes for dying they do not reach out to a strange hand. The researcher mentioned that it is the ultimate right of any child not to die among strangers.

2.8.5 **The psychosocial consequences of aids and related needs**

Rabbets (1997) mention that in terms of the psychosocial aspects of HIV/AIDS, stereotypes and stigmatization have emerged as major variables complicating the experience of AIDS, and the process of coping and dying with it. AIDS shares many of the features of other terminal diseases, as is apparent from findings discussed in more detail further on such as the fact that both AIDS and cancer patients who adopt more positive coping mechanisms

are likely to survive longer with the disease. AIDS is however separated from other terminal and chronic illness by its marginal status in the economy of disease seen in the ambivalent or outright opposition attitudes of the general public, family members and health care workers towards people with HIV/AIDS.

Research by O'Rawe, Amenta and Tehan (1991) indicates that one of the most notable experiences of young people with AIDS is social isolation, often extending to isolation from the social support probably correlates significantly with negative coping styles or avoidance and the prevalence and anxiety among people with HIV/AIDS.

2.8.6 **The effect of stigma**

Wiener *et al.* (1996) asserts that in the black community AIDS is a particularly stigmatizing disease. As a result traditional social supports may not be available during times of stress and illness to black families who are coping with HIV disease. Historically, black churches have rallied to organize communities around illness among its members. However, this has not necessarily occurred for HIV-infected blacks. As a consequence, caregivers will be confronted with socially isolated families who do not have supports normally accessed in times of difficulty.

Through out this pandemic, grandparents have perhaps been among the hardest hit. Wiener *et al.* (1996) argues that grandparents are experiencing the potential loss of two generations, their children and their grand children. More and more grandparents are assuming care for their grandchildren following the

death of their own child. To support the above statement, Embargo (1999) mention that a common pattern that is emerging in families is that more and more grand parents are being called on to care for their sick children as well as their infected grandchildren. The impact of the loss of facing death again is great and, for many, their own health is of concern. Grandparents need a tremendous amount of support and guidance, as they are often not well educated about AIDS. They may not always be present at the hospital or clinic, but their support "behind the scene" is often the foundation that keeps the family together. For example: the death of the murdered AIDS activists Gugu Dlamini will be commemorated. Gugu Dlamini was a KZN NAPWA member who publicly disclosed her HIV status. During December 1998 Gugu Dlamini was attacked by an unknown group of people. She was accused of shaming her community by disclosing her HIV status. To date, there has not been any substantial progress with the states criminal prosecution of her murderers.

The murder of Gugu Dlamini is just one extreme example of the level of violence and the nature of discriminatory attitudes against people living with HIV/AIDS in our society (PLWHA's) (Hassan 1999:2).

To support the above statement I would argue that people who have been diagnosed as HIV positive, or who have AIDS, are being discriminated against very severely in a range of contexts and environments, from sports and various spheres, to education and aspects.

2.8.7 **The vulnerability of orphans with HIV/AIDS**

Of the many vulnerable members of society, young people who have lost one or both parents are among the most exposed of all. Embargo (1999) argues that in Sub-Saharan Africa, there are few social support systems exist outside of families and where basic social services are largely inadequate. It is further asserted that orphans run greater risks of being malnourished and stunted than children who have parents to look after them do are. They also may be the first to be denied education when extended families cannot afford to educate all the children of the household. A study in Zambia, for example, showed that 32 per cent of orphans were not enrolled in school, as compared with 25 per cent of non-orphaned children.

The underlying argument Embargo maintain is that children who have been orphaned by AIDS may also not receive the health care they need, and sometimes this is because it is assumed they are infected with HIV and their illnesses are untreatable. Increasingly, children whose burdens of responsibility as head of house hold when a grandparent or caregivers dies. Orphan enduring the grave social isolation that often accompanies AIDS when it strikes a family are at far greater risk than most of their peers of eventually becoming infected with HIV/AIDS. Often emotionally vulnerable and financially desperate, orphaned children are more likely to be sexually abused and forced into exploitative situations, such as prostitution, as a means of survival (Embargo 1999).

In cases where families are unwilling or unable to provide support, foster care becomes the only alternative. Pizzo *et al.* (1996) asserts that HIV infected

children may move to and from foster homes or from one chaotic system to another due to parental incarceration, illness, abandonment, or homeless. The lack of appropriate foster homes, in home programs in certain communities has resulted in some HIV infected children remaining hospitalized for as long as two years in acute care hospitals when their conditions no longer required hospitalization.

In addition, because HIV infection progresses from initial infection to mild HIV related illnesses called "AIDS", children can live with long periods of uncertainty and intermittent crises, as both parents slowly sicken and die. In Sub-Saharan Africa, where effective relief for pain or other symptoms is often unavailable, children who live through their parent's pain and illness frequently suffer from depression, stress, and anxiety. Many children lose everything that once offered them comfort security and hope for the future (Embargo 1999).

2.8.8 **Counseling needs for person with AIDS**

According to Tartler (1993) asserts that health care institutions are a source of cure, care and comfort for most ill people. This may eventually not be the case for AIDS patients. Whose behaviour and lifestyle are alien to the dominant culture of the staff? It is further asserted this may further cause many patients be reluctant or even refuse to share personal information with physicians and hospital staff for the fear of loss of human rights. Most recent research shows that this type of loss has been experienced and continues to be experienced by many AIDS sufferers.

Barlow and Durand (1995) highlighted that people with AIDS know that they

have a disease that will eventually kill them. They further suggested that until a cure is found, the diagnosis of AIDS is equivalent to the death sentence. Thus, individuals with AIDS have social psychological, physical, spiritual and emotional needs, which according to Cook *et al.* (1989) are common to the dying process.

Cook *et al.* (1989) argues that with the diagnosis of AIDS people may often experience a wide variety of fear and losses. The most common are discussed below:

Loss of control and dignity

Cook *et al.* (1989) asserts that people with AIDS may lose a sense of control over their health status and body functioning. They often face a loss of independence, dignity and control as others may insist on performing tasks and / or making decisions for them.

Loss of body image

Tartler (1993) defines body image as the interpersonal experience of the person's feelings and attitudes towards one's body and the way she/he organizes these experiences. The human immune deficiency virus compromises the immune system so that a number of opportunistic infections can invade the body. Many of these infections lead to progressive physical deterioration. This may affect a previous sense of body image as a result of changes like weight loss, and dermatological problems. Due to this deterioration some people may find it difficult to be around those with AIDS. This may lead to

isolation and eventually abandonment, with this in mind; both physical and psychological support should be given to the dying person in order to help them deal with the changes.

Fear of pain and suffering

Kelly (1992) argues that although pain is physical in nature, it also has emotional and psychological components. Kelly goes on arguing that fear may heighten their existential anxiety. This anxiety may in turn magnify the sensation of pain or other physical stress. The individual's interpretation of pain may result in some type of emotional pain to the extent that they can no longer eat (e.g. oral candidiasis or esophagitis) or they can no longer walk. Consequently they feel depressed due to loss of independence and control.

An anticipated loss of any and everything that is important to them

According to Kelly (1992) rejection, isolation and guilt may compound the feeling that the person is useless hence their self-esteem is lost. At this stage people with AIDS may express various fear such as fear of dying, of the process of dying and what happen after death. It is reported that coming to terms with dying is painful even to those who have lived a full life (Eagle *et al.* 1995).

People with AIDS are reported have needs too. These include the need for love, acceptance and security. Kelly (1992) emphasize that it is important that the counselor address these needs particularly because many people with AIDS have experienced rejection at its worst, for much of their lives. People

with AIDS may also have the need to maintain hope. Research has shown that this may at times pose problems for the counselor in that the course of the confirmed illness cannot always be predicted. He writes that in spite of the unpredictable nature of patient prognosis. Kelly still recommended that professionals should try to address this need because the absence of hope is equivalent to hopelessness.

People with AIDS have often found to worry about the following issue:

Need for confidentiality: Due to fear of loss of confidentiality, which may lead to job loss and social discrimination, people with AIDS may be reluctant to share personal information. They may be extremely hesitant to give information until they feel secure that their confidentiality will be maintained and that they are respected and accepted.

Loss of self-esteem: Once diagnosed with AIDS, individuals experience drastic physical changes. Consequently, they struggle with tremendous loss of self-esteem over those changes. The visible and aversive sign of the disease become a constant reminder of the disease or interference with adaptive denial.

Anxiety: A bout an uncertain disease course. This is reported to be profoundly disturbing and stressful to the patient, since they never know when the next medical crisis will occur.

Abandonment and isolation: Patients may fear that their loved ones will abandon them. This fear is exacerbated when family, friends and

colleagues who are frightened by the confrontation with death, distance themselves over long periods of times.

2.8.9 **Care for the child with HIV infection and AIDS**

Rabbets (1997) assert that one needs help to cope with having AIDS. He defines coping as a process where by the person's cognitive and behavioural efforts manage the internal and external demand of the person-environment transaction that is appraised as taxing or exceeding the person's resources. This help could be in the format of inpatient or outpatient care. Inpatient treatment and care is preferable since it provides the experience of more consistent, enduring, uninterrupted care that seems more nurturing and reliable. Additionally the consistency of inpatient care ensures a sustained relationship with one's caregiver that relieves the experience of isolation due to having AIDS. Outpatient treatment appears inconsistent and episodic, relapses occur between periods of care and this is distressing.

According to Rabbets (1997) the important element of care is compassion and empathy should characterize the helping relationship with caregivers. The caring relationship re-establishes a sense of belonging or a shared sense of being human that is very affirming and reassuring. The underlying argument is that the primary care taker is commonly a single grandparent who must rely on public welfare programs that are inadequate for a family whose grand child suffers from chronic and debilitating illnesses.

2.8.10 **Support groups for children with HIV/AIDS**

Social support, as the feeling of being cared for and loved, valued and esteemed, and able to count on others should the need arise. Friedland *et al.* (1996) has been shown to be an important reinforce of positive coping with HIV/AIDS. Since coping and social support are considered to be closely linked, coping strategies may, in fact, determine the appropriateness and effectiveness of supports for AIDS patients as they do for other experiencing stress. Whereas social support has been a strong focus of the stress outcome paradigm within sociological conceptualizations, coping has been emphasized in psychological models of adjustment to illness (Rabbets 1997).

Rabbets (1997) asserts that people with HIV/AIDS have specific stresses to which support can be directed, but they have an added difficulty in that disease impact directly on the support they receive. The stigma attached to the disease makes it difficult to gather some forms of support, the high incidence potential sources of support and the erratic progression on the disease makes it difficult for care givers to sustain the high levels of support needed. Additionally persons with aids are often alienated, both emotionally and geographically, from the natural support groups of their own families and communities (Friedland in Rabbets 1997).

Rabbets (1997) mention that persons with HIV/AIDS often feared rejection or did not want to bother others with their problems and consequently did not disclose their HIV status and experienced and associated lack of social support. This indicates that there is a need for intervention aimed at assisting patients in seeking support and for a general acceptance of HIV disease and

a variety of lifestyles to give patients less reason to fear rejection and withdraw from established social networks such as families.

2.8.11 **Social support group for grandparent**

Tartler (1993) argues that social support groups are a very important aspect of bereavement services. Social get-togethers, such as luncheons, pot-luck suppers, picnics, and other outings, provide a means for bereaved grandparents to meet each other. These groups are not therapy sessions or counseling sessions, but grandparents can meet others who have experienced similar losses, hear about coping techniques, and may feel less anguish because they are no longer the only ones they know who have suffered such a tragedy. Family grief counseling should include information and education for the parents in order that they might assist the surviving children with their grief. As children mature and develop, they need to reprocess the loss. It is important that the grandparents continue to provide support and information to orphans with HIV/AIDS.

Often, children are excluded from discussion or information about grief or the dying and death of their parents. Children do not have the same opportunity to gather information or seek a sympathetic person, as do adults. Usually the only source of information and sympathy for the child is the family (Rabbets 1997).

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The aim of this study as stated in chapter one, is to obtain the views of grand parents who have grandchildren with HIV/AIDS. Do grand children have negative or positive feelings about their grand children?

- To find out from grand parents whether the school does meet the needs of the grand children in terms of their expectations.
- To provide additional knowledge on young orphans with HIV/AIDS and to offer the finding and recommendations to interested parties, such as non-governmental organisation with a view to enlightening grand parents and other relatives about the attitudes of young orphans with HIV/AIDS towards their problems.

The researcher decided to make use of the survey method to collect data. The aims of this chapter are to discuss methodology followed to collect and analyse data for purposes of testing the assumption mention in chapter one of the study.

3.2 RESEARCH DESIGN

The research design is actually a plan of action aimed at the expanding of knowledge.

The approach that the researcher used is both quantitative and qualitative research techniques. The researcher use quantitative methods to study variables that can be measured in this research such as age, educational level, and gender. Popenoe (1995:37) assert that quantitative measurement lies at the very heart of all sciences, most sociologist try to use these methods whenever possible. As the researcher stated above that she use both methods. The researcher use qualitative methods it was designed to describe reality in accurate verbal terms, not in numbers and measurements (Popenoe 1995). The research methods includes a literature survey and interviews.

3.2 **RESEARCH INSTRUMENTS USED IN THE STUDY**

Neuman (1997) states that questionnaires used by researchers to convert into data the information directly given by a person (subject). By providing access to what is "inside a person's head", these approaches make it possible to measure what a person knows (knowledge or information) what a person likes or dislikes (values and preferences), and what a person thinks (attitudes and beliefs). This information can be transformed into numbers of quantitative data by using the attitude scaling or by counting the number of respondents who give a particular response, thus generating frequency data.

3.3 **OPEN ENDED AND CLOSED-ENDED QUESTIONNAIRES**

Questions in questionnaires can be either open ended or closed ended. Popenoe (1995:38) states that in a close-ended questionnaire respondents are offered a set of answers from which they are asked to choose the one that most closely represent their views.

Closed- ended questions are easy to ask and quick to be answered. They require no writing by either respondents or interviewer. Their analysis is straight- forward. Their major draws back is that they may introduce bias, either by forcing the respondent to choose from given alternatives or by making the respondent select alternatives that might not have otherwise occurred.

Open- ended questions are not followed by any kind of specified choice, and the respondent's answers are recorded in full. The virtue of the open-ended question is that it does not force the respondent to pre-conceived answers having understood the intent of the question; one can express one's thoughts freely, spontaneously, and in one's own language.

Open-ended questions are flexible, they enable the interviewer to clear up, misunderstandings and they encourage rapport. However, open-ended questions are difficult to answer and still more difficult to analyse. The researcher has to design a coding frame in order to classify the various answers (Nachmias & Nachmias 1981:211).

The researcher has used the questionnaire method for this study because of the following advantages. The advantages are summarised by Orlich (1998) as follows:

- The used of questionnaires permits a wide coverage at minimum expense in both money and effort.
- Many individuals may be contacted at the same time,

- Each selected respondent receives identical questions,
- Responses are easily tabulated,
- Person in remote or distant areas are reached,
- Uniform data are gathered which allow for long range research implications, and

Time is saved; it took +1hour to administer each respondent.

Provides vehicle for expression without fear of embarrassment to the respondent. This is especially the case if the respondents are assured that their answers would be kept in confidence. Respondents such as Orphans with HIV/AIDS and grand parents would be in a position to respond at the convenience. All respondents receive identical instructions (Cohen 1989).

This reduces bias of the investigator. Questionnaires are typically more efficient, practical and allow the researcher to reach a large sample. There would be no need to strain interviewers and this would imply considerable saving in costs.

It has been stated above how advantageous questionnaires are. However, there are also a number of disadvantages as well, as can be seen from the following paragraph.

Neuman (1997) confirms that mailed questionnaires pose a number of problems. It is not easy to check on the respondent motivation nor can rapport be established. Neuman further adds that the disadvantage of mailed questionnaires is the low return,

which results in biased sampling as well as results. However, the researcher in this study did not experience the above disadvantages because the Orphans with HIV/AIDS, school children, schoolteachers, and grand parents of Orphans with HIV/AIDS questionnaires were personally handed to them. The researcher also considered some disadvantages that would affect the questionnaire instrument. These would be:

- Free expression by respondents might be curtailed because of the design of the questionnaire. There would be no assurance that the intended respondent actually completes the questionnaire.
- Other reasons, which might cause respondents not to answer some questions completely, could be due to faulty perception and lack of interest Behr (1988:13).

The questionnaire used in this study was comprised of both closed and open - ended questions most of the items were of a closed type, which facilitated answering and also made coding and classifying the responses easy. However there were a few of open- ended type of question as well. These were analysed by employing a coding frame. Most respondents replied very briefly in answering the open-ended questions.

3.4 **INTERVIEW AND OBSERVATION**

3.4.1 **Interview**

The researcher conducted interviews with the schoolteachers. Since the

schoolteachers were the smaller representative sample, the interview became an appropriate tool (Neuman 1997:64).

The interview as a research method in research is unique in that it involves the collection of data through direct verbal interaction between individuals. Its principal advantage is adaptability.

The above method of research was of great help to the researcher because, there was direct interaction with the Head, principal and the teachers at the school visited. The interview yielded complete data because the researcher first told the respondents to take it easy and answer questions frankly. This method allowed the investigator to clarify questions. Consequently this enhanced the validity of the responses as respondents answered without misinterpretations of the questions. It gave the researcher an opportunity to observe verbal as well as non-verbal behaviour.

There are some disadvantages, however, in the interview method as well. It has been noted that interviews are costly in time and effort. There is also the interview bias. The main source of the bias is the interviewer. Popenoe (1995:40) pointed out that "no matter what he does, the interviewer is bound to have some effect upon his data". Taking notes during the interview might present some problems. The major disadvantage observed by Popenoe lies in that attention of the respondent is distracted and some might even be curious, some especially if a tape recorder is used.

3.4.2 **The teacher population**

A population of teachers from two schools in Esikhawini/Kwa-Dlangezwa made up a sample of 20 teachers. Most of them taught children who had been pre-scholars and non-pre-scholars. The teachers were classified into three clusters, and taught various classes, that are grade 1-4, grade 5-8, and grade 9-12. A sample of 20 teachers that were used comprised of 10 teachers from Esikhawini and 10 teachers from KwaDlangezwa.

Name of the schools from KwaDlangezwa: _____ Khandisa Primary School _____
Ongoye Primary.
Esikhawini: _____ Nsabalele H.P. School
Masibonisane H.P. School

3.4.3 **The grandparents population**

Another population of 20 grandparents were selected from the grandparents meeting at YMCA where they make the AIDS pin with beads every Friday. These grandparents made up a sample, which comprised various careers, for example, sewing clothes, making Aids pins, and others are doing garden.

Both the above-mentioned sample of teachers and grandparents were found in the Esikhawini/Kwa-Dlangezwa area. The collection of data was done in the month of August and October.

3.4.4 **The school children without HIV/AIDS population**

This made up a sample of 30 school children without HIV/AIDS from the schools visited. The researchers visit included an interview and observation. The school children were between ages 6 – 18.

3.4.5 **The orphans with HIV/AIDS**

This made up of 30 orphans with HIV/AIDS from Esikhawini/Kwa-Dlangezwa — — area. The researcher's visit included an interview and observation. The age of orphans were between ages 6 – 12.

3.5 **AREA OF STUDY**

The researcher had wished to spread her population over the Empangeni area. However because of time and cost involved she decided to concentrate on Esikhawini and Kwa-Dlangezwa community. The researcher interviewed grand parents, teachers, and school children without HIV/AIDS and Orphans with HIV/AIDS in the identified communities.

Reference is usually made to the grand parents as a collective term. This study assumes that grand parents are the people who end-up taking care of their grand children when their children died of HIV/AIDS.

The researcher chose Esikhawini community because it is the area where she volunteered to a people in need (PIN) project, which dealt with Orphans, infected with HIV/AIDS. The researcher chose Kwa-Dlangezwa because is where she lives.

3.6 **CONCLUSION**

This chapter presented methodology that was followed by the researcher in analysing and interpreting data on how grandparents of orphans with HIV/AIDS cope or treated by the community. The researcher also wants to analyse and interpret how the orphans feel by being orphans with HIV/AIDS at school and at home.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

This chapter comprises of the analysis and interpretation of the findings resulting from this study. Respondents responded by either marking with a cross (x) in the appropriate box opposite the number chosen, or by giving explanations and reasons where necessary.

Trends in the nature of the perceptions, support and treatment of HIV/AIDS orphans. The data demonstrates a wide and varied range of perceptions, support and treatment of HIV/AIDS orphans.

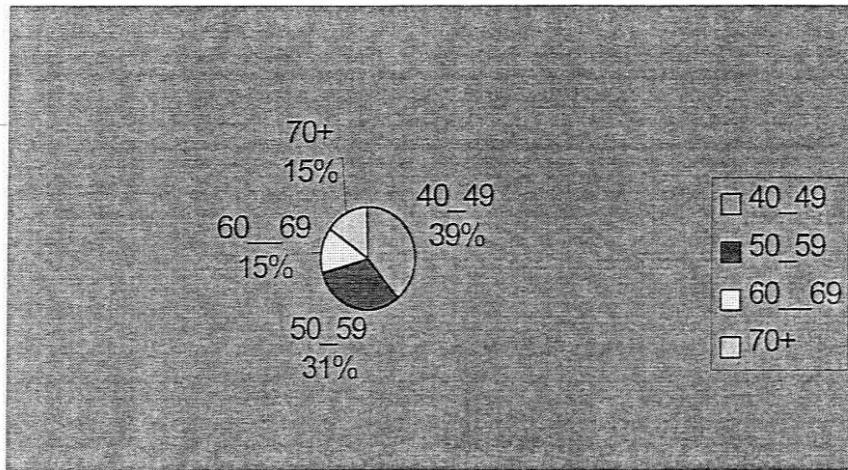
From the findings of the study it will be demonstrated whether or not, orphans with HIV/AIDS are discriminated at schools by other school children or by teachers. Continue demonstrating if the school meet the needs of orphans with HIV/AIDS. Analysis and interpretation of data is in the same sequence as the items appearing in the questionnaire. The analysis of data collected will be dealt with in this chapter. It will be analysed by means of using charts.

4.2 QUESTIONNAIRE FOR GRANDPARENTS

Section One: Demographic Data

4.2.1 Distribution of the Respondents According to Different Age

CHART 4.2.1 AGE



Most respondents were between 40 – 49 years old with forty percent, thirty percent of the respondents were between ages 50 – 59, fifteen percent were between age 60 – 69, and another fifteen percent were from 70 upwards of age.

4.2.2 Distribution of the Respondents According to Gender

CHART 4.2.2 GENDER

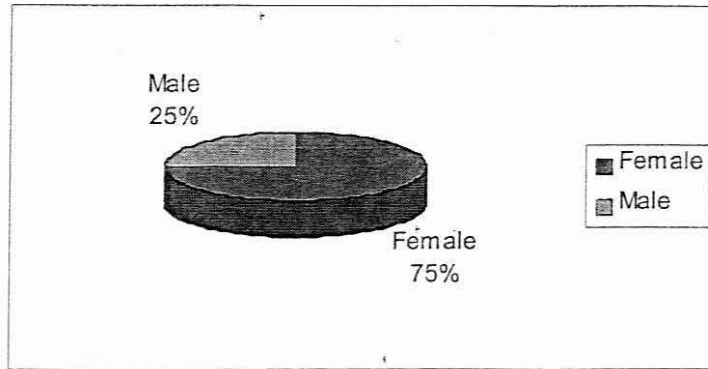
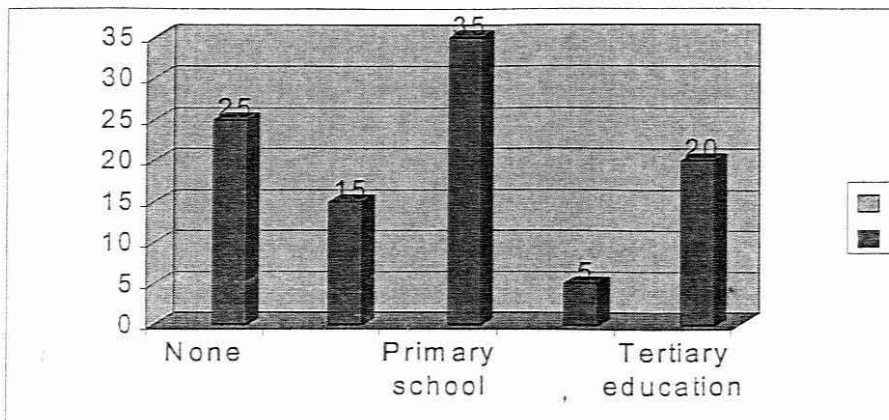


Chart 4.2.2 shows that the highest percentages of the respondents were females with seventy five percent (75%) respondents and only twenty five percent (25%) of the respondents were males.

4.2.3 Distribution of the Respondents According to the Level of Education

This question was asked in order to see how grandparents of different age groups respond to the level of education.

CHART 4.2.3 LEVEL OF EDUCATION



This chart shows that twenty five percent (25%) of the respondents does not attend school, fifteen percent (15%) of the respondents were respondents with informal education, thirty five percent (35%) were respondents with primary education; five percent (5%) were respondents with high school education. And twenty percent (20%) were respondents with tertiary education.

CHART 4.2.4 MARITAL STATUS

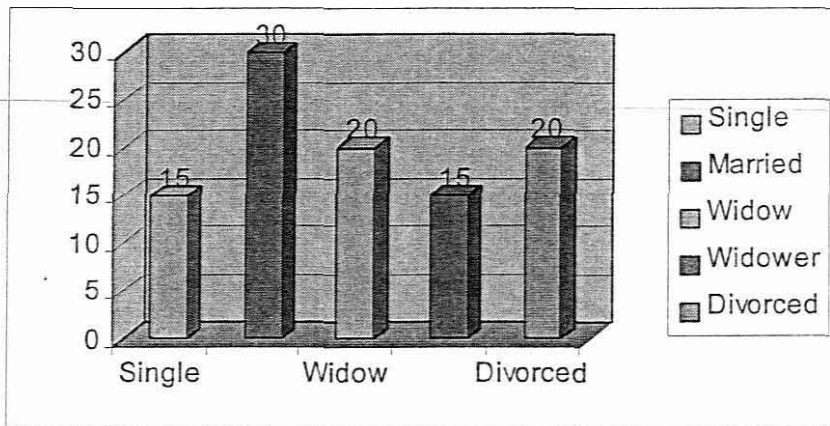


Chart 4.2.4 shows that fifteen percent of the respondents were single, thirty percent of the respondents were married, twenty percent of the respondents were widow, fifteen percent of the respondents were widower, and twenty percent of the respondents were divorced.

4.2.4 Distribution of Respondents According to Home Location

CHART 4.2.5 HOME LOCATED

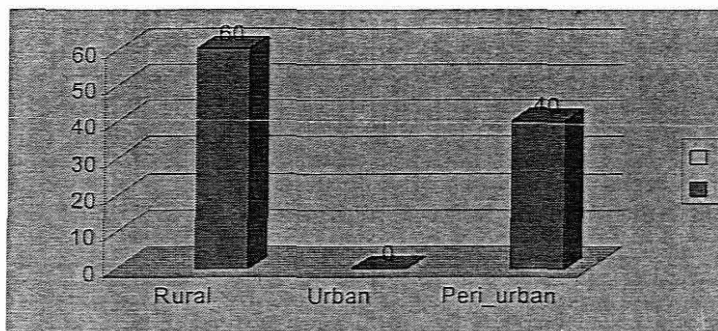
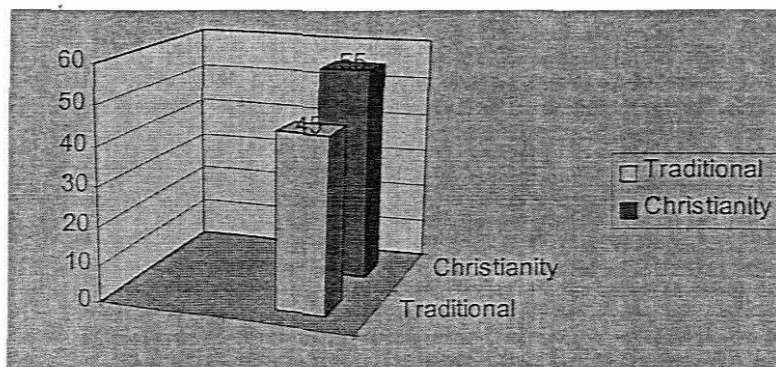


Chart 4.2.5 indicated that sixty percent of the respondents were located in rural areas, forty percent of the respondents were located in peri-urban areas and none of the respondents were located in urban areas.

4.2.5 Distribution of Respondents According to Different Religion

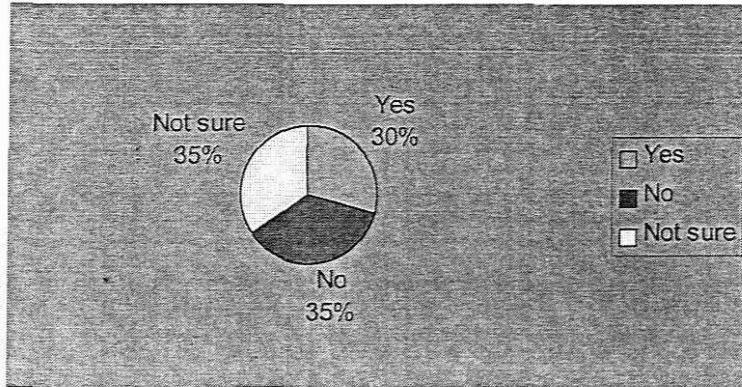
CHART 4.2.6 RELIGION



Fifty-five percent of the respondents were Christians. Only forty five percent the respondents were traditionalist.

4.2.6 Distribution of the Respondent According to the Believe that Condoms Cause Aids

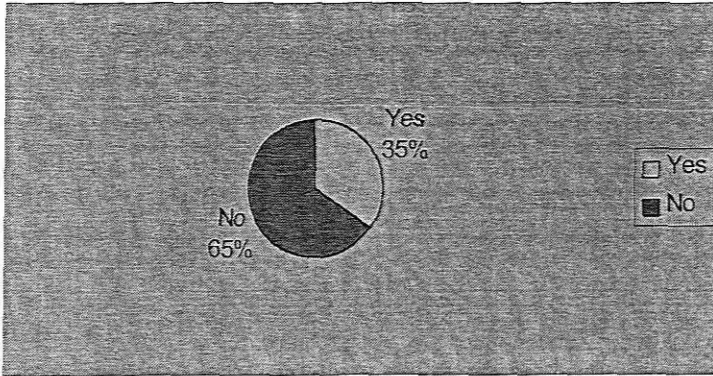
CHART 4.2.7 CONDOMS CAUSE AIDS



When asked, "Do you believe that condoms cause AIDS" thirty percent (30%) of the respondents agreed that condoms cause AIDS, thirty five percent of the respondents were not sure if condoms do prevent AIDS or cause AIDS, thirty percent of the respondents disagreed that condoms cause AIDS.

4.2.7 Distribution of the Respondents According to the Preparation

CHART 4.2.8 MENTALLY PREPARED



The above chart shows that sixty five percent of the respondents were not prepared about having a grand child with HIV/AIDS. Only thirty five percent were prepared.

4.2.8 Distribution of Respondents According to Meeting Other People with Similar Losses

CHART 4.2.9 MEET OTHER PEOPLE WITH SIMILAR LOSSES

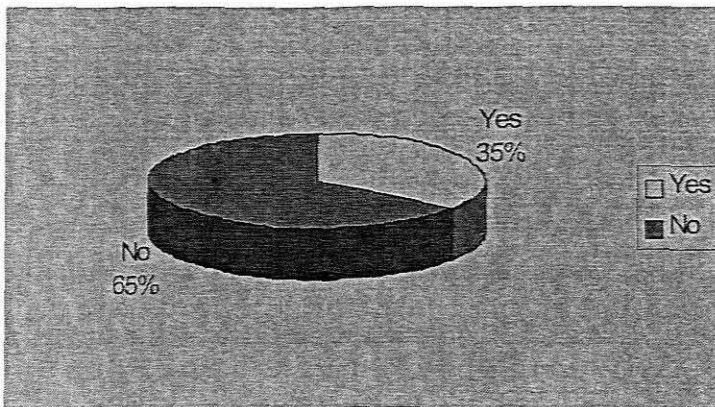


Chart 4.2.9 shows that sixty five percent of the respondents do not meet other people with similar losses and only thirty five percent indicated that they do meet other people.

During the focus discussion group one respondent indicated that people do not talk open about AIDS.

4.2.9 **Distribution of the Respondent According to the Type of Care Support**

CHART 4.2.10 **TYPE OF CARE SUPPORT**

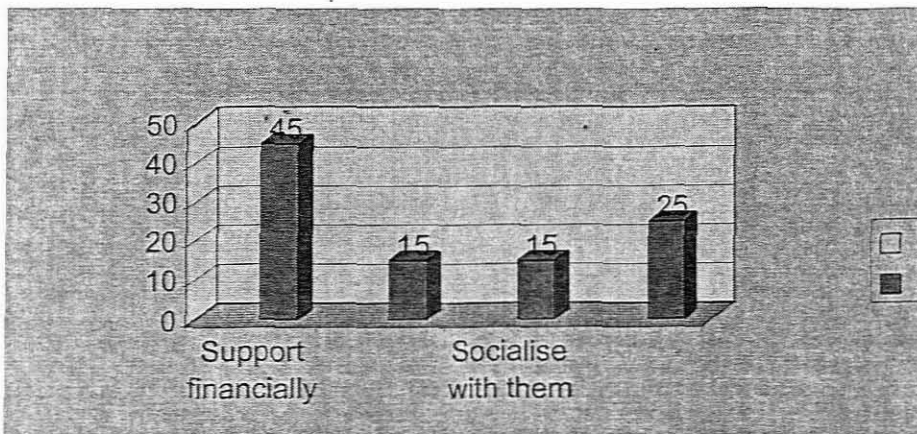


Chart 4.2.10 shows that forty five percent of respondents indicated financial support were more preferable, fifteen percent of respondents prefer emotional support, another fifteen percent of the respondents prefer to socialise with the infected people, and twenty five percent of the respondents prefer medical care. One respondents summed up the discussion of care support when he said, " All these care support are important if we are going to build the HRC dream. That is public education and awareness raising. If there is no money for the HRC then may be there can be money for training so that we can go and,do the AIDS awareness ourselves.

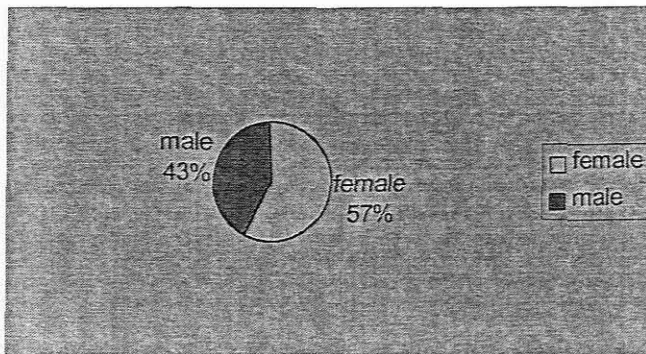
4.3 QUESTIONNAIRE FOR SCHOOLCHILDREN WITHOUT HIV/AIDS

Section 1: Demographic Data

4.3.1 Distribution of Respondents According to Gender

This question was asked in order to measure the distribution of gender with the intention of assessing the how HIV/AIDS has impact in different genders.

CHART 4.1 GENDER

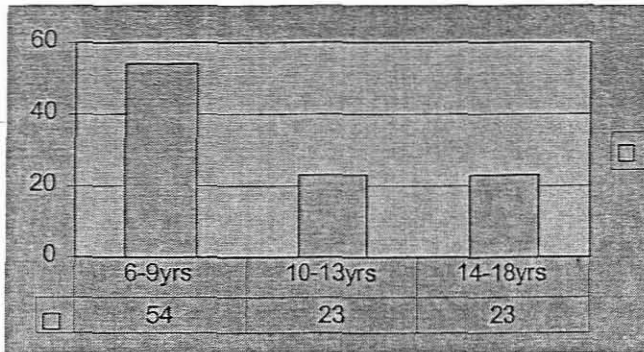


The above table shows that fifty seven percent (57%) of the respondents were females. Forty three percent (43%) of the respondents were males. Luthuli (1996) writes, "the majority of nursery and primary teachers 77,6% are women". The findings in this study confirm this. A response on the gender variables did not matter much in this work. Nothing was reported about it in the list of aims for the study. Nothing was hypothesized about gender.

4.3.2 Distribution of Respondents According to Age

This question was asked in order to measure the distribution of age with the intention of assessing the extent to which HIV/AIDS at school affect the children of different age groups.

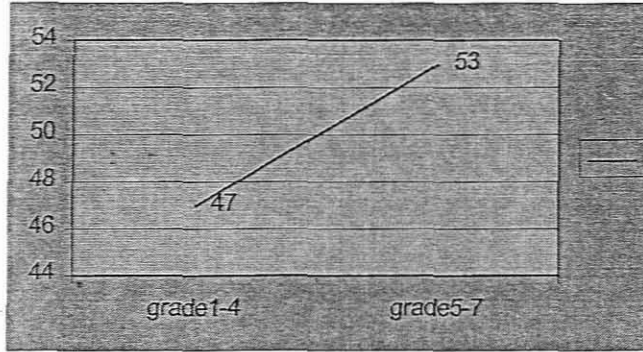
CHART 4.3.2 AGE RANGE



Most of the respondents were between 10 – 13 years old. This number decline to 10% because most children at higher primary level are from 6 – 13 years old. In this study the pattern of age (10 – 13) seemed to be contact for the 6 – 9 and 10 – 13. The range of children at most high primary schools still accommodates children who are between six (6) of age, ten (10) and over.

4.3.4 Distribution of the Respondents According to Respondents According to the Level of Education

CHART 4.4 LEVEL OF EDUCATION

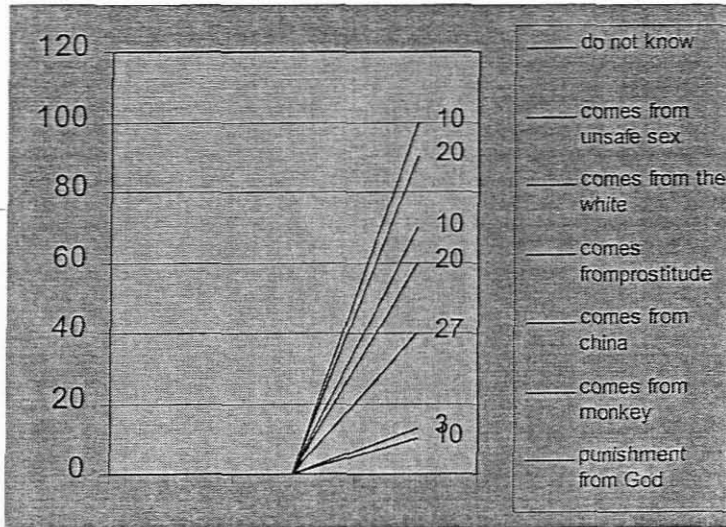


The above chart reveals that fifty three percent (53%) were females. This is the highest percentage and forty seven percent (47%) were between Grade 1 and Grade 4 (that is 53%) respondent were between Grade 5 and Grade 7. The highest percentage of males (that is, 23%) were between Grade 5 and Grade 7. Reason might be the fact that most parents are working and children stay at home alone during the day, no one supervised them during the day or check if they do attend school.

Section 2: Children Without HIV/aids

4.2.3 Distribution of the Respondents According to the Origin of HIV/AIDS

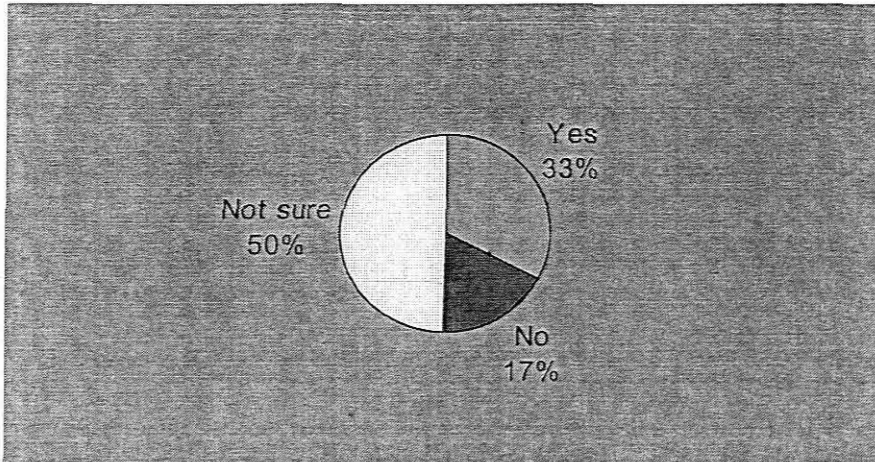
CHART 4.2.1 ORIGIN OF HIV/AIDS



The chart indicates that ten percent (10%) respondents believed that HIV/AIDS is a punishment from God; three percent (3%) were respondent who indicated that HIV/AIDS came from monkey; twenty seven percent (27%) were respondents who believed that HIV/AIDS came from the China's, twenty percent (20%) respondents reveals that AIDS came from the Prostitute, ten percent (10%) respondents indicates that HIV/AIDS came from the white people, twenty percent (20%) respondents shows that HIV/AIDS came from unsafe sex and ten percent (10%) respondents mention that they do not know where HIV/AIDS came from. The highest percentages were twenty seven percent (27%) of school Children believed that HIV/AIDS came from the Chines. This might be partly knowing that so far there is no cure.

4.3.4 Distribution of the Respondents According to Reaction of Respondents about Dying of People with AIDS

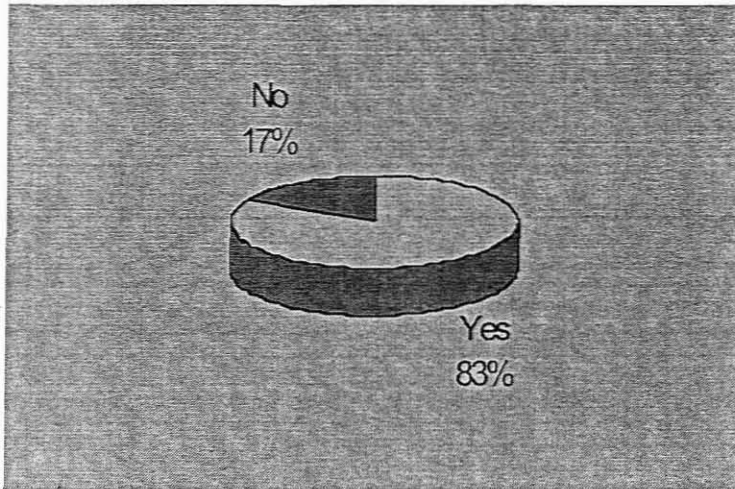
CHART 4.2.2 PEOPLE TOWARDS AIDS



50% of children indicated that they are not sure about people dying of HIV/AIDS. (33%) indicated that there are people dying of HIV/AIDS. Only (17%) indicated that they do not know about people dying of HIV/AIDS. This indicated that half of the children are not aware of what is taking place in their community.

4.3.5 Distribution of the Respondents According to Respondents Who Believe That People Die of AIDS

CHART 4.2.3 PEOPLE DIE OF AIDS

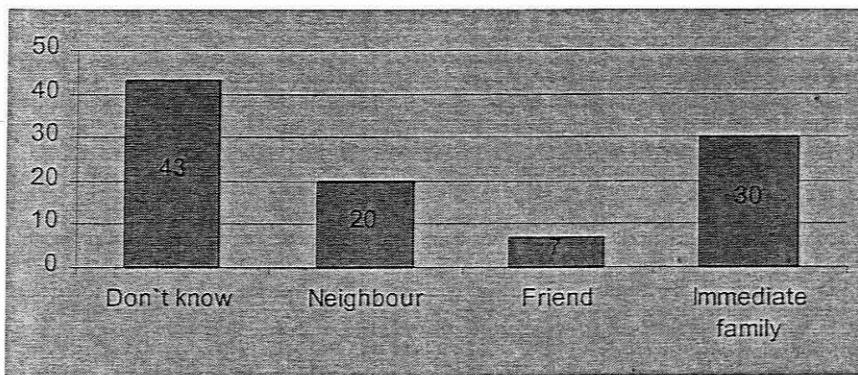


From the chart above eighty three percent (83%) agree that people can die of HIV/AIDS, seventeen percent (17%) of respondents disagree. Their home environment might cause this, where young people are not allowed to talk about sex or about death.

4.3.5 Distribution of the Respondents According to Respondents Who Know People Who Died of AIDS

This question was asked in order to see if young children know that their relatives died of AIDS.

CHART 4.2.4 PEOPLE DIED OF AIDS

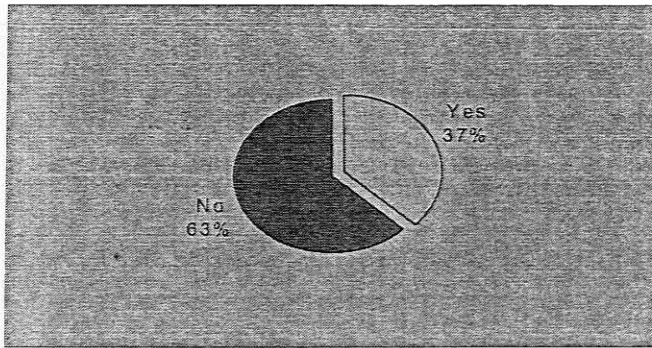


Only forty three percent (43%) of the children indicated that they do not know any young person in their area that died of HIV/AIDS. Twenty percent (20%) indicated that there were neighbour who die of HIV/AIDS (7%) do know a friend and thirty percent (30%) agree that there were members in their immediate family who died of HIV/AIDS.

This means that the majority of children were aware that AIDS do kill.

4.3.6 Distribution of the Respondents According Respondents According to AIDS Awareness

CHART 4.2.5 , GET AIDS FROM TOUCHING PEOPLE WITH AIDS

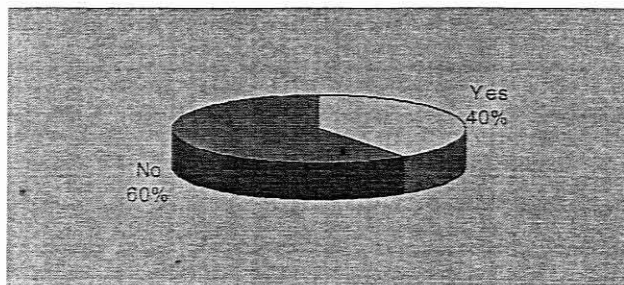


The above chart indicated the highest percentage that is sixty four percent (64%), where respondents indicated that people cannot get HIV/AIDS from touching someone and thirty seven percent (37%) shows that people can get AIDS from touching someone.

4.3.7 Distribution Respondents According to Different Understanding About Modes of Infection

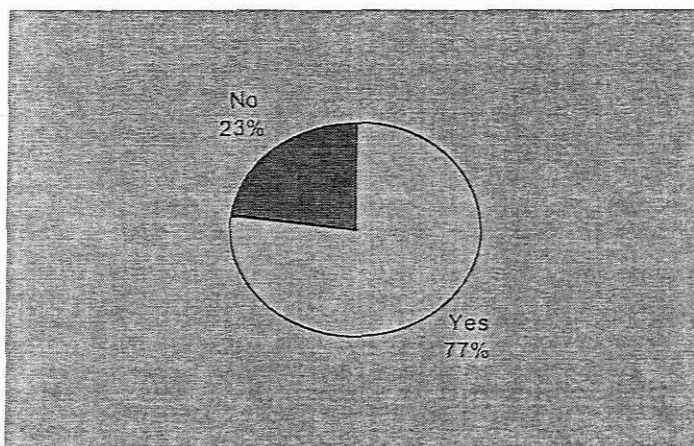
This question was asked in order to see how much knowledge they have about AIDS.

CHART 4.2.6 GET AIDS FROM KISSING



Only sixty percent (60%) of the children disagree that people can be infected by HIV/AIDS through kissing. Forty percent (40%) of children agreed that AIDS infected people through kissing someone. The researcher agrees with the sixty percent (60%) that disagreed.

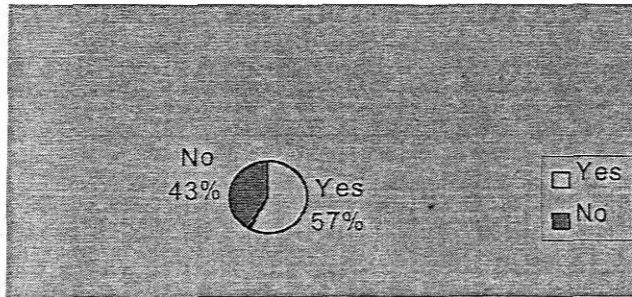
CHART 4.2.7 GET AIDS FROM MAKING LOVE



Only seventy seven percent (77%) of the children agreed that people can get HIV/AIDS from making love, twenty three percent (23%) disagreed. According to the researcher's parents are not playing their roles in educating their children about HIV/AIDS. Educators are left all by themselves at the schools. The researcher has observed this through her AIDS awareness campaign at Khandisa LP School.

4.3.8 **Distribution of Respondents According to the Mode of Infection**

CHART 4.2.8 INFECTED PEOPLE WILL NOT INFECT OTHER PEOPLE



It is disappointing to note that only seventeen respondents (17) out of 30 respondents (that is 57 percent) agreed that an infected individual who shows no signs of illness will infect their partners and thirteen (13) respondents (that is 43 percent) disagreed. This shows that grandparents are not playing their role in promoting AIDS awareness. This suggested that there is a lack of communication between the children and grandparents.

4.3.9 **Distribution of Respondents According to the Reaction of People Towards AIDS**

This question was asked in order to see how young people view the origin of HIV/AIDS and how they feel about it.

CHART 4.2.9 AIDS IS A SCOURGE

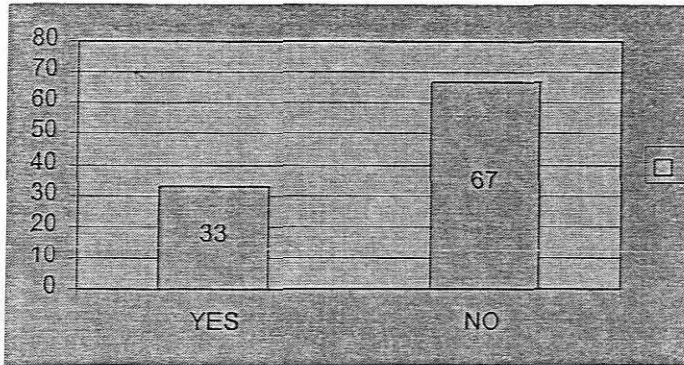
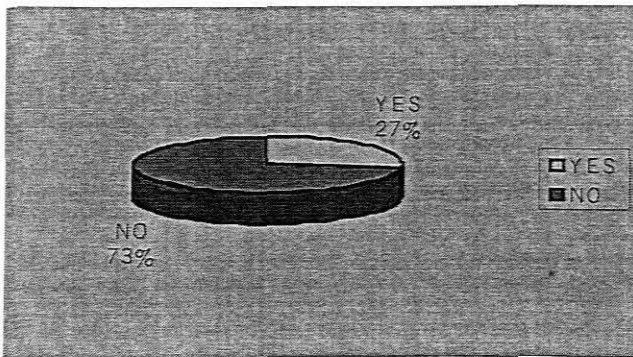


Chart 4.2.9 shows that the total number of respondents was thirty percent (30%) and seventy three percent (73%) is the highest number of respondents who agree that AIDS is a boon for the environment because there will be less people to mess it up and twenty seven percent (27%) are those who disagreed.

4.3.10 Respondents According to Different Views About HIV/AIDS

CHART 4.2.10 AIDS IS SOMEBODY`S PROBLEM



When asked "HIV/AIDS is somebody else's problem" only thirty three percent (33%) of the respondents agree. Sixty seven percent (67%) of the respondents disagreed.

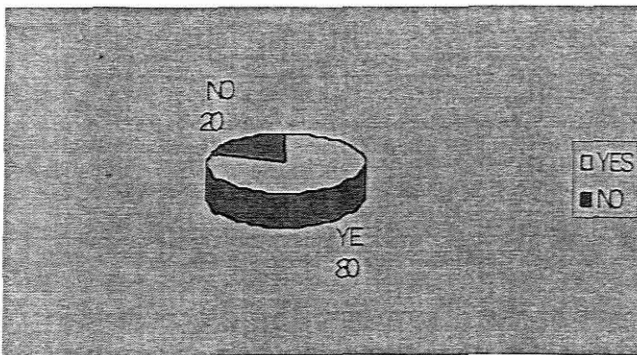
During the focus discussion groups some respondents expressed the opinion that people are infected by HIV/AIDS because they misbehave or being faithful to their partners. Another respondents said it is every body's problem because AIDS can infect even a newborn baby.

Section 3: Behaviour

4.3.11 Distribution of the Respondents According to Different Views About Relationship

When asked "should one have a girl/boy friend", most of the respondents indicated that they should have a girl/boy friend to socialized with, eighty percent (80 %) felt that it is important to have a friend of the opposite sex, only 20 percent disagree (see chart 4.3.1 below)

CHART 4.3.1 SHOULD ONE HAVE A RELATIONSHIP



Eighty percent (80%) of the respondents indicated that one should have a girl/boy friend. Only twenty percent indicated that one should not have a girl/boy friend.

During the focus discussion groups some respondents said having a girl /boy friend does not mean that they are husband and wife.

4.3.12 **Distribution of Respondents According to Those Who Have Friends Who Are Involved and Those Who Are Not Involved in a Relationship**

This question was asked in order to see how many respondents are involved in a relationship.

CHART 4.3.2 HAVE YOU HAD A RELATIONSHIP

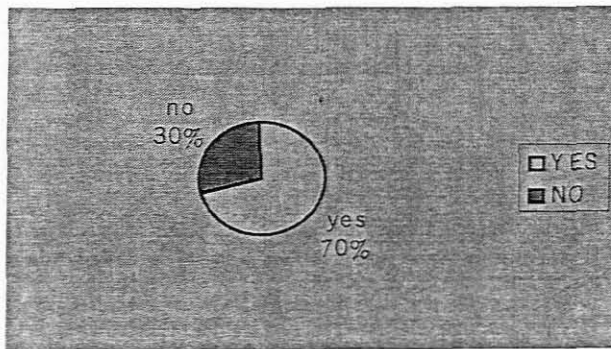


Chart 4.3.2 shows that the highest percentages of the respondents were those who agree with seventy percent (70%) and thirty percent (30%) were those who disagree.

During the focus discussion groups one respondent expressed that they are still small to be involved in a relationship.

4.3.13 Distribution of Respondents According to Relationships

This question was asked in order to see how young children feel about being involved in a relationship.

CHART 4.3.3 NUMBER OF RELATIONSHIPS

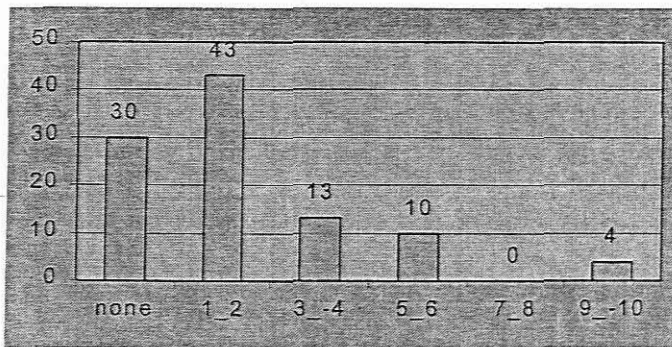
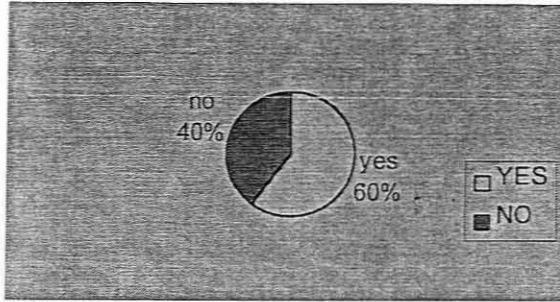


Chart 4.3.3 reflects that thirty percent (30%) respondents were not involved in a relationship, forty percent (40%) respondents were having one to two girl or boy friends. Thirteen percent (13%) were having three to four girl or boy friends, and only four percent were having 9 to 10 girl or boy friends.

During the focus discussion groups some respondents expressed that there is no need for rushing themselves in a relationship.

4.3.14 Distribution of Respondents According to Safe Sex Practice

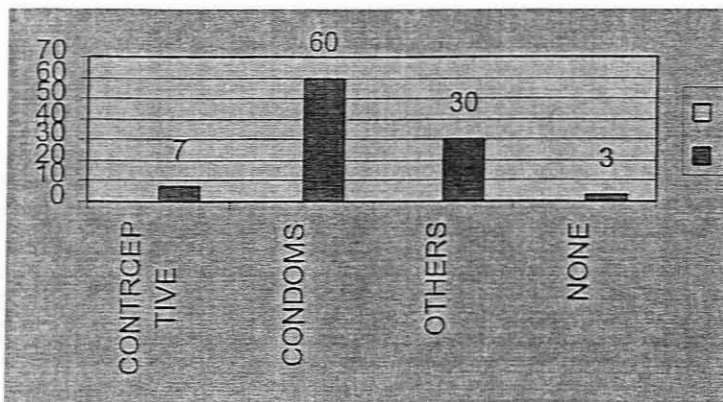
CHART 4.3.4 SAFE SEX MEASURES



When asked, "Do you take any safe sex measures?" sixty percent (60%) said yes, and forty percent (40%) said no. It is interesting to note that lots of respondents do take safe sex measures.

4.3.15 Distribution of Respondents According to the Type of Safe Sex Measures They Take

CHART 4.3.5 TYPE OF SAFE SEX MEASURES

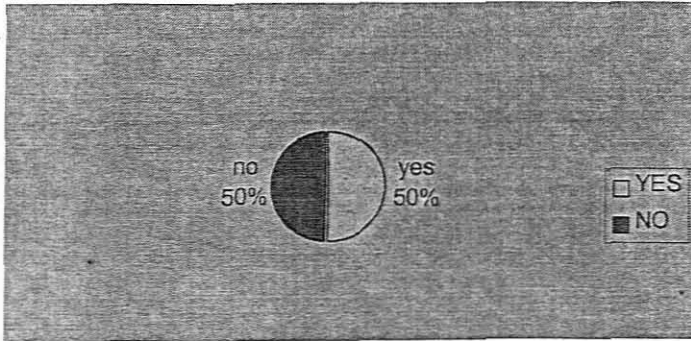


When the respondents were asked, "what safe sex measures do they take," seven percent (7%) respondents said take contraceptive, sixty percent (60%) respondents said that they use condoms, thirty percent use others and three percent indicated that they does not sue any safe sex measures.

4.3.16 **Distribution of Respondents According to the Treatment of Orphans with HIV/AIDS**

The question was asked in order to see how school children without AIDS treat orphan with HIV/AIDS.

CHART 4.3.6 DO ORPHANS NEED SPECIAL TREATMENT



When respondents were asked "Do orphans need special treatment at school", fifty percent (50%) said yes, and fifty percent (50%) said no. One respondents said, "all people must be treated equal" (see chart 4.3.6).

4.3.17 Distribution of Respondents According to the Treatment of Orphans

CHART 4.3.7 TREATMENT OF ORPHANS WITH AIDS

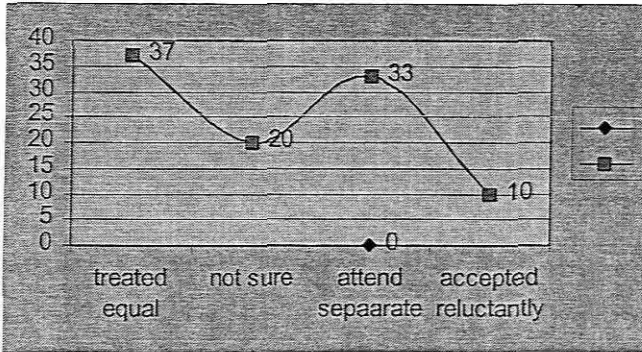


Chart 4.3.7 reflects that thirty seven percent (37%) respondents said that young orphans living with AIDS must be treated like other students, twenty percent (20%) said they accepted reluctantly, thirty three (30%) percent reflect that ten percent (10%) indicated that orphans with AIDS must attend separate classes.

During the focus discussion groups two respondents identified that there are a lack of information about modes of infection and can how they protect themselves against AIDS.

4.4 QUESTIONNAIRES FOR THE SCHOOL TEACHERS

Section One: Demographic Data

4.4.1 Distribution of Respondents According to Different Age

This question was asked in order to see how the respondents of different age groups respond and how they feel about teaching young orphans with HIV/AIDS.

CHART 4.4.1 **AGE**

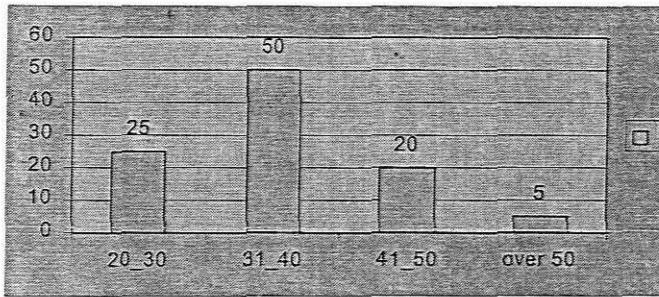
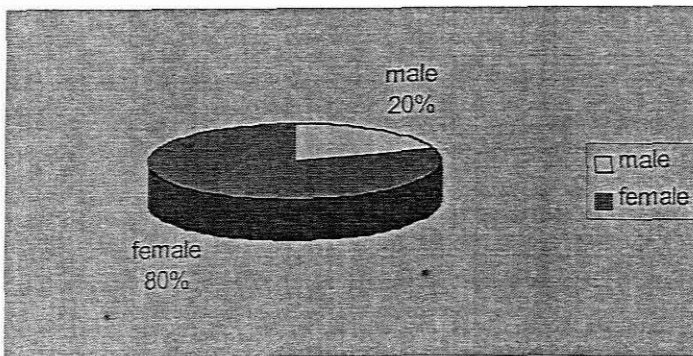


Chart 4.4.1 shows that the highest percentages of respondents were fifty percent (50%) of respondents between ages thirty-one to forty years old. Twenty five percent (25%) were respondents between ages twenty to thirty years old, twenty percent (20%) were between age forty one to fifty years old, and five percent (5%) were over fifty years old.

4.4.2 Distribution of Respondents According to Gender

This question was asked in order to measure the distribution of gender with the intention of assessing how teachers deal with their emotionally feeling of knowing that they have young orphans in their classroom with HIV/AIDS.

CHART 4.4.2 **GENDER**



The above chart shows that eighty percent of the respondents were females with the highest percentage. Twenty percent were males.

4.4.3 Distribution of the Respondents According to Marital Status

CHART 4.4.3 MARITAL STATUS

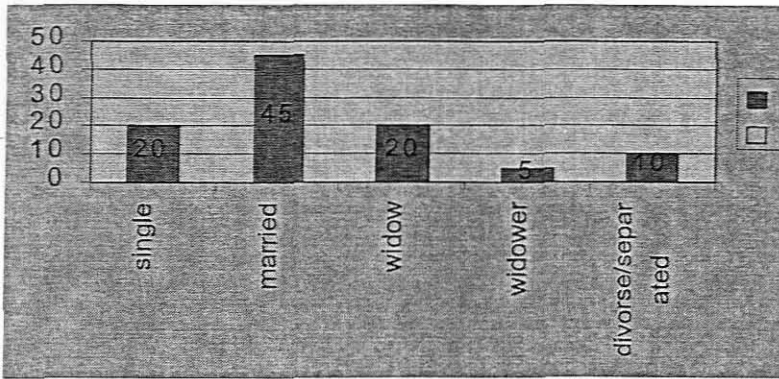


Chart 4.4.3 shows that twenty percent of respondents were single. Forty five percent of respondents were married. Twenty percent of the respondents were widow. Five percent of the respondents were widower and ten percent of the respondents divorced.

4.4.5 Distribution of the Respondents According to the Level of Education

This question was asked in order to see the respondent's level of education.

CHART 4.4.5 LEVEL OF EDUCATION

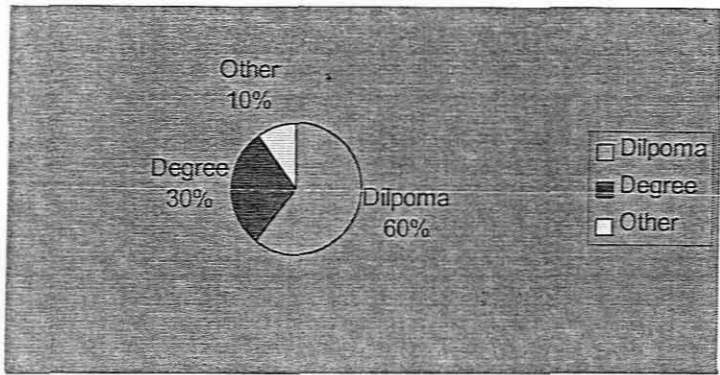
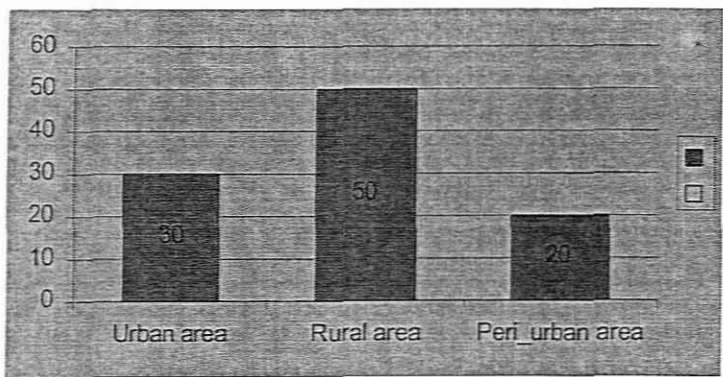


Chart-4.4.5 shows that the highest percentages with sixty percent (60%) were respondents with diploma. Thirty percent were respondents with degree and ten percent of respondents have other qualification.

4.4.6 Distribution of the Respondents According to Home Location

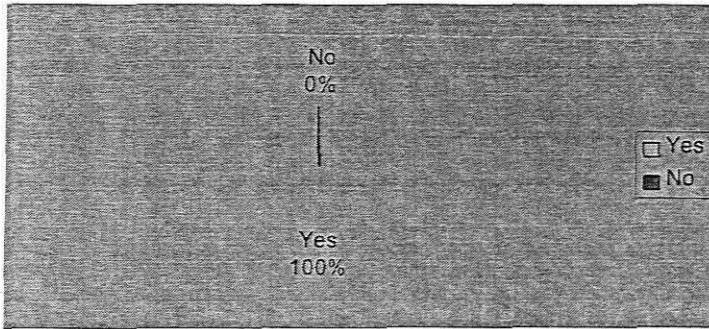
CHART 4.4.6 HOME LOCATED



The above chart shows that thirty percent of the respondents were located in urban area. Fifty percent of the respondents were located in the rural area and twenty percent of the respondents were located in peri-urban area.

4.4.7 Distribution of the Respondent According to HIV/AIDS Awareness

CHART 4.4.7 HAVE YOU HEARD OF HIV/AIDS



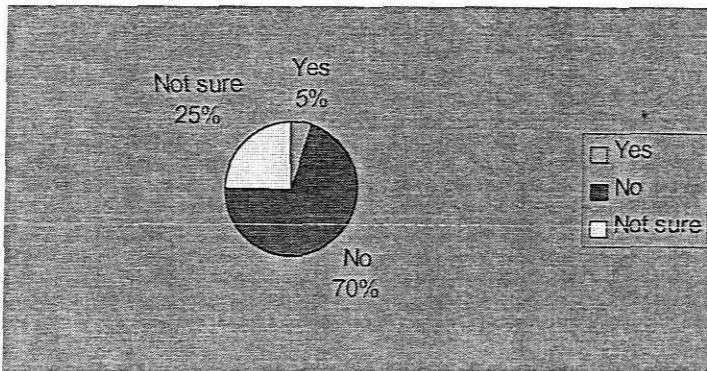
One hundred percent of the respondents indicated that they heard about HIV/AIDS.

During the focus discussion groups some respondents expressed that they attended several workshop about HIV/AIDS.

4.4.8 Distribution of the Respondents According to HIV/AIDS Cure

When asked, "Is there any cure that has been invented for HIV/AIDS" seventy percent of the respondents pointed out that there is no cure for the pandemic. Twenty five percent of the respondents indicated that they are not sure if there is a cure for AIDS. Five percent said yes there is a cure for the pandemic.

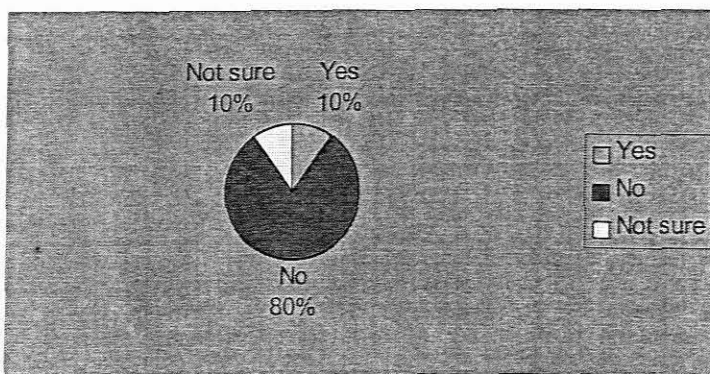
CHART 4.4.8 ANY CURE FOR HIV/AIDS



During the focus discussion groups one respondents identified that: he is confuse because he heard that retroviral can cure AIDS. This shows that even qualified teachers do need workshops about AIDS.

4.4.9 Distribution of the Respondents According to Discrimination Of People with HIV/AIDS

CHART 4.4.9 SHOULD A PERSON WITH AIDS BE DISCRIMINATED?

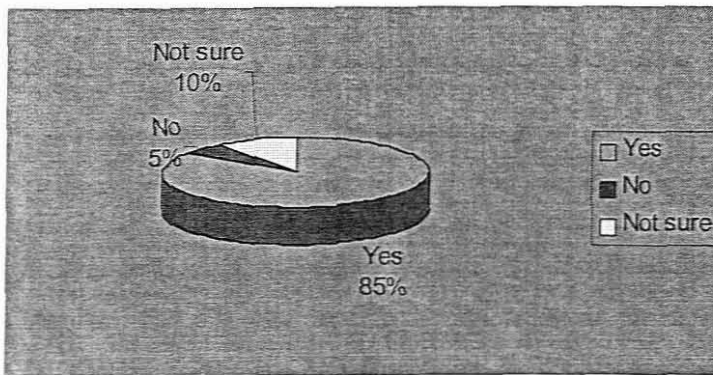


The above chart shows that the highest percentages were respondents who said people with HIV/AIDS must not be discriminated. Ten percent of the respondents were not sure, and another ten percent indicated that the infected people must be discriminated.

When asked, "Do you have children who are infected with AIDS in your classroom," eighty five percent of the respondents agreed that they do have children with HIV/AIDS. Five percent of the respondents disagreed that they have children with AIDS in their classroom, and ten percent of the respondents were not sure.

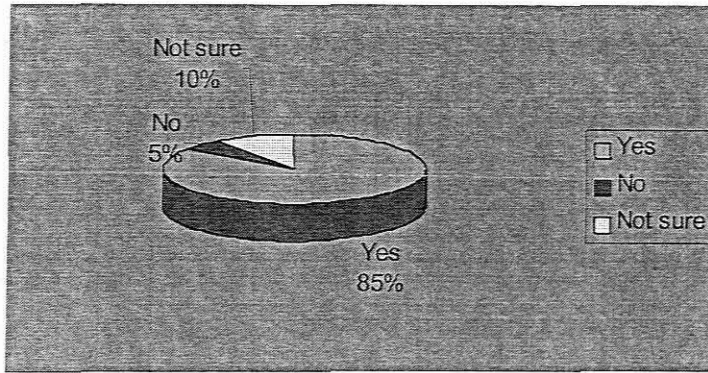
4.4.10 Distribution of the Respondents According to Children with HIV/AIDS

CHART 4.4.10 DO YOU HAVE CHILDREN WHO ARE INFECTED WITH AIDS?



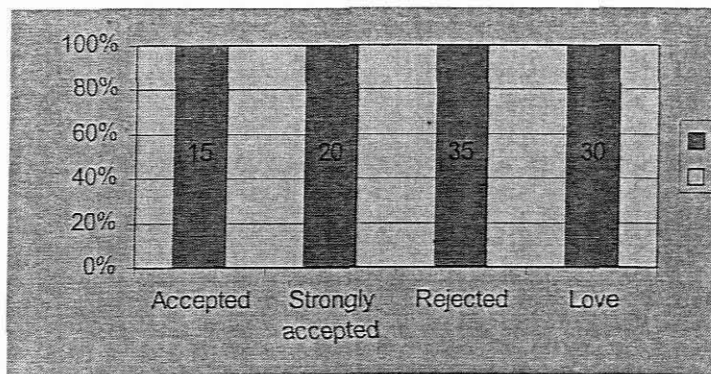
During the focus discussion groups the respondents expressed concern that teachers must involved themselves in awareness training.

4.4.11 Distribution of the Respondents According to the Presence of A Child with AIDS in Their Classroom



This question was asked in order to see how the respondents feel about having children with AIDS in their classroom.

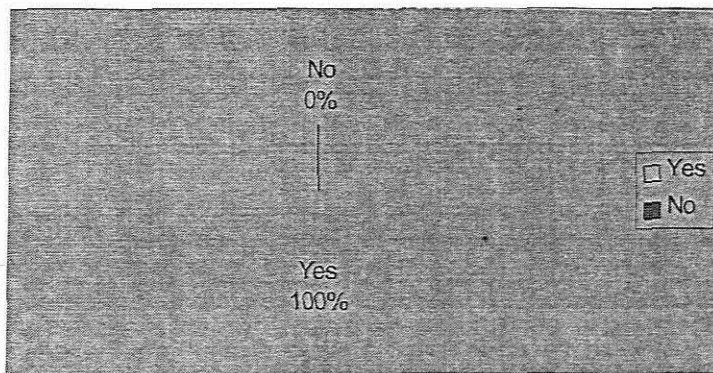
CHART 4.4.11 HOW THE STAFF FEEL ABOUT THE PRESENCE OF A CHILD WITH AIDS?



Fifteen percent of respondents identified that they were accepted. Twenty percent were strongly accepted, thirty five percent were rejected and thirty percent were receiving love from their colleagues.

4.4.12 **Distribution of the Respondents According to Any Support Receive by the Orphans From School**

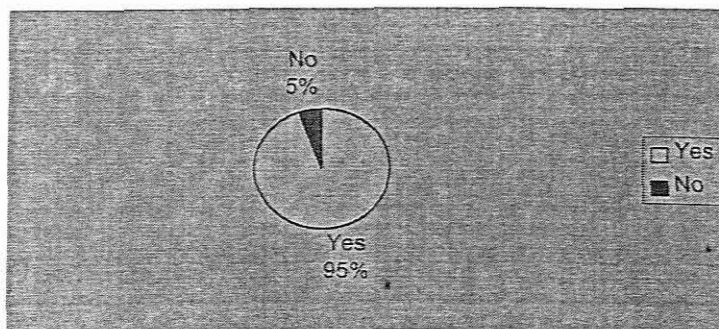
CHART 4.4.12 ANY SUPPORT FROM THE SCHOOL TO THE ORPHAN



The above chart shows that ninety five percent of the respondents agreed that the school does provide orphans with support. Only five percent disagreed.

4.4.13 **Distribution of the Respondents According to the Service of the Social Worker**

CHART 4.4.13 SHOULD YOU REGARD THE SERVICE OF A SOCIAL WORKER IN THE DEPARTMENT OF EDUCATION



Hundred percent of respondents expressed a relatively high interest in regarding the service of a social worker in the department of education.

One respondent said, "It would be very truly wonderful to work hand in hand with social workers".

4.5 QUESTIONNAIRE TO SCHOOL CHILDREN WITH HIV/AIDS

SECTION 1: DEMOGRAPHIC DATA

4.5.1 Distribution of Respondents According to Gender

This question was asked in order to measure the distribution of gender with the intention of assessing how young orphans with HIV/AIDS deal with their emotional feelings after knowing that they are HIV positive and assess how their relatives will treat them.

CHART 4.5.1 GENDER

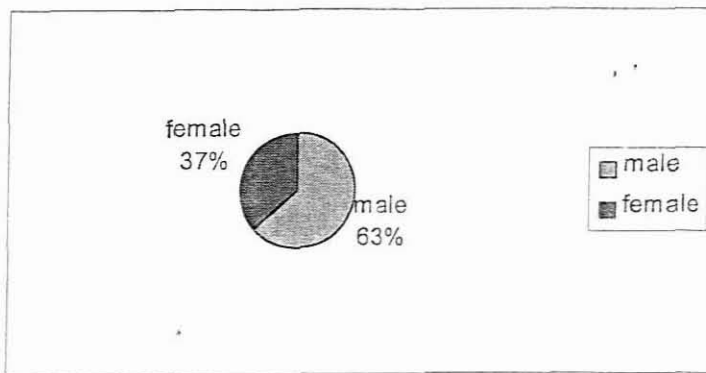
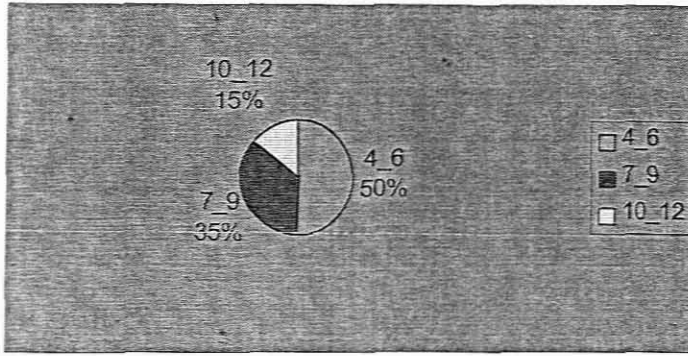


Chart 4.5.1 shows that the highest total numbers of respondents were females with sixty three percent (63%) respondents and only thirty seven percent (37%) were males.

4.5.2 Distribution of the Respondents According to Age

This question was asked in order to see how the respondents of different age groups respond and how do they feel about being of orphans with HIV/AIDS.

CHART 4.5.2 **AGE**

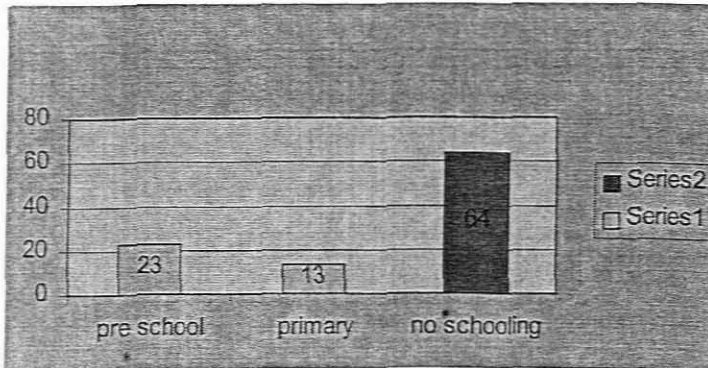


Fifty percent (50%) of the sample fell between the ages of 4 and 6. With significant minorities of thirty five percent (35%) falling between the age of 7-9. Significantly, very few of the respondents were fifteen percent (15%) between the ages of 10-12 (see chart 4.5.2).

4.5.3 Distribution of the Respondents According to the Level of Education

This question was asked to see the respondent's level of education.

CHART 4.5.3 **LEVEL OF EDUCATION**



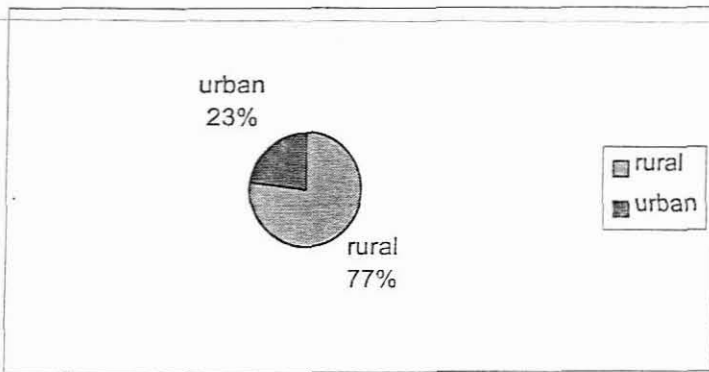
Twenty three percent (23%) of the respondents attend pre-school and thirteen percent (13%) attend primary school. Sixty four percent (64%) of the respondents had received

no schooling.

4.5.4 Distribution of the Respondents According to Home Location

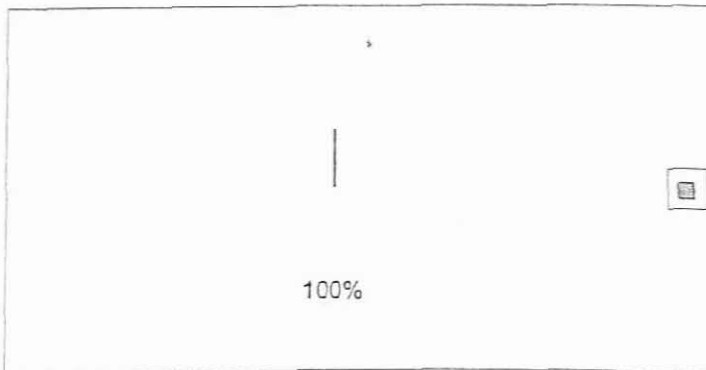
The vast majority of the respondents (77%) in chart 4.5.4 indicated that they live in rural areas. The remaining 23% of respondents live in urban area (see chart 4.5.4).

CHART 4.5.4 HOME LOCATION



4.5.5 Distribution of the Respondents According to Language

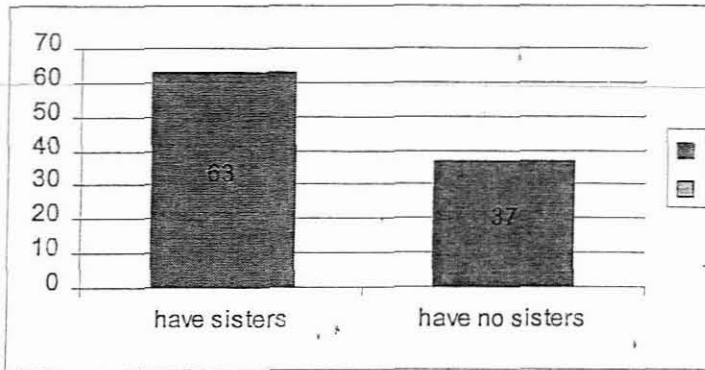
CHART 4.5.5 LANGUAGE



The respondents were asked, "What is your language?" The overwhelming majority of the respondents in the focus groups were Zulu speaking people (100%).

4.5.6 **Distribution of the Respondents According to Orphans Who Have Sister(s)**

CHART 4.5.6 ORPHANS WITH SISTER(S)



Sixty three percent (63%) of respondents indicated that they do have sister(s). Thirty three percent (37%) of respondents indicated that they have no sister(s) at all.

During the focus discussion groups one respondent pointed out that having a sister at home is like having a best friend to socialise with any time.

4.5.7 **Distribution of the Respondents According to Treatment of Orphans by Their Sister(s)**

This question was asked in order to see how young orphans with HIV/AIDS are being treated by their sister(s).

CHART 4.5.7

TREATMENT OF ORPHANS BY THEIR SISTER(S)

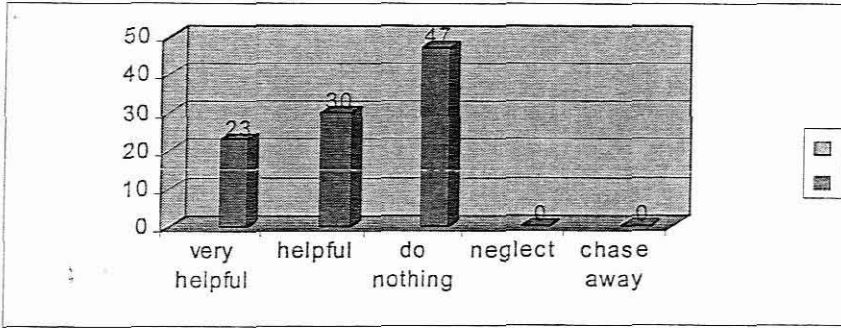


Chart 4.5.7 indicated that twenty three percent (23%) of the respondents have sisters who are very helpful. Thirty percent of respondents show that their sisters are helpful. Forty seven percent pointed that their sisters do nothing.

One respondent said "Nobody wants to talk about it. But if it is true, and it is true, then we must face up to it and not just hid in shame. If we do no talk about it we cannot do anything about it".

4.5.8 Distribution of the Respondents According to Orphans Who Have/have No Brother(s)

CHART 4.5.8

ORPHANS WITH/WITHOUT BROTHER(S)

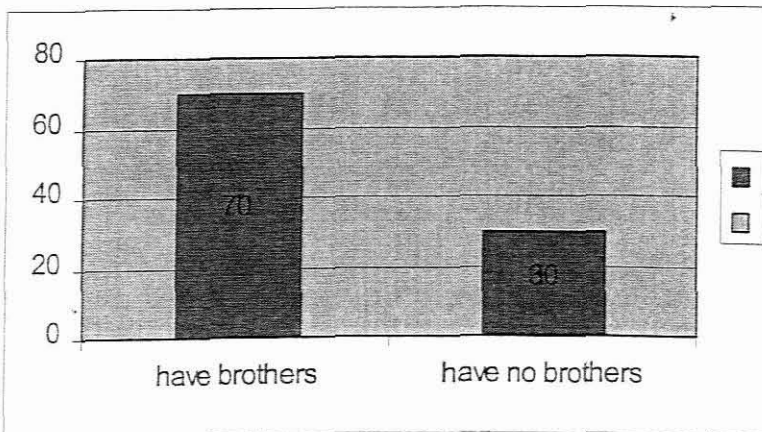
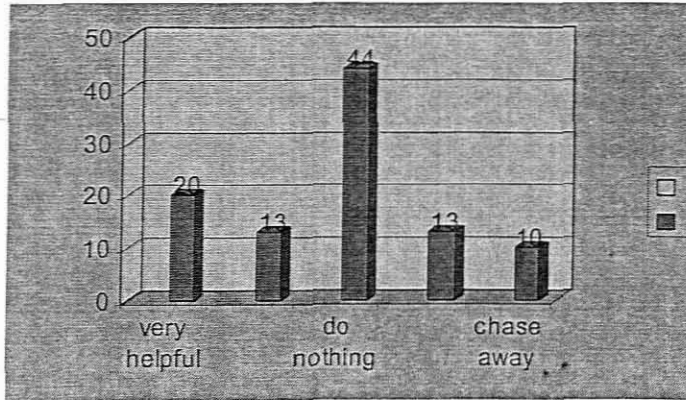


Chart 4.5.8 indicated that seventy percent (70%) of respondents agree that they do have sisters. Only (30%) thirty percent disagree.

4.5.9 **Distribution of the Respondents According to Treatment**

CHART 4.5.9 TREATMENT FROM YOUR BROTHER(S)

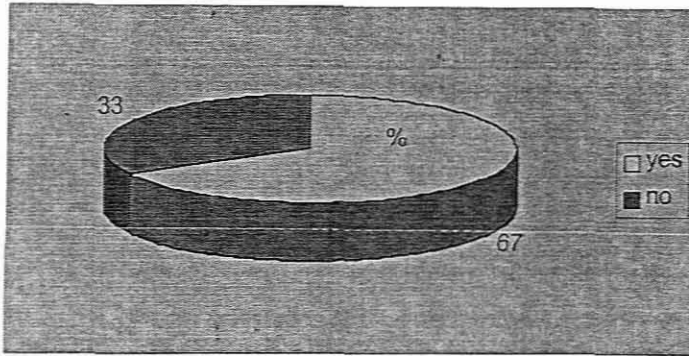


The above chart indicated that twenty percent of the respondents have brothers who treat them very helpful. Thirteen percent (13%) of respondents pointed out that their brothers do them help. The highest percentage is forty four percent (44%) where respondents indicated that they receive nothing from their brothers. Thirteen percent (13%) of respondent's shows that their brother(s) neglect them and only ten percent of respondents were chased away.

4.5.10 **Distribution of the Respondents According to Orphans Who Have/Have No Friend(s)**

This question was asked in order to see how young orphans with HIV/AIDS cope with their friends.

CHART 4.5.10 DO YOU HAVE FRIENDS

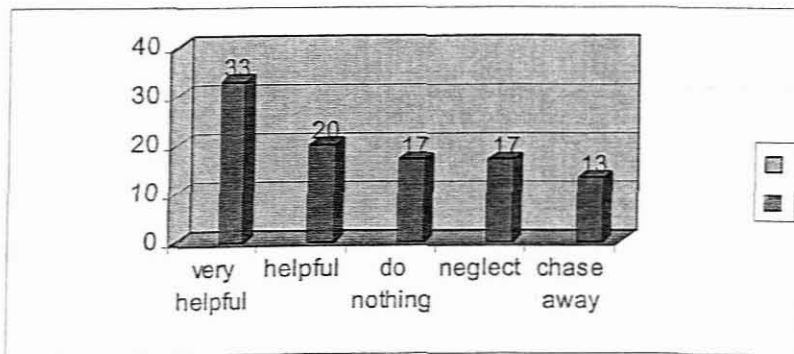


Sixty seven percent (67%) of respondents shows that they do have friends. Only thirty three percent (33%) of the respondents shows that they do not have friends.

4.5.11 **Distribution of the Respondents According to Treatment From Friends**

This question was asked in order to see how their friends treated the young orphans.

CHART 4.5.11 TREATMENT FROM FRIEND(S)



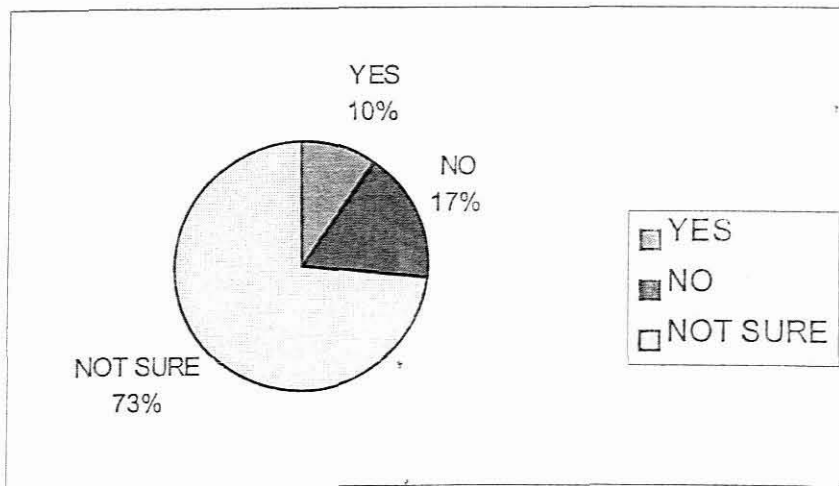
From the above chart thirty three percent (33%) of the respondents indicated that the friends they have treated them very helpful. Twenty percent also shows that they have friends who treat them well, seventeen percent indicated that their friends do nothing, and thirteen percent indicated that their friends neglect or chase them away.

another seventeen percent (17%) indicated that their friends neglect them and twelve percent of the respondents indicated that were chased away.

During the focus discussion groups one respondent pointed out that even if she has energy, she never ventures out anywhere except to the clinic because people are starting to say that she looks like someone with *ingculazi* (AIDS).

4.5.12 **Distribution of the Respondents According to Friend With/Without AIDS**

CHART 4.5.12 FRIENDS WITH/WITHOUT AIDS



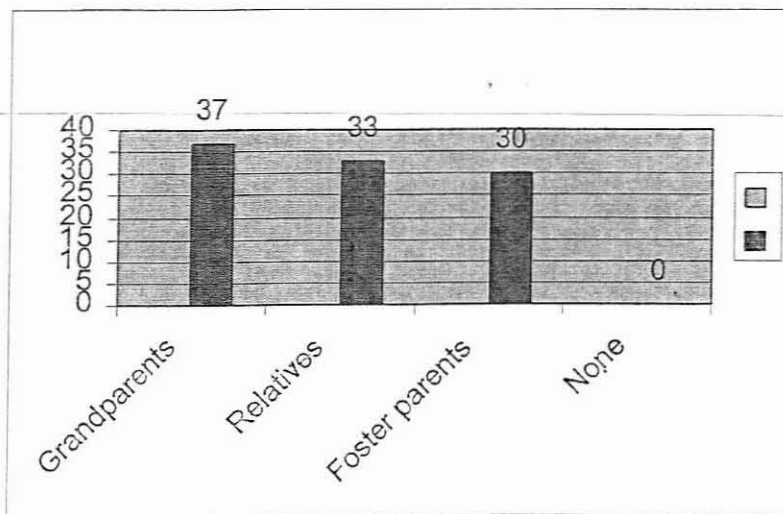
The above chart indicated that the highest percentages seventy three percent (73%) of respondents were not sure if their friends were infected. Seventeen percent (17%) of respondents stated that their friends were not infected by the pandemic. Only ten percent (10%) of respondents pointed out that their friends are infected.

During the focus discussion groups the respondents expressed concern that too many people were treating the matter as a joke.

Yet another respondent said, "We wanted to participate in an HIV/AIDS awareness training.

4.5.13 **Distribution of the Respondents According to the People the Orphans Live with**

CHART 4.5.13 PEOPLE THE ORPHANS LIVE WITH

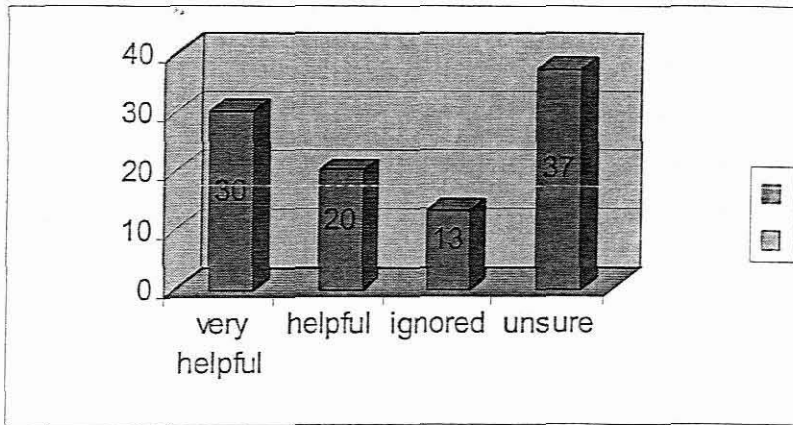


When the respondents were asked with whom do you live thirty seven percent (37%) said that they live with grandparents, thirty three percent live with relatives, thirty percent live with foster parents.

During the focus discussion groups no one was living alone.

4.5.14 **Distribution of the Respondents According to the Treatment Receive by the Orphans**

This question was asked in order to see how young orphans with HIV/AIDS were treated by the people they live with.

CHART 4.5.14**TREATMENT OF ORPHANS BY THE PEOPLE THEY LIVE WITH**

When the respondents were asked how did the treat you (30%) thirty percent of respondents said very helpful. Twenty percent (20%) of respondents indicated that they were treated helpful. Thirteen percent (30%) said that relatives ignored them and other people and thirty seven percent (37%) of respondents indicated that they were not sure the treatment they receive from the people they live with.

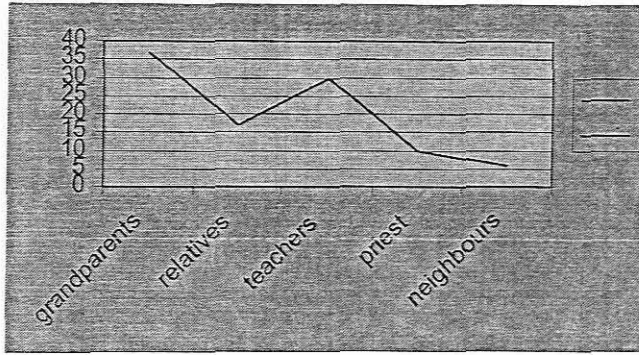
During the focus discussion group one respondent said, "There is nothing that I do. I get washed. My grandparents bring me breakfast porridge in my bed".

4.5.15 **Distribution of the Respondents According to Treatment Receive by Orphans From Other People**

This question was asked in order to see how other people treated the young orphans with HIV/AIDS.

CHART 4.5.15

TREATMENT RECEIVE BY ORPHANS FROM OTHER PEOPLE

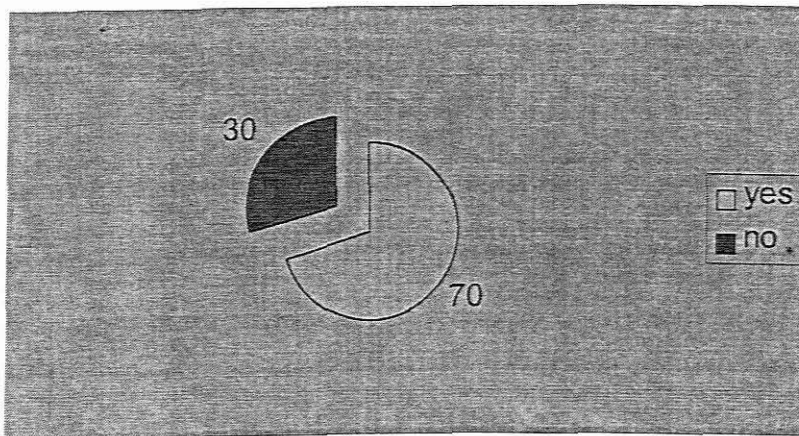


Thirty-seven percent of respondents indicated that grandparents were the one who treated them well. Seventeen percent shows that relatives treated them well too. Thirty percent indicated that teachers treated them well. Ten percent of respondents said they received better treatment from the priest and six percent indicated that the best treatment the received were from the neighbour.

4.5.16 Distribution of the Respondents According to Knowledge About HIV/AIDS

This question was asked in order to see how much they now about HIV/AIDS.

CHART 4.5.16 KNOWLEDGE ABOUT HIV/AIDS

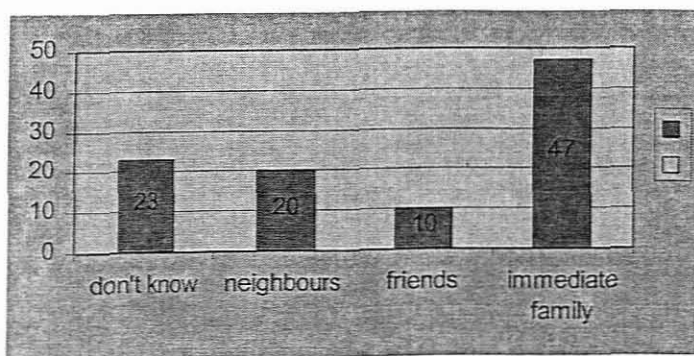


From the above chart seventy percent of respondents shows that they have knowledge about HIV/AIDS. Thirty percent of respondents do not know anything about HIV/AIDS.

During the focus discussion groups one respondent said that, "Do not share toothbrushes, razors or any items, which may be contaminated with blood. He continued saying that, "If a traditional practices involving a cutting and bleeding takes place, the blood must be properly disposed of and the razor or Knife used must be boiled for thirty minutes between use on different people. Ideally new razor should used for every person or each person should take his/her own blades along".

4.5.17 **Distribution of the Respondents According to Knowledge About Anyone Dying of HIV/AIDS**

CHART 4.17 ANY ONE DIED OF HIV/AIDS



Forty seven percent of respondents indicated that their immediate families do died of AIDS. Twenty percent of respondents claimed that they don't know any one in their community who died of AIDS. Twenty percent of respondents indicated that there are neighbours who died of AIDS. Ten percent indicated that they do not have friends who died of AIDS.

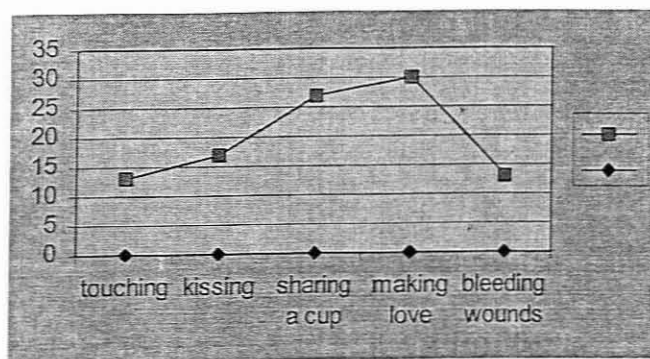
During the focus discussion groups another respondent said, "our parents do not talk

about HIV/AIDS and death with us, there are things that are happening in our family and they hid it”.

4.5.18 **Distribution of the Respondents According to the Modes of Infection**

When respondents was asked if people can get AIDS from the following thirteen percent of respondents indicated that people can infected by AIDS through touching someone who is infected. Seven percent of respondent indicated that AIDS could infect people by kissing the infected person. Twenty seven percent of respondents indicated that AIDS could infect people by sharing a cup. Thirty percent of respondents indicated that AIDS could infect people by making love. Only thirteen percent said AIDS could infect people through a bleeding wound (see chart 4.5.18 below).

CHART 4.5.18 MODES OF INFECTION

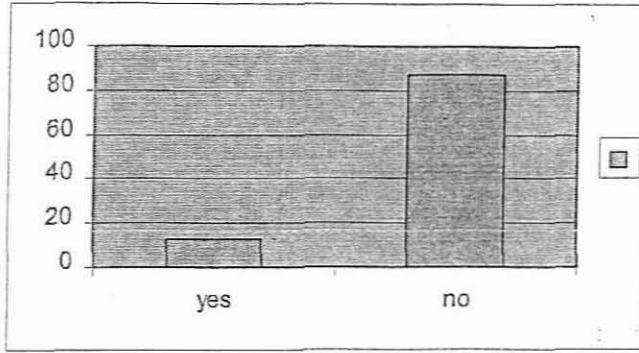


4.5.19 **Distribution of the Respondents According to the Feeling of People About HIV/AIDS**

This question was asked in order to see how other people feel about HIV/AIDS in our community.

CHART 4.5.19

FEELING OF PEOPLE ABOUT HIV/AIDS



The above chart indicated that thirteen percent of respondents said that they have heard others saying bad things about AIDS. Eighty seven percent indicated that they never heard people saying bad things about AIDS.

CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter gives the concluding remarks of the research undertaken. The format adopted is to give overall conclusions in respect of the topic under study is, an investigation of HIV/AIDS at Esikhawini in the context of the South African AIDS pandemic. Firstly the conclusions from chapter four will be discussed with sub-topics and conclusions of the whole study will be discussed.

This study was designed to uncover some important facts about the attitudes and feelings of grandparents of children with HIV/AIDS in Esikhawini and its surrounding. The researcher wants to find out what attitudes grandparents of such children do have towards them and to examine clearly the experience that are encountered by young orphans with HIV/AIDS while attending school or playing with their classmates or peer groups.

5.2 RESTATEMENT OF THE PROBLEM

It has been mentioned in chapter one that AIDS is undoubtedly the most formidable public health problem facing South Africa today. Perhaps no disease in modern times has created as much as fear and panic, as has HIV/AIDS. In recent years the pandemic has rapidly involved the heterosexual community, mainly affecting people from socio-economic groups.¹ South Africa currently has a high proportion of children who are not continuously cared for by either parents or very high rates of care by grandparents and by other relatives. This is due to the history of displacement the people to implement

the racially segregated society envisaged during the years of apartheid, combined with the migrant labour system.

Whiteside and Sunter asserted that at present, South Africa is witnessing the emergence of child-headed households and the conversion of facilities designed for early childhood education into *de facto* residential homes.

According to South African Red Cross Society there are about 300 000 orphans with HIV/AIDS at KwaZulu-Natal (Gibson 2001). Children who suffer a loss of a parent to AIDS have their loss exacerbated by prejudice and social exclusion can lead to the loss of education and health care. Whiteside, *et al.* (2000) asserts that the growing up without parents, and badly supervised by relatives and welfare organisations, this growing pool of orphans will be at greater than average risk to engage in criminal activity in order to survive.

5.3 **METHODS EMPLOYED IN THE STUDY**

Since the research envisaged was of a descriptive nature, the literature review and an empirical study were the main methods that were used.

5.3.1 **Literature Review**

A careful study of literature with a view and a theoretical background within which the problem could be investigated was undertaken. The method was particularly employed in chapter two, three and four.

5.3.2 **Empirical Investigation**

Questionnaires were used to collect data for empirical study. The advantages and disadvantages of questionnaires were discussed in chapter five. An empirical study presented experience and first hand information in the collection of data from different teachers, grandparents, School children without AIDS and the orphans with HIV/AIDS.

5.4 **CONCLUSIONS**

5.4.1 **Respondents According to Age**

This study has confirmed that people of different age groups has a trend of concern about AIDS which increases with age. Clearly the overall interest in HIV/AIDS awareness training is high, though it is significant that the younger one without AIDS is the more one shows a relative lack of interest.

5.4.2 **Gender and Level of Education**

This study has confirmed that females are the people who dominate most in our community. This is shown by the percentage of females in the data analysis.

5.4.3 **Attitudes of Respondents Towards Orphans with HIV/AIDS**

This study has confirmed that most people do not like the way people who are living with AIDS are treated in our community. This is reflected by the highest percentage of those who said orphans with AIDS must not be isolated but they must be treated like everybody else.

5.5.4 **Feelings of Respondents Towards Orphans with HIV/AIDS**

This study has confirmed that the majority of the respondents feel that there is a need for care support for the orphans with HIV/AIDS. There were a small percentage of respondents who said people are being infected because of immoral.

5.5.5 **Need of A Social Worker**

The findings in chapter four reflect the importance of a social worker in the department of education since very few blacks go for consultation. In view of the above findings it is clear that there is a need for support groups where young and old can go for social support. In this regard social support is taken as "the feeling of being cared for and loved, valued and esteemed, and able to count on others".

5.6 **RECOMMENDATIONS**

The recommendation is that further research of the quantitative and qualitative nature must be undertaken pertaining the role of teachers, School children, grandparents and orphans with the interest on AIDS awareness.

5.7 **FINAL REMARK**

It is trusted that this study will be of value, particularly to the various rural areas with regard to meeting the needs of orphans with HIV/AIDS. It is also hoped that the study will contribute towards brightening the future of orphans with AIDS in our community.

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