CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Over two decades into the HIV/AIDS pandemic, a cure for HIV/AIDS is still not at hand and the negative impact of high adult HIV/AIDS mortality on child welfare, particularly on the welfare of orphans, is potentially large. In addition, many countries are suffering from civil unrest and post-conflict situations, resulting in war orphans and displaced children. HIV/AIDS is adding to an already elevated number of orphans from high adult mortality in developing countries (Martha & Deon, 2005).

The increasing number of orphans in developing countries is leading to an accumulation of personal tragedies, with potentially dramatic socio-economic consequences. A particular fear is that orphans will acquire less education, thereby deteriorating their good quality life chances, as well as the long-term economic prospects of the countries they live in (Zavis, 2003).

In a number of ways, children are affected by HIV/AIDS differently. Usually orphaned children under the age of 18 (whose fathers, mothers or both parents have died of HIV/AIDS) are made vulnerable to poor quality of life. Millions are living with ill and dying family members, or are infected themselves. The HIV/AIDS orphanage in Southern Africa and the individual stories of children orphaned by HIV/AIDS are often portrayed in highly simplistic terms. More often than not, these stories and articles read within the following lines: '*Children are abandoned or found in need of care when parents die of HIV/AIDS'*; ' *extended families have been disrupted by migrant labour and repeated shocks due to poverty and HIV/AIDS and they are unable to take care of affected children'*. '*Children have to be placed in residential facilities to secure their health and development'* (Martha & Deon, 2005, p. 34).

What is frightening, however, is that the number of HIV/AIDS orphans is just the tip of the iceberg of the larger problem of vulnerable children living with HIV/AID infected parents (Martha & Deon, 2005).

1.2 BACKGROUND OF THE PROBLEM

HIV/AIDS in Africa is decimating tens of millions of men, women and children. HIV/AIDS affects everyone, but children are always the most vulnerable. The death of one parent with other diseases different from HIV/AIDS at a young age usually does not imply that the other parent will also die. By contrast, in the case of HIV/AIDS, if one parent is infected, there is a high probability that the other parent would also be HIV positive and therefore likely to die also (Lachman, Poblete, Ebigbo, Bundy, Killian & Doek, 2002*).*

The vulnerability of HIV/AIDS orphans starts well before the death of their parent(s). The emotional suffering of HIV/AIDS orphans usually begins with their parent’s distress and progressive illness. This is compounded as the disease causes drastic changes in family structure. This results in a heavy economic toll, requiring children to become caretakers and breadwinners, and fuelling conflict between the children, family relatives and the community in general as a result of the stigma, blame and rejection. HIV/AIDS orphans also lack the necessary parental guidance through crucial life-stages of identity formation and socialization into adulthood (Bradshaw, Johnson, Schneider & Dorrington, 2002).

Contemporary studies have shown that children who grow up without parents are more likely to become criminals. They are likely to be involved in criminal activities such as gangsters, drug addicts, and prostitution. They are less likely to be skilled and able to find proper employment. They are also less likely to grow into secure and stable adults. Orphaned girls are more prone to sexual abuse and are at a higher risk of contracting HIV/AIDS - the very disease that would have killed their parents in the first place (Longwe & Karanja, 2004).

As has been indicated above, millions of children have already lost at least one parent as a result of the HIV/AIDS epidemic, and millions more are likely to lose one or both parents over the next few years. Consequently, there is an urgent need to help, care and protect these children, as well as to prevent more children from becoming HIV/AIDS orphans in the future. There are of course programmes in place to combat HIV/AIDS and its consequences. These include government programmes, non-governmental organization (NGOs) programmes, as well as other community based organizations (CBOs). There are also some very dedicated officials in the Ministry of Health, who are trying to coordinate all these programmes though with very little effectiveness because most of HIV/AIDS orphans are still in dire need (Parry, 2006).

Also, there is a lack of support from the communities within which HIV/AIDS orphans live. HIV/AIDS orphans need to be accepted as part of the community and be afforded access to all essential services such as basic health care and education. This requires improvement in the delivery of existing services and education to reduce the stigma surrounding children affected by HIV/AIDS so that they are not discriminated against, and denied the services that they need. HIV/AIDS orphans can also be empowered by recognising them as active members of their communities rather than just victims (Parry, 2006).

1.2.1 RESEARCH QUESTIONS

- How do HIV/AIDS orphans relate with their caregivers?
- How do HIV/AIDS orphans feel about living without parents?
- What are the attitudes of children living with their biological parents towards HIV/AIDS orphans?
- How do HIV/AIDS orphans cope with the situation?

1.4 AIM OF THE STUDY

- To investigate the psychological difficulties encountered and ways of coping by HIV/AIDS orphans in Limpopo Province.

1.3 OBJECTIVES OF THE STUDY

- To determine ways in which HIV/AIDS orphans experience their conditions.
- To identify the coping strategies of HIV/AIDS orphans used within their environment.

1.4 HYPOTHESES OF THE STUDY

1. HIV/AIDS orphans experience depression as a result of their parental loss.
2. There is a significant difference between the experiences of depression by demographics (age, gender, home language, religion, number of siblings, and level of education).
3. There is a significant difference between the ways of coping used by HIV/AIDS orphans (cognitive, behavioural, and avoidance ways of coping).
4. There is a significant difference between the ways of coping by demographics (age, gender, home language, religion, number of siblings and level of education)

1.5 ETHICAL CONSIDERATIONS

The participants were informed about the aim and procedures of the study and the risks involved, and their consent to participate in the study was requested. Where identified participants were minors, the researcher obtained the informed consent from their respective guardians. In child headed households, the informed consent was obtained from the eldest child (above the age of 18) and/or headmaster of a care-giving centre that takes care of the concerned child or from an adult in the place where the participant was residing. The participants were also guaranteed that they would not be forced to participate and that they would also be free to withdraw from the study at any time if they felt uncomfortable. The researcher also assured the participants that the information that was to be shared during the interviews would remain confidential unless the participant gave the consent to do otherwise. For emotions that may be evoked by the research, HIV/AIDS orphans will be referred to professional counsellors/therapists for counselling (American Psychological Association, 2003).

CHAPTER 2

THEORETICAL FORMULATIONS, OPERATIONAL DEFINITIONS, AND INDICATORS

2.1 INTRODUCTION

The main focus of this chapter is on operational definitions and indicators. The chapter will also discuss the different theories that explain the psychological difficulties encountered, as well as ways of coping used by HIV/AIDS orphans.

2.2 DEFINITION OF CONCEPTS

2.2.1 HIV

Refers to the virus that causes Acquired Immune Deficiency Syndrome (AIDS). This virus then replicates and kills the T helper cells (Hubley, 1995).

2.2.2 AIDS

AIDS, or Acquired Immuno Deficiency Syndrome is clinically defined as the appearance of antibodies to the Acquired Immuno Deficiency Syndrome, called HIV, associated with a fall in the number of $CD4^+$ T-lymphocytes, a type of white blood cell, and the appearance of indicator diseases that are otherwise rarely encountered in the population, such as Karposi's sarcoma (UNAIDS, 2004).

2.2.3 An orphan

An orphan is defined as a child under the age of 18 that has lost one or both parents (Johnson, 2001). The same definition will be used for the participants in the study; however it will be referring to those children who have lost either one parent or both parents into HIV/AIDS disease.

2.2.4 Caregiver

In this study, a caregiver is referred to as any person above the age of 18 who is responsible for a specific household that support children whose parent (s) died of HIV/AIDS.

2.2.5 Psychological difficulties

Psychological difficulties, in this study refer to the emotional problems encountered by HIV/AIDS orphans.

2.3 THEORETICAL PERSPECTIVE

The focus will be on various theories explaining the psychological distress after loss as well as the various ways of coping. After the loss of their parent(s), HIV/AIDS orphans experience trauma such as lack of nurturance, guidance and sense of attachment that may impede their socialization process (through damaged self-confidence, social competencies, and motivation). Orphans' psychosocial distress and trauma are often not as visible as that of their health, education and economic needs, but they are of fundamental importance. The psychosocial challenges faced by HIV/AIDS orphans include coping with grief, loss of identity (self-, family, and cultural identity), coping with shame, stigmatization, fear of abandonment, rejection and anxiety (Ebersöhn & Eloff, 2002).

Children's coping ways equals the integration and application of developmental skills (motor control, communication, cognitive and socio-emotional skills) into their daily living. In fact, a primary developmental task in childhood is to transform early adaptive behaviours into mature coping styles. Trauma creates tension and motivates a child to develop by interaction with their surrounding environment. Thus, by learning to cope children gradually gain more autonomy and interdependence. An individual's response to trauma is contextualized by the dynamics of perception, cognition, and affective processing, which include the need to create meaning and construct personal narratives (Kaplan, 2005).

2.4 CONSTRUCTIVIST SELF-DEVELOPMENT THEORY

Constructivist self-development theory is an integrative personality theory that describes the impact of a traumatic event (or traumatic context) on self-development. By integrating constructs from psychoanalytic and social learning theories, CSDT describes personality development as the interaction between core self-capacities related to early relationships, secure attachments, and ego resources and constructed beliefs and schemas, related to cumulative experiences and the attribution of meaning to those experiences that shape perception and experience. Thus, constructivist theory is a theory of personality development since it highlights those aspects of development most likely to be affected by traumatic events. CSDT is also a clinical trauma theory (National Association of School Psychologists, 2003).

Beyond instinctual responses lies the realm of thought or meaning. When a significant person dies, the issue of meaning is central for the survivors: What does this death mean? What does this life mean? What did this person mean to me and to this community? The task of meaning making is done in the interchange between the individual and the culture. An individual seeks to make sense of his or her experience using cognitive or mental models supplied by that individual's culture. Cultural models are objectifications formed over time from the inner experiences of a group of individuals in a community. Cultural forms, including models of grief, change as individuals in the culture accommodate their cognitive models to make sense of the deaths in their lives (National Association of School Psychologists, 2003).

2.5 THE CONSTRUCTIVIST MODEL

The constructivist model grounds grief both in the interplay between cultural and individual meaning and in concrete interpersonal relationships. By contrast, in attachment theory, the purpose of grief is to reconstruct the autonomous individual, who, in large measure, leaves the dead person behind in order to form new attachments, which s/he accomplishes by working through and resolving negative feelings. Grief is conceptualized as an innate process that, if allowed to run its course, will bring the survivor to a new equilibrium in a changed world that no longer includes the dead person (Klass, 2007).

In the constructivist model, the process by which people make sense of their world is social interaction. When something important happens in individuals' lives, they do not just think about it; they talk about it with others. Grief and mourning do not just happen inside a person; they happen in the interactions between people. In most cultures over human history, myth and ritual provide the inter-subjective space in which one can construct the meaning of the deceased's life, death, and influence over the survivors' lives. In contemporary Western culture, in which rituals and myths from earlier times have fallen into disuse, inter-subjective space is characterized by informal verbal and nonverbal interaction aimed largely at communicating shared meaning. Often, people see contemporary communities constructing their narrative by inventing new rituals that allow community members to feel a sense of togetherness (Klass, 2007).

2.6 THE HEALTH BELIEF MODEL

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM has been adapted to explore a variety of long- and short-term health behaviours. It is based on the understanding that a person will take a health-related action if that person: feels that a negative health condition can be avoided; has a positive expectation that by taking a recommended action s/he will avoid a negative health condition; and believes that he/she can successfully take a recommended health action.

The HBM was spelled out in terms of six constructs representing the perceived threat and net benefits. This includes perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy.

2.6.1 Perceived Susceptibility

Perceived susceptibility is referred to one's opinion of chances of getting a condition. It defines population(s) at risk (risk levels), personalizes risk based on a person's features or behaviour, and heightens perceived susceptibility if too low.

2.6.2 Perceived Severity

It is referred to one's opinion on how serious a condition is and its consequences. It further specifies consequences of the risk and the condition.

2.6.3 Perceived Benefits

This is referred to one's belief in the efficacy of the advised action to reduce risk or seriousness of impact. It defines action to take (how, where, when) and clarifies the positive effects to be expected.

2.6.4 Perceived Barriers

Perceived barriers focus on one's opinion of the tangible and psychological costs of the advised action. They identify and reduce barriers through reassurance, incentives, and assistance.

2.6.5 Cues to Action

This is based on strategies to activate "readiness". It provides how-to information, promote awareness, and reminders.

2.6.6 Self-efficacy

Self-efficacy is referred to confidence in one's ability to take action. It provides training, as well as guidance in performing action.

2.7 KUBLER-ROSS'S STAGES OF GRIEF

According to Christ & Christ (2006), there are five stages of grief identified by Kubler-Ross namely; denial, anger, bargaining, depression, and acceptance. These stages are not necessarily a one-time experience. Each step helps with the healing process. The grieving process also varies from child to child in terms of the order in which one experiences the stages of grief, as well as the time it takes to go through each stage. Thus, some children may start with anger, while others may start with denial. It is helpful to be aware of these stages and to consider that intense emotions and swift changes in mood are normal.

2.7.1 Denial

In this stage, grieving children are unable or unwilling to accept that the loss has taken (or will shortly take) place. They can feel as though they are experiencing a bad dream, that the loss is unreal, and they are waiting to "wake up" as though from a dream, expecting that things will be normal.

2.7.2 Anger

After children have passed through denial and accepted that the loss has occurred (or will shortly occur), they may begin to feel anger at the loss and the unfairness of it. They may become angry with the person who has been lost or is dying. Feelings of abandonment may also occur.

2.7.3 Bargain

In this stage, children beg their "higher power" to undo the loss, saying things along the lines of, "I'll change if you bring her (or him) back to me". This phase usually involves promises of better behaviour or significant life change that will be made in exchange for the reversal of the loss.

2.7.4 Depression

Once it becomes clear that anger and bargaining are not going to reverse the loss, children may then sink into a depression stage where they confront the inevitability and reality of the loss and their own helplessness to change it. During this period, grieving children may cry, experience sleep or eating habit changes, or withdraw social relationships and activities while they process the loss they have sustained. Children may also blame themselves for having caused or in some way contributed to their loss, whether or not this is justified.

2.7.5 Acceptance

Children enter a stage of acceptance when they have processed their initial grief emotions, are able to accept that the loss has occurred and cannot be undone, and are once again able to plan for their futures and re-engage in daily life.

2.8 THEORETICAL FRAMEWORK

The salutogenic approach was used as a theoretical framework. This approach serves as a guideline to explain how some individuals become ill while others stay well, even though they are exposed to similar stressors. Salutogenic paradigm in psychology arose as an alternative response to dealing with illness in individuals, and the paradigm as a whole suggests that instead of focusing on illness and disease there should be a focus on that which promotes wellness. It seeks to discover why certain people are situated on the positive side of the health ease/dis-ease continuum. It also takes the view that disease, stressors are inevitable, and that individuals must actively pursue adaptive strategies.

The neologistic construct of salutogenesis is derived from the Latin *salus* meaning ‘health’, and the Greek *genesis* meaning ‘origins’ (Poppius, Tenkanen, Kalimo & Heinsalmi, 1999).

2.9 The theory of Salutogenesis

Salutogenesis is related to the sense of coherence concept that explains why some individuals become ill following a stressful situation while others, after having experienced the same stressful situation, manage to stay well. Antonovsky (1988) coined the term ‘salutogenesis’ to denote the factors that distinguish between those individuals who stay well and those who become ill after experiencing the same stressor or stressors. He identified six constructs that are viewed as the core dimensions of the salutogenic individual. These six construct equip individuals to deal more effectively with stress and include factors such as hardiness, coping, social support, religion, happiness, humour, love and selective perception. These six constructs include sense of coherence, locus of control, self-efficacy, hardiness, potency, and learned resourcefulness.

2.9.1 Sense of Coherence (SOC)

Sense of Coherence is the main precept of salutogenesis. It is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence; that the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable, and explicable. SOC concept comprises three main components: comprehensibility, manageability, and meaningfulness. The first of the three components, which is comprehensibility, is the sense that an individual’s internal and external environments are viewed as structured, predictable, consistent and occurring events are also viewed as making sense. The second component, which is manageable, is the extent to which the individual copes with stimuli and views the available resources as adequate to meet the demands posed by the various stimuli or environment. The third component, which is meaningfulness, is the emotional identification with events in the environment and a feeling that life makes sense emotionally and that the individual plays a primary role in determining his/ her own daily experiences. It includes the belief that these demands are challenging and worthy of personal investment.

2.9.2 Locus of Control (LOC)

LOC can be defined as the extent to which individuals perceive that they have control over a given situation and the difference between internal and external LOC lies in the experience of freedom. It derives from the social learning theory with its focus on reinforcement in the acquisition of knowledge and skills and maintains that behaviour in a specific situation is a function of expectation and reinforcement value.

2.9.3 Generalised Resistance Resources

The sense of coherence is connected to a variety of coping mechanisms called generalised resistance resources (GRRs), which are defined as any characteristic of the individual, the group or the environment that facilitates effective stress management. Antonovsky supported the notion that work plays a significant role in moulding the individual's sense of self-coherence. For instance, a predictable and manageable work environment that allows the individual to participate in decision-making and provides the employee with a voice, will lead to productive performance, recognition, reward and promotion. In turn, these experiences will become work-related generalised resistance resources (GRRs) that will strengthen the individual's sense of coherence to a further degree.

2.9.4 Hardiness

This construct is based on the degree to which an individual has a sense of control and has the ability to control the pace of events. According to this construct, individuals behave in ways that are characteristic to themselves, by making conscious decisions to recognise and act on their environments. This construct is defined as a constellation of personality characteristics that functions as a resistance resource during the encounter with stressful life events.” In this construct, it is supposed that the outlook of people who tend to stay healthy in stressful situations consists of three factors: control, commitment, and challenge. Control is the person's belief that they are able to influence the course of events. It is not a naive expectation of complete power over their destiny, but an acknowledgement of their own role and influence through imagination, knowledge, and choice. Commitment is the person's curiosity about life and its sense of meaningfulness and includes a generalised sense of purpose and ability to find importance in their own circumstances. Lastly, challenge captures the person's expectation that change is normal and beneficial. Change is perceived as stimulating, instead of a threat.

2.9.5 Potency

Potency is referred to as “a person’s enduring confidence in his own capacities, as well as confidence in and commitment to his/her social environment, which is perceived as being characterized by a basically meaningful and predictable order and by a reliable and distribution of rewards.”

2.9.6 Learned resourcefulness

The salutogenic construct is based on the importance of coping skills-training, through self-regulation and it is an acquired repertoire of behaviours and skills through which an individual self-regulates internal responses (e.g. emotions, cognitions or pain) that interfere with the smooth performance of desired behaviour. In essence, it is a set of complex behaviours, cognitions and effects in constant interaction with individuals' physical and social environment. It is learned from birth and serves as a coping skill in stressful situations and also provides a framework for further learning. Learned resourcefulness can include several enabling skills such as self-monitoring of internal events, self-evaluative skills and ability to verbalise and label feelings. The learned-helplessness model focuses on the individual's actual or perceived control over external events. According to the learned-helplessness model, subjects learn that it is futile to respond in uncontrollable situations and they generalise this to controllable situations.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

The human toll and suffering due to HIV/AIDS is enormous. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Since the beginning of the epidemic, over 15 million Africans have died from HIV/AIDS. During 2004, an estimated 2.3 million adults and children died as a result of HIV/AIDS in sub-Saharan Africa. Many countries in sub-Saharan Africa have failed to bring the epidemic under control. There is a significant risk that some countries will be locked in a vicious cycle, as the number of people falling ill and subsequently dying from HIV/AIDS has a tremendous impact on many parts of African society, including demographic, household, health sector, educational, workplaces and economic aspects (UNAIDS, 2004).

In African countries that have already had long severe epidemics, HIV/AIDS is generating orphans so quickly that family structures can no longer cope. Researchers have found that more children have been orphaned by HIV/AIDS in Africa than anywhere else. Typically, half of the people with HIV/AIDS become infected before they are aged 25; developing HIV/AIDS and dying by the time they are aged 35, leaving behind a generation of children to be raised by their grandparent(s) or left on their own in child-headed households (Fredrikson & Kanabus, 2005).

3.2 EPIDEMIOLOGY OF HIV/AIDS ORPHANS IN SOUTH AFRICA

Worldwide, over 14 million children have been orphaned due to HIV/AIDS. Recent Actuarial Society of South Africa (ASSA) model-based calculations of the number of orphans in South Africa estimated that in July 2003, 990 000 children under 18 had been maternally orphaned and 2.13 million children were paternally orphaned. Of these children, 190 000 were double orphans, resulting in a total estimate of 2.93 million children under 18 who had lost one or both parents. Projections derived from the same models predict that by 2015, in the absence of any major treatment intervention or behaviour change, roughly 3.05 million children under 18 will be maternally orphaned and 4.51 million paternally orphaned, of whom 1.97 million children would be double orphans. This equates to a total of 5.6 million children under the age of 18 having lost one or both parents (Patel, Allen, Keatley & Jonsson, 2002).

3.3 THE IMPACT OF HIV/AIDS ON CHILDREN

The impact of HIV/AIDS pandemic on the number of orphans in Africa is well documented. Over two decades into the HIV/AIDS pandemic, a cure for HIV/AIDS is still not at hand and the negative impact of high adult HIV/AIDS mortality on child welfare, particularly on the welfare of HIV/AIDS orphans, is potentially large (Patel *et al*., 2002).

In most extreme cases of deprivation that results from orphan-hood where adequate care is not forthcoming, orphans become vulnerable to the extremes of hunger and starvation with a high risk of malnutrition. Most HIV/AIDS orphans, on being left alone like this, are forced to take on responsibility of taking care of their younger siblings. The pressure to get finances to support their families sometimes become the reason for criminal activities; and female orphans become particularly vulnerable to sexually transmitted infections including HIV/AIDS, as well as to other forms of abuse through being involved in commercial sex work exploitation. As a result of these circumstances, HIV/AIDS orphans often face decreased access to adequate nutrition, basic health care, housing and clothing; with subsequent high school drop-out rates (Lachman *et al*., 2002).

Research has shown that HIV/AIDS affects and impacts on many of the rights of the child, encroaching upon all the four pillars of a child's basic rights: the right to non-discrimination, the right to survival and development, the right to the best interests of the child prevailing in all matters concerning the child, and the right to child's participation (Grant & Strode, 2003).

3.4 CARE FOR HIV/AIDS ORPHANS

During the last two decades, HIV/AIDS epidemic in sub-Saharan Africa has made a huge global impact, permeating the social, cultural, and economic fabric of societies, resulting in the mass orphan-hood of a generation of children. Although the plight of these children initially was seen as a short-term problem, attention now is being paid to the long-term social consequences of a situation in which millions of children may grow up without parental love and guidance. The possibility that these children could evolve into a large subculture of dysfunctional and disaffected adults, with the potential for further destabilizing societies already weakened and impoverished by HIV/AIDS, has increased the urgency of finding a proportionate and effective solution to the orphan crisis (Avinash, Shetty & Powell, 2003).

Care for orphans and children affected by HIV/AIDS are again complex. The situations and needs of HIV/AIDS orphans vary and as such, no single solution is best for all. Thus, the issue of HIV/AIDS orphans is the most vexing issue related to care because there are not many adults left to provide the necessary care; no one to hand down knowledge or experience, or perhaps most important of all, to hand down values from one generation to another. It is appalling that so many HIV/AIDS orphans are growing up without the kind of emotional anchor that leads to a life of stability (Lewis, 2005).

The ratio of children to adults is completely out of balance. The depth of psychological distress that plagues an entire generation of HIV/AIDS orphans numbering in the millions is simply overwhelming, and the struggle to cope is complicated fiercely by a lack of resources at the grassroots. As HIV/AIDS orphans become more vulnerable, they have less access to the kinds of preventive work and education needed to ensure that they do not become infected as well. They are in danger of becoming dysfunctional adults alienated and deprived individuals, unable to live peaceably and work productively in a society that has failed them (White, 2006).

An important aspect of the distress felt by HIV/AIDS orphans following loss of their parent(s) is a disruption in the pattern of mentoring, care and support guided by the household head (usually the father or mother). There are several destinations for HIV/AIDS orphans after the loss of their parent(s), and these include: staying with the mother (woman-headed households) or the father (men-headed households), grandparents (grandparent(s)-headed households), remaining in the parental home (child-headed households), extended families, or go into some kind of institutional care (Barnett & Blaikie, 1992).

3.4.1 Woman or man-headed households

Research conducted in South Africa shows that some men or women abandon their children once their spouse dies of AIDS, with the consequence that children have to fend for themselves with limited resources. It has also been discovered that HIV/AIDS orphans are sometimes abandoned by single HIV mothers because of the presumption that their babies are also HIV positive (Pillay, 2005).

In the other study conducted in South Africa, it has been found that the majority of HIV/AIDS orphans are cared for by their single mothers rather than their single fathers. It has been noted that HIV/AIDS orphans are rendered extremely vulnerable after the death of their mothers (primary caregivers), even though they might officially be in the care of their fathers. A 13 year-old-boy said, *“My father stopped loving us shortly after our mother passed away. He used to make us sleep under the tree. He never bought us food. He only paid school fees when he wanted to. We don’t want to go back home again because he fights us when he is drunk”* (Paula, 2002, p. 42).

3.4.2 Grandparents-headed households

There are a number of reports of grandparents giving care to, and providing for as many as 10 to 20 grandchildren after they have lost all or most of their own children to HIV/AIDS. The grandparents are impoverished, their days are numbered, and the decimation of families is so complete that there is often no one left in the generation coming up behind. Grandparents typically lack the energy to work long and hard in their gardens, so the food available to them and their dependents is naturally insufficient and household nutritional status falls. Furthermore, household income is unlikely to be supplemented by cash as the elderly are unable to cultivate crops for the market (Anderson, Ryand, Taylor-Brown & White-Gray, 1999).

3.4.3 Remaining in the parental home (child-headed households)

Within the HIV/AIDS orphans population, child-headed households and children living on the streets form the two most vulnerable groups. The phenomenon of child-headed households is already escalating, with 0.6% of homes headed by children aged 14–18 years. HIV/AIDS orphans may remain in the parental home if there are no grandparent(s) or any other relative with whom they can live. This occurs because the grandparent(s) are either dead or too old to look after their HIV/AIDS orphaned grandchildren; and in the case of other relatives, if they are unwilling or cannot afford to assume the extra burden (Fleshman, 2001).

Research conducted in Africa has indicated that in cases where the eldest HIV/AIDS orphan becomes the head of the household, clearly the age of the children and the number of very young siblings is crucial to survival. In these circumstances, relatives and neighbours sometimes provide assistance in the form of cooking or helping with house repairs on the basis of goodwill and individual discretion rather than upon the stipulations of ‘custom’. However, such arrangements are optional and cannot be relied on. Inevitably, in many cases care may not be available (Barnett & Whiteside**,** 2000).

3.4.4 Extended families

In traditional African cultures, children are members of a broad extended family and arrangements. Their care and upbringing are the concern of not just their biological parents but also of the extensive network of relatives. Where and with whom an orphan lives is likely to be influenced by available alternatives. For instance, in many parts of Africa, child fostering within the extended family is relatively common. However, the extended families that traditionally have to take care for HIV/AIDS orphans are less and less able to do so as they are in turn financially and emotionally overburdened by the disease and so the traditions themselves break down and fade (Lee, 2002).

In the studies conducted in sub-Saharan Africa, HIV/AIDS orphans cared for by the extended family are treated as second-class family members. They are exploited by being given excessive household chores (working harder than other children), forced to drop out of school to contribute to the added financial burden on the extended family, and subjected to physical and sexual abuse (Meintjes & Giese, 2004).

3.4.5 Institutional care

It is a fact that there needs to be an actual place where HIV/AIDS orphans can sleep, be secure, and feel safe. In South Africa, HIV/AIDS orphans who are deprived of any family support can be placed in foster families, adopted at a local level, and family-like households that are integrated into the communities. In addition, they can also be placed within religious institutions, and/or as a last resort be placed in orphanages (Aubourg, 2004).

For several decades, building orphanages was considered an appropriate response to the growing number of HIV/AIDS orphans. Numerous studies carried out in sub-Saharan Africa have revealed how ill-suited the implemented institutional structures such as orphanages are to foster HIV/AIDS orphans. They have shown that placing orphans in such institutions represents a break within family and community structures, impeding the HIV/AIDS orphans’ well-being and socialisation that leads to them failing to respond to their needs. As such, most people now believe that HIV/AIDS orphans should be cared for in family units through extended family networks, foster families and adoption, and that, siblings should not be separated (Lachman *et al*., 2002).

Based on the study done in orphanages in South Africa, orphans reported that they would prefer to live in foster families or communities than living in orphanages. Furthermore, it has been discovered that adult HIV/AIDS orphans who have grown up in orphanages are vulnerable to stigma of not having a family, isolation, unemployment and poverty. In addition, they may find themselves exposed to abuse and exploitation, or drawn into crime (White, 2006).

3.5 PSYCHOLOGICAL DISTRESS EXPERIENCED BY HIV/AIDS ORPHANS PRE- AND POST THE DEATH OF THEIR PARENT(S)

The HIV/AIDS orphans' challenge is an unfolding tragedy in which the erosion of family structures is set to continue for many years to come. Even if HIV infection rates could drop, the number of HIV/AIDS orphans in South Africa will continue to rise as parents and the heads of households continue to die of HIV/AIDS-related diseases. The effects of being orphaned range from social, economic and psychological consequences of losing one or both parents, to less obvious impacts such as reduced access to quality education and health services (Mizota, Ozawa, Yamazaki & Inoue, 2006).

Children who have experienced the death of a parent or sibling, regardless of the cause, have been exposed to many psychological challenges. However, the "specific constellation and intensity of problems facing families affected by HIV/AIDS set this disease apart from all other contemporary health problems" (Bauman, Wiener, Geballe & Gruendel, 1998).

3.5.1 Uncertainty

Both before and after the death of parent(s), HIV/AIDS orphans are exposed to a high degree of uncertainty. Unfortunately, it seems the only thing that is certain is the eventual death of the loved one. HIV/AIDS orphans are faced with many questions which often are impossible to answer. Questions such as "When will the sickness strike again?", "How long will it last?", "How will we afford medicine if our father is unable to work?", "Will my parent die?", "What will happen to me and my siblings once they die?", "Where will I live?", and "Will I be able to go to school?". Such questions can lead to a feeling of lack of control in a child's life, and the resulting uncertainties pose great challenges to the secure psychological base essential to a child’s development of a healthy and functional personality (Lee, 2002).

After the death of their parents, HIV/AIDS orphans continue to face enormous uncertainties. If they are living with extended family members, they may be uncertain about their role within the existing family, and how much of a burden they would be placing upon the family. They may also be uncertain about their education, and whether the family would be able to pay the fees to send them to school (Bauman *et al*., 1998).

3.5.2 Multiple Losses

HIV/AIDS often leads to the sickness and death of more than one family member, and often in more than one generation of the family. However, the term ‘multiple losses’ does not only refer to deaths, but also to the social disruptions that AIDS-affected children often face. For instance, during the sickness and death of a parent, HIV/AIDS orphans may be sent to live with relatives or friends in other parts of the country, thereby removing them from communities and schools where they feel comfortable (Lewis, 2005).

Additionally, the relatives and friends may not be able to accommodate all of the siblings who have been orphaned, and therefore brothers and sisters would split up to live with different members of the extended family. Thus, the loss of a parent is compounded by the loss of siblings. By wearing away the support system that HIV/AIDS orphans need to successfully cope and develop resilience, the multiple losses of parents, siblings and familiar surroundings may prove to be particularly adverse (Lewis, 2005).

As HIV/AIDS orphans are usually less physically and emotionally developed than adults and more vulnerable due to limited experience and lack of political and economic power, they can easily be subjects of abuse and exploitation when there are no caring adults around to protect them. Unfortunately, such situations put them at a higher risk of contracting HIV than children of a similar age. In a sad cycle of trauma, such HIV infected children would go through the same uncertainties that they experienced during the illnesses of their parents. They would once again ask questions such as, “When will I get sick?” and “How will I afford medicine?” Only, this time, those children may be in a much poorer financial situation, and may even have to experience their trauma alone (Wijngaarden & Shaeffer, 2002).

Another loss to consider is the loss of innocence and childhood as many HIV/AIDS orphans become the head of a household, and responsible for the well-being of numerous siblings. Such children often must pass up their own childhood experiences to assume the role of the adult within the family, even when they are at a developmental age when parents and other influential adults are very important in their own lives. Thus, HIV/AIDS orphans in need of an adult must become the surrogate adult for others (Anderson *et al*., 1999).

3.5.3 Bereavement

Keeping quiet in the face of difficulties, including emotional ones, was a strategy that adults expected children (including teenagers) to use, as they largely interpreted withdrawal and quietness as a positive coping strategy. A lay psychology of childhood trauma emerged from conversations with adults. On one hand, the view was that children required a great deal of love and patience, and that an understanding and communicative relationship needed to be cultivated between HIV/AIDS orphans and their carers. Thus, love is the basic foundation needed by a child (Zavis, 2003).

The study done in Africa discovered that rebelliousness, which in psychological terms can be an ‘externalised’ expression of grief, was one of the signs which indicated that HIV/AIDS orphans were not dealing effectively with the changes in their lives, but this was often not managed sympathetically by adults. Furthermore, grandmothers who frequently found their young grandchildren hard to control and who were often themselves under substantial stress, having lost more than one of their own children to HIV/AIDS, expressed particular frustration about stealing and other anti-social behaviour, thereby considering them unacceptable (Avinash *et al*., 2003).

Additionally, the study discovered that HIV/AIDS orphans’ strain of their parental illness and death was usually associated with long-term mental health problems, including anxiety disorders, guilt, and fear. Internalized behaviour changes such as depression and low self-esteem were also noted more commonly in HIV/AIDS orphans than were externalized reactions such as stealing, truancy, aggression, and running away (Lee, 2002).

3.5.4 Resentment

According to Barnett & Whiteside (2000), HIV/AIDS orphans can reveal resentment at the termination of the life of the deceased. Although a very long time would have passed after the death, most of HIV/AIDS orphans would still feel strong anger. They may express resentment not only toward a specific person, but toward the very fact that their loved ones died. On top of anger, HIV/AIDS orphans may also express frustration, irritation, helplessness, despair, and resignation.

3.5.5 Sense of guilt and regret

HIV/AIDS orphans may also feel a sense of guilt and regret in various degrees. This may include not doing enough for the deceased, and this feeling can lead to strong self-reproach (Sandhei & Richter, 2003).

3.5.6 Anxiety over discrimination, stigmatization and loneliness

Despite the efforts to the mainstream discussion of HIV/AIDS, to clarify its causes, and to teach about the treatment and care of the infected, HIV/AIDS still has a high degree of stigma attached to it. The blaming of people with HIV/AIDS-related sicknesses for their condition has been widely reported. People with HIV/AIDS continue to be stigmatized, perceived to be deserving of the disease as punishment for offensive or immoral behaviour. Such stigma leads those infected, as well as the affected, to be discriminated against or ostracized by their communities and families. Such discrimination may manifest itself through the denial of schooling or health care to HIV/AIDS orphans, where evidence suggests that HIV/AIDS orphans may be at greater risk of dying of preventable diseases and infections because of the mistaken belief that when they become ill it must be due to HIV/AIDS and therefore there is no point in seeking medical help (Lyons, 1999).

A study conducted in South Africa has indicated that, many of the bereaved children feel anxious over discrimination or prejudice due to disclosure of the fact that their parent(s) had HIV related diseases, and would have to conceal this fact. It has been discovered that many of the HIV/AIDS orphans mentioned that they did not talk about HIV/AIDS due to the stigma attached to it. The study further revealed that stigmatization and/or anxiety over discrimination causes various self-restrictions in daily living amongst HIV/AIDS orphans, resorting to hiding the name of the disease and advance to avoiding talking about the deceased. Stigma and discrimination that often surround people affected by HIV/AIDS further compound the emotional distress and social isolation experienced by HIV/AIDS orphans (Wijngaarden & Shaeffer, 2002).

3.5.7 Lack of self-esteem

The death of a parent(s) also means children are deprived of affection, attention, love and interpersonal and environmental stimulation. As such, their self-esteem and view of themselves as individuals are also affected. They are plunged into insecurity by their parents' death and struggle without services or support systems in impoverished communities (Fredrikson & Kanabus, 2005).

With the death of their parents, without the support of family and community to offer guidance and education, HIV/AIDS orphans are growing up at the margins of society without the normal socially accepted attitudes and behaviour. Furthermore, this has important implications for the reintegration of HIV/AIDS orphans into society or, even more importantly, if they are not reintegrated into society (Mizota, *et al*., 2006).

3.5.8 Trauma and the frustration of basic needs

The frustration of HIV/AIDS orphans’ basic psychological needs would hinder their ability to become optimally functioning individuals; and one way that basic needs could be frustrated is through trauma. Trauma is the experience of forceful events, which threaten children’s life or profoundly threaten their psychological integrity, and overwhelm their resources, as well as their ability to cope. As a result of these challenges and traumas, the basic needs of HIV/AIDS orphans would become frustrated and at risk of not having those needs met, thus reducing the likelihood that they could become optimally functioning individuals (Sandhei & Richter, 2003).

3.5.9 Depression

Often, we imagine HIV/AIDS orphans enduring their worst challenges after the death of their parents. However, with HIV/AIDS the pre-orphan years when their parent(s) become sick and grow increasingly frail could be exceptionally traumatic as well. The challenges HIV/AIDS orphans endure may take place over many years, and could often go unnoticed by teachers and other adults (Wood, Chase & Aggleton, 2006).

Results from several focus group discussions and interviews held with HIV/AIDS orphans in South Africa have shown that HIV/AIDS orphans experience, and have more self-reported depression than children orphaned due to other reasons or children in intact families (UNAIDS, 1999).

3.5.10 Resilience

Resilience may be defined as the process of, or capacity for, successful adaptation despite challenging or even extremely threatening circumstances. As it was mentioned above on trauma and the frustration of basic needs, the trauma experienced by HIV/AIDS orphans could frustrate many if not all of their basic needs. However, not everyone is destroyed or horrifically affected by difficult circumstances and events. The concept of resilience helps to explain why some children bounce back from trauma, while others become permanently affected by it. As such, understanding resilience and how it is fostered may help to protect HIV/AIDS orphans, and promote the fulfilment of their basic needs (Killian, 2004).

3.6 SOCIAL RELATIONSHIP BETWEEN HIV/AIDS ORPHANS AND NON-ORPHAN CHILDREN

Researchers have asserted that due to the prevalence of stigma as a result of misperceptions about the transmission of the virus, children whose parent(s) have died from HIV/AIDS encounter pervasive victimization from their peers which manifests in symptoms such as depression, aggression, stigmatization, violence, anxiety, low self esteem, and loneliness. In a study carried out in South Africa a 16-year old girl alluded to the rejection, stigmatization and the discrimination perpetrated by her friends and schoolmates. She asserted that she did not feel like walking in the street because of the name calling and whispering that prevails when she passes because of the assumption and the generalized perception that all the members of her family are sick. "*People talk about us negatively everywhere and we feel ashamed*", she complained (Cluver, Gardner & Operario, 2007, p. 755-763).

The psychological impact of peer victimization is cumulative to the point that children choose to withdraw or minimize interaction with their peers as a method of coping and this also leads to dropping out of school altogether. Consequently, HIV/AIDS orphans do not get education about HIV/AIDS since schools are the primary venues where information about HIV/AIDS is learned. This is an ominous oversight because orphan-hood, coupled with rejection, isolation, abandonment, discrimination, harassment and victimization by peers set the platform for psychological angst (Pillay, 2005).

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The focus of this chapter is on the plans, methods, tools, and the procedures employed in undertaking this study.

4.2 RESEARCH DESIGN

In this study, triangulation method which includes both qualitative and quantitative approaches was employed. This entails the application and combination of several research methodologies in the study of the same phenomenon. The main reason of using triangulation method was to holistically understand the context of the research in question and to overcome the weakness or intrinsic biases and the problems resulting from single use of method, observation, and theory (Guy, 1987).

4.3 SAMPLING

Purposive method of sampling was employed. David & Sutton (2004) define purposive sampling as a method of sample in which the units are selected according to the researcher’s own knowledge and opinion about which ones they think was appropriate to the topic area, in this case orphans of parents who died of HIV/AIDS were targeted for the study.

4.4 PARTICIPANTS AND SETTING

The researcher selected 70 HIV/AIDS orphans between the ages of 5 and 18 years whose parent(s) died of HIV/AIDS related diseases. Out of 70 participants 19 come from Itumeleng Community Orphanage Centre (Makanye Village), 31 come from

Reakgona Drop-In Centre (Manwkeng Township), while the other 20 are from the Church of Christ Community Centre in Venda (Tshifudi village). Throughout the interview process, the researcher was assisted by Itumeleng Community Orphanage Centre, Reakgona Drop-In Centre, as well as Church of Christ Community Centre management and their staff members.

4.5 PROCEDURE

The researcher requested the permission to use one of the offices at Reakgona Drop-In Centre, Itumeleng Community Orphanage Centre, and Church of Christ Community Centre for the purpose of conducting the study. Before an actual interview was conducted, a pilot study was done with a group of children with similar characteristics as those of the targeted group. This helped in checking whether the subtopics were appropriate and if they could be interpreted differently by different people.

4.6 METHODS OF DATA COLLECTION

4.6.1 Qualitative method

The researcher used face-to-face interview where the participants personally answered the research questions presented to them verbally. This helped the researcher to gently probe respondents for a position. In addition to asking questions, the researcher was able to make observations that included general reactions to the respondents dress, grooming, mannerisms and body language. The participants were asked about their experiences of being HIV/AIDS orphans with more emphasis on their relationship with their caregivers and their peers, as well as on the general feelings concerning living without their parents.

A tape recorder was used to record the participants’ responses in order to help the researcher not to miss some of the information when taking notes during the process of the interview. The researcher also used observations of every body language and reactions on some questions. In doing so close attention was paid to the language used by the participants as well as how the actual words were expressed.

4.6.1.1 Measuring instrument for qualitative approach

4.6.1.2 An interview guide

According to Maraise (1990), an interview is considered as a guide to a virtual series of topics or focus area the researcher uses to guide the conversation with the participants. The information obtained from literature review helped in structuring the interview guide. The interview guide sought to help tease out answers to the following questions:

- How do HIV/AIDS orphans and their caregivers relate?
- How do HIV/AIDS orphans feel about living without their biological parents?
- What are the attitudes of children living with their biological parent(s) towards HIV/AIDS orphans?
- How do HIV/AIDS orphans cope with the situation?

4.6.1.3 Participants

Out of 70 participants, the researcher selected 25 HIV/AIDS orphans between the ages of 5 and 18 years whose parents died of HIV/AIDS related diseases. Out of the 25 participants 9 come from Itumeleng Community Orphanage Centre (Makanye Village), 8 from Church of Christ Community Centre, while the other 7 are from Reakgona Drop-In Centre (Manwkeng Township).

4.6.1.4 Procedure

The process of interviewing the participants was initiated in June 2007 and was completed after a period of four weeks. The researcher was assisted by Reakgona Drop-In Centre and Itumeleng Community Orphanage Centre staff members when conducting the interviews with the participants. The staff members organized the participants, arranged the appointments and also ensured that there were no interruptions during the interview process. Participants were reassured that the information they were to provide would remain confidential.

4.6.1.5 Method of Data Analysis

Qualitative data analysis was used to capture as much information as possible. As such, thematic approach was used. During the process of interview, the researcher wrote down some notes while the tape recorder was capturing the data. Then, the data were transcribed verbatim by listening to the tape several times in order to be familiar with the data. Those statements as well as words that seemed important were highlighted into meaningful phrases. The data based on what the researcher had seen and heard in terms of verbal words, phrases, themes and patterns were grouped together and then compared to establish if they were similar.

4.6.2 Quantitative method

In this study, systematic sampling procedure, which is defined as an approach that involves drawing every *nth* element from a population was employed (Wilson, 1993). The researcher was provided with a registry book used to compile names of HIV/AIDS orphans at Itumeleng Community Orphanage Centre, Reakgona Drop-In Centre, and Church of Christ Community Centre.

4.6.2.1 Participants and setting

The researcher selected 45 HIV/AIDS orphans between the ages of 5 and 18 years old whose parent(s) died of HIV/AIDS related diseases. Out of 45 participants, 10 were from Itumeleng Community Orphanage Centre, 15 from Reakgona Drop-In Centre, while the other 20 participants where from the Church of Christ Community Centre in Venda (Tshifudi Village). For the purpose of the study, the researcher was granted the permission to use one of the offices at these centres. This helped to prevent the disturbance of the sessions with the participants and to enhance security for them.

4.6.2.2 Measuring instrument for quantitative approach

For the purpose of this study, a questionnaire was used to obtain information from the participants. The list of 45 participants who completed the questionnaire also included those who participated in face-to-face interviews. The questionnaire was translated from English to Sepedi, Tshivenda, and Xitsonga to cater for participants from the three language groups that were not conversant with English.

The questionnaire comprised of three sections. The first section included items asking the fundamental demographic details which entails age, home language, religion, number of siblings, and highest level of education. The second section included the Beck's Depression Inventory (BDI) self-report rating inventory (Beck *et al*., 1961) which was modified to measure the characteristic attitudes and symptoms of depression which HIV/AIDS orphans undergo due to the loss of their parents. The third section included Ways of Coping Scale (WCS) which is a revised version of Coping Strategies Procedures, developed by Billings and Moos (1981). The questionnaire was modified for the purpose of measuring the coping strategies used by HIV/AIDS orphaned in this study. The scale contained 32-item measures of three types of coping, namely: active behavioural strategies (13 items), active cognitive strategies (11 items), and avoidance strategies.

Scale 1: Behavioural strategies

This scale describes simulation and contemplation about a variety of possible behavioural alternatives by comparing their imagined effectiveness and includes brainstorming, analyzing problems and resources, and generating hypothetical plans of action.

Scale 2: Cognitive strategies

This scale is aimed at regulating temporary emotional distress by disclosing to others feelings, evoking empathy and seeking companionship from one's social network. It is emotional self-regulation with the assistance of significant others.

Scale 3: Avoidance Coping

Avoidance coping eludes action in a demanding situation by delaying.

4.6.2.3 Procedure

To complete the questionnaires, participants were subdivided into groups each with five individuals. The participants were divided into two groups using age as a criterion. Participants from age less than 12 were grouped as junior participants, while those who were aged 12 to 18 were considered senior participants. The questionnaires were administered for a period of six weeks starting in June 2007. Participants were further guaranteed about the confidentiality of their information that they provided.

4.6.2.4 Method of data analysis

SPSS 14.0 was used for the purpose of analyzing the data. This method was appropriate as it allowed the researcher to use the data to provide descriptive statistical information about the groups investigated. Descriptive statistics were used to summarize quantitative data in relatively understandable forms. The data sets were presented in the form of tables and figures.

4.7 ETHICAL CONSIDERATIONS

Before the process of interviewing the participants was engaged, the participants were informed about the aims, procedures, and risks involved in the study. The researcher obtained informed consent from the participants and managers of Itumeleng Community Orphanage Centre, Reakgona Drop-In Centre, and Church of Christ Community Centre who were presented as guardians. The participants were guaranteed that they were not forced to participate and that they would also be free to withdraw at any time if they were feeling uncomfortable. The researcher also assured the participants about the information shared during the interview that it would remain confidential unless the participant gave the consent to do otherwise. For emotions that were evoked by research, participants were referred to the professional therapists for counselling and the social worker for further management.

CHAPTER 5

DATA ANALYSIS AND INTERPRETATION OF THE FINDINGS

5.1 INTRODUCTION

The focus of this chapter is on data analysis and interpretation for both qualitative and quantitative research findings. The data analysed were collected through individual interviews and questionnaires.

5.2 QUALITATIVE FINDINGS

5.2.1 Introduction

The qualitative study covered twenty-four (24) participants who are HIV/AIDS orphans. These included males and females HIV/AIDS orphans between the ages of 05 and 18 years, who came from different family backgrounds. Most of these orphans' livelihoods were mostly characterized by living with adult relatives, usually grandparents. More often, it would be a grandmother, a mother or an aunt. Other HIV/AIDS orphans interviewed in this study included those who were living in households headed by older siblings in their late teens or early twenties.

The information was gathered through the use of face-to-face interview. During the interview process the researcher observed and wrote down some critical notes while using a tape recorder to simultaneously capture the same data. Then, the data were transcribed verbatim. Participants were requested to answer the following questions: How do HIV/AIDS orphans and their caregivers relate? How do HIV/AIDS orphans feel about living without their biological parents? What are the attitudes of those children living with their biological parents towards HIV/AIDS orphans? How do HIV/AIDS orphans cope with the situation? The following themes emerged and were drawn from their responses:

How do HIV/AIDS orphans relate with their caregivers?

In most cases, mothers and grandmothers were reportedly taking better care of the HIV/AIDS orphans. They were also reportedly more approachable and more loving. In some few cases mothers and fathers were reportedly less caring and abused alcohol. For instance, in one case, an 11 year-old-girl complained about her mother who was not supportive, while acknowledging the support she received from her grandmother.

"I feel like my mother is neglecting and abandoning us; and it is more like we are somehow developing a negative attitude towards her due to this behaviour", **she said.**

Furthermore, HIV/AIDS orphans reportedly relied on neighbours for material and emotional support since they had lost the sympathy and respect from most of their relatives during the crucial stage of their parents' illness due to the stigma attached to HIV/AIDS.

A 16-year-old girl stated that: ***"When my mother was still alive, I overheard my aunt one evening gossiping about my mother with her friends saying that she would never visit my mother again because she might contract AIDS from her".***

How do HIV/AIDS orphans feel about living without parents?

Throughout the research process, the researcher noted that the effects of losing parent(s) are highly complex and their actual nature depended on the developmental stage of orphans, orphans' resilience, quality of care provided to orphans, and social support networks accessible to them. Many HIV/AIDS orphans stated that they had taken on significant caring responsibilities during their parents' illness. When

HIV/AIDS orphans reported on the impact and adjustment following the loss of their parent(s), they revealed the tendency of exhibiting the signs of grief such as depression, social withdrawal, anger, and aggression. HIV/AIDS orphans complained that the feeling of sadness about the loss of their parent(s) overwhelmed them. While many were emotionally contained, several broke down in tears in the course of the personal interview. Those who are heads of households were discovered to have acute emotional burdens, having to deal with the grief of their younger siblings as well as with their own sense of loss.

A 17 year-old-girl whose mother was chronically ill and had lost her father reported being afraid of losing her mother too.

> ***"I feel scared that my mother can pass away too any moment from now because the illness she is suffering from resembles the one my father died of", she said. "Now that my mother is sick, things are just becoming bad by the day; if she dies then it would be worse and unbearable".***

They indicated that after the death of their parent(s) they felt that there was nobody they could share their feelings with.

What are the attitudes of children living with their biological parents towards the HIV/AIDS orphans?

Most of HIV/AIDS orphans who participated in this study explained that mixing with non-orphaned peers was emotionally distressing. However, the study discovered that HIV/AIDS orphans enjoy a significant friendship with other orphaned peers. They explained the way non-orphaned peers reminded them, as well as exacerbated their feelings of their loss.

They indicated that the stigma attached to HIV/AIDS occupies the minds of their non-orphaned peers, and that this influences them to be malevolent towards HIV/AIDS orphans. In this study, HIV/AIDS orphans reported that they were ill-treated and discriminated against by their non-orphaned peers:

> ***“They tease us of not having fathers, and they always talk about wonderful things which their parents do for them”. “They discriminate me against me saying that when they play with me, I will infect them with the disease my father died of”.***

For many HIV/AIDS orphans, the behaviour of non-orphaned peers devastates, frustrates and brings the feeling of desperation on them.

How do HIV/AIDS orphans cope with the situation?

In this study, it was found that HIV/AIDS orphans lack adults whom they can trust and express their feelings following the loss of their parent(s). This is due to the stigma attached to HIV/AIDS. Few HIV/AIDS orphans reported to have support from their remaining parent, caregivers, and/or their relatives while most of them complained of not receiving any emotional support. The orphans reported that it became hard for them since they felt that they needed somebody they could rely on and talk to whenever they needed. They further reported that when they did not get support they became discouraged and felt frustrated about the future, hence, they stated that the relationship with their caregivers also determined whether they were comfortable enough to express their feelings following the loss of their parent(s). In this study, some HIV/AIDS orphans revealed that they tried to cope on their own while some said they felt better by putting their trust in God.

5.3 QUANTITATIVE FINDINGS

5.3.1 Biographical data

Table 1: Frequency table for biographical data

Variables	Frequency	Percentage
Age: 5-12	14	31.1
13-18	31	68.9
Gender: Male	26	57.8
Female	19	42.2
Home language: Pedi	24	53.3
Tshivenda	10	22.2
Xitsonga	11	24.4
Religion: Christian	38	84.4
Traditional	7	15.6
Number of siblings: One	9	20.0
Two	8	17.8
Three	15	33.3
Four	19	20.0
Five & more	4	8.9
HLOED: Primary level	21	46.7
Secondary level	24	53.3

This study covered 45 HIV/AIDS orphans; 31% ranged from age 5-12 while 67% ranged form age 13-12; 58% were males, whereas 42% were females. Pedi speaking group constituted 53% while 22% constituted Tshivenda speaking group and 24% constituted Xitsonga speaking group. Christian group formed 84% whereas traditional group formed 16%. In terms of the number of siblings, 20% of the participants had one sibling, 18% had two siblings, 33% had three siblings, 20% had four siblings, and 9% had five and more siblings. Lastly, 47% of the participants comprised primary level group while 53% comprised secondary level group (See table 1 above).

5.3.2 Experience of depression

Beck's Depression Inventory was used to measure depression among HIV/AIDS orphans. On the scale, 10-18 indicate mild depression, 19-29 indicate moderate, and 30-63 indicate severe depression. The results indicate that more HIV/AIDS orphans experience severe depression (91.3%) as against moderate to mild depression (6.5%). (See table 2).

Table 2: Levels of depression

BDICAT

		Frequency	%
Valid	Moderate	3	6.5
	Severe	42	91.3
	Total	45	97.8
Missing	System	1	2.2
Total		46	100.0

5.3.2.1 Experience of depression by demographics

HIV/AIDS orphans' experience of depression is explained according to age, gender, home language, religion, number of siblings, and highest level of education. The relationship between depression and demographics was sought using Pearson's (X^2) and the relationship between the two was be interpreted through the use of mean scores.

Table 3: Chi-square test showing the significant difference between depression by demographics.

Demographics	**Levels of depression**		**X^2**	**df**	**p**
	Moderate	Severe			
Age: 05-12	1	13	6.422	1	*.011
13-18	2	29			
Gender: Male	2	24	1.089	1	.297
Female	1	18			
Home Language:			8.133	2	.017*
Sepedi	2	22			
Tshivenda	0	10			
Xitsonga	1	10			
Religion: Christianity	2	36	21.356	1	*.000
Traditional	1	6			
Number of siblings:			6.889	4	.142
One	2	7			
Two	0	8			
Three	1	14			
Four	0	9			
Five & more	0	4			
HLOE: Primary level	1	20	.200	1	.655
Secondary level	2	22			

*Significant at 0.05 level

5.3.2.1.1 Experience of depression by age

Table 4: Mean scores for depression by age

AGE IN YEARS	Mean	N	S.D
5-12	2.9286	14	.26726
13-18	2.9355	31	.24973
Total	2.9333	45	.25226

Relationship between age and depression was sought using X^2. The findings indicated that there is a significant difference between the experience of depression by age (X^2=6.422; df=1; p=.011) (See table 3 above). In this study, this means that younger orphans (N=14) showed depression lesser than older orphans (N=31). See table 4.

5.3.2.1.2 Experience of depression by gender

Table 5: Mean scores for depression by gender

GENDER	Mean	N	S.D
Male	2.9231	26	.27175
Female	2.9474	19	.22942
Total	2.9333	45	.25226

Table 3 indicates that there is no significant difference between the experience of depression by gender (X^2=1.089; df=1; p=.297). This suggests that in this study females (N=19), showed lesser depression as compared to males (N=26). (See table 5).

5.3.2.1.3 Experience of depression by home language

Table 6: Mean scores for depression by home language

HOME LANGUAGE	Mean	N	S.D
Pedi	2.9167	24	.28233
Tshivenda	3.0000	10	.00000
Xitsonga	2.9091	11	.30151
Total	2.9333	45	.25226

As noted on table 3, there is a significant difference between the experience of depression by home language (X^2=8.133, df=2, p=.017). This indicates that in this study Pedi speaking orphans (N=24) showed more depression, followed by Xitsonga speaking orphans (N=11), thereafter Tshivenda speaking orphans (N=10).

5.3.2.1.4 Experience of depression by religion

Table 7: Mean scores for depression by religion

RELIGION	Mean	N	S.D
Christian	2.9474	38	.22629
Traditional	2.8571	7	.37796
Total	2.9333	45	.25226

The findings in table 3 shows the significant difference between the experience of depression by religion (X^2=21.356; df=1; p=.000). This study results suggests that orphans who believe in tradition (N=7) showed depression lesser than those who believe in Christianity (N=38). (See table 7).

5.3.2.1.5 Experience of depression by number of siblings

Table 8: Mean scores for depression by number of siblings

NUMBER OF SIBLINGS	Mean	N	S.D
One	2.7778	9	.44096
Two	3.0000	8	.00000
Three	2.9333	15	.25820
Four	3.0000	9	.00000
Five & more	3.0000	4	.00000
Total	2.9333	45	.25226

The findings in table 3 indicate that there is no significant difference between the experience of depression by number of siblings (X^2=6.889; df=4; p=.142). This indicates that in this study, the number of siblings does not have a greater influence on the experience of depression; however, orphans with five and more siblings show less depression than those with fewer siblings. (See table 8).

5.3.2.1.6 Experience of depression by level of education

Table 9: Mean scores for depression by level of education

HLOE	Mean	N	S.D
Primary level	2.9524	21	.21822
Secondary level	2.9167	24	.28233
Total	2.9333	45	.25226

Table 3 indicates that there is no significant difference between the experience of depression by level of education (X^2=.200; df=1; p=.655). This shows that the level of education does not play an important role on the experience of depression. The results imply that orphans who are in primary level showed less depression than those who are in the secondary level (N=24). (See table 9).

5.4 Ways of coping

5.4.1 HIV/AIDS orphans' ways of coping

Findings on HIV/AIDS orphans' ways of coping are given according to cognitive, behavioural, and avoidance ways. The results are also given according to the levels of depression. The findings were interpreted through the use of mean scores, and ANOVA.

5.4.1.1 Ways of coping by levels of depression

Table 10: Mean scores for ways of coping by levels of depression

BDICAT		COG	BEH	AVO
Moderate	Mean	28.0000	28.3333	14.6667
	N	3	3	3
	S.D	4.35890	3.05505	4.16333
Severe	Mean	24.4048	25.5714	12.1905
	N	42	42	42
	S.D	3.18579	4.02518	2.27648
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

Table 11: ANOVA showing the significant difference between ways of coping by levels of depression

		Sum of Squares	df	Mean Square	F	Sig.
COG	Between Groups	36.192	1	36.192	3.427	*.051
	Within Groups	454.119	43	10.561		
	Total	490.311	44			
BEH	Between Groups	21.359	1	21.359	1.345	.253
	Within Groups	682.952	43	15.883		
	Total	704.311	44			
AVO	Between Groups	17.168	1	17.168	2.987	*.049
	Within Groups	247.143	43	5.748		
	Total	264.311	44			

*Significant at 0.05 level

5.4.1.1.1 Cognitive ways of coping by levels of depression

In looking at the way of coping used by HIV/AIDS orphans at different levels of depression, using ANOVA, it was found that there is a significant difference between moderately and severely depressed orphans with regard to the use of cognitive ways of coping (F=3.427; df=1; $p < 0.05$) (see table 11). The moderately depressed orphans were found to use more cognitive ways of coping (mean score=28.00) than the severely depressed (mean score= 24.40). (See table 10).

5.4.1.1.2 Behavioural ways of coping by the levels of depression

Table 11 indicates that there is no significant difference with regard to the use of behavioural ways of coping (F=1.345, df=1, p=253). However, the findings in table 10 shows that those who are moderately depressed (mean score=28.33) use behavioural ways of coping more than those who are severely depressed (mean score=25.57).

5.4.1.1.3 Avoidance ways of coping by the levels of depression

According to table 11, there is a significant difference with regard to the use of avoidance ways coping (F=2.987, df=1, p<0.05). The findings indicate that individuals who are moderately depressed (mean score=14.66) use more of avoidance ways of coping than the severely depressed (mean score=12.19) (See table 10).

However, the overall findings on ways of coping by levels of depression reveal that HIV/AIDS orphans who are moderately depressed use more cognitive and avoidance ways of coping than behavioural ways of coping.

5.4.2 Ways of coping by demographics

Findings on ways of coping by HIV/AIDS orphans are explained according to age, gender, home language, religion, number of siblings, and highest level of education. The findings will be presented through the use of chi-square test and mean scores.

Table 12: Chi-square test showing the significant difference between ways of coping by demographics.

Items	Demographics		X^2	df	p
	Age				
	05-12	13-18			
Cognitive	14	31	6.50	13	.926
Behavioural	14	31	8.61	13	.801
Avoidance	14	31	5.06	9	.829
	Gender				
	Male	Female			

Cognitive	26	19				17.03	13	.198
Behavioural	26	19				19.33	13	.113
Avoidance	26	19				12.64	9	.179
	Home language							
	Sepedi	Tshivenda	Xitsonga					
Cognitive	24	10	11			21.74	26	.702
Behavioural	24	10	11			39.69	26	*.042
Avoidance	24	10	11			18.64	18	.414
	Religion							
	Christianity	Traditional						
Cognitive	38	7				6.76	13	.914
Behavioural	38	7				6.12	13	.942
Avoidance	38	7				8.11	9	.523
	Number of siblings							
	One	Two	Three	Four	Five & More			
Cognitive	9	8	15	9	4	49.88	52	.557
Behavioral	9	8	15	9	4	60.73	52	.190
Avoidance	9	8	15	9	4	28.10	36	.824
	Highest level of education							
	Primary level	Secondary level						
Cognitive	21	24				10.89	13	.620
Behavioral	21	24				14.14	13	.363
Avoidance	21	24				10.80	9	.290

*Significant difference at 0.05 level.

5.4.2.1 Ways of coping by age

Table 13: Mean scores for ways of coping by age

AGE IN YEARS		COG	BEH	AVO
5-12	Mean	25.2857	25.4286	12.0000
	N	14	14	14
	S.D	2.94641	3.36759	1.88108
13-18	Mean	24.3548	25.9032	12.5161
	N	31	31	31
	S.D	3.50760	4.30004	2.68168
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

As noted on table 12, there is no significant difference between the ways of coping by age, for cognitive ways of coping (X^2=6.50, df=13, p=.926); for behavioural (X^2=8.61, df=13, p=.801) ways of coping; and for avoidance ways of coping (X^2=5.06, df=9, p=.829). These results indicate that both younger and older group use ways of coping the same way. However, the younger group tends to use cognitive ways of coping more (Mean=25.285) than the elder group (mean=24.354). With regard to the use behavioural ways of coping, a slight difference is noted with the older group 13-18 showing more inclination towards behavioural ways of coping (mean=25.9), and the younger age group 5-12 showing less inclination (mean=25.4). The same inclination for the older group towards avoidance strategy was noted (mean=12.516), and the younger age group showing lesser inclination (mean=12.00).

5.4.2.2 Ways of coping by gender

Table 14: Mean scores for ways of coping by gender

GENDER		COG	BEH	AVO
Male	Mean	24.4615	26.1154	12.1923
	N	26	26	26
	S.D	3.51261	4.42110	2.51427
Female	Mean	24.8947	25.2632	12.5789
	N	19	19	19
	S.D	3.16043	3.39676	2.41099
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

Table 12 indicates no significant difference with regard to the use of cognitive way of coping by gender, for cognitive ways of coping with (X^2=17.03, df=13, p=.198), for behavioural ways of coping (X^2=19.33, df=13, p=.113); and for avoidance ways of coping (X^2=12.64, df=9, p=.179).

In this study, this suggests that both male and female orphans use ways of coping the same way. However, the trivial difference was noted on the way male and female orphans use cognitive ways of coping, with male orphans (mean=24.461) showing less inclination towards cognitive ways of coping as compared to female orphans (mean=24.894). A slight difference was also noticed, however, on the way male and female orphans use behavioural ways of coping with female orphans (mean=26.115) using behavioural ways of coping less than male orphans (mean=25.263). With regard to the use of avoidance ways of coping, the same fondness was observed with female orphans showing more inclination towards the use of avoidance ways of coping than male orphans (mean=12.192). (See table 14).

5.4.2.3 Ways of coping by home language

Table 15: Mean scores for ways of coping by home language

HOME LANGUAGE		COG	BEH	AVO
Pedi	Mean	24.7917	27.5000	12.5833
	N	24	24	24
	S.D	3.24344	4.11783	2.33902
Tshivenda	Mean	25.7000	23.1000	11.2000
	N	10	10	10
	S.D	3.05687	2.68535	2.25093
Xitsonga	Mean	23.3636	24.3636	12.9091
	N	11	11	11
	S.D	3.66804	2.90767	2.73695
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

Table 12 shows that there is a significant difference with regard to the use of behavioural way of coping ($X^2=39.69$, df=26, $p<0.05$). The findings of this study imply that Pedi speaking individuals (mean=27.500) prefer to use behavioural ways of coping more than Tshivenda (mean=23.100) and Xitsonga speaking individuals (mean=24.363). A trivial difference is observed towards the use of cognitive ways of coping. Xitsonga speaking individuals seem to use cognitive ways of coping less than Pedi (mean=24.791), and Tshivenda speaking individuals (mean=25.700). Another slight difference noted was the tendency to use avoidance ways of coping with Tshivenda speaking individuals (mean=11.200) using avoidance ways of coping less than Pedi (mean=12.583), and Xitsonga speaking individuals (mean=12.909).

5.4.2.4 Ways of coping by religion

Table 16: Mean scores for ways of coping by religion

RELIGION		COG	BEH	AVO
Christian	Mean	24.3684	26.1053	12.3158
	N	38	38	38
	S.D	3.20828	4.09871	2.39487
Traditional	Mean	26.1429	23.8571	12.5714
	N	7	7	7
	S.D	3.89138	2.96808	2.93582
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

As noted on table 12, there is no significant difference with regard to the ways of coping by religion, for cognitive ways of coping (X^2=6.76, df=13, p=.914); for behavioural way of coping (X^2=6.12, df=13, p=.942); and for for avoidance way of coping (X^2=8.11, df=9, p=.523). The findings indicate that orphans who believe in Christianity are likely to use ways of coping the same way with orphans who believe in tradition.

Even though there is no significant difference noted, the slight difference was observed on the way orphans who believe in Christianity and those who believe in traditional religion use cognitive ways of coping. Orphans who believe in traditional religion (mean=26.142) seem to use cognitive ways of coping more than orphans who believe in Christianity (mean=24.368). A slight difference is also observed with regard to the use of behavioural ways of coping, with orphans who believe in Christianity (26.105) showing the tendency of using behavioural ways of coping more than those with traditional beliefs (N=23.857). Another insignificant difference is observed in the use of avoidance ways of coping; Orphans with Christian (N=12.315) beliefs seem to use avoidance ways of coping lesser as compared to those with traditional beliefs (N=12.571). (See table 13).

5.4.2.5 Ways of coping by number of siblings

Table 17: Mean scores for ways of coping by number of siblings

NUMBER OF SIBLINGS		COG	BEH	AVO
One	Mean	23.7778	28.0000	13.2222
	N	9	9	9
	S.D	3.96162	6.10328	2.68225
Two	Mean	23.8750	23.1250	11.0000
	N	8	8	8
	S.D	2.90012	1.64208	1.60357
Three	Mean	23.8667	25.6667	12.6667
	N	15	15	15
	S.D	2.97289	3.24404	2.05866
Four	Mean	26.5556	25.8889	12.0000
	N	9	9	9
	S.D	3.32081	3.95109	3.46410
Five & more	Mean	26.7500	26.0000	12.7500
	N	4	4	4
	S.D	2.75379	2.16025	1.70783
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

The findings of this study in table 12 reveal that there is no significant difference between the ways of coping by number of siblings, for cognitive way of coping (X^2=49.88, df=52, p=.557); for behavioural way of coping (X^2=60.73, df=52, p=.190); and for avoidance way of coping (X^2=28.10, df=36, p=.824). This suggests that

HIV/AIDS orphans with one sibling are likely to use ways of coping the same way. This also implies that number of siblings does not have an influential role on the ways of coping used by HIV/AIDS orphans. However, as table 17 shows the minimal difference with regard to the use of cognitive ways of coping; with orphans who have one sibling (mean=23.777) showing less inclination on the use of cognitive ways of coping than orphans with two siblings (mean=23.875), three siblings (mean=23.866), four siblings (mean=26.555) as well as orphans with five and more siblings (mean=24.644).

Another slight difference is noted with regard to the use of behavioural ways of coping. Orphans with one sibling (mean=28.000) seem to use behavioural ways of coping more, followed by orphans with five and more siblings (26.000), then orphans with four siblings (mean=25.888), orphans with three siblings (mean=25.666), and then orphans with two siblings (mean=23.125). An insignificant difference is also observed with regard to the use of avoidance ways of coping. It was found that orphans with one sibling (13.222) prefer to use more avoidance ways of coping as compared to those orphans with two siblings (mean=11.000), three siblings (mean=12.666), four siblings (12.000), and five and more siblings (12.750). (See table 17).

5.4.2.6 Ways of coping by level of education

Table 18: Mean for ways of coping by level of education

HLOE		COG	BEH	AVO
Primary level	Mean	24.6190	26.2381	12.0952
	N	21	21	21
	S.D	2.94068	4.14614	1.72930
Secondary level	Mean	24.6667	25.3333	12.5833
	N	24	24	24
	S.D	3.71444	3.90837	2.96232
Total	Mean	24.6444	25.7556	12.3556
	N	45	45	45
	S.D	3.33818	4.00088	2.45093

The study results in table 12 revealed significant difference with regard to the ways of coping by level of education; for cognitive ways of coping (X^2=10.89, df=13, p=.620); for behavioural ways of coping (X^2=14.14, df=13, p=.363); for avoidance ways of coping (X^2=10.80, df=9, p=.290). This shows that level of education does not a direct impact on the way orphans use ways of coping. However, a trivial difference was noted with orphans who are in primary level primary level (24.619) showing less fondness with regard to the use of cognitive ways of coping as compared to orphans who are in secondary level (24.666). Noted was also the minimal difference on the use of behavioural was of coping. Orphans who are in secondary level (N=25.333) were found to use behavioural ways of coping less than orphans who are in primary level (N=26.238). Furthermore, the slight difference is observed on the use of avoidance ways of coping with orphans who are in secondary level (N=12.583), showing a tendency of using more avoidance ways of coping than those in primary level (12.095). (See table 18).

5.5 Summary

In this study, psychological difficulties experienced by HIV/AIDS orphans were identified, as well as ways of coping used by HIV/AIDS orphans. The qualitative result found that HIV/AIDS orphans are adversely affected emotionally by living without their parent(s) and they end up suffering from sadness, helplessness, anger, guilty, aggression and frustration that often lead to social withdrawal and depression. These results were confirmed by quantitative results of this study that show that (91.3%) of HIV/AIDS orphans experience severe depression as opposed to moderate to mild depression (6.5%) (See table 2).

Based on qualitative study, HIV/AIDS orphans were found to experience and perceive the relationship with their caregivers as sore and not supportive. The study findings revealed that HIV/AIDS orphans enjoy a significant friendship with other orphaned peers. Yet, they explained mixing with non-orphaned peers as emotionally distressing. Furthermore, HIV/AIDS orphans complained of not receiving any emotional support from their remaining parent, caregivers, and/or their relatives. This forces them to try to cope on their own. Some HIV/AIDS orphans reported feeling better by trusting to God.

In quantitative findings, the significant areas in relation to the experience of depression by demographics were identified. These include age, home language, and religion. Areas where no significant difference was found include gender, number of siblings, and level of education. It was also found that depressed HIV/AIDS orphans prefer to use more of cognitive and avoidance ways of coping than behavioural ways of coping. On ways of coping by demographics, only home language was identified as significant. Areas which were identified as non significant include; age, gender, religion, number of siblings, as well as level of education.

CHAPTER 6

DISCUSSION OF THE RESULTS

6.1 INTRODUCTION

The focus of this chapter is on the discussion of both qualitative and quantitative results. The main focus was on emotional experiences encountered by HIV/AIDS orphans, and their ways of coping. These findings were also supported by the literature.

6.2 QUALITATIVE DATA

6.2.1 Emotional impacts faced by HIV/AIDS orphans

Seeing a parent becoming sick and subsequently die is clearly a major trauma for any child. Children whose parent(s) have died of HIV/AIDS related disease often experience many negative changes in their lives and usually start to suffer some form of neglect, including emotional neglect. This usually happens long before they are orphaned. Eventually, they suffer emotional trauma and grief resulting from the eventual death of their parent(s) (Fredriksson & Kanabus, 2008). This study discovered that HIV/AIDS orphans suffer from sadness, helplessness, anger, guilty, aggression and frustration that often lead to their social withdrawal and subsequent depression. This finding is in line with those of a study conducted by Cluver, Gardner & Operario (2007) which has further discovered that HIV/AIDS orphans are more likely to report symptoms of depression than children orphaned by other causes of death as well as the non-orphaned children.

6.2.2 Relationship among HIV/AIDS orphans and their caregivers

Much of the literature that has been recorded on the treatment of HIV/AIDS orphans by their caregivers is mostly negative, though there are some notable exceptions. This study discovered that HIV/AIDS orphans are usually cared for by their surviving parent, grandparents, or they remain in their parental home where the eldest child becomes the head of the family. In some situations, HIV/AIDS orphans might move in with other members of their extended families or relatives (Johnson, 2001). This study's findings also revealed that HIV/AIDS orphans experience and perceive the relationship with their caregivers as sore and unsupportive. The study conducted by Meintjes & Giese (2004) on the relationship between HIV/AIDS orphans and their caregivers revealed that, mostly, caregivers especially from the extended families treat HIV/AIDS orphans as second-class family members who are usually subjected to hard labour and sexual abuse, and are also often forced to drop out of school.

In most cases, grandmothers were said to be taking better care of the HIV/AIDS orphans, were more approachable, and exhibited love with greater ease. However, in some cases their biological mothers and fathers were said to be more likely careless and dependent on alcohol. In the study conducted by Miller (2007) on the treatment of HIV/AIDS orphans by their caregivers, it was revealed that maternal HIV/AIDS orphans, especially those in child-headed households, together with those living with some of their relatives were significantly more depressed than HIV/AIDS orphans living with grandparents.

6.2.3 Attitude of non-orphans towards HIV/AIDS orphans

A survey conducted in South Provinces of Zimbabwe covering 1, 510 HIV/AIDS orphans revealed that there is a greater tendency for HIV/AIDS orphans to be bullied by their non-orphaned counterparts. Furthermore, it was discovered that HIV/AIDS orphans are subjected to taunting, name calling, labelling, isolation, and violence by non orphaned children (Pillay, 2005). Most of the HIV/AIDS orphans who participated in this study explained that mixing with non-orphaned peers is emotionally distressing in most times. Furthermore, they explained that the actions and negative attitudes of the non-orphaned peers usually exacerbate their feelings of loss.

The findings of the study have further revealed that HIV/AIDS orphans maintain and enjoy normal friendship ties with other orphaned peers, but not with non-orphaned peers. A recent study conducted in South Africa (Cape Town) on the psychological well being of HIV/AIDS orphans discovered that a very small percentage of HIV/AIDS orphans felt that they definitely could make good friendship with non-orphaned peers. A large percentage perceived that they did not have or were unable to develop good friendship with their non-orphaned peers. The latter was reportedly due to the stigma and myths attached to HIV/AIDS patients (Cluver & Gardner, 2006).

6.2.4 Ways of coping used by HIV/AIDS orphans

It seems not to be a part of any culture in many African countries for parents to talk to their children about their emotional reactions to trauma. Evidence has shown that often adults do not talk about death with their children, by fear of causing distress, thereby consequently causing more distress (Christ & Christ, 2006). In African culture, especially within the black community, it was discovered that children find it difficult to express their fear, grievance and anger effectively. The findings of this study revealed that HIV/AIDS orphans lack adults unto whom they can trust and be able to express their feelings following the loss of their parent(s). Hence, this study has discovered that HIV/AIDS orphans try to find their own ways of coping while some indicated that they feel better by casting their trust to God. Most of them reported feeling much better when they were around other fellow orphans.

6.3 QUANTITATIVE RESULTS

Quantitative results in this study confirmed that HIV/AIDS orphans experience substantial depression (moderate to severe) following parental loss. This was also confirmed by qualitative findings of the current study. In the study conducted by

Miller (2007), it was acknowledged that HIV/AIDS orphans scored significantly higher on the Beck Depression Inventory when compared to orphans by other causes of death. This finding concurs with the findings of a study conducted by Ssewamala, Alicea, William, Bannon & Ismayilova (2008) concerning depression and HIV/AIDS orphans and orphan-hood by other causes which revealed that children that are orphaned by other causes of death are not highly associated with depression to the same extent as HIV/AIDS orphans.

6.4 DEPRESSION AND DEMOGRAPHICS

In a recent study conducted by Christ & Christ, (2006) it was found that bereaved adolescents younger than 15 years old are vulnerable to depression than those between 15 to 19 years of age. The findings of this study revealed that there is a significant difference between the experiences of depression among orphans of different age groups. This means that younger orphans show less depression than older orphans. This is in line with the findings of a study conducted by Cluver, Gardner & Operario (2007) which investigated the psychological consequences of HIV/AIDS orphan-hood.

Meta-analysis of studies conducted in various countries has shown that females are roughly twice as likely as males to experience depression. According to the theory of learned helplessness theory, repeated exposure to negative situations where one has little control produces feelings of helplessness and symptoms of depression. Girls also reported experiencing a greater number of stressful events and a lower sense of feeling in control than boys did. Learned helplessness theory holds that feelings of powerlessness should result in greater rates of depression in girls than in boys, which is indeed the case (Culbertson, 1999). The results of this study revealed no significant difference between the experiences of depression by gender. However, the results showed that female orphans, experience less depression as compared to male orphans. Nazroo (2001) reported that women in the United States are about two-thirds more likely than men to be depressed. This is in line with the results of a national psychiatric morbidity survey in Britain that showed a similar greater risk of depression for women.

In this study, a significant difference was noticed between depression and home language. The Pedi speaking orphans in this study showed depression more than Xitsonga and Tshivenda speaking orphans. Researchers have shown that culture, family beliefs and values that are believed to lessen the aftermath of death could play an important role in determining the relationship between depression by home language. For instance, in Venda culture depending on the developmental stage of a child, a child is allowed to attend the burial ceremony, and the practice is the same to both Tsonga and Pedi cultures. It is also a common belief that a great part of a young boy's emotional self must be silenced to fit into the notion of "being a man", even in a difficult and tough situation; and indeed, men soon learn that crying is viewed as "breaking down," and being “more of a coward” whereas "biting the bullet" is highly commendable (Christ & Christ, 2006).

The study findings also show the significant difference between the experience of depression by religion, but both Christian and traditional groups were found to experience depression in a similar way. There is no research evidence found to substantiate the findings of this study.

No significant difference was found between the experiences of depression by number of siblings. This indicates that the number of siblings does not have an influence on the experience of depression. Yet, on a thin margin, orphans with five and more siblings were found to be experiencing less depression than orphans with fewer siblings. The study done by Brigham and Women’s Hospital (2007) indicates that there is a strong connection between closeness of siblings during childhood and lower risk of depression in adulthood. Beginning in their late teens, 229 men were evaluated for the quality of their childhood relationships with siblings. Research found that poorer relationships with siblings during childhood independently predicted both the occurrence of major depression.

Level of education was also found not to be significantly different for the orphans experience of depression. The implication of these findings is that individuals who have a primary school level of education seem to experience less depression than those who have a secondary school level of education. These findings are in contrast with the findings of a cross sectional study designed to survey the relationship between depression in relation to educational level, and socio-economic status that has found that depression had negative correlation with education. In other words, with the raise of education level depression decrease (Ramezanzadeh, Aghssa, Abedinia, Zayeri, Khanafshar, Shariat & Jafarabadi, 2004).

6.5 STRATEGIES OF COPING EMPLOYED BY HIV/AIDS ORPHANS

According to Oosthuizen (2005), Antonovsky argues that microbiological, chemical, physical, psychological, social and cultural pathogens are everywhere, and because individuals are confronted with them every day, it would seem natural if everyone succumbed to them and died. However, this does not happen in the same manner. Thus, it is a given that everybody experiences multiple stressors throughout their lives, yet some people who experience a high stress load manage to survive and sometimes even do very well. It is believed that mechanisms used by individuals who function optimally, enable them to manage stress in an effective way, through creative energy sources, which lead to a healthy/optimal life style.

Long-term studies of children in so-called “problem situations” have shown that they react to traumatic stress situations such as the death of a parent in very different ways. While some find that their opportunities in life are drastically restricted, others manage to cope with the situation and even emerge from it stronger (Johnson, 2001). This research study looked at ways of coping that are used by HIV/AIDS orphans that help them to rebound from their loss. These ways of coping include cognitive, behavioural, and avoidance. The study results show that HIV/AIDS orphans use of cognitive and avoidance ways of coping as compared to behavioural ways coping. The findings of this study imply that depressed individuals think about their situations more negatively than positively; for instance, they struggle to see the positive side of the situation, and fail to tell themselves any possible things that can help them feel better. They further avoid their feelings and the facts concerning their situation. They may refuse to believe that the loss has happened, as well avoid being with people, and keep their feelings to themselves. This means that instead of them paying much attention to things that may help them feel better about their situation, they implant negative thoughts in their minds. The investigation conducted by Kuyken & Brewin (2004) to assess the self-esteem, and coping style of depressed children, confirmed that more children had lower self-esteem, more negative thoughts, and coped through more avoidance. Demographic factors were considered to find out whether they have an influence on the way HIV/AIDS orphans employ ways of coping.

Most children between the ages of 5 and 11 can understand the difference between a temporary separation and death. They know that death is irreversible and universal, has a cause, and involves permanent separation. Children from 5 to 19 years of age are more likely to understand the physical changes that death brings and are helped by seeing these changes for themselves, as such, their cognitive level of functioning plays a significant role on the use of ways of coping (Felsten, 1998). The findings of this study showed no existing relationship between the ways of coping by age. This means both younger and older individuals use ways of coping the same way. However, the younger group were found to be using cognitive ways of coping more than the older group. This could suggest that younger people think negatively about their situations more than older people. With regard to the use of behavioural ways of coping, older people were found to use behavioural ways of coping more as compared to the younger ones. The implication of this study finding is that the older individuals seek emotional support more than the younger individuals do. Furthermore, a slight difference was observed on the use of avoidance ways of coping where older individuals were more likely to use avoidance ways of coping than younger individuals. In this study, this suggests that older individuals ignore to face the reality of their situation more than young individuals.

The results of this study indicate no significant difference with regard to the use of cognitive way of coping by gender. These suggest that both male and female orphans use ways of coping the same way. Even though no significant difference was found, a trivial difference was noted on the way male and female orphans use cognitive ways of coping. Male orphans seem to use cognitive ways of coping less than female orphans. This could mean that female orphans think negatively about their situations more than male orphans do. A slight difference was also noted with regard to the use of behavioural ways of coping where male orphans were found to use behavioral ways of coping more than female orphans. This could mean that male orphans prefer to seek emotional support as opposed to female orphans. The findings of this study was confirmed by the study done by Felsten (1999) to evaluate gender differences in the use of three distinct coping strategies and in associations between those strategies, stress, and symptoms of depression. Women were found to slightly use more social support seeking than men.

Furthermore, the minimal insignificant difference was noted with regard to the use of avoidance ways of coping with female orphans showing more inclination on avoidance ways of coping than male orphans. This suggests that when female orphans avoid dealing with their situations more than male orphans. By contrast, the study done by Felsten (1998) discovered that men are more likely to experience situations where they are made to ignore even though it is difficult to do so; while women are more likely to react to emotional distress by thinking over their problems.

This research study has revealed that there is a significant difference with regard to the ways of coping by home language. This implies that home language has direct influence in the ways of coping used by HIV/AIDS. Tshivenda speaking individuals were found to use more of avoidance ways of coping than Pedi and Xitsonga speaking individuals. This implies that Tshivenda speaking individuals develop more negative thoughts towards their situations than Pedi and Xitsonga speaking individuals. The same trend was noticed on the use of behavioural ways of coping where Pedi speaking individuals were found to use behavioural ways of coping more than Xitsonga and Tshivenda speaking individuals. This could mean that Pedi speaking individuals do not seek emotional support as do Xitsonga and Tshivenda speaking individuals. In addition, Xitsonga speaking individuals were found to use more avoidance ways of coping than Pedi and Tshivenda speaking individuals. This suggests that Xitsonga speaking individuals avoid facing the reality of their situations.

Religious coping refers to the use of religious beliefs or practices to cope with stressful life circumstances. A study done by Abernethy, Chang, Seidlitz, Evinger & Duberstein (2002) discovered that orphans who indicated that religion is not important reported more depression, whereas those who found religion moderately important reported less depression. The findings of this study show no significant difference with regard to the ways of coping by religion. This could mean that orphans who believe in Christianity are likely to use ways of coping the same way as those who believe in traditional religion. However, a slight difference was observed with regard to the use of cognitive ways of coping, with orphans who believe in traditional religion showing more inclination to the use of cognitive ways of coping than orphans who believe in Christianity. This suggests that orphans who adhere to traditional belief think negatively about their situations more than orphans who are Christians. A slight difference was also noticed on the way orphans who believe in Christianity and those who believe in traditional religion use behavioural ways of coping. Orphans who believe in Christianity were found to use behavioural ways of coping more than traditional believers. This means that orphans who believe in Christianity prefer seeking emotional support more than those who believe in traditional religion.

In addition, insignificant difference was shown in the use of avoidance ways of coping. Orphans who believe in traditional religion were more likely to use avoidance ways of coping less as compared to those with who believe in Christianity. This suggets that orphans with traditional belief avoid their situations more than orphans who are Christians. Previous investigators who have studied children and death have focused on cognitive aspects of grief, and on the child's innate search for meaning. None has explored the specific role of spirituality as coping mechanism for grieving children (Makoae, *et al*., 2008).

This study revealed no significant difference between the ways of coping by number of siblings. This implies that number of siblings does not have an influential role on the ways of coping used by HIV/AIDS orphans. Nonetheless, an insignificant difference was found with regard to the use of cognitive ways of coping. Orphans with many siblings were found to use cognitive ways of coping more than orphans with fewer siblings. This means that orphans with more siblings think negatively about their situations more than orphans with fewer siblings.

Another slight difference was noted on the use of behavioural ways of coping where orphans with one sibling and those with five and more siblings were found to use behavioural ways of coping more than orphans with three and four siblings. This implies that orphans with one and five and more siblings prefer to seek emotional support when they are going through difficult times than orphans with three and four siblings. Furthermore, another slight difference was noted with regard to the use of avoidance ways of coping; with few siblings likely to use more avoidance ways of coping as compared to those with more siblings. By implication, orphans with few siblings avoid dealing with their situations more than orphans with many siblings. No substantial literature was found to support these findings, however.

The findings of this study show no significant difference with regard to the ways of coping by level of education. This suggests that level of education does not have an influential role on the way HIV/AIDS orphans use ways of coping. However, a minimal difference was found with regard to the use of cognitive ways of coping, wherein orphans who are in secondary level were found to use more cognitive ways of coping than those who are in primary level. Possibly, this could mean that orphans who are in secondary level have more negative thoughts than those who are in primary level. A slight difference was also noted on the use of behavioural ways of coping. Orphans who are in primary level were found to use more behavioural ways of coping than those who are in primary level. This suggests that orphans who are in primary level prefer to seek emotional support more than those who are in secondary level. In addition, with regard to the use of avoidance ways of coping, orphans who are in secondary level were found to use avoidance ways of coping more than those who are in primary level. This could suggest that orphans who are in secondary level avoid dealing with their situations more than those who are in primary level. There was no relevant evidence to support these study findings. However, the study done by Ramezanzadeh, Aghssa, Abedinia, Zayeri, Khanafshar, Shariat & Jafarabadi (2004), show that depression decreases more steeply for girls than for boys as the level of education increases.

6.6 CONCLUSION

The findings of this study of showed that HIV/AIDS orphans suffer from sadness, helplessness, anger, guilty, aggression and frustration that often lead to withdrawal and subsequent depression. This is because of the traumatic experience they undergo when taking care of ill parent (s) and watching them die. Depression is a vicious circle that could further isolate these children and continue to perpetrate the pattern. Quantitative study findings acknowledged that HIV/AIDS orphans experience moderate to severe depression. With regard to the relationship between depression by demographics, the findings of the study show no significant difference between the experiences of depression by the following demographics: gender, number of siblings, and level of education. However, the findings of the study have further revealed some significant differences between the experiences of depression by the following demographics: age, home language, and religion.

A qualitative study of the relationship between caregivers and HIV/AIDS orphans was explored and it was discovered that HIV/AIDS orphans do not perceive the relationship with their caregivers as being supportive. Furthermore, the findings of this study discovered that mingling with non-orphaned peers is emotionally distressing to HIV/AIDS orphans. It was also discovered that HIV/AIDS orphans enjoy a significant friendship with other orphaned peers. Lastly, the qualitative study discovered that HIV/AIDS orphans lack many adults, whom they can trust and be able to express their feelings, leading them to finding their own ways of coping with grief.

Quantitative study findings have further revealed that HIV/AIDS orphans prefer using more of cognitive and avoidance ways of coping than behavioural way of coping. With regard to the relationship between ways of coping by demographics, the findings of this study show that there is no significant difference between the ways of coping by the following demographics: age, gender, religion, number of siblings, and level of education. Yet, a significant difference between the ways of coping by demographics was found only on home language.

CHAPTER 7

RECOMMENDATIONS FOR FUTURE RESEARCH, CONCLUSION AND LIMITATIONS OF THE STUDY

7.1 INTRODUCTION

This chapter covers recommendations for future research and conclusion, as well as the limitations of this study.

7.1.1 Recommendations for future research and conclusion

Findings in this study showed that, HIV/AIDS orphans suffer from sadness, helplessness, anger, guilty, aggression and frustration that often lead to withdrawal and subsequent depression as a result of traumatic experience they undergo when taking care of their incapable ill parent(s) and watching them die. Since this study has focused more on depression, it is recommended that the focus for future research should explore other psychological difficulties experienced by HIV/AIDS orphans such as anxiety, post traumatic disorder, conduct disorders, and other related disorders.

Furthermore, findings revealed that HIV/AIDS orphans experience and perceive the relationship with their caregivers as sore and inconsiderate; it is thus recommended that future research focus on HIV/AIDS orphans and caregiver relations (e.g., extended family members). This could encourage caregivers to have a supportive and compassionate relationship with HIV/AIDS orphans.

Findings further suggested that non-orphaned peers have negative attitudes towards HIV/AIDS orphans. HIV/AIDS orphans described mingling with non-orphaned peers as emotionally distressing due to the stigma attached to HIV/AIDS; by contrast, they enjoy a significant friendship with other orphaned peers. It is recommended therefore, that future research be focused on studying the gaps that exist between non-orphaned children and HIV/AIDS orphans so as to uproot the underlying stigma to create empathy and non-judgemental relationship towards HIV/AIDS orphans.

In this study, only Beck's Depression Inventory was used to measure the levels of depression. it is recommended that future research should focus on other scales to measure depression.

With regard to strategies of coping, HIV/AIDS orphans were found to be inclined to using more of cognitive and avoidance ways of coping than active-behavioural ways of coping. Recommendations for future research could be around investigation of more efficient coping strategies for these orphans. Studies should also focus on the effective use of cognitive strategies as well as on other coping strategies.

Significant differences between the ways of coping by demographics was found only on home language with Pedi speaking orphans using more of behavioural ways of coping followed by Xitsonga speaking orphans and then, Tshivenda speaking orphans. It is then recommended that the focus of future research should explore more on factors that make Pedi, Xitsonga, and Tshivenda speaking HIV/AIDS orphans differ in their use of coping strategies.

Since it was discovered that HIV/AIDS orphans experience psychological difficulties, it is recommended that they should be referred to professional counsellors or therapists for counselling where possible, and their conditions should be regularly monitored. It is recommended that since the sample size of this study is small future research should consider large population.

7.1.2 LIMITATIONS OF THE STUDY

This research study was conducted in three orphanage centres in Limpopo Province. Therefore, the outcomes of the study may not be generalizable over HIV/AIDS orphans population in other provinces. The sample size of this study was small, as such the results should not be generalized. This research study also focused only on one race which is black. The results therefore cannot apply to HIV/AIDS orphans of other racial groups. In this study only one scale of measuring depression (BDI) was utilised, thus the results should be interpreted with caution as the use of other scales might show different results.

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Appendix i

SECTION A

Informed consent

I am Nemadondoni Ndivhudzannyi, an MA student in Clinical psychology at the University of Limpopo. I am conducting this study to understand the challenges or difficulties encountered by HIV/AIDS orphans when staying without their biological parents. The participants will include HIV/AIDS orphans between ages 6 and 18. All the information that is gathered in the survey will be treated with the utmost confidentiality and you will not be identified by name.

Your participation in this interview is voluntary and you are free to withdraw at anytime but your participation will be highly appreciated.

Are you happy to participate in the study? Do you have any question?

Could you please sign the consent form?

Consent form

I have heard the details of the study explained to me. I understand that all the information gathered will be held in strict confidence. I am aware that I may withdraw from the study at anytime.

Signed (participant)..
Signed (researcher)..
Date..

Appendix ii

SECTION A

A. BIOGRAPHICAL DATA

Instruction

Thank you for being part of this study. Kindly answer the following questions sincerely and honestly by marking your response with an x in the space provided.

Age

05-12	
13-18	

Gender

Male	
Female	

Home language

Sepedi	
Tshivenda	
Xitsonga	

Religion

Christian	
Muslim	
Islam	
Traditional	
Others (Specify)	

Number of Siblings

One	
Two	
Three	
Four	
Five & more	

Highest level of Education

No formal education	
Primary level	
Secondary level	

SECTION B

Beck's Depression Inventory (BDI)

Instruction

Answer the following questions by marking the appropriate response with an x in the space provided.

	Yes	**No**
1. Do you feel sad or unhappy that you cannot stand it?		
2. Do you feel that the future is hopeless and that things cannot improve?		
3. Do you feel that you are a complete failure as a person?		
4. Do you get dissatisfied or bored with everything?		
5. Do you feel guilty?		
6. Do you feel that you are being punished?		
7. Do you feel disappointed in yourself?		
8. Do you blame yourself for everything bad that happens?		
9. Do you feel like killing yourself when you have the time?		

10. Do you cry more than usual?		
11. Do you become annoyed or irritated more easily than you used to be?		
12. Have you lost interest in other people?		
13. Do you have great difficulty in making decisions?		
14. Do you worry that you look older and unattractive?		
15. Do you have to push yourself very hard to do anything?		
16. Do you have difficulty with falling asleep?		
17. Do you become too tired to do anything?		
18. Have you lost appetite?		
19. Have you lost much weight, lately?		
20. Are you worried about your health than usual?		
21. Have you noticed any recent change in your interest in sex?		

SECTION C

Ways of Coping Scale (WCS)

Instructions

Mark the correct response that best describes the way you cope with an x in the space provided.

Active – Cognitive Strategies			
	Not at all	**Sometimes**	**Regularly**
Prayed for guidance and/or strength			
Prepared for the worst			
Tried to see the positive side of the situation			
Considered several alternatives for handling the			

problem			
Drew on my past experiences			
Took things a day at a time			
Tried to step back from the situation and be more objective			
Went over the situation in my mind to try to understand it			
Told myself things that helped me feel better			
Made a promise to myself that things would be different next time			
Accepted it, nothing could be done			
Active – Behavioural Strategies			
	Not at all	**Sometimes**	**Regularly**
Tried to find out more about the situation			
Talked with spouse or other relative about the problem			
Talked with friend about the problem			
Talked with professional person (e.g. doctor, lawyer, clergy)			
Got busy with other things to keep my mind off the problem			
Made a plan of action and followed it			
Tried not to act too hastily or follow my first hunch			
Got away from things for a while			
I knew what had to be done and tried harder to make things work			
Let my feelings out somehow			
Sought help from persons or groups with similar experiences			
Bargained or compromised to get something positive from the situation			

Tried to reduce tension by exercising more			
Avoidance Strategies	**Not at all**	**Sometimes**	**Regularly**
Took it out on other people when I felt angry or depressed			
Kept my feelings to myself			
Avoided being with people in general			
Refused to believe that it happened			
Tried to reduce tension by drinking more			
Tried to reduce tension by eating more			
Tried to reduce tension by smoking more			
Tried to reduce tension by taking more tranquilizing drugs			

Appendix iii

SECTION A

Interview guide

The researcher will first give an explanation about the nature and purpose of the study. The researcher will also obtain permission to use an audio-tape from the participants. Furthermore, the researcher will discuss the issue of confidentiality of the information obtained during interview with the participants.

QUESTIONS FOR HIV/AIDS ORPHANS

How do HIV/AIDS orphans and their caregivers relate?
How do HIV/AIDS orphans feel about living without their biological parents?
What are the attitudes of children living with their biological parent(s) towards HIV/AIDS orphans?
How do HIV/AIDS orphans cope with the situation?

Appendix iv

UNIVERSITY OF LIMPOPO

ETHICS COMMITTEE

APPLICATION FOR HUMAN EXPERIMENTATION

(Completed forms, preferably typed, should reach the Chairperson of the Ethics Committee at least one month before the experimentation is due to start. Projects where the researcher only receives human material for analysis without actually being involved with collection from the experimental group must still register in the normal way. Researchers who are involved with projects which have been approved by Ethical Committees of other Institutions should provide this Committee with the necessary information and provide it with a shortened protocol for approval)

PROJECT TITLE: Psychological difficulties encountered by HIV/AIDS orphans in Limpopo province.

PROJECT LEADER: NEMADONDONI NDIVHUDZANNYI

DECLARATION

I, the signatory, hereby apply for approval to execute the experiments described in the attached protocol and declare that:

1. I am fully aware of the contents of the Guidelines on Ethics for Medical Research, Revised Edition (1993) and that I will abide by the guidelines as set

out in that document (available from the Chairperson of the Ethics Committee); and

2. I undertake to provide every person who participates in any of the stipulated experiments with the information in Part II. Every participant will be requested to sign Part III.

Name of Researcher: NEMADONDONI NDIVHUDZANNYI

Signature:

Date: 05/11/2007

PROJECT TITLE :(*it is compulsory for the researcher to complete this field before submission to the ethics committee*)

Psychological difficulties encountered by HIV/AIDS orphans in Limpopo Province.

PROJECT LEADER: (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)

NEMADONDONI NDIVHUDZANNYI

APPLICATION FOR HUMAN EXPERIMENTATION: PART II

Protocol for the execution of experiments involving humans

1. Department: Psychology

2. Title of project: Psychological difficulties encountered by HIV/AIDS orphans in Limpopo Province.
3. Full name, surname and qualifications of project leader: NEMADONDONI NDIVHUDZANNYI, BA (Hons) PSYCHOLOGY

4. List the name(s) of all persons (Researchers and Technical Staff) involved with the project and identify their role(s) in the conduct of the experiment:

Name: NEMADONDONI N	Qualifications:BA(Hons) psychology Responsible for: Interviewing the participants
Name: Staff members (Reakgona Drop-In Centre, Itumeleng Community Orphanage Centre, and Church of Christ Community Centre.)	Responsible for: organizing participants

5. Name and address of supervising physician: Prof T-A.B Mashego

6. Procedures to be followed: A centralized office at Itumeleng Community Orphanage Centre, Reakgona Drop-In Centre, and Church of Christ Community Centre will be used for operation to prevent interruptions of the sessions and to enhance more security for the participants.

7. Nature of discomfort: Emotional provocation

8. Description of the advantages that may be expected from the results of the experiment: Emotional relief through the expression of feelings.

Signature of Project Leader:
Date: 05/11/2007

PROJECT TITLE: (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)
Psychological difficulties encountered by HIV/AIDS orphans in Limpopo Province.

PROJECT LEADER: (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)
NEMADONDONI NDIVHUDZANNYI

APPLICATION FOR HUMAN EXPERIMENTATION: PART II

INFORMATION FOR PARTICIPANTS

1. You are invited to participate in the following research project/experiment:

   (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)
   Psychological difficulties encountered by HIV/AIDS orphans in Limpopo province.

2. Participation in the project is completely voluntary and you are free to withdraw from the project/experiment (without providing any reasons) at any time.

3. It is possible that you might not personally experience any advantages during the experiment/project, although the knowledge that may be accumulated through the project/experiment might prove advantageous to others.

4. You are encouraged to ask any questions that you might have in connection with this project/experiment at any stage. The project leader and her/his staff will gladly answer your questions. They will also discuss the project/experiment in detail with you.

5. Your involvement in the project.

The nature of the specific project/experiment, the alleged risk-factors, factors that might possibly cause discomfort, the expected advantages and the known and/or likely side-effects should be explained under this item.

This study aims to investigate the psychological difficulties encountered and ways of coping by HIV/AIDS orphans. As a result emotional feelings may be evoked. However, the participants may feel relieved when expressing those feelings.

This section is to be drawn up by the researcher and must be submitted together with the application form.

(*it is compulsory for the researcher to complete this field before submission to the ethics committee*)

UNIVERSITY OF LIMPOPO
ETHICS COMMITTEE

PROJECT TITLE: Psychological difficulties encountered by HIV/AIDS orphans in Limpopo province.

PROJECT LEADER: NEMADONDONI NDIVHUDZANNYI

CONSENT FORM

I, Nemadondoni Ndivhudzannyi hereby voluntarily consent to participate in the following project: (*it is compulsory for the researcher to complete this field before submission to the ethics committee*)

I realise that:

1. The study deals with the emotional experiences (e.g. effect of certain medication on the human body) (*it is compulsory for the researcher to complete this field before submission to the ethics committee*);

2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage;

3. The Ethics Committee has approved that individuals may be approached to participate in the study;

4. The experimental protocol, i.e. the extent, aims and methods of the research, have been explained to me;

5. The protocol sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage;

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation;

7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research;

8. Any questions that I may have regarding the research or related matters will be answered by the researchers;

9. If I have any questions about, or problems regarding the study, or if I experience any undesirable effects, I may contact a member of the research team;

10. Participation in this research is voluntary and I can withdraw my participation at any stage;

11. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor;

12. I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the

above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

SIGNATURE OF RESEARCHED PERSON SIGNATURE OF WITNESS

SIGNATURE OF PERSON THAT INFORMED SIGNATURE OF PARENT/GUARDIAN
THE RESEARCHED PERSON

Signed at ____this _____day of 2006