THE CHALLENGE EXPERIENCED BY ORPHANS AND CHILD-HEADED
FAMILIES IN TOP VILLAGE, MAFIKENG, NORTH WEST PROVINCE.

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Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have no previously in its entirety or part submitted it at any University for a degree.

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Date:

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ABSTRACT

The question, Is our political and religious leaders doing enough to deal with this problem of orphans and child-headed families in our country? However, in the North West province the intervention of NGO's such as Tsibogang Christian Action Group which was founded in 2002 with its headquarters in Lomanyaneng, Mafikeng play an important role in assisting orphans and child-headed families. Tsibogang is interdenominational organization, operating in the area of the Central District (Ngaka Molema District Municipalities) of the North West Province.

The newest project of Tsibogang Christian Action Group is Godisang Orphan Care Project. It runs a computerized data base with more than 1000 orphans and vulnerable children. They visit various homes in the villages, taking orphans and child- headed families to Home Affairs to be registered for birth certificates, and assist those who are older to apply for Identity documents and also start to apply for child social grants.

There are currently 12,1million AIDS orphans in Sub-Saharan Africa alone equating to 80% of the Worlds Children who have been orphaned by AIDS. This is too much for any society to cope with in traditional ways, let alone a society eroded by AIDS (http://www.orphansknowmore.com/the-statistics). However, the problem continues to grow, by the year 2010 UNAIDS (2004) predicts orphan population in excess of 25million in Sub-Saharan Africa. In South Africa there are 1.2million AIDS Orphans in 2005, (www.avert.org/aids orphans.htm) and 83 000 child-headed household.

OPSOMMING

Die vraag, "Doen ons politieke en religieuse leiers genoeg om met die problem van weeskinders en families met kinders as hoof van die huishouding in ons land?"

In die Noordwes Provinsie het die tussenbeidetreding van die NRO's soos bv, die Tsibogang Christelike Aksiegroep, welke gestig was in 2002 met sy hoofkantoor in Lomanyaneng, Mafikeng, 'n belangrike rol gespeel in die bystand van weeskinders en waar kinders as hoof van 'n huishouding staan. Tsibogang is 'n interkerklike organisasie, welke opereer in die Sentrale Distrik (Ngaka Modiri Molema Distrik Munisipaliteit) van die Noord-wes Provinsie.

Die nuutste projek van Tsibogang Christelike Aksiegroep is "Godisang Wees Sorg Projek". Dit bestuur 'n gerekenaariseerde databasis met meer as 1000 wees-en kwesbare kinders. Die organisasie besoek verkillende huis in die "statte", neem weeskinders en die kinders wie as hoof staan van huishouding na die Departement van Binnelandse Sake om geregistreer te word vir geboortesertifikaate, en staan ook daardie ouer persone by wie aansoek wil doen vir identiteitdokumente as ook vir kinderwelsyn toelae.

Daar is tans 12.1 miljoen Vigs weeskinders in Sub-Sahara Afrika alleen welke gelyk is aan 80% van die wereldse kinders wie wees gelaat is deur VIGS. Dit op sigself is te veel vir enige gemeenskap om meet e handel met 'n tradisionele uitgangspunt, wat nog van 'n gemeenskap wat kwyn weens VIGS.
(http://www.orphansknowmore.com/the-statistics).

In elk geval, neem die problem steeds toe en UNAIDS(2004) voorspel dat die getal weeskinders teen 2010 meer as 25 miljoen in die Sub-Sahara Afrika streek sal wees. In Suid Afrika was daar as 1.2 miljoen VIGS wesies in 2005, (www.Avert.org/aids orphans.htm) en 83 000 huishoudings van wie kinders die hoof is.

1. INTRODUCTION

The battle against AIDS in the villages and hamlets of rural South Africa is made more difficult by the inability of provincial Governments to roll-out basic services to those areas. The problem is of such a magnitude that the Minister for Social Development. Dr. Zola Skweyiya has seriously considered resigning from politics over it, (Doolan 2006:78). HIV/AIDS is still not perceived as a fundamental development issue, a basic health focus still persists. This continued health focus appears to be based on the lack of substantive social and economical data and a lack of understanding of the impact of HIV/AIDS epidemic on social, economical and cultural development in the sub-region, (Qubuda, 2007). The reason is that the virus is extremely aggressive now lately, which means in short, the province is urged to go an extra mile in this regard.

Whilst the strategic plans are to be implemented to fight the pandemic, projects which alleviate the poverty (one of the most contributing factors to HIV/AIDS) are very important. Education is an umbrella and must be given priority number one. However, balance of theory and practice should always be maintained, for example; the managers should not only be academically advanced but also be exposed to the grassroots level to know how the affected and the infected cope with the pandemic. Some of the provinces have done a remarkable job; an awards ceremony to honour remarkable people taking the bull by the horns, added to the inspirational value of the event. The Africa Centre, through (Du Toit 2007), gave an award as a token of appreciation to the Education Department of Mpumalanga, because of their ongoing investment in their educators. For the past four years they have sent 330 students to enroll in the Africa Centre's Postgraduate Diploma in HIV/AIDS Management. They also encourage their educators to further their studies in other disciplines. Ms Ntombi Mxenge and Mr Sipho Sukati received the award on behalf of the department (Du Toit, 2007).

The Western Cape Department of Health acknowledged and graced the event by giving an award to the Swellendam sub-district for their exceptional voluntary counseling and testing services. Their success recipe is multi-faceted and includes lay counselors working outside the health facilities and workplace blitzes and campaigns,

targeting specific communities. Kruger received the award on behalf of the Swellendam sub-district (Du Toit, 2007).

"It is events like these that stand out as a beacon of light in a country where many people see the battle against HIV and AIDS as hopeless. The established and talented artists who take the time and effort to make a difference and the people who give everything to change the situation around HIV and AIDS for better, show that it is never too late to make a positive turn around and to restore a nation's dignity, step by step," said (Du Toit;   2007). Understanding and responding to the impact of HIV/AIDS on children, depends on having as much information as possible (Saving Children 2005:54).

Doolan (2006:78), also states that the scourge of HIV/AIDS has led to some very distinctive and difficult to-deal-with problems which are not unique to South Africa, but do not exist as major concern in countries with more developed social security infrastructures. One of the most poignant and pitiful of these is the phenomenon of child-headed households and orphans. According to Doolan (2006:78) the death of parents, as a result of HIV/AIDS related diseases, has meant that the burden of keeping the house falls on the older survivors, who in several instances are still pre-adolescent. This in itself then leads to some even more sinister problems, for example; the first of these is education, or rather the lack thereof.

South Africa is experiencing high rate of orphanage due to HIV/AIDS. This is emphasized by the Khomanani Campaign (2001-2004:16), that one of the most tragic consequences of the HIV/AIDS epidemic is the large number of children left without care and support of adults. Another problem is nutrition; Doolan (2006:78) argues that lack of proper nutrition is a further contributor to the incidence of HIV, whereby abused children cannot hope to fight the infection without a regular and balanced diet.

In the light of the 16 days of activism for "No Violence against Women and Children", Western Cape Premier Ebrahim Rasool said that overcoming patriary is the key to the way forward in the battle against HIV and AIDS: "The liberation and assertion of the equalization of women is essential for us to make the progress we

should be making," and also made an appeal to all for meeting the challenges of HIV and AIDS with a sense of humanity and compassion (World AIDS Day, 2007).

According to Barnett and Whiteside (2002), changes in mortality and life expectancy result from the many hundreds and thousands of individual deaths. The impact of individual ill health and death depends on who the individuals are, their place in society and the resources they, their households, communities and societies have available.

There are dilemmas: in how health is perceived and its costs, a tension between the pressing and urgent demands of our own or our family's ill health and the more measured approach we adopt when confronted with the opportunity costs of aggregate health expenditure. We value others' health differently; or perhaps more rationally. We accept that some interventions are costly and not available for all. Politics decides public health expenditure in the face of competing demands. This is an important issue because it raises two questions:

• Do we perceive individual health and welfare as just that, individual, or take account of the wider contributions- often non-economic which individuals make to their societies?

• Do we limit ourselves to individual health or attend to issues of public health?

This is where the impact is felt first and worst. But it is also here, beyond the obvious clinical and medical consequences, that it is hardest to measure.

In the absence of treatment, infected individuals can expect to experience periods of illness that increase in frequency, severity and duration. A few individuals may, through a combination of appropriate lifestyle, good nutrition and good luck, not fall ill. However for most, as CD4 cell counts decline, so does their state of health (Barnett & Whiteside, 2002:184)

Thus individuals who are infected always confront an impact on their health. In most cases they also face an impact on the resources they have at their disposal. Your individual resources may not be affected if you are fortunate enough to live in a

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society where care is provided free by the state (and this is currently not the case in all poor and many rich countries) or if you have insured medical benefits (Barnett & Whiteside, 2002: 184)

The reality for individuals is that, as with their chance of being infected, the impact of the disease will depend on their circumstances and the resources they can command. But individuals exist in networks of relationships. How does the loss of an individual affect the broader society and community in which he or she lives and functions? Impact will depend on who that individual is, where he or she fits in the communities and society and how replaceable he or she is. A key idea is 'social reproduction': the uncosted and literally invaluable labour and effort that goes into reproducing the life ways of our households, communities, institutions and even nations. And the same applies to all the other symbolic and practical activities that reproduce society and cultures from day to day, year to year and across time.

Because HIV is sexually transmitted, it clusters in households. This has given rise to some misconceptions about the impact. Average households in communities will not be affected. This can be illustrated with a simple example. In a village of 100 households with an average of three adults per household, in a region with 10% HIV prevalence and a mature epidemic, we would expect to see three to five adult deaths per annum. It is likely that only one or two households will experience illness or death in any one year. It is possible that these households will dissolve and so not to be counted (Barnett and Whiteside, 2002: 182).

The effects of illness and death in households depend on:
• The number of cases the household experiences-this is where clustering becomes important
• The characteristics of the deceased individuals: age, gender, income and cause of death
• The household's composition and asset array
• The community's attitudes towards helping needy households and the general availability of resources – the level of life – in that community

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- The broader resources available for assistance to households – from the state or from community-based organizations (CBOs) and Non-Governmental Organizations (NGOs).

The measurement of impact on households during illness is difficult. Illness ranges from not feeling very well to complete inability to function. It is difficult to unravel these subtleties with survey methods because:

- Even in the worst affected areas adult illness and death is comparatively rare
- The unit of measurement, the household, means that those that dissolve or disappear are lost to the research
- Surveys of households' will not collect data on complex relations between clusters of households
- The epidemic and its impact are still evolving. The HIV epidemic has apparently run its course in Uganda and Thailand. In all other countries HIV prevalence continues to rise and the number of AIDS related illnesses and deaths will follow suit some years hence. Thus surveys are trying to measure and quantify something that is still to happen (Barnett and Whiteside: 2002).

It has been argued by some that an entity called 'the extended family' will absorb the orphans and destitute, created through AIDS-related mortality. This view has been heard from people ranging from senior policy makers in international agencies to politicians in Africa, Asia and people in local communities. It is now heard less as the full effects of the epidemic become apparent (Barnett & Whiteside, 2002)

The extended family:
- is a variable, it is dynamic and can become more or less extended depending on resource availability
- is ideological, it is something people want to believe because it validates their traditions
- is ideological because belief in it, relieves politicians of responsibility for thinking through the implications of the epidemic
- reaches a point where it can no longer cope.

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1.1 Background

In other countries for example, Zimbabwe orphans and child-headed families are not protected and well cared for at all.   Starving and assault is common. In other instances, abuse in Zimbabwe which is very rife now lately, it contributes to orphanage and child-headed families because they are vulnerable to rape and kidnapping. Some adults are detained or being assaulted to death which always aggravate the vulnerability of children.

www.timesonline.co.uk/tol/news/world/Africa/article/2511698.ece.

Drimie (2004) their intervention involve ensuring food security for orphans and vulnerable children in Swaziland (Indlunkulu project, February 11)

Magome, K. (ed) The W.K Kellogg Foundations Orphans and Vulnerable Children Projects: In 2002, the Human Science Research Council was commissioned by the WK Kellogg Foundation to develop and implement a five year intervention project focusing on Orphans and Vulnerable Children (OVC) in South Africa.   In collaboration with several partner Organizations, the project currently focus on how children, families and communities in Botswana, South Africa and Zimbabwe and coping with poverty and HIV/AIDS challenges.

1.2 Household reproduction, size and structure

What effect does the epidemic have on household reproduction, the household's ability to sustain itself from day to day and to reproduce itself over time? The demographic impacts on households affect their ability to reproduce themselves at all. Households with adult female infections experience lower birth rates and higher infant and child mortality rates. In households where a parent or both parents have AIDS, the likelihood is that fewer children will be born and that a significant proportion of those who are born will die in infancy or early childhood. Inevitably this means that the personnel of the household are not replaced and that the life ways and traditions of that household are not carried forward (Barnett & Whiteside, 2002).

Deaths in individual households have implications for other households because of their interdependence. Rugalema (1999) shows how coping mechanisms become

increasingly weakened as more households in a community are affected and communal support networks are less and less able to cope.

Affected households will try to adapt. One way in which they do this is by changing their composition. Three key points must be made:

- Societies where extended households are the rule or where clusters of households operate together to pursue a common livelihood strategy may be more robust in the face of adult death.
- Sending children to stay with relatives, means the effect of the adult death will be felt beyond the sending family. Whoever takes care of the children can expect to expend resources.
- Orphans need care, either in other families or through some form of public support. Increasingly they do not receive this support (Barnett & Whiteside: 2002).

Orphans are part of all communities. There will always be children who have had the misfortune to lose parents. In many poorer countries families routinely took in children from the wider family. In rich countries institutions were available to care for these children. The scale of AIDS orphaning is such that these coping mechanisms are collapsing in the poor world. This stress is evidenced by the growing number of street children around the developing world, (Barnett & Whiteside: 2002)

2. STATEMENT OF THE PROBLEM

A child running a home and taking responsibility for a number of siblings, cannot hope to complete basic secondary education-always assuming that the facilities are available without a firm grounding in literacy. It is even more difficult to educate the AIDS orphans on the scourge of the disease, for example many young people, usually girls turn to commercial sex worker (CSW) as a source of income (Health 24.com, 2006).

It hurts to realize how poverty can mess up our South African children (future leaders) by exposing their lives to danger, which mostly leaves results of being HIV positive. For example; child abuse, rapes and child labour, etc.

2.1 Child abuse

This is not a new phenomenon, what is new is the recognition, reporting and scientific study of and the intervention in child abuse. It was the seminar paper by the pediatrician Henry Kemp and his colleagues on battered child syndrome that initiated the scientific and professional study of child abuse (Wolfe & Levy 1999; 1989). Child abuse has long existed because children, by their very nature and immaturity, require considerable care, guidance and control from adults, yet many adults including parents, are ill prepared for this vital, challenging and stressful role (Wolfe, 1999). Child abuse is defined as actions or omissions by a parent, guardian, and a caregiver, and any adult, intentional and /or accidentally that harms, endanger and impair a child's physical, mental emotional health, well being and cognitive development. A child is generally defined, according to the UNO'S Child Charter, as a person below the age of 18 years. Child abuse is a generic phrase that covers the whole range of behavior patterns whether anchored by law or custom, which are in some way injurious to the child's economic, emotional or moral being, (Baruah, 2003).

2.2 Child abuse may be identified in four types;

Child neglect: failure or omission by a parent, guardian or caregiver, to provide for the child's basic needs. Physical child abuse: an abuse in terms of visibility, detection, police reports, media coverage and research. It is also characterized by infliction including punching, kicking, biting, shaking, beating, choking, and hair pulling and burning. The severity and nature of injuries resulting from physical abuse may range from minor bruises and lacerations, to moderate scars and abrasions to severe burns, sprains, broken bones and even death (Wolfe, 1999).

Child sexual abuse: the most recently recognized and debated form of child abuse, (Levy, 1989). It involves developmentally immature children in sexual activities they do not truly understand, or which they are unable to give informed consent, or that violates social taboos (Levy, 1989). Sexual child abuse acts include fondling, touching or kissing a child's sexual organs or making a child to fondle adult, exposing

children to pornography and sexual act with the child through vaginal, anal, or object penetration, oral sex and child prostitution.

Emotional Abuse: also known as verbal, mental and psychological abuse is present in, and is culmination of all types of child abuse. Emotional abuse is characterized by acts or omissions by parents, caregiver or any adult and children such sibling school bullies and peers that cause serious behavioral, cognitive, emotional disorders. Emotional abuse can range from a simple occasional shouting and insult, to habitual scape-goating, belittling, and child kidnapping (Wolfe, 1999 and www. helpguide.org). Emotional abuse exists, to different degrees in all forms of child abuse. Because it does not leave physical evidence, emotional abuse is difficult to detect, but can be devastating to the victim and his family.

Child labour: It is a work that harms and interferes with the child's rights to education, may harm the physical health especially work with very hazardous and dangerous chemicals and machinery, work which undermines the child's psychological social and moral development. The orphans and child-headed families may be exploited easily as a part of a desperate effort to survive extreme poverty. There are some types of child labour that are especially damaging. These have been recognized internationally by many countries that subscribe to the International Labour Organization (Child Labour Programme of Action: 2006:45)

International Labour Organization's Convention No. 182 on Worst Forms of Child Labour. South Africa has signed the Convention and is committed to taking measures within a specified period of time to eliminate the worst forms of child labour. For example, the sale of a child, child trafficking, child labour to pay back a debt, forced a compulsory labour including forced participation in armed conflict, work that country defines as hazardous because it poses a high risk of harm to the health, safety and morals of children.

South Africa has developed draft regulations on hazardous work by children. While children aged 15-17 years may work, the regulations propose to prohibit them from; work with dangerous chemicals and machinery work involving heavy loads, work before 5 am or after 6 pm, except for child- minding and working in shops or

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restaurants which are allowed until 23h00, provided that the child need not be at school the following day and that safe transport home is provided. Work for more than 40 hours a week, and work in a shebeen or in a bar. (Child Labour Programme of Action: 2006:45).

Latest statistics (2005) indicate that more than 60 children are raped everyday, and these are the only reported cases. It is highly likely that child rapist would be sexually deviant as well, and would most likely pass the HIV virus on to their victims.

The purpose of this research is to determine the challenges experienced by orphans and child-headed families.

The following are the research questions guiding this study:

- Do the orphans and child-headed families know and understand about HIV/AIDS?

- What type of care and support could be given to HIV/AIDS infected people?

- What are the challenges experienced by orphans and child-headed families?

- What are the views of relevant stakeholders on the challenges experienced by orphans and child-headed families?

3. AIMS AND OBJECTIVES

The aim of this study is to investigate the challenges experienced by orphans and child-headed families. The following are the objectives of this study:

- To find out the HIV/AIDS knowledge and understanding on the orphans and child-headed families.

- To find out the type of care and support given to HIV/AIDS infected people.

- To get the views and perceptions about the orphans and child-headed families from the social workers and health practitioners.

4. RESEARCH HYPOTHESIS

The study tests the hypothesis whether it is true that the orphans and child-headed families experience some challenges.

5. LITERATURE REVIEW

The lives of millions of children around the world have been assailed by HIV/AIDS as it ravages families, communities, schools, health-care and welfare systems and national economies. Over 11 million children are affected in sub-Saharan Africa. By 2010, more than 25 million children are expected to be orphaned due to AIDS. Orphans are those whom both father and mother died.

Child-headed families are the families which are headed by children of about 12-15 years. Millions of these children are living with dying families or are infected themselves. Orphans and child-headed families are frequently stigmatized by society, exploited, denied affection and protection. This makes them to be more vulnerable to HIV infections and other conditions which may aggravate the situation are:

- Commercial sex work often leads to vulnerability to HIV infections.
- Divorce, death and drugs addiction of the parents are contributing factors towards orphanage and child-headed families.
- HIV/AIDS led to high drop-out rate of learners in schools, and according to the 2003 joint report of the UNICEF, UNAIDS and WHO stated that, because the youth is more susceptible to the diseases and that, over 50% of new HIV infections occur among the 15 to 24 years old youngsters.
- Negative signs such as aggression, bullying, drug and high rate of failure displayed by orphans and child-headed families may affect the community very negatively.

The orphans and child-headed families face challenges such as poverty and HIV/AIDS, which are qualitative, and the extent of the challenges, for example, estimating the number of the HIV infected, is quantitative, Christensen (2007: 184).

In addition, the availability of foster-care grants does go some way towards assisting with the funding of these care-givers, but it is also open to corrupt practices by unscrupulous individuals. The rise in the incidence of child farming (where the alleged foster parent does not spend the funds on the child, but fosters several children

for personal gain), has led to a situation where it has been suggested that foster-care grants should be linked to school registration. This will go a long way towards preventing the abuse of rural children. Stigma towards these orphans and child-headed families is also identified as a barrier to helping.

The unpleasant scenario painted above is underpinned by the fact that most children in South Africa who die before they turn five, succumb to HIV/AIDS (40 percent) and the related diseases of poverty such as diarrhea, respiratory tract infection and malnutrition (approximately 30 percent). www.aidsinfo.co.za

Diminishing poverty means teaching people to become self-sufficient and not always depending on donor funding. Food systems to diminish poverty and to improve nutrition governance can be implemented when national policy makers, political decisions-makers and institution for pro-poor, agriculture, and natural resource management system put into place; appropriate programmes, safe food and water policies, policies to address hidden hunger, quality for poor people and " nutrition transition" in developing countries, interventions for poverty reduction, research on regional food, nutrition and agricultural strategies for developing countries.

South African National Health Minister Dr Manto Tshabalala Msimang is encouraging families to grow their own vegetable garden- even if available space is not bigger than a door. Projects like the annual Nestle' community Nutrition Award help to motivate, applaud and sustain projects such as growing community vegetable gardens that will benefit the very people who grow them. "Give a man a fish and you feed him for a day. Teach him to fish and you feed him for life". (Health and Hygiene: Dec 2005:3 Care for orphans and other vulnerable children volume 16, No 12) www.aidsinfo.co.za

According to Marian Jacobs, 2005 across the globe, concerns about the deteriorating state of the world's children are paralleled by concerns about their rights. Among these, the child's right to survival remains high on the unfinished agenda for promotion and protection of children's rights.

South Africa is widely acknowledged as having one of the most progressive constitutions in the world, with a special Bill of Rights for children. Alongside this provision for children, there are also well-developed, tried and tested means of preventing and treating the common causes of child deaths. Yet child mortality rates remain unacceptably high, with wide disparities between the rich and the poor, and between urban and rural communities. And in this setting, attainment of the rights to survival of all country's children remains elusive. The Saving Children (2005), report makes a valuable contribution to advancing the achievement of these rights. Describing child mortality in South Africa through a database of information from several sites in the country, it sketches a picture which not only characterizes the extent of deaths, but also provides detail and texture of their causes and associations.

This comprehensive account of child mortality is complemented by particularly useful road map of simple actions to be taken towards reducing child deaths.

Focusing on priority conditions such as HIV infection, the report recommends a range of health sector interventions – from high level policy, through education, to bedside clinical practice- related to this and other major causes of children's death in South Africa. The recommendations are simple, focused and detailed and with a pool of essential resources made available at each level of care, the goal of reducing the burden of child deaths in the country is attainable. As child health professionals, this report thus gives us a clear mandate for delivering interventions which are effective in addressing priorities identified by Child PIP, and which can have a lasting impact on child survival.

But we have a further responsibility – not only to heal and care, but also to act as advocates for this practically powerless constituency. Drawing the attention of the broader health and development sectors, and the public at large, to the scourge of child deaths is a challenge to us as advocates for child rights and child survival. Saving Children 2005 is a powerful advocacy tool which can be used from the level of community-based organizations all the way to the portals of parliament

5.1 North West

The Central District (Mafikeng region) consists of five sub-districts: Ramotshere Moiloa, Ditsobotla, Mafikeng, Ratlou and Tswaing. There are four district hospitals; Zeerust, Lehurutshe, Thusong-General DelaRey and Gelukspan. Mafikeng Provincial Hospital (MPH) serves as a District Hospital for Mafikeng sub-district and as level two referral hospital for the smaller hospitals. All five hospitals participate in Child PIP mortality audit.

In Central District hospitals, 180 out of 3 180 admitted pediatric patients died, giving a fatality rate (CFR) of 5,6%. In MPH the total number of medical pediatric admissions was 2 123 with a CFR of 9.5%. The prevalence of severe malnutrition in child deaths has increased from 30% in 2004 to 44% in 2005. In 2005, 27 % of children with severe malnutrition were HIV-infected, 24% HIV- exposed, one child was HIV- negative and the remaining were not tested or had no results.

There were ten cases of TBM and nine cases of military/extra-pulmonary TB. Ten children had hospital-acquired infections. Caregiver-related modifiable factors: The most common modifiable factors were: Delay in seeking care; declining HIV test; and infrequent clinic attendance.

Administrative modifiable factors: The most common factor for Gelukspan was the lack of doctors. Forty-four percent of all children who died had severe malnutrition (compare to 30% in 2004). Of these, 51% were HIV-exposed or HIV infected, 1% was HIV-negative and the remainder was not tested. This shows the tremendous triple burden of HIV: infections (including chronic infections like TB), malnutrition and poverty. The children admitted in 2005 were sicker than in 2004. This also explains the increased case fatality rates.

PMTCT and detailed HIV data were not available in previous versions of Child PIP. The data from the hospitals in Central District demonstrate the crisis in the PMTCT programme, which must be addressed, as well as a tremendous lack of information. Pediatric ART services are being expanded in Central District, and subsequently data collection by health workers about PMTCT should become more rigorous.

Sixty-eight percent of the children who died were clinically HIV stage 111 or IV. Forty percent of the children who died tested HIV-positive and only 4% tested HIV-negative. The remainder was not tested. The availability of PCR testing in Central District should greatly improve the accuracy of HIV testing in children less than 15 months of age.

Pneumonias including PCP were the main killers of children, followed by sepsis, DD and TB. Most of these causes are preventable and treatable. An improvement in adult TB case detection and complete treatment will reduce paediatric TB.

6. RESEARCH DESIGN

To achieve the above mentioned objectives, both qualitative and quantitative approaches will be used. The researcher will choose the method of:

6.1.   Interviews

This study is qualitative because data was be collected by interacting with participants in their natural settings, for example, clinics, orphanage homes and child-headed homes. Interview schedule, semi-structured and face- to-face interview has been conducted. The purpose of the interviews was to gather information from people who are in charge of giving support and care to the orphans and child-headed families. The researcher has interviewed 50 people including 10 social workers, 20 health practitioners, 10 orphans and 10 child-headed families. An open ended question has been used because the interviewee could answer freely. The researcher's tool prepared will be open-ended questionnaires and interview guidelines for each of the interviewees (Appendix-B).

6.2. Ethics

Researchers are committed to increasing scientific and professional knowledge of behaviour and peoples' understanding of themselves and others and to the use of such knowledge to improve the conditions of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching and publication. They strive to help the public in developing informed judgements and choices concerning human

behaviour.   In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness,   This Ethics code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics code is intended to provide specific standards to cover worst situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologist's work-related conduct requires a personal commitment and lifelong effort to act ethically, to encourage ethical behavior by students, supervisors, employees, and colleagues, and to consult with others concerning ethical problems.

6.3 General Principles

This section consists of general principles. General principles, as opposed to Ethical standards, are inspirational in nature.   Their intent is to guide and inspire psychologists towards the very highest ethical ideals of the profession.   General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

PRINCIPLE A: Beneficence and Nonmaleficence, Psychologists strive to benefit these with whom they work and take care to do no harm. In their professions and actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of this own physical and mental health on their ability to help those with whom they work.

PRINCIPLE B: Fidelity and Responsibility

Psychologists establish relationship of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologist uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the Ethical compliance of their colleagues' scientific and professional conduct.   Psychologists strive to contribute a portion of their professional time for or no compensation of personal advantage, (http://www.apa.org/ethics/rules.html).

Contribution by Johnson & Johnson:

Certain corporate have a tremendous and outstanding projects and programs which has a great impact in the fight of pandemic. Johnson & Johnson is one of them: In their mission, as global company dedicated to human health for more than 120 years, Johnson and Johnson has a deep and abiding commitment to use its expertise and resources to help enhance health care for people suffering from HIV/AIDS.

Johnson & Johnson aspires to make a difference in the lives of those infected and affected by HIV/AIDS through:

• Developing effective new medicines and diagnostics for HIV and related opportunities

• Enhancing access to the company's products as well as patient care and support

• Providing contributions to assist communities and individuals at risks for HIV(www.africacncl.org)

Mother2Mothers

In South Africa the increase of child-headed families and Orphanage is a big challenge positive mother. The initiative offers HIV-positive pregnant women and new mother's medical, social and emotional support, which empowers these women to protect their own healthy babies.

The program was established as a counseling service and connects HIV-positive new mothers, known as "Mentor Mothers" with HIV positive pregnant women accessing services to prevent mother-to-child transmission of HIV. The program has expanded to provide treatment and support to mothers and babies during the critical first year after delivery. Mentor Mothers teach the expectant HIV positive mothers infant feeding techniques and life skills necessary to adjust to their communities as women- and mothers living with HIV/AIDS. In 2005, with support of Johnson & Johnson, the first Mothers2Mothers site was opened at the Frere Hospital in the Eastern Cape, and East London, which now serves more than 10 000 women. The program currently operates 65 sites in five provinces in South Africa (cca@africacncl.org).

6.4 Field Study

The researcher will visit three Hospices and 10 care givers, as a field survey to gather more data on a presented state of affairs representing the orphans and child-headed families. In other instances, the study may involve the use of telephone. The participants will be made aware of the purpose of the research. None of the participants will be forced to participate, and biasness will be avoided at all costs during the research.

In case of the challenges experienced by the orphans and child-headed families: "challenges", will be classified as attributes of the variable, but the degree of "experience" is the variable, because they vary and take on a range of values. Cause variable or the one that identifies forces or conditions that act on something else is independent variable; for example, the orphans and child-headed families are classified as independent. It means being independent prior causes that act on it. The dependent variable depends on the cause. If it is a variable that is the effect or the result or outcome of another variable, the challenges can be classified as dependent.

7. DATA ANALYSIS TECHNIQUE

The use of statistics is not an integral part of a quantitative study. The main reason as a test is to confirm or contradict the conclusions that one has drawn on the basis of ones understanding of the analyzed data. Statistics among other things, help to quantify the magnitude of an association or relationship provide an indication of the

confidence one can place in one's findings and help one to isolate the effect of different variables (Ackroyd and Hughes, 1992: 30). The results of the survey were captured manually. All the information collected from the questionnaire guidelines was analyzed and the results were presented as the findings

8. EXPECTED RESULTS

Researcher's findings are that the orphans and child-headed families are facing psychosocial distress, lead by death and HIV/AIDS. Those who are attending school have divided mind for example, they are worried about the future. Most of the families already struggle financially and it adds the distressful situation. Most of the child-headed families are young girls between twelve to fifteen years old and orphans at the same time.

However, the problems and challenges may be managed by engaging organizations such as:

• Nelson Mandela Children Fund which is available to the destitute, orphans and child-headed families (NMCF, 2004©). Global Approach needed to fight AIDS; according to the manager Maeline Engelbrecht: Beyond basic needs like food and education these, children need emotional support, protection and a sense of belonging. The fund focuses on empowering local community based organisations to provide these elements to orphans and vulnerable children. For its part the government allocated R1, 2 billion in 2003 for sustainable food security to poor households and communities, especially those headed by children.

• Mandela also stresses the need for a "global approach" in fighting the pandemic, and emphasizes the importance of strengthening relationship with UNICEF. Safe the Children Fund and other governments. Other programme run by the fund cover the following areas:

• Early child care and development in the context of HIV/AIDS.

• The well-being of children and youth.

• Children and youth with disabilities.

• Education and developments.

• Leadership and excellence.

- Social and Welfare, Social Development and Department of health will be engaged to address the challenges professionally.

- The Department of Education might assist with Early Learning and Day Care Centers to the young orphans and siblings.

- The Department of justice may teach the older orphans and child-headed families how to take legal actions in case their rights are violated. The Department of Agriculture to assist in providing skills to the older orphans & child-headed families how to catch fish for themselves for example, in gardening for vegetables, chicken and pig farming.

- By engaging the community members to participate in assisting to bring the difference to the orphans and child-headed families, through holding training workshops to teach them hygienic precautions, preventative measures for infections VCT(Voluntary Counseling and Testing) and other facts about HIV/AIDS and behaviour.

9. CONCLUSION AND RECOMMENDATIONS

The way to create and maintain safety for orphans and child-headed families, would be for NPO's and government coming together and forming committees and teams of volunteers to visit and supervise the home in which these children live. Orphans should be placed in a place of safety until a family member, or foster parents can be found.

The orphans and child-headed families are more vulnerable to the various abuse especially sexual abuses which, in case of the girls, they experience teenage pregnancy and STI's and even HIV/AIDS, rejection from the communities and family members, experience hardships for example lack of food, clothing, medical care, schooling and the love and guidance of parents which adds up to their challenges.

In case of rape, child labour, physical and sexual abuse the child has legal rights, police, social workers, teachers and courts can be involved. There are also centres which can offer assistance in case of the abovementioned issues e.g. LifeLine Southern Africa, FAMSA, Crisis centers, Child protection units, Clinics and Hospitals

Orphans and Child-Headed Families should be given special preference when applying for birth certificates and Identity documents in order to access grants. The religious centers (churches) should be seen playing a role in assisting orphans and child-headed families in spiritual beings, in order to live free from crime, rape and corruptions. The church is a burying sector, and looses its members because of HIV/AIDS, being destroyed spiritually and having a feeling of hopelessness. There is a lack of religions intervention. If the orphans and child-headed families are not well cared for, they will develop anger and hopelessness, this might result in country experiencing high rate of killings, crime, HIV/AIDS and lawlessness. They will revenge and the country will suffer the consequences.

The ideal thing would be to place these children with adult guidance, fosters and adopted parents, who in turn should get some sort of tax relief from the government. With the given fact that children are sexually active from as young as twelve it would be wise to start sex education at nine or ten and also incorporate HIV education. The younger the children learn the greater the hope that we can slow down the pandemic of HIV/AIDS.

The research programme can help and guide the researcher to encourage the community to adopt AIDS orphans or child-headed families either legally or illegally, so that these children must also have a sense of belonging and with guidance of adults, to enjoy years of being a toddler, teenager and a youth. It is wished to have an AIDS free country, continent and society at large. If children could be respected, well cared, protected, educated and not only academically, but also norms and values to be adhered to, there would be a chance of having a country free from excessive crime, violence, rape in order to revenge as people are bitter.

 Tips for a family to survive:
- Emotional and social support through the crises.
- The family needs to prepare for the future with counseling, education, support and planning. The extended family needs to be involved. Children need special attention.
- Discrimination against people with AIDS must be broken down. It builds barriers between the affected family, the community and government services.

- Families need to plan for extra expenses and protect themselves against unnecessary expenses. Contributions from extended family and community are needed to get the family through crisis.

- Adopt and fostering of orphans in family or the community, with welfare support.

Protect family income through:

- Retaining jobs, benefits and housing

- Find out if your Municipality provides any free water, housing or electricity

- Careful budgeting and avoiding debt through financial planning.

- Develop healthy family members to run small business to earn money.

- Families need to know how to use government and NGO services.

- Burial costs are a big burden to poor families. Families, religions, all of us, we need to talk about how to simplify funerals to reduce costs, while still giving full respect to the deceased and the family. By so doing the surviving children will be left with something to survive after the funeral. Religious organizations need to play a leadership role here.

Who can help?

Churches, Women's groups, Civics, Youth, Companies, NGOs and all Community groups, "Making A Difference " Gauteng Health Department.

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APPENDIX A

<u>**QUESTIONAIRE**</u>

1. How safety of Orphans and Child-Headed families is maintained?

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2. What type of care and support could be given to Orphans and child-headed families?

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3. From which level can the HIV/AIDS and sex education can be taught to the orphans and child-headed families?

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4. How can we ensure that the orphans and child-headed families know and understand the HIV/AIDS?

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5. What are the challenges experienced by the orphans and child- headed families?

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6. What approach can be follow when telling the orphans and child-headed families about their HIV status?

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7. How to handle cases whereby these children keep on loosing their loved ones, brothers, sisters and other siblings?

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8. Psychosocial distress begins when the child becomes aware that the parent is infected the child start to worry about the future, how can I live without my parents? What will happen to me? Who will look after me? What about my brothers and sisters? Where will I find money to buy food and clothing? What about school? The child may blame him/ herself. How can the orphan and child-headed families be reassured regarding the abovementioned issues?

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9. In case of rape, child labour, physical and sexual abuses where these children can find assistance or help?

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10. What are the procedures to be taken to make the orphans and child-headed families to have access to State grants?