

**EVALUATION OF PSYCHOLOGICAL PROGRAMMES FOR CHILDREN  
ORPHANED BY HIV/AIDS IN SOUTH AFRICA**

**BY**

**JABULILE DOROTHY ADAMS**

**2005**

**Evaluation of psychological programmes for children  
orphaned by HIV/AIDS in South Africa**

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**JABULILE DOROTHY ADAMS**

A dissertation submitted in partial fulfillment of the requirements for the degree of  
Masters of Arts (Counselling Psychology) in the Department of Psychology University of  
Zululand.

**SUPERVISOR: PROF N.V MAKUNGA**

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## DECLARATION

I Jabulile Dorothy Adams hereby declare that the work on “**Evaluation of psychological programmes for children orphaned by HIV/AIDS in South Africa**” is my own initiative, both in conception and in execution and that the sources that I have consulted or cited are acknowledged in the text as well as in the list of references.

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Signature.

J.D. ADAMS

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Date

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- My final and the most important thanks goes to the Almighty God, Who is ever there for me and Who never fails me. I thank HIM for giving me wisdom, knowledge and strength to bring this study to finality.

## **DEDICATION**

This project is dedicated to all the caregivers of orphans who are young, old, childless and those who have children. Your contributions made up this project.

May the God Almighty be with you and lead you as you undertake your chosen mammoth task.

## ABSTRACT

Programmes addressing psychosocial needs of children orphaned by HIV/AIDS already exist in Sub-Saharan countries (Germann, 2002), yet in South Africa, few if any, of the relief programmes take cognisance of psychological support. Failure to provide psychological support to children orphaned by HIV/AIDS may have negative, long lasting effects like mental illness, crime, street children and these can in turn result in dysfunctional societies.

Thus the aims of the present study were to report on findings concerning available psychosocial intervention programmes and to provide information about the effectiveness of these programmes. Using purposive sampling to select research respondents, the researcher collected data personally.

A questionnaire was administered to 19 female caregivers at Emoyeni Hospice in Northern Kwa-Zulu Natal to evaluate psychological support intervention in their programmes. The questionnaire was translated to Zulu in order to avoid any misunderstanding. Qualitative and quantitative data analysis was used in order to conclude about the state of psychological interventions for children orphaned by HIV/AIDS at Emoyeni.

*Research findings led to the following conclusions:*

- Care-givers at Emoyeni Hospice do include the component of psychological intervention support in their intervention programme.
- The care-givers at Emoyeni Hospice still need to be helped to recognize the importance of letter writing, and facilitating remembrance of the deceased parent/parents as a technique of psychological intervention.

- The present study revealed that caregivers consider spiritual and physical support as important aspects for inclusion in the psychological intervention programme in order to maximize psychological well-being.

## **CHAPTER 1**

### **OVERVIEW OF THE STUDY**

#### **1.1 Introduction**

HIV / AIDS continues to spread unabated in many developing countries (Lindegger & Wood, 1995; Macphail & Campbell, 1999). This is especially true for South Africa during recent years. The previously largely silent epidemic of HIV has shifted to a visible epidemic of AIDS. Referring to this notion Buthelezi (2003) notes that in South Africa the impact of HIV and AIDS has been felt on all levels both national and provincial. Indeed, along with violent crime, AIDS constitutes the biggest threat to South African Society since the death of apartheid.

Over the last few years it has also become clear that AIDS is not only one of the greatest health problems, but is increasingly a social problem as well. Russell and Schneider (2002) agree that the impact of AIDS on families and communities is emerging at a rapid pace. Conservative predictions are that by the year 2005, there will be nearly one million children orphaned by AIDS in the country, clearly overwhelming the current capacity of the welfare system (Russell & Schneider, 2002).

The impact of parental death on children is immense and complex. According to Germann (2002), it influences various aspects of mental health, physical well-being and future potential. Germann (2002) further explains that children from families affected by HIV / AIDS often experience loss of family and identity, psychosocial distress, increased

malnutrition, loss of health care, increased demand for labour, reduced educational opportunities, homelessness and exposure to HIV Infections themselves.

Surely, children so affected need some form of psychological support to be able to cope with their trauma.

## **1.2 STATEMENT OF THE PROBLEM**

Most programmes that support AIDS orphans and HIV vulnerable children focus on providing material needs such as food and clothing. Numerous organizations including Non-Governmental Organizations (NGO's), Community-Based Organizations (CBO's), Faith-Based Organizations (FBO's) access funding to purchase food and clothing particularly school uniforms for these destitute children. Good Samaritans and churches also, have begun relief programmes that organize food and clothing for distribution to these children. According to Simasiku (2002) such relief programmes are not addressing children's emotional or psychological needs. Failure to provide psychological support to children may have long lasting negative life effects such as mental illness, crime, street children and these can in turn result in dysfunctional societies. Mental health professionals, therefore, need to make a contribution in assisting children affected by HIV / AIDS firstly by identifying them and secondly by providing relevant support programmes.

### **1.3 MOTIVATION FOR THE STUDY**

Programmes addressing the psychological needs of children affected by Human Immuno Deficiency (HIV/ AIDS) already exist in other Sub-Saharan countries like Zimbabwe, Malawi and Tanzania (Yamba, 2002). However, very few programmes in South Africa, if any take cognisance of psychological support, yet, helping deal with emotional pain is of utmost importance for healthy childhood and psychological well being in adulthood. For these purposes it would be useful, firstly, to know which psychological interventions exist in South Africa, particularly in the province of Kwa-Zulu Natal and secondly, to determine which programmes are effective in assisting children affected by HIV / AIDS. Thus the present research wishes to evaluate psychological intervention programmes for children orphaned by HIV/AIDS in South Africa.

It is predicted that being a caregiver of children orphaned by HIV/ AIDS is a huge responsibility that needs one to have specific skills in order to deal effectively with these children's circumstances. This situation dictates therefore that health professionals assume the responsibility of providing programmes that will equip caregivers of children affected by HIV/AIDS with skills that will enable them to maximize emotional healing, that will provide a healthy childhood and psychological wellbeing in adulthood. Thus it is the ultimate goal to empower the caregivers with skills that will promote the mental health of orphans and mental growth to caregivers.

#### **1.4 SCOPE AND LIMITATIONS OF THE STUDY**

In view of practical considerations, the present study was conducted at Emoyeni in the UMthunzini District- of Northern Kwa-Zulu Natal (see map attached)

#### **1.5 AIM OF THE STUDY**

The aim of this study was to report on findings concerning the psychological intervention programmes for children orphaned by HIV/ AIDS in South Africa. More specifically programmes that are available to assist HIV / AIDS orphans and their effectiveness will be ascertained. In this way the individual feelings of these children can be dealt with. The present study will provide sufficient information about intervention programmes that will assist with emotional stability of these children and thus general well being (Germann, 2002; German & Madörin, 2002).

#### **1.6. DEFINITION OF CONCEPTS**

Concepts frequently used in this dissertation are defined below.

##### **1.6.1 Psychological intervention programmes**

Psychological intervention programmes are support structures meant to maximize the well being and mental health of children who have been affected by the death of parent/ s through HIV / AIDS. In these support structures different strategies are used and these range from individual to group support, and to caregivers. These programmes assist children to cope with difficult circumstances like bereavement, loss and other traumas resulting from losing their parents (Germann, 2002; Germann & Madörin, 2002).

### **1.6.2 Children orphaned by AIDS**

Children orphaned by AIDS are those under 15 or 18 years of age and have lost one or both parent as a result of AIDS. These are children whose lives will be profoundly changed by the epidemic and whose needs will require psychological intervention. The term will be used when referring to children orphaned by AIDS, children affected by AIDS; and orphans and vulnerable children (OVC's) (Germann, 2002; Germann & Madörin, 2002; Foster, Jiwli, Germann, & Masifure., 2000).

### **1.6.3 HIV / AIDS**

HIV is known as the Human Immunodeficiency Virus or HIV. A person infected with HIV is open to other infections or diseases that can cause death. When HIV enters the body, it attacks white blood cells (of the body's four kinds of T-cells). A person is diagnose as having AIDS when the person's T-cell count is below the 200 and certain diseases are present (Meeks & Heit, 1990; Merki, 1993). The word AIDS refers to an acquired immunodeficiency syndrome. This is a deadly disease that interferes with body's natural ability to fight infections.

### **1.6.4 Caregivers**

The word is composed of two words care and giver. According to the "Longman's Dictionary of Contemporary English (1985), **to care** means to nurse or attend to or look after. **To give** is to pass into someone's hands. In this study the two words will be joined together to refer to someone who looks after or takes care of children orphaned by HIV/AIDS.

## **1.7 VALUE OF THE STUDY**

The findings of the study should be of benefit to:

- Orphans- by increasing their self-acceptance knowing that they are people of worth, and that caregivers are contributing towards their welfare.
- Caregivers – by being able to contribute positively in sustaining the quality of life of orphans
- Health professionals – by providing ground for research undertaken that will assist with improved intervention strategies
- Public – especially communities of those affected by the disease.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

“The AIDS pandemic is regarded as the greatest social disaster in Africa since slavery” (International Conference on AIDS, Durban , 2000). It impacts on families and communities, the most vulnerable being children. This chapter reviews literature relating to children affected by HIV/ AIDS, emphasizing the impact of parental death on children orphaned by HIV / AIDS. Review of literature also covers prevention measures.

#### **2.1.1 The impact of HIV / AIDS on children orphaned by HIV / AIDS**

Several studies (USAID, 2000; Richter, 2001; Foster & Williams, 2000) have been conducted on the impact of HIV/ AIDS on children. According to these studies HIV / AIDS impacts on children in different ways as the discussion that follows illustrates.

##### **2.1.1.1 Economic Impact**

Richter (2001), in her study on the impact of HIV / AIDS on children reveals that when a family member has AIDS, the average income falls by 52% -67%, expenditure on health care quadruples, savings are depleted and families go into debt to care for the sick and food consumption drops by 4% in households of orphans. According to Richter (2001), loss of income of breadwinners, asset selling to afford care, and debt incurred by funeral costs usually deplete all current and future financial reserves of households. This scenario implies that children either have to find themselves dropping out of school to look for means that will supplement the depleting family income or find other means of

generating money. Lyons (2002) indicates that in the absence of capable adult caretakers, children themselves take on responsibilities for the survival of the family and home. In economically disadvantaged communities, the child's contribution is often necessary for the survival of the household. As a result of this economic hardship, in some instances the affected children look for alternative sources of income such as prostitution (Richter 2001). Economic hardships impact negatively on most of the children affected by HIV and AIDS. Evidence from literature (Richter 2001) is that children affected by HIV / AIDS, provide a high rate of child labor and early marriages. As soon as one or both parents die, children take responsibilities of adults, including economic responsibilities. The USAID (2002), "Situation analysis of orphans in Uganda" considers the potential of the socioeconomic impacts on orphans and caregivers as given in Figure 1.

Level	Potential Socioeconomic impact	
	Short – term	Long – term
Orphan	<ul style="list-style-type: none"> <li>■ Loss of inheritance</li> <li>■ Reduced health nutrition</li> <li>■ Reduced school attendance</li> <li>■ Increased labor</li> <li>■ Increased social isolation</li> <li>■ Vulnerability and abuse</li> <li>■ Increased homelessness</li> </ul>	<ul style="list-style-type: none"> <li>■ Reduced productivity</li> <li>■ Reduced socialization</li> </ul>
Family	<ul style="list-style-type: none"> <li>■ Increased dependency ratio</li> <li>■ Increased poverty</li> <li>■ Increased workload</li> <li>■ Reduced per person food consumption and uptake of services (education, health)</li> </ul>	<ul style="list-style-type: none"> <li>■ Entrenched poverty</li> <li>■ Genderization of poverty</li> <li>■ Further breakdown of traditional extended family structures</li> </ul>
Community and Nation	<ul style="list-style-type: none"> <li>■ Increased poverty</li> <li>■ Reduced child health school enrollment</li> <li>■ Increased inequalities</li> <li>■ Increased crime, homelessness</li> <li>■ Increased social instability</li> <li>■ Changes in cultural practices</li> <li>■ Diversion of resources for orphan care</li> </ul>	<ul style="list-style-type: none"> <li>■ Reduced quality of human capital</li> <li>■ Entrenched poverty</li> <li>■ Increased inequalities</li> <li>■ Reduced economic growth, development</li> <li>■ Increased social, political instability</li> <li>■ Diversion of resources for orphan care.</li> </ul>

**Figure 1: Socio-economic impact of HIV / AIDS on orphans (Reproduced from USAID, 2002).**

### **2.1.1.2 Educational Impact**

Children affected by HIV / AIDS usually cannot afford to go to school and thus are deprived of a number of educational related benefits. Richter (2001) in her study states that in households affected by HIV / AIDS, the school attendance by children drops because child labor is required for subsistence and the money earmarked for school expenses is used for medication and other health services. School tends to compete with many other duties that affected children are required to take on. Again, stigmatization may prompt affected children to remain away from school rather than endure exclusion and / or ridicule at school. Basaza and Kaija (2002) in their study conducted in Uganda, discovered that the percentage of children dropping out of school due to AIDS increased from 45% to 53% in 1999. This according to them shows the impact AIDS might be having on child education. Another survey (Ntozi, 1997) revealed that 43%; 11% and 45.4% of school drop out by orphans were due to aids, aids related diseases and other diseases respectively. Of these 58%, irrespective of the cause of death, had problems with money. Although these children can attain free education they still had to incur costs of scholastic materials. Ntozi, (1997) mentions that it is plausible to assume that this percentage fails to get money to go to school. Even those who manage to remain at school, face problems of lack of parental guidance, inadequate socialization, financial and material support.

Lyons (2002) also made an observation that in families where children are left without parents or guidance because of HIV/ AIDS they may be unable to go to school because there is no money to pay for books and fees or because they experience rejection or

discrimination. Some leave school to help take care for the younger children or to earn income to support the household. Fear and frustration lead to some running away from home in search of better life, often only to join the growing numbers of homeless and exploited children. Niang and Ufford (2002) in their study found that with respect to children whose parents are infected by HIV /AIDS, for a school year 1999-2000. 6% of adults living with HIV / AIDS declared that the disease had resulted in at least one of their children being dismissed from school. In this study parents also reported frequent missing of the classes (due to the children's involvement in domestic duties as they replace a mother or father admitted to hospital) dismissals and poor results due to difficulties in paying school registration fees, in buying school stationary and to failure to look after their children's education.

From the studies above one can make a deduction that the impact of HIV /AIDS has a negative effects on children's education. These children fail to achieve according to their expected potential while others fail to attain their goals. This may obviously lead to psychological problems such as low self-esteem, aggression, elective mutism, juvenile delinquency. There are many other problems usually not recognized by teachers in particular. These and other educational problems later manifest as psychological problems and will thus necessitate psychological support.

### **2.1.1.3 New responsibilities and work for children**

Studies (Richter, 2001; Lyons, 2002 ) have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents are ill or have died. Richter (2001) states that children as early as five years of age are given new responsibilities when parents are ill or die. She identified domestic chores, subsistence agriculture and care given by the young, to old sick members of the household. Work she identified for outside the home, involved a variety of formal and informal labour, including begging for food and supplies from nearby communities and taking the place of the ill parent in farm work. Besides the above roles and responsibilities, Lyons (2002) has observed that these children also assume the role of decision-making and responsibilities that transform roles within families and households. Lyons (2002) laments that these children act like adults, but it cannot be forgotten that these heads of “households” are children, whose childhood has been impoverished by HIV/ AIDS.

### **2.1.1.4 Failing to meet the goals of childhood**

UNAIDS (2000) states that in many families and communities the environment for healthy growth and well being has been devastated by HIV / AIDS. According to Lyons (2002) this impact has resulted in children failing to meet the goals of childhood. UNAIDS (2002) accepts that instead of receiving special care and assistance, childhood is spent providing care and assistance. The loss of material, emotional and developmental support from an adult according to UNAIDS (2000) exposes children to distress which results from lack of affection, insecurity, fear, loneliness, grief, or despair.

It limits the possibility of a successful, childhood, which in turn, affects their future as adults.

#### **2.1.1.5 Vulnerability**

Vulnerability has been identified as a factor that impact on children affected by HIV/AIDS (Richter, 2001).

Children affected by AIDS can themselves become vulnerable to HIV infection. Their risk for infection arises from early onset of sexual activity, commercial sex and sexual abuse which are precipitated by economic need, peer pressure, lack of supervision, exploitation and rape (Richter,2001). The study by Lyons (2002) reveals that as a results of the sickness or death of parents or guardians, children are often made to leave the place that they have always known as “home” and sometimes they are separated from their closest remaining family members, their siblings. Separated from family members, without a secure home, the vulnerability of children can take new dimensions (Lyons 2002). As expressed by Lyons (2004) also found that some children are offered a home with caring adults but nonetheless resist being absorbed into new families and homes because of fear and distress, others run away, some react with behaviors that provoke rejection. It is argued that although these guardians or foster parents work hard to furnish a caring substitute home and family for children, there are often limits to how much care and support they are actually able to provide. Carnegie (2004) shares the same sentiments with Lyons (2002) regarding vulnerability when he states that these children become exposed to sexual abuse and exploitation, and that they become exposed to the infection and some of them end up living with HIV.

Lyons (2002), contends that some children become easy prey to adults who are unconcerned with the child's best interest. Some adults might take children into their households to serve an ulterior purpose. Some of these children are used to provide extra income or free labor and can be treated like property or servants, kept from school and given inferior food and care. Millions of them suffer neglect and physical and sexual abuse. In the absence of alternatives, more and younger girls marry early. Boys and girls trade abusive situations for the streets where life and survival are even more difficult. The risk of HIV infection rapidly increases as children are exposed to drug-use and engage in unprotected sex (willingly or coerced), exacerbated by the increased susceptibility to infection of bodies which are still in the process of physical development and maturation.

The situation portrayed by findings of Lyons (2002) is quite disturbing, especially when one considers the fact that for the majority of these children counselling and psychological support services are unavailable.

#### **2.1.1.6 Discrimination**

A large group of children affected by HIV and AIDS are victimized because their parents have contracted the diseases (Brown & Sittitrai, 1996). To understand the impact of discrimination on lives of people living with HIV and families affected by HIV / AIDS, Brown and Sittitrai (1996) conducted research on 116 households in the north of Thailand. The findings of this study show that 48 percent of the households had

experienced discrimination against the infected individuals and 15 percent reported discrimination against other household members. The effects on children were also observed. It is revealed that in 20 percent of the cases, other children in the community were prohibited from playing with children from affected families. In two households it was reported that children were forced to leave school. Brown and Sittitrai (1996) found that children who find themselves having to be cared for by other members of the family, found themselves discriminated against. Many of these relatives wrongly assumed that the children were themselves HIV infected and were reluctant to care for them or divert resources to help them. It was reported that other relatives feared that their own family would suffer in the community because of stigma that came with these children, and thus rejected them. Those going to institutional care were treated poorly compared to the general population of other children. Many orphanages and children's homes refused to take them and referred them elsewhere. van Dyk (2001) shares the same sentiments with Brown & Sittitrai, (1996) on the issue of discrimination when he states that stigma associated with AIDS deaths in many communities contributes to the fact that many families don't want to look after AIDS orphans. The consequences of this, according to van Dyk (2001) is that these children are often socially isolated and are deprived basic social services such as education. The situation in Thailand is not that different from the situation in South Africa and elsewhere. The issue of discriminating against children affected by HIV is really a cause for concern. "For a child, sensing that nobody wants her can be a crushing blow to self-esteem" (Brown & Sittitrai, 1996: 40).

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### **2.1.1.7 The Social Impact**

UNICEF (1999) reveals that HIV / AIDS changes the kinship and family ties in the community, and that it leads children orphaned by AIDS to rely on extended family members for labour and resources. It is indicated that in some cases children have to be distributed to non-related persons. The problem that arises from this arrangement (UNICEF, 1999) is that in some communities it is a taboo to take non-related children and very elderly people. With the death of the head of the household, the possibility of the disintegration of the household becomes great. Many a times when a “will” is written, it is disregarded by relatives who leave nothing for the orphaned children.

After their parents death, children often loose the family land or the family house hold. Relatives and non-relatives move in and often exploit the children by taking possession of their property and not providing any support to them. These children often end up living on the streets and they suffer more from exploitation, illness, abuse and sexual abuse than children orphaned by other causes.

### **2.1.1.8 Psychological Impact**

Evidence (UNAIDS, 2001) on the effects of HIV / AIDS on Children’s lives indicate that these children reveal psychological disturbances. According to Germann (2002) the psychological effect is the least visible effect because it is not tangibly seen. Madörin (1999) agrees with this assertion and adds that the psychological impact is often

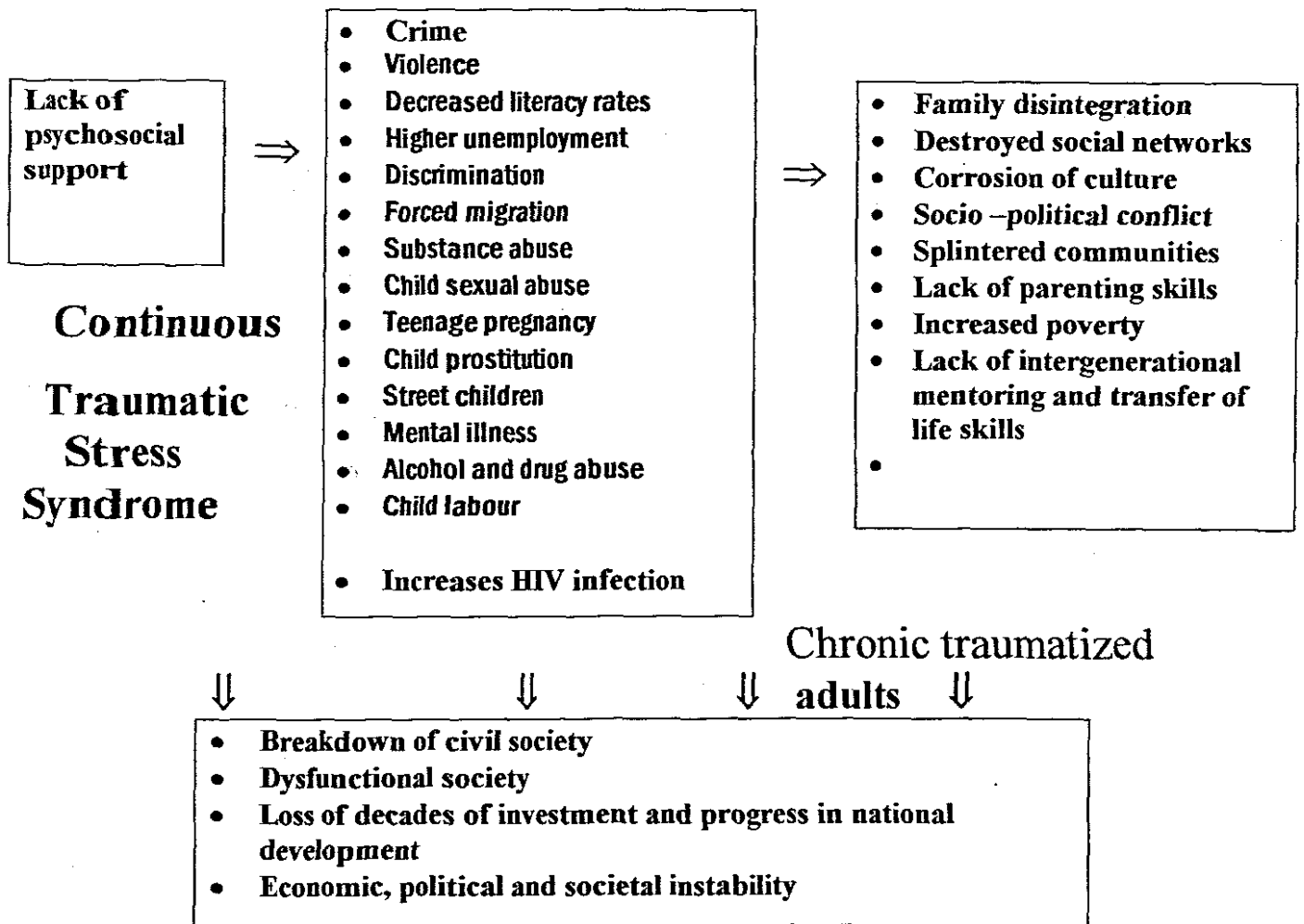
neglected. Madörin (1999) provides an explanation why the psychological impact is not visible by giving the following reasons:

- this impact is a “private” and hidden one
- this impact appears in very different forms; one person may become distressed, the other may start to consume alcohol or drugs, the other may become aggressive, another may have difficulties to sleep or eat. So it is sometimes difficult to recognize that there is a link between a certain stressing and painful event and the corresponding reaction;
- this impact can arise even months after the event (i.e. the death of the beloved persons, such as a partner, a child or parent);
- additional in the case of children, adults often lack the understanding of what is happening inside children, and children are sometimes unable to express their grief in a form of what adults can understand. Children construct their “hidden world” where adults, do not automatically have access, because they are adults.

Germann (2002) in his study of the impact of psychosocial support to orphans at Masiye Camp, in Bulawayo, Zimbabwe, found that these children manifest emotional trauma ranging from depression, aggression, drug abuse, insomnia, failure to thrive among others. He also found that they often worry about their future that is, where would they go in case their parents die and who will take care of them. They may not understand the situation and therefore cannot express their grief effectively. Even if they went to express their feelings, there is no one to listen. Richter (2001) on the other hand argues that affected and orphaned children have traumatic psychological reactions to parental

illness and death, they suffer exhaustion and stress from work and worry, as well as from insecurity and stigmatization, because it is assumed that they too are infected with HIV. Loss of home and dropping out of school, separation from siblings and friends, increased work loads and social isolation may all be associated with adverse mental health. Richter (2001) further states that children show internalizing rather than externalizing symptoms: depression, anxiety and withdrawal in contrast to aggression and other forms of antisocial behavior.

Becoming an orphan may further result in stunted emotional and intellectual development, and limited life skills in communication and decision making (Germann & Madörin, 2002). All the mentioned psychological consequences jeopardize not only psychological development but future relations of the child with other people and the child's adulthood. Germann and Madörin (2002) provides information on the potential impact if psychosocial support is not provided. Figure 2 provides the information.



**FIGURE 2: Potential Long Term Impact of Poor Psychosocial Systems**  
 (Reproduced from Germann and Madörin 2002)

Richter (2001) has noted about the long term psychological effects of deprivation. Her findings are that children who grow up without the love and care of adults devoted to their well being, are prone to psychological problems associated with relating to others. She states that as a result of this, these children lack empathy, which arises from their

deprivation as recipients of empathetic care. She adds that they develop antisocial behaviors which could cause antisocial behaviors on an unprecedented scale.

Studies on impact of HIV / AIDS on children have outline above revealed both the direct and indirect adverse effects of HIV / AIDS on children. The situation portrayed by these studies suggest an urgent need for support programs.

## **2.2 PROGRAMMES FOR PSYCHOLOGICAL SUPPORT**

HIV/AIDS is associated with a range of psychological sequelae that must be addressed throughout various stages, that is, from the sickness of the parents, to death of parents, and finally orphanhood (Osborne, Van Praag & Jackson, 1997). Psychological support is critical for helping individuals and families affected by HIV/AIDS, particularly children who are the most vulnerable. These children have to be helped to cope with their fears and emotions. There are different views on and different types of psychological support for children affected by HIV/ AIDS.

According to (USAID, 2000) psychological needs of children continue to be one of the most neglected areas of support. The HIV epidemic has increased the urgency to address psychological problems of children who are affected by their parents' emotional and physical state. Most of the time they do not know what is happening to their parents and they thus become confused and frightened. In the study (USAID, 2000), it is espoused that without proper support mechanisms upon the death of a parent these children experience a profound sense of loss, grief, hopelessness, fear and anxiety. It is stated that

long –term consequences can include psychosomatic disorders, depression, low self-esteem, low levels of life skills, learning problems and disturbed social behavior.

Foster et al., (2002) in their dealings with orphans observed that many children orphaned by AIDS showed psychosomatic disturbances, inappropriate social behavior, helplessness, depression and low levels of motivation. As a result of these observations they started a project involving children affected by AIDS. The project was done at Masiye Camp in Bulawayo, Zimbabwe. The special emphasis was on the provision of psychosocial support. Culturally appropriate interventions to provide psychosocial support were pioneered. The interventions were directed to:

- Restore self-esteem
- Provide support processes and overcome mild trauma
- Enable development of goal setting, decision-making and negotiation skills
- Empower a healthy sense of responsibility
- (Re-) instill values and hope for the future

Interventions took place at a camp for 10 days. The idea was to encourage trust and team building and to afford orphaned children a chance to relax and to express themselves to someone who listens. Counsellors were volunteers, mostly who were orphans, a factor which enabled most children to identify easily with them. Lifeskills education through play and adventure – based learning was provided for orphans. Key aspects of the intervention included targeted outdoor activities games, and facilitation of positive grief and bereavement processes based on building the relationship of trust with counselors.

The programme also included HIV / AIDS education on prevention and care, first aid, nutrition and practical sessions in arts and crafts. A training course for teenage parenting and household management was also offered to orphans. The background of this course was the recognition that increasing numbers of children were providing parenting for younger siblings and that many more were living with elderly grand parents or sick parents.

Besides providing psychosocial support by fostering camps, Foster et al., (2002), set up a girls secondary education support program. This program was started upon a realization that girls drop out first from secondary education once the family is affected by AIDS. To ensure continuum of care and support for children who participated in life skills, camps at Masiye camps psychosocial clubs were established. Children were referred to these clubs after camps, for follow up support and continuous opportunity for group therapy.

Foster et al., (2002) state that through the support program they have started, encouraging results to improve resilience and coping capacity of children have been achieved, and the psychological and social consequences of orphanhood have been addressed and solved.

The Humuliza programme for psychosocial support of orphans in Tanzania, conducts 14 weeks programs with orphans, with the aim of stabilizing children psychologically (Humuliza project / terres des Hommes Switzeland, 1999). The programme is aimed at group interventions and it also employs a child – to child approach. The child – to child

approach recognizes that children who are similar situations benefit from exchanging information and understanding that their situation is not unusual and is no way a “failure”. This programme takes into account the fact that young people are much more ready to accept emotional support from people of their own age. “Favourable” conditions allowing them to cope with their traumatic situation and to develop hope and plans for their future are created. The aim in terms of “empowerment” is to encourage the children’s development and growth and to promote their abilities. The assumption is that orphans are active and competent “survival artists” who can show initiative and already have some of the knowledge, abilities and experience. Their first step involves getting the children to show their own potential, and strengthening their confidence.

Humuliza programme also provides training and further education for persons who work with orphans. Here, caregivers are also workshopped on bereavement and mourning. The aim is to help these people understand the orphans special situation. The stages they go through in their training are as follows:

- *Understand death as a reality and recognition and acceptance of loss.*

Bereaved child / children in this phase is / are helped: by

- Having time to talk to them, listening to them and being sensitive to their different reactions
- Trying to prepare the child very carefully to the eminent loss
- Not misleading the child that his / her mother will come back to leave with him / her in this world.

- Helping the child go through the realistic concept of death in the child's daily observation. For example dead animals, death of people the child knows and others
- Helping the child to learn to distinguish real from imaginary causes of death
- Making the child feel personally safe in his / her daily routine and, not to be separated from siblings.

- Remembering, sadness, longing, yearning and idealization / identification.

At this stage children need a loved person who can either share their grief or share their suffering and expression of feelings. The children here can be assisted by:

- Giving him / her 'permission' to remember the diseased person.
- Sharing their grief or suffering and allowing them to express their feelings (children need a loved and trusted person to do this)
- Encouraging them to recognize and express their feelings.
- Trying to diminish all additional painful experiences, so that the child has to cope with other stresses at the same time.

- Differentiation and detachment

Here, bereaved children can be assisted by:

- making sure that their basic needs are met
- responding to the need to love and to be loved by encouraging the child to establish contact with others for example (close classmates, peers, uncles, aunts, grandparents and others).

- Helping the child to remember what he / she received from the deceased parent (of good and not so bad things) and who could now, in the opinion of the child, fulfil these needs.
- Giving the bereaved child all the information he / she wants about life and death of the loved parent.
- Establish new relations

This can be done by:

- allowing residual attachment to the late loved one, by the new parent / caregiver.
- Working on the child's suspicions about security of the new relationship to keep your word than to promise a lot and not to abandon the child. (Humuliza Project / Terre des Hommes, 1999).

### **2.3 INITIATIVES TO PSYCHOSOCIAL SUPPORT**

Literature ( Madörin, 1999) identifies some possibilities of how responsible adults can support the bereaved children go through their loss and meet some specific needs. For counselling and intervention the following is suggested:

- That children receive clear comprehensive and age appropriate information about the cause of death, because without clear and adequate information the child can develop unrealistic fear about death and disease.
- That children's fears be addressed directly by those attending to the needs of these children. Common questions that arise due to fear are: will the other parent also die? Will I be separated from my brothers and sisters? Can we stay in this house? Who will pay for my school fees.

- That these children need to know that they didn't cause death, and be assured that they have not (yet) the power to harm a person. Giving the children opportunity to talk about their feelings for the deceased, both positive and negative can help parents or counsellor to identify any problem of guilt that the child want to test against reality.
- That children have, fantasies and questions so they need persons who will listen to them. It is important not to give children superficial answers.
- Their feelings must be acknowledged and respected as valid. For example feelings of sadness cannot and should not be stopped by trying to convince the child that the feeling should be over because the brother or sister has stopped crying. If the feeling is there, it is there. Children's experiences must be treated as unique to the individual.
- Children must be helped with overwhelming feelings – these feelings might be too scary for the child to express directly. Adults need to work out with them the possibilities of expressing these feelings or help them to find safer ways of expressions. It must be noted that children also cope and communicate with activities. Children affected by HIV/AIDS need to be involved and included before the death as well as afterward. For example included in the funeral planning and the funeral itself.
- They need to be supported in their endeavor to remember and to memorize the lost parent not only after death but continuously as they go through the remaining stages of their life. Pictures and other things belonging to the deceased can be useful reminders. Van Dyk (2001) suggests strategies of facilitating the mourning process.

Karienza (1998) suggests that protective environmental factors should be built into programmes of children affected by HIV and AIDS. The understanding is that those environmental factors when built into a programme can protect children and help them to endure traumatic experiences. The factors include:

- a supportive relationship with a caregiver, a supportive educational climate and social support from people outside the family
- caregivers who model resilience by reassurance and encouragement during adversity, help the children to process stress and become resilience
- community support to influence and guide the child and his or her caregiver
- providing strong religion and belief to provide stability and understanding in times of hardship.

On this issue of a supportive environment Werner and Smith (1989: 20) put it clearly when they say “It is true that children have enormous capacity to survive, if they at least get some minimal support and if there is a supportive environment”.

Basaza and Kaija (2002) reveal that organizations like the Uganda Women’s Effort to Save Orphans (UWESO) support orphans in the area of vocational training, HIV /AIDS counselling, income schemes, day care centres and school fees sponsorship.

Ramsden (2001) offers advice to those working with children on helping children to handle bereavement and death. The advice she gives is that “if you want children to

recover, you need to understand needs according to their age development” she revealed for example that, babies age 0 – 3 years (babies and toddlers) cannot talk about their grief. These children express grief physically, for example by crying a lot, showing problems in their eating, toileting, sleeping and often regress and become like younger babies. She states that older children are better able to think, to talk and remember, so they recover from death and disaster more rapidly than younger children, so they will grieve as adults do – by going through periods of denial, anger, grief, apathy, aggression towards others, having nightmares and attacks of anxiety. Adolescents on the other hand are said to see grief and the need for consolation as babyish and try to deny it and instead become angry and rebellious, become suicidal, find bad company and may become promiscuous.

As a follow-up Ramsden (2001) explains that to best help babies and toddlers, caregivers will need to give them a lot of cuddling, holding, rocking and tell them stories sing songs, and play baby-games with them for example. Older children she advises, can be encouraged to talk about their feelings and events of the bereavement; art, music, and stories that express what they feel could be encouraged. Ramsden’s (2001) work is of great significance and relevance as it provides guidelines on what to look for when evaluating programmes? What kind of support and what is considered when providing support?

The study (USAID, 2002) uses a different approach to psychosocial support. In an attempt to provide support it argues for accommodating periods of mourning and opening

discussions on the subject of the dead parents. The argument is that if the traditional system advocates for very short periods of mourning and minimal discussion on the subject of the dead then, orphans will have no where to turn when they are feeling down and trying to deal with their grief. It is believed that the result will be children who learn not to speak of their parents and who will become emotionally withdrawn. According to the study the use of the "Memory Book" will do much to overcome some of the problems of orphans. The motivation for use of the "Memory Book" is not only to provide details or children of their family history and a sense of continuity, but basically to stimulate communication between parent and child in planning for the future of the children while the parent is still alive. Open communication by communities with orphans on matters relating to their parents is encouraged. It is noted in the study (USAID, 2002) that in Zambia the principles of children being heard and consulted are taken care of via monthly discussion groups with children in outlying districts. It is mentioned that orphaned children congregate in the local village hall and talk with Care Teams about their problems. It is felt that in this way children receive the message that they have not been forgotten but that someone in fact cares and is prepared to listen. This method of encouraging communication also indirectly fosters children participation in issues involving them. Ewing (2000) suggested principles for adults who are practicing children's participation. These principles are divided into three categories: listening to children, enabling children and protecting children. **In listening to children she suggested the following:** listen to the child; be prepared to learn from the child and to be proved wrong; 'listen' to children's behavior; listen to children's wisdom' remember how it is to be a child; and have respect for children. In the category **enabling children**

**she included:** do not think for children; do not underestimate children's capabilities; do not assist children too much; involve children from the beginning; believing children; encourage children and show appreciation; and be honest. The category **protecting children involves:** considering their safety; their rights to privacy and confidentiality and paying attention to runaway behavior. Kanya (1997) also, identified group treatment approach to help children deal with emotional and safety issues. Group work has been identified as an effective strategy in helping children and youth. Rajah (2001) in her attempt to initiate support in the face of grief and loss initiated a group of 10 children aged between 8 and 12, all of whom had lost parents through AIDS the previous year. The aim was to help them deal with their grief and loss. According to her these children had not been 'allowed to grieve appropriately' and were for the first time allowed to express their feelings in the group setting. She stipulated that the group used creative means of expression for example stories, letters to the deceased parents and drawings. It appears that this group did not only provide an opportunity for the children to grieve, but an added bonus was that members gained support from each other.

Studies (Bonnie, 1995; Unicef, 1999; Jewitt, 2001) also revealed that other programmes in their pursuit of providing psychological support to orphans include resilience. The argument is that HIV/AIDS also impacts on the child's resilience. What then is resilience?

The meaning of resilience according to Longmans Dictionary of contemporary English (1985) is being:

- able to spring back to the former shape or position when pressure is removed.
- strong enough to recover from difficulty, disease etc.

So “resilience” is the quality of being resilient.

Other literature (<http://helping.apa.org/resilience>) defines resilience as bouncing back from difficult experiences, a process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress. According to Bonnie (1995) resilience is a term used to describe a set of qualities that foster a process of successful adaptation and transformation, despite risk and adversity. UNICEF (1999) on the other hand describes resilience as the faculty to, recover relatively fast and comprehensively from severe events if there is a supportive environment. Kinrad (1998) on the other hand defines resilience as ability to survive despite of experiencing life in a high risk environment.

A summary that can be drawn from resilience from the above definitions is that it is a capacity to survive and recover under difficult circumstances if there is a supportive environment. The idea is that even if people have resilience they need support to build it up or strengthen it.

Jewitt (2001) in her article titled “Building resilience and hope for the future”, explains that coping with death and dying has a major impact on children’s resilience and ability to cope with circumstances. According to her a child who is bereaved by AIDS often has to cope not only with being orphaned, but also with multiple deaths in the family, the secrecy, stigma and many misconceptions still attached to the diseases, as well as

extreme poverty. The situation as described by Jewitt (2001) dictates that these children need as way of psychological support to be provided with skills or strategies for fostering resilience. Literature (Kinrad, 1998) reveals that we are all born with an innate capacity for resilience by which we are able to develop social competence, problem solving skills, a critical consciousness, autonomy, and a sense of purpose

Literature (Humuliza / Terre des Hommes, 1999) reveals that projects like Humuliza / terre des hommes consider fostering resilience as one of their priorities in psychological support. In their approach to fostering resilience in children orphaned by AIDS they stress maximal support and a supportive environment. Their strategy involves:

- Helping these children to recover from shock of losing a parent.
- Making the children aware of resources they have in themselves.
- Assisting them to overcome the feeling of helplessness that everything is lost and “that there is no future”
- Helping them to maintain and to develop self-esteem and self-confidence.
- Making them feel that the community does not abandon them.

It cannot be overemphasized that building resilience to children affected by HIV / AIDS is not a choice in their support programmes but an obligation. It is one of the necessary interventions for assisting them to deal with the stress and trauma that AIDS has brought to them.

Reviews (USAID, 2000; Richter, 2001; Foster & Williams, 2000) on the impact of HIV / AIDS reveal various different ways in which HIV impacts on children. Upon looking at these, non-seemed to have positive effects. Comparing intensity of impact, the psychological impact seemed to have, the most devastating effects. This does not suggest that other impacts do not leave scars on the affected children, but the idea is that scars that are visible can be better endured and attended to than scars that are invisible, which is the case with psychological impact. The pain experienced can be described as “the pain of pains” because its existence, is usually denied or ignored by the unaffected. Besides, this fact, the psychological impact is actually the outcome of the cumulative effect of kinds of all factors that impinge on the child as a result of the loss of the parent / s through AIDS. The present study will consider all impacts in order to better understand what goes into programs of support.

Most reviews (Osborne, Van Praag & Jackson, 1997; Madörin, 1999; van Dyk, 2001; Foster et al., 2002) on programmes and initiatives to psychological support indicate a need for psychological support. The concern emanates from the fact that children orphaned by AIDS display psychological problems. Reviews (Basaza & Kaija, 2002) also reveal various approaches to psychological support, these include: life skills teaching, parenting skills, child to child support, encouraging mourning and building resilience. All these approaches seem to be anchored in counselling –basically grief counselling. The overall goal of these approaches is to help orphaned children overcome trauma and maximize mental health.

It is therefore important to establish healthy and supportive environments in which children can grieve, express themselves and begin to heal, and also that systems of care are developed for later psychological integrity. In other words we need effective programs that will cater for the psychological needs of affected children.

These programmes should in addition include strategies that can guide caregivers on how to maximize the mental health and well being of children affected by AIDS.

## **2.4 STRATEGIES FOR CARE AND SUPPORT OF ORPHANS**

Besides the psychological support and initiatives that have been developed in response to the crisis of children orphaned by HIV/AIDS, strategies for care and support for orphaned children have been advanced.

Van Dyk (2001) identified the following strategies or models: extended family foster care, community-based foster care model, group foster care and child headed households.

The South African National Council for Child and Family Welfare (1996) identified the following models of care: adoption, fosters care and residential care. All the models are discussed hereunder.

### **2.4.1 The extended family**

The extended family strategy involves the placement of the child with extended members. Here attempt is made to trace the family members. Van Dyk (2001) states that families who cannot afford to look after orphaned children should be helped financially so that they can care for these children. He adds that UWESO, an organization in

Uganda funds the education of AIDS orphans and also runs a micro-finance scheme to help the caretakers –usually female relatives of children to start small business and trading activities.

#### **2.4.2 Foster care**

Foster care is the placement of the child under a care of a non-relative. According to the South African National Council for Child Welfare (1999), in their document “HIV/AIDS and the care of children”, formal foster care is an established practice in South Africa and allows the legal placement of the child with alternate caregivers when the life circumstances of a child dictate that this is necessary for his or her care, protection and development. Literature (Van Dyk, 2001) reveals that families who foster children usually receive a grant from the government to assist them with some of the costs involved in caring for the child. Reviews (South African National Council for Child and Family Welfare, 1996) reveal that the position with regard to formal foster care is somewhat different in Southern African Developing Countries (SADC) countries to that of South Africa. There appears to be little or no financial support for SADC countries, whereas in South Africa foster care carries with it a State Grant. South Africa also has historically well established foster care practices while in the SADC countries there has been a need to help develop these to meet the care requirements of children affected by HIV/AIDS. Literature (South African National Council for Child and Family Welfare , 1996) also revealed that in Zimbabwe, the organization “Farms orphans a support Trust (FOST) emerged as a pro-active response to the plight of orphans in commercial farms. Farmers in the FOST programme provide inputs such as housing, clothing, food and

assistance with school fees for orphaned children and in some cases even care-giver allowances.

### **2.4.3 Community-based foster care model**

This model requires initiatives on part of the community. This model has been used successfully in Alexandra Township. This model is based on the premise that orphans and their foster care parents should be actively supported by each other and by the community. *In this Alexandra model, the Alexandra community was divided into wards. Each ward has its own pool of trained foster mothers, a social worker who is the coordinator, a leader foster parent who networks with the foster mothers in her ward, with the social worker and with other informal community service providers. The foster mothers are trained in home-based care, and get lots of support and advice. In addition they are supported by team of community workers such as students, volunteers, region organization and schools. The merit of the Alexandra model according to van Dyk (2001) is that it has led to improved health, weight gain, longer life and psychological well – being of the orphaned babies. The model is said to have also helped promote acceptance of children by the community and has in addition changed the attitudes of some of the community members.*

Another community based care model is Kwasha Mukweni –“Help Your Friend” in Lusaka. It was started by 120 women with the aim of looking after orphans. The women worked through the local Roman Catholic parish priest who secured a small amount of funding from his mother country, Slaveria. Equipped with a roof, stove and money, the

women identified their various talents. Those good at baking set out to sell scones, whilst those able to sew set out to make clothes. The women began to provide lunch for 75 orphans on a daily basis. It revealed that the children think of the volunteer women as their “new mothers” and are freely able to present any problems they may have. Kwasha Mukweni goes beyond providing food to their orphaned children. The children are also educated on personal hygiene and awareness about AIDS is raised. Twenty seven bigger youth (orphans) are already involved in carpentry through the assistance of funding donated by the Diplomats Wives Club (The South African National Council for Child Welfare, 1999). It will be noted that this model is community based, but it differs from the Alexandra model when it comes to the method of operation.

#### **2.4.4 Group foster care (the ‘granny’ programme)**

A group foster care model was started in Uganda to accommodate more children in foster care by using group foster care programmes. Older women (grannies) were appointed and trained as foster parents and were then allocated different tasks. Some of them tended a food garden, while the other older, less agile grannies looked after the children. A third group worked in the kitchen where they did cooking. All the caregivers got food from the kitchen to feed their families. The granny programme resulted in better care and nutrition for the orphans, better nutrition for the whole community (excess food was given to nearby squatters), improved community services, job creation and general alleviation of poverty (van Dyk, 2001).

#### **2.4.5 Child-headed household**

According to van Dyk (2001) households headed by adolescents (sometimes as young as 12 years) are often seen in our communities. There are children who care for the young siblings after the death of the parents. The majority of these children start caring for the younger sibling even before the death of the parent / s. Usually they care even for the sick parent. Van Dyk (2001) suggested that these children should either be accommodated in foster care programmes or community support should be afforded to help them cope with their plight.

#### **2.4.6 Adoption**

Adoption is another existing model of care. According to South African National Council for Child Welfare (1999) the idea of formal adoption is new to many African communities, because orphan care used to take place quite naturally through customary practices and with family members stepping into the breach.

Formal adoption intended to provide for the child, new parents and a new home in which he or she will receive love as well as every opportunity for maximum development of his / her potential. The legal process allows the child to be taken to a home and be treated as a real child of the new family. The adopted children have the same rights of inheritance as other children of the family and the adoptive parents have the same responsibilities and rights as other parents (South African National Council Child and Family Welfare, 1996). Financial limitations have been identified as a major obstacle for poorer families who would otherwise agree to accommodate the additional children in their households.

Some alternate carers are just not in financial position to adopt. Subsidized adoption has been introduced to increase the probability of needy families adopting a child (South African National Council for Child Welfare, 1999).

#### **2.4.7 Orphanages / Residential care**

Literature (Children on the Brink, 2002) reveal that for care and support of orphaned children, some people suggested the building of more orphanages or group residential facilities as an effective way to care for the increasing numbers in AIDS affected countries. Not everybody is for the idea, orphanages are seen as the last resort. The criticism leveled against orphanages is that care provided in institutional settings often fails to meet the developmental and long-term needs of children. Besides, it is maintained that orphanages are much more expensive to maintain than providing direct assistance to families and communities to care for orphaned children themselves. In addition, it has been discovered that children raised in orphanages have difficulty re-entering society once they reach adulthood and that many find it difficult to fend for themselves in the outside world. According to South African National Council for Child Welfare (1999). Orphanages in general, have limited success in the central Africa context where they have proved impossible to fund and operate as they break down the traditional system of fostering.

Alternatives to residential facilities and which are aimed at helping children remain in their communities are already existing here (in South Africa). In Soweto for example, NGO efforts focus on keeping in AIDS afflicted families fed in school, while

empowering them for economic independence following the death of their parents (Webb, 1997).

## 2.5 CONCLUSION

Madörin (1999), concludes by saying “so it seems we need some more specific information in order to understand and assist them (orphans of HIV/ AIDS) in this difficult period”. All literature reviewed in this chapter is relevant to the evaluative study of psychological support of orphans because they bring to surface the importance of the need to take psychological support as one of the priorities in the support of orphans. Also highlighted is a need for a specific training in order to be able to help the child go through grief in order to understand the dynamics of grief. Strategies for care and support of children orphaned by HIV/AIDS were provided.

In the next chapter the design and methodology of the study will be detailed.

## CHAPTER 3

### RESEARCH METHODOLOGY

One of the tasks of the researcher is to choose a method that is suitable to gather information for the research to be conducted. Thus in this chapter the research design used by the researcher to collect data is described.

#### 3.1 THE STUDY

##### 3.1.1 Aim of the study

The present study aimed to report on findings concerning the psychological intervention programmes for children affected by HIV / AIDS in South Africa. The idea here, is to ascertain the effectiveness of programmes that are currently available to assist HIV/AIDS orphans.

##### 3.1.2 Research technique

The descriptive method was used in this study. This method concerns itself with the current status of things (Champion, 1993). This approach was used by researchers like Foster et al., (2002) in the evaluation of psychosocial programmes of orphans at Masiye Camp in Zimbabwe. Since researcher also wanted to evaluate the present status of psychological intervention programmes, the present researcher found it appropriate to follow the footsteps of Foster at al., (2002).

It is reasoned that the use of a qualitative approach would widen the scope of information gathered.

##### 3.1.3 The sample

Sampling is the taking of the proportion of elements from a whole population of these elements. It helps to economize such resources as money, time and person power

(Champion, 1993). Out of the different types of sampling that exist, the purposive sample was seen as the best option. This technique involves collecting data from information-rich participants about the phenomena under study (Ary, Jacobs & Razavich, 1996; Bailey, 1992). In this case the target group to provide answers to the researcher's questions were caregivers.

The sample was drawn from caregivers at Emoyeni Hospice in Kwa-Zulu Natal. Nineteen (19) caregivers took part in the study. All the caregivers were females. An explanation to this might be that care giving is considered by most societies, particularly Africans as a responsibility of females. For the total sample, the ages ranged from 21 to 50 years. The subjects were predominantly Zulu Speaking, which reflected the language of the area in which the study was conducted.

#### **3.1.4 Confidentiality**

Before the researcher collects data, the researcher must assure the participants that the data collected from them will be safe-guarded and will not be disclosed to the public in a way that it could identify them (Kerlinger, 2000). In order to comply with this ethical consideration for conducting behavioral science research, the researcher took the precaution to assure anonymity of participants by requesting them not include their names in the questionnaire. The participants were further assured that their responses were going to be treated with confidentiality and would only be released if they give consent.

#### **3.1.5 Research instrument**

A questionnaire comprising of 20 statements and three open-ended questions was used as a measuring instrument. The choice of the researcher was based on the fact that a questionnaire will create non-threatening and relaxed atmosphere and would gather data rapidly and inexpensively (Frankfort –Nachmias & Nachmias, 1992).

All the questions were translated into Zulu in order to avoid any misunderstanding. The participants were requested to indicate with tick (✓) next to YES if they agree with a

statement or a tick (✓) next to NO if they disagree with the statement. They were further requested to provide additional information on spaces that were provided.

It was hoped that this format of a mixture of open-ended and closed-ended questions would capture almost all aspects of the state of affairs of the psychological intervention programme presently evaluated.

### **3.1.6 Procedure**

Permission to conduct research at Emoyeni Hospice in Northern Kwa-Zulu Natal was obtained from Sister Priscilla (person responsible for the Hospice). Once permission was granted, informed consent was obtained from the participants prior to briefing and data collection. The purpose of the study was explained to the respondents.

Attempts were made to minimize any confusion or misunderstanding which may arise by providing an explanation of how respondents were to go about answering the questions. The questionnaires were then handed to respondents to answer and return.

### **3.1.7 Scoring**

Data was coded and scored by the researcher. Information on scored data is reported in Chapter 4.

### **3.1.8 Data analysis**

To make sense out of the data collected, the quantitative method was used. The researcher decided to use tables in order to present data descriptively and to compute percentages for the closed-ended questions.

Qualitative analysis was used to analyze open-ended questions. The statements were analyzed into meaningful themes.

Information on analyzed data is reported in the next chapter (Chapter 4).

## CHAPTER 4

### RESULTS AND DISCUSSION

#### 4.1 Introduction

In this chapter, the researcher analyzes and presents data which has been collected so as to make meaning out of it. The aim of the present study was to determine whether psychological intervention strategies do provide emotional support on children orphaned through HIV/AIDS. In answering this question, the researcher presents collected data with comments about findings.

#### 4.2 General characteristics of caregivers

A total of 19 caregivers at Emoyeni were interviewed.

##### 1. Gender of caregivers

**Table 1: Sex distribution of caregivers**

Sex of caregivers	Frequency (f)	Percentage
Females	19	100
Males	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

According to Table 1 there were only female caregivers (100%) at Emoyeni Hospice. As seen in Table 1 no male caregivers were found at Emoyeni Hospice.

##### 2. Age of the caregivers

**Table 2: Age distribution of the caregivers**

Age of caregivers	Frequency (f)	Percentage
21 – 30	12	63
31 – 40	06	32
41 – 50	01	5
<b>Total</b>	<b>19</b>	<b>100</b>

Table 2 shows that the majority (63%) of caregivers looking after children orphaned by AIDS fell between the age group 21 and 30 years. A small number (32%) of caregivers were between 31 and 40 years of age. Only one caregiver was between 41 and 50 years of age. All participants were above 21 years of age.

### 3. Caregivers with own children.

**Table 3: Distribution of own children**

Age of caregivers	Frequency (f)	Percentage
Have children	17	89
Do not have children	02	11
<b>Total</b>	<b>19</b>	<b>100</b>

The majority of caregivers (89%) have children of their own. Only two caregivers (11%) did not have children of their own.

### 4. Number of orphaned children cared for

**Table 4: Distribution of orphaned children per caregivers**

Number of orphaned looked after	Frequency (f)	Percentage
2	1	5
4	1	5
5- 10	7	38
11 -15	1	5
16 - 20	-	-
20+	9	47
<b>Total</b>	<b>19</b>	<b>100</b>

The number of children who are given support by caregivers ranged from two to more than twenty.

## 5. Years of care giving

**Table 5: Number of years being a caregiver**

<b>Period looking after orphaned children</b>	<b>Frequency (f)</b>	<b>Percentage</b>
Over six months	01	5
1 – 2	10	53
3 – 4	06	32
4 – 6	-	-
6 +	02	10
<b>Total</b>	<b>19</b>	<b>100</b>

Table 5 reveals that 53% of the caregivers have been looking after orphaned children from between one and two years, while 32% have done so from between three to four years. Only 2 (10%) caregivers have cared for orphans for more than two to six years. One caregiver (5%) is fairly new (over six months but less than a year) in the task of looking after children orphaned by AIDS.

### 4.3 Psychological intervention for children orphaned by AIDS

Although all the caregivers participated in this research on psychological support to children orphaned by AIDS, it is still considered important to ascertain what kind of psychological help was provided.

**Table 6: Caregivers willingness to provide information about the cause of the Parents' death**

<b>Willingness to provide information about the cause of death</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	18	95
NO	01	5
<b>Total</b>	<b>19</b>	<b>100</b>

Table 6 reveals that the majority of respondents (18 or 95%) do provide appropriate information about the cause of the death of parent (s) to the children. One (5%) caregiver did not provide appropriate information about the cause of the parent's death.

**Table7: Caregivers willingness to help children go through the realistic concept of death.**

Willingness to help children with the realistic concept of death	Frequency (f)	Percentage
YES	19	100
NO	-	-
<b>Total</b>	<b>19</b>	<b>100</b>

Table 7 reveals that the majority of caregivers (100%) allow children to go through the realistic concept of death. No caregiver failed to help the orphaned children through the realistic concept of death.

**Table 8: Caregivers willingness to permit children to remember the deceased parent/ parents.**

Being permitted to remember the deceased parent/s	Frequency (f)	Percentage
YES	08	42
NO	11	58
<b>Total</b>	<b>19</b>	<b>100</b>

Table 8 reveals that just under half of the caregivers (42%) acknowledged that they do allow orphaned children to remember their deceased parents. The majority of caregivers (58%) indicated that they do not allow children to remember the deceased parent.

**Table 9: Caregivers willingness to allow expression of feelings.**

<b>Willingness to express feelings</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	19	100
NO	-	-
<b>Total</b>	<b>19</b>	<b>100</b>

As can be seen from Table 9, all (100%) of the caregivers indicated that they allowed children to express their feelings, this means that they acknowledged that children orphaned by AIDS should express their feelings.

**Table 10: Caregivers response to allowing children to recognize their feelings**

<b>Allowing to recognize feelings</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	18	95
NO	01	.5
<b>Total</b>	<b>19</b>	<b>100</b>

The above Table 10 reveals that the majority of respondents (95%) allowed children to recognize their feelings. Only one caregiver (5%) did not allow the children to recognize their feelings. When the findings are compared to those in Table 9, where all caregivers (100%) agreed that they allowed children to express their feelings, it can be seen that the difference is insignificant.

**Table 11: Caregivers willingness to respond to the children's need to love**

<b>Willingness to help children with the realistic concept of death</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	19	100
NO	-	-
<b>Total</b>	<b>19</b>	<b>100</b>

Table 11 reveals that all the caregivers responded to children's need to love.

**Table 12: Caregivers response to the need to be loved**

<b>Caregivers respond to being loved</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	19	100
NO	-	-
<b>Total</b>	<b>19</b>	<b>100</b>

As can be seen from Table 12 that, all (100%) caregivers do respond to the need to be loved.

**Table 13: Caregivers response to encouraging children to establish contact with others.**

<b>Children establishing contact with others</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	18	95
NO	1	5
<b>Total</b>	<b>19</b>	<b>100</b>

It can be seen from Table 13 that the overwhelming majority of caregivers (95%) encourage children to establish contact with others.

Only one caregiver (5%) revealed that she did not encourage children to establish contact with others.

**Table 14: Caregivers willingness to permit children to talk about their problems.**

Allowing children to talk about their problems	Frequency (f)	Percentage
YES	18	95
NO	1	5
<b>Total</b>	<b>19</b>	<b>100</b>

The research findings indicate that 95% of the respondents do allow orphaned children to talk about their problems. Only one caregiver (5%) gave negative response to this issue.

**Table 15: Caregivers willingness to allow children to express overwhelming feelings through talking about the deceased parent / parents.**

Expressing overwhelming feelings through talk about deceased parent	Frequency (f)	Percentage
YES	09	47
NO	10	53
<b>Total</b>	<b>19</b>	<b>100</b>

It can be seen from Table15 that 53% (10 caregivers) do not allow children to express their overwhelming feelings through talking about the deceased parent / parents, while 47% (below half) do allow children to do so.

**Table 16: Caregivers willingness to allow children to express overwhelming feeling through writing letters to the deceased parent.**

Expressing overwhelming feeling through writing letters to the deceased	Frequency (f)	Percentage
YES	04	21
NO	15	79
<b>Total</b>	<b>19</b>	<b>100</b>

As can be seen from Table 16, fifteen (79%) out of nineteen caregivers acknowledged that they do not allow children to express overwhelming feelings through writing letters to the deceased parent. Only 4 caregivers (21%) revealed that they do allow orphaned children to express their overwhelming feelings through writing letters to the deceased parents.

**Table 17: Caregivers willingness to encourage children to play.**

<b>Encouraging children to play</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	19	100
NO	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

It can be seen from Table 17, that all caregivers encouraged children to play.

**Table 18: Caregivers willingness to assist children to accept that change is part of living**

<b>Helping children to accept change as part of living</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	100	100
NO	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

Table 18 reveals that all caregivers assisted children to accept that change is part of living.

**Table 19: Caregivers willingness to help children maintain a hopeful look**

<b>Allowing children to talk about their problems</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	18	95
NO	1	5
<b>Total</b>	<b>19</b>	<b>100</b>

One caregiver indicated that she does not help children to maintain a hopeful look. This suggests that the caregiver might not be aware of the importance of this activity. It is encouraging that 95% of the caregivers indicated that they do help children maintain a hopeful look.

**Table 20: Caregivers willingness to make children aware of resources they have in themselves.**

<b>Racing awareness to children about resourceful they have in themselves</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	17	90
NO	02	10
<b>Total</b>	<b>19</b>	<b>100</b>

Table 20 indicates that seventeen caregivers do make aware of the resources they have in themselves, whereas two do not make them aware.

**Table 21: Caregivers acknowledgement of feelings as valid**

<b>Acknowledging feelings as valid</b>	<b>Frequency (f)</b>	<b>Percentage</b>
YES	19	100
NO	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

As can be seen from Table 21, all the caregivers (100%) acknowledged that the feelings that are expressed by children are valid.

**Table 22: Caregivers ability help children to build a positive image about themselves.**

Caregivers could help build a positive image	Frequency (f)	Percentage
YES	17	90
NO	02	10
<b>Total</b>	<b>19</b>	<b>100</b>

Table 22 reveals that just above three-quarter (90%) caregivers assist children to build a positive self-image, whereas 2 (10%) caregivers do not help in this regard.

**Table 23: Caregivers ability to help children develop self-esteem**

Caregivers could help children to develop self-esteem	Frequency (f)	Percentage
YES	19	100
NO	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

Table 23 indicates that all caregivers (100%) help children to develop self-esteem.

**Table 24: Caregivers willingness to help children build confidence**

Caregivers could help children build confidence	Frequency (f)	Percentage
YES	19	100
NO	0	-
<b>Total</b>	<b>19</b>	<b>100</b>

It is revealed in Table 24 that caregivers are unanimous (100%) on the issue of helping children build confidence.

**Table 25: Caregivers making children aware that the deceased loved one will never be forgotten.**

Caregivers could help children not to forget the deceased.	Frequency (f)	Percentage
YES	15	79
NO	04	21
<b>Total</b>	<b>19</b>	<b>100</b>

Table 25 indicates that 79%, that is, fifteen of the nineteen caregivers take it upon themselves to make children aware that the deceased loved one will never be forgotten. Only four (21%) did not realize this need.

The questionnaire having thus far asked caregivers closed-ended questions relating to psychological interventions provided to children orphaned by AIDS, respondents were asked (open-ended questions) to provide any additional information regarding psychological support they provide, their needs and their wishes. These will be discussed.

#### **4.4 Additional information regarding psychological intervention**

##### **4.4.1 Additional psychological support from care-givers**

In addition to close-ended questions regarding psychological support, the nineteen respondents were asked to provide additional information regarding this aspect. This type of questions were meant to cater for psychological intervention which the researcher might have omitted and psychological support which the researcher might not have been aware of. In total, three out of nineteen participants (21%) did provide additional information regarding psychological interventions they provide. One caregiver stated that she tells them stories that amuse them. She added that she asked them to tell stories and then return reinforce their behavior with praise. She also mentioned that she also keeps them busy with drama. In another case, the caregiver stated that she involves the orphaned children in gardening projects where they compete with each other for the best garden; encourage them to go to sunday school; encourages them to read long and short

stories; and finally encourage them to listen to radio programmes that encourage moral and self-empowerment and development. Another caregiver indicated that she teaches them skills. The skills were not identified though. The caregiver added that where she has limitations in terms of providing psychological intervention, help from professionals is always sought.

#### **4.4.2 The needs of caregivers**

As the study sought to provide sufficient information about intervention programmes that will assist with emotional stability of these children and thus general well being, it was therefore necessary to establish what the needs of the caregivers were.

All the caregivers (100%) provided information about their needs. Four (21%) caregivers indicated that they needed to include spiritual support in the programme. One of these caregivers mentioned that there is a need to have a priest who will do home visits like priest who provide spiritual healing to the sick. Another of these caregivers mentioned that these children need to be encouraged to go to church for spiritual growth.

Three caregivers (16%), indicated that they needed more information on psychological support in order to be effective in helping children orphaned by HIV/AIDS. One (5%) caregiver indicated that there are times where she needs psychological support for herself in order to be able to overcome her feelings and to be more effective in her work. Four (21%) of the caregiver felt that they needed to help the children to be self-reliant and independent so that they can be able to face the future by themselves in future. Four other caregivers (21%) stated that there was a need for forums where the children can be together to share their problems. Individual caregivers indicated the following needs: food parcels; shelter, visits and toys; medical help; open communication and more time with children.

It was be observed that these needs come in different forms. These are spiritual needs; emotional needs; physical needs; social needs and mental needs. All these needs are considered to be essential elements for meaningful and positive development.

#### **4.4.3 Wishes of caregivers**

In addition to needs, caregivers were asked to indicate what their needs are with regard to psychological support of children orphaned by AIDS.

Caregivers expressed different kinds of wishes. The most dominating wish was related to physical needs. This was expressed as a wish to have: shelter food, clothing, and provision of educational needs for the children. A wish to satisfy the social need of the children was also indicated. This was expressed by indicating that they wish to have recreational centres like playground, formation of music groups and provision of toys for the children. Caregivers also expressed a wish to see the emotional needs of children orphaned by AIDS met. The indicators of this category were: needs for love, need to be happy, a need to be protected (security) and need for respect and self-respect. Other wishes expressed included: a need for spiritual growth; a wish that child headed families must be helped; and a wish that assistance for children orphaned by AIDS must readily available.

## CHAPTER 5

### SUMMARY, CONCLUSION AND RECOMMENDATION

#### 5.1 Introduction

In this chapter, the researcher discusses psychological interventions on data collected and other relevant issues as reviewed in the literature. Limitations of the study including recommendations and avenues for future research are also considered.

#### 5.2 Summary of the main findings and their discussions

The study was designed to investigate current activities in programme that provide psychological support to children orphaned by HIV/AIDS in South Africa. It aimed at:

- Reporting findings concerning psychological intervention programmes and provide sufficient information about these programmes.
- Helping organizations determine broad directions for future plans regarding programmes for children orphaned by HIV/AIDS.

The problem was stated in the form of a following question:

- What is the nature of psychological support provided in programmes that support children orphaned by HIV/AIDS?

##### 5.2.1 Findings

The results show that psychological support is provided by females only. This may be due to the fact that caring and nursing is seen by society as the responsibility of females. This is a gender role stereotype. This gender stereotype is due to the socialization agents and forces that have enforced gender roles and stereotypes. There appears to be a need to involve males in projects that support children orphaned by HIV/AIDS. Results of the study also indicated that people (caregivers) who provide psychological support cut across all ages. This finding seems to suggest that people are becoming aware of the plight of orphaned children. It also becomes evident that people, who have their own

children, do provide psychological support to orphaned children as indicated by the fact that the majority of caregivers have their own children. There appears to be a need to involve even people who do not have children, as the plight of orphans is great. In addition the study revealed that caregivers look after a varying number of orphans, from two to more than twenty. The researcher would attribute this high number to the fact that the scourge of AIDS is ravaging the country and families every second and every minute – killing parents. Many children are often left behind either as single orphans or double orphans. This means that caregivers find themselves in situation which demands that they take more and more children in their care, as more and more parents are dying. The findings also revealed that the experience of caregivers varies (6 months to more than 6 years). It is encouraging to see that new people are involving themselves in orphan support programmes.

The results indicated that caregivers provide support to a certain extent. All caregivers realized the need to help children go through the realistic concepts of death. A possible explanation lie in the fact that the concept of death is known from early childhood (through religion) that we are all going to die one day. Humuliza Project / Terre des Hommes (1999) of children orphaned by AIDS, considers understanding the death's reality as a very important aspect, hence in a training of caregivers who work with orphans they include the aspect of helping the child to go through the realistic concept of death by using daily observations, for example dead animals, death of the people the child knows, and others. All caregivers do allow children to express their feelings. This is accordance with findings in the literature (Humuluza Project / Terre des Hommes, 1999) which state that children need a loved person who can either share their grief or share their sufferings and expression feelings through encouraging them to recognize and share feelings. Findings reveal that caregivers accept children's feelings as valid response. These results are not surprising, as findings in the previous study (Madörin, 1999) stipulated that their feelings must be acknowledged and respected as valid. The results indicated that caregivers do respond to the need to love. Also revealed by the finding is that caregivers allow children to express a need to be loved. This is not a surprising finding as most people particularly Africans have been socialized to give love

to orphans. Generally caregivers are aware that children need to accept that change is part of living. This indicated that they realize of the fact that “that every person who experiences loss is forced to adjust to new circumstance and the new environment that has been created by the loss (Van Dyk, 2001). Also revealed by the findings is that caregivers do encourage children to play. This response suggests that caregivers recognize that children need time for themselves and with others. The response may also show that caregivers conscious of the fact that play can help and redirect feelings and that it also facilitates relationships with others. Most of caregivers helped children to build positive self-image and self esteem. These findings are consistent with literature (Humuliza, Terre des Hommes, 1999) where emphasis is put on helping children to maintain and develop self-esteem. These results also suggest that caregivers are aware of the importance of developing this attribute in children particularly children orphaned by AIDS.

The majority of caregivers who provide support do give children appropriate information about the cause of the death of the parent. These results are not surprising because attempts are being made to make people including children to be aware of the fact that AIDS is an ordinary disease that people should not avoid talking about. In literature (Madörin, 1999) it is actually encouraged that children receive clear comprehensive and age appropriate information about the cause of death because without clear and adequate information the child can develop unrealistic fear about death and disease. Most respondents reveal that they assist children orphaned by HIV /AIDS to maintain a hopeful look. This is in accordance with findings in the literature which states that interventions must reinstall values for hope for the future (Madörin, 1999) and help children maintain a hopeful look (Kinrad, 1998). On the whole, the caregivers’ feelings are that they should take initiative at making children aware of resources they have themselves. The caregivers’ actions are in line with literature (The Humuliza project) where resilience is fostered by making them aware of resources they have in themselves. The results reveal that participants encourage children to establish contact with others. What the caregivers are practicing concurs with what is modeled at Masiye Camp in Zimbabwe where children are encouraged to establish contact with others through a camp

intervention as literature revealed (Foster, et al 2002). This need for establishing contact has also been realized and demonstrated by the Humuliza Project where the child-to-child approach employed. Here children who have the similar situations are encouraged to exchange information about their situations (Humuliza / Terre des Hommes, 1999). This finding is also supported by literature (HIV / AIDS and care of children, 1999) where it mentioned that in Zambia orphaned children, congregate in the local village hall and talk with care-teams about their problems. This method is said to send a message that someone in fact cares and is prepared to listen.

It also emerged that about above average (58%) of the caregivers do give children permission to remember the deceased parent and the rest do not provide this support. Literature (Madörin, 1999) support this gesture when it indicates that orphaned children must be supported memorize the lost parent not only after death but continuously as they go through the remaining stages of their life. Pictures and other things belonging to the deceased are said to be useful reminders it is added. Although permitting orphaned children to remember the deceased is recognized task, nevertheless some caregivers are still not aware of the importance of this task. Most caregivers (74%) admitted that they do not allow children to express overwhelming feelings through writing letters to the deceased parent. The researcher might attribute a poor response to the fact that few people, if any, might think that one could write a letter to a person who is not physically accessible. The response to this question suggests lack of information about letter writing as a technique for expressing overwhelming feelings. The majority of participants do not allow children to express the overwhelming feelings about the deceased parent / s. An explanation to this response is thought to be linked with the cultural aspect where it is considered as a taboo for children to talk about a deceased person / s. There appears to be a lack of understanding that doing such, has a therapeutic function. There might be other explanations for underlying this thought. It is encouraging though, that other caregivers have recognized the significance of considering aspect in supporting children orphaned by AIDS.

In summary, section B of the questionnaire indicated that caregivers do provide psychological support in order to help children to recover from the situation as soon as possible. However, caregivers still need to be helped in the area of the importance letter writing as a tool to help children express feelings, and the area of allowing children to remember their deceased parent.

Caregivers indicated a need to include the spiritual aspect in supporting orphaned children. This seems to suggest a need to facilitate a sense of connectedness with the higher being plus the deceased parents and ancestors. The results also seem to suggest that caregivers perceive support on physical needs as vital support for programmes of children orphaned by HIV/AIDS. It appears both from former studies cited in the literature and from the present study, that caregivers are aware of the importance of psychological support interventions, but they should be assisted with other aspects that they considered as part of psychological support.

### **5.3 Recommendations**

It appears both from former studies cited in literature and the present that psychological support should be a component any programme supporting orphans. The programme supporting children orphaned by HIV/AIDS at Emoyeni Hospice has been evaluated to document current activities and future plans related to psychological support interventions. The findings of the present study have revealed that caregivers at Emoyeni do provide psychological support in their programme. This is generally significant because it gives us a picture of the type of psychological support that is provided at Emoyeni Hospice. The present study has also revealed that caregivers have other plans regarding psychological intervention. In view of these findings, the following is recommended:

- Caregivers should receive increased training counselling methods to enable them to share skills and experience with other organizations in support of orphaned children in the surrounding areas.

- There is need to establish a caregivers-orphan ratio formula in order to ensure that caregivers support the same number of orphaned children. By so doing caregivers will be more effective.
- Caregivers should be monitored, and appraisals should be carried out annually, based on previously agreed performance areas.
- Peer approaches to support should be considered, as provision of these will encourage interaction and instill a sense of taking care of each others need, by children of the same situation.
- Support provided should be extended to include other aspects of concern, like the spiritual part.
- Caregivers should also be provided with the psychological support themselves as their dealings with children who are affected also affect them.

#### 5.4 Limitations of the study

There were limitations in the research study, some of which were inherent in the research design and methodology and some which were independent of it.

- There were limitations emanating from a sample. Only one non-governmental organisation (NGO) that provides psychological assistance could be located. The rest either provided physical support – that is food, clothing or provided psychological support to children infected by HIV/AIDS. This thus compelled the researcher to use the available NGO.
- There was limit in the use of questionnaire as a tool for gathering data. The content of questions might have been biased or loaded in one direction.
- A further limit relating to questionnaire might have been that questions were understood differently by different respondents
- In Part III of the questionnaire, the respondents were asked to indicate additional psychological support that is provided to orphans besides the one stated in Part II (fixed response items), many stated their wishes and their needs, yet the section for needs and wishes appeared further below. So only items of those who answered the question correctly were considered.

- It was also a limitation that only female African respondents participated in this study.
- It is again a limitation that the study was conducted in a rural area only.
- Only one programme was evaluated, as a result of this, the findings might be limited and not generalizable.

It is recommended that future studies in this area take cognisance of the mentioned limitations.

### **5.5 Avenues for future research**

The study has succeeded in achieving its objectives and has opened the following areas for future research.

- The sample of study was drawn from caregivers of a Non-Governmental Organization (NGO). There is a need for a study involving Community-Based organization (CBO) and Faith-Based Organization (FBO).
- There will be a need to evaluate psychological intervention programmes for children infected by HIV/AIDS since the study only focused on children orphaned by HIV/AIDS.
- A comparative study of psychological intervention of children orphaned by HIV/AIDS and children infected by HIV/AIDS will be necessary in order to establish which one provided quality psychological support.
- It will also be necessary to do an investigation, where orphaned children will evaluate psychological intervention provided to them.
- Since the study was done in a rural setting, it will also be to useful undertake one in an urban setting, in order to establish if there will be a significant difference in psychological intervention practices.
- More programmes will need to be evaluated in future since only one programme was evaluated. This will be necessary in order to identify differences among them.

## **5.6 Conclusion**

Perhaps some of the limitations mentioned above could have been avoided if a follow-up interview was conducted with each respondent. However for practical reasons, this was not possible. In spite of the mentioned limitations, this study has managed to document the current psychological intervention status of programmes of children orphaned by HIV/AIDS in South Africa particularly at Emoyeni Hospice. It provided recommendations and avenues for further research for researchers who are interested in the same field.

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**APPENDIX A**

**UNIVERSITY OF ZULULAND  
PRIVATE BAG X 1001  
KWA-DLANGEZWA  
3886**

Dear Sister Priscilla

I am a Masters Counselling Intern at the University of Zululand. I am currently engaged in a project concerning the psychological intervention for children affected by HIV / AIDS as part of my thesis in the Department of psychology.

My basic concern is to evaluate psychological interventions currently provided in your programme. I would greatly appreciate your assistance by allowing me access to your care-givers. This research will add to the already existing knowledge of intervention provided to children orphaned by HIV / AIDS.

Your contribution is of utmost importance and will be highly appreciated.

Thanking you in anticipation.

J.D. ADAMS

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Masters Counselling Intern.

## APPENDIX B

### PART 1: Biographical information

#### Instructions

- Please answer all questions.
- Indicate your answer by placing a cross (X) in the appropriate space.

#### 1. GENDER

Female	Male

#### 2. AGE

20 and below	21-30	31-40	41-50	51 and above

#### 3. CHILDREN

Have children	Does not have children

#### 4. NUMBER OF CHILDREN UNDER YOUR CARE

5 – 10	11-15	16 -20	More than 20

#### 5. FOR HOW MANY YEARS HAVE YOU BEEN LOOKING AFTER ORPHANED CHILDREN

1 –2 years	3 – 4 years	5 – 6 years	More than 6

**PART 11**

**Psychological interventions provided to children orphaned by AIDS.**

**Instructions**

Please indicate your agreement by placing a cross (X) in the provided box.

**Key: YES means Agree**

**NO means Disagree**

<b>QUESTIONS</b>	<b>YES</b>	<b>NO</b>
1. Do you give children appropriate information about the cause of death of the parent (s)?		
2. Do you allow them to go through the realistic concept of death?		
3. Do you give them the permission to remember the deceased person?		
4. Do you allow them to express their feelings?		
5. Do you encourage them to recognize their feelings?		
6. Do you respond to their need to love?		
7. Do you respond to their need to be loved?		
8. Do you encourage the children to establish contact with others?		
9. Do you allow children to talk about their problems?		
10. Do you allow them to express overwhelming feelings through Allowing to talk about the deceased		
11. Do you encourage them to express overwhelming feelings through Writing letters to the deceased parent (s)?		
12. Do you acknowledge their feelings as valid?		
13. Do you help them accept that change is part of living?		
14. Do you help them maintain a hopeful look?		
15. Do you make them aware of resources they have in themselves?		
16. Do you encourage play and recreation?		
17. Do you help them build a positive image about themselves?		
18. Do you help them develop self-esteem?		
19. Do you help them build confidence?		
20. Do you make them aware that the deceased loved one will never be Forgotten?		

**Part III**

**Please include any additional information regarding psychological intervention that you provide. Use the space below.**

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**I Need**

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**I wish**

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**Thank you for participation.**

## APPENDIX C

### IMININGWANE NGawe (CAREGIVER)

#### ISIGABA 1: Imibuzo ephathelene nokukwazi

##### Imiyalelo

- Uyacelwa ukuba iphendule yonke imibuzo.
- Gwalisa impendulo yakho ngokufaka uphawu (X) esikaleni esivumelana nempendulo yakho.

#### 1. UBULILI

Owesifazane	Owesilisa

#### 2. IMINYAKA

Ingaphansi Kwa-20	21-30	31-40	41-50	51 Nangaphezulu

#### 3. IZINGANE

Nginazo	Anginazo

#### 4. ZINGAKI IZINGANE EZIYIZINTANDANE OZINAKEKELAYO?

5 - 10	11 - 15	16 - 20	Ngaphezulu kwa - 20

#### 6. UNEMINYAKA EMINGAKI UBHEKELELA IZINTANDANE?

1 - 2yrs	3 - 4 yrs	5 - 6 yrs	Nengaphezulu kwa 6

**ISIGABA 11**

**Imininingwane yohlelo lokusiza izingane eziyizintandane ngenxa yesifo sengulaza namayelana nendlela osiza ngayo lezingane ngokushonelwa ngabazali bazo, ukuze zilulame ngokwengqondo nangokomphefumulo.**

**Imiyalelo**

- Faka uphawu (X) phezu kuka YEBO uma uvumelana nokushiwoyo, noma
- Faka uphawu phezu kuka CHA uma ungavumelani naloko okushiwoyo.

<b>IMBUZO</b>	<b>YEBO</b>	<b>CHA</b>
1. Uyazinika yini izingane ulwazi mayelana nembangela yokushona Komzali / abazali		
2. uyazivumela yini izingane ukuba zifinyelele ekwazini ngeqiniso lenqikithi yokufa ?		
3. Uyazinikeza yini izingane / ingane ithuba lokucabanga noma Lokukhumbula abazali asebashona?		
4. Uyazivumela yini ukuba ziveze imizwa yazo mayelana Nokushonelwa abazali?		
5. Uyazikhuthaza yini izingane ukuba ziqonde imizwa yazo?		
6. Ngabe uyasamukela yini isimo lapho bekhombisa ukuthi badinga Ukunikezwa uthando?		
7. Uyabanikeza yini uthando lapho bekhombisa ukuludinga?		
8. Uyazikhuthaza yini izingane ukuba zakhe ubudlelwane nabanye Abantu?		
9. Uyazivumela yini izingane ukuba zixoxe ngezinkinga zazo?		
10. Uyaqikelela yini ukuthi izingane ziyayiveza imizwa yazo engaphezukwamandla azo ngokuzivumela zixoxe ngabazali bazo Asebashona zedlulise imizwa?		
11. Uyazigunyaza yini izingane ukuba zikhiphe imizwa yazo Engaphezu kwamandla azo ngokuthi zibhalele umzali esewashona Incwadi, zidlulise imizwa.		
12. Uyayamukela yini imizwa eziyivezayo njengeyiyonayona?		
13. Uyazisiza yini izingane ukwamukela ukuthi ushintsho luyinxenye Yempilo?		
14. Uyazisiza yini izingane ukuhlala zinethemba lokuthi izinto Zolunga ezimpilweni zazo?		
15. Uye usize yini ingane ngayinye ukuthi yazi iziphiwo enazo?		
16. Uyazikhuthaza yini izingane ukuba zidlale imidlalo enhlobonhlobo?		
17. Uyazikhuthaza yini izingane ukuba zakhe izithombe ezinhle ngazo?		
18. Uyazikhuthaza izingane ukuba zizibheke zizethemba ngasosonke isikhathi?		
19. Uyazikhuthaza yini izingane ukuba zingazenyenzi kodwa zizethembe?		
20. Uyazazisa yini izingane ukuthi abathandiwe bazo abasoze balibaleka?		

### **ISIGABA III**

**Uyacelwa ukusho lokho ungafiso ukukunzela mayelana nendlela osiza ngayo izingane eziblukumezekile ngokushonelwa ngabazali , ukuthi zilulame ngokwengqondo nangokomphefumulo. Sebenzisa isikhala Esingezansi.**

**Ngidinga**

**Ngifisa**

**Siyabonga ukuba ubeyinxenye kulolucwaningo.**