THE PHENOMENON OF RESILIENCE IN AIDS ORPHANS

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DECLARATION

I declare that the dissertation entitled: **The phenomenon of resilience in AIDS orphans** is my own work. It is submitted for the MAGISTER EDUCATIONIS degree to the North-West University, Vanderbijlpark. It has not been submitted before for any degree or examination at any other university.

E Wood
Name

20/4/2007
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SUMMARY

Many South Africans experience the severe impact of the HIV/AIDS pandemic. The AIDS orphan, specifically, has to suffer the adverse effects of this relentless worldwide catastrophe. The HIV/AIDS orphan is not just another orphan, but someone who suffers from exceptional pressures which may lead to depression, hopelessness and psychological trauma later in life (Coombe, 2003). In order to function well in these circumstances, interventions that target resilient functioning are needed to empower the AIDS orphan.

The purpose of this study was to document, by means of a literature review and empirical research, the phenomenon of resilience among AIDS orphans. In order to achieve this goal, it was necessary to elucidate the concepts *HIV/AIDS, pandemic, impacts of the pandemic on South Africa and its orphans, resilience and empowerment of orphans.*

The aim of the empirical research was to investigate the phenomenon of resilience among HIV/AIDS orphans by conducting both survey and phenomenological research and to compare the functioning of resilient and non-resilient orphans. Some of the important findings include:

- South African AIDS orphans face multiple risk;
- the participants of this study show remarkable resilience in spite of adversity; and
- the resilient AIDS orphans in this study alluded to several intrapersonal and interpersonal protective factors which contribute to their resilience.

The findings were used to generate guidelines for individuals, families, education and community stakeholders who interact with AIDS orphans and wish to intervene meaningfully in order to empower AIDS orphans towards (continued) resilient functioning.

Key words: HIV/AIDS pandemic, impacts, orphanhood, vulnerable children, resilience, risk and protective factors, wellness, wellbeing and coping.

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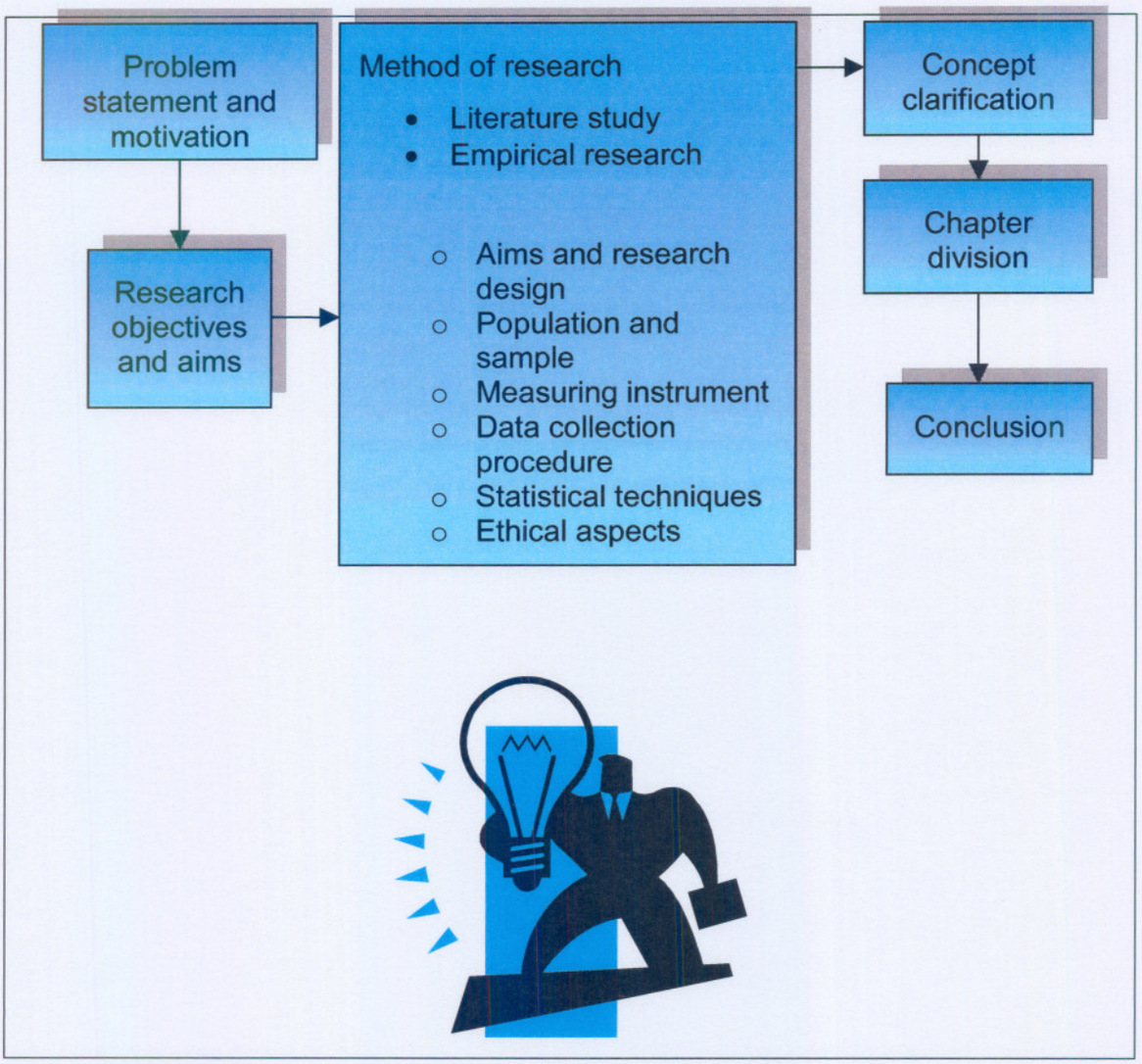


1.2 PROBLEM STATEMENT AND MOTIVATION

Media confronts South Africans daily with the reality of HIV/AIDS and the dire consequences of this disease. The HIV/AIDS pandemic, as it is now referred to,

is of great concern both in South Africa and worldwide because of its dire socio-economic and humanitarian impacts.

In South Africa, research has shown that an estimated 10.8% of all South Africans are living with HIV/AIDS (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste, Pillay *et al.*, 2005:135). Increasing numbers of South Africans are affected by the HIV virus because copious numbers of South Africans are infected daily. An estimated 1000 people are dying of HIV/AIDS related illnesses every day (Theron, 2005:56). When adults die, their children are often left emotionally and / or materially destitute. The pressing concern for the estimated 1.2 million AIDS orphans left behind in South Africa (in 2005) is well documented (Fredriksson, Kanabus & Pennington, 2005; UNAIDS, 2006:505). The term AIDS orphan is preferred because it refers to an orphan who has lost a parent due to AIDS related illness (-es).

HIV/AIDS is generating orphans so quickly that traditional, extended family structures can no longer cope (Anon., 2003b). Families and communities can barely fend for themselves, let alone take care of the mushrooming number of orphans. The economic impact of HIV/AIDS related illnesses and death has serious consequences for an orphan's basic needs such as shelter, food, clothing, health and education (Fredriksson *et a.l,* 2005). Needless to say, the South African community at large will have to carry the responsibility to fend for these children and this will result in a greater economic burden on tax paying citizens because a debilitated adult population cannot function adequately as providers or caregivers (Theron, 2005:57).

Orphanhood is likely to be a highly traumatic situation for affected children and the numbers of these vulnerable children will increase as the HIV/AIDS pandemic advances. There is a great need in all sectors of society to respond to the needs of these orphans. The AIDS orphan is not just another orphan, but a child who suffers from unique and heightened pressures and influences which may lead to depression, hopelessness and psychological trauma later in life (Coombe, 2003).

There is a great need to develop and maintain sustainable programmes to assist South Africa in its HIV/AIDS awareness, prevention and education efforts and to

cater for and empower AIDS orphans. There is growing evidence of the perilous impacts of HIV/AIDS and its concomitant orphanhood on education and the socio-economic environment (Ainsworth & Semali, 2000:1; Theron, 2005:56). It is evident that the HIV/AIDS orphans should be empowered to acquire skills to enhance their wellbeing.

To instill wellness in the orphans, one has to learn to be more sensitive to the orphans' wellbeing and to consider their personal and environmental factors. The impact of their diminishing numbers of caregivers, results in a huge burden on society to stand in for deceased parents (Barnett, Prins & Whiteside, 2004:19). It also impacts on the wellbeing of these children, the future of our country. Wellbeing is allied to resilience.

Resilience is defined as the quality or capacity to be bent without breaking, and the capacity, once bent, to spring back or recover to the original form. It can also be seen as a characteristic of individuals which makes them less likely to develop problems when they have experienced difficult circumstances (OALD, 1989:1075; Theron, 2004:317). Without adversity, there can be no resilience – it is only in the presence of risk, that the phenomenon of resilience can come to the fore (Schoon, 2006:139). The reality of orphanhood, especially as a result of HIV/AIDS, is undoubtedly equivalent to risk. It cannot be assumed that all individuals respond similarly to risk or that all contexts of risk are equal. For this reason recent research has begun to specify the context in which resilient functioning is being scrutinized (Schoon, 2006:146).

If orphans and communities are able to "spring back" (OALD, 1989:1075) from the adversity of being orphaned, successful continuation of life is more possible, which in turn results in a lighter burden for society. Defining inherent personal characteristics of resilient orphans, as well as the contextual protective processes which contribute to their resilient functioning, can help researchers to better understand the phenomenon of resilience within the specific context of AIDS-related orphanhood and contribute to the empowerment of less resilient orphans in similar circumstances to cope with life's adversities (Schoon, 2006:144).

If AIDS orphans are resilient, or can be taught to be, the burden on society could probably be lessened and the circumstances in which the orphans find themselves can be alleviated. In order to encourage resilience among AIDS orphans, it is necessary to understand what the phenomenon of resilience among AIDS orphans entails. Previous research in at-risk populations of youth has indicated that some youth manage to respond resiliently despite risk-laden circumstances (Mash & Wolfe, 2005:334; Schoon, 2006:6-7). This notion made the researcher curious about the phenomenon of resilience in AIDS orphans. Therefore, for the purposes of this study, the specific context in which resilient functioning will be surveyed is that of the AIDS orphan.

The researcher is of the opinion that, if one could foster resilience in the AIDS orphans, one could empower both the orphans as well as the community they live in.

1.3 RESEARCH OBJECTIVES AND PROBLEM STATEMENT

If one tried to cultivate resilience in South Africa's AIDS orphans, one would firstly need to determine what would be typical of resilient AIDS orphans and what their resilience entails.

Thus, the problem that is to be targeted by this research is:

What does the phenomenon of resilience among AIDS orphans entail?

The following research questions stem from the above research problem:

- What is the phenomenon of AIDS orphans?
- What is the nature of resilience?
- What does the phenomenon of resilience among AIDS orphans entail?
- How do resilient orphans differ from non-resilient orphans?
- What guidelines can be provided to inculcate resilience among AIDS orphans?

1.4 AIMS

The overall aim of this study is to document the phenomenon of resilience among AIDS orphans in South Africa.

The overall aim can be operationalised in the following sub-aims, which include:

- an overview of the phenomenon of AIDS orphans;
- an overview of the phenomenon of resilience;
- an investigation of the phenomenon of resilience among AIDS orphans;
- a comparison between resilient and non-resilient orphans; and
- provision of guidelines to encourage resilient functioning amongst AIDS orphans.

1.5 RESEARCH METHODOLOGY

1.5.1 Literature overview

An in depth study of the phenomena of AIDS orphans and resilience will be conducted, consulting recently published articles, appropriate literature/books as well as the Internet. The Nexus Database will also be consulted. Useful keywords used to direct the search for literature sources will include: HIV/AIDS,

orphans, HIV/AIDS impacts, vulnerable children, resilience, risk factors, protective factors, wellness and wellbeing.

The following themes emerged in literature regarding the phenomenon of AIDS orphans:

Table 1.1: Summary of the literature study on AIDS orphans

Theme	Sources
What is the extent of the HIV/AIDS pandemic? 	Anon., 1999a Anon., 2000 Anon., 2003a Anon, 2005d Connolly, Engle, Mayer, McDermott, Mendoza *et al.*, 2004 Haygood, 1999 Rehle & Shisana, 2003 Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste, Pillay *et al.*, 2005 Togni, 1997 UNAIDS, 2004 UNAIDS, 2006 Van Vollenhoven, 2003
What are the impacts of the pandemic? 	Anon., 1999b Anon., 1999c Bachmann & Booysen, 2004 De Waal, 2002 Dickinson, 2004 Ingham, 1999 Mvulane, 2003 Prinsloo, 2005 Richter, Manegold & Pather, 2004 Theron, 2005 Togni, 1997

What are the impacts of the HIV/AIDS pandemic on the orphans? 	Alant & Harty, 2005 Anon., 2003a Ansell, 2004 Bray, 2003 Connolly *et al.*, 2004 Cook & Du Toit, 2005 Ebersöhn & Eloff, 2002 Fox, Oyosi & Parker, 2002 Freeman & Nkomo, 2005 Germann, 2004 Giese, Meintjies & Proudlock, 2001 Haygood, 1999 Janjaroen & Khamman, 2002 Jooste & Jooste, 2005 Madhavan, 2004 Prinsloo, 2005 Richter, Manegold & Pather, 2004 Theron, 2005
How can the orphans be empowered? 	Connolly *et al.*, 2004 Shisana *et al.*, 2005

The following themes emerged from the literature regarding resilience among children:

Table 1.2: Summary of the literature study on resilience

Theme	Sources
What is resilience? 	Elias, 2006 Masten & Reed, 2005 Neill, 2005 Schoon, 2006 Theron, 2004 Van Rensburg & Barnard, 2004
What do resilient individuals use to cope? 	Christenson & Brooke, 1999 Collings & Magojo, 2003 Dornbusch, Laird & Crosnoe, 1999 Edgar, 1999 Frydenberg, 1999 Masten & Reed, 2005 Pargament & Mahoney, 2005 Rapp-Paglicci, Dulmus & Wodarski, 2004 Schoon, 2006 Theron, 2004 Van Rensburg & Barnard, 2004
What are threats to resilience? 	Christenson & Brooke, 1999 Collings & Magojo, 2003 Dornbusch, Laird & Crosnoe, 1999 Edgar, 1999 Frydenberg, 1999 Masten & Reed, 2005 Pargament & Mahoney, 2005 Rapp-Paglicci *et al.*, 2004 Schoon, 2006 Theron, 2004 Van Rensburg & Barnard, 2004

How can resilience be enhanced? 	Barter, 2005 Collings & Magojo, 2003 Cook & Du Toit, 2005 Govender & Killian, 2001 Masten & Reed, 2005 Neill, 2005 Rapp-Paglicci *et al.*, 2004 Van Rensburg & Barnard, 2004

1.5.2 Empirical research

This study conforms to the prescriptions of the International Youth Resilience Study (IYRS) because of the study leader's research collaboration with the Canadian leaders of the IYRS. The IYRS emphasizes the contextual nature of resilience and uses qualitative and quantitative research methods to examine what helps youth cope with the many challenges they face.

1.5.2.1 Aim of the empirical research

The overall aim of the empirical research is to document the phenomenon of resilience among AIDS orphans in South Africa using survey and phenomenological research methods.

1.5.2.2 Research design

The design consists of two parts, namely survey research and phenomenological interviews:

- survey research is conducted with resilient and non-resilient youth using a close-ended questionnaire; and
- a phenomenological study using semi-structured interviews is conducted with resilient youth and with elders from the community from which the youth come.

Because the design consists of survey research (quantitative research) as well as phenomenological interviews (qualitative research), the research design is a mixed methods approach (De Vos, 2001:361).

1.5.2.3 Study population and sample

The population in this study consists of all AIDS orphans in South Africa, but given logistical and time constraints, the population was limited to a sample of 60 adolescent orphans found in HIV/AIDS affected communities in Gauteng, South Africa. The IYRS specifies a minimum number of 60 participants for the survey research. According to the specifications of the IYRS 30 of these participants (AIDS orphans in the case of this study) must be resilient and 30 non-resilient.

These participants needed to be identified by the elders (i.e. their caretakers, social workers or guardians) from the community from which the participants are drawn. The identification procedure entails a process of information and debate: the concept of resilience was debated and clarified with elders once the literature definition had been shared with them and then applied to their specific community. For the purposes of this study, resilience was taken to mean orphaned youth who demonstrated:

- academic achievement;
- pro-social conduct;
- peer acceptance;
- normative mental health; and
- involvement in age-appropriate activities (Masten & Reed, 2005:76).

For the purposes of the phenomenological study, a group interview was held with six elders who represented the community and had close ties to the orphans and three in-depth interviews were held with resilient AIDS orphans.

1.5.2.4 Measuring instruments

A questionnaire, to distinguish characteristics of non-resilient youth as opposed to resilient youth, was used. This measuring instrument was developed by the IYRS and is called The Child and Youth Resilience Measure (CYRM) (Ungar & Liebenberg, 2005:219). The CYRM is a closed questionnaire consisting of 58 questions with a 5-point scale. Fifteen questions are added by the researcher and an advisory committee (the study leader and elders - caretakers, social workers or guardians - from the community from which the orphans are drawn) to cover aspects specifically related to the community of the youth in this study, namely AIDS orphans. The CYRM is included as Addendum A.

Semi-structured interviews including standard IYRS questions and additional site-specific questions were used to get clarity on the resilient orphans' perceptions of resilience as well as their elders' perceptions of the antecedents of resilience. The interview protocols are included as Addenda B and C.

1.5.2.5 Data collection procedure

With the help of elders (i.e. community stakeholders such as social workers, caretakers or guardians of AIDS orphans) 30 resilient and 30 non-resilient HIV/AIDS orphans were identified after the elders had been informed about and agreed on the concept of resilience as it manifests in their community among AIDS orphans.

These youth were then informed of the study and with their consent (Addendum D) they would each complete the CYRM. Because the participants were not first language English speakers their elders helped to clarify and / or translate difficult concepts to facilitate the completion of the CYRM.

Three of the resilient AIDS orphans who completed the CYRM questionnaire were then selected after they had been identified by the elders as demonstrating significant traits of resilience and being most suitable for an interview. The interviewees were then given the chance to participate in or decline the interview. Afterwards the elders were interviewed on a date suitable for all.

1.5.2.6 Statistical techniques

To determine the differences between the resilient and non-resilient groups, the Statistical Consultation Services of the North-West University was consulted to analyse the data. Frequency counts and descriptive statistics were used for the responses generated by the CYRM and Statistica (Version 7) was used to analyse the data obtained.

Content analysis was used to draw conclusions generated by the interviews.

1.5.2.7 Ethical aspects

Recommended ethical guidelines were adhered to (Strydom, 2001:24-34; Tuckman, 1994:13, 14). Permission was obtained from the relevant social workers and elders as well as from the orphans to take part in the study. The orphans were requested to give their consent to participate in the study.

Participation was strictly voluntary and all responses were treated with confidentiality. The identities of the participants were not disclosed.

1.6 DEFINITION OF KEY TERMS

The following terms will be used repeatedly in this study and therefore require definition:

1.6.1 AIDS orphans

An orphan is defined as a child under the age of 18 who has lost at least one parent. A child whose mother has died is known as a maternal orphan; a child whose father has died is a paternal orphan. A child who has lost both parents is called a double orphan (Shisana *et al.*, 2005:112; UNAIDS, 2004). An AIDS orphan would then be a child who has lost one or both parents due to an AIDS related death.

1.6.2 HIV/AIDS pandemic

At first the HIV/AIDS disease was called an epidemic, which meant that it was a disease that was spreading among many people in the same place for a time.

But a disease that occurs over the whole world is called a pandemic (OALD, 1989:404,893). An estimated 38,6 million adults and children in the world are living with HIV and 24,5 million of these people live in Sub-Saharan Africa according to a report on the global statistics – 2005 (UNAIDS, 2006).

1.6.3 Empowerment

In order to empower the orphans, in other words give them the power to survive, a wide range of government and civil society stakeholders need to provide financial and emotional support to children, families and communities, along with HIV prevention, care and support (UNAIDS, 2004). Empowerment means to enable, inspire and encourage and to give people greater sense of confidence (Microsoft Corporation, 2005). In order for empowerment interventions to succeed, they need to be tailored to suit their target population (Mash & Wolfe, 2005:98).

1.6.4 Vulnerability

Vulnerable children are children that are unprotected, can be hurt or injured and / or be exposed to danger (OALD, 1989:1428). In South Africa, poverty and social circumstances like HIV/AIDS have created many vulnerable children who need help and protection from their adverse circumstances.

1.6.5 Resilience

Resilience is the ability to recover from setbacks and the ability to react adaptively to potential crises. It means flexibility, toughness and strength (Microsoft Corporation, 2005). It is specifically understood as a dynamic process which empowers individuals to behave adaptively when faced with adversity. In the absence of adversity, there can be no talk of resilience (Schoon, 2006:6-7).

1.6.6 Risk

Risk means a threat to something; the chance of something going wrong; danger that can cause injury. A risk factor is something that contributes to illness or the probability of disease or harm to health (Microsoft Corporation, 2005). Within the study of resilience, risk refers to circumstances and / or contexts which increase

the probability of maladjustment or negative outcomes. Risk factors comprise inter- and intrapersonal factors (Schoon, 2006:8-9). Multiple or accumulated risk factors increase the prognosis of maladjustment (Schoon, 2006:158).

1.6.7 Protective factors

A protective factor would be the opposite of a risk factor, in other words, something that protects people from harm or injury. In the research on resilience, protective factors are those factors which modify the potential negative impacts of risk-laden circumstances and / or contexts. Protective factors are also intra- and interpersonal in nature (Schoon, 2006:8-9).

1.7 CHAPTER DIVISION

The chapters of this study are divided as follows:

Chapter 2: The phenomenon of AIDS orphans

Chapter 2 will focus on the phenomenon of orphanhood, the extent of the HIV/AIDS pandemic and the impacts thereof on South Africa and its people and in particular on the AIDS orphans. It also offers information on the programmes already implemented to empower the orphans and vulnerable children.

Chapter 3: The nature of resilience

This chapter deals with the phenomenon and nature of resilience. It outlines the risk and protective factors that influence and are related to resilience as well as how resilience can be enhanced.

Chapter 4: Research design

The aims, objectives and method of research are outlined in this chapter.

Chapter 5: Results of empirical research

In Chapter 5 the statistical analysis of the data collected in this study is offered and statistical interpretations of the qualitative and quantitative research results are given.

Chapter 6: Summary

In the final chapter the researcher gives a conclusion regarding the literature and the empirical study as well as recommendations for further studies. Limitations and contributions of this study will also be incorporated.

Chapter 6 will be followed by a Bibliography and addenda of the survey and interviews as well as some poetry by a resilient orphan.

1.8 CONCLUSION

The number of AIDS orphans in South Africa is staggering and is unlikely to remain static during the next few decades. There is a crisis and this crisis is not projected to diminish any time soon. The effects of orphanhood may only manifest in later years and may have important social-economic consequences in many communities.

This study will therefore focus on one of many aspects, namely resilience, which may have a significant effect on the survival and coping strategies of these orphans. There is a great need to develop sustainable programs or strategies to help South Africa to support the sick and vulnerable and to care for and support the orphans by teaching them life skills to help them cope with the crisis at hand. One of these coping skills will be to instill resilience so that they can bounce back from their trauma and resume their lives.

The next chapter will deal with AIDS orphans.

CHAPTER TWO

THE PHENOMENON OF AIDS ORPHANS

2.1 INTRODUCTION

HIV/AIDS is not just a health problem. It has become a social, economic, cultural, developmental and political catastrophe of unprecedented proportions, with consequences as ravaging as any war (Booysen, 2003:419; Hernes, 2002:115-120).

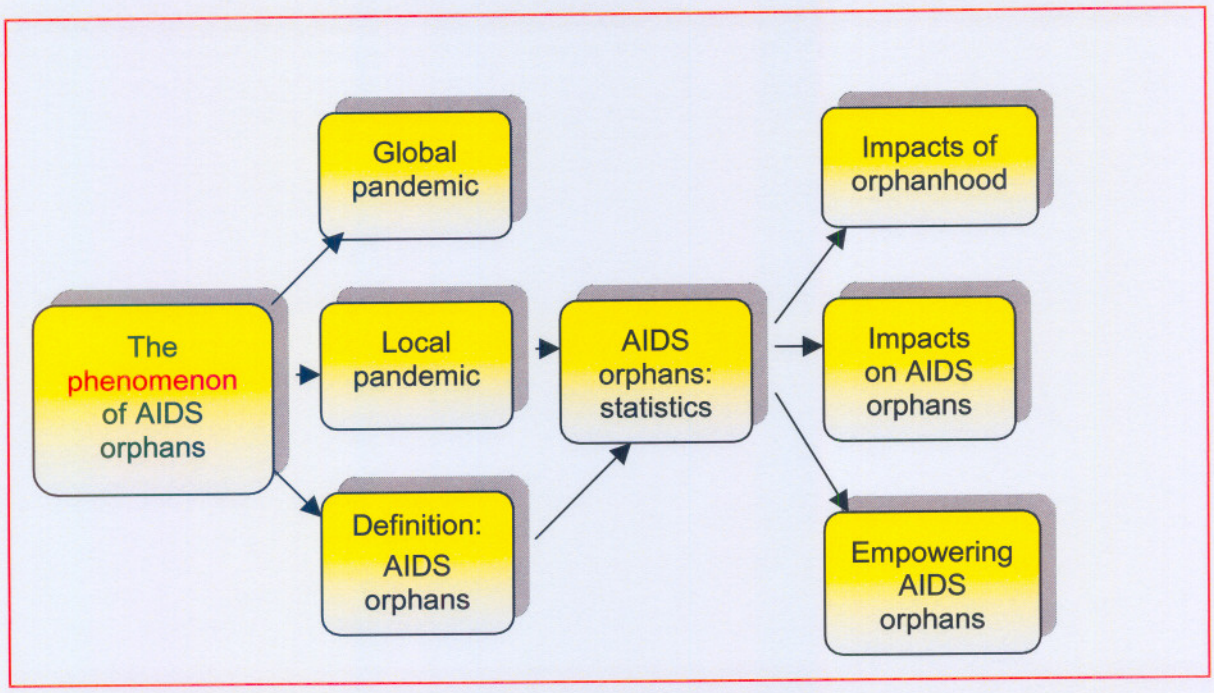
While the tragedy of the HIV/AIDS epidemic has been drawing increased media attention, one of the most troubling aspects of it – the long-term impact on African societies of millions of AIDS orphans in sub-Saharan Africa – has been featured less often (Anon., 2003b; Dickinson, 2004:627).

Because of this catastrophe, millions of children live traumatized, unstable lives, robbed not just of their parents, but of their childhoods and futures.

This chapter will focus on the AIDS pandemic (globally and locally) and its wide-ranging impacts, orphanhood in general, as well as the impacts of the AIDS pandemic on the AIDS orphans themselves and how these orphans are being empowered by programmes in South Africa.

The following flow chart (Figure 2.1) summarises the contents on which this chapter will focus:

Figure 2.1: Overview of Chapter 2



2.2 THE AIDS PANDEMIC GLOBALLY

HIV/AIDS is a recognized threat to children and families worldwide. AIDS is known to be one of the leading causes of death in the world (see the evidence in the following paragraphs) and one assumes that most people are well informed of the statistical proportions of the AIDS pandemic worldwide.

Less than ten years ago "The Star" (Anon., 1999a) already reported that AIDS had become the biggest cause of (child) deaths in the world. The fourth edition of Children on the Brink -The National Children's Forum on HIV/AIDS: Workshop report, 2004 - states that AIDS is the leading cause of death worldwide for people between the ages of 15 and 49 and although most of the people living with AIDS are adults, the pandemic has devastating effects on families and communities and especially the children (Connolly, Engle, Mayer, McDermott, Mendoza, 2004).

In December 2004 statistics, published by UNAIDS/WHO, indicated that an estimated 39.4 million people (estimate range 35.9 – 44.3 million) worldwide were living with HIV/AIDS. Two point two million (estimate range 2.0 – 2.6 million) of

them were children. Four point nine million (estimate range 4.3 – 6.4 million) people were newly infected with HIV. A total of 3.1 million people (range 2.8 – 3.5 million) had died of AIDS in 2004 (Anon., 2005d).

Between 1981 and 2003, more than 20 million people worldwide had died of AIDS. By December 2004 women accounted for 47% of all people living with HIV worldwide. In 2003, young people (15-24 years old) accounted for half of all new HIV infections; more than 6 000 became infected with HIV every day (Anon., 2005d).

The number of people living with HIV has been rising in every region of the world, with the steepest increases occurring in East Asia (with an increase of 50%), in Eastern Europe and Central Asia (with an increase of 40% in each region). But Sub-Saharan Africa remains by far the worst-affected, with 64% of all people living with HIV in this region (UNAIDS, 2004; UNAIDS, 2006).

In its Global Report of 2006, UNAIDS have released new data with reference to the statistics of 2003 and 2005. In the following table (Table 2.1) the data more or less supports the above mentioned report published in 2004. The estimates and data provided relate to 2005 and 2003 and have been produced and compiled by UNAIDS/WHO. They have been shared with national AIDS programmes for review and comments, but are not necessarily the official estimates used by national governments (UNAIDS, 2006).

Table 2.1: UNAIDS 2006 HIV/AIDS Estimates

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV/AIDS				
Adults and Children 2005 Mil. (±)		Adults and Children 2003 Mil. (±)	Adults (15+) 2005 Mil. (±)	Adults (15+) 2003 Mil. (±)
Globally	33,4 – 46,0	31,4 – 42,9	31,4 – 43,4	29,5 – 40,5
Sub-Saharan Africa	21,6 – 27,4	20,8 – 26,3	19,9 – 25,1	19,2 – 24,1
South Africa	4,9 – 6,1	4,8 – 5,8	4,8 - 5,8	4,6 – 5,6

Although available statistics may often vary radically (Togni, 1997:29) between sources (because of the complexity of estimating the exact numbers and the controversy surrounding the acquisition and the measuring of the data), they remain staggering.

2.3 THE AIDS PANDEMIC LOCALLY

While the pandemic has affected people worldwide, the region most affected is Sub-Saharan Africa. Only a few years ago, Sub-Saharan Africa was home to 24 of the 25 countries with the world's highest levels of HIV prevalence (Connolly *et al.*, 2004).

The total number of people living with HIV/AIDS in 2005 is an estimated 38.6 million, and 24.5 million of them (an astounding 64%) reside in Sub-Saharan Africa (Anon., 2005d; UNAIDS, 2006). Less than 10% of the world's population lives in eastern and southern Africa, but they account for more than half of the world's HIV-positive people (Anon., 1999b:6). Southern Africa remains the worst affected sub region in the world and South Africa continues to be one of the countries with the highest number of people living with HIV in the world (18,8% of its population) (UNAIDS, 2004; UNAIDS, 2006).

Less than ten years ago, Haygood already reported that South Africa was the land of the dying and the dead (Haygood, 1999). In 2002, South Africa had an estimated 5 million people living with HIV/AIDS and more people were infected with HIV/AIDS than in any other country in the world (Anon., 2002). Van Vollenhoven quotes Steyn and De Waal estimating that between 5.3 and 6.1 million South Africans would have been HIV positive by 2005, and between 6 and 7.5 million would be HIV positive in 2010 (Van Vollenhoven, 2003: 242-247).

In 2004, available statistics (supplied by the UNAIDS/WHO) supported many of the predictions made as much as five years ago. UNAIDS (2004) reported that South Africa, by the end of 2003, had an estimated 5.3 million (range 4.5 million – 6.2 million) people living with HIV. Of these people, 2.9 million were women. Overall HIV prevalence among pregnant women was 27.9% compared to 26.5% in 2002 and 25% in 2001. There is no sign of decline yet and the data suggested that prevalence levels were still increasing in all age groups (UNAIDS, 2004).

Based on antenatal data provided by The South African Department of Health Study, 2004, it was estimated that 6.29 million South Africans were HIV positive, including 3.4 million women and 104 863 babies (Noble, Berry & Fredriksson, 2005).

The UNAIDS Global Report 2006 reports that in 2005 an estimated 5, 3 million people in South Africa were HIV positive of which 3, 1 million were women (UNAIDS, 2006).

The original Nelson Mandela Study, 2002, which was based on a "household" survey, estimated that 11.4% of all South Africans over the age of 2 years were HIV positive and among those 15.6% were between 15 and 49 years old (Noble *et al.*, 2005). The more recent South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005, reports a HIV prevalence of 10,8% among persons aged two years and older which is similar to the prevalence level of 11,4% recorded in 2002 (Shisana, Rehle, Simbayi, Parker, Zuma, Bhama, Connolly, Jooste, Pillay *et al.*, 2005:135). HIV prevalence among young adults in the 15-49 age groups increased only slightly from 15, 6% in 2002 to 16,2% in 2005. The results may indicate a leveling off of the epidemic in the general population of South Africa, but it is no reason to be complacent, especially as the HIV prevalence among children aged 2-9 years is high (3,3% in children aged 5-9 years) (Shisana *et al.*, 2005:135).

Even though adult HIV prevalence in Sub-Saharan Africa has been roughly stable in recent years, and South Africa's HIV prevalence is now growing more slowly (Noble *et al.*, 2005), it does not mean that the epidemic is slowing. It still means that equally large numbers of people are being newly infected with HIV and are dying of AIDS (UNAIDS, 2004).

Although it is very difficult to reflect the number of AIDS related deaths, because people are not killed by the virus alone, in February 2005, the South African Government reported that the annual number of deaths rose by a massive 57% between 1997 and 2002. Among those aged 25-49 years, the rise was 116%. The UNAIDS/WHO reported that in 2003 AIDS had claimed 370 000 lives, more than 1 000 every day (Noble *et al.*, 2005). The most recent UNAIDS statistics,

however, estimate 320 000 deaths in 2005 and 290 000 deaths in 2003 (UNAIDS, 2006). It is projected that the annual number of deaths due to AIDS will peak at 487 320 deaths in 2008 and by 2020 the total population of South Africa will be 23% smaller than it would have been without AIDS (Rehle & Shisana, 2003:1-8).

What is clear from the available data is that, although the numbers or digits might not always look exactly the same, there is an exceptionally severe epidemic of HIV/AIDS in South Africa which is affecting all parts of the population (Noble, *et al.*, 2005). The epidemic has become a pandemic.

2.4 THE IMPACTS OF THE AIDS PANDEMIC

De Waal (2002) states that HIV infection is the first wave of the pandemic, AIDS morbidity and mortality is the second wave and the economic and governance impact is the third wave of the pandemic. Thus, the impacts of the AIDS pandemic are far reaching and all-pervasive, affecting almost every aspect of our daily lives and activities world wide and especially in South Africa.

The impact of AIDS is most keenly felt in Africa, the continent that has the least financial and educational resources but the largest HIV population in the world (Ingham, 1999:17). Nelson Mandela's words from as far back as 1997 were: "AIDS kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern countries" (Anon., 1999c).

The economic implications of the crisis are staggering. It was predicted in 1999 that in 2004 HIV/AIDS was expected to cost South Africa 1% of its gross domestic product, and to consume 75% of its health budget (Anon., 1999c). Heimann, as quoted by Cullinan, says that this epidemic is the biggest socio-medico-economic disaster this country has ever seen (Cullinan, 1999c:12). Shisana (2005) claims that the gross national product has shown a decline in the years from 1975 to 2003, that the South African government already spent 15,4% of its national budget on health in 2003 and that the per capita expenditure on HIV/AIDS was already as high as US$ 225. According to the United States Central Intelligence Agency, HIV/AIDS is potentially the biggest threat to the economy of Africa and South Africa. They predict that the pandemic will reduce the region's GDP by at least 20% by 2010 (Prinsloo, 2005:31; Shisana, 2005).

Government and business in South Africa are equally affected by the pandemic. They have to cope with the death and illness of workers or officials, staff absence due to attendance of funerals and illness, poor productivity due to illness and absence from work, poor education due to illness and death of educators and poor attendance of affected students, high medical costs, depletion of medical aid resources and similar calamities. In short, the pandemic undermines the effectiveness of bureaucracies and bureaucratic norms (De Waal, 2002; Richter, Manegold & Pather, 2004).

In addition to the abovementioned burdens, HIV/AIDS will impact on the representation in government, through a reduction in the number of skilled and experienced public figures, which can impel political change (De Waal, 2002; Richter *et al.*, 2004).

The following implications of the AIDS pandemic have also been predicted: property ownership will be affected; the state's control on violence will be affected; public finances will come under strain; institutions for public care will be affected; AIDS affected states will be less able to protect against demographic crises including famines, epidemics and other communicable diseases; and forced migration and demoralisation will be prevalent (De Waal, 2002; Richter *et al.*, 2004).

There is compelling evidence that teachers are dying faster than they can be replaced, health professionals are severely affected, and armies, police forces and government departments are becoming depleted. The loss of trained professionals represents a major loss of human capital (De Waal, 2002). The outcome of teacher mortality is a ruthless, constant cycle of illiteracy; declining human capital, national knowledge and economic growth; less money for education and increased HIV prevalence (Theron, 2005:56). In addition to the loss of skilled workers, there is a reduction in returns to higher education and training because there are not enough incentives to acquire skills (De Waal, 2002; Dickinson, 2004:629; Richter *et al.,* 2004).

Should the infection rate continue to rise at the present rate, South Africa will be faced with a mammoth medical problem that will have a pronounced influence on

its economy and general development in the near future (Togni, 1997). Already, an estimated 20% of the labour force and 40 000 teachers are infected with the virus (Prinsloo, 2005:31) causing absenteeism, high medical bills (depleting medical funds) and expectations of support from Government who have to supply anti-retroviral treatment.

While companies are worried about how they will cope with the loss of skilled workers claimed by the disease, governments are grappling with the mounting tragedy of how to look after the children left orphaned by AIDS (Ingham, 1999). HIV/AIDS has brought South Africa's child welfare system to its knees (Mvulane, 2003:29-31).

Society is severely affected because of the vast number of illness, deaths and the resulting orphans that have to be cared for. They have to cope with the limited resources made available by international support organizations, government health services and the business sector. The impact of AIDS orphans on society is putting a severe strain on society (Anon., 1999b:6; Bachmann & Booysen, 2004:818).

Although AIDS has, it seems, the greatest impact on the lives of the AIDS orphans, orphaning is not the only way children may be affected by AIDS. Other children made vulnerable by HIV/AIDS include those who have an ill parent, are in poor households that have taken in an orphan, are discriminated against because of a family member's HIV status, or who have HIV themselves. HIV/AIDS is therefore making more children and adolescents vulnerable (Connolly *et al.*, 2004).

2.5 AIDS ORPHANS DEFINED

An orphan is defined as a child under the age of 18 who has lost at least one parent. A child whose mother has died is known as a maternal orphan; a child whose father has died is a paternal orphan. A child who has lost both parents is called a double orphan (Anon., 2004a; Shisana *et al.*, 2005:112).

An AIDS orphan would then be a child who had lost one or both parents due to an AIDS-related death. It should, however, be noted that many people now avoid

the term "AIDS orphan" because of the stigma attached to the term. Today, these AIDS orphans are commonly referred to as OVC's (orphans and vulnerable children) in a bid to avoid prejudice and stigmatization. Nevertheless, the term "AIDS orphan" will be used in this study as it clearly refers to children who have become orphaned because of the HIV/AIDS pandemic.

The AIDS-orphaned child is not just another orphan, but a child who suffers from unique pressures and influences which may lead to depression, hopelessness and psychological trauma later in life. Because the concept of "orphanhood" is relatively new in African communities, more needs to be learned about orphanhood and about AIDS orphans in particular (Coombe, 2003).

2.6 STATISTICS OF AIDS ORPHANS

Children orphaned by Aids are found in almost every country of the world. In Africa there are millions who have suffered the loss of one or both parents to AIDS. The worst orphan crisis is in Sub-Saharan Africa where the number had risen to 12 million in 2004 and by 2010 this number is expected to climb to more than 18 million. As staggering as these numbers are, the crisis will still worsen if HIV infected parents do not have access to life-prolonging treatment and effective prevention services (Anon., 2004a) and therefore fall ill and die.

In 1999, the number of AIDS orphans was described as skyrocketing. The staggering figures suggested that by the end of that year the world would have seen 11.2 million AIDS orphans, 95% of them living in Sub-Saharan Africa (Anon.,1999b:6). In just two years, from 2001 to 2003, the global number of AIDS orphans increased from 11.5 million to 15 million (estimate range, 13-18 million) (Connolly *et al.*, 2004).

On 26 November 2003, a UNICEF report warned that the staggering number of African children already orphaned due to AIDS was only the beginning of a crisis of gargantuan proportions and the worst was yet to come (Anon., 2003b).

Predictions for 2005 suggested that 14% of children under the age of 15 (over 2.3 million) in southern Africa were expected to have lost their parents (Cullinan, 1999a:5). This was a conservative prediction as the pandemic orphaned more

than 11 million African children and even in countries where HIV prevalence had stabilized, the numbers of orphans would stay high or even rise as parents already infected would continue to die from the disease (Anon., 2003b).

UNAIDS/WHO statistics, published in 2005, showed that the total number of orphans due to AIDS in South Africa was 1, 1 million and the number of orphans was expected to increase to 3, 1 million (18% of all children) in 2010 (UNAIDS, 2006). The UNAIDS Global Report (2006) estimated 1, 2 million children were orphans in 2005 in contrast to the 780 000 in 2003 (UNAIDS, 2006). In some countries, a larger proportion of orphans have lost their parents to AIDS than to any other cause of death – meaning that, were it not for the AIDS epidemic, these children would not have been orphaned (Anon., 2000; Anon., 2005d).

Rehle & Shisana (2003:1-8), however, claimed that there will be over 2.5 million AIDS orphans in South Africa by 2013, and Madhavan (2004: 1443-1454) claimed that an estimated 4 million children would be orphaned by AIDS in 2015. It has, however, been projected that without major shifts in behaviour and comprehensive treatment programmes by around 2015, as many as one third of all children in South Africa will have lost one or both parents (Freeman & Nkomo, 2005:9)

The most recent South African report, the 2005 HSRC study, shows that the overall orphanhood prevalence rate of children aged 2-18 years is 14, 4%. This means that there were a total of 2 531 810 orphans in South Africa in 2005 (Shisana *et al.*, 2005:xxxv). There is evidence of an escalating orphan problem in South Africa. Within the next ten years it is predicted that 2 – 4 million orphans will have to be cared for. There is consensus in literature that the HIV/AIDS epidemic in South Africa has peaked and the number of orphans and vulnerable children will therefore continue to increase for the foreseeable future (Prinsloo, 2005:31; Shisana *et al.*, 2005:124). These most recent statistics suggest that earlier predictions were too conservative.

The ages of the AIDS orphans are fairly consistent across countries. In 2004 it was suggested that overall about 15% of the AIDS orphans were 0-4 years old,

35% were 5-9 years old, and 50% were 10-14 years old (Fredriksson, Kanabus & Pennington, 2005).

In order to understand the phenomenon of the AIDS orphan, it is necessary to delineate the concept of orphanhood.

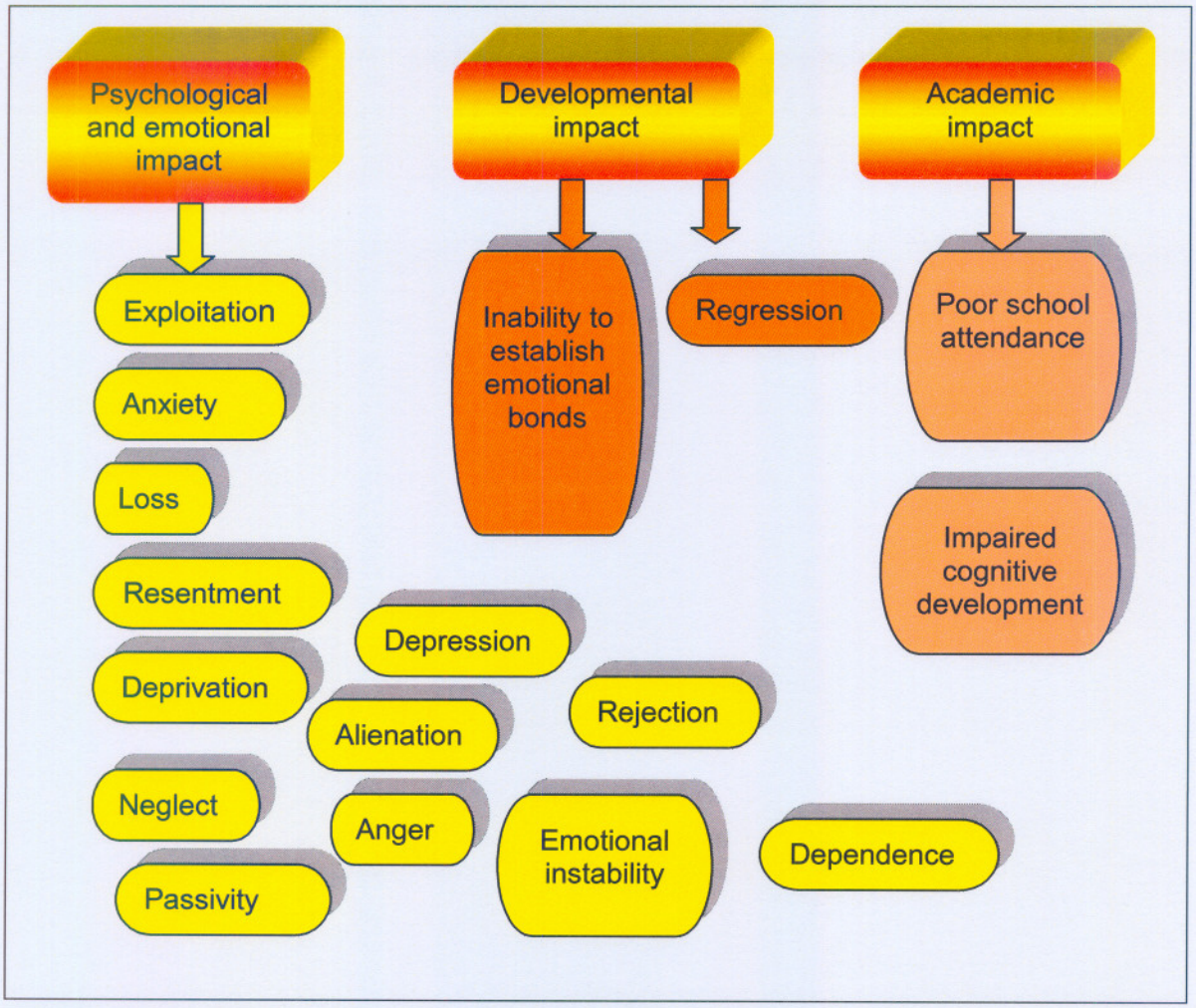
2.7 ORPHANHOOD

2.7.1 Orphanhood in general

As indicated in 2.5, an orphan refers to any child under the age of 18 who has lost one or both parents. By the end of 2003 there were an estimated 143 million orphans in Sub-Saharan Africa, Asia, Latin America and the Caribbean (Connolly *et al.*, 2004). Of the 7.7 million double orphans in Sub-Saharan Africa, just over 60% have lost one of their parents due to AIDS and the number of double orphans in this area is projected to increase through 2010 (Connolly *et al.*, 2004).

The following figure (Figure 2.2) summarises some of the major impacts orphanhood can have on individuals:

Figure 2.2: The general impacts of orphanhood



(Cicchetti & Carlson, 1989:169,328; Connolly *et al.*, 2004; Giese, Meintjies & Proudlock, 2001; Iwaniec, 1995:5; Lifton, 1993:75; McWhirter, McWhirter, McWhirter and McWhirter, 1998:25; Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou & Chitiyo, 2004).

The impacts summarized in the Figure 2.2 above will not be discussed as they overlap with the phenomenon of an AIDS-orphan and will be discussed as such.

2.7.2 AIDS orphans

While not all orphaning is due to HIV/AIDS, orphaning remains the most visible, extensive, and measurable impact AIDS has on children (Connolly *et al.*, 2004) therefore this study will concentrate on these orphans whose survival, wellbeing and development is threatened by AIDS.

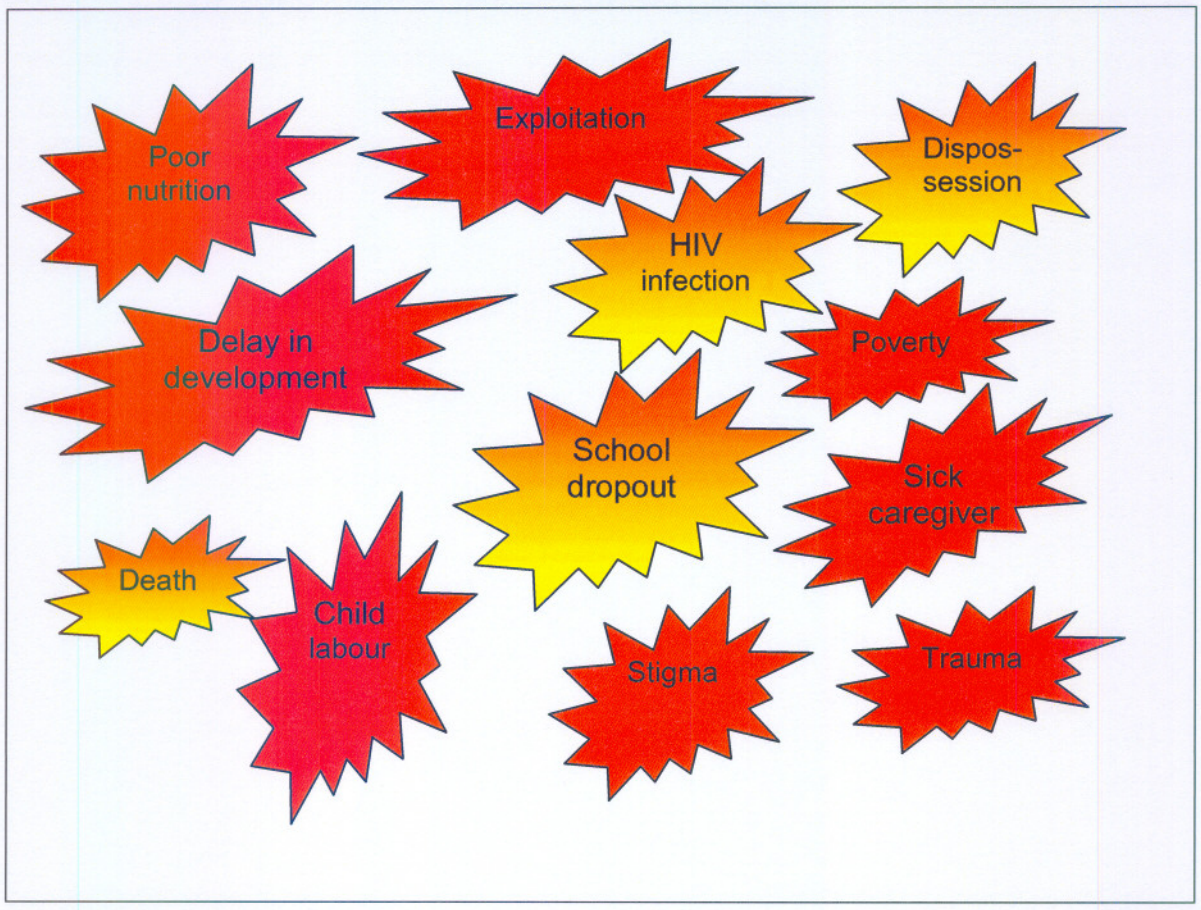
As previously mentioned, many people avoid using the term "AIDS orphan" because it may contribute to inappropriate categorization and stigmatization of the children, but to avoid confusion, this study will refer to AIDS orphans as no stigmatization is intended or attached to the term.

2.7.2.1 What distinguishes the AIDS orphan from other OVC's

When one refers to orphans and / or vulnerable children, it is implied that these children are exposed to circumstances that leave them traumatized, deprived, suffering and disadvantaged because of having lost a parent or lacking proper parental care (Cf. Figure 2.2). With AIDS orphans, these circumstances are a result of the AIDS pandemic. Although being an orphan is not unique, being an AIDS orphan exposes the child to maybe more unique and tragic circumstances than other orphans.

The following summative diagram (Figure 2.3) provides information relating to the unique experiences an AIDS orphan may be exposed to. The contents will be expounded in the sections that follow.

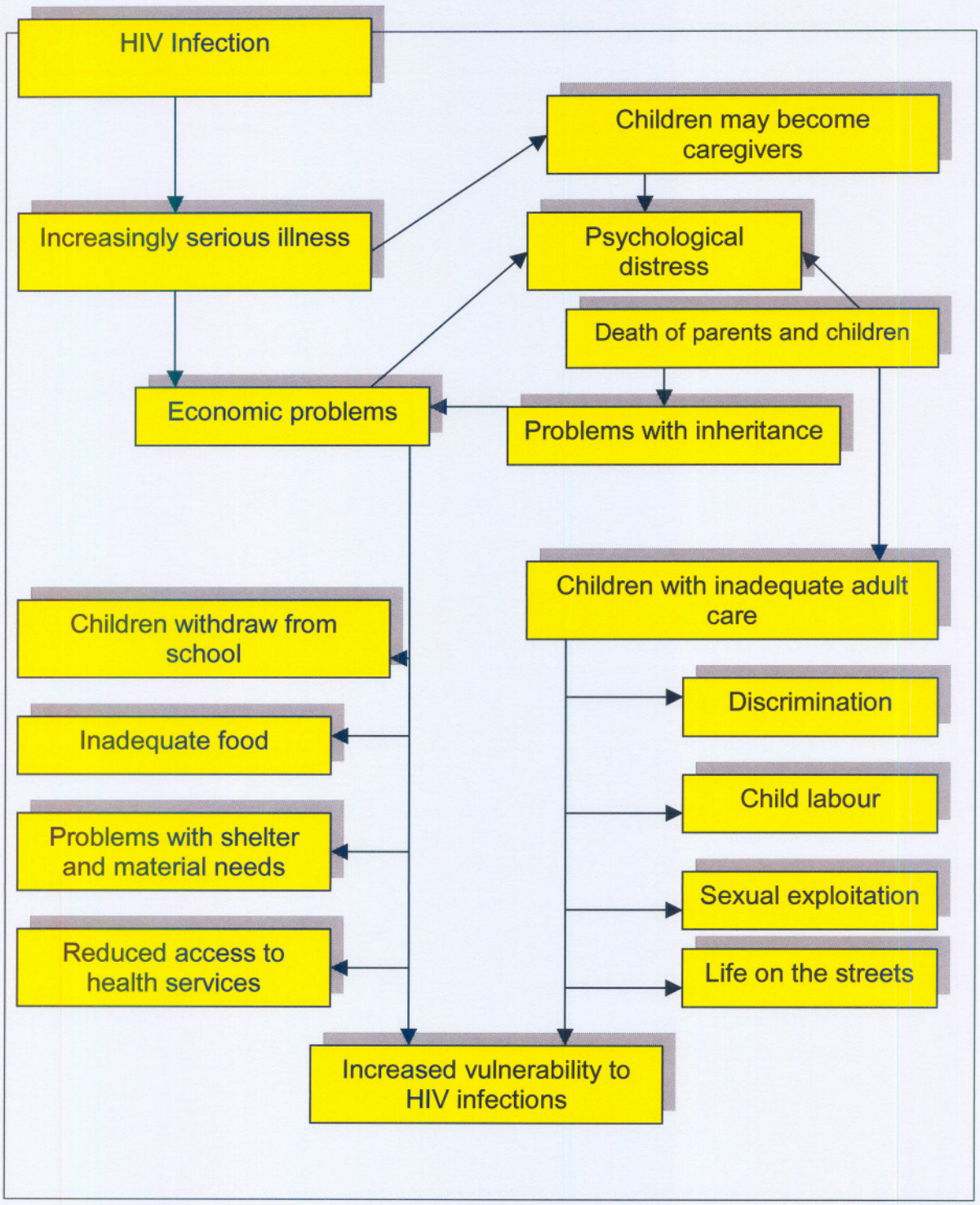
Figure 2.3: The experience of the AIDS orphan



(Anon., 2000; Anon., 2003a; Anon., 2004a; Anon., 2005c; Anon., 2005d; Connolly *et al.*, 2004; Fox, Oyosi & Parker, 2002:10).

The inter-related nature of the problems that affect the AIDS orphans (as summarized in Figure 2.3 above) can be graphically demonstrated by the following order of events experienced by children whose parents become ill with HIV/AIDS as indicated in Figure 2.4 below (Richter *et al.*, 2004):

Figure 2.4: The order of events depicting the experience of AIDS orphans (Foster & Williamson as quoted by Richter *et al.*, 2004:11)



2.7.2.2 The stigma of being an AIDS orphan

Stigma surrounding AIDS is a complex concept. Orphans are stigmatized as a result of people having an inadequate knowledge of the illness, their fear of death and disease, sexual traditions and poor acknowledgement of the stigma. Some people have the prejudiced perceptions that HIV is associated with sexual taboos and immoral behaviour and that it is a punishment from God for sexual sin (Theron, 2005:57). Others believe that HIV is caused by sorcery or witchcraft or that it can be casually transmitted, which make people fearful of the orphans coming from AIDS affected households or having AIDS themselves.

Children who are infected or affected by HIV are discriminated against at home, in schools, taxis and other settings. Sometimes, the discrimination borders on abuse. The discrimination is often linked to the belief that HIV is spread by touching or through the sharing of utensils. The stigma attached to AIDS orphans often impairs their access to health and educational services. Stigma and discrimination related to HIV/AIDS can negatively affect a child's social environment and relationships and damage her[1] self-esteem (Connolly *et al.*, 2004; Giese *et al.*, 2001:31).

Children grieving for dying or dead parents are often stigmatized by society because of the children's association with AIDS. The distress and social isolation experienced by these children, both before and after the death of their parent(s), is strongly exacerbated by the shame, fear, and rejection that often surrounds people affected with AIDS (Fredriksson *et al.*, 2005). They are constantly exposed to high levels of stigma and psychological stresses (Anon., 2004a) to which other children their age are not exposed.

2.7.2.3 Psychological and emotional impact of being an AIDS orphan

Orphans have many physical needs such as nutrition and health care, and these can often appear to be the most urgent, but they will have significant emotional

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[1] In this thesis, female pronouns have been chosen. This does not suggest that orphans exclude boys.

needs as well. The sickness and death of a parent is a major trauma for the AIDS orphan and her emotional needs must not be forgotten (Fredriksson *et al.*, 2005).

Most people struggle to understand the emotional anguish a child experiences as she watches one or both parents die. When one parent is HIV-infected, it is probable that the other parent will also be infected. Children often lose both parents in quick succession and often their caregivers also succumb to AIDS. This makes them suffer multiple bereavements and often the children's suffering is compounded by being separated from their siblings (Anon., 2004a).

AIDS orphans start to suffer emotional neglect long before the death of the parent or caregiver, seeing the parent suffering with illness as well as having to cope emotionally without the sick parent (Fredriksson *et al.,* 2005) and afterwards they generally have to adapt to a new situation, with little or no support (Fox, Oyosi & Parker, 2002:11).

Poverty and social dislocation (having to stay with other caregivers in a new environment) also add to the AIDS orphan's emotional distress. Factors such as loss of household incomes, the cost of treating HIV-related illnesses, and funerals often leave them destitute and some orphans even have to start working to support their families or take on major household work, leave school and forego necessities such as food and clothes or be sent away from home (Anon., 2004a).

Living with AIDS can be highly distressing and stressful. This stressful condition is made more difficult by stigma, difficulties in disclosure, lack of social support, difficulties with establishing and maintaining relationships, and inadequate services to deal with psychological problems (Freeman & Nkomo, 2005:9). Many people who are HIV positive have committed suicide because they find it difficult to cope and to get rid of the stigma and myths attached to the disease (Haygood, 1999:11). The orphan experiences emotional deprivation and feelings of depression, because she feels generally uncared for and not supported in a hostile environment, creating detrimental consequences for her mental health (Janjaroen & Khamman, 2002:21).

Without stable homes and families in which to grow up, the emotional health of many children is likely to be severely compromised (Freeman & Nkomo, 2005:9). Many AIDS orphans face the prospect of sad and lonely deaths (Cullinan, 1999b:5); having lost their parents to an AIDS related death and being infected with HIV themselves.

Most southern African orphans are cared for by extended families but the implications of the geographical separateness of such families are seldom recognized. AIDS orphans often have to migrate to new homes and communities, finding it traumatic to settle into their new environments. Often these orphans are ill-treated by new families, which results in renewed migration and trauma (Ansell, 2004:3-10).

The emotional demand of HIV/AIDS on children's lives is heartbreaking. These children, many of them already orphans, suffer multiple stresses in their short lives. They face fear, worries, caring for parents in pain, stigmatization, hospital visitations, shattered hope and eventual loss (Germann, 2004:18-20). They experience depression, anger, guilt and fear for their futures. This experience can lead to serious psychological problems such as post-traumatic stress syndrome; depression, anxiety, psychosomatic reactions, alcohol abuse, aggression, and even suicide (Anon., 2004a; Ebersöhn & Eloff, 2002:79).

2.7.2.4 Developmental impact of being an AIDS orphan

The process of giving the child the best in life begins even before birth. Poor nutrition and ill health (as in the case of a mother infected with the HIV-virus) lead to low birth weight in her child, putting her at much greater risk of developmental delay, malnutrition and death (Anon., 2005c). The AIDS orphan has a disadvantage right from the beginning of her life.

The early years of life are crucial. Children are more likely to survive when they are well nurtured and cared for in their earliest years and are more likely to grow in a healthy way, have less disease and fewer illnesses, and to develop thinking, language, emotional and social skills. When they enter school, their prospects for performing well are improved and as adolescents, they are likely to have a greater self-esteem. Later in life they also have a greater chance of becoming

creative and productive members of society (Alant & Harty, 2005:82; Anon., 2005c).

The development of a child's full potential is seriously threatened if the family environment deteriorates as a result of parental illness and death. The illness and death of a parent has differing effects on children, depending on the child's age and stage of development. The physical, cognitive, emotional and psychosocial differences that characterize children and adolescents must be catered for. To survive and thrive, these children have to grow up in an environment that provides for these changing needs (Connolly *et al.*, 2004).

Boys and girls in all stages of development are orphaned as a result of AIDS with the following developmental implications:

- In infancy and early childhood the AIDS orphan is at risk of illness and death, stunting, lack of attachment, lack of curiosity and interest, emotional withdrawal or instability, fearfulness and reduced learning ability (Connolly *et al.*, 2004). Orphans living with foster families are more likely to be malnourished, underweight, or short for their age in comparison to non-orphans (Anon., 2004a; Jooste & Jooste, 2005: 383).

- During middle childhood the AIDS orphan may display inappropriate demanding of attention, withdrawal, destructive and cruel behaviour to self and others, lack of sense of morality and rules and difficulty in learning (Connolly *et al.*, 2004; Jooste & Jooste, 2005: 383).

- The adolescent orphans may lack capacity for intimacy and responsibility to others, demonstrate poor peer relations and lack of problem solving skills and fail to recognize adults who may assist in problem solving. They display risky behaviour and experience emotions of anger, resentment, hopelessness, depression and social and cultural marginalization (Connolly *et al.*, 2004).

Possibly the best intervention for children who have lost parents would be to place them in a family environment which will provide support critical to healthy development. A problem, though, is that as the number of deaths of people of childbearing age increases, there are more pressures on older people, while the

availability of potential younger guardians decreases (Freeman & Nkomo, 2005: 9). Almost throughout Sub-Saharan Africa, there have been traditional systems in place to take care of children who lose their parents, but the onslaught of HIV slowly but surely eroded this good traditional practice by simply overloading its caring capacity by the sheer number of orphaned children needing support and care. HIV also undermines the caring capacity of families and communities by deepening poverty due to loss of labour and the high cost of medical treatment and funerals (Fredriksson *et al.,* 2005).

Many countries are seeing growing proportions of families headed by women and grandparents. These households are generally poorer, and are progressively less able to adequately provide for the children in their care (Anon., 2003a) thus having a negative impact on the early childhood development. Grandmothers have to raise their orphaned grandchildren while they have to cope with the loss of their own children. They find it difficult to cope emotionally and physically (Anon., 2004a). The AIDS orphan is therefore deprived of a normal upbringing.

Overburdened families may not have the information or time to spend in stimulating play with the child. If the extraordinary receptive brain of the child lacks the stimulation for which it is primed during the first three years, the possibility for various types of learning may be substantially reduced (Anon., 2005c).

A parent's death can also deprive the AIDS orphan of the learning of values she needs to become socially knowledgeable and an economically productive adult (Anon., 2004a).

It is a child's right to have every chance to survive and thrive. Ensuring optimal conditions for a child's early years is one of the best investments that a country can make if it wants to compete in a global economy based on the strength of its human capital (Anon., 2005c). Unfortunately, AIDS orphans are mostly deprived of the love, care, nurturing, health, nutrition and protection that they need to survive, grow, develop and learn. Due to the poverty caused by AIDS, AIDS orphans suffer from malnutrition, are not immunized against the basic childhood

diseases, lack access to safe drinking water and adequate sanitation and some never even go to school (Anon., 2005c).

The AIDS orphan is thus stunted developmentally because of the lack of parental guidance, the lack of opportunities to develop optimally, the deprived environment she is faced with, the emotional deprivation due to isolation, the strain on older guardians to provide a sound upbringing, the lack of funds to provide for a sound education and a stimulating environment and malnutrition due to poverty.

2.7.2.5 Academic impact

AIDS-orphans are more likely to suffer damage to their cognitive and emotional development and to have less access to education. Young children, who head families due to HIV/AIDS, often have to raise their siblings. Households are headed by children as young as 12, who drop out of school to go onto the streets to support younger brothers and sisters. Their cognitive development is consequently slowed because they cannot attend school regularly. Their younger siblings are then also deprived of adequate cognitive stimulation (Anon., 2003a; Jooste & Jooste, 2005: 383). Dropout or failure to enroll is the grossest manifestation of the impacts of orphanhood on education. Attendance, learner performance and school completion may be affected (Cullinan, 1999c:12; Prinsloo, 2005:31; Schierhout, 2002).

AIDS orphans don't thrive. Many suffer some form of physical and/or mental disability or developmental delay when suffering from AIDS. An even larger number suffer from diminished learning capabilities and other disadvantages that limit their overall prospects of reaching their full potential because poor families do not always manifest child rearing practices that are conducive to cognitive development. The children are not encouraged to think and reason or make their own decisions (Anon., 2005c; Jooste & Jooste, 2005:383).

When a child is raised in poverty, as is mostly the case in an AIDS affected household, the child becomes malnourished, experiences inadequate medical care, sterile learning environments, and restrictions in movement and freedom, which can cause irreversible stunting, linguistic deprivation and impaired cognitive functioning. Their schooling can be affected through economic stresses on their

households, psychological impacts that are a result of changes in family structure that involve new responsibilities to care for the sick, the elderly or siblings, as well as loss of parental guidance and interest in children's education. In addition to these impairments, they are often labeled as slow learners or repeaters or as ineducable. Mostly, these children are forced to fall behind or drop out of school; they lose all interest in learning and have little hope of attaining academic achievements, compromising their psychological development as well as their future prospects. This affects a country's long term recovery from the epidemic (Alant & Harty, 2005:82; Anon., 2004a; Connolly *et al.*, 2004; Jooste & Jooste, 2005:383; Prinsloo, 2005:31; Schierhout, 2002).

AIDS is more likely to create double orphans than other causes because if one parent is infected, it is more than likely that the other parent will also be or become infected. Surveys show that double orphans are more disadvantaged than single orphans. In Tanzania, the school attendance rate for children whose parents are alive and who live with at least one of them is 71%, but for double orphans it is only 52% (Connolly *et al.*, 2004). Data on this topic, however, is inconsistent and can be influenced by the gap between children from poorer and richer households, where children from poorer households are less likely to attend school than children from richer households (Richter *et al.*, 2004). Nevertheless, staying away from school diminishes orphans' chances of escaping extreme poverty and its associated risks (Anon., 2004a).

Additional contributing factors which affect orphans' proper schooling include erratic attendance due to household circumstances, poorer concentration due to hunger, household demands and psychological impacts (Schierhout, 2002).

Education can work as a safety net in the child's life. It can help break the cycle of poverty, but unfortunately the AIDS orphan is the first to be denied education when extended families cannot afford to educate all the children of the household (Fredriksson, *et al.*, 2005).

In many African countries school fees result in many poor children being excluded from school, and extended families sometimes see school fees as a major factor in deciding not to take on additional children orphaned by AIDS, denying them the

privilege of an education the other orphans might have (Ebersöhn & Eloff, 2002: 79; Fredriksson, *et al.*, 2005).

During the National Children's Forum on HIV/AIDS which was held in Cape Town in 2001, the following observations were made regarding the education of the AIDS orphan: Although the school should provide a valuable opportunity for the identification, monitoring and support of vulnerable children, many children are denied their right to a sound education. Many orphans are being held back, expelled, teased and discriminated against because they are unable to pay school fees. The combined effect of HIV/AIDS and poverty results in children starving and as a result they struggle to concentrate in class. Transport to school is seldom available and children have to walk long distances, sometimes on an empty stomach. Many teachers are ignorant of the children's circumstances and are therefore not able to address the needs of the children in the class. As a result of HIV/AIDS, many children are caregivers and breadwinners in their households (Giese *et al.*, 2001). The AIDS orphan, therefore, has a severely compromised education if any at all.

2.7.2.6 Social impact

Perhaps the most frightening aspect of HIV/AIDS is the capacity of the disease to sever those human bonds and social ties that children need to survive and thrive. Across southern Africa and especially in South Africa, there is not only a reversal in development trends, but also the destruction of age-old patterns of traditional family, community and social supports for AIDS orphans (Cook & Du Toit, 2005: 248).

An analysis by UNICEF shows that, in 40 countries in Sub-Saharan Africa, extended families have taken responsibility for more than 90% of orphaned children. Twenty percent of households with children in southern Africa are caring for one or more orphans. These family networks are central to the social welfare of these countries. However, as the number of orphans increases over the coming decade and an even larger number of adults will become affected by AIDS, many of these family networks will face even greater burdens (Connolly *et al.*, 2004; Fox *et al.*, 2002:9).

In five countries in southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland), 15% of all orphans became orphans in 2003 and the majority of these orphans had lost their parents to AIDS. Similar numbers of children are living with a chronically ill family member (or members) and will become orphans. With the traditional support systems in these countries already under pressure, many extended families will soon be overwhelmed and in greater need of external support and protective safety nets (Connolly *et al.,* 2004). This has negative implication for the healthy socialization of AIDS orphans.

The increasing proportion of children who are orphans is placing a tremendous strain on the social fabric of communities and nations. Even cultures and communities with strong social cohesion and traditions (like those in Southern Africa) of providing support to orphans can be overwhelmed by the increasing numbers of orphans. Government and civil society have a critical role to find ways to rebuild the circles of care or support networks to reverse this negative development trend (Connolly *et al.*, 2004; Cook & Du Toit, 2005:248).

2.7.2.7 Moral impact

At this stage, there is much speculation in current literature about the moral impacts of the AIDS pandemic on orphans.

During the National Children's Forum, the children themselves reflected the important role that religious institutions can and do play in the lives of HIV/AIDS-affected children. However, they also highlighted the lack of understanding of HIV/AIDS on the part of many church leaders (Giese *et al.,* 2001).

Orphans may be particularly challenged by the developmental tasks of adolescence. Psychosocial and economic distress can lead to risk-taking behaviour linked with unsafe sexual practices and substance abuse (Connolly *et al.*, 2004).

Bray (2003:39-55) investigated the predictions found in the academic and policy literature of social breakdown in southern Africa in the wake of anticipated high rates of orphanhood caused by the AIDS epidemic. The study found mixed evidence that the increase in orphanhood might cause children who do not live in

appropriate social environments to be ill equipped as adult citizens. Furthermore, the study could not find substantial evidence that AIDS orphanhood will cause rising rates in juvenile delinquency or that it precipitates social or moral breakdown (Bray, 2003:39-55).

2.7.2.8 Economic impact

The death of a prime-age adult is obviously a tragedy for any household. Survivors have to contend with profound emotional loss as well as with medical and funeral expenses, plus the loss of income and services that an adult would typically provide. Some households are destroyed by AIDS, especially if both parents become ill and the children are very young (Worldbank, 2005b). Because of the epidemical proportions of this phenomenon, Government and NGO's will have to supply resources and the already poor countries will be burdened even more.

The AIDS epidemic contributes to deepening poverty in many communities, since the burden of caring for the vast majority of orphans, falls on already overstretched extended families; women or grandparents with the most meager resources. Such households are expected to earn less than other households. Economies burdened by AIDS are starting to crumble. The high mortality rate will result in the depletion of much of the labour force, having a profound impact on the very foundations of economies and state administration (Anon., 2003b). Financial and social demands of the current crisis on communities already struggling with insufficient resources will cause a reversal of development gains and, as a result, current development goals will be unattainable (Anon., 2000).

AIDS orphans in developing countries face extreme economic uncertainty and run higher risk of malnutrition, illness and sexual exploitation than children orphaned by other causes because traditional support systems in Africa are under severe strain. The grandparents, who are in many cases taking care of their orphaned grandchildren, have limited resources (Anon., 1999b:6). There is a growing consensus that the extended family system is no longer capable of providing for the orphans given severe economic constraints. There is an urgency to develop appropriate interventions to support families and take care of these children

(Madhavan, 2004:1443-1454). Although there is a high willingness among family members to take orphans into their homes if needed, there are deep levels of poverty that impede the good intentions of many (Freeman & Nkomo, 2005: 9).

Orphaned adolescents may be caught in the dilemma of having to work to support themselves or their younger siblings, which prevents them from attending school and receiving education and training they need to obtain productive work (Connolly *et al.*, 2004; Ebersöhn & Eloff; 2002:79). Because orphans are also deprived of learning values to become economically productive adults from their parents, it is suggested that this breakdown in intergenerational knowledge may also play a part in a country's economic decline (Anon., 2004a).

Catholic Relief Services stated that the situation in southern Africa is an emergency that has immediate and long-term repercussions for the development of the region and for the lives of its people. Urgent national strategies are needed to strengthen governmental, community and family capacities and to redouble cooperation to reverse the tide of this global calamity (Anon., 2002; Anon., 2003b). If the issues of AIDS infection are addressed effectively and proactively, it may be possible to maintain the workforce and productivity (Anon., 2000) and therefore establish more resources to care for the orphans in need.

2.8 CURRENT INTERNATIONAL AND SOUTH AFRICAN PROGRAMMES TO EMPOWER AIDS ORPHANS

From the above discussion of the impact of the HIV/AIDS pandemic on children and adolescents orphaned by the pandemic, it is clear that AIDS orphans are in need of empowerment.

In order to empower the AIDS orphan, the challenge of caring for these orphans, needs to be met through resolute political action before it reaches further crisis proportions. In AIDS-affected countries, a wide range of government and civil society stakeholders needs to provide financial help to children, families and communities, along with HIV prevention, care and support (Anon., 2004a).

Programs should target geographic areas seriously affected by HIV/AIDS and then support the residents of these communities in organizing to identify and

assist the most vulnerable children and households. Generally, the people who live in these communities are in the best position to determine which children are at greatest risk and what factors should be used to assess vulnerability and set priorities for local action (Connolly *et al.*, 2004).

Family capacity represents the single most important factor in building a protective environment for children who have lost their parents to AIDS and other causes. There is an urgent need to develop and scale up family- and community based care opportunities for these children who are living outside of family care (Connolly *et al.*, 2004). If preserving the family is the best option for orphaned children, then the family's capacity to care for, and protect these children must be urgently strengthened. This means adopting programs that keep parents living with AIDS alive and healthy as long as possible, improving a household's money-earning capacity, and providing children and their caregivers with psychological and other support (Anon., 2004a).

If orphans should be cared for in family units through extended family networks, foster families and adoption, and siblings should not be separated, they must be adequately supported by the state, community and other sectors (Fredriksson *et al.*, 2005).

The community needs to support the orphans and to accept them as part of the community. They should have access to essential services such as health care and education. Existing services must be improved and the stigma surrounding children affected by AIDS should be reduced so that they are not denied the services they need (Fredriksson *et al.*, 2005).

AIDS orphans can be empowered by regarding them as active members of a community rather than just victims. Many AIDS orphans already function as heads of the households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of HIV/AIDS in their families and communities (Fredriksson *et al.*, 2005).

A vast number of organizations and projects have already taken action to try to diminish the impacts of the AIDS pandemic and to empower the people and

especially the orphans affected by AIDS. The following are some of the well known and most active projects and organizations:

- The International HIV/AIDS Alliance (An international non-governmental organization that supports communities in developing countries to make a significant contribution to HIV prevention, AIDS care and support to children affected by the epidemic).

- UNAIDS (The Joint United Nations Children's Programme on HIV/AIDS that unites the world against AIDS to improve the health and lives of people in the world's poorest countries).

- UNICEF (The United Nations Children's Fund – An organization that focuses on child survival and development, basic education and gender equality, HIV/AIDS and children, child protection and policy advocacy and partnerships).

- USAID (The United States Agency for International Development – A United States organization that extends a helping hand to people overseas struggling to make a better life, recovering from a disaster or striving to live in a free and democratic country).

- UNICEF and UNAIDS devised *The Framework* to respond to the needs of the orphans and vulnerable children and to protect their rights and to "pull them back from the brink" (Connolly *et al.*, 2004).

The five key strategies of this framework are:

- to strengthen the capacity of families to care for the orphans;

- to mobilize and support community-based responses to provide help to vulnerable households;

- to ensure access to essential services including education, health care, etc.;

- to improve policy and legislation to protect vulnerable children; and

- to create a supportive environment for children affected by AIDS (Connolly *et al.*, 2004).

Other organizations and projects that have been founded and initiated to aid the vulnerable children in South Africa include:

- ACHWRP (Amajuba Child Health & Well-Being Research Project)
- CHGA (Commission on AIDS & Governance in Africa)
- Framework for Democracy and Governance
- The Actual Burden of HIV/AIDS on the KwaZulu-Natal Provincial Health Services project
- KwaZulu-Natal Department of Health Project
- HIV/AIDS, Land reform and Land-based Livelihoods in three Provinces in South Africa (funded by HSRC)
- MTT (Mobile Task Team) funded by USAID
- Developing a Spatial Framework for the management of support to Orphans and Vulnerable Children (Funded by Rockefeller Brothers Fund)
- Orphans and Vulnerable Children in the Western Cape (Funded by Rockefeller Brothers Fund)
- PEPFAR (President Bush's Emergency Plan for AIDS relief)
- SAVI (Southern African Vulnerability Initiative)
- SIPAA (Support to International Partnership against AIDS in Africa)
- Nelson Mandela Foundation
- Nelson Mandela Children's Fund
- National black Leadership Commission on Aids

- The World Bank
- The Global Fund to Fight AIDS
- The Displaced Children and Orphans Fund
- The International Federation of Red Cross and Red Crescent Societies
- Save the Children Fund/UK
- The Hope for African Children Initiative
- Save the Children USA, HIV/AIDS programmes
- Unite for Children. Unite against AIDS
- World Vision Canada: Hope Initiative
- NextAid (dedicated to creating sustainable solutions for African children orphaned as a result of AIDS)
- Gazlam and Tsha Tsha(television series about HIV/AIDS)
- Takalani Sesami (television and radio programmes about HIV/AIDS)
- Khomanani, Soul City and Love Life (broadcast, print and outdoor media campaigns to promote awareness about HIV/AIDS) (Connolly *et al.*, 2004; Shisana *et al.*, 2005:101).

An enormous gap, however, remains between what has been done, and what needs to be done. Closing the gap is possible with the combined efforts of governments, faith-based organizations, donors, nongovernmental organizations, the private sector and the thousands of community groups already struggling on the front line of response. Through committed partnerships and collaboration, millions of children and adolescents who are AIDS orphans will have a chance of a better future (Connolly *et al.*, 2004).

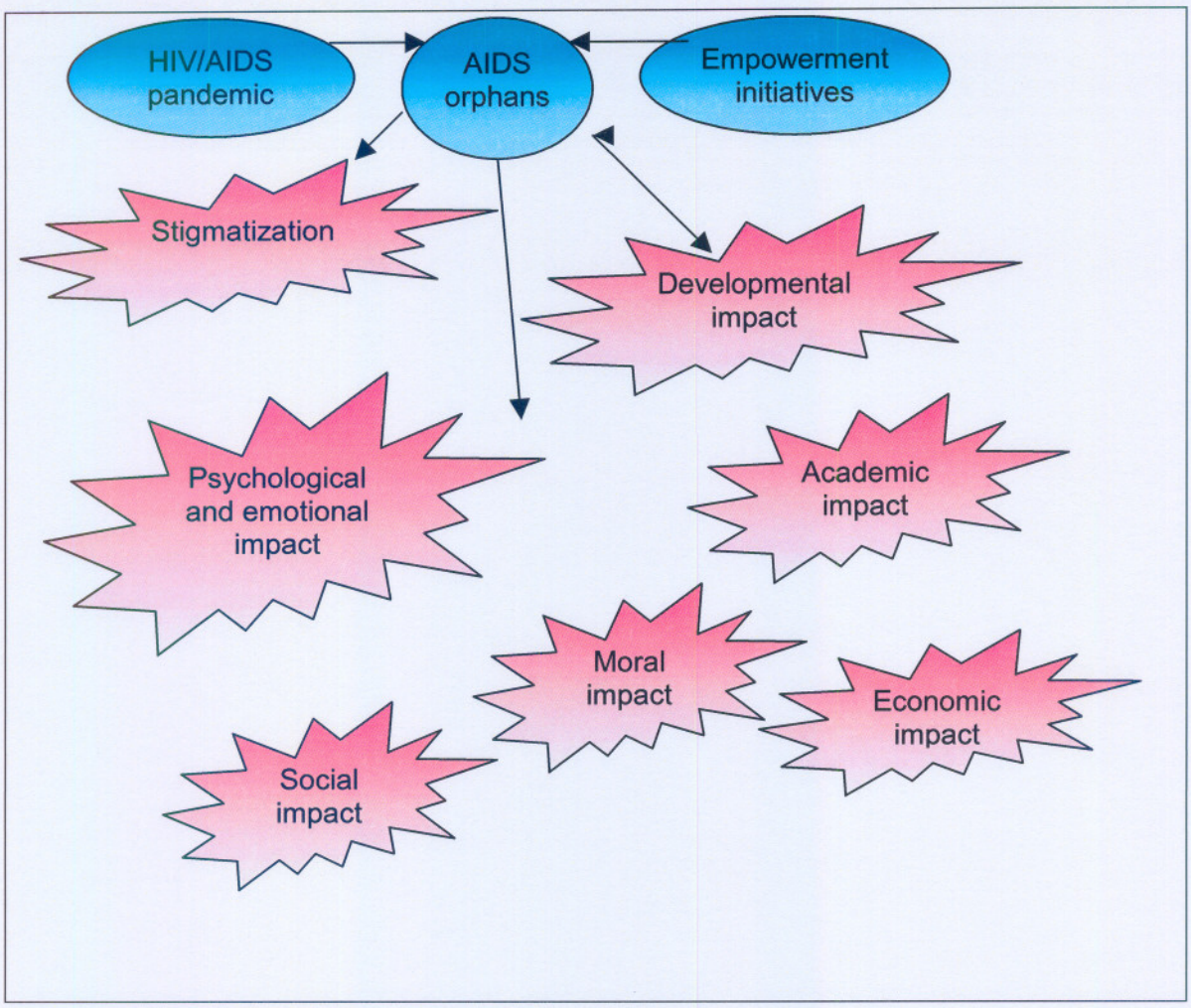
2.9 CONCLUSION

Millions of children have already lost at least one parent as a result of the AIDS epidemic, and millions are likely to over the next few years. There is an urgent need to help, care and protect these children, as well as preventing more children from becoming orphans in the future. In many countries a variety of initiatives is now taking place to help AIDS orphans, but the number of these children is increasing rapidly, and in many instances the increase in response is not keeping up with the increase in need. There is an urgent need to scale up responses and this is going to need both increased financial resources and commitment over the next few years (Fredrikson *et al.*, 2005).

Whether a child fulfils his or her vast potential is largely in the hands of the family, community and country into which he or she is born (Anon., 2005c), especially when the child is an AIDS orphan. A resilient child would be able to overcome or cope with most of these above mentioned crises because of his ability to "spring back" (OALD, 1989:1075) or recover from shock or adversity. In the following chapter the researcher will delve into the concept of resilience in order to find a solution, not enough researchers have looked into, for the AIDS orphan to fulfill his potential.

The following figure (Figure 2.5) summarises the contents of Chapter 2:

Figure 2.5: Summary of Chapter 2



CHAPTER THREE

THE NATURE OF RESILIENCE

3.1 INTRODUCTION

I ask not for good health, but for an alert and discerning mind.

I ask not that things go my way, but that I have perseverance and courage.

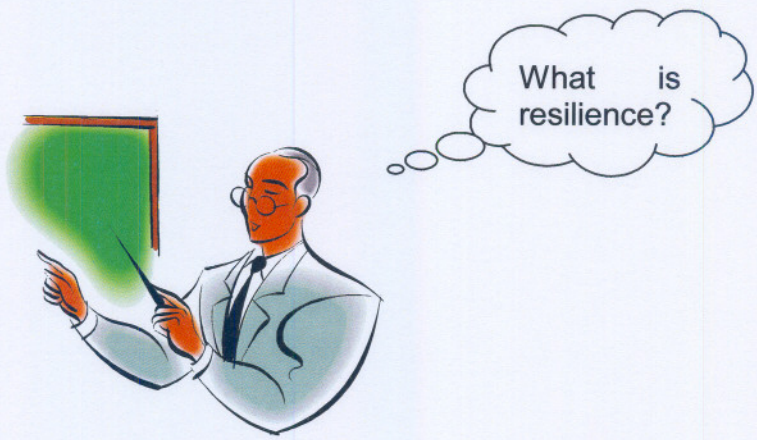
I ask not for less responsibility, but for increased strength.

-Master Cheng Yen, Tzu Chi

(Neill, 2005)

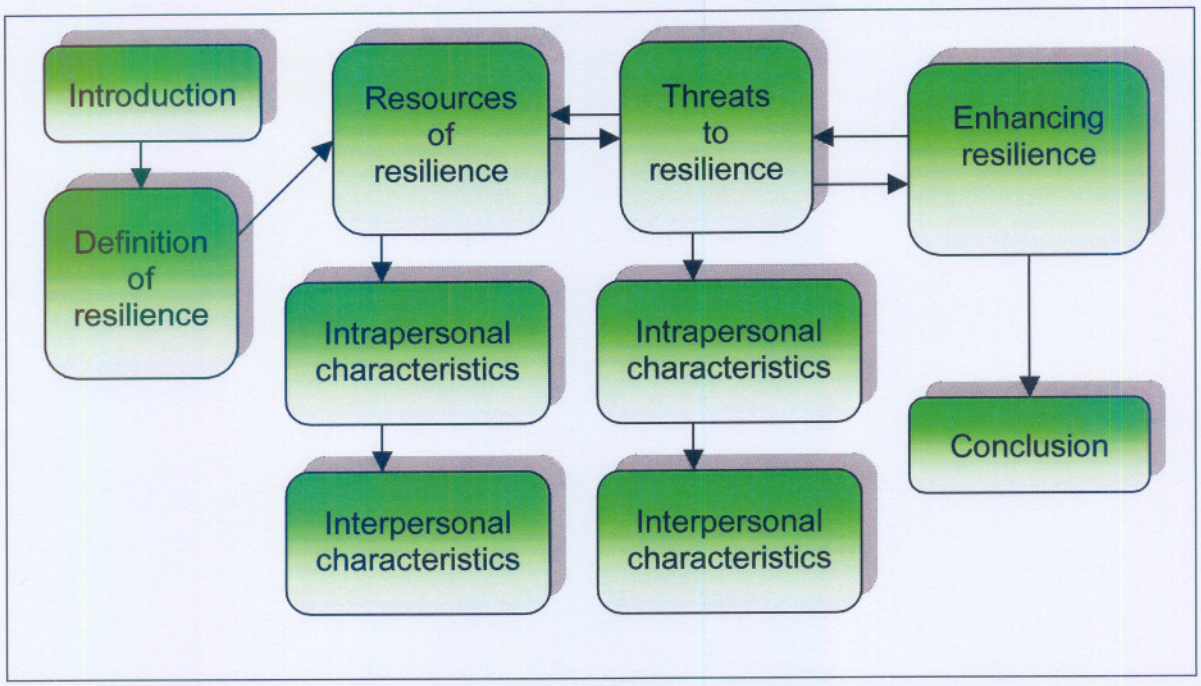
Resilience is that quality which lays the foundation for and gives rise to the triumph of the human spirit (Neill, 2005).

This chapter will focus on the phenomenon of resilience, how a resilient person functions and which resources contribute to resilience. Furthermore, it will look at resilience in young people (especially in vulnerable children) and finally investigate how psychological resilience can be enhanced.



The following diagram (Figure 3.1) summarises the contents of this chapter:

Figure 3.1: Overview of Chapter 3



3.2 DEFINITION OF RESILIENCE

Resilience originally meant being able to spring back after being pushed away, being bent, stretched or crushed (OALD, 1989:1075). Psychologically speaking, it has come to mean an individual's ability or psychological elasticity to overcome or cope with life's adversities and continue with normal development (Ungar, 2005:xv; Theron, 2005:56).

Masten and Reed (2005:75) define resilience as "a class of phenomena characterized by patterns of positive adaptation (adjustment) in the context of significant adversity or risk". In other words, when there is no threat to development, an individual cannot be thought of as resilient. Such threats are often considered to include premature birth, divorce, maltreatment, teenage pregnancies, parental illness or psychopathology, poverty, homelessness, war and natural disasters (including epidemics such as HIV/AIDS), experiences of major or chronic stress such as the death of someone else, chronic illness, sexual, physical or emotional abuse, fear, unemployment and community

violence (Masten & Reed, 2005:77; Neill, 2005). Threats to development are termed risk factors and will be discussed in detail later on (Cf. 3.4).

Because resilience refers to an individual's capacity to thrive and fulfill potential despite risks or stressors, as well as the ability to resist the negative impact of trauma, resilient people, families, or communities seem to manage, become stronger and / or not manifest psychological dysfunction under difficult conditions and environmental hazards. They are more inclined to see problems as opportunities for growth. They seem not only to cope well with unusual strains and stressors, but actually to experience such challenges as learning and development opportunities (Anon., 1995; Anon., 2005a; Neill, 2005; Van Rensburg & Barnard, 2004: 2).

Resilience or coping skills usually involve the following process: a stressor (risk) or potential source of stress occurs and cognitively the individual decides whether or not the stressor represents something that can be dealt with or is a source of stress because it may be beyond one's coping resources. If a stressor is considered to be a danger, coping responses are triggered. These coping strategies are generally either outwardly focused on the problem, inwardly focused on emotions or socially focused, such as gaining emotional support from others. If the individual possesses stress resistance, hardiness and shows a good recovery rate (to these stressors), she is indeed resilient (Neill, 2005; Van Rensburg & Barnard, 2004:2).

A more comprehensive and more up-to-date definition of resilience emphasizes both the individual's role in creating health or wellness and the relational, social and cultural protective factors that must be present to create that health when facing multiple risks. Multiple risks increase the probability of an undesirable outcome. Researchers are now emphasizing that resilience does not originate from exceptional qualities but from the protective processes of ordinary human support systems, found in children and in their relationships in their family, community, schools, religion and other cultural traditions (Masten & Reed, 2005:85; Ungar, 2005:xvi).

Resilient youth are understood to be youth who demonstrate academic achievement; pro-social conduct; peer acceptance; normative mental health and involvement in age-appropriate activities (Masten & Reed, 2005:76). Whilst some individuals seem to be more resilient than others, it should be mentioned that resilience is a dynamic quality, not a permanent capacity. Resilient individuals demonstrate dynamic self renewal, whereas less resilient individuals find themselves worn down and negatively impacted by life stressors (Neill, 2005).

Relevant psychological literature on resilience has not always used the term "resilience", therefore one could also explain resilience using the following terms: adaptive coping, emotional intelligence, hardiness, learned optimism, learned resourcefulness, life orientation, self-esteem, self-concept, self-confidence, self-efficacy, self healing, sense of coherence, sense of meaning or thriving, and even invulnerability (Elias, 2006; Neill, 2005).

3.3 RESOURCES OF RESILIENCE

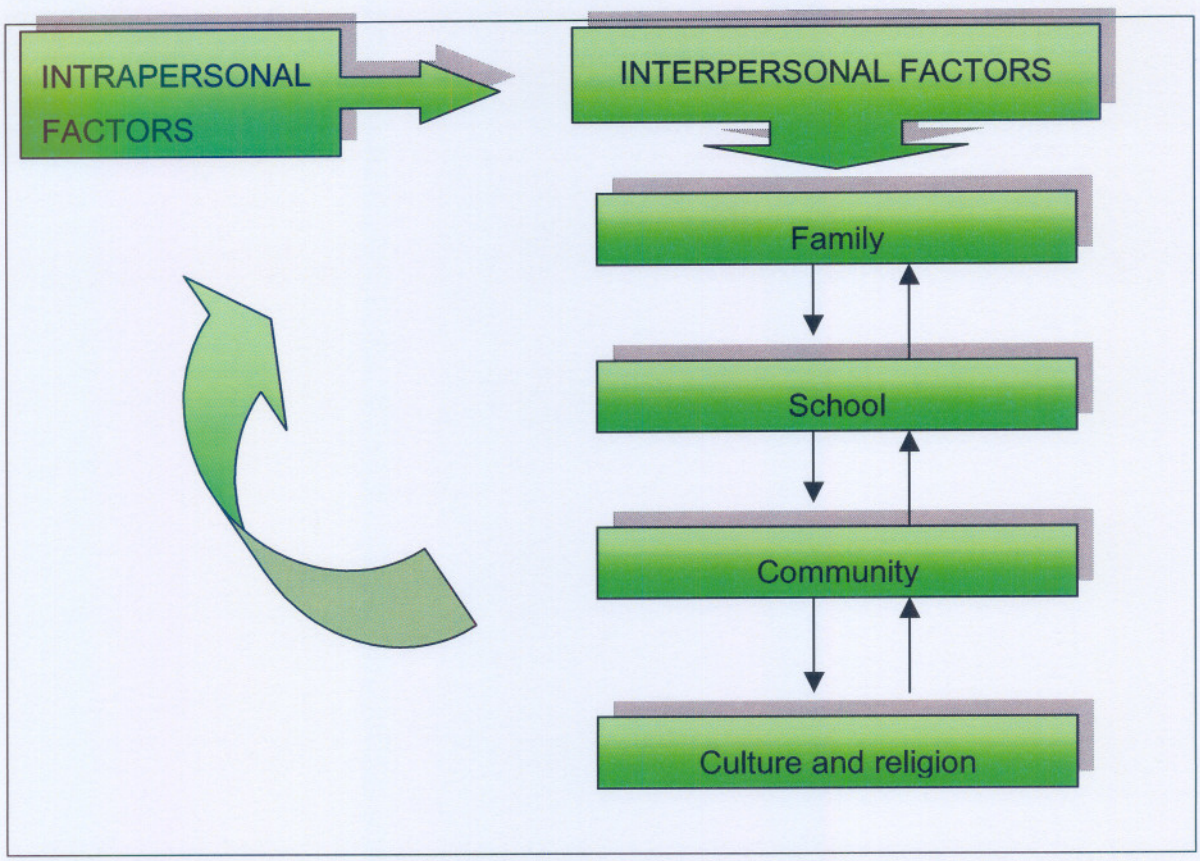
Resilience is not a coincidence; it generally emerges in people who have trained hard, who have particular attitudes, cognitive and emotional skills and a deep determination to overcome serious challenges (Kelley, 2005:265; Neill, 2005).

In order to be able to learn how to be resilient or to teach vulnerable individuals the necessary and appropriate coping skills, one has to clearly understand which protective factors (the resources or antecedents which encourage resilience are termed protective factors) (Anon., 1995) or qualities allow some people to fare better than others in the face of hardship.

Protective factors can be divided into two broad groups, namely intrapersonal and interpersonal factors.

Maddux (2005:279) emphasizes the social embeddedness of the individual and acknowledges that individual wellness depends to a large degree on the ability to cooperate, collaborate, negotiate, and otherwise live in harmony with people. Resilience is not the result of either social constructs or personal characteristics but rather the result of continuous interaction between these (Frydenberg, 1999:347). This interaction is graphically demonstrated in Figure 3.2.

Figure 3.2: Protective factors



3.3.1 Intrapersonal factors

When an individual faces adversity, certain traits/qualities within a resilient person have been found to be protective factors against stressful situations. Protective or

resilient personality traits begin to form early in life. Some may be genetic, while others are greatly affected by family and social influences (Anon., 1995).

The following intrinsic personal factors may differentiate the resilient individual from the non-resilient individual (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3):

- Firstborns seem to have the tendency to be resilient.
- Having age appropriate skills like sensory-motor and perceptual skills can foster empowerment. Childhood competence, as demonstrated by things like doing regular chores, having a part time job, participating in both school and extracurricular activities, and doing relatively well in school, also buffers risk.
- Resilient individuals seem to be more intelligent or show cognitive competence. Above-average intelligence would seem to be an advantage for a child caught up in unfavourable circumstances.
- There is a desire to improve which means that second chances will be relished and persistence evidenced. A sense of commitment characterizes resilient individuals.
- The individual shows the ability to function autonomously and to ask for help when needed. A sense of challenge is experienced and hardiness is exhibited in the face of stress.
- There is an absence of distressing habits which facilitates positive social interaction.
- A sense of curiosity promotes enthusiasm and problem-solving which results in a repertoire of problem-solving skills. Proactive approaches are employed to take control of the relevant life-situation.
- A good natured disposition (character) promotes positive relations with others reducing emotional reactivity. This includes a temperament characterized by a positive and optimistic nature, trust and a sense of hope.

- A high activity level encourages active participation across a spectrum of activities which leads to greater variety of experience.

- Representational competence refers to the ability to make meaning out of adversity. Critical thinking skills are vital in this regard.

- An internal locus of control discourages a sense of helplessness and encourages a survivor mentality. Fewer tendencies to blame the self for negative experiences are also noted.

- A positive self-concept prompts a sense of personal power. This is emphasized as one of the most important constructs of the formation and maintenance of psychological resilience among children. Self esteem is also noted.

- Special interests or hobbies allow the individual to experience competence and a sense of accomplishment. Humour and creativity also contribute.

- An ability to focus and to control impulses fosters positive social interaction and attests to self-discipline.

- Effective communication skills lessen emotional frustration and improve social interaction. An ability to experience a range of emotion also contributes to lessened frustration.

- Autonomy, or the ability to assert the right to safe boundaries, fosters a sense of empowerment. A sense of coherence contributes to assertive autonomy.

- Positive social orientation fuels the ability to develop intimate relationships that provide emotional support.

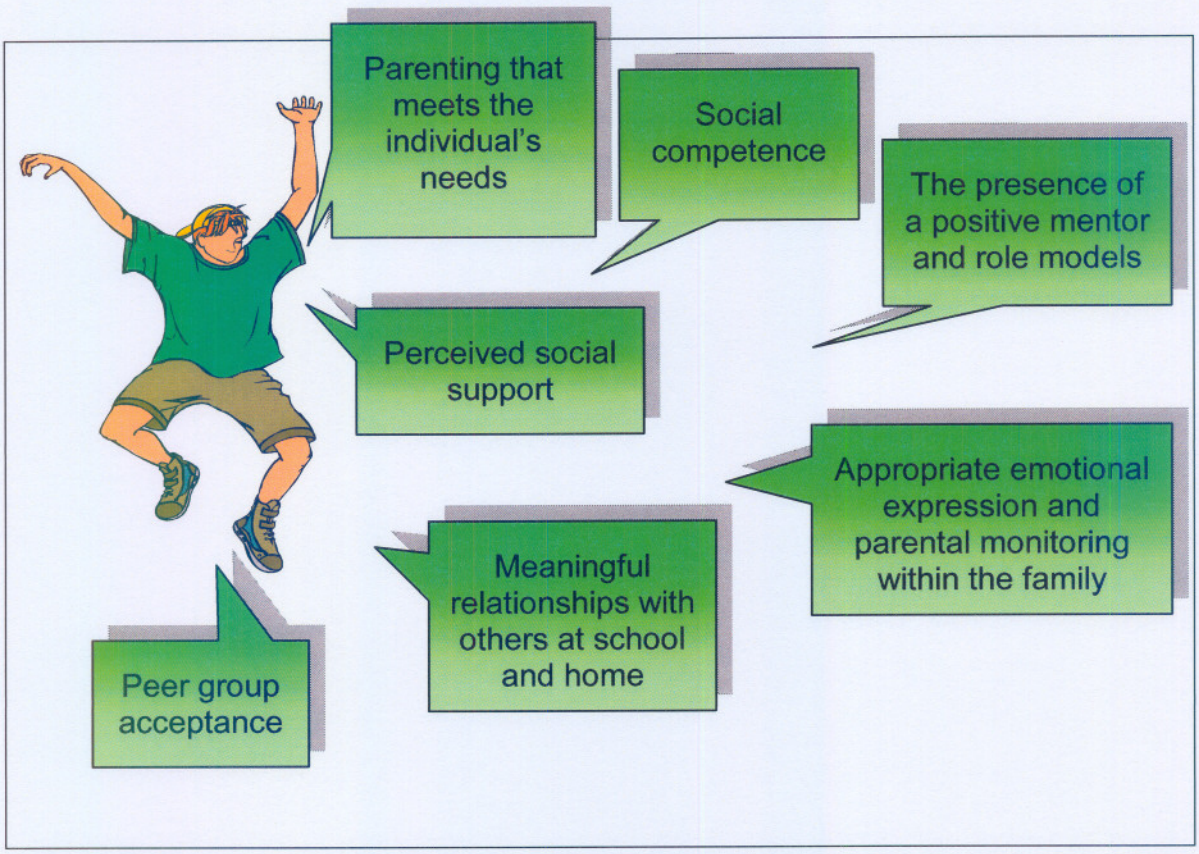
One has to remind oneself; however, that resiliency has limits. There is no such thing as a super individual or an individual that is invulnerable. Resiliency does not mean absolute protection against the effects of hardship, stress, poverty, hopelessness or lack of opportunity. It does, however, help to explain why many individuals who are at risk do not develop significant problems (Anon., 1995).

3.3.2 Interpersonal factors

Additional factors, apart from the above mentioned intrinsic factors are also associated with psychological resilience. Research has shown that relationship bonds to other competent and involved adults and also to prosocial peers are widely reported correlates and predictors of resilience (Masten & Reed, 2005:84). For resilient functioning to occur, protective family factors and social support as provided by the peer group, the school setting and community role models are essential (Masten & Reed, 2005:85; Van Rensburg & Barnard, 2004:3).

The following relationship factors (as summarized in Figure 3.3 below) have been related to young individuals demonstrating resilience:

Figure 3.3: Relationship factors that promote resilience (Masten & Reed, 2005: 85; Ungar & Liebenberg, 2005: 219)



These factors are discussed as part of the following discussion on familial and extra-familial protective factors.

3.3.2.1 Family

The family does play an important protective role in the lives of resilient children, especially if it is close, stable, warm and supportive (Anon., 1995; Carew, 2005:283; Frydenberg, 1999:343). The following protective factors are noted:

- Individuals raised in "close" families characterized by bonding, are less likely to develop behaviour problems. Warm supportive relationships with parents and siblings are factors which enhance resiliency. These children are better at handling stress and traumatic events.
- A stable and supportive relationship with at least one responsible adult throughout childhood is a significant protective factor.
- Family stability (little conflict or discord between parents) and security are factors in reducing psychological stresses in young children.
- High, positive parental expectations regarding school attendance and performance and parents who are involved in the child's education as well as his future.
- Support and supervision are important protective factors for problem behaviours.
- Parental control or authoritative parenting is a protective factor only when balanced with warmth, interest and involvement. This holds true regardless of socio-economic status, family structure and family history.
- An organized home environment.
- Postsecondary education of parents.
- Socioeconomic advantages.
- Parents with qualities related to resilient individuals.
- Recognizing and acknowledging core events such as birthdays and Christmas, which has a stabilizing effect on the family.

- Family members share a strong and durable faith in their ability to take control of their lives.

- Families who maintain routines in a wide variety of activities (Anon., 1995; Der Kinderen & Greeff, 2003:86, 87; Dornbusch, Laird & Crosnoe, 1999:278-279; Masten and Reed, 2005:86).

Figure 3.4: The stable, supportive and nurturing family

Nurturing (attentiveness, sensitivity and acceptance) is strongly related to resiliency in young children. Nurturing - or lack of it – interacts with temperament to produce an "easy" or "difficult" baby and this in turn starts the child on an easy or a difficult path. The family responds positively to an "easy" baby, who responds positively in return. A cycle, that gains either positive reinforcement leading to greater success and affiliation, or negative reinforcement leading to powerlessness and alienation, begins (Anon., 1995).

The extended family can also make a difference. It is a vital support system that plays a central role in helping some children develop resilience that continues into childhood. For many children the earliest and most significant influence is to be found outside the family. Grandparents, aunts, uncles and cousins can play a supportive role, helping children to feel loved and important, providing role models and giving extra guidance as needed (Anon., 1995; Van Rensburg & Barnard, 2004:4).

Other protective factors include influences beyond the immediate family. The risks for many young individuals begin with the social, economic and emotional

hardships with which they live. Young children are particularly vulnerable to these hardships and growing up in deprived living conditions appears to put people at increased risk. To foster resilience, children and their families should not be labeled and healthy environments, where all children can thrive, should be fostered (Anon., 1995; Edgar, 1999:120-121).

3.3.2.2 School protective factors

School does more than develop just knowledge: it is probably the most important setting for human development outside the home. The school is many children's first trial in life and has the potential to develop independence, self-confidence and self determination. At school children learn ways of interacting socially that will be brought into adult life (Anon., 1995; Dornbusch *et al.*, 1999:280).

Although school is regarded as a place of security and a sanctuary from painful circumstances, high value is placed on education and school achievement, and this can make school a place of competition and of success (or failure). The school experience can be a powerful protective (and risk) factor for mental distress and other problems. The school and associated scholastic activities can enhance the child's self-concept, sense of challenge, sense of coherence, and critical thinking. The cycle that began in the family is reinforced at school as the learner responds to feedback from teachers and other learners (Anon., 1995; Van Rensburg & Barnard, 2004:4).

In addition to a sound education, schools can provide the following protective factors, as summarized in Figure 3.5, to empower learners (Anon., 1995; Dornbusch *et al.*, 281; Van Rensburg & Barnard, 2004:4):

Figure 3.5: School protective factors

PROTECTIVE FACTORS IN SCHOOL

Schools that provide or have:

- counselling and support;
- life skill courses to help learners with decision making, problem solving, self awareness, creative and critical thinking, coping with emotions and stress, communication skills and so forth.;
- referrals to social services;
- food and uniforms to support learners to improve their circumstances;
- high standards and expectations that are encouraging of the learner and her entire family, and that are integrated and conflict free;
- learners with more or less the same courses and age appropriate activities;
- a non bureaucratic system but a learner focused curriculum;
- the same values as the learner's family;
- reaching out to parents, in other words a family-school partnership or collaboration;
- routine communication between the school and the learner's family (Anon., 1995; Christenson & Brooke, 1999:266-268; Masten & Reed, 2005:83; Van der Westhuÿsen & Schoeman, 1984:323-325; Van Rensburg & Barnard, 2004:4).

Teachers that provide or have:

- good teacher-learner relationships where teachers serve as role models and mentors, give effective advice and sufficient praise, and work to understand and accept their learners' culture, language and communication style;
- warmth and supportiveness as well as understanding and empathy;
- cooperative learning methods and creating an effective learning environment;
- supportive teaching styles;
- active learner participation;
- high (but realistic) expectations and rewards (Anon., 1995; Christenson & Brooke, 1999:266-268; Masten & Reed, 2005:83; Van der Westhuÿsen & Schoeman, 1984:323-325; Van Rensburg & Barnard, 2004:4).

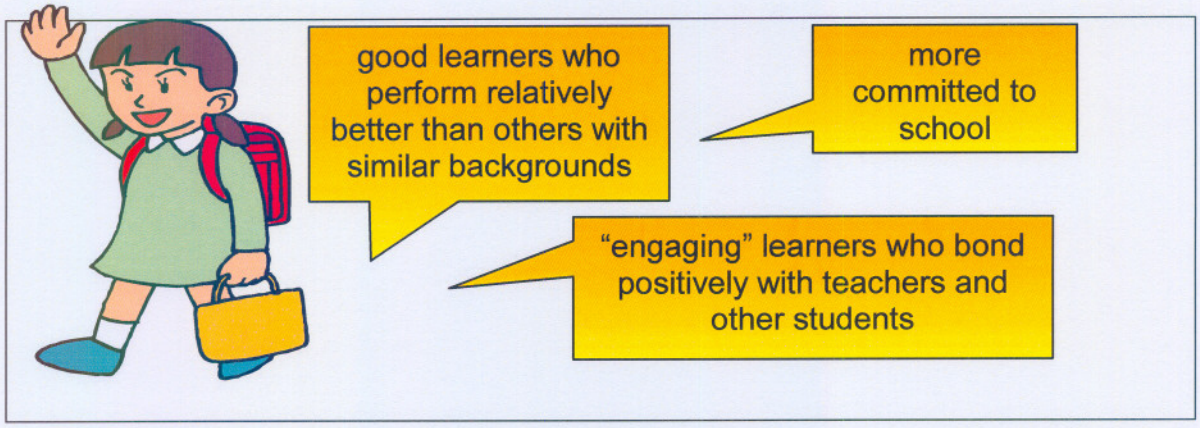
The important role of the peer group (in terms of emotional support) and role models/mentors provided by the school environment should also not be forgotten. In the absence of traditional social support networks, peer group influence has a potential for becoming an even more important frame of reference (Collings & Magojo, 2003:126; Van Rensburg and Barnard, 2004:4).

Schools should reach out to learners who are not particularly receptive or successful in school, but who like all of us need recognition and encouragement. Schools can support some learners emotionally and socially (Anon., 1995) creating another environment for the individual to experience psychological wellness.

Schools can be envisioned as places where children can experience empowerment and enhanced development rather than places where the focus is on stresses and challenges. If teachers and children are taught to use interpersonal cognitive problem-solving skills in interactions, these skills enhance positive growth and development without focusing on any of a child's shortcomings (Dornbusch *et al.*, 1999:278-279; Masten & Reed, 2005:83).

In school, typically resilient children have a positive learner profile as summarized in Figure 3.6 below:

Figure 3.6: Resilient learners are ... (Anon., 1995)



3.3.2.3 Community protective factors

Social support is viewed as a potential element of positive psychology for individuals facing the challenges of stressful events as well as coping and adjusting in everyday living. Social support includes providing direct assistance, emotional concern and affirmation (Masten & Reed, 2005:84).

Friends and neighbours as well as psychologists, teachers, supervisors, school aftercare, sports trainers, and mental health workers who make up a social support system are important protective agents (Anon., 1995; Van Rensburg & Barnard, 2004:4).

In the following figure (Figure 3.7) protective factors associated with the broader community are summarized.

Figure 3.7: Community protective factors

There are a number of ways the broader community can promote resiliency:

To foster resilience the community should provide:

- social support in the form of belonging, stability and community;
- adults who help children develop trust, autonomy and initiative. These adults are especially significant, in that they believe in the child and help children learn to believe in themselves;
- support to parents in their nurturing roles by offering them formal and informal guidance, as well as a forum for shared action;
- basic infrastructure where family life is lived, including such things as employment, child care and a context where shared values and experiences are developed;
- opportunities for age-appropriate work;
- avoidance of exposure to violence in the family, community and with peers;
- government provision for children's safety, recreation, housing and jobs when older;
- meaningful rights of passage with an appropriate amount of risk;
- tolerance of high risk and problem behaviour;
- safety and security;
- perceived social justice;
- access to school and education, information and learning resources;

- ties to prosocial organizations, including schools, clubs, scouts or girl guides and so forth;
- neighbourhoods with high collective efficiency;
- good emergency social services;
- good public health and health care availability; and
- community projects to uplift the needy and disadvantaged people (Anon., 1995; Anon., 2005b; Masten & Reed, 2005:84; Strümpfer, 2003:71; Ungar & Liebenberg, 2005:218-219).

One fairly recent example of a successful community project in Africa can be found in Nairobi, where a parish centre, run in a poor neighbourhood, has been providing education, daily meals, care, music, poetry, theatre and physical education to street children and orphans. It has been found that these children usually perform well at school. This programme (called Upendo) is proof of how successful society's efforts can be in the empowerment of children at risk. Pastor Gerry Whelan, who runs the programme stresses that Upendo children become models of ethical behaviour as they grow older because they are provided with the love they need, together with enough practical assistance for them to grow into healthy and self-reliant adults (Repssi, 2005a).

3.3.2.4 Cultural and religious factors

Not much research has been done on cultural and / or religious impacts on resilience, though there have been numerous calls for such research (Lopez, Prosser, Edwards, Magyar-Moe, Neufeld & Rasmussen, 2005:705).

Resilience is related to ideological factors such as:

- affiliation with a religious organization;
- tolerance of differing ideologies and beliefs;
- adequate management of cultural dislocation and a changing shift in values;
- self-betterment;
- having a life philosophy;

- cultural and spiritual identification; and
- being culturally grounded by knowing where you come from and being part of a cultural tradition that is expressed through daily activities (Ungar & Liebenberg, 2005:218-219).

Faith and spirituality/religion are factors that promote good health and contribute to the state of wellness that characterize health, but unfortunately not much research has been done in this field. Pargament and Mahoney (2005:647) contend that research in this area may be well worth the while because it holds promise for understanding a neglected dimension in life and may help people enhance their well-being.

At a symposium of the Hope for African Children Initiative, held in South Africa in June 2002, the urgency of mobilizing faith communities was stressed because they are the largest in (the South African) society. Consequently, religious leaders have a pivotal role to play in empowering society because they have the opportunity to talk to their members almost every week (King, 2004).

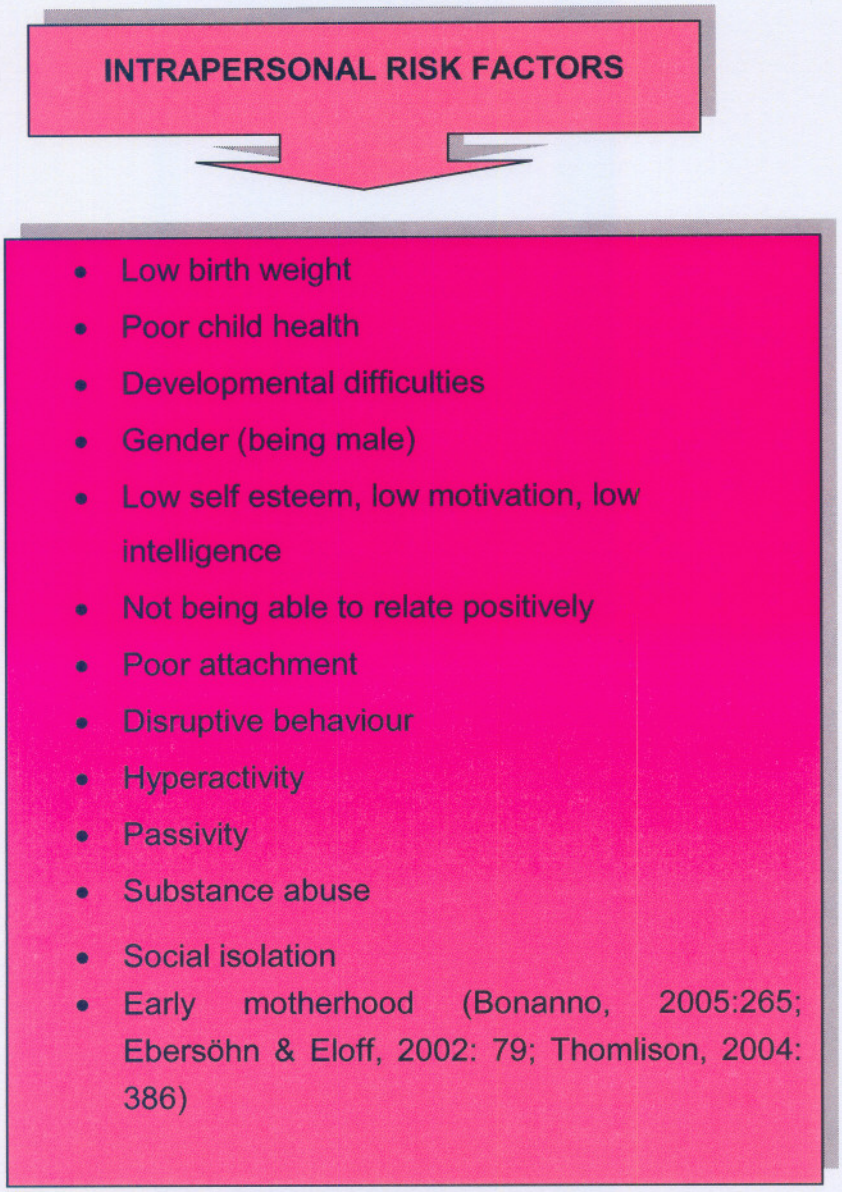
3.4 THREATS TO RESILIENCE

When risk factors are present, the potential for resilience (or continued successful adaptation) is undermined. Risk factors can also be categorized into two broad groups, namely intra- and interpersonal risk factors. Although the deduction can be made that risk factors would be the opposite of the protective factors mentioned earlier, this is not necessarily true. For example, having a teenage mother is considered to be a risk factor, but the opposite (an older mother) is not necessarily protective (Schoon 2006:15). In Figure 3.8 below, risk factors are summarized (Anon., 1995; Thomlison, 2004:384-387; Van Rensburg & Barnard, 2004:4).

It must be emphasized, that although risk factors are itemized in Figure 3.8 below, risk factors are more likely to be cumulative and that risk increases when cumulative risk factors are present (Bonanno, 2005:265; Carson, Swanson, Cooney, Gillum & Cunningham, 1992:275; PHAC, 2006). In other words, when an AIDS orphan has lost both parents, is facing poverty, has teachers who

discriminate against orphans and is a male child, the likelihood of resilience is more threatened compared to an AIDS orphan whose only risk factor is the loss of one parent.

Figure 3.8: A summary of risk factors



INTERPERSONAL RISK FACTORS

Familial risk factors, which include:

- Fragmented family structures (divorce, death)
- The placement of children into foster care / Separation from parents
- Low socioeconomic status / Poor support / Low income
- Inadequate housing / Lack of material resources
- Severe marital discord / Conflict
- Abuse
- Overcrowding or large family size
- Disorganization
- Paternal criminality / Paternal pathology
- Lack of a positive and healthy adult model
- Disturbed parent-child relationships
- Mobility
- Lack of tradition
- Poor adult supervision
- Low parental education
- Employment stress or unemployment
- Prolonged economic distress
- Rapid and stressful life changes
- Inaccessible or unaffordable health and child care

(Carew, 2005: 283; Der Kinderen & Greeff, 2003: 87; Thomlison, 2004: 384-387).

School risk factors, which include:

- Rigid policies and practices
- Large class size
- Repressive discipline
- No preventive measures
- Inappropriate learning content
- Passive teaching strategies
- Competitive exam-dominated assessment
- Unsupportive school culture
- Negative educator-learner relationships
- No student participation
- Poor school – parent relationships
- Poor staff development
- Early educational failure
- No school counselors
- Isolation from school and poor school performance are serious risk factors for problem behaviour. Unfortunately, learners from disadvantaged backgrounds (like AIDS orphans) are less likely than other learners to feel a sense of belonging or being cherished at school (Ebersöhn & Eloff, 2002:79; Thomlison, 2004:386-387).

Environmental and community factors, which include:

- High levels of neighbourhood crime/violence
- Social disintegration or disorganization
- Social intolerance or discrimination/stigma/racism
- Socially impoverished community
- Community norms
- Neighbourhood disorganization (Ebersöhn & Eloff, 2002:79; Thomlison, 2004:386-387).

3.5 ENHANCING PSYCHOLOGICAL RESILIENCE

What can be done to enhance resilience in individuals at risk?

Garmezy, as quoted by Dulmus & Rapp-Paglicci (2004: 5), states that the central element in the study of resilience lies in the power of recovery and in the ability to return once again to those patterns of adaptation and competence that characterized the individual prior to the pre-stress period. Practitioners, policymakers and researchers must look for protective factors that promote health and resiliency and presumably compensate for risk elements that are inherent in the lives and in the environments of many underprivileged children. One should focus on those elements in person, family and community that may be conducive to the development of adaptive behaviours (Dulmus & Rapp-Paglicci, 2004:7). In other words, in order to aid youngsters to function resiliently, it is necessary to focus on both inter- and intrapersonal factors and the interaction between these factors.

Masten and Reed (2005:85) state that the greatest threats to children are those adversities that undermine basic human protective systems for development. Basic protective systems include families, schools, cultural and religious traditions and the interplay of these with individual protective factors. It follows that efforts to promote competence and resilience in children at risk should focus on strategies that prevent damage to, restore, or compensate for threats to these basic systems. Programmes and policies that support effective parenting and the availability of competent adults in the lives of children are crucial.

Resilient research classifies three basic strategies for intervention, being:

- Risk-Focused Strategies - which aim to reduce exposure of children to hazardous experiences. More specific strategies for reducing risk and stressors include:
    - preventing or reducing the likelihood of low birth weight or prematurity through prenatal care;
    - preventing child abuse or neglect through parent education;

- reducing teenage drinking, smoking, or drug use through community programmes;
- preventing homelessness through housing policy or emergency assistance;
- reducing neighbourhood crime or violence through community policing;
- and reducing the incidence of HIV infections (Masten & Reed, 2005:84-85).

- Asset-Focused Strategies – which aim to increase the amount of, access to, or quality of resources children need for the development of competence. To foster someone's competence there has to be both challenge and support (or resources that provide support). Any level of challenge can be provided if the support is corresponding. A small amount of challenge may be too much and lead to traumatic experience if there are inadequate support resources. Children benefit from a variety of different programmes, including those that focus directly on the child (e.g. the provision of a tutor) and those that provide parent education and support (Dulmus & Rapp-Paglicci, 2004:7; Masten & Reed, 2005:84-85; Neill, 2005; Schoon, 2006:144-148).

- Process-Focused Strategies – which aim to mobilize the fundamental protective systems for development. Efforts go beyond removing risk or adding assets. They attempt to influence processes that will change a child's life. Promoting healthy development and competence is just as important as preventing problems (Masten & Reed, 2005: 84).

Building the psychological resilience of at risk populations has become an increasingly popular target of community intervention, youth work, social work and personal development programmes (Neill, 2005). Individual personality, the family, the school and the community all play a role in determining the risk and protective factors in a child's life and how resilient she will become (Anon., 1995). Professionals, teachers, community workers, police, neighbours and friends can all make a difference. Everybody can influence the lives of the children with

whom they come in contact. They can play a part in helping children grow up healthier and more resilient, by:

- accepting them for who they are and giving them support and encouragement;
- understanding their reality and providing experiences that challenge rather than overwhelm their ability to cope;
- encouraging them to develop competency through special interests and activities;
- inviting at-risk children to reach out beyond their own families for contact, activities and sources of fulfillment;
- modeling constructive thinking and the conviction that life can get better;
- understanding the realities of disadvantaged families, supporting parents in their role and promoting a community infrastructure that better meets their needs; and
- helping schools find ways to better help at-risk children (Anon., 1995; Dulmus & Rapp-Paglicci, 2004:7).

Parents and other influential adults need to understand the importance of competency and how to help children develop it. Opportunities for responsibility and success through positive effort must begin early and be supported consistently. Masten and Reed (2005:84) add that children need opportunities to experience success at all ages. This means that families, schools and communities have a responsibility to provide such opportunities and to ensure that the talents of an individual child are developed. Feelings of self-confidence and self-efficacy grow from mastering experiences. Children who feel effective persist in the face of failure and achieve greater success because of their efforts (Anon., 1995; Masten & Reed, 2005:84).

Social policy and community services also play a vital role in protecting children and fostering resiliency (Anon., 1995). Bronfenbrenner contends that when numerous children are facing increased risk because of parental unemployment,

other income losses and diminished health and family services, it is vital to determine which policies and programmes will best empower families to perform the magic intrinsic to families, namely: "making and keeping human beings human" (Anon., 1995). Community capacity must be strengthened in order to rope families in as agents of resilience (Barter, 2005:351).

Community efforts to enhance resilience through intervention programmes have been increasingly seen as pro-active, preventative, potentially cost-saving and positive approaches to minimizing psychological dysfunction. Enhancing psychological resilience seems to be an underlying theme in both clinical and humanistic or positive psychological work, as well as in challenge-based personal development programmes (Neill, 2005).

Although there is no comprehensive intervention at a single time that accomplishes comprehensive goals of prevention for a lifetime, the ultimate goal to achieve prevention should be to build the principles of prevention that enhance development into the ordinary activities of everyday life and into the community structures over the entire life span. Risk factors that occur in multiple domains - home, school, peer group, neighbourhood, or work sites – require interventions in all of these domains (Bowen, Powers, Woolley & Bowen, 2004:340-341). To buffer youth, interventions need to pay attention to both intra- and interpersonal risk and protective factors.

3.5.1 South African interventions /studies that target resilience

Locally, youth experience similar problems as do (vulnerable) children worldwide, but in South Africa and the Sub-Saharan countries the youth have to deal with the added devastating effect of HIV/AIDS and the traumatic consequences thereof (Cf. 2.7.2.1 to 2.7.2.8).

Given the traumatic effects of grief, loss, exposure to HIV/AIDS and other hardships (such as living in foster care) faced by AIDS orphans and vulnerable children, there is an increasing recognition of the importance of (local) programmes to help strengthen their social and emotional support systems (Repssi, 2005b).

Although much is being done and many programmes have been established and are currently running to empower the orphans and vulnerable children worldwide, and specifically in South Africa (Cf. 2.8), relatively little research has been done to enhance the psychological resilience of these children.

In her study, Theron (2006:209-212) found that by implementing a group intervention programme to foster resilience in learners with learning disabilities, it is possible to foster resilience, by strengthening or building personal protective factors.

The following South African research and interventions to promote resilience in HIV/AIDS affected children have been recorded (Collings & Magojo, 2003:126; Cook & Du Toit, 2005:260-261; Govender & Killian, 2001:2):

Table 3.1: Summary of research and interventions to promote resilience among AIDS affected children

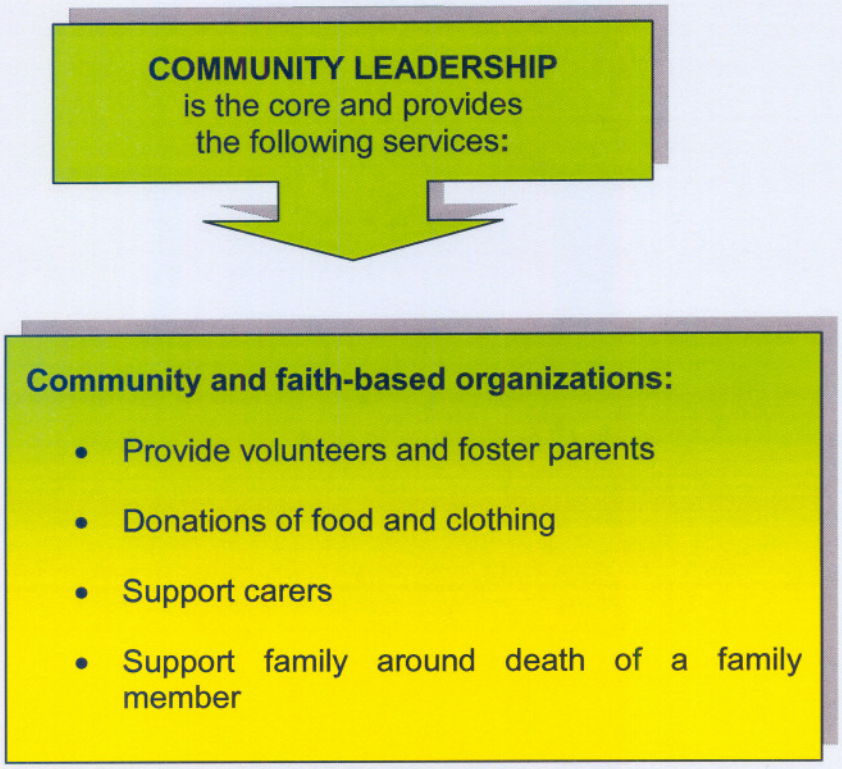
Researchers	Name of Project and Location	Findings
Cook and Du Toit (Cook & Du Toit, 2005: 260-261)	Circles of Care: Community Capacity Building project in 3 Free State municipalities	• Community capacity building that supports traditional African community structures and local government was focused on. • A circle of care was formed around the vulnerable citizens and children. • A rights-based approach involved children purposefully. • Numerous actions were taken to foster resilience, for example: o establishing vegetable gardens; o teaching parenting skills; o recreational work with youth;

		○ establishing day care facilities; ○ establishing cultural clubs for youth; ○ raising awareness about children's rights; ○ inviting orphans for meals; and ○ collecting and dispensing clothes. • It was found that children showed greater self-efficacy and increased self esteem following these interventions. • Youth self-efficacy promoted collective adult self-efficacy.
Collings and Magojo (Collings & Magojo, 2003: 126)	Youth violence in South African townships	• Youth exposed to high levels of violence had transcended the limited horizons of their environment. • Personal resources attributed to these resilient outcomes were: ○ a determined desire to transcend the limitations of the environment; ○ procurement of resources to achieve long term goals; and ○ an ingrained sense of personal morality • This has not been extended to an intervention programme.

Govender and Killian (Govender & Killian, 2001: 2)	Violence in KwaZulu Natal's townships	• Evidence of resilience can be accounted to: o gender based differences; o developmental stage of adolescence; o society (especially school); and o family support. • This has not been extended to an intervention programme.

In South Africa the Gauteng Provincial Government has recently launched a comprehensive support programme to help children and families fight the effects of HIV/AIDS. Figure 3.9 summarises the stake holders involved as well as the processes involved in this programme (Gauteng Provincial Government, 2005):

Figure 3.9: Summary of support programme in Gauteng



Health and social services:

- Provide free clinic services
- Fund NGO's to look after sick people at home
- Social workers
- Fund and train NGO's
- Grants
- Involve civil society

NGO's

- Children's NGO's help to look after children in their homes
- Help with food, clothes, education, a home, solve problems and refer
- Give counselling
- Help families get services

Education

- Schools provide counselling and support
- Free education
- Some food
- Some uniforms
- Refer to Social Services

Justice

- Helps with inheritance and protection of rights
- Children's courts place abandoned or abused youth

Agriculture

- Trains people to grow food gardens
- Provides some gardening supplies

Home affairs

- Birth certificates and ID's provided

Housing

- Helps children to inherit the house or get a house if the parents die

Police

- Respond to child abuse

Co-ordination

- Local AIDS council
- Municipal AIDS co-ordinator
- Local database of services

Workplace

- Business provides support to NGO's
- Donations of food, clothing etc.
- Benefits for families of employees

Municipality

- Co-ordinates efforts
- Provides subsidized housing, water and electricity
- Protects children

Although the programme has been implemented for a while, the question still remains whether it is working (Gauteng Provincial Government, 2005). However, theory on resilience stresses that interpersonal factors and intrapersonal factors work together to foster resilience and this programme has omitted the effect or influence the individual protective factors have on resiliency.

Finally, Govender and Killian (2001:10) stress that the cognitive, social, emotional and psycho-physiological functioning (in vulnerable children) can be severely affected by many risk factors, but that there is still much "we do not know". This suggests that there is still much research to be done on what antecedents function protectively to result in resilience and what would constitute successful interventions.

3.6 CONCLUSION

"More than education, more than experience, more than training, a person's level of resilience will determine who succeeds and who fails" (Becker, 2003).

There is an urgent need to develop standardized and validated measures of resiliency. Researchers must continue to do empirical research in the area of childhood resiliency and assist practitioners in the development and implementation of resiliency enhancement programmes for both children and families (Dulmus & Rapp-Paglicci, 2004:7).

The most striking conclusion arising from all the research on resilience is that the extraordinary resilience and recovery power of children arises from ordinary processes. The evidence indicates that the individuals who "make it" have basic human protective systems operating in their favour. Resilience does not come from rare and special qualities but from the operations of ordinary human systems, arising from individual brains, minds, and bodies, from relationships in the family and community and from schools, religions and other cultural traditions (Masten & Reed, 2005:85).

Finally, amidst calls for help from all over the world, and thousands of campaigns and programmes that help alleviate the effects of HIV/AIDS on the children, it has to be stated that The New York Times recently reported that a new book, written by Stephen Lewis, the United Nations' special envoy to Africa on AIDS, brings to light an extraordinary breach between the organization and South Africa over the HIV/AIDS crisis. South Africa's government, headed by Mr. Thabo Mbeki, is singled out for what it calls bewildering policies and a lackadaisical approach to treatment of the nation's millions of HIV-positive citizens (Worldbank, 2005a).

This should serve as an even greater motivation for continued research for answers on how to promote resilience in the millions of vulnerable and at risk people of this country, including AIDS orphans.

The following chapter will focus on the research planned to determine the measure of resilience found in the HIV/AIDS orphans of South Africa using the CYRM as well as interviews with resilient orphans.

CHAPTER FOUR

RESEARCH DESIGN AND METHOD

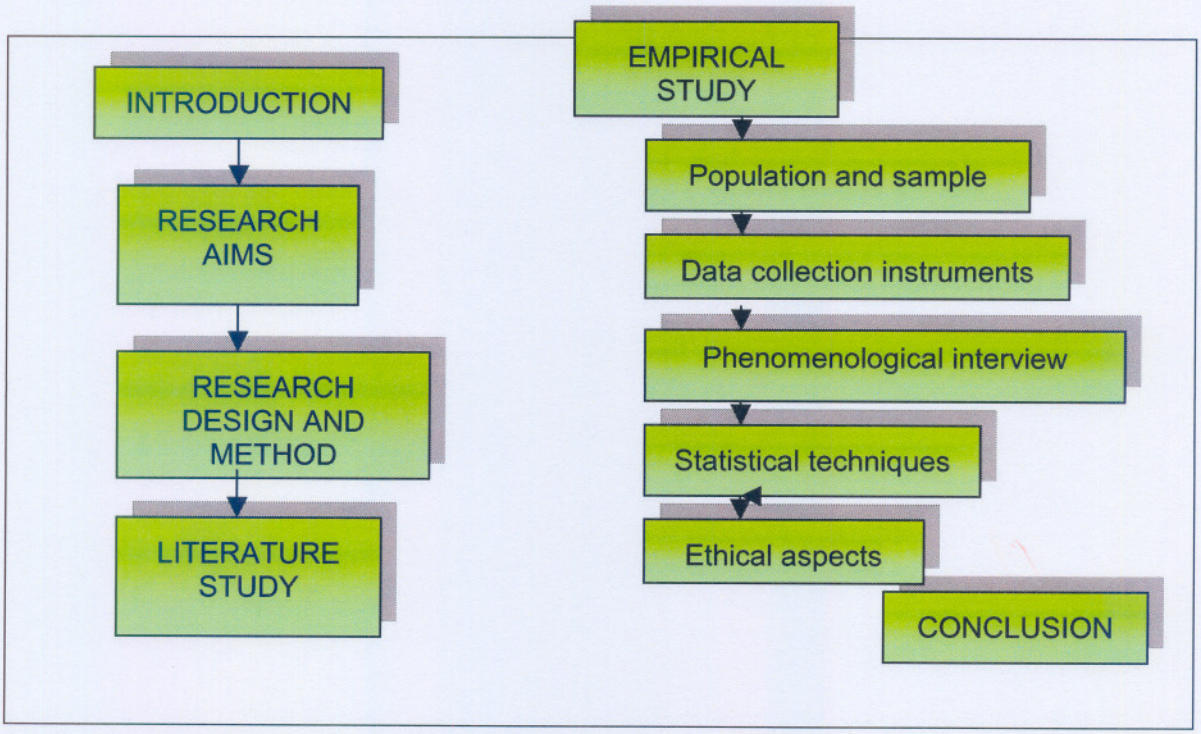
4.1 INTRODUCTION

One has to delve or "dig deeper" to get a complete understanding of the phenomenon being studied (namely resilient functioning among AIDS orphans), and in order to be able to do this, numerous forms of data have to be collected and examined to create a meaningful picture of this intricate situation (Leedy & Ormrod, 2005:133).

This chapter will focus on the aims, the design and method, the empirical study, the statistical techniques and the ethical aspects of research which were followed in order to gain a complete understanding of the phenomenon of resilient functioning among AIDS orphans.

The following flow chart (Figure 4.1) summarizes the contents of this chapter:

Figure 4.1: Overview of Chapter 4



4.2 RESEARCH AIMS

The overall aim of this study is to document the phenomenon of resilience among AIDS orphans in South Africa.

The following sub aims will also come into operation:

- an overview of the phenomenon of AIDS orphans;
- an overview of the phenomenon of resilience;
- an investigation of the phenomenon of resilience among AIDS orphans;
- a comparison between resilient and non-resilient orphans; and
- provision of guidelines to encourage resilient functioning amongst AIDS orphans.

4.3 RESEARCH DESIGN AND METHOD

The study is designed to fit the prescriptions of the International Youth Resilience Study (IYRS). The IYRS is an international project, initiated by Dalhousie University in Canada which uses different types of research methods to examine what helps children and youth function resiliently despite the many challenges they face. IYRS looks at resilience from the perspective of youth and elders in each community that participates.

The design consists of two parts:

- survey research (with resilient and non-resilient youth) using a close-ended questionnaire; and
- a phenomenological study using semi-structured interviews (this entails in-depth interviews with resilient youth and with elders from the same community as the youth who are knowledgeable about resilience).

Because the design consists of survey research (quantitative research) as well as phenomenological interviews (qualitative research), the research design is a mixed methods approach.

4.3.1 The mixed-methods design

In this study, a mixed-methods design will be used, as a quantitative as well as a qualitative approach is used. This implies that data will be quantified (counted) and participants' perceptions and emotional reactions will be reported (Leedy & Ormrod, 2005:97). In other words, quantitative data and qualitative data are collected to answer a single research question (De Vos, 2001:361; Leedy & Ormrod, 2005:99). Typically, the qualitative data illuminates or clarifies the quantitative data.

Mouton (1996:39) argues that for many researchers doing social research it is desirable to combine qualitative and quantitative methods to improve the quality of their research. Both approaches represent complementary components of the research process (Leedy & Ormrod, 2005:94). The researcher learns more about the issue being studied when both methodologies are used than when the researcher is limited to only one approach (Leedy & Ormrod, 2005:95).

In practice it means that, in this study, interviews will be conducted with caretakers of AIDS orphans (i.e. elders) to distinguish resilient orphans from non resilient orphans and to understand what elders believe the antecedents of resilience to be (qualitative research), in order to establish a sample to which questionnaires will be administered and to quantify the data (quantitative research). Following the survey, semi-structured interviews will be conducted with a small number of the resilient orphans to further embellish the quantitative results. The semi-structured interviews with the resilient orphans will aim to obtain a deeper understanding of what promotes resilience from their perspective.

To motivate the choice of a mixed research designs, a brief description of qualtitative research design, quanitative research design and the investigation group is provided.

4.3.1.1 Qualitative research

Qualitative research is used to answer questions about the complex nature of phenomena in order to describe and understand the phenomena from the participant's point of view. It is also called the interpretative, constructivist or post

positivist approach (Leedy & Ormrod, 2005:94) and focuses on phenomena that occur in natural settings and it involves studying those phenomena in all their complexity. Qualitative researchers recognize that the issue they are studying has many dimensions, so they try to portray the issue in its multilayered form (Leedy & Ormrod, 2005:133; Tuckman, 1994:380-383).

Although research should be influenced as little as possible by perceptions and biases, qualitative researchers believe that the researcher's ability to interpret what she sees is critical for understanding any social phenomenon. The researcher becomes an instrument of research (Leedy & Ormrod, 2005:133). Qualitative researchers enter the research setting with open minds and are prepared to engross themselves in the complexity of the situation and interrelate with their participants (Leedy & Ormrod, 2005:95; Tuckman, 1994:378-380).

A qualitative researcher begins her research by formulating general research problems and asking general questions about the phenomenon she is studying, but as the study proceeds, the researcher gains increasing understanding of the phenomenon being investigated, and so becomes more able to ask specific questions and formulate specific hypotheses (Leedy & Ormrod, 2005:134; Tuckman, 1994:370-372).

Because qualitative researchers tend to ask open ended questions at the beginning of an investigation, they find it difficult to specify which methods they will use, but as they learn more about what they study, they can better specify what methods they should use to answer those questions. Therefore, the methodology in these studies continues to evolve over the course of the investigation. Despite this fact, considerable preparation and planning is essential. The researcher should be well trained in observation techniques, interview strategies and other relevant data collecting methods and the researcher must have a firm grasp of previous research related to the problem, so that she knows what to look for and to be able to separate important information from unimportant details in what is being observed (Leedy & Ormrod, 2005:134).

The researcher must be skilful in processing huge amounts of data and finding meaningful order amidst multiple data. Qualitative research can be very

challenging and should not be used if quick results and answers are needed (Leedy & Ormrod, 2005:134).

The advantages of a qualitative study include:

- it can reveal the nature of certain situations, settings, processes, relationships, systems or people;
- it enables a researcher to gain new insights about a particular phenomenon;
- it enables a researcher to develop new concepts or theoretical perspectives about the phenomenon;
- it enables the researcher to discover the problems that exist within the phenomenon;
- it allows the researcher to test the validity of certain assumptions, claims, theories or generalizations within real world contexts;
- it provides a means through which a researcher can judge the effectiveness of particular policies, practices or innovations; and
- it is conducted within natural contexts, and is thus more "true to life" (Leedy & Ormrod, 2005:97, 134).

A disadvantage of a qualitative study can be that the findings of the study may be so specific to a particular context that they can not be generalized to other contexts (Leedy & Ormrod, 2005:97).

Qualitative studies, however, do not allow the researcher to identify cause-effect relationships. To be able to answer cause-effect questions, one will need quantitative research (Leedy & Ormrod, 2005:134).

4.3.1.2 Quantitative research

Leedy and Ormrod (2005:94) define quantitative research as research "used to answer questions about relationships among measured variables with the purpose of explaining, predicting, and controlling phenomena". It is also

sometimes called the traditional, experimental or positivist approach (Leedy & Ormrod, 2005:94).

Quantitative researchers usually start with a hypothesis researchers want to test. They isolate the variables they want to study, use standardized methods to collect the numerical data and then use statistical procedures to analyze the data and draw some conclusions. This kind of study usually ends with confirmation or disconfirmation of the hypotheses that were tested (Leedy & Ormrod, 2005:94; Welman, Kruger & Mitchell, 2005:181).

Quantitative researchers also seek explanations and predictions that can be generalized to other persons and places. They intend to establish, validate or confirm relationships and to develop generalizations that contribute to theory (Leedy & Ormrod, 2005:95).

They identify one or more variables that they intend to study and then collect data specifically related to those variables. Specific methods of measuring each variable are identified, developed and standardized, with attention to the validity and reliability of the measurement instruments. The collected data from a population or samples of the population are then transformed to numerical indices (Leedy & Ormrod, 2005: 95; Welman *et al.*, 2005: 181: 13).

In this study, the quantitative method is limited to survey research. Survey research involves acquiring information about one or more groups of people by asking them questions and tabulating their answers. The ultimate goal of survey research is to learn about a large population by surveying a sample of that population (Leedy & Ormrod, 2005: 183).

Quantitative researchers remain detached from the research participants in order to draw unbiased conclusions (Leedy & Ormrod, 2005: 95). They also tend to rely more heavily on deductive reasoning, beginning with certain theories and then drawing conclusions about them, remaining objective in analyzing the data and conducting predetermined statistical procedures and using objective criteria to evaluate the outcomes of the procedures (Leedy & Ormrod, 2005: 96).

A disadvantage of a quantitative study may be that the studies can be conducted in a somewhat artificial setting and then the results obtained may, in some cases, not be generalized to more natural settings (Leedy & Ormrod, 2005: 97).

4.3.2 The literature study

A literature study formed the foundation for this research and was conducted on the following topics:

- The AIDS pandemic (globally and locally) and the impacts thereof in general, orphanhood in general, as well as the impacts of the AIDS pandemic on the AIDS orphans themselves and how these orphans are being empowered by programmes in South Africa.

- The phenomenon of resilience; the profile of resilient individuals and the resources which fuel resilience. Furthermore, it investigated resilience in young people and especially in vulnerable young people and finally investigated how psychological resilience can be enhanced.

4.3.3 The empirical study

Ungar and Liebenberg, (Ungar, 2005:210) uphold the view that a mixed-method design refers to the inclusion of both qualitative and quantitative research work, where qualitative methods are imperative in order to contextualize quantitative instruments. With specific reference to the study of resilience, such a mixed-method design must include debate between professionals with regard to an acceptable definition of resilience for the context in which it is being studied and semi-structured interviews with participants.

In this study, the empirical study consists of a survey research using a standard questionnaire (quantitative research) and semi-structured interviews (qualitative research).

4.3.3.1 Population and sample

In order to conduct research, a population must be identified from which a sample will be drawn. The researcher considers this sample as representative of the population (Strydom & De Vos, 2001: 190; Welman *et al.*, 2005: 52-53).

The research question(s) will indicate how the sample will be identified. If the researcher wants to draw inferences about the whole population, the researcher must choose a sample that will represent that population. The sample should be chosen randomly and should reflect appropriate proportions of each subgroup within the overall population (Leedy & Ormrod, 2005:145; Welman *et al.*, 2005: 55).

Survey sample

The population in this study consists of all AIDS orphans in South Africa, but given logistical and time constraints, the population will be limited to a sample of 60 adolescent orphans found in HIV/AIDS affected communities in Gauteng, South Africa. The IYRS specifies a minimum number of 60 participants for the survey research. According to the specifications of the IYRS, 30 of these participants (orphans in this study) must be resilient and 30 non-resilient. These participants will be identified by the community from which they are drawn (i.e. caretakers, social workers or guardians who interact on an ongoing basis with AIDS orphans will identify the sample).

The concept of resilience was debated and clarified with members from the youths' communities (the social workers and caretakers). For the purposes of this study, resilience was taken to mean orphaned youth who demonstrated:

- academic achievement;
- pro-social conduct;
- peer acceptance;
- normative mental health; and
- involvement in age-appropriate activities (Masten & Reed, 2005:76).

By contrast, vulnerable youth were typically orphaned youth who

- lacked academic achievement;
- displayed unacceptable social behaviour;
- evinced poor mental health;
- and were not involved in age appropriate activities either.

Based on this definition which was essentially taken from prevailing literature (Masten & Reed, 2005:76) and then debated and accepted as true of local orphaned youth who displayed resilient functioning, the elders identified a sample of 30 resilient youth and 30 vulnerable youth.

The sample was purposive in that the following criteria were adhered to:

- all 60 youths were AIDS orphans residing in Gauteng;
- 30 of the youth conformed to the resilience criteria as identified by the panel (consisting of six involved elders – social workers, caretakers and the site researcher); and
- 30 of the youth conformed to the vulnerability criteria as identified by the panel (consisting of six involved elders – social workers, caretakers and the site researcher).

Phenomenological study sample

No sample size is stipulated for phenomenological studies but the sample should have direct experience of the phenomenon being studied (Gall, Borg & Gall, 1996:601). The typical sample size for phenomenological studies ranges from 5 to 25 individuals (Leedy & Ormrod, 2005:139). The IYRS stipulated that there must be interviews with at least five elders and two or more interviews with resilient adolescents. For the purposes of this research, a group interview was held with six elders who represented the community and had close ties to the orphans and three in depth interviews were held with resilient youths.

The following criteria governed the inclusion of participants. Participants being interviewed as elders must:

(a) be an adult in the community where the orphans grew up, as well as involved in the lives of these orphans;

(b) have meaningful insights to contribute about resilience among AIDS orphans; and

(c) have meaningful insights to contribute about how youth are growing up / functioning in their community.

Adolescent orphans being interviewed must also adhere to certain specifications. They must:

(a) have completed the survey questionnaire and therefore also adhere to the previous criteria that was set out for the survey sample; and

(b) be randomly chosen from the resilient group who completed the questionnaires. They will initially be identified by the elders and then be given the chance to participate or decline the interview.

4.3.3.2 Data collection instruments

The survey

The survey is based on administration of a questionnaire.

Questionnaires often make use of checklists and rating scales. Paper-pencil questionnaires can be sent to remote places, saving the researcher travel expenses and telephone call expenses. They also have the added advantage of placing a distance between the researcher and the respondent, making it easier for the respondent to be more truthful especially with sensitive or controversial issues (Fouche, 2001:89,152; Leedy & Ormrod, 2005:185).

Unfortunately, questionnaires also have a low return rate and the willing respondents may not always be representative of the originally selected sample. Their responses may also be influenced by their reading and writing skills, which

may lead to misinterpretation of the questions. Furthermore, because all the questions to be asked are specified in advance, other questions that could have been asked are eliminated, and the researcher may gain only limited information (Leedy & Ormrod, 2005:185).

In this study The Child and Youth Resilience Measure (CYRM) will be used. The CYRM is a closed questionnaire consisting of 58 statements with a 5-point rating scale. 15 site-specific statements with a 5-point rating scale must be added by the researcher to cover aspects specifically related to the community of the youth in this study. These site-specific questions cover resilience in terms of the AIDS orphans' school, family, community and individual risk and protective factors in order to clarify their resilience or vulnerability within the township and South African context. The aim of the questionnaire is to distinguish characteristics of non-resilient orphans as opposed to resilient orphans. A copy of the questionnaire is included as Addendum A.

The youth will be informed of the study and with their consent (Addendum D) they will each complete the CYRM. Because the participants are not first language English speakers, their elders and the researcher will help clarify and/or translate difficult concepts to facilitate the completion of the CYRM.

In their paper reporting on the reliability and validity of the CYRM following its administration to 1451 youth across multiple international sites, Ungar and Liebenberg (2005) report that the findings show the CYRM is a consistent measure of resilience across the entire sample, as well as for unique sub-populations. The Child and Youth Resilience Measure appears to be a reliable and valid self-report measure that adequately assesses resilience in youth across a variety of cultures. Initial research results suggest that the CYRM is a valid measure for understanding how resilient youth make use of resources within their communities, families and themselves in order to function resiliently (Ungar & Liebenberg, 2005:211).

4.3.3.3 The phenomenological interview

In order to understand the phenomenon of resilience from the perspective of resilient AIDS orphans and their caregivers and social workers, phenomenological interviews were conducted.

A phenomenological study using semi-structured interviews is a study that attempts to understand people's perceptions, perspectives and understandings of a phenomenon or particular situation (Leedy & Ormrod, 2005:139). The researcher may follow standard questions with one or more individually tailored questions to get clarification or probe a person's reasoning (Leedy & Ormrod, 2005: 184; Welman *et al.*, 2005: 166-167). It is their understanding, interpretation and meaning creation in a given situation that the researcher wants to understand.

An interview can yield useful information about the phenomenon in question and the researcher may ask questions about the phenomenon related to:

- factual information;
- the individual's beliefs and perspectives about the facts;
- feelings;
- motives;
- present and past behaviours;
- what people think should be done in certain situations (i.e. standards for behaviour); and
- why people think that their particular behaviour is desirable or not (Leedy & Ormrod, 2005:146).

Face to face interviews used in qualitative studies tend to be informal and friendly and the researcher becomes known and trusted, establishing rapport with potential participants and gaining their cooperation (Leedy & Ormrod, 2005: 185). Interviews are either open-ended or semi structured, revolving around a few

central questions. These interviews are more flexible and more likely to yield information that the researcher hadn't planned for. A disadvantage of this interview can be that different information gathered from different people can make comparisons difficult (Leedy & Ormrod, 2005: 146).

In this study, semi-structured interviews consisting of standard IYRS questions will be used. The phenomenon being studied is resilient functioning despite adverse circumstances (AIDS orphans in South Africa). The standard questions have been formulated as part of the IYRS.

Interviews were conducted with:

- six stakeholders who are knowledgeable about AIDS orphans (and their families where applicable) in their community; and
- three orphaned resilient adolescents.

The two groups who were interviewed had different sets of questions.

- The interviews with the elders consisted of six questions relating to their personal views and experiences of resilient AIDS orphans. The questions focused on their view of orphans and the adversities adolescent AIDS orphans experience. The questions were based on the literature study and were compiled by the researcher and the advisory committee (consisting of social workers and caretakers and elders demonstrating resilience). The questions are included in Addendum B.
- The interviews with the adolescents consisted of nine catalyst and probing questions relating to their experience of orphanhood and their personal views on resilience. The questions were based on the literature study and interviews with the elders. The questions were compiled by the researcher and the advisory committee as well as the IYRS guide. An example of the questions is included in Addendum C.

4.3.3.4 Statistical techniques

In this study, statistical techniques refer to the process of content analysis and inferential statistics.

Content analysis

Content analysis is a detailed and systematic examination of the contents of a particular body of material for the purpose of identifying patterns, themes or biases (Leedy & Ormrod, 2005:142; Welman *et al.*, 2005:222-223). Content analysis was used to make meaning of the data generated by the phenomenological study. A detailed and systematic examination of the data to determine patterns or themes of reasoning formed the content analysis.

Leedy and Ormrod (2005: 142) and Welman *et al.* (2005: 222-223) name the following steps that are typical to content analysis:

1) the specific body of material to be studied is identified by the researcher;
2) the characteristics or qualities to be examined are defined in precise, concrete terms by the researcher;
3) if the material contains complex or lengthy items, the material to be analyzed is broken down into small manageable segments and analyzed separately; and
4) the research material is scrutinized for instances of each characteristic or quality defined in step 2. The frequency of each characteristic found, is noted and helps to interpret the data on the problem being investigated.

From a phenomenological point of view, data analysis consists of four steps that are followed after the interviews are transcribed (Leedy & Ormrod, 2005: 140):

1) Statements that relate to the topic are identified and the relevant information is separated from the irrelevant information in the interview.
2) Statements are grouped into meaningful units or categories which reflect the various aspects of the phenomenon as it is experienced.
3) The researcher looks at the various ways in which different people experience the phenomenon.

4) The various meanings that are identified are used to develop an overall description of the phenomenon as people typically experience it.

Quantitative data analysis used for the CYRM

Responses from the CYRM will be analyzed using a frequency count and descriptive statistics. The Statistical Services of the Vaal Triangle Campus of the North West University analyzed and processed the data by means of the Statistica (Version 7) -programme. The programme was used to find frequencies and means. Frequency tables were used to represent the results.

In order to make sense of the CYRM data, the statements were grouped thematically as follows: individual characteristics (questions 1, 3, 4, 7, 12, 13, 14, 15, 16, 18, 26, 28, 30, 33, 36, 45, 49, 51, 58) as well as community and cultural factors (questions 5, 6, 8, 17, 25, 32, 35, 41, 42, 44, 47, 50, 53, 56), family factors (questions 39, 52, 54, 55) and school factors (questions 10, 23, 37).

4.3.3.5 Ethical aspects

In studies where human subjects are the focus of investigation, there are ethical implications to consider. The following ethical issues were observed:

- **Protection from harm:** Participants should never be exposed to physical or psychological harm. This means that the risk of participating in research should not be bigger than everyday living. Apart from being protected from physical harm, should participants experience some psychological discomfort, they should know this ahead of time and should be debriefed or counseled immediately after participation.

  In this study protection from harm was ensured by informing the participants about the study and assuring them that they would remain anonymous at all times. The study did not pose any physical harm to the participants and the questions would not inflict any psychological harm.

- **Informed consent:** Participants should be informed about the nature of the study and should be given the choice to participate or not. Participation is strictly voluntary. Should they agree to participate; participants have the right

to withdraw from the study at any time. However, sometimes if participants are given too much information about the study, it can influence their responses. In this case they should only be given sufficient information to make a reasonable, informed judgment whether they still want to participate. Participants should be given an informed consent form which describes the nature of the research project, as well as the nature of their participation in it (Addendum D). In this study a letter written by the study leader was presented to the elders as well as the participants after which they gave their verbal consent.

- **Right to privacy:** Participants have the right to privacy and under no circumstances should the responses or nature and quality of the participant's performance be revealed. Respondents should be given code numbers and if a particular person's behaviour is described in depth in the research report, he or she should be given a pseudonym to remain anonymous. In this study participation was strictly voluntary and all responses were treated confidentially. All names are withheld and participants are referred to as participant A, B and so forth. The questionnaires do not require of them to reveal their names.

- **Honesty with professional colleagues:** Researchers should at all times report their findings honestly without misinterpretation or misleading others. Credit should also at all times be given to others to avoid plagiarism and documentary theft. Without acknowledgement using other's ideas is unethical and circumspect. The researcher documented and acknowledged all sources and care was taken that data was presented and analysed correctly.

- **Internal Review Boards:** These boards which are found at universities or other research institutions scrutinize all research proposals for conducting human research and check that no harm will be done to participants and that the correct procedures will be followed in ensuring their safety, privacy and anonymity. The University of the North West, and specifically the study promoter, will manage these functions (Leedy & Ormrod, 2005:101-103; Strydom, 2001:23-30; Tuckman, 1994:13-14; Welman *et al.*, 2005:181-182)

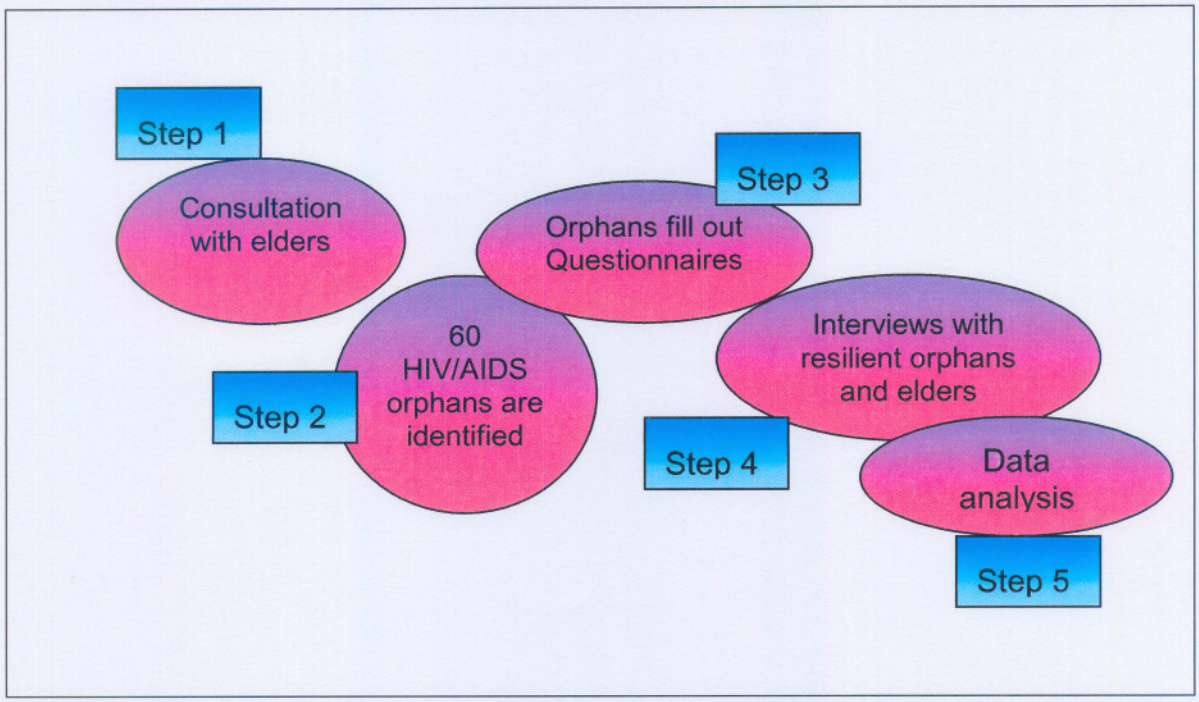
4.4 CONCLUSION

The researcher has already done extensive literature study on AIDS orphans and resilience and now wishes to employ qualitative as well as quantitative research methods to research resilience among AIDS orphans in Gauteng and conduct a comparison between resilient and non-resilient orphans.

The qualitative research method (the semi-structured interviews) will be supported by the quantitative research method (the questionnaires) resulting in a mixed-method design.

The following figure (Figure 4.2) will summarize the research process that was followed:

Figure 4.2: A practical explanation of the research process:



In the following chapter the researcher will document the findings of the above mentioned research and make inferences about the subjects that have been questioned and interviewed.

CHAPTER FIVE

DISCUSSION OF RESEARCH RESULTS

5.1 INTRODUCTION

The aim of this research is to document the phenomenon of resilience in AIDS orphans in South Africa.

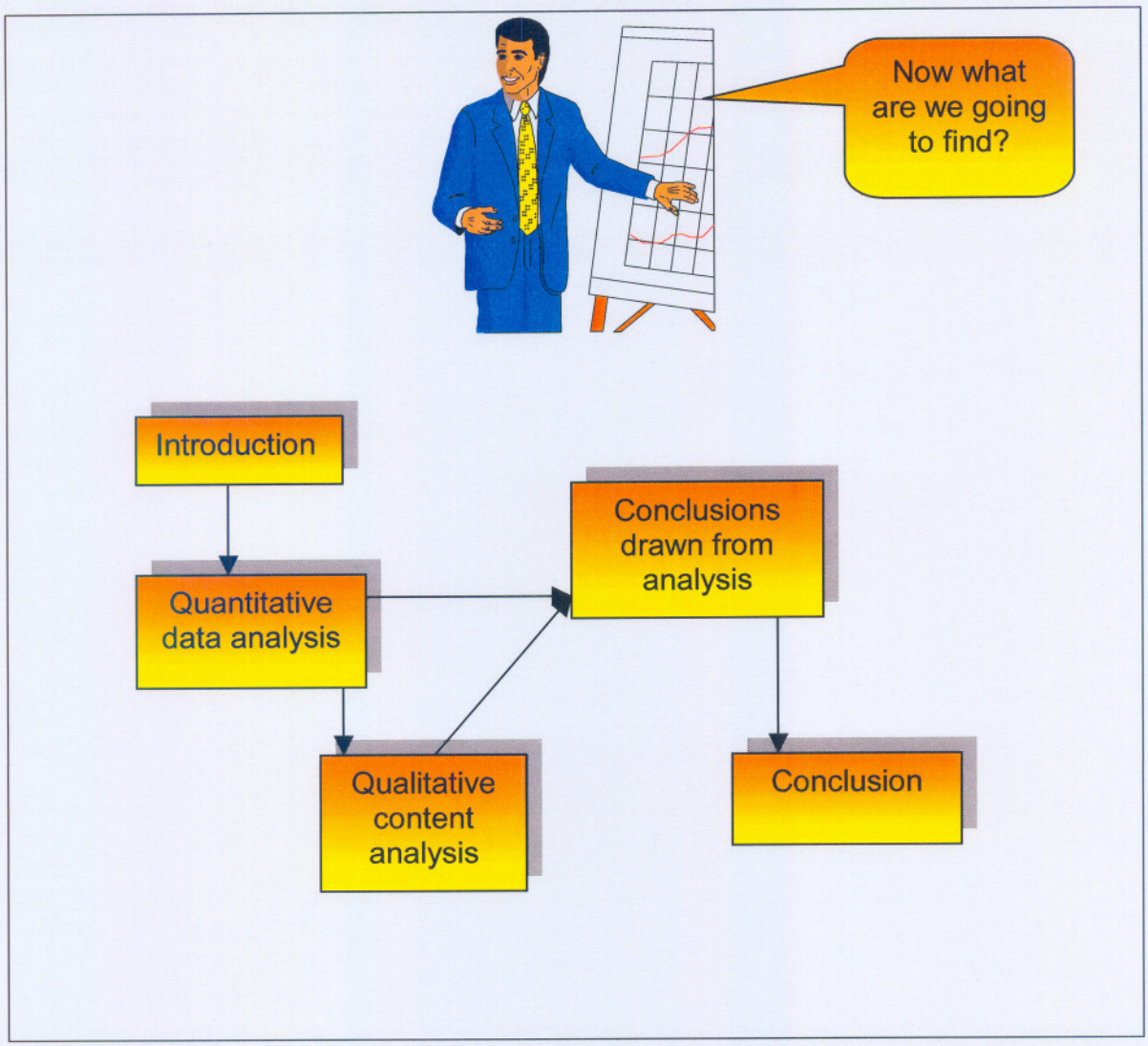
The target population of the empirical survey included 30 resilient and 30 non-resilient AIDS orphans in the Gauteng region, representing the AIDS orphans of South Africa.

This chapter presents the analysis and interpretation of the empirical investigation conducted by means of survey research (using the CYRM) and phenomenological research (using interviews) (see addendums E to H) to document resilient functioning in resilient AIDS orphans compared to non-resilient AIDS orphans.

The information on the quantitative data is presented first in Section 5.2 and the qualitative content analysis is presented in Section 5.3.

Chapter 5 is summarized in Figure 5.1 which follows:

Figure 5.1: Overview of Chapter 5



5.2 QUANTITATIVE DATA ANALYSIS

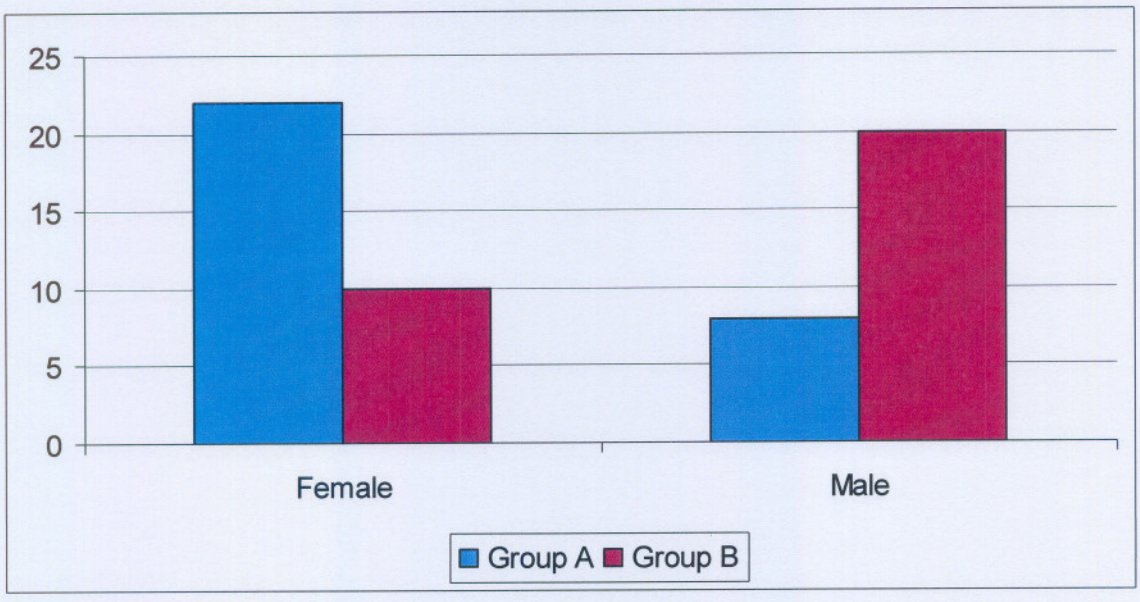
5.2.1 General information

Data concerning the background of respondents are shown in Figures 5.2, 5.3, 5.4 and 5.5. Regarding biographical information, the resilient group, named Group A, and the non-resilient group, named Group B, will be compared in terms of gender, age, ethnicity and academic qualifications as these characteristics can be seen as risk or protective factors regarding resilience.

5.2.1.1 Gender

Figure 5.2 below represents the gender of the resilient group (Group A) and the non-resilient group (Group B).

Figure 5.2: AIDS orphans: Male and female distribution



According to Figure 5.2 the majority of the respondents in the resilient group (Group A) were females (n = 22) compared to males (n = 8), while in the non-resilient group (Group B) the majority of respondents were males (n = 20) compared to females (n = 10) according to Figure 5.2. The data indicates that females were mainly identified as resilient. Theory confirms that female adolescents are generally more resilient than male adolescents (Govender & Killian, 2001:2).

5.2.1.2 Age

Figure 5.3 depicts data on the ages of the orphans of the two groups:

Figure 5.3: Age distribution of AIDS orphans

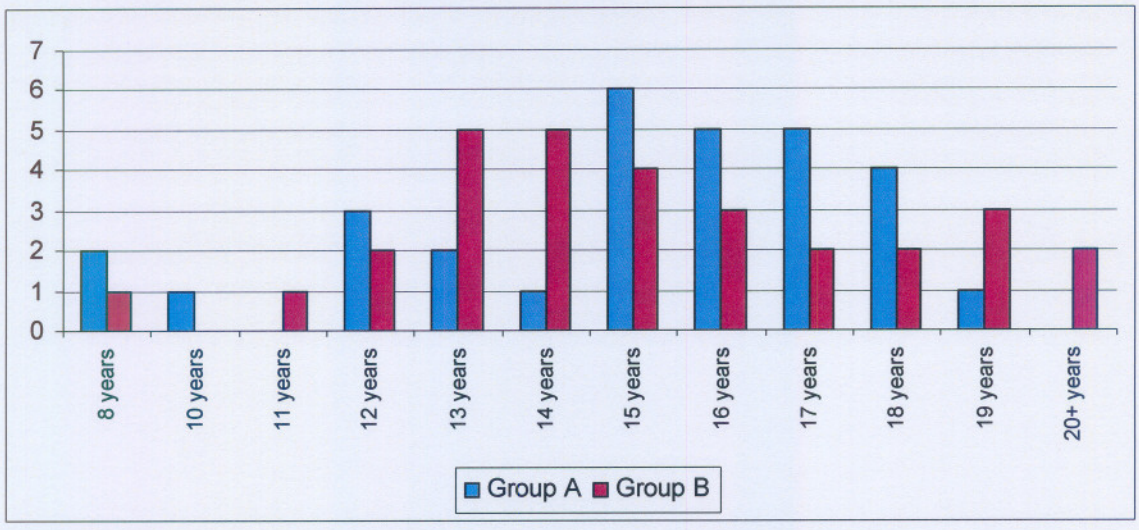


Figure 5.3 illustrates that the ages of the respondents varied from early adolescence to late adolescence in both groups and that the average age of the resilient group was slightly higher (14, 9 years) than the non-resilient group (13, 1 years). Theory confirms that age plays an important role in the resilience of people (C.f. 3.3.1 and 3.5.1 of this study) (Govender & Killian, 2001:2; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

5.2.1.3 Ethnic group

Figure 5.4 shows data on the different ethnic groups representing different cultures or ethnic groups that took part in the study.

Figure 5.4: Ethnic/cultural group distributions

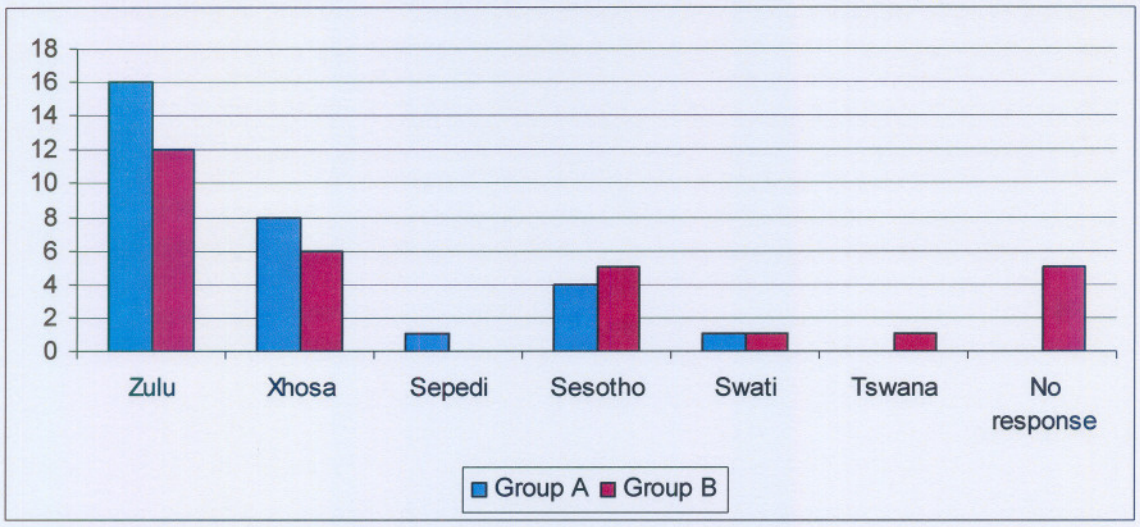


Figure 5.4 reveals that the majority of the respondents came from the Zulu ethnic group, followed by the Xhosa and then the Sesotho groups, followed by other minor groups. Theory suggests that being culturally grounded and knowing where you come from and being part of a cultural tradition that is expressed through daily activities, can enhance resilience (Ungar & Liebenberg, 2005:218-219).

5.2.1.4 Highest qualification

Figure 5.5: Academic qualifications

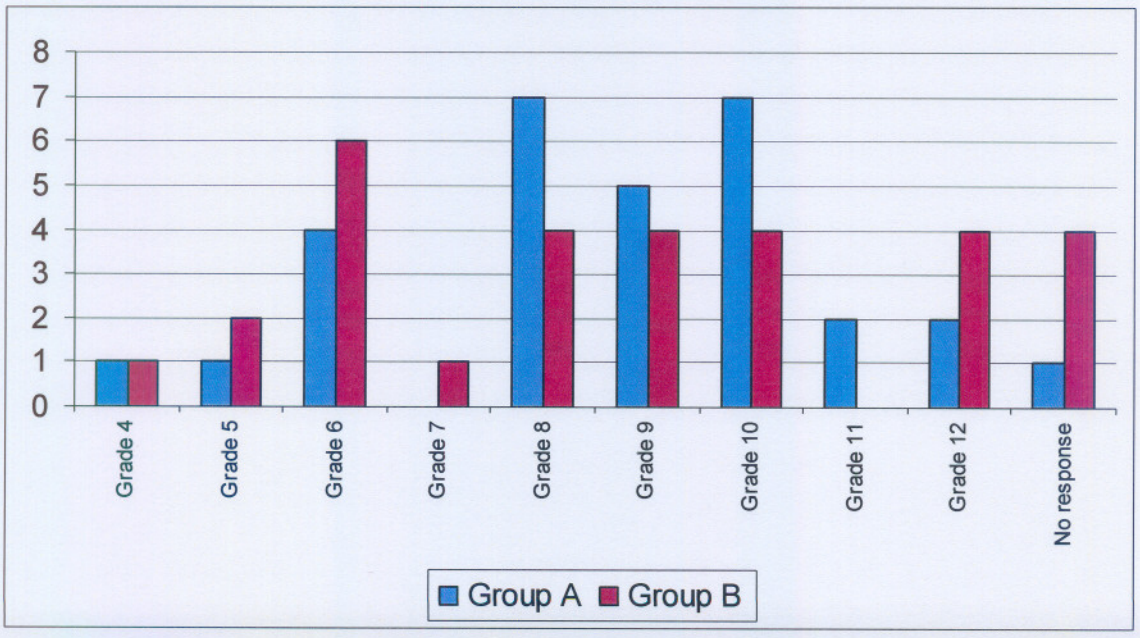


Figure 5.5 demonstrates that Group A (the resilient group) had the highest average qualifications which correlates with current literature that the more they are educated (having acquired amongst others, appropriate life skills at school) the more resilient youth become (Schoon, 2006:6).

5.2.2 An analysis of the respondents' responses on the CYRM and site specific questions

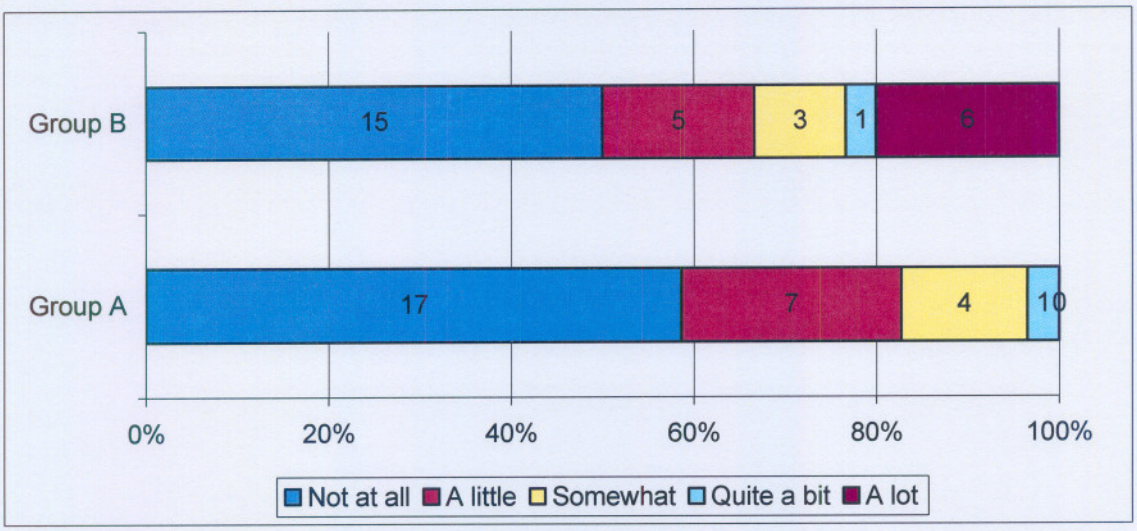
The literature study highlights the significance of individual, family, community and relationship/social factors in determining resilience (Cf. 3.3).

In the second and third sections of the questionnaire, respondents were asked to rate their experiences relating to resilience on a five-point scale (1 = Not al all; 2 = A little; 3 = Somewhat; 4 = Quite a bit; 5 = A lot). Firstly (in Section 2), participants were asked 15 site specific questions and then 58 CYRM questions (in Section 3). In the CYRM questionnaire (Section 3) a score of 1 would suggest non-resilience and 5 would demonstrate resilience, whereas in the site-specific questions a score of 1 would indicate resilience and 5 and would suggest non-resilience in the majority of questions (See Addendum A).

5.2.2.1 Comparison between the resilient and non-resilient groups

The following figures reveal that there was a significant difference between the responses of the resilient group and the non-resilient grouping in only 4 of the 15 site specific questions and 4 of the 58 CYRM questions in the questionnaire (i.e. 8 questions in total). Figures 5.6 – 5.13 below deal with these questions:

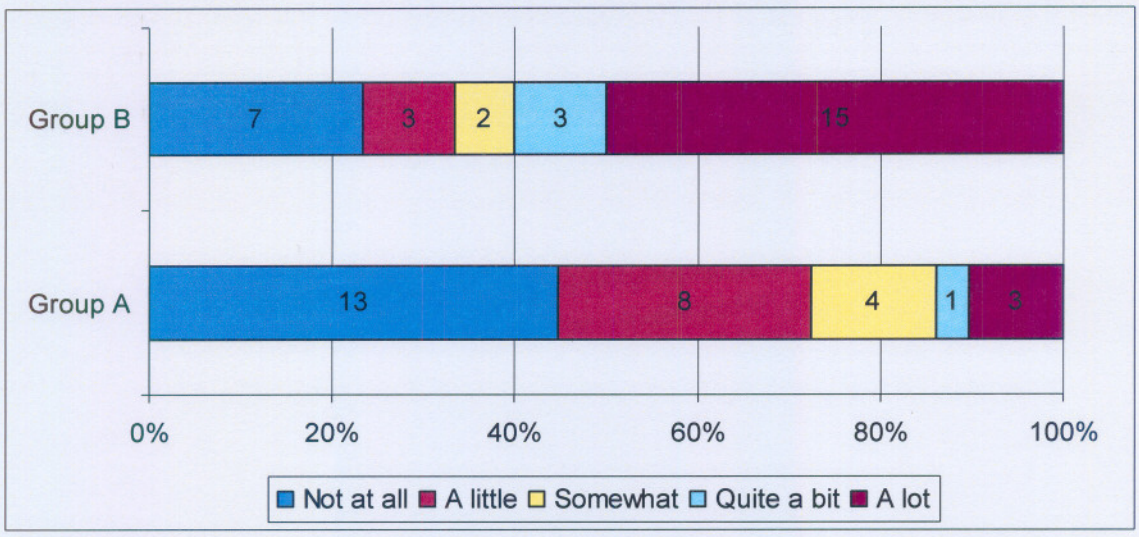
Figure 5.6: Site specific Question 2.1: Do you feel that you are badly treated at school or in the community for being an orphan?



(0 result for Group A – A lot)

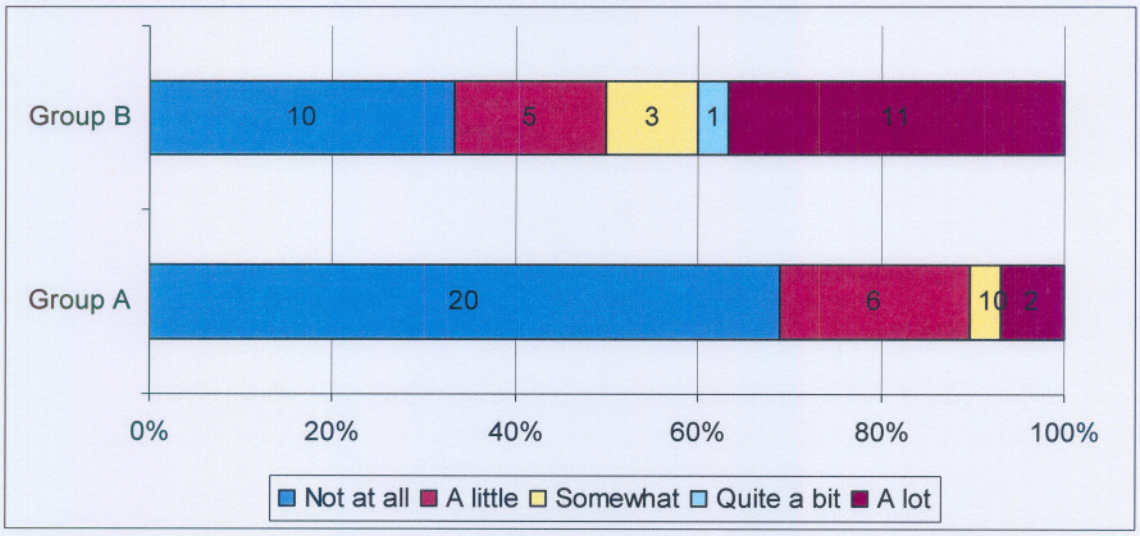
Figure 5.6 indicates that the resilient group felt that they were not treated badly at school and in their community for being an orphan than the non-resilient group. Seven respondents of the non-resilient group indicated that they were treated badly at school and in the community for being an AIDS orphan, compared to only one respondent in the resilient group confirming literature which reports that social acceptance and support within the community are important protective factors which can enhance resilience (Frydenberg, 1999:347; Maddux, 2005:279; Masten & Reed, 2005:76).

Figure 5.7: Site specific Question 2.5: Do you feel financially poorer than your friends at school?



From Figure 5.7, it is evident that the majority of the non-resilient group (n = 18) felt financially poorer than their peers or friends at school while the majority of the resilient group (n = 21) did not feel poorer. Poverty is a significant risk factor for non-resilient outcomes (Masten & Reed, 2005:77; Neill, 2005).

Figure 5.8: Site specific Question 2.6: Do you feel that your education has been neglected because you are an orphan?



(0 result for Group A – Quite a bit)

Figure 5.8 shows that more non-resilient orphans (n = 12) than the resilient group (n = 2) felt that their education was neglected, because they were orphans. The school and associated scholastic activities can enhance the child's self-concept, sense of challenge, sense of coherence, and critical thinking. The cycle (of nurturing the self-concept, a sense of challenge and the forming of critical thinking) which began in the family, is reinforced at school as the learner responds to feedback from teachers and other learners (Anon., 1995; Van Rensburg & Barnard, 2004:4). In this non-resilient group, participants expressed vulnerability because of a lack of such opportunity.

Figure 5.9: Site specific Question 2.10: Do you feel that you have a harder life than your peers at school?

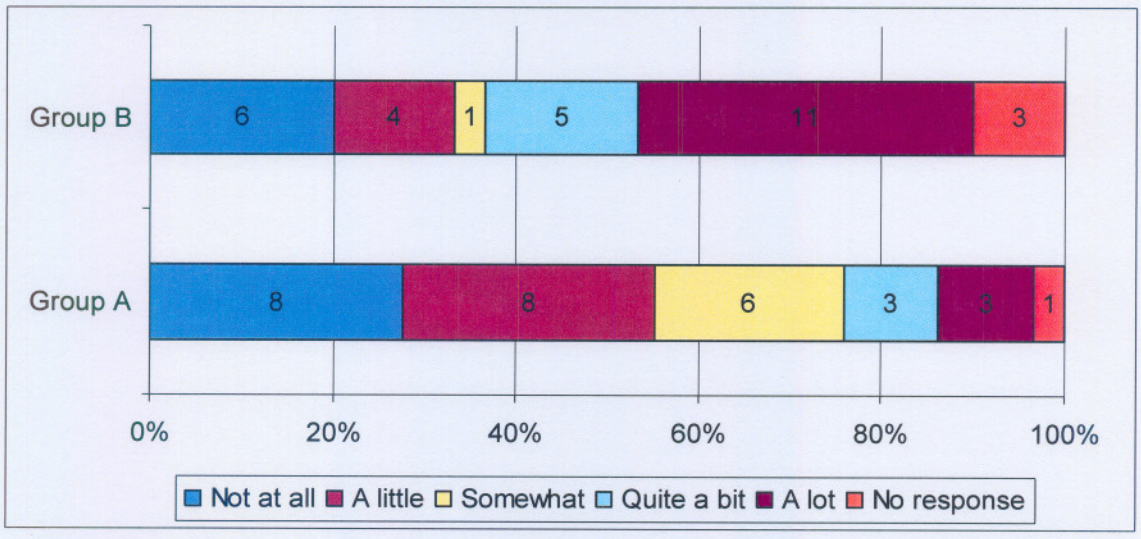
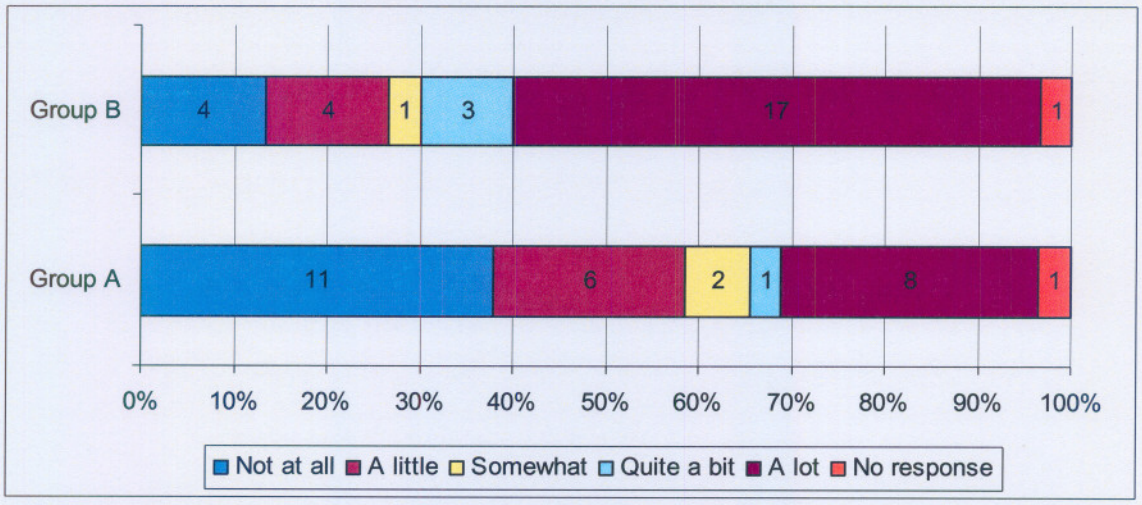


Figure 5.9 indicates that the non-resilient group (n = 16) indicated that they had a harder life than their peers, while the resilient group did not feel the same (n = 6), confirming literature that reports that factors such as poverty, maltreatment, homelessness, the death of someone else, chronic illness, unemployment (all resulting from the AIDS pandemic) are indeed threatening to development (Masten & Reed, 2005:77; Neill, 2005). Resilient AIDS orphans perceive these risks as less present in their lives.

Figure 5.10:CYRM Question 3.2: Do you know where your parents and /or grandparents were born?



From Figure 5.10, it can be deducted that the non-resilient group (n = 17) had a better substantial knowledge of where their parents and grandparents were born than the resilient group (n = 8). This contradicts literature which suggests that the resilient person is culturally grounded (Masten & Reed, 2005: 85; Ungar, 2005: xvi), in other words, knows where she comes from.

In this particular study (HIV/AIDS affected families and the stigma attached to it), one could conclude that knowing where they come from could, in this instance, be a risk factor rather than a protective factor.

Figure 5.11:CYRM Question 3.22: Do you strive to finish what you start?

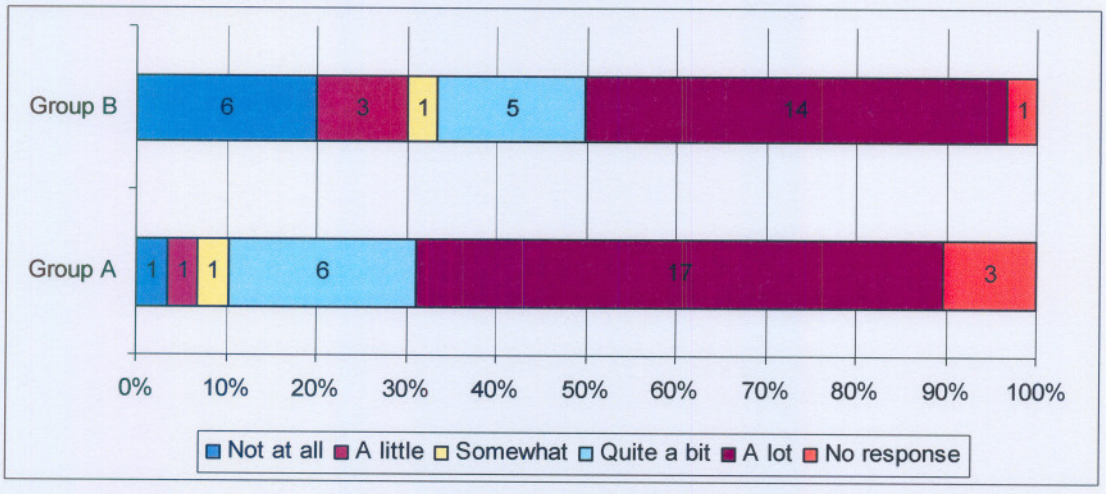
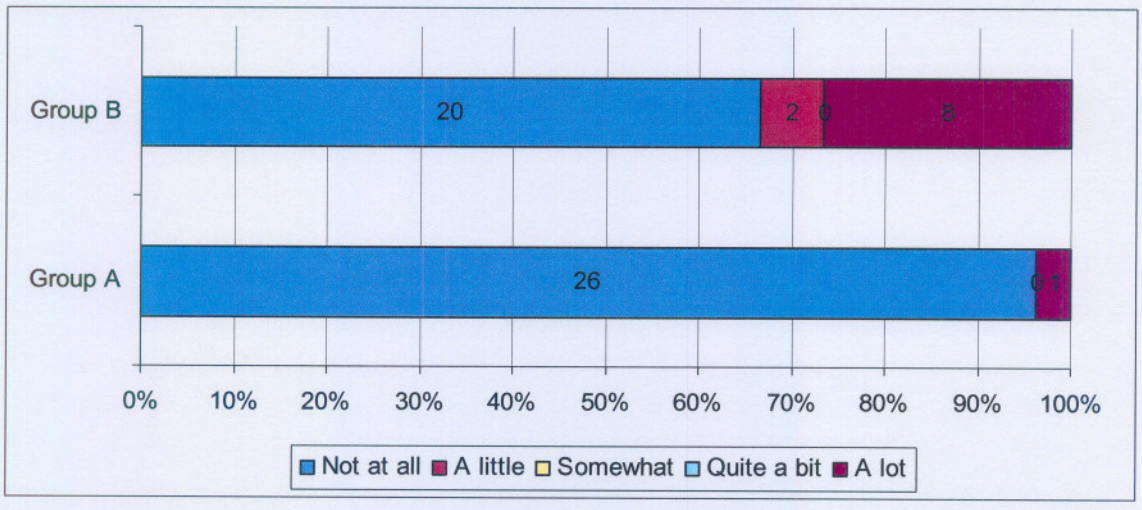


Figure 5.11 shows that the resilient group strives harder to finish what they start than the non-resilient group. Nine of the non-resilient respondents claimed that they do not strive to finish what they start as opposed to only two in the resilient group, confirming theory about problem solving skills and motivation (Anon., 1995; Anon., 2005a; Neill, 2005; Theron, 2006:200; Van Rensburg & Barnard, 2004:2) which suggests that a sense of commitment and drive characterizes resilient individuals.

Figure 5.12:CYRM Question 3.33: Do you think non-prescription drugs and/or alcohol will help you when you have to deal with lots of problems?



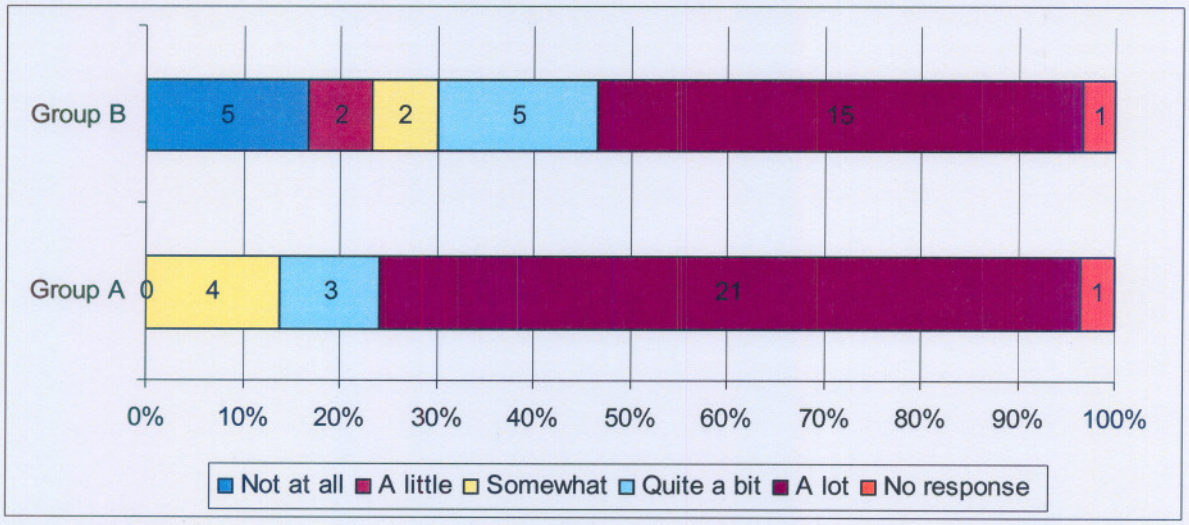
0 result for Group A, B – Quite a bit;

0 result for Group A, B – Somewhat;

0 result for Group A - A little

According to Figure 5.12, more respondents from the non-resilient group (n = 8) would use alcohol or drugs to help them deal with problems than the respondents from the resilient group (n = 8) which confirms literature suggesting that teenage drinking, smoking and drug abuse are serious hazardous experiences which can threaten development and are more typical of vulnerable youth (Masten & Reed, 2005: 84-85).

Figure 5.13:CYRM question 3.37: Do the teachers and other learners make you feel you belong at school?



(0 result for Group A – Not al all)

(0 result for Group A – A little)

Figure 5.14 indicates that the non-resilient group felt significantly more unwelcome (n = 7) at school than the resilient group (n = 0). The majority of participants in the resilient group indicated that they felt very welcome at school (n =21). This confirms literature concerning social acceptance and support: when adolescents experience social acceptance and support, resilient functioning is promoted (Frydenberg, 1999:347; Masten & Reed, 2005:76; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

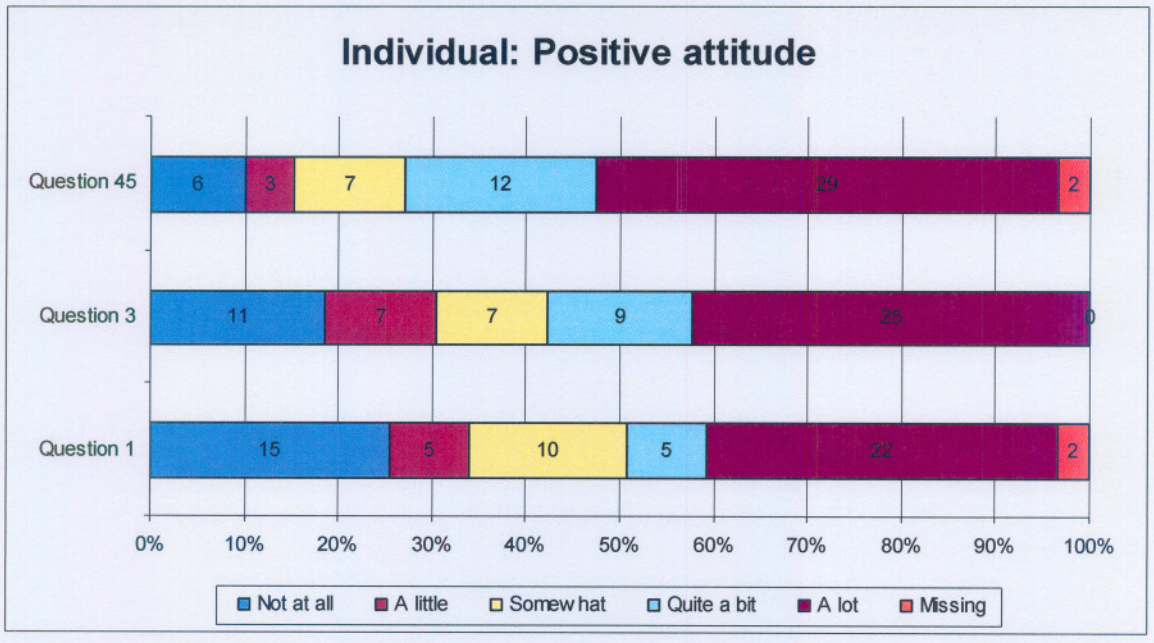
5.2.2.2 Analysis of responses of the entire group of orphans

Initially, the researcher set out to compare resilient orphans to non-resilient orphans but since there were no significant statistical differences in the responses of the resilient and non-resilient participants regarding the greatest part of the questionnaire, the researcher will now look for resilient and non-resilient traits in the entire group. The following graphs will group the different factors, (Figures 5.14 to 5.20 depict individual protective factors, Figures 5. 21 to 5. 25 relate to community and cultural protective factors, Figures 5. 26 and 5. 27 relate to family

factors and Figure 5. 28 depicts school factors) which determine resilience. No distinction is made between the two groups.

5.2.2.2.1 Individual protective factors

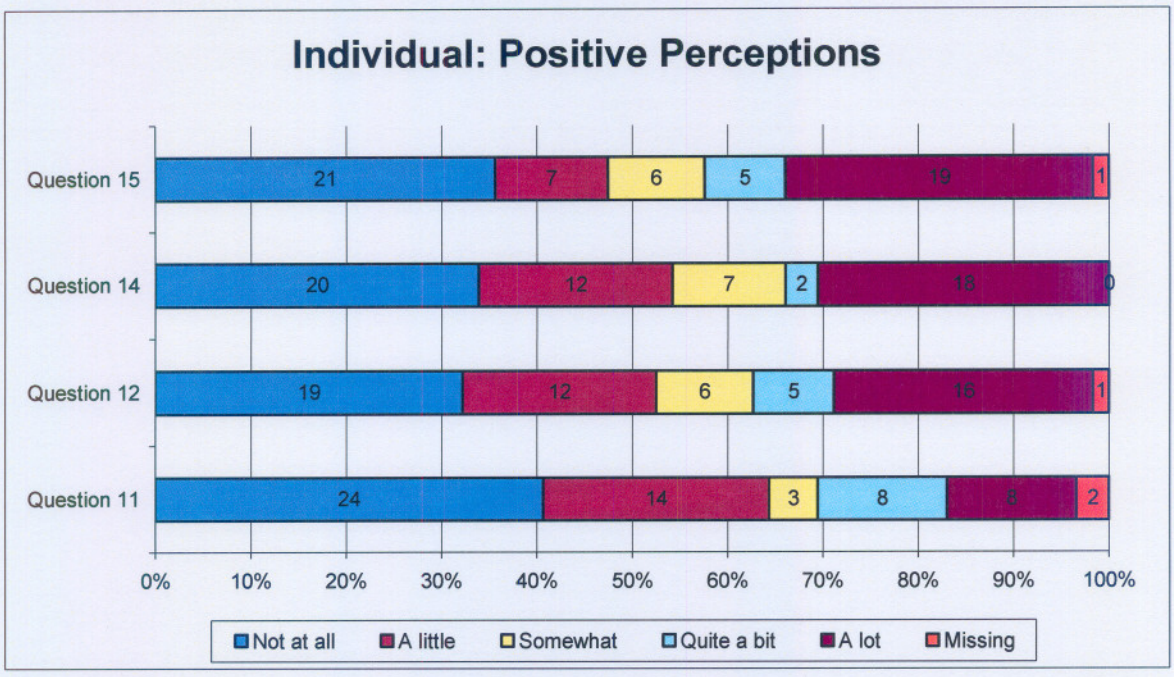
Figure 5.14:CYRM questions related to an individual's positive attitude



(0 result for Question 3 – Missing)

According to Figure 5.14, the majority of respondents indicate that they are aware of their own strengths (question 45); that they keep going when life gets difficult (question 3) and that fun and humour can help solve their problems (question 1). Having a positive attitude towards life and a sense of humour are important intrapersonal protective factors (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

Figure 5.15:Site specific questions: Positive individual perception



(0 result for Question 14 – Missing)

Figure 5.15 shows that the majority of orphans had an overall positive social attitude and social experiences (they do not fear the future, are not scared of being abandoned again, do not experience more stress than before becoming an AIDS orphan and do not feel that they are not good enough because they do not have a parent). Literature suggests that a positive social attitude and positive social experiences empower youth to function resiliently (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

Figure 5.16:CYRM questions relating to individual problem solving skills

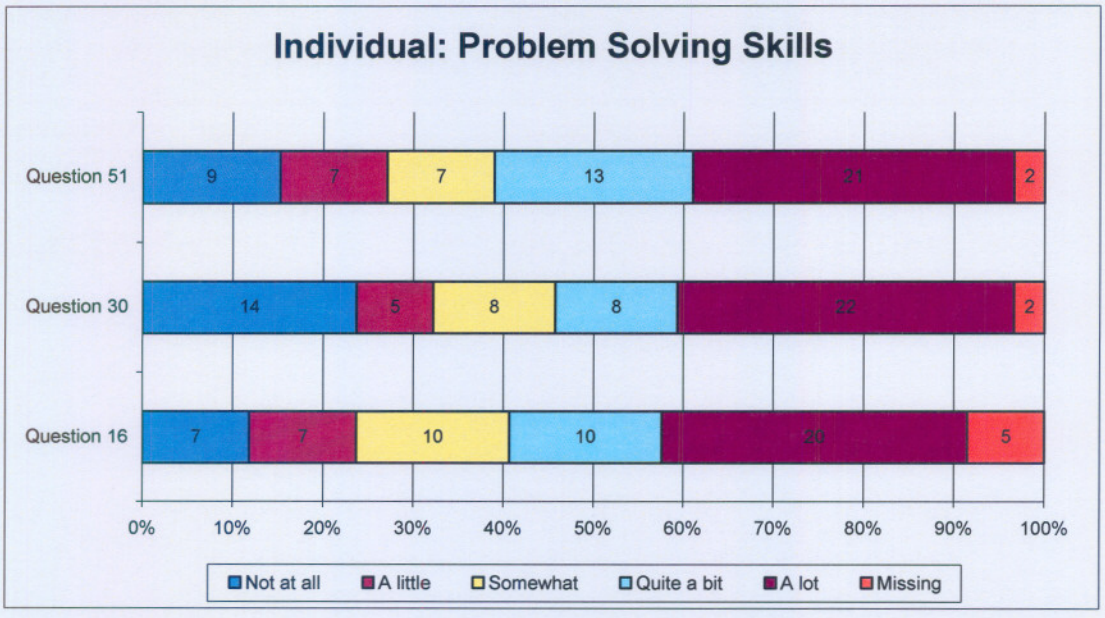


Figure 5.16 suggests that the orphans indicated a majority of positive responses towards being able to solve most problems in life in a positive or independent way (question 51 and 30). The majority felt confident when they were in challenging and confusing situations (question 16). Literature suggests that individuals with strong problem solving skills seem to be resilient (Anon., 1995; Anon, 2005b; Norton, 2005: 56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

Figure 5.17:CYRM questions indicating self-esteem

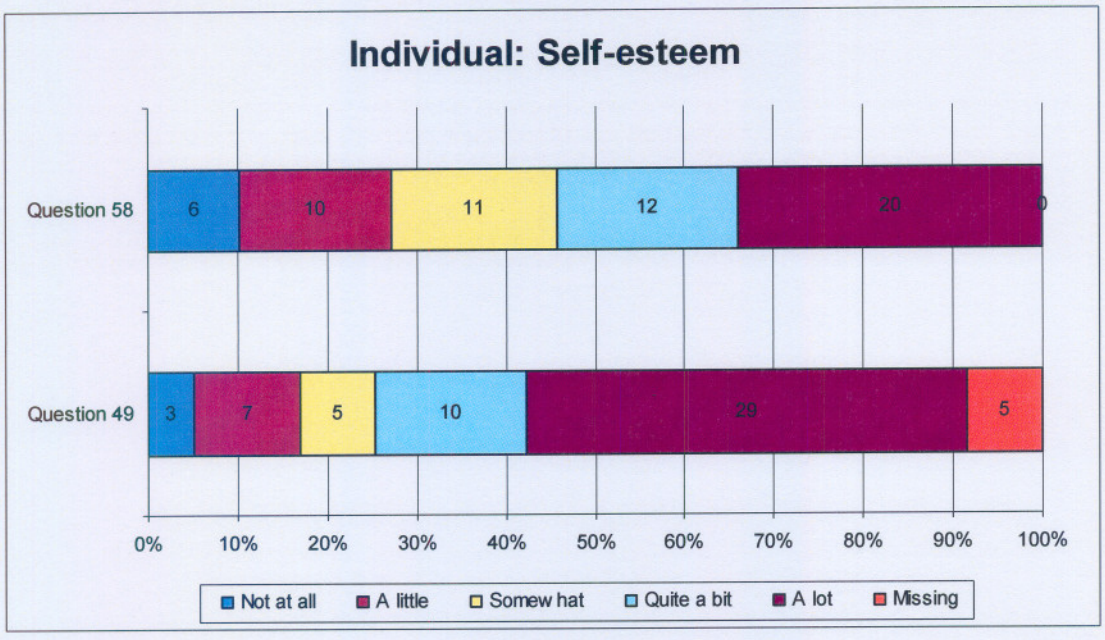
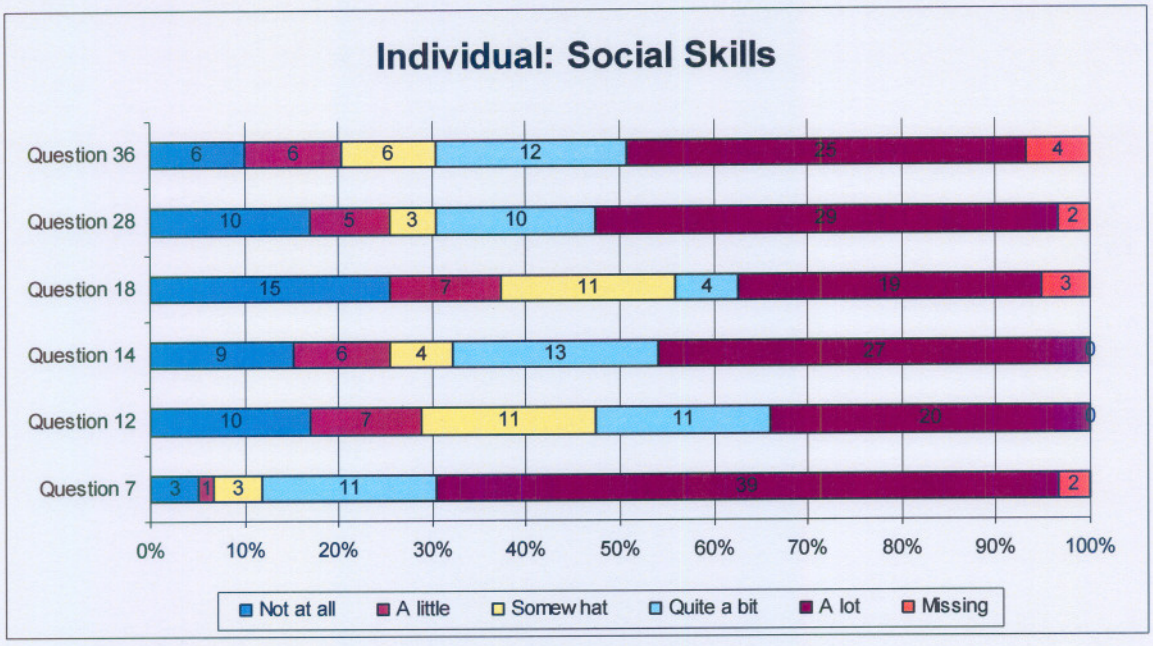


Figure 5.17 shows that the majority of orphans who participated do have a healthy self-esteem (Question 58: Do you think you are at least as good as other youth you know?; Question 49: Are you aware of your own weaknesses?), which suggests that the individual has insight into her own character. According to literature, having a positive self esteem is a significant protective factor (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3). Participant responses suggest the potential for resilient functioning.

Figure 5.18:CYRM questions relating to the individual's social skills



In Figure 5.18, it is suggested that most orphans felt comfortable when asking for help, did feel that they were fun to be with, and felt kindness towards people they don't like (questions 36, 28 and 14). The majority also felt that they did understand other people's feelings (question 7), showing empathy, an important protective factor. Questions 28 and 12 indicated certainty towards being fun to be with and feeling comfortable when talking to people they do not know, respectively, demonstrating that good social skills can be an indication of resilience (Frydenberg, 1999:347; Maddux, 2005:279).

Figure 5.19:CYRM questions relating to individual responsibility

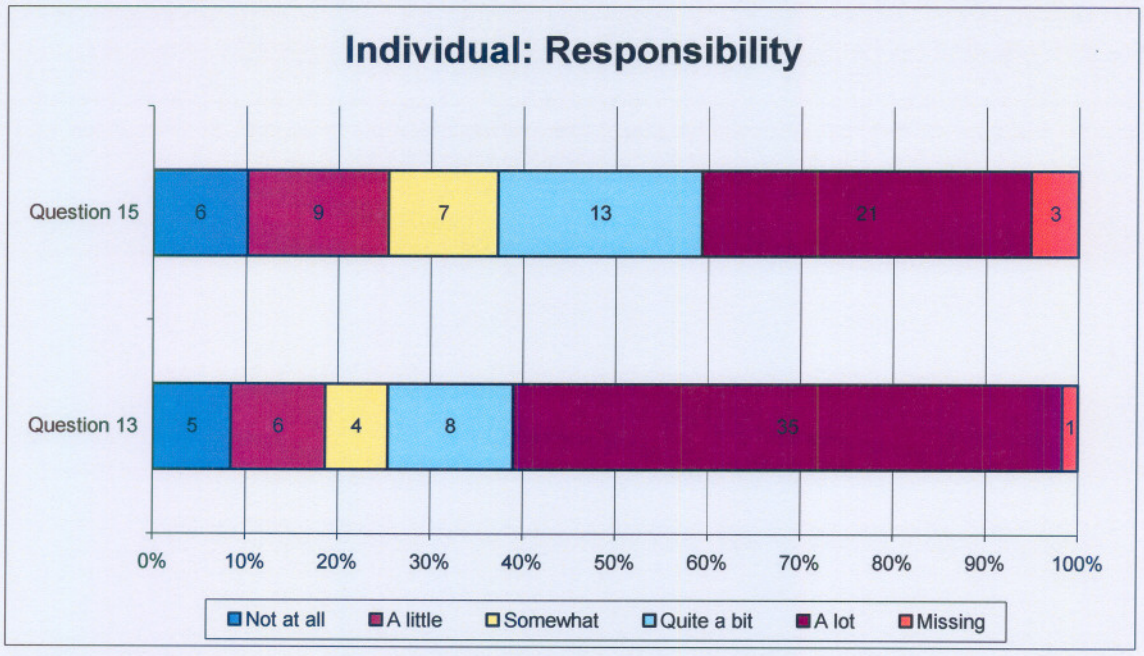
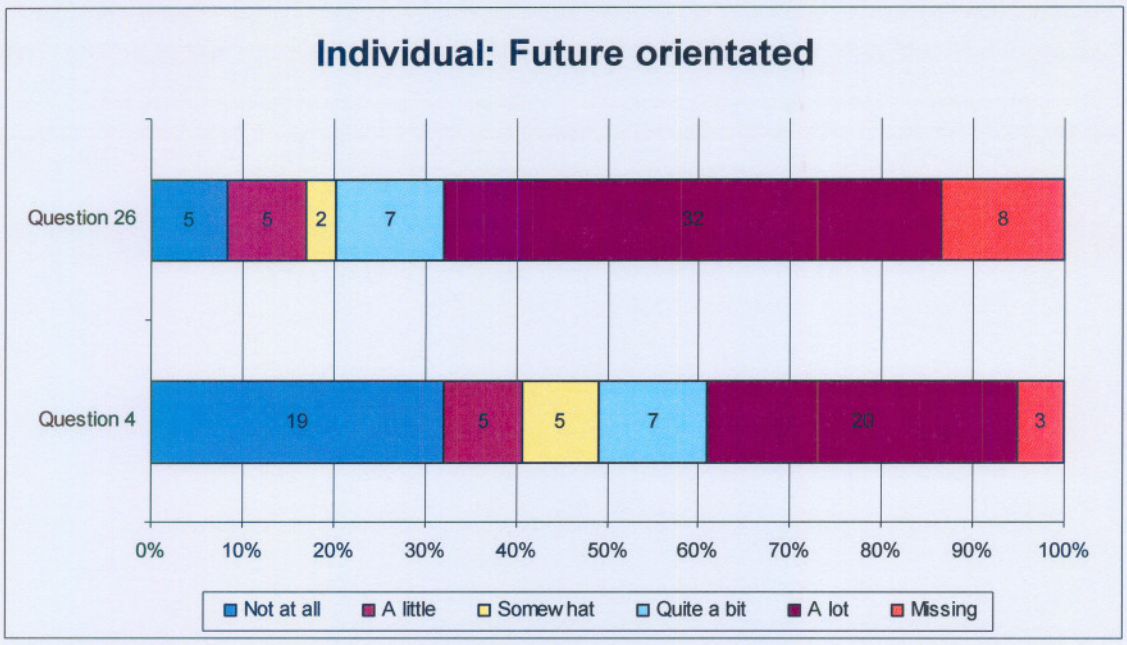


Figure 5.19 indicates that the majority of orphans showed significant individual responsibility and commitment. They believe that life should be lived in a certain way (question 15) and they feel that every individual has a responsibility to make the world a better place (question 13). Literature confirms that having a sense of responsibility or commitment can indicate resilience (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

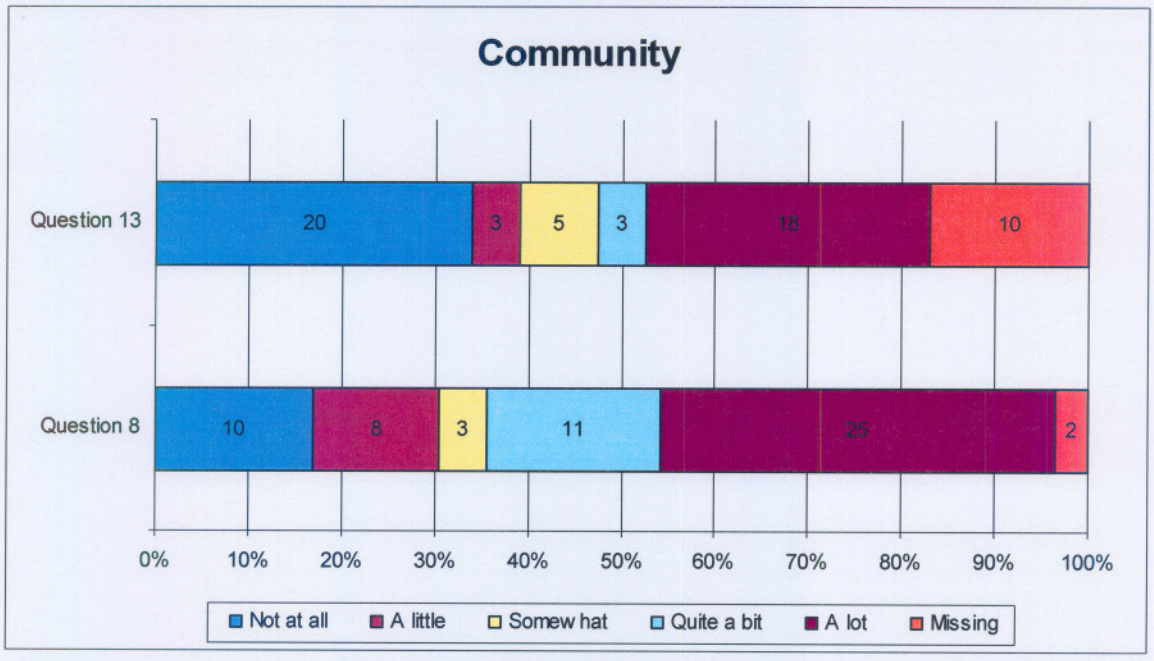
Figure 5.20:CYRM questions relating to future orientation



According to Figure 5.20, the respondents show a positive future orientation. The majority of respondents have a vision of what the future should be (question 26) and they strongly feel that what they do now, will influence what will happen later in their lives (question 4). Literature suggests that a temperament characterized by a positive and optimistic nature, trust and a sense of hope may differentiate the resilient individual from the non-resilient individual (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

5.2.2.2.2 Community and cultural protective factors

Figure 5.21: Site specific questions relating to community

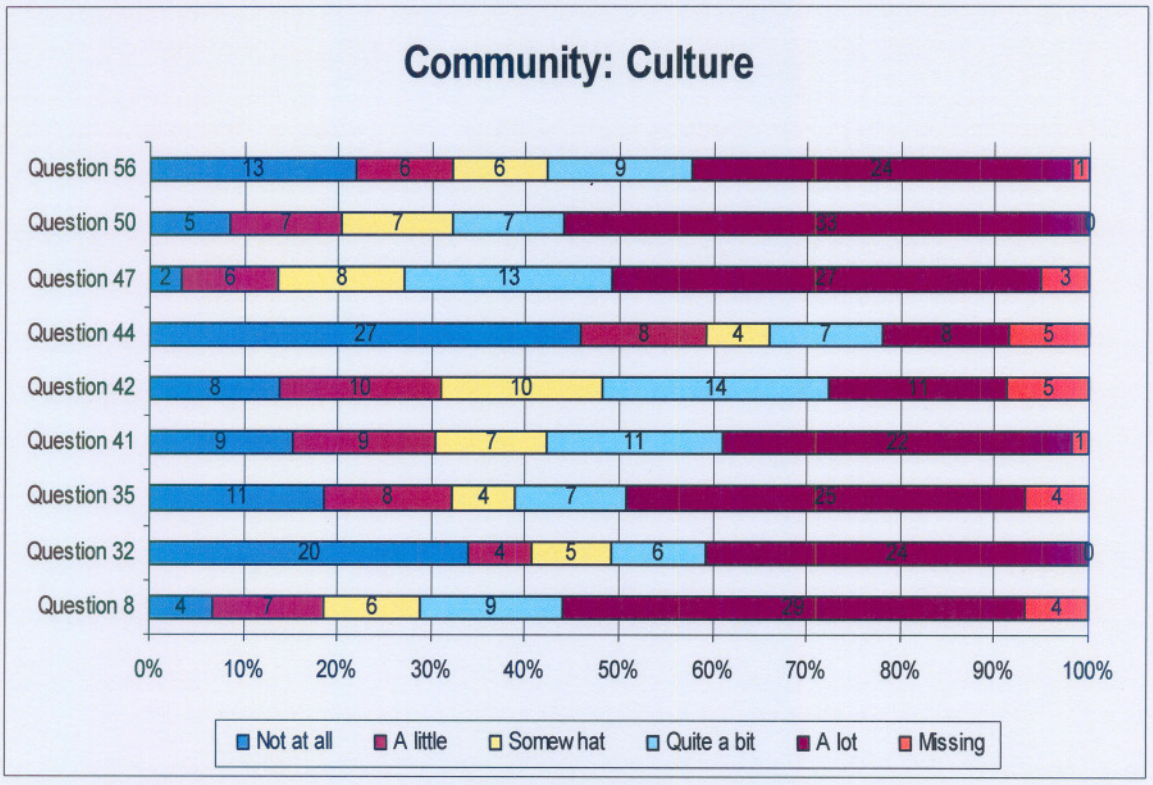


In Figure 5.21 it becomes evident that the majority of orphans (n = 18) do not feel that they are shunned by the community for being an AIDS orphan (question 13), therefore indicating community support and a sense of acceptance. The majority of orphans (n = 25) also have a role model or somebody whose example they can follow (question 8), which can be a protective factor as confirmed by literature (Masten & Reed, 2005:85; Van Rensburg & Barnard, 2004:3).

The number of missing responses (n = 10) to question 13 (Do you feel ashamed for being an AIDS orphan?) should be explained: Due to the stigma attached to AIDS orphans, one of the elders indicated that the fact that they were AIDS orphans was often withheld from

AIDS orphans. The researcher will not comment on the potential risk of withholding such vital information from individuals.

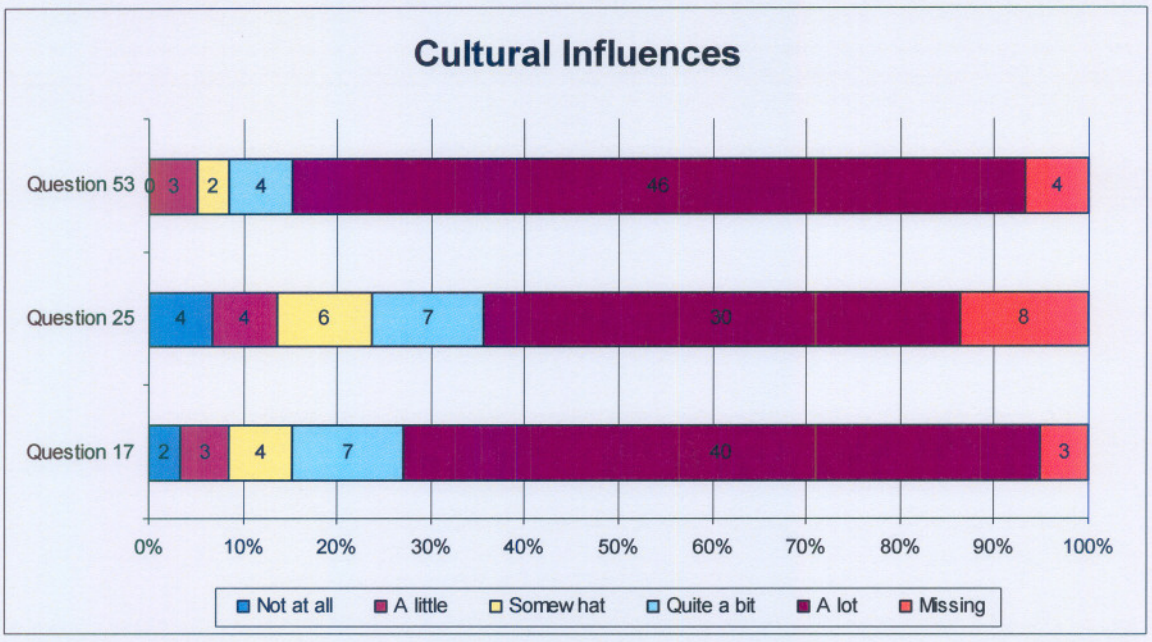
Figure 5.22:CYRM questions relating to general community factors



(0 result for Questions 50 and 32 – Missing)

From Figure 5.22 it is evident that the responses to questions 44 (age appropriate work or volunteer work) and 42 (being treated fairly in the community) indicate that the orphans experience negativity towards job opportunities, volunteering for jobs and being treated fairly in the community. It is evident from the majority of the responses to the other questions (boys and girls are treated fairly; there are opportunities to develop job skills that will be useful later in life; they are able to avoid violent situations; they know where to get help in the community; they are able to see a doctor when needed and they need to cooperate with others if they want to succeed) that the respondents feel secure in their environment. The community and culture play important roles in fostering resilience (C.f. 3.3.2.3) (Anon., 1995; Anon., 2005b; Masten & Reed, 2005:84; Strümpfer, 2003:71; Ungar & Liebenberg, 2005:218-219).

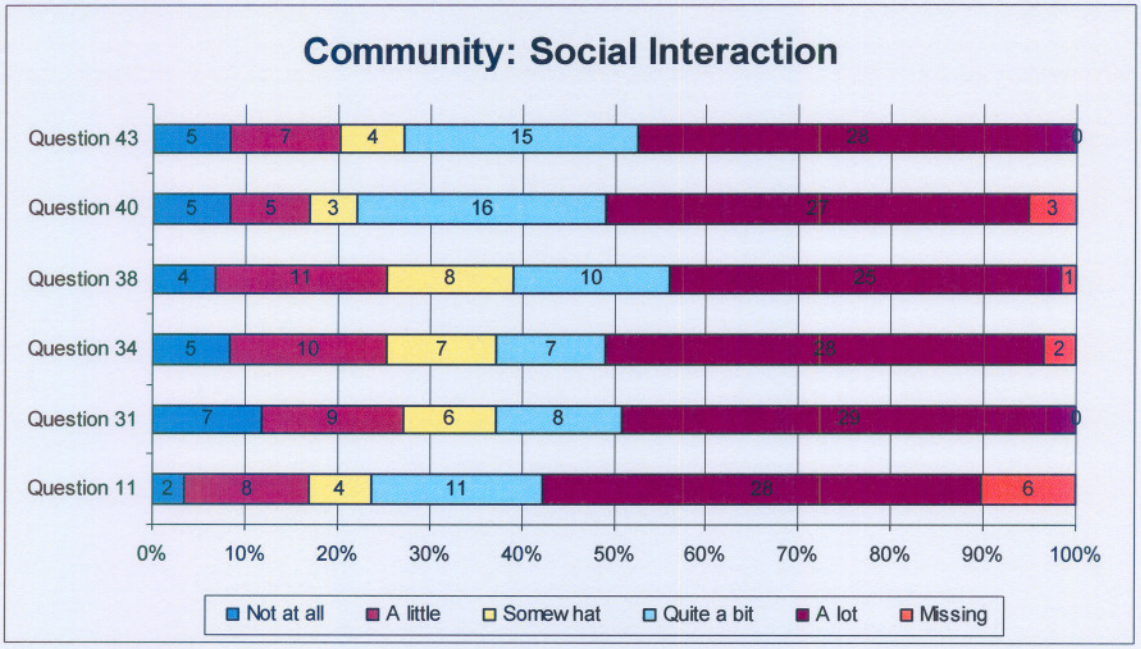
Figure 5.23:CYRM questions relating to cultural influences within the community



(0 result for Question 53 – Not at all)

According to Figure 5.23, the majority of orphans (n = 46) were proud of being South African (question 53) as well as of their ethnic background (n = 30) (question 25), and the majority (n = 40) also felt that their culture did teach them to become a better person (question 17). Literature confirms the importance of cultural embeddedness as an antecedent to resilience (Ungar & Liebenberg, 2005:218-219). For these orphans, their culture and nationality are positive experiences and could, therefore, potentially fuel resilient functioning.

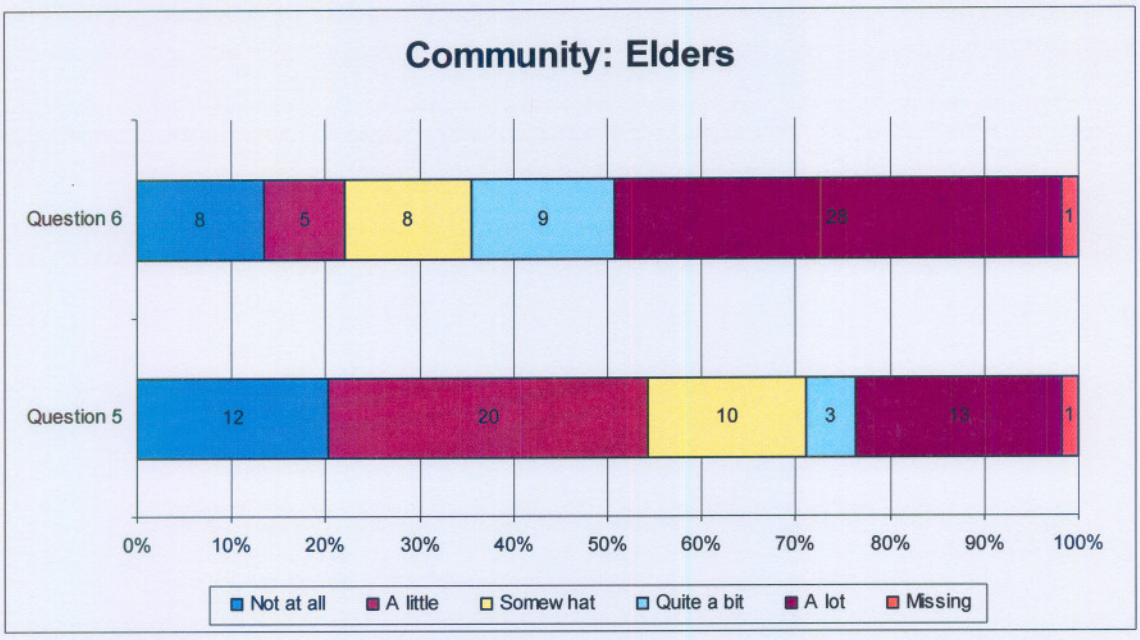
Figure 5.24:CYRM questions relating to social interaction within the community



(0 result for Questions 43 and 31 – Missing)

Figure 5.24 indicates that there is an overwhelming positive response concerning the AIDS orphans' social interaction in the community. They do have meaningful opportunities to show others that they are becoming adults (question 43); they have meaningful relationships with their peers (question 40); support from family (question 38), friends (question 34, 31) and social skills (question 11). This indicates that the majority of orphans feel social support and security. Literature recommends strong social support in order to instill resilience (Anon., 1995; Anon., 2005b; Masten & Reed, 2005:84; Strümpfer, 2003:71; Ungar & Liebenberg, 2005:218-219).

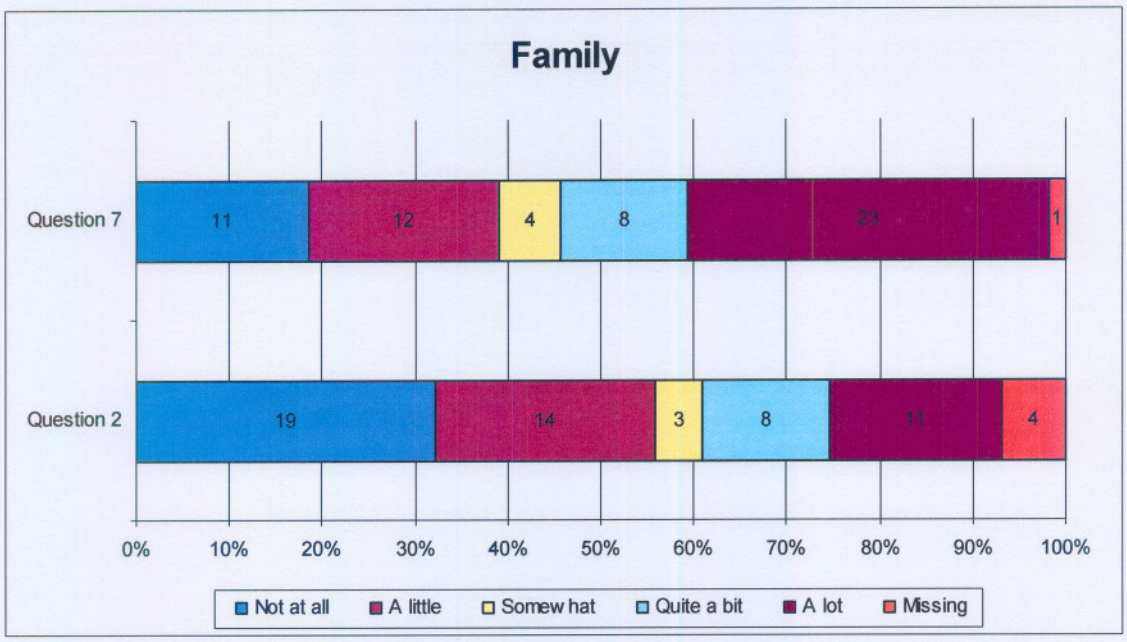
Figure 5.25:CYRM questions relating to elders and role models



According to Figure 5.25, the majority of orphans (n= 28) feel that they have somebody to look up to (question 6), however, they (n = 32) do not feel that the older generation tolerates and understands the ideas and strong beliefs of people their age (question 5). The presence of a role model indicates a protective factor, but there seems to be community intolerance towards the youth which indicates a risk factor (Anon., 1995; Anon., 2005b; Masten & Reed, 2005:84; Strümpfer, 2003: 71; Ungar & Liebenberg, 2005:218-219).

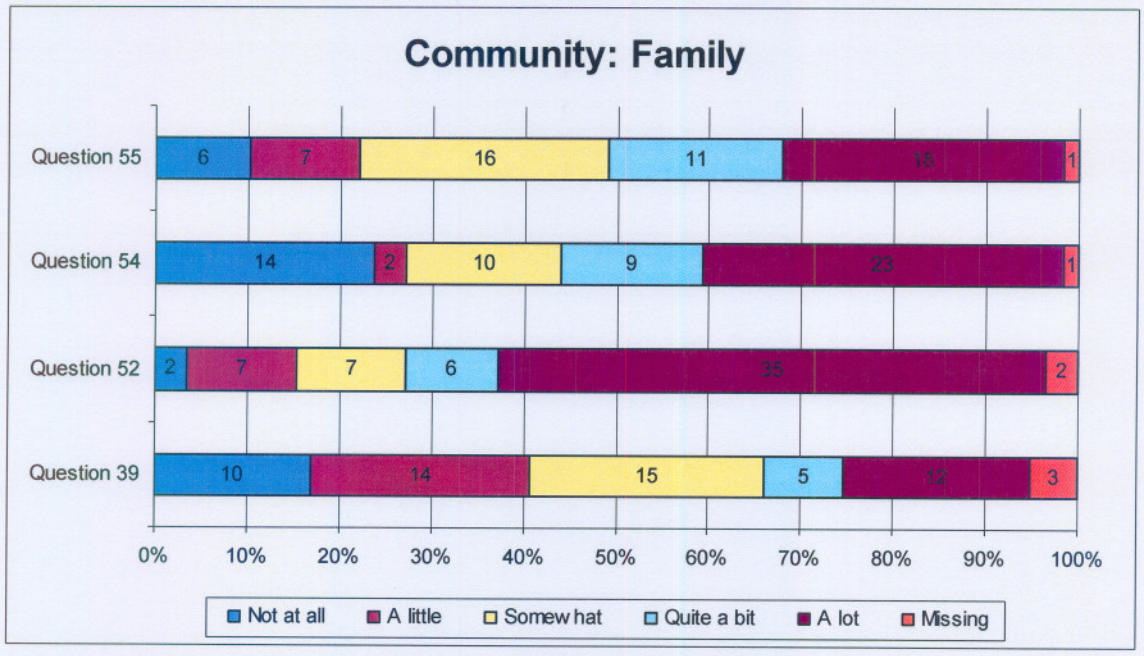
5.2.2.2.3 Family and relationship factors

Figure 5.26:Site specific questions: Family factors



In Figure 5.26 it becomes evident that the majority of orphans (n = 31) do feel angry for not being able to live with their parents (question 7), as well as feeling that they can not cope with the grief of losing their parents (question 2). This suggests lack of perceived family support, a risk factor reported in literature (Masten & Reed, 2005:85; Van Rensburg & Barnard, 2004:3).

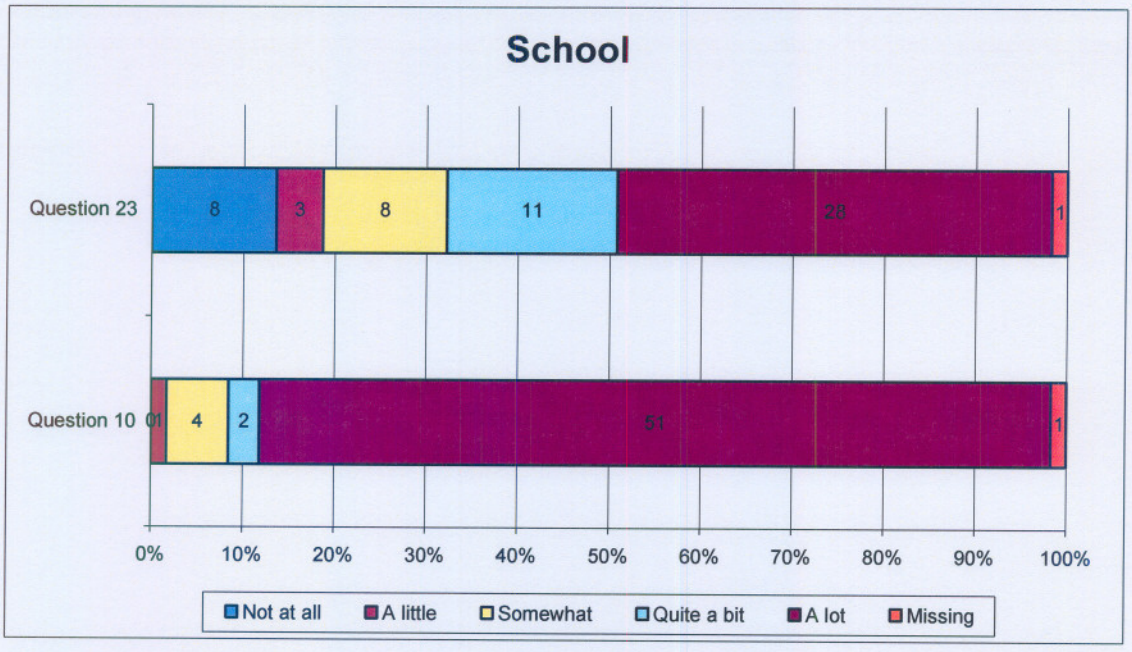
Figure 5.27:CYRM questions relating to family involvement



From Figure 5.27 it becomes evident that the families of the AIDS orphans do play a big role in their lives. (Their families mostly consist of extended families including sometimes one parent – in the case of single orphans, grandparents, uncles, aunts or siblings who are the heads of the households). Their responses indicate that they can openly disagree with parents or elders regarding different points of view (question 55), their families do not really encourage non-violent solutions to deal with criminals (question 54), they really enjoy their family's traditions (question 52) but there is not a lot of familial acceptance of people who do unacceptable things (question 39). Having a family (even if it is a foster family or an extended family where most orphans find themselves) can play a significant role in fostering resilience (Anon., 1995; Der Kinderen & Greeff, 2003: 86, 87; Dornbusch *et al.*, 1999:278-279; Masten and Reed, 2005:84).

5.2.2.2.4 School factors

Figure 5.28:CYRM questions relating to school factors

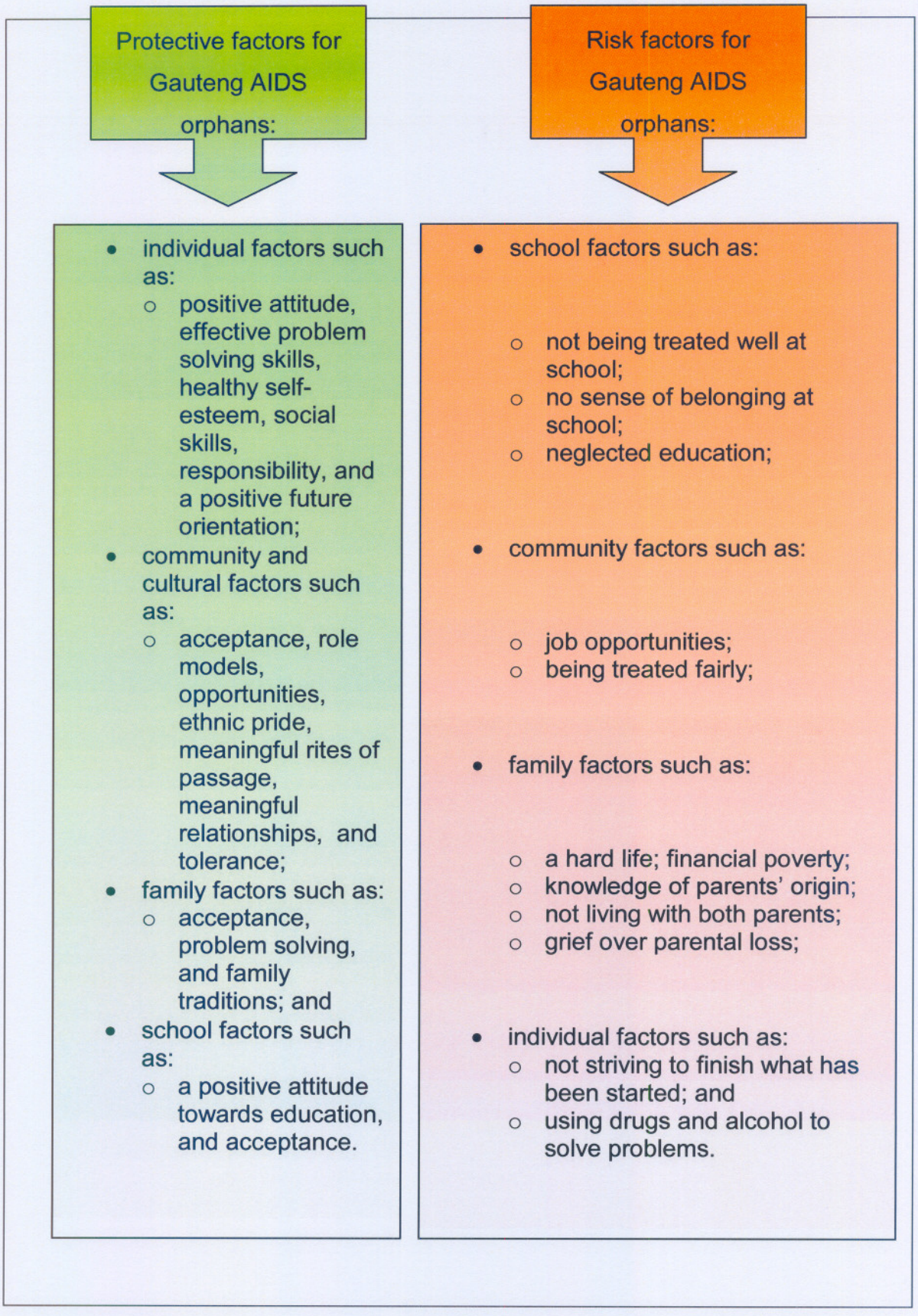


(0 result for Question 10 – Not at all)

Figure 5.28 suggests that the majority of orphans feel very positive towards their education and schooling environment (they feel free to talk with teachers about problems; they understand the importance of an education). This is an important protective factor. In other words, their school environment does, indeed, play a potential role in the promotion of their resilience, as confirmed by literature (Anon., 1995; Christenson & Brooke, 1999:266-268; Dornbusch *et al.*, 1999:280; Govender & Killian, 2001: 2; Masten & Reed, 2005: 83; Van der Westhuÿsen & Schoeman, 1984:323-325; Van Rensburg & Barnard, 2004:4).

Figure 5.29 summarizes the risk and protective factors that emerged from the qualitative data analysis:

Figure 5.29: Summary of quantitative data analysis



5.3 QUALITATIVE DATA ANALYSIS

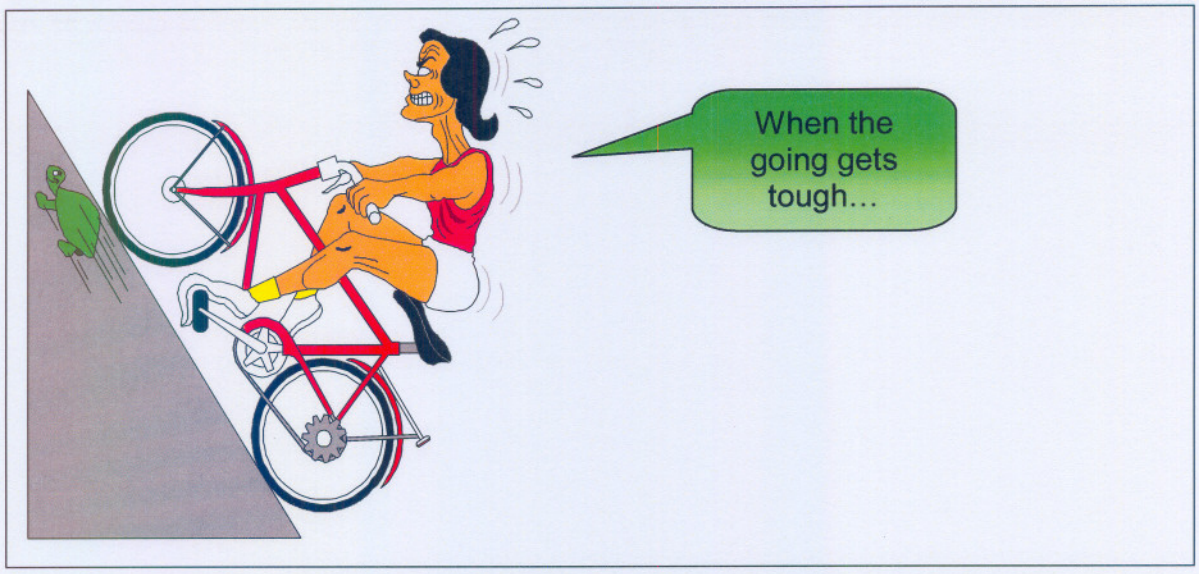
Three in-depth interviews with resilient AIDS orphans, a group interview with six elders and two poems by a resilient orphan (included as conclusion in Chapter 6 and as Addendum I) were content analyzed to find recurring themes in order to make deductions regarding the specific risk factors the AIDS orphans are exposed to, as well as the protective factors they use to cope with their circumstances. See Addendums E to H for transcripts of the interviews. The following table summarises the background data of the three AIDS orphans that were interviewed:

Table 5.1: Summary of background data of the interviewees

PARTICIPANT A	PARTICIPANT B	PARTICIPANT C
• Female • Age: 20 years • Academic qualifications: Grade 12 • Maternal orphan • Lives with grandmother	• Female • Age: 15 years • Academic qualifications: Grade 10 • Maternal orphan • Lives with grandmother	• Male • Age: 14 years • Academic qualifications: Grade 9 • Maternal orphan • Lives with father and stepmother

5.3.1 Content related risk factors

Figure 5.30:Risk factors make coping difficult



Recurrent themes, depicting resilience inhibiting factors mentioned by the AIDS orphans (who participated in the interviews) and the elders interviewed, will be delineated. The themes were identified and categorized and then listed in order of the most mentioned to the least mentioned, as well as from the seemingly most serious to the least serious factors.

5.3.1.1 Community risk factors

The risk factors intrinsic to the community can be clustered as four major themes, namely risky communities; poor communities; communities with limited opportunities and judgmental communities. Each will be delineated using sub-themes.

5.3.1.1.1 Risky communities

- The orphans live in an unsafe environment ridden with crime. The community cannot provide a safe and secure environment, as can be seen from the following excerpts:

PARTICIPANT A: *"We have lots of crime."*

"We have many robberies, hijacking, rape, especially after dark."

after dark."

PARTICIPANT B: *"The bad things hang over us like a dark cloud."*

"But we have lots of corruption going on."

PARTICIPANT C: *"...when there is violence..."*

"People who rape. They murder other people."

- The quality of the environment is dubious. They live in a troubled community as can be deduced from the following extracts:

PARTICIPANT A: *"I live in a troubled community."*

"They don't think that the solutions are effective."

"The government doesn't play a role.... The government is failing."

PARTICIPANT B: *"We have no sanitary facilities. We also have lots of littering and pollution..."*

GROUP INTERVIEW PARTICIPANTS: *" ...there is hunger and starvation... and no help from the government".*

- There is a lack of discipline and an inability to avoid exposure to violence as can be seen in the following extracts:

PARTICIPANT A: *"But my cousins and people I know...are exposed to violence"*

But most people are not driven to avoid violence."

"The children are disrespectful."

PARTICIPANT B: *"There's also teenage pregnancy and drugs like dagga and tobacco in schools."*

"Coming home late. Drugs and sex. Children making decisions without thinking."

GROUP INTERVIEW PARTICIPANTS: *"Children are having sex at younger ages. They are promiscuous. There's lots of alcohol abuse, violence, abortion and crime."*

5.3.1.1.2 Poor communities

- There is a serious lack of employment; recreational and basic needs are not met, as can be deduced from the following excerpts:

PARTICIPANT A: *"There are playgrounds that are being developed. But there's not much"*

"People get dragged into doing the wrong behaviour because there are no extra mural activities. There's nothing there for them to do."

PARTICIPANT B: *"Things like unemployment and poverty."*

"The money we get to uplift the community goes to the wrong places."

PARTICIPANT C: *"But there is no work. There is no recreation."*

GROUP INTERVIEW PARTICIPANTS: *"Especially poverty, HIV/AIDS, hunger..."*

- The following excerpts indicate that poverty is a serious problem.

PARTICIPANT A: *"I can not afford it financially."*

PARTICIPANT B: *"We have a lack of food. I'm always hungry. We are poor."*

PARTICIPANT C: *"We also have people begging."*

"... when they come to our homes, asking for money..."

GROUP INTERVIEW PARTICIPANTS: *" ...there are no jobs"*

5.3.1.1.3 Communities with limited opportunities

- There are limited opportunities for adolescents to grow up well, as can be deduced from the following quotes:

PARTICIPANT A: *"Sometimes I feel jealous because of opportunities I don't get and they have."*

"There's nothing there for them to do."

"I don't have the same opportunities."

PARTICIPANT B: *"We have fewer opportunities than richer people."*

- There is little future orientation and a lack of goals and aspirations as indicated in the following excerpts:

PARTICIPANT A: *"It makes us lose hope. We are not driven anymore."*

PARTICIPANT B: *"They have no hope."*

"Some people give up."

5.3.1.1.4 Judgmental communities

- The community does not tolerate problem or risk behaviour, as indicated by the following extracts:

PARTICIPANT A: *"...when the people in prison are on parole, these people come back into the community. They feel that the punishment is not harsh enough."*

"They are not tolerant at all."

PARTICIPANT B: *"...and they beat the criminals when they are caught."*

"The elders shout at the youth."

"They are not tolerant at all."

PARTICIPANT C: *"The people are afraid of the police."*

- The following excerpts suggest that the community tends to be judgmental.

PARTICIPANT A: *"People judge me."*
"The community tends to judge people."

PARTICIPANT B: *"They think I'm stupid because I don't want to do wrong things."*

- The community is perceived as inflexible and not providing sufficient role models as indicated by the following excerpts:

PARTICIPANT A: *"I rely on myself, not others."*

PARTICIPANT B: *"Some people are very stubborn." "At first they are negative..."*

The above mentioned community factors which can impact negatively on resilience have been noted in literature. High levels of neighbourhood crime/violence; social disintegration or disorganization; social intolerance or discrimination/stigma/racism; a socially impoverished community; lack of community norms; and neighbourhood disorganization are detrimental to fostering resilience (Ebersöhn & Eloff, 2002:79; Thomlison, 2004:386-387). In the case of the AIDS orphans, their community seems to pose a significant risk to resilience.

5.3.1.2 Family risk factors

The risk factors intrinsic to the families can be clustered as three major themes, namely: dysfunctional families, rigid families and poor families. Each will be delineated using sub-themes.

Before discussing the risk factors inherent to these orphans' families, it is necessary to reiterate that the AIDS orphans in this interview sample are maternal orphans living with remaining family members (C.f. Table 5.1).

5.3.1.2.1 Dysfunctional families

- The main prohibiting factor regarding resilience in the family is poor family relationships, which include a lack of communication and marital conflict or discord as can seen in the following extracts:

PARTICIPANT A: *"I feel threatened by my father."*

"I cannot speak my mind."

"Communication is very difficult."

PARTICIPANT B: *"They don't understand."*

"They always fight in their house."

"...when my father used to beat me..."

PARTICIPANT C: *"Fathers beating mothers."*

"...people don't care..."

"...when children run away from home..."

"...or when we do not do our parents any favours..."

"My father is absent most of the times."

- Families are fragmented and disrupted as indicated by the following extracts:

PARTICIPANT A: *"I've been living with my granny for five years."*

"I don't have a mother."

"She has a mother and a stepfather."

PARTICIPANT B: *"Her mother married her father because he has money."*

PARTICIPANT C: *"My father is absent most of the times."*

- From the following excerpts one can deduce that there is lack of family cohesion and harsh discipline is experienced:

PARTICIPANT A: *"But everybody is doing his or her own thing."*

"Children stay apart from the parents."

"The children are disrespectful. They don't care. They are selfish."

PARTICIPANT B: *"The elders shout at us. They swear at us."*

"...when my father used to beat me..."

- Sometimes there is a lack of discipline and adult supervision, as can be deduced from the following extracts:

PARTICIPANT A: *"The children are disrespectful."*

PARTICIPANT B: *"Coming home late."*

PARTICIPANT C: *"When children run away from home. Or when we do not do our parents any favours."*

not do our parents any favours."

- Some children seem to have little respect for their parents or caregivers, as can be deduced by the following excerpt:

PARTICIPANT A: *"The children are disrespectful."*

5.3.1.2.2 Rigid families

- The following excerpts suggest that there is a serious lack of a feeling of belonging, acceptance and support from parents and family members.

PARTICIPANT A: *"I feel like an outcast."*

"But my family is reserved."

"Her granny is not supportive..."

"She has no one there for her."

"We get little support from our parents."

PARTICIPANT B: *"They don't understand."*

PARTICIPANT C: *"...people don't care."*

- Children experience too much control and little freedom, suggesting an inflexible family structure, as can be seen in the following excerpts:

PARTICIPANT A: *"They have set ideas of what I have to do. They try to control us."*

"Our behaviour is regulated."

"My dad controls me a bit."

PARTICIPANT B: *"...the old generation is very strict."*

- There seems to be intolerance on the part of the parents, as indicated by the following quote:

PARTICIPANT B: *"... they are not tolerant."*

- Parents are perceived as incompetent and judgmental, as can be seen from the following extracts:

PARTICIPANT B: *"But I'm living for myself."*

PARTICIPANT A: *"She has no one there for her."*

"He doesn't know the way I feel. Communication is very difficult."

"They are judgmental. They have set ideas of what I have to do."

"I also take care of my sister."

"She has no experience with kids. She doesn't know how to handle us."

5.3.1.2.3 Poor families

- Poverty within the family is a debilitating factor, as can be deduced from the following quotes:

PARTICIPANT A: *"I cannot afford it financially."*

PARTICIPANT B: *"We have a lack of food."*

PARTICIPANT C: *"They want to make me happy, but they can't, because there's no money."*

The above mentioned risk factors, which can impact negatively on resilience, have been noted in the literature and have been expounded in 3.4 of this study. Family cohesion, effective parenting and familial support are important factors which enhance resilience (Carew, 2005:283; Der Kinderen & Greeff, 2003:87; Thomlison, 2004:384-387). In the case of these AIDS orphans, their family context seems to pose a significant risk to resilience as the family context is risk-laden.

5.3.1.3 Individual risk factors

The individual risk factors can be clustered as four major themes, namely: demotivation, limited coping skills, social isolation and poor self esteem. Each will be delineated using sub-themes.

5.3.1.3.1 Demotivation

- There is some lack or motivation and hope and a negative future orientation, as can be seen from the following excerpts:

PARTICIPANT A: *"You lose focus on life. It makes us lose hope. We are not driven anymore."*

"But I cannot go any further."

PARTICIPANT B: *"They have no hope or confidence."*

"Some people give up"

"... I didn't care."

5.3.1.3.2 Limited coping skills

- None of the interviewees were able to live with uncertainty, as can be deduced from the following extracts:

PARTICIPANT A: *"I cannot live with uncertainty."*

PARTICIPANT B: *"I don't like uncertainty. I want to know what's going to happen with me."*

PARTICIPANT C: *"I want certainty. I want answers."*

- One orphan (14 year old male) struggles to solve serious problems, as can be deduced from the following quote:

PARTICIPANT C: *"I can handle ordinary problems, but not serious problems."*

5.3.1.3.3 Social withdrawal

- There seems to be an aversion to being responsible for others and a proclivity for survival of the self. While their ability to put themselves first can function as a protective factor, avoidance of others may be more of a risk factor during times that support is needed.

PARTICIPANT A: *"But people rely too much on me."*

"I shut people out."

PARTICIPANT B: *"But I'm living for myself. Some people will do nothing."*

"Some people are very stubborn."

5.3.1.3.4 Poor self-esteem

- The following excerpts suggest that the AIDS orphans seem to lack self esteem only in specific circumstances:

PARTICIPANT C: *"...they think I'm stupid..." (when he does not conform to peer pressure)*

PARTICIPANT A: *"I am not really popular."*

"I feel I am not equal..."

PARTICIPANT B: *"I lost my backbone." (when her mother died)*

The above mentioned individual risk factors pose a threat to instilling resilience and have also been noted in literature concerning individual risk factors. These intrapersonal risk factors have been summarized in 3.4 of this study (Ebersöhn & Eloff, 2002:79; Thomlison, 2004:386-387).

5.3.1.4 Social interaction and relationships

The risk factors intrinsic to social interaction can be clustered as three major themes, namely: lack of social support, intolerance and risky behaviour. Each will be delineated using sub-themes.

5.3.1.4.1 Lack of social support

- The most important risk factor mentioned is a lack of social support and a feeling of social isolation, as can be seen from the following extracts:

PARTICIPANT A: *"I don't have many friends."*

"...make me feel like an outcast."

"I don't rely on others much."

"She has no one there for her."

PARTICIPANT B: *"They don't understand."*

5.3.1.4.2 Intolerance

- There seems to be some lack of empathy, perceived social inequity, as well as intolerance from society, as can be deduced from the following excerpts:

PARTICIPANT A: *"...opportunities I don't get and they have."*

"They feel that the punishment is not harsh enough."

"There's lots of nepotism."

"They are not tolerant at all."

"I feel that I am not equal to my elders."

5.3.1.4.3 Risky behaviour

- At school there seems to be some use of substances and a lack of discipline, as can be seen in the following quote:

PARTICIPANT B: *"...drugs like dagga and tobacco in schools."*

From the above, it is clear that the AIDS orphans and the community they live in are exposed to risk factors which can be threatening to enhancing resilience. From literature it is evident that the above mentioned factors are indeed social/environmental risk factors (Ebersöhn & Eloff, 2002:79; Thomlison, 2004: 386-387).

5.3.1.5 Cultural and religious factors

- There seems to be slight cultural alienation, as can be deduced from the following extracts:

PARTICIPANT A: *"I do believe in all our customs and beliefs. I identify with them. But it is not always easy."*

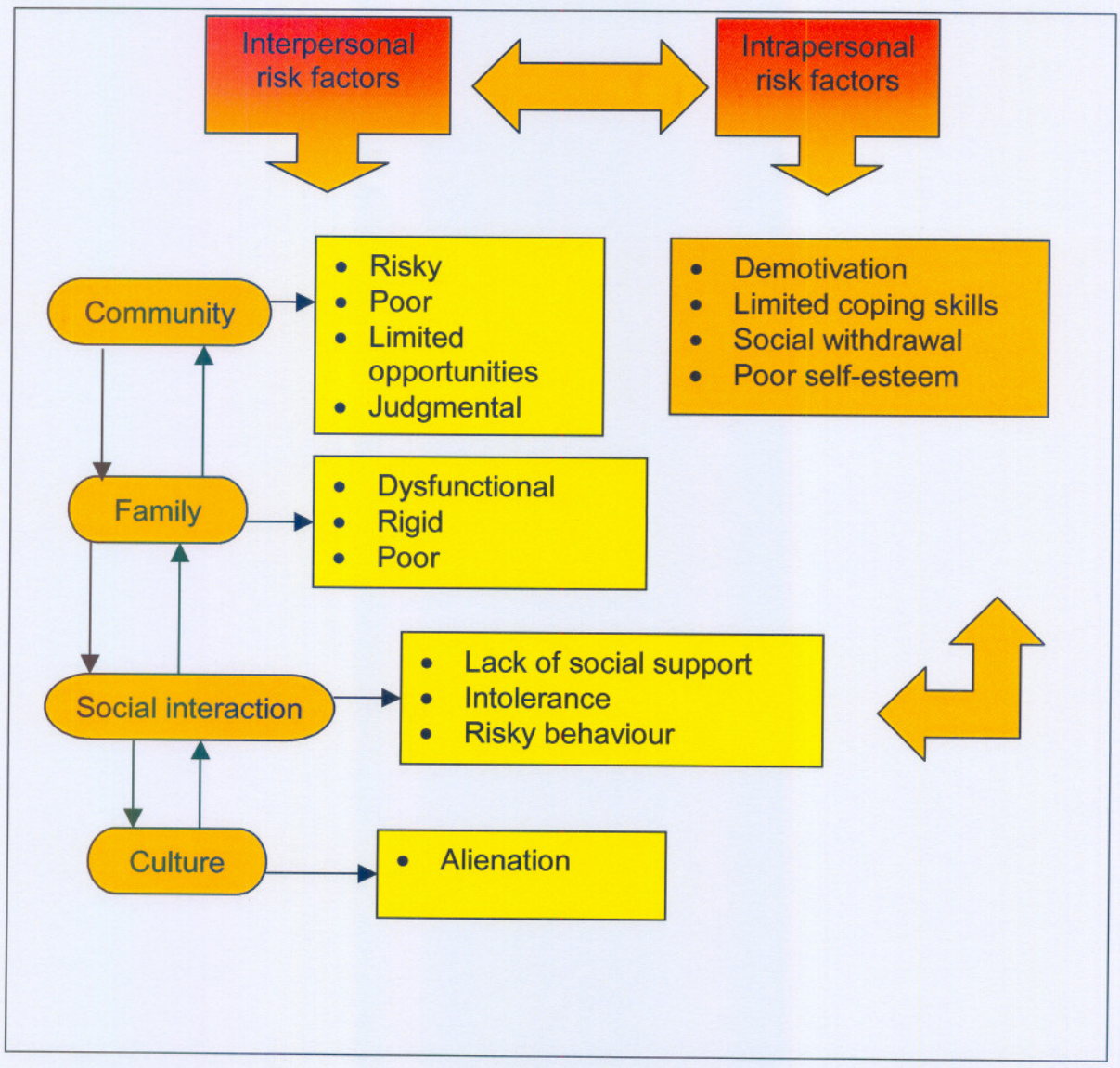
PARTICIPANT B: *"I don't feel very much part of all the cultural activities and customs."*

Cultural embeddedness and identification seem to be important factors in fostering resilience and a lack of it can pose a threat to resilience (Ungar & Liebenberg, 2005: 218-219).

5.3.1.6 Overall summary

It has become evident from the responses of the AIDS orphans that there are several inter- and intrapersonal risk factors within the community and themselves, or others who are perceived as not coping, which pose a threat to promoting resilience. The most significant risk factors seem to come from the community in which they find themselves. Figure 5. 31 will provide a summary of these factors:

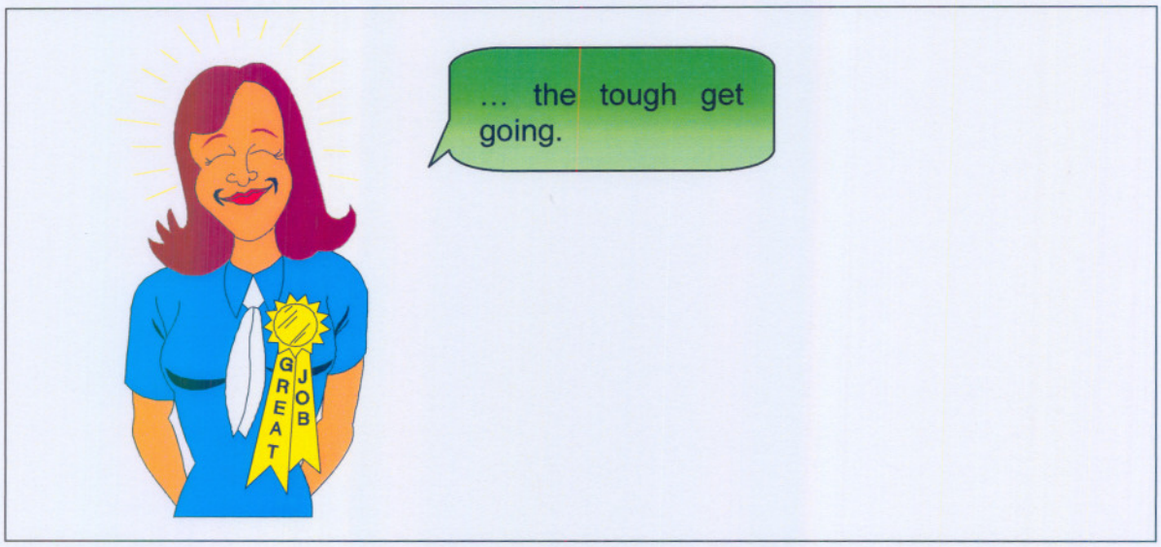
Figure 5.31:Summary of risk factors



There are, however, protective factors which promote resilience within the three interviewees and others who are perceived as resilient by them as well as the elders (see Addendum H), as will be expounded in the following section.

5.3.2 Context related protective factors

Figure 5.32:Protective factors enhance wellbeing



The following recurrent themes (5.3.2.1 – 5.3.2.5), regarding protective factors the AIDS orphans, as well as others which they perceive as resilient, have at their disposal to inculcate resilience, were identified. These factors are also grouped from seemingly most important – because they were mentioned most - to the least important factors – which were mentioned least. Each theme is followed by excerpts or quotes from which the themes were deduced.

5.3.2.1 Individual or intrinsic protective factors

The protective factors intrinsic to the individual can be clustered as 8 major themes, namely positive attitude, positive self-concept, drive, internal locus of control, assertiveness, good interpersonal relationships, a positive future orientation and physical attributes. Each will be delineated using sub-themes.

5.3.2.1.1 Positive attitude

- The most outstanding and most mentioned personal characteristic by far was being optimistic and having a positive outlook on life, as can be deduced from the following extracts:

PARTICIPANT A: *"I had good teachers. I am grateful about my education."*

"There's always a way out."

"She had a good spirit"

PARTICIPANT B: *"... am happy with my life."*

"I am not jealous. It motivates me."

"She's so positive."

PARTICIPANT C: *"Being happy helps you to cope."*

"I am in control of my life. It is a good feeling."

GROUP INTERVIEW PARTICIPANTS: *"They bring smiles to sad faces."*

"Be positive."

- Being emotionally expressive is helpful, as well as having a sense of humour, as can be seen in the following extracts:

PARTICIPANT A: *"Humour plays a big role. I get along with people. Being able to laugh decreases your stress levels."*

PARTICIPANT B: *"You keep healthy by showing your emotions, by crying and laughing."*

"You must express yourself the way you are."

PARTICIPANT C: *"They laugh a lot."*

"Oh, I love laughing. It plays a big role in my life."

5.3.2.1.2 Positive self-concept

- Self awareness and insight were very important factors that were mentioned, as can be seen in the following quotes:

PARTICIPANT A: *"You need to have an understanding of what you have to do."*

"I know I have the ability to do it."

PARTICIPANT B: *"I accept the way I am."*

"I'm unique."

"...but mostly you must have self awareness."

PARTICIPANT C: *"I just want to make them laugh. It comes from myself."*

- The AIDS orphans have a healthy self esteem and avoid exposure to risk behaviour, as can be deduced from the following excerpts: (Although it seems like a contradiction of the previous section, the instances of low self-esteem that were reported surfaced in specific and isolated circumstances.)

PARTICIPANT A: *"It also makes me feel good about myself."*

"I am confident. I know I have the ability to do it."

PARTICIPANT B: *"I accept the way I am. I accept myself."*

"I am popular and liked by others."

"I use nothing. My friends drink."

PARTICIPANT C: *"I am well liked."*

"I don't smoke. I feel good about it."

5.3.2.1.3 Drive

- Individual problem solving abilities were mentioned very regularly, as can be seen in the following quotes:

PARTICIPANT A: *"The teenagers give suggestions to the community leaders."*

"I fight my own battles."

PARTICIPANT B: *"I'm accepting things the way they are."*

"Life is a challenge."

PARTICIPANT C: *"Change brings difficulties, but I will cope."*

"I'll stop my friends when they want to fight."

GROUP INTERVIEW PARTICIPANTS: *"They do not quit. They want to be the best."*

"The successful children have the drive to succeed."

- The participants make use of opportunities as can be deduced from the following extracts:

PARTICIPANT A: *"We all learn from change. It gives you opportunity."*

"I have worked at a hair salon previously to earn some money."

PARTICIPANT B: *"They create their own opportunities. And use their opportunities."*

5.3.2.1.4 Internal locus of control

- Self efficacy and having an internal locus of control are very important factors that were mentioned, as can be deduced from the following extracts:

PARTICIPANT A: *"I have to put up a mask for the sake of everybody."*

"If plan A fails, I always have a plan B."

"I mainly get strength from myself."

PARTICIPANT B: *"After school I'm going to find a job to get money."*

"I don't have to, because I know who I am."

PARTICIPANT C: *"I tell people what I want."*

"I am in control of my life."

- Intrinsic strength and having a life philosophy were mentioned, as can be seen in the following quotes:

PARTICIPANT A: *"I fight the battle myself."*

"Grab life with both hands."

PARTICIPANT B: *"She hides her problem."*

PARTICIPANT C: *"Just be happy."*

- Leadership, hard work, creativity and acceptance of the situation were mentioned, as can be seen in the following quotes:

PARTICIPANT A: *"You must be confident and creative."*

PARTICIPANT B: *"I also accepted my situation."*

PARTICIPANT C: *"I teach my friends how to do gumboot dancing."*

5.3.2.1.5 Assertiveness

- Being assertive is an important characteristic mentioned, as can be seen in the following excerpts:

PARTICIPANT A: *"They are confident."*

"I am not scared to speak my mind."

PARTICIPANT B: *"But the youth will fight for what they want."*

"Everybody has rights."

PARTICIPANT C: *"I tell people what I want. They accept it sometimes. If they don't, I ignore them."*

5.3.2.1.6 Good interpersonal relationships

- The participants demonstrate a balance between dependence and independence, as can be deduced from the following extracts:

PARTICIPANT A: *"I fight my own battles."*

"But I would ask for help if necessary."

PARTICIPANT B: *"But I'm living for myself."*

"I do rely on my grandmother for food and shelter."

PARTICIPANT C: *"They are independent."*

"I am independent. But I need many people to survive."

GROUP INTERVIEW PARTICIPANT: *"They talk to their friends, you know, share secrets."*

- There is a definite sense of duty and being a responsible individual, as can be seen in the following quotes:

PARTICIPANT A: *"I work at MacDonalds on Saturdays. I also take care of my sister."*

"I was there to teach them English."

PARTICIPANT B: *"I talk to others to help them."*

PARTICIPANT C: *"I'll stop my friends when they want to fight."*

"I only want to give advice."

GROUP INTERVIEW PARTICIPANT: *"They volunteer to run activities with youth in and around the local communities."*

- Participants have effective social skills, as seen in the following excerpts:

PARTICIPANT A: *"They are not self centered. They understand and have*

empathy because they have been there."

PARTICIPANT B: *"Other people love her."*

PARTICIPANT C: *"I just want to make them laugh."*

- Having empathy and being flexible and adaptable are coping strategies.

PARTICIPANT A: *"We all learn from change."*

"They understand and have empathy because they have been there."

PARTICIPANT B: *"I talk to others to help them."*

"They accept things."

PARTICIPANT C: *"Change brings difficulties, but I will cope."*

"I want to help people with their problems."

5.3.2.1.7 Positive future orientation

- The AIDS orphans are future orientated and have goals and aspirations, as can be deduced from the following extracts:

PARTICIPANT A: *"You must follow your dreams."*

"They are motivated and driven."

PARTICIPANT B: *"...and I love school. It's my future."*

"I want to become a lawyer."

PARTICIPANT C: *"They think I'm going to be something one day."*

"I want to become a social worker."

GROUP INTERVIEW PARTICIPANT: *"They know that they have a future."*

- Self betterment is also a factor mentioned in the following quotes:

PARTICIPANT A: *"I had good teachers. I am grateful about my education."*

"I want to succeed in life. I want a job in an office. I want to be a career woman."

PARTICIPANT B: *"Being able to live well. ... Having a good life style."*

"I want to become a lawyer."

PARTICIPANT C: *: "I want to uplift my community."*

"I want to be rich and have a good life."

GROUP INTERVIEW PARTICIPANT: *"They try to go to school."*

"... one should live one's dreams."

5.3.2.1.8 Physical attributes/factors

- Age and maturity (late adolescence) play roles in protecting the individual from risk, as can be seen form the following extracts:

PARTICIPANT A: *"I am 20 years old."*

"There's another girl who's nineteen years old."

PARTICIPANT B: *"I am fifteen years old."*

"I know a girl. She's sixteen years old."

PARTICIPANT C: *"I am fourteen years old."*

- Gender plays a role, in that females seem to show more coping strategies, as seen in the following quotes:

PARTICIPANT A: *"...I am a Zulu girl."*

"There's another girl..."

"...also the females..." (Are the ones who are protective of the family)

PARTICIPANT B: *"I am a Zulu girl."*

"I know a girl..."(When asked to share a story of another person who seems to cope)

- Physical and mental health, as well as material needs being met, were mentioned as protective factors, as can be seen in the following extracts: (Although these factors are not inherent individual factors, they do play an important role in fostering well-being of the individual.)

PARTICIPANT A: *"Living a good life. When you have the ability to do something. When you are in a good condition and able to generate energy."*

PARTICIPANT B: *"Being able to live well. Being able to do things. Having a good life style. When everything is going good."*

PARTICIPANT C: *"Growing well. Being able to eat."*

"But they do provide me with food and clothes and transport."

From the above, it has become evident that the AIDS orphans rely heavily on their intrinsic or inherent strengths to counteract the risk they are exposed to. From the literature study (Cf. 3.3.1), it is evident that certain intrapersonal factors play a very important role, together with factors found in the community (which will be expounded in the following sections) in enhancing resilience (Anon., 1995; Anon., 2005b; Norton, 2005:56; Strümpfer, 2003:70; Theron, 2004:317-318; Van Rensburg & Barnard, 2004:3).

5.3.2.2 Community factors

The protective factors intrinsic to the community can be clustered as 5 major themes, namely sufficient opportunities, drive, stability, positive attitude and tolerance. Each will be delineated using sub-themes.

5.3.2.2.1 Sufficient opportunities

- The participants who demonstrate resilience live in a community that provides most importantly, schooling opportunities, employment, housing and recreational facilities, as can be deduced from the following excerpts:

PARTICIPANT A: *"The government provided the school. I had good teachers."*

"We can go to a community centre that offers sports and sports equipment. We have drama teachers to help us."

PARTICIPANT B: *"The government gave us dustbins to educate the community about littering. We also have a library where we can go to get information about drugs and that."*

PARTICIPANT C: *"The government provides us with a house."*

GROUP INTERVIEW PARTICIPANT: *"They have special buildings for orphans and help for the orphans."*

- The community provides schools which in turn provide:
    - special programmes (life skills);
    - effective/quality teachers;
    - support; and
    - access to information as seen in the following quotes:

PARTICIPANT A: *"Yes. I did go to school."*

"The government provided the school. I had good teachers."

"We have drama and teachers to help us."

PARTICIPANT B: *"At school we get education about AIDS and things like*

that."

"The counselors tell us about the dangers of having unprotected sex."

PARTICIPANT C: *"I am in grade 9. I still go to school."*

GROUP INTERVIEW PARTICIPANT: *"In KwaZulu Natal they have better schools than here in Daveyton. They have special buildings for orphans and help for the orphans."*

5.3.2.2.2 Drive

- The community is motivated to solve problems, as can be deduced from the following excerpts:

PARTICIPANT A: *"They try to look at the cause of the problems."*

"They ask: 'How can we handle it'?"

PARTICIPANT B: *"...follow the examples of others."*

- Empathy, dependence, a sense of duty and active participation and goals and aspirations were also mentioned in the following extracts:

PARTICIPANT A: *"It was for an organization that helped orphans."*

"...leaders are proactive."

PARTICIPANT B: *"We do have community services..."*

PARTICIPANT C: *"All the people talk about it."*

"...trying to do good for other people."

"We play soccer and golf. Singing also helps and dancing."

5.3.2.2.3 Safe environment

- The community provides safety and security, as can be deduced from the following excerpts"

PARTICIPANT A: *"...now we have people who have volunteered to stand guard."*

PARTICIPANT B: *"We have section police..."*

PARTICIPANT C: *"...sometimes the police interferes."*

"They give us safety."

- There is an avoidance of risk behaviours, as seen in the following quotes:

PARTICIPANT A: *"The people around me don't use it." (substances)*

Not really." (Are you exposed to violence?)

5.3.2.2.4 Positive attitude

- The community wants to better itself, as seen in the following quotes:

PARTICIPANT A: *"We have to do something. The community and street leaders are proactive."*

"We will create our own jobs."

"...he's trying to do good for other people."

- An optimistic attitude within the community is helpful, as can be deduced from the following excerpts:

PARTICIPANT A: *"When everything is going well."*

"We create our own jobs."

PARTICIPANT B: *"...then they become positive."*

PARTICIPANT C: *"They think that they do a good job."*

5.3.2.2.5 Tolerance

- There is perceived community support and social equity, as can be deduced from the following extracts:

PARTICIPANT A: *"I do get support from my community."*

INTERVIEWER: *Do you feel equal to others?*

PARTICIPANT B: *"Yes, of course."*

"I have many friends."

"They respect my decisions."

PARTICIPANT C: *"I feel equal to everybody."*

- Role models and mentors are available to the participants of this interview, as can be seen in the following quotes:

PARTICIPANT B: *"You have to have a role model. Or a hero."*

PARTICIPANT C: *"I saw Zola. He advised people not to look at bad things."*

"Thabo Mbeki. Because he's trying to do good..."

- Youth have the opportunity to meaningful rights of passage, as can be deduced from the following extracts:.

PARTICIPANT A: *"Yes. The government provides us freedom."*

PARTICIPANT B: *"I feel free. I can express myself."*

PARTICIPANT C: *"I feel free to do anything. I am not at risk."*

- The community shows some degree of tolerance towards risk behaviour, has adequate communication, and is flexible and adaptable, as can be seen in the following quotes:

PARTICIPANT A: *"They realize things must change."*

PARTICIPANT B: *"We have a community leader who talks about these things."*

"They respect my decision."

PARTICIPANT C: *"They say 'shame, it is a pity'."*

"Sometimes they are tolerant."

From this section, it has become evident that the participants of this study perceive the community as having an important role in providing protective factors which can inculcate resilience. The literature study mentions the importance of the community, in particular schools, providing opportunities for the youth to be able to thrive (Anon., 1995; Christenson & Brooke, 1999:266-268; Dornbusch *et al.*, 1999:281; Masten & Reed, 2005:83; Van Rensburg & Barnard, 2004:4).

5.3.2.3 Family influences

The three interviewees are all maternal orphans and their families consist of extended families including sometimes one parent, grandparents, uncles, aunts and siblings. The protective factors intrinsic to the family can be clustered as 4 major themes, namely supportive and secure families, functional families, sufficient opportunities, and tolerance. Each will be delineated using sub-themes.

5.3.2.3.1 Supportive and secure families

- Most important is parental involvement and support, factors mentioned by the participants, as can be seen in the following quotes:

PARTICIPANT A: *"They approve of me going to church."*

"They tell me how to behave and tell me about life's dangers."

"We have some family time when we talk."

PARTICIPANT B: *"Sometimes the adults will give me advice how to protect myself."*

"My family think that I am a positive person."

"My parents pay my school fees."

"They sit down with me and they ask questions."

PARTICIPANT C: *"They talk to me sometimes. They think I'm going to be something one day."*

"I always tell them where I'm going."

- Parental authority, control and supervision are important factors mentioned by the AIDS orphans, as can be deduced from the following extracts:

PARTICIPANT A: *"The adults are very strict."*

(My parents) "teach me the way to behave. It makes me a mannered person."

PARTICIPANT B: *"My father is the head of the house."*

They sit down with me and ask questions."

- The resilient individual's family provides safety and security, as seen in the following quotes:

PARTICIPANT A: *: "...also the females because they are protective of the family."*

PARTICIPANT B: *"Sometimes the adults will give me advice how to protect myself."*

"They look after me well."

PARTICIPANT C: *"My (step) mother protects me."*

5.3.2.3.2 Functional families

- Having meaningful relationships and bonding with parents or siblings or past experiences of strong bonding are important factors, as can be deduced from the following excerpts:

PARTICIPANT A: *"My mother is my role model....I could rely on her.*

"Also my grandmother. She inspires me. I respect her...I like her and love her."

"My little sister is looking up to me."

PARTICIPANT B: *"My grandmother is very good to me."*

"She always asks me how I feel."

PARTICIPANT C: *"...my youngest sister. We talk about everything."*

- Communication within the family and being able to express oneself emotionally are important factors, as can be seen in the following extracts:

PARTICIPANT A: *"...they do show emotions."*

"We have some family time when we talk."

"They ask me what I do."

PARTICIPANT B: *"They talk to me. They always ask me how I am coping..."*

"They give advice and offer help."

PARTICIPANT C: *"We talk about everything."*

5.3.2.3.3 Sufficient opportunities

- The family provides opportunities for schooling, as can be deduced from the following excerpts:

PARTICIPANT B: *"My parents pay my school fees." (father and grandmother)*

PARTICIPANT C: *"My parents provide me with access to getting a school education." (referring to his father and stepmother)*

- The family also provides role models, and material needs are met, as seen in the following quotes:

PARTICIPANT A: *"...my grandmother. She inspires me...I learn a lot from her."*

"My mother is my role model." (Referring to her late mother)

PARTICIPANT C: *"...they do provide me with food and clothes and transport. They give me taxi money."*

5.3.2.3.4 Tolerance

- Although the family provides structure, it is also flexible, as seen in the following quote:

PARTICIPANT A: *"They try to control us...But everybody is doing his or her own thing."*

- Parents have realistic expectations of their children, as seen in the following excerpt:

PARTICIPANT C: *"They think I'm going to be something one day. They are proud of me."*

From the above section, it has become evident that, although the AIDS orphans function in families disrupted by death (i.e. they rely on extended family members or step-parents for nurturance), the family members they still have provide them with sufficient protective factors to instill resilience. The family does play an important protective part in the lives of resilient children, especially if it is close, stable, warm and supportive (Anon., 1995; Carew, 2005: 283; Frydenberg, 1999: 343).

5.3.2.4 Social factors and relationships

Social and relationship protective factors can be clustered as 2 major themes, namely support and acceptance. Both will be delineated using sub-themes.

5.3.2.4.1 Support

- Society (in the form of acquaintances, friends or teachers) provides support, making the individual feel accepted, as can be deduced from the following excerpts:

PARTICIPANT A: *"...I am not fought. People tend to like me."*

"I have a kind of friendship group. We give each other group support."

"Her teacher also helped her to get a job."

PARTICIPANT B: *"I talk to my friends and help them."*

- Meaningful relationships are possible, especially at school, as can be seen in the following quotes:

PARTICIPANT B: *"...I love school. It's my future."*

"I regularly take part in group discussions at school with my friends..."

"The counselors tell us about the dangers of having sex."

5.3.2.4.2 Acceptance

- Peer group acceptance is important, as can be seen in the following excerpts:

PARTICIPANT B: *"I regularly take part in group discussions at school with my friends..."*

"I am popular and liked by others."

"I have many friends."

PARTICIPANT C: *"I teach my friends how to do gumboot dancing. We enjoy it."*

- Communication and equity are also important factors, as seen in the following extracts:

PARTICIPANT A: *"I make myself feel equal."*

PARTICIPANT B: *"I talk to others to help them."*

Being accepted socially and having good and meaningful relationships are important protective factors within the community in which the individuals find themselves. A social support system (in which the AIDS orphans seem to function well) is an essential protective agent (Anon., 1995; Van Rensburg & Barnard, 2004:4).

5.3.2.5 Cultural and religious factors

Cultural and religious protective factors can be clustered as 2 major themes, namely cultural identification and spiritual identification. Both will be delineated using sub-themes.

5.3.2.5.1 Cultural identification

- Cultural identification plays an important role in the resilient adolescent's life, as can be seen in the following extracts:

PARTICIPANT A: *: "I am a Zulu girl."*

"We do have rituals that we have to follow."

"I do believe in all our customs and beliefs. I identify with them."

PARTICIPANT B: *"I am a Zulu girl and you know, us girls are inspected to see if we are virgins."*

PARTICIPANT C: *"Our culture teaches us to have respect for everybody."*

5.3.2.5.2 Spiritual identification

- A religious affiliation, spiritual identification and actualization play important roles, as can be seen in the following quotes:

PARTICIPANT A: *"Going to church gives me a lot of security. I go to church at least three times a month. Religion plays an important role in my life."*

PARTICIPANT B: *"I also rely on my religion. My Christianity. I pray to God and Jesus."*

"When there are hard times, I accept it, especially with God next to me."

"But I prayed to God... But God knows His purpose."

PARTICIPANT C: *"I go to church every Sunday. It helps me to cope."*

GROUP INTERVIEW PARTICIPANT: *"They spend lots of time praying. Their faith in God inspires them. Things that seem impossible to achieve, seem easier."*

Faith and spirituality/religion and affiliation with a religious organization (which are evident from the responses of the AIDS orphans) are factors that promote good health and contribute to the state of wellness that characterize health (Ungar & Liebenberg, 2005:218-219).

5.3.2.6 Overall conclusion

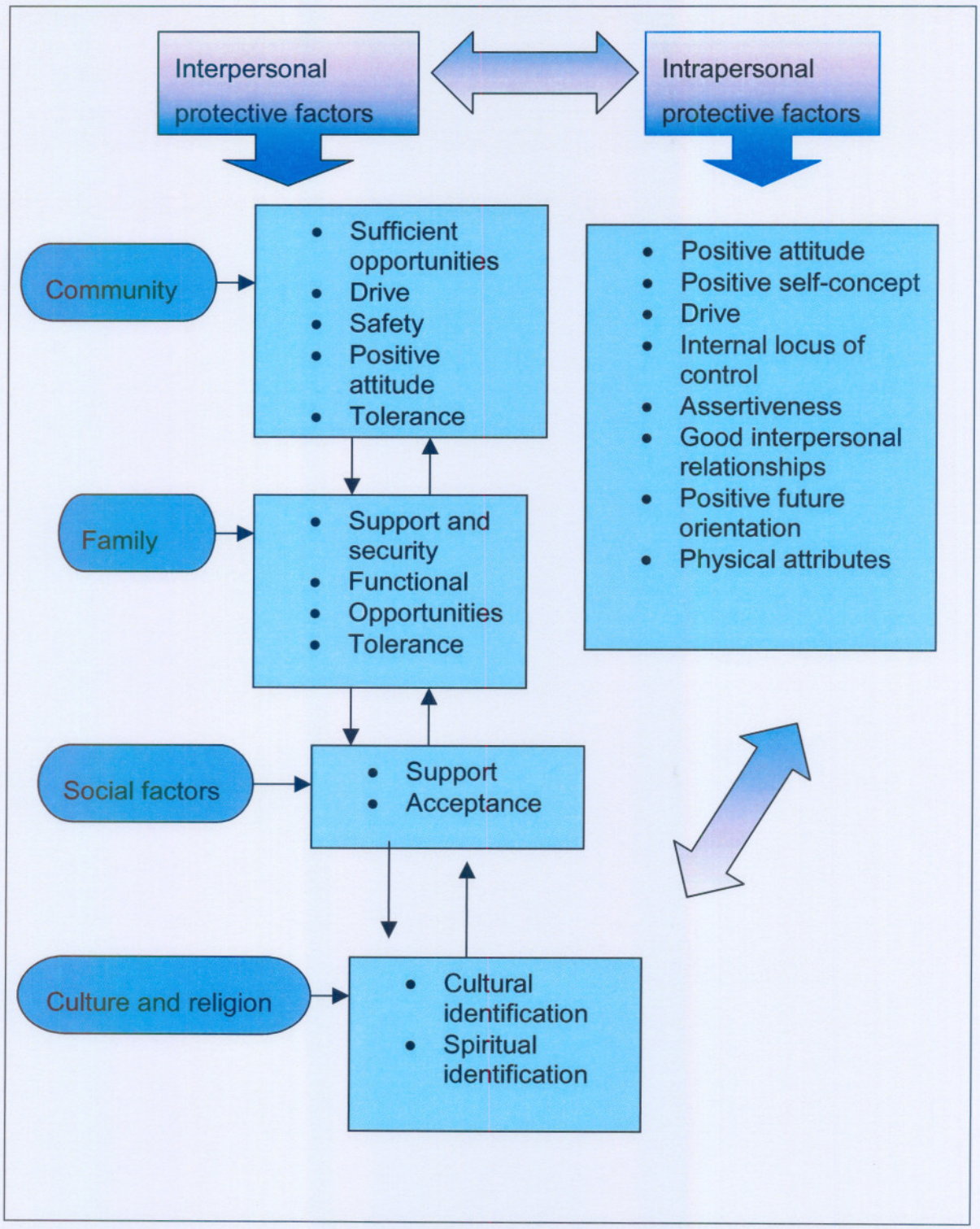
Although there seems to be contradiction in the risk and protective factors mentioned by the interviewees, such as lacking self-esteem in one instance and then demonstrating self-esteem, it should be noted that every community and individual has negative and positive experiences within a given context, and specific circumstances and processes will determine the experience and reaction

of the individual. For the orphans who participated in this study, there seems to be a complex interaction between the positive and negative factors intrinsic to their context of AIDS orphanhood. It must be remembered that the concept of resilience is multidimensional and complex, so a resilient individual may evidence vulnerability with regard to certain factors whilst responding resiliently to others (Schoon, 2006: 154).

From the above section, it has become clear that the AIDS orphans draw inspiration (in order of importance) from within themselves (intrapersonal), their community, their families, socially, their culture and their religion (interpersonal) which all serve to provide numerous significant protective factors. All of the above mentioned protective factors that can enhance resilience, have been noted in literature (Cf. 3.2 of this study).

Figure 5.33 below will provide a summary of the protective factors:

Figure 5.33:Summary of protective factors



5.4 CONCLUSIONS DRAWN FROM ANALYSIS

In this study, participants referred to both protective and risk factors that enhance and inhibit resilient functioning respectively. These factors are summarized in Table 5.2 below. The summary reflects participant perception as manifested in both the survey and phenomenological studies.

Table 5.2: Comparison of resilience inhibiting factors and resilience enhancing factors

Factors that inhibit resilience	Factors that enhance resilience
• Being male • Early adolescence • Poverty • Community fails to provide for basic needs, education and employment • Lack of role models • Little support and acceptance from community, school, family and friends, creating social isolation • Lack of meaningful relationships with family and peers • Lacking of social skills and communication • Intolerant, non-accepting, inflexible and judgmental community and families • Unsafe, troubled communities and family environment • Negative attitude towards school and education • Negative, low self esteem	• Being female • Late adolescence • Material needs are being met or opportunities to provide own income are created • Individual uses opportunities created by the community and family for education and employment • Role models and mentors are important role players • Much perceived support and acceptance from the community, school, family and peer group • Meaningful relationships and bonding with family members and peers • Effective social skills, social competence and realization of the importance of communication • Tolerant older generation, flexible, adaptive, empathetic

• No future orientation
• Lack of empathy
• Insufficient problem solving skills including:
  ○ Use of substances
  ○ Not finishing what they started
  ○ Violent solutions to problems
  ○ No/poor avoidance of risk behaviour
• Little sense of responsibility and sense of duty
• Lack of freedom (feeling controlled)
• No self awareness and insight
• Lack of discipline and respect
• Pessimism and lack of humour
• Little pride and identification with culture and family traditions (not culturally grounded)
	community and families with perceived gender equality
	• Community and family provide some form of safety
	• Positive attitude towards school, education and teachers who provide special programmes, support and information
	• Positive outlook and attitude towards society, life and a strong self esteem
	• Future orientated, having goals and aspirations
	• Empathy and understanding of other's feelings
	• Effective problem solving skills including:
	  ○ Abstinence of substances
	  ○ Striving to finish what they started
	  ○ Using humour and fun to solve problems
	  ○ Avoidance of risk behaviour
	  ○ Not fostering anger and grief towards the circumstances
	• Strong sense of duty and responsibility and community service and cooperation
	• Self efficacy and an internal locus of control
	• Strong self awareness and insight
	• Parental control and supervision

	• Optimistic and possessing a sense of humour • Cultural identification • Being assertive • Maintaining a balance between dependence and independence • Opportunity for meaningful rites of passage • Religious and spiritual identification and actualization • A need for the self and community for betterment

In answer to the original question informing the problem statement (C.f. 1.3), what does the phenomenon of resilience in AIDS orphans entail, the following summary is presented as an answer.

The resilient orphan:

- believes she is treated no worse at school or in the community for being an AIDS orphan;
- feels welcome at school;
- does not feel financially poorer than friends at school;
- does not feel that her education is more neglected because she is an AIDS orphan;
- does not feel that she has a harder life than her peers;
- has scant knowledge of where her grandparents and parents were born;
- is more inclined to finish what she started;
- is less inclined to use alcohol and / or drugs to help her solve problems;
- refers to individual protective factors such as positive attitude, positive self-concept, drive, internal locus of control, assertiveness, good interpersonal relationships, positive future orientation and physical attributes;
- refers to environmental protective factors like communities that provide sufficient opportunities, have drive, are safe, are positive and are tolerant;

- refers to familial protective factors like families that are supportive, are functional, supply opportunities and are tolerant;
- refers to environmental protective factors like social support and acceptance; and
- refers to environmental protective factors like cultural and spiritual/religious identification.

5.5 GUIDELINES FOR THE ENCOURAGEMENT OF RESILIENCE IN AIDS ORPHANS

For intervention programs targeting resilient functioning to be successful, they need to relate to cultural context, the educational programs and the personal behaviours of the individual (Schoon, 2006:162-3). Therefore the guidelines suggested in Table 5.3 below relate directly to the AIDS orphans and their specific context as outlined in this study.

In order to encourage resilient functioning, the researcher recommends the following broad guidelines. The guidelines are based on the perceptions of participants in this study and current literature (C.f. Chapter 3) and may be useful to school principals, school based support teams, life orientation teachers, health care providers, community leaders and religious leaders.

It is emphasized that Table 5.3 should not be interpreted prescriptively per stakeholder or agent, but rather that all the agents referred to should collaborate to achieve resilient outcomes for AIDS orphans.

Table 5.3: Guidelines and recommendations on how to foster resilience in AIDS orphans

Agent	Process
• The individual (in collaboration with others):	• needs to use opportunities created by the community and family for education and employment; • should focus on fostering effective social skills and competence and realize the importance of

communication;

- needs to demonstrate a positive attitude towards school;
- needs to acquire a positive outlook and attitude towards society, life and foster a strong self esteem;
- needs to be future orientated and have goals and aspirations;
- should be able to demonstrate empathy and an understanding of others' feelings;
- needs to acquire effective problem solving skills which include:
  - avoidance of substances;
  - striving to finish what she started;
  - using humour and fun to solve problems;
  - avoidance of risk behaviour; and
  - not foster anger and grief towards the circumstances;
- should demonstrate a strong sense of duty, responsibility towards community service and cooperation;
- needs to instill self efficacy and an internal locus of control;
- needs strong self awareness and insight;
- needs to be optimistic and possess a sense of humour;
- needs to maintain a balance between dependence and

	independence; • should demonstrate a need for self betterment; • needs to learn to be assertive;
• the community at large: 	• needs to provide appropriate role models and mentors; • needs to provide support and acceptance; • needs to be more tolerant, flexible, adaptive, empathetic and demonstrate gender equality and avoid being judgmental; • needs to provide some form of safety and security; • needs to provide opportunities for meaningful rites of passage; • should demonstrate and foster the need for betterment; • needs to provide opportunity for cultural identification and instill pride in cultural traditions; • needs to provide meaningful job opportunities;
• the family (including the extended or foster family):	• needs to meet the material needs of family members and / or provide or create its own opportunities to generate an income; • needs to provide support and acceptance; • needs to provide meaningful relationships and bonding with members of the family;

	• needs to be more tolerant , flexible, adaptive and empathetic; • needs to provide some form of safety and security; • needs to provide adequate parental control and supervision; • needs to provide opportunity for cultural identification and instill pride in cultural traditions; • needs to communicate effectively;
• the school: 	• needs to provide support and acceptance; • needs to provide effective teachers and an education programme which provides special programmes (especially life skills), support and information, as well as opportunities for peer interaction to foster acceptance and support;
• the church and cultural leaders: 	• need to provide opportunities for religious and spiritual identification and actualization; and • need to provide opportunities for cultural activities in order to instill cultural identification.

The researcher is of the opinion that, should one apply the above mentioned guidelines, together with the findings of the literature research (Cf. 3.3 and 3.5), one should be able to empower AIDS orphans towards (continued) resilient functioning.

5.6 CONCLUSION

The aim of this research was to document the phenomenon of resilience amongst AIDS orphans in South Africa.

Based on the statistical analysis of the quantitative data, (C.f. 5.2), it was found that there wasn't an overall significant difference between the resilient group and the non-resilient group's functioning: apart from responses to only 8 out of the 73 questions, both groups indicated generally resilient functioning. This could either mean that the initial identification of the groups by a community-based panel was inaccurate; or that, although they were perceived as non-resilient, the non-resilient group also demonstrated resilient characteristics. Possibly the reality of orphanhood promotes resilience as these youths have had to cope with so much.

The findings from the quantitative research as well as the qualitative research show that the antecedents of risk and resilience are found in the community (including the family, society, culture and religion) as well as in the individual. The majority of AIDS orphans in this study described their functioning as resilient, and it is this resilience that one would like to introduce to vulnerable individuals who are struggling to cope with their adverse circumstances.

In the instance of AIDS orphans, intra- and interpersonal protective factors empower them to cope with the intra- and interpersonal risk factors they face every day, and no single factor can be pinpointed. Literature suggests that resilience is dependent on a complex interaction resulting in a dynamic process of resilience (Frydenberg, 1999:347). In other words, resilience cannot be limited to a prescriptive list of do's and don'ts, but should rather be understood to be the result of a complex interaction of risk and resilience factors found in all levels of the individual's context. In essence, this is how the participants in this study portrayed resilience.

The following chapter will deal with the summary, limitations, contributions and recommendations of this study.

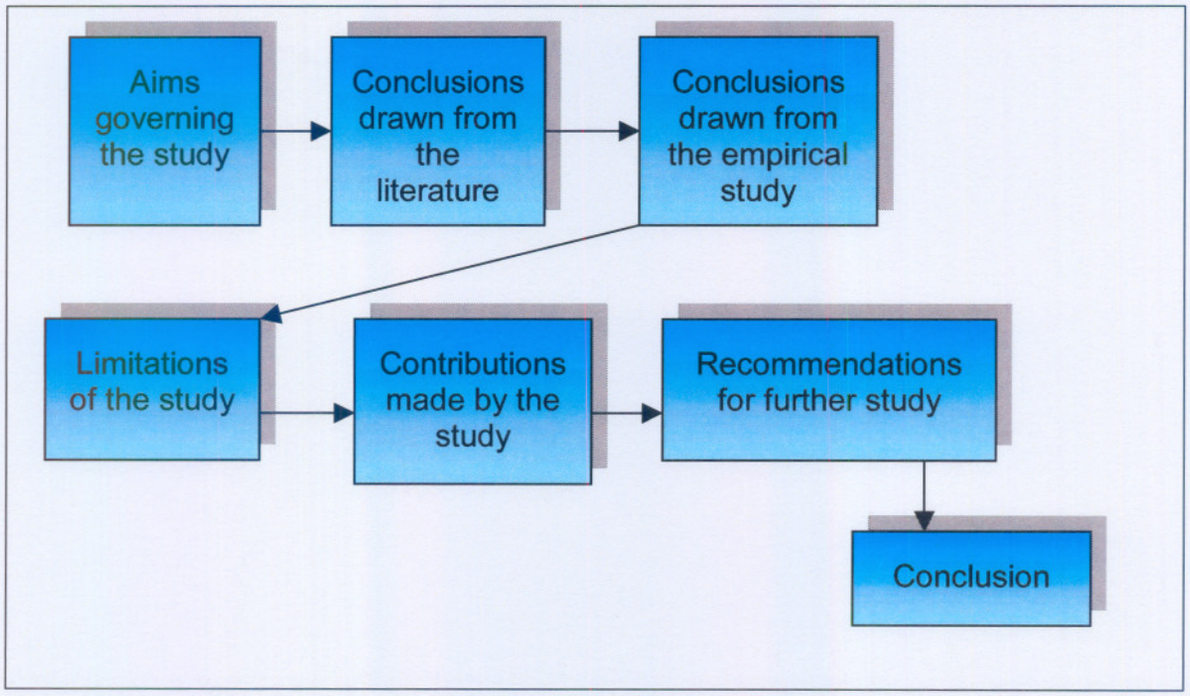
CHAPTER 6

SUMMARY

6.1 INTRODUCTION

The contents of this chapter are summarized in Figure 6.1 below:

Figure 6.1: Chapter overview



This chapter will:

- provide a summary of the findings of this study;
- clarify the conclusions deducted from the study;
- discuss the limitations of the study;
- discuss the contributions made by the study; and
- recommend future research options.

6.2 AIMS GOVERNING THE STUDY

The aims and the achievements of this study are summarized in Table 6.1:

Table 6.1: Aims of the study

AIMS	• ACHIEVEMENTS
• To provide an overview of the phenomenon of AIDS orphans;	• An intensive literature study was conducted into the HIV/AIDS pandemic, the resulting numbers of orphans and the impact of the disease on the AIDS orphans. The literature study was elucidated in Chapter 2 of this study.
• to provide an overview of the phenomenon of resilience;	• In Chapter 3 the nature of resilience was extensively investigated by means of a literature study.
• to investigate the phenomenon of resilience among AIDS orphans;	• Survey research and a phenomenological study were used to document the phenomenon of resilience among AIDS orphans in South Africa. It was found that the AIDS orphans manage to respond resiliently to their risk laden circumstances.
• to compare the resilient and non-resilient AIDS orphans, by means of survey research; and	• Statistical analysis indicated that there were very little significant differences between the responses of the resilient and non-resilient groups, and that both groups generally alluded to resilient functioning. Thus, the

	risk factors that all the AIDS orphans face, as well as the protective factors that contribute to all of their resilient functioning, were documented.
• to provide guidelines to encourage resilient functioning amongst AIDS orphans.	• The experiences of the AIDS orphans and factors that the resilient AIDS orphans and elders commented on in their interviews were documented and they can be used as guidelines for youth facing similar adverse circumstances.

From the above, it is clear that the aims that were set out were achieved.

6.3 CONCLUSIONS DRAWN FROM THE LITERATURE

The following conclusions were drawn from the literature:

- the impacts of the AIDS pandemic are far reaching and all-pervasive, affecting almost every aspect of the daily lives and activities of people world wide and especially in South Africa (Cf. 2.4);

- the numbers of AIDS orphans world wide are of great concern. Millions of children live traumatized, unstable lives, robbed not just of their parents, but of their childhoods and futures (Cf. 2.6);

- orphanhood is not a new concept, but being an AIDS orphan exposes the child to maybe more unique and tragic circumstances than other orphans (Cf. 2.7.2);

- the AIDS orphan suffers stigmatization and negative psychological, emotional, developmental, academic, social, moral and economic impacts as a result of the AIDS pandemic (Cf. 2.7.2.2 – 2.7.2.8);

- worldwide support has been initiated in the form of monetary aid and projects to try to diminish the impacts of the AIDS pandemic and to empower the people, especially the orphans, affected by the pandemic (Cf. 2.8);

- resilience is the ability to function adaptively in adverse circumstances and it usually involves stressors or risks which trigger coping responses (Cf. 3.2);

- the resources which encourage resilience are termed protective factors, and these factors can broadly be grouped into intrapersonal and interpersonal factors (Cf. 3.3);

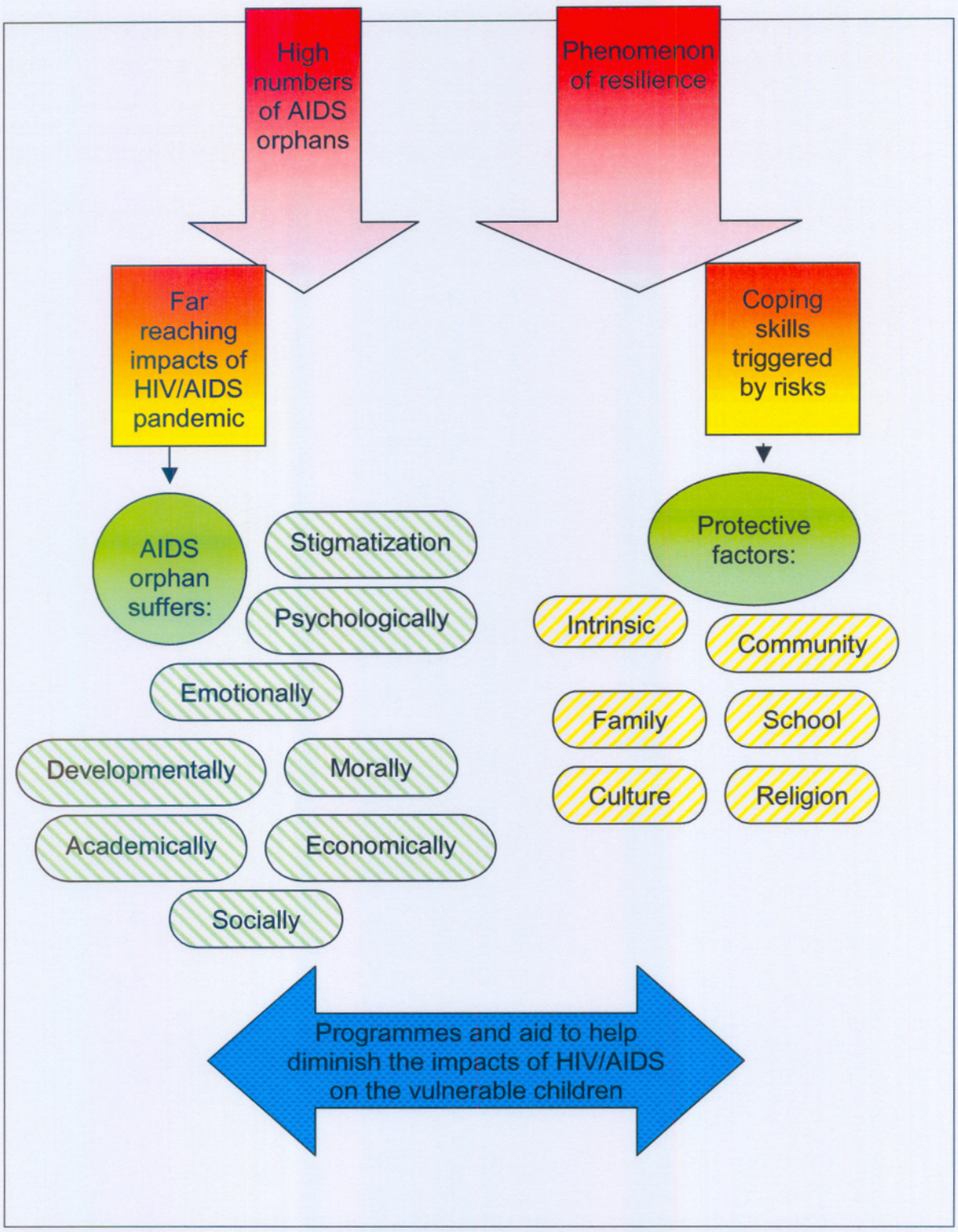
- the protective factors are drawn from the individual's psychological make-up as well as from the environment in which the individual functions. These environmental factors include the family, school, community, as well as culture and religion (Cf. 3.3.1 – 3.3.2.4);

- AIDS orphans can be exposed to cumulative risk factors and therefore face serious risk (Cf. 3.4); and

- AIDS orphans can be helped through numerous programmes and initiatives which focus on the AIDS orphan in its community.

Figure 6.2 serves as a graphic illustration of the conclusion that can be drawn from the literature overview of the study:

Figure 6.2: Overview of the literature study



6.4 CONCLUSIONS DRAWN FROM THE EMPIRICAL STUDY

From the empirical study, the following emerged regarding the resilience of the participants could be drawn from both the quantitative and qualitative data:

6.4.1 Quantitative data

The results from the quantitative study indicated that there were very little significant differences regarding resilience between the resilient and the non-resilient groups, and both groups demonstrated inter- and intrapersonal protective factors which can be an indication of resilience. However, there were significant differences regarding the following factors:

- the non-resilient group felt that they were treated worse at school and in the community for being AIDS orphans than the resilient group;
- the non-resilient group felt less welcome at school than the resilient group;
- the non-resilient group felt financially poorer than their friends at school than the resilient group;
- the non-resilient group felt that their education was more neglected because they were AIDS orphans than the resilient group;
- the non-resilient group felt that they had a harder life than their peers than the resilient group;
- the non-resilient group had a better knowledge of where their grandparents and parents were born, than the resilient group;
- the non-resilient group was less inclined to finish what they started than the resilient group;
- the non-resilient group was more inclined to use alcohol and / or drugs to help them solve their problems than the resilient group;
- the mean age of the non-resilient group was younger than the mean age of the resilient group; and
- there were more females in the resilient group than in the non-resilient group.

From the quantitative study, the following factors also emerged as being protective factors in the lives of the AIDS orphans generally:

- individual factors such as a positive attitude, social interaction and skills, problem solving skills, self-esteem, responsibility and future orientation; and
- community factors, including culture, society, elders, family and school.

6.4.2 Qualitative data

From the qualitative study, the following context related resilient inhibiting risk factors emerged as playing a role in the lives of the AIDS orphans (C.f. Figure 5. 31):

- community factors, namely: poor, risky, judgmental communities with limited opportunities;
- families that are dysfunctional, rigid and poor;
- individual factors such as demotivation, limited coping skills, social withdrawal and poor self-esteem;
- social interaction where there is a lack or support, intolerance and risky behaviour; and
- cultural and religious alienation.

The the following context related protective factors regarding the lives of the AIDS orphans emerged from the qualitative study (C.f. Figure 5.33):

- individual factors such as positive attitude, positive self-concept, drive, internal locus of control, assertiveness, good interpersonal relationships, positive future orientation and physical attributes;
- communities that provide sufficient opportunities, have drive, are safe, have a positive attitude and are tolerant;
- families that are supportive, are functional, supply opportunities and are tolerant;
- social support and acceptance; and

- cultural and spiritual/religious identification.

Finally, it should be noted that in the instance of the AIDS orphans, intra- and interpersonal protective factors empower them to cope with the intra- and interpersonal risk factors. No single factor can be pinpointed, as suggested by literature (Schoon, 2006:148-9). There is an ongoing complex interaction resulting in a dynamic process of resilience.

6.5 LIMITATIONS OF THE STUDY

The following limitations are noted:

- the questionnaire was distributed to only 60 AIDS orphans, which makes the size of the sample too small for generalizations to be made from this study;

- the 60 AIDS orphans who participated in this study come from the same geographical region, making the sample fairly homogenous, which means the findings of the study can not be generalized cross-culturally;

- the study was limited to the phenomenon of resilience in AIDS orphans only. Therefore, it is not possible to generalize the results of this study to all orphans and vulnerable children;

- because of the stigma attached to AIDS orphans, some orphans were identified by the elders as being AIDS orphans but they were not really aware of the fact, as this information was withheld from them to protect them, or possibly they did not want to acknowledge the fact that they were AIDS orphans as such. This could impact negatively on their responses to certain site specific questions of the questionnaire; and

- most importantly: because of the lack of behavioural test instruments normed for South African township youth, the limited resources of the study and its adherence to the International Resilience Project norms, the sorting of the individuals into resilient versus non-resilient groups, did not rely on standardized tests of functioning. It was therefore necessary to rely on the judgment of community stakeholders to distinguish youth by category. The

validity of their judgment cannot be proven and may have impacted on the lack of significant differences between the resilient and vulnerable groups.

6.6 CONTRIBUTIONS MADE BY THE STUDY

The study made the following contributions:

- the findings from current literature were summarized, facilitating an easy overview of the current literature;
- the study promoted local community communication and understanding of problems the AIDS orphans encounter as well as the phenomenon of resilience;
- donations have been made (and will hopefully continue) in the form of food, second hand clothes, shoes, make-up, books, magazines and other useful articles to the participants of the study, which means that the plight of the AIDS orphan has been highlighted and people from the researcher's community are reaching out to help; and
- the study provides guidelines (Cf. 5.5) for individuals, education stakeholders and communities to empower AIDS orphans towards resilient functioning within their context.

6.7 RECOMMENDATIONS FOR FURTHER STUDY

The following recommendations for further study can be made:

- the promotion of resilience in the institutionalization of AIDS orphans compared to placement in extended families;
- the impact of communities ridden with violence, crime and poverty compared to the impacts of the HIV/AIDS pandemic on the resilience of AIDS orphans;
- the impact of cultural norms and influences on the resilience of AIDS orphans;

- research on the resilience of AIDS orphans in the African context as opposed to the Western context;

- the success rate of social services and aid in HIV/AIDS ridden communities in fostering resilience in these communities;

- the tracking and monitoring of HIV/AIDS funding towards AIDS orphans in order to alleviate poverty (a serious risk factor) which undermines resilience; and

- the creation of an intervention programme aimed at inculcating resilience among AIDS orphans based on the guidelines provided in Chapter 5 of this study.

6.8 CONCLUSION

The plight of the AIDS orphan is a reality, not only in South Africa but also in the whole world. Communities and relevant stakeholders need to acknowledge the problems faced by the AIDS orphans without being judgmental. It is necessary for communities, and responsible elders in schools and society to help ease the difficult circumstances in which the AIDS orphans are entangled. From this study it would seem that some AIDS orphans function resiliently despite these difficult circumstances. It is important for elders, teachers, parents and community leaders to be practically and continually empowered to meet the challenges that the AIDS orphan face daily and for them to empower AIDS orphans towards (continued) resilient functioning. It is hoped that this study makes a contribution in this regard and that the guidelines in Table 5.3 are used by relevant stakeholders and AIDS orphans for ongoing empowerment.

Finally, the researcher would like to add a poem, written by one of the participants of the study, which highlights the plight of the AIDS orphan but also the essence of resilience – a determination to keep going, no matter what:

STOP!

Stop telling me what to do
Stop telling me negative things
Stop from judging who I am
I am what I am and you cannot do anything
Stop what you are doing

Stop I am telling you
Not having money it doesn't mean
I have no future
Stop I don't care I have love
Whatever you do I will stop you
Poverty does not mean everything
It does not mean living on your own

Stop I don't care
Whatever my family goes through we will –
Fight against it
I don't care what you tell people about my family
Because we are better than yours
Your family has no life or love forward them
My family has it all

Stop I have life after this
Do you have one, maybe your family's always
Having problems don't hide them fight against
That problem
You can have money but no life
You can have everything but no love
But look at me the poor one I have everything
And I can stop poverty just going to school

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ADDENDUM A
QUESTIONNAIRE

For office use only	
Participant number:	
Site ID:	
Data number:	

Child and Youth Resilience Measure (CYRM)

Directions:
Listed below are a number of questions about you, your family, your community, and your relationships with people.
Please complete the questions in Section One.
For each question in Sections Two and Three, please circle the number to the right that describes you best. There are no right or wrong answers.

Section One:

What is your date of birth?_____

Are you male or female? _____

What is your race?_____

What is your ethnic group?_____

What is the highest level of education you have completed?_____

Who do you live with?_____

How long have you lived with these people?_____

Please describe who you consider to be your family (For example, friends on the street; foster family; 2 biological parents with siblings; single parent home; adopted family etc.) _____

_____

_____

Section 2:

To what extent...	Not at all	A little	Some-what	Quite A bit	A lot
1. Do you feel that you are badly treated at school or in the community for being an orphan?	1	2	3	4	5
2. Can you cope with your grief of having lost your parents?	1	2	3	4	5
3. Do you feel badly treated by the people who look after you?	1	2	3	4	5
4. Do you feel that you have fewer opportunities than your peers who have parents?	1	2	3	4	5
5. Do you feel financially poorer than your friends at school?	1	2	3	4	5
6. Do you feel that your education has been neglected because you are an orphan?	1	2	3	4	5
7. Do you feel angry for not being able to live with your parents?	1	2	3	4	5
8. Is there somebody in your life whose example you can follow?	1	2	3	4	5
9. Do you have more responsibilities than other children your age?	1	2	3	4	5
10. Do you feel that you have a harder life than your peers at school?	1	2	3	4	5
11. Do you feel that you are not good enough because you have no parents?	1	2	3	4	5
12. Do you experience more stress than before you became an orphan?	1	2	3	4	5
13. Do you feel ashamed for being an AIDS orphan?	1	2	3	4	5
14. Do you feel scared of being abandoned/alone again?	1	2	3	4	5
15. Do you feel fear for the future being an orphan?	1	2	3	4	5

Section Three:

To what extent ...	Not at All	A Little	Some-what	Quite a Bit	A Lot
1. Do you think having fun and laughing can help solve problems in life?	1	2	3	4	5
2. Do you know where your parent(s) and / or grandparents were born?	1	2	3	4	5
3. Do you keep going even when life gets difficult?	1	2	3	4	5
4. Does what you do now, influence what will happen later in your life?	1	2	3	4	5
5. Does the older generation understand and tolerate the ideas and strong beliefs of people your age?	1	2	3	4	5
6. Do you have people you look up to?	1	2	3	4	5
7. Do you understand others' feelings?	1	2	3	4	5
8. Do you need to cooperate with people around you if you want to succeed?	1	2	3	4	5
9. Can you express yourself without worrying about being criticized?	1	2	3	4	5
10. Is getting an education important to you?	1	2	3	4	5
11. Do you know how to behave in different social situations?	1	2	3	4	5
12. Are you comfortable talking with people you do not know?	1	2	3	4	5
13. Do you think each individual is responsible to make the world a better place?	1	2	3	4	5
14. Do you feel kindness for people you don't like when bad things happen to them?	1	2	3	4	5
15. Do you believe that life should be lived in a certain way?	1	2	3	4	5
16. Do you feel confident when you are in challenging and confusing situations?	1	2	3	4	5
17. Does your culture teach you to become a better person?	1	2	3	4	5
18. Are you comfortable with how you express yourself sexually?	1	2	3	4	5
19. Does your family have a ritual or routine around mealtimes?	1	2	3	4	5
20. Do you feel that your parent(s) watch you closely and know a lot about you?	1	2	3	4	5
21. Do you eat enough most days?	1	2	3	4	5
22. Do you strive to finish what you start?	1	2	3	4	5
23. Do you feel free and comfortable to talk to your teachers and / or other adults about your problems?	1	2	3	4	5
24. Are religious or spiritual beliefs a source of strength for you?	1	2	3	4	5
25. Are you proud of your ethnic background?	1	2	3	4	5
26. Do you have a vision of how the future should be?	1	2	3	4	5
27. Do your parent(s) respect how you express yourself sexually?	1	2	3	4	5
28. Do people think you are fun to be with?	1	2	3	4	5
29. Do you talk to your family about how you feel?	1	2	3	4	5
30. Do you feel you can solve your own problems?	1	2	3	4	5

To what extent ...	Not at All	A Little	Some-what	Quite a Bit	A Lot
31. Do you feel a sense of being part of a group when you are with your friends?	1	2	3	4	5
32. Are you able to see a doctor when you need one?	1	2	3	4	5
33. Do you think non-prescription drugs and/or alcohol will help you when you have to deal with lots of problems?	1	2	3	4	5
34. Do you feel supported by your friends?	1	2	3	4	5
35. Do you know where to go in your community to get help?	1	2	3	4	5
36. Are you comfortable asking for help?	1	2	3	4	5
37. Do the teachers and other students make you feel you belong at your school?	1	2	3	4	5
38. Do you think your family, friends and / or relatives will always stand by you during difficult times?	1	2	3	4	5
39. Are members of your family or community who do unacceptable things accepted afterwards?	1	2	3	4	5
40. Are you comfortable with how you express yourself in close relationships with others your own age?	1	2	3	4	5
41. Are you able to avoid violent situations at home, school, or in your community?	1	2	3	4	5
42. Are you treated fairly in your community despite how others see you?	1	2	3	4	5
43. Do you have opportunities to show others that you are becoming an adult?	1	2	3	4	5
44. Do you do a job or volunteer work that you feel is appropriate for your age?	1	2	3	4	5
45. Are you aware of your own strengths?	1	2	3	4	5
46. Do you participate in organized religious activities?	1	2	3	4	5
47. Do you think it is important to serve your community?	1	2	3	4	5
48. Do you feel safe when you are with your family?	1	2	3	4	5
49. Are you aware of your own weaknesses?	1	2	3	4	5
50. Do you have opportunities to develop job skills that will be useful later in life?	1	2	3	4	5
51. Do you think most problems in life will get solved in a positive way?	1	2	3	4	5
52. Do you enjoy your family's and community's traditions?	1	2	3	4	5
53. Are you proud to be (Nationality: _____)?	1	2	3	4	5
54. Does your family or community encourage non-violent solutions to deal with somebody who commits a crime?	1	2	3	4	5
55. Can you openly disagree with your parent(s) and elders when you believe things different from what they believe?	1	2	3	4	5
56. Are boys and girls both treated fairly in your community?	1	2	3	4	5
57. Is there a difference between your family's values and those of most others in your community?	1	2	3	4	5
58. Do you think that you are at least as good (or better) than other youth you know?	1	2	3	4	5

ADDENDUM B

GUIDELINES: QUESTIONS TO ASK THE ELDERS

- What are the biggest challenges youth in the community face?
- What are some of the common things that help youth cope with the challenges they face?
- What do people in this community think helps children cope with challenges?
- How do the experiences of other children compare with the experiences of children here?
- How would children here handle the problems these other children face?
- What advice would you give to these other children?
- What patterns do you see in how these other children cope with life's problems?
- Are there specific themes, or aspects of their lives, that protect these other children from the challenges they face?
- What do you understand resilience is?

ADDENDUM C

THE YOUTH INTERVIEW GUIDE

The Youth Interview Guide

- "What would I need to know to grow up well here?"
  - Probing Questions:
    1) What role do religious organizations play in your life?
    2) What do other members of your family think about the way you live your life, your beliefs (such as regarding gender roles, etc.)
    3) How do you handle change, both at an individual level, and the changes taking place for everyone in your community?
    4) How do you contribute to your community?
    5) What is it like for you when people around you succeed?
    6) Do you have a life philosophy and if you feel comfortable sharing it, can you tell me what it is?
    7) Do you identify in any way(s) with your culture. Can you describe your culture? Can you describe (or show me) day to day activities that are part of your culture and the way things are done in this community?
- "How do you describe people who grow up well here despite the many problems they face? What word(s) do you use?"
- "What does it mean to you, to your family, and to your community, when bad things happen?"
  - Probing Questions:
    1) Can you tell me what some of these bad things are?
    2) What do people do to cope?
    3) What do they say about these things when they happen?
    4) Who talks about them most? Least? And who is most likely to come up with the solution to problems when they occur?
    5) What do other people think of these solutions?
    6) Can you give me examples?
- "What kinds of things are most challenging for you growing up here?"
  - Probing Questions:
    1) Are there opportunities for age-appropriate work?
    2) Are you or people you know exposed to violence? How do you avoid this in your family, community, and when with peers?
    3) How does the government play a role in providing for your safety, your recreation needs, housing, and jobs now and when you get older?
    4) Do have opportunities to experience meaningful "rites of passage"? What are these? Do they present you with an amount of risk that you can handle?
    5) How tolerant is your community of problem behaviours among people your age? What are some of these behaviours?
    6) Do you feel safe and secure here? How do others protect you?
    7) Do you feel equal to others? Are there others you do not feel equal to? How do these others make you feel? What do they do that makes you feel this way?
    8) Do you have access to school and education and any other information you need to grow up well? How do you get this access? Who provides it to you?

- "What do you do when you face difficulties in your life?"
- "What does being healthy mean to you and others in your family and community?"

- Probing Questions:
  1) Could you describe the way your parents or caregivers look after you?
  2) How does your family express themselves and what they think of you?
  3) How does your family monitor you, keep track of what you are doing?
  4) How do you know how to act with other people? How well do you do socially? Are you thought of well by others, popular, liked?
  5) Do you have some you consider a mentor or role model? Can you describe them?
  6) Do you have other meaningful relationships with people at school, home, or in your community?

- "What do you do, and others you know do, to keep healthy, mentally, physically, emotionally, spiritually?"
  - Probing Questions:
    1) Are you assertive? How do you show this?
    2) Can you describe your ability to problem-solve? Are you better or worse than others? How do you know this?
    3) Do you have a sense of control over your world? How does this affect your life?
    4) How much uncertainty are you able to live with?
    5) Do you value self-awareness, insight? How does this affect your life and what you do day to day?
    6) Would you describe yourself as optimistic or pessimistic about life?
    7) Do you have personal goals and aspirations? What are these?
    8) How much can you be independent and how much do you have to rely on others in your life for your survival?
    9) How much do you use substances like alcohol and drugs? What do others around you think about this?
    12) What role does humour play in your life?
- "Can you share with me a story about another child who grew up well in this community despite facing many challenges?"
- "Can you share a story about how you have managed to overcome challenges you face personally, in your family, or outside your home in your community?"

ADDENDUM D

LETTER

YUNIBESITI YA BOKONE-BOPHIRIMA
NORTH WEST UNIVERSITY
NOORDWES UNIVERSITEIT

P.O.Box 1174

Vanderbijlpark

1900

17 February 2006

To Whom It May Concern

Ms E. Wood is currently completing her master's study. The work that has been completed to date is excellent.

The title of her study is: THE PHENOMENON OF RESILIENCE IN AIDS ORPHANS. Resilience is a relatively new field of research and focuses on what makes the human spirit indomitable. For many adolescents, life is a tough and characterized by unremitting hardship. Many do not cope with this reality and develop pathological outcomes (e.g. depression; school attrition; violent behaviour; substance abuse; etc). Some, however, do cope and avoid developing pathology, despite their difficult circumstances. Those who do cope are thought to be resilient. Precisely what constitutes resilience has enjoyed scrutiny from a growing number of researchers since the middle to late 1900's. Currently an international project (under leadership of Dr Michael Ungar in Canada) is researching what contributes to resilience in youth world-wide and how resilience is shaped by local or contextual factors. The overall goal of this research is document what can be done in practice to encourage youth to be resilient. Ms Wood's research focuses on which factors help OVC's cope with the difficulties they face.

In order to establish what contributes to resilience, the following research design will be followed:

- A survey using a close-ended questionnaire. This involves acquiring information about the sample group by asking them questions and tabulating their answers.
- A phenomenological study using semi-structured interviews. A phenomenological study attempts to understand people's perceptions and understanding of the particular phenomenon i.e. resilience. The researcher may follow the standard

questions with one or more individually tailored questions to get clarification or probe a person's reasoning.

- A sample of 30 resilient OVC's and 30 non-resilient/vulnerable OVC's is needed. The researcher will work with community members to explain what characterises resilience.
- The researcher would then like to interview 10 resilient OVC's.

The following ethical principles will be adhered to:

- Protection from harm - the researcher will not expose participants to undue physical or psychological harm.
- Informed consent – participants will be told the nature of the study beforehand and will be given a choice to participate. They have the right to withdraw from the study at any time.
- Right to privacy – the anonymity of participants is guaranteed.
- Internal review - the proposed research has been approved by an internal review board at the North-West University.

Should you have any further questions, please do not hesitate either of the undersigned.

Yours truly

Dr Linda Theron
Study Leader

E. Wood

E. Wood
Master's student

ADDENDUM E

INTERVIEW 1

INTERVIEWER: Before we start with the questions, tell me something about yourself.

PARTICIPANT A: My name is Patience and I am a Zulu girl. I am 20 years old. I live in a troubled community. I have been living with my granny for 5 years. I don't have many friends. I've been doing part time work since grade 12. We have financial problems. I work at MacDonalds on Saturdays. I also take care of my sister. I have to put up a mask for the sake of everybody.

INTERVIEWER: Tell me, Patience, what would I need to know to grow up well here?

PARTICIPANT A: You need to have an understanding of what you have to do. You need job opportunities and you must realize the importance of education. You must follow your dreams.

INTERVIEWER: Okay, thanks. Tell me, what role do religious organizations play in your life?

PARTICIPANT A: Going to church gives me a lot of security. I go to church at least three times a month. Religion plays an important role in my life. The Bible studies are a means of communication.

INTERVIEWER: That's good. What do the other members of your family think of the way you live your life, such as your beliefs and going to church?

PARTICIPANT A: They are judgmental. They have set ideas of what I have to do. They try to control us. They approve of me going to church. But everybody is doing his or her own thing. We don't have much freedom.

INTERVIEWER: How do you handle change, both at an individual level, and the changes taking place for everyone in your community?

PARTICIPANT A: We al learn from change. It gives you opportunity. But the community's changes make me feel like an outcast.

INTERVIEWER: Okay. How do you contribute to your community?

PARTICIPANT A: I have worked at a hair salon previously to earn some money. I also do some domestic help. I have also offered to do voluntary work in the community to help kids in KwaZulu Natal. I was there to teach them English. It was for an organization that helped orphans. But people rely too much on me. My grandmother also helps the organization.

INTERVIEWER: That's excellent. What is it like for you when people around you succeed?

PARTICIPANT A: It makes me more determined. It also makes me feel good about myself. Sometimes I feel jealous because of opportunities I don't get and they have.

INTERVIEWER: Do you have a life philosophy and would you like to share it with me?

PARTICIPANT A: Yes. Grab life with both hands. If plan A fails, I always have a plan B.

INTERVIEWER: Excellent. Tell me something about your Zulu culture. Can you describe it? What day to day activities are part of your culture and how are things done in your community?

PARTICIPANT A: We do have rituals that we have to follow. We slaughter cows for funerals and believe in our ancestors. I do believe in all our customs and beliefs. I identify with them. But it is not always easy.

INTERVIEWER: Why?

PARTICIPANT A: Our behaviour is regulated. We are not allowed to be with a boyfriend in front of our elders. Children stay apart from the parents. I feel threatened by my father. I cannot speak my mind. He doesn't know the way I feel. Communication is very difficult.

INTERVIEWER: That's bad. Tell me, how do you describe people who grow up well here despite the many problems they face?

PARTICIPANT A: They are confident. They're not self centered. They understand and have empathy because they have been there. They are motivated and driven. They follow their dreams.

INTERVIEWER: What does it mean to you, your family and to your community, when bad things happen?

PARTICIPANT A: You lose focus on life. It makes us lose hope. We are not driven anymore. The community tends to judge people. They try to look at the cause of the problems. The adults are very strict. They want to find out the cause of what has happened. They realize things must change. They always look for the root of the problem.

INTERVIEWER: Can you tell me what some of the bad things are?

PARTICIPANT A: Oh, yes. We have lots of crime.

INTERVIEWER: Such as?

PARTICIPANT A: We have many robberies, hijacking, rape, especially after dark.

INTERVIEWER: Anything more?

PARTICIPANT A: Yes, we have misbehaviour such as smoking dagga, people that are careless especially after drinking in public. There are also riots because of the drinking. People are using drugs. They are drinking and plant and grow dagga. We also have groups or gangs fighting. They all have tattoos.

INTERVIEWER: That's bad. What do people do to cope?

PARTICIPANT A: They shut it out. Some call the cops. They have community meetings where everybody goes.

INTERVIEWER: Is it effective?

PARTICIPANT A: It is effective because now we have people who have volunteered to stand guard. People get dragged into the wrong behaviour because there are no extra mural activities. There's nothing for them to do. There are no fun things to do.

INTERVIEWER: Is there really nothing for the children to do?

PARTICIPANT A: There are playgrounds that are being developed. But there's not much.

INTERVIEWER: What do the people say when these bad things happen?

PARTICIPANT A: They ask: How can we handle it? We have to do something. The community and street leaders are proactive.

INTERVIEWER: Who talks about these things most?

PARTICIPANT A: Mostly the street commuters, also the females because they are protective of the family.

INTERVIEWER: Who is likely to come up with the solution to the problems when they occur?

PARTICIPANT A: The teenagers give suggestions to the community leaders.

INTERVIEWER: What do other people think of these solutions?

PARTICIPANT A: They don't feel like the solutions are effective.

INTERVIEWER: Can your give me examples?

PARTICIPANT A: Yes. For instance when the people in prison are on parole, these people come back into the community. They feel that the punishment is not harsh enough.

INTERVIEWER: Patience, what kinds of things are most challenging for you growing up here?

PARTICIPANT A: I feel like an outcast. I don't have the same opportunities. I don't have a mother. People judge me.

INTERVIEWER: Are there no job opportunities for people your age?

PARTICIPANT A: There are opportunities, but there's lots of nepotism.

INTERVIEWER: You work at MacDonalds. How did you get the job?

PARTICIPANT A: My teacher helped me to get a job at MacDonalds.

INTERVIEWER: That's nice of her. Are you or people you know exposed to violence?

PARTICIPANT A: Not really. But my cousins and people I know, yes.

INTERVIEWER: How do you avoid this in your family, community, and when with peers?

PARTICIPANT A: I shut people out. But most people are not driven to avoid violence. They are not motivated.

INTERVIEWER: How does the government play a role in providing for your safety, your recreation needs, housing, and jobs now and when you are older?

PARTICIPANT A: The government doesn't play a role. The police are corrupt. They accept bribes. They cannot provide us safety. The government is failing.

INTERVIEWER: Why?

PARTICIPANT A: They make promises but we have a library with a lack of books. We don't have water and electricity. After the elections, nothing has been done. The housing is inadequate. The houses are not well built. They are terrible. The government doesn't create fobs. We create our own jobs. Not even if we have good grades. We will create our own jobs.

INTERVIEWER: Do you have opportunities to experience meaningful rites of passage?

PARTICIPANT A: Yes. The government does provide us freedom.

INTERVIEWER: How tolerant is your community of problem behaviours among people your age?

PARTICIPANT A: They are not tolerant at all.

INTERVIEWER: What are some of these behaviours?

PARTICIPANT A: Crime, especially robbery, hijacking and rape. The children are disrespectful. They don't care. They are selfish.

INTERVIEWER: Do you feel safe and secure here?

PARTICIPANT A: Not really.

INTERVIEWER: How do others protect you?

PARTICIPANT A: The police are not helpful. I protect myself. I fight my own battles.

INTERVIEWER: Do you feel equal to others?

PARTICIPANT A: Yes. I make myself feel equal.

INTERVIEWER: Are there others you do not feel equal to and how do these people make you feel? Also, what do they do to make you feel this way?

PARTICIPANT A: I feel that I am mot equal to my elders because I respect them. They make me feel that I am still a child. I accept it. It teaches me the way to behave. It makes me a mannered person.

INTERVIEWER: Good. Do you have access to school and education and any other information you need to grow up well?

PARTICIPANT A: Yes. I did go to school. But I cannot go any further. I cannot afford it financially.

INTERVIEWER: What about bursaries?

PARTICIPANT A: I cannot comply with bursary terms.

INTERVIEWER: Who provided you with access to getting a school education?

PARTICIPANT A: The government provided the school. I had good teachers. I am grateful about my education.

INTERVIEWER: What do you do when you face difficulties in your life?

PARTICIPANT A: I have to find a solution. There's always a way out. I rely on myself, not on others. I fight the battle myself. But I would ask for help if necessary.

INTERVIEWER: Excellent. What does being healthy mean to you and others in your family and community?

PARTICIPANT A: Living a good life. When you have the ability to do something. When you are in a good condition and able to generate energy.

INTERVIEWER: Can you describe the way your parents or caregivers look after you?

PARTICIPANT A: They tell me how to behave and tell me about life's dangers.

INTERVIEWER: How does your family express themselves and what do they think of you?

PARTICIPANT A: They think I am confident. We are all equal. But my family is reserved. They don't speak a lot. But they do show emotions. I think that I am self driven. I have lots of patience.

INTERVIEWER: How does your family monitor you, or keep track of what you are doing?

PARTICIPANT A: We have some family time when we talk. But not my father. They know everything.

INTERVIEWER: How?

PARTICIPANT A: They ask me what I do.

INTERVIEWER: How do you know how to act with other people?

PARTICIPANT A: I am confident. I know I have the ability to do it.

INTERVIEWER: How well do you do socially?

PARTICIPANT A: I am very good socially.

INTERVIEWER: Are you thought of well by others? Are you popular or liked?

PARTICIPANT A: I am not really popular but I am not fought. People tend to like me.

INTERVIEWER: Do you have a role model and can you describe him or her?

PARTICIPANT A: My mother is my role model. Even though she died when I was eleven years old. She has a good spirit. She always found her way out of trouble. She was a go-getter. She saw opportunities. She was always there for me. I could rely on her.

INTERVIEWER: That's good. Do you have other meaningful relationships with people at school, home, or in your community?

PARTICIPANT A: Yes. I have a kind of friendship group. We give each other group support. We are eleven girls of different ages. Also my grandmother. She inspires me. I respect her. I learn a lot from her. I like her and love her.

INTERVIEWER: What do you do, and others you know do, to keep healthy, mentally, physically, emotionally and spiritually?

PARTICIPANT A: We can go to a community centre that offers sports and sports equipment. We have drama and teachers to help us.

INTERVIEWER: Are you assertive? How do you show this?

PARTICIPANT A: Yes, I am. I'm able to make my own decisions. I'm not scared to speak my mind.

NTERVIEWER: Can you describe your ability to solve problems?

PARTICIPANT A: I always look at more than one solution, even if I have to find help.

INTERVIEWER: Are you better or worse than others and how do you know this?

PARTICIPANT A: I'm average. I'm good at what I do, but I'm not comparing myself with other people.

INTERVIEWER: Do you have a sense of control over the world?

PARTICIPANT A: Yes, because I have my own income. My dad controls me a bit.

INTERVIEWER: How does this affect your life?

PARTICIPANT A: It makes my life easier. I am more confident. I face my own consequences.

INTERVIEWER: How much uncertainty are you able to live with?

PARTICIPANT A: Not much. I don't like uncertainty.

INTERVIEWER: Do you value self-awareness and insight?

PARTICIPANT A: Yes.

INTERVIEWER: How does this affect your life and what you do day to day?

PARTICIPANT A: I know what I have to do and I'm able to do it.

INTERVIEWER: Would you describe yourself as optimistic or pessimistic about life?

PARTICIPANT A: Optimistic, definitely.

INTERVIEWER: Do you have personal goals and aspirations and what are these?

PARTICIPANT A: I want to succeed in life. I want a job in an office. I want to be a career woman. I just want to be able to look after myself. I want to be self reliant. I want my own house.

INTERVIEWER: How much can you be independent and how much do you have to rely on others in your life for your survival?

PARTICIPANT A: I am very independent. I don't rely on others much.

INTERVIEWER: How much do you use substances like alcohol and drugs?

PARTICIPANT A: I don't use it at all. I have never touched it. I have used prescription medication when I was sick.

INTERVIEWER: What do others around you think about this?

PARTICIPANT A: The people around me don't use it. I distance myself from it. It's not good for me.

INTERVIEWER: What role does humour play in your life?

PARTICIPANT A: Humour plays a big role. I get along with people. Being able to laugh decreases your stress levels.

INTERVIEWER: Can you share with me a story of another child who grew up well in this community despite facing many challenges?

PARTICIPANT A: Yes. There's another girl who's nineteen years old. She has a mother and a stepfather. Her granny is not supportive like mine. She has no one there for her. She basically works for her family. She is saving some money for herself. She works at a baker. Her teacher also helped her to get a job. She's going to move out and keep her job.

INTERVIEWER: Can you share a story about how you have managed to overcome challenges you face personally, in your family, or outside your home in your community?

PARTICIPANT A: Life is not that bad. I accept things. I reach out. I find people I can talk to. I have stopped shedding tears. It was a sad day when my mother died. I now live with my father. But life goes on. I'm looking after my little sister. I have more responsibility. My little sister is looking up to me.

INTERVIEWER: How old is your sister?

PARTICIPANT A: She's fifteen.

INTERVIEWER: How is your sister coping?

PARTICIPANT A: She's coping. She's very brave. She's courageous and assertive.

INTERVIEWER: Anything else you want to add?

PARTICIPANT A: Yes. We have a stepmother who doesn't have her own children. She doesn't know how to handle us. She is trying to make life easier for us, but she doesn't know how to handle us. She has no experience with kids.

INTERVIEWER: What about your community?

PARTICIPANT A: I do get support from my community. I'm a religious person. I go to the Apostolic church. We get little support from our parents. I mainly get strength from myself.

ADDENDUM F

INTERVIEW 2

INTERVIEWER: Before we start with the questions, tell me something about yourself.

PARTICIPANT B: I am a Zulu girl and happy with my life. I'm accepting things the way they are. I'm in grade ten and fifteen years old, and I love school. It's my future. I'm doing well. After school I'm going to find a job to get money. I would like to become a lawyer. Money is very important to me.

INTERVIEWER: That's nice. Now what would I need to know to grow up well here?

PARTICIPANT B: My culture means a lot to me. I still believe in my ancestors. I also rely on my religion. My Christianity. I pray to God and Jesus.

INTERVIEWER: Okay, that's good. Tell me, what role do religious organizations then play in your life?

PARTICIPANT B: I go to church often. It plays a very big role.

INTERVIEWER: How?

PARTICIPANT B: It shows me the way. What to do, where to go.

INTERVIEWER: That's good. What do the other members of your family think of the way you live your life, such as your beliefs and going to church?

PARTICIPANT B: They don't understand. Their cultural beliefs are stronger. I accept the way I am. I accept myself.

INTERVIEWER: That's good. How do you handle change, both at an individual level, and the changes taking place for everyone in your community?

PARTICIPANT B: Change is change. I accept it. Sometimes it's easy to accept it. When the change is for the good, I love it. When there are hard times, I accept it, especially with God next to me.

INTERVIEWER: Okay, good. How do you contribute to your community?

PARTICIPANT B: I regularly take part in group discussions at school with my friends and then we talk about teen pregnancy and sex before marriage. I talk to others to help them. I love to communicate.

INTERVIEWER: That's excellent. What is it like for you when people around you succeed?

PARTICIPANT B: I and not jealous. It motivates me. I'm unique. I then realize I can also do it.

INTERVIEWER: Excellent. Tell me something about your culture. Can you describe it? What day to day activities are part of your culture and how are things done in your community?

PARTICIPANT B: I am a Zulu girl and you know, us girls are inspected to see if we are virgins. We still believe in our ancestors. At funerals we slaughter cows. Specific cows are slaughtered for specific occasions. Sometimes we slaughter a goat. We eat meat and drink beer at a ceremony after the death. The food is actually for our ancestors.

INTERVIEWER: What about the role of your father?

PARTICIPANT B: My father is the head of the house. But I don't feel very much part of all the cultural activities and customs. It's not really that important to me.

INTERVIEWER: Okay. Tell me, how do you describe people who grow up well here despite the many problems they face?

PARTICIPANT B: You have to have a role model. Or a hero. You must be confident and creative. People who are successful are go-getters. They create their own opportunities. And they use their opportunities.

INTERVIEWER: Excellent. What does it mean to you, your family and to your community, when bad things happen?

PARTICIPANT B: The bad things hang over us like a dark cloud. Life is a challenge. But I'm living for myself. Some people will do nothing. They have no hope or confidence.

INTERVIEWER: Can you tell me what some of the bad things are?

PARTICIPANT B: Yes. Things like unemployment and poverty. We have no sanitary facilities. We have a lot of crime. There's also teenage pregnancy and drugs like dagga and tobacco in schools. We also have lots of littering and pollution, especially smoke from the coal fires.

INTERVIEWER: How is the crime curbed in your community?

PARTICIPANT B: We have section police and they beat the criminals when they are caught.

INTERVIEWER: That sounds bad. What do people do to cope?

PARTICIPANT B: Some people are very stubborn. They accept things. Some people give up. Some people try to solve the problems. But we have lots of corruption going on. The money we get to uplift the community goes to the wrong places.

INTERVIEWER: What do the people say when these bad things happen?

PARTICIPANT B: The elders shout at the youth. They swear.

INTERVIEWER: Who talks about these things most?

PARTICIPANT B: We have a community leader who talks about these things. Also the unemployed people will talk about the bad things that happen to them. The ones who have the problems avoid the issue. But the youth will fight for what they want. That's why there is a June 16th. You have to raise your voice. You must fight for what you want.

INTERVIEWER: Who is likely to come up with the solution to the problems when they occur?

PARTICIPANT B: The adults. They compare the black people to the white people. They think their solutions will work.

INTERVIEWER: What do other people think of these solutions?

PARTICIPANT B: At first they are negative, and then they become more positive.

INTERVIEWER: Can your give me examples of the solutions?

PARTICIPANT B: Yes. The government gave us dustbins to educate the community about littering. We also have a library where we can go to get information about drugs and that. At school we get education about AIDS and things like that.

INTERVIEWER: What things?

PARTICIPANT B: The counselors tell us about the dangers of having unprotected sex.

INTERVIEWER: Can you tell me, what kinds of things are most challenging for you growing up here?

PARTICIPANT B: Oh, yes. We have a lack of food. I'm always hungry. We are poor. We have fewer opportunities than richer people.

INTERVIEWER: Are there no job opportunities for people your age?

PARTICIPANT B: No.

INTERVIEWER: Are you or people you know exposed to violence?

PARTICIPANT B: Yes.

INTERVIEWER: How do you avoid this in your family, community, and when with peers?

PARTICIPANT B: I don't get drawn into the situation. I don't have to, because I know who I am. I am unique.

INTERVIEWER: How does the government play a role in providing for your safety, your recreation needs, housing, and jobs now and when you are older?

PARTICIPANT B: They don't play a great role. We are helping ourselves.

INTERVIEWER: Do you have opportunities to experience meaningful rites of passage?

PARTICIPANT B: Yes. I feel free. I can express myself. I know what I want.

INTERVIEWER: How tolerant is your community of problem behaviours among people your age?

PARTICIPANT B: Oh, the old generation is very strict. They are not tolerant at all.

INTERVIEWER: What are some of these behaviours?

PARTICIPANT B: Coming home late. Drugs and sex. They don't like that we have boyfriends. Children making decisions without thinking.

INTERVIEWER: Do you feel safe and secure here?

PARTICIPANT B: Yes, staying at home is safe, but when you go out on the streets, it's not safe, especially at night time.

INTERVIEWER: How do others protect you?

PARTICIPANT B: We protect ourselves. Sometimes the adults will give me advice how to protect myself. The police force is totally inadequate. They accept bribes, so we have to protect ourselves.

INTERVIEWER: That's a pity. Do you feel equal to others?

PARTICIPANT B: Yes, of course. I don't care about other people. I live for myself.

INTERVIEWER: Are there others you do not feel equal to and how do these people make you feel?

PARTICIPANT B: No. Everybody has rights. We are all human beings.

INTERVIEWER: Good. Do you have access to school and education and any other information you need to grow up well?

PARTICIPANT B: Yes, do. I have textbooks, and teachers and I'm able to pay my school fees.

INTERVIEWER: Who provided you with access to getting a school education?

PARTICIPANT B: My parents pay my school fees. The government school provides the education. Everybody has the right to have an education.

INTERVIEWER: What do you do when you face difficulties in your life?

PARTICIPANT B: I sit and think about it. I always think before I do. I think of all my options.

INTERVIEWER: Excellent. What does being healthy mean to you and others in your family and community?

PARTICIPANT B: Being able to live well. Being able to do things. Having a good life style. When everything is going good.

INTERVIEWER: Can you describe the way your parents or caregivers look after you?

PARTICIPANT B: They look after me very well. They talk to me. They always ask how I am coping and "Can I help you?" My grandmother is very good to me.

INTERVIEWER: How does your family express themselves and what do they think of you?

PARTICIPANT B: Some of my sisters will talk to me. My family think that I am a positive person. But you cannot really know a person.

INTERVIEWER: How does your family monitor you, or keep track of what you are doing?

PARTICIPANT B: They sit down with me and they ask questions. They give advice and offer help.

INTERVIEWER: How do you know how to act with other people?

PARTICIPANT B: Firstly by looking at that person I know what to do. I follow the examples of others. Then you must express yourself the way you are.

INTERVIEWER: How well do you do socially?

PARTICIPANT B: Oh. I am a social person. I like to talk and to communicate.

INTERVIEWER: Are you thought of well by others? Are you popular or liked?

PARTICIPANT B: Yes. I am popular and liked by others.

INTERVIEWER: Do you have a role model and can you describe him or her?

PARTICIPANT B: Yes. My grandmother. I respect her. She's always helping people. I love and respect her. She's a nice person. Other people love her. Also the younger people like her. She's so positive.

INTERVIEWER: That's very good. Do you have other meaningful relationships with people at school, home, or in your community?

PARTICIPANT B: Yes. I have many friends. Boys and girls.

INTERVIEWER: Do you have a boyfriend?

PARTICIPANT B: Yes, I do have one. I can always talk to him.

INTERVIEWER: What do you do, and others you know do, to keep healthy, mentally, physically, emotionally and spiritually?

PARTICIPANT B: We do have community services but mostly you must have self awareness. You keep healthy by showing your emotions, by crying and laughing.

INTERVIEWER: Are you assertive? How do you show this?

PARTICIPANT B: Yes, certainly. People know that what I say, I do. My answers are always the same. I am stable.

INTERVIEWER: Can you describe your ability to solve problems?

PARTICIPANT B: I'm good at solving problems. I talk to my friends and help them.

INTERVIEWER: Are you better or worse than others and how do you know this?

PARTICIPANT B: I'm better than others at solving problems. After I've solved the problem, I know that I have done the right thing. I see that I have succeeded. I never fail.

INTERVIEWER: Do you have a sense of control over the world?

PARTICIPANT B: Yes I do.

INTERVIEWER: How does this affect your life?

PARTICIPANT B: I'm always on the good side. I forgive and forget.

INTERVIEWER: How much uncertainty are you able to live with?

PARTICIPANT B: I don't like uncertainty. I want to know what's going to happen with me.

INTERVIEWER: Do you value self-awareness and insight?

PARTICIPANT B: Absolutely. Everything is great. I accept myself.

INTERVIEWER: How does this affect your life and what you do day to day?

PARTICIPANT B: It makes me positive.

INTERVIEWER: Would you describe yourself as optimistic or pessimistic about life?

PARTICIPANT B: I'm optimistic.

INTERVIEWER: Do you have personal goals and aspirations and what are these?

PARTICIPANT B: I want to become a lawyer. I want to communicate with people. I want to work with a computer. I want to be out in nature. I'd also like to be married, but I still want to be independent. I want to work. I don't want to become a housewife.

INTERVIEWER: How much can you be independent and how much do you have to rely on others in your life for your survival?

PARTICIPANT B: I can be independent very much. I make my own decisions. I do rely on my grandmother for food and shelter. Otherwise I don't need other people.

INTERVIEWER: How much do you use substances like alcohol and drugs?

PARTICIPANT B: I use nothing! My friends drink.

INTERVIEWER: What do others around you think about this?

PARTICIPANT B: They respect my decision.

INTERVIEWER: What role does humour play in your life?

PARTICIPANT B: You have to laugh at things that have happened. I laugh a lot.

INTERVIEWER: Can you share with me a story of another child who grew up well in this community despite facing many challenges?

PARTICIPANT B: Yes. I know a girl. She's sixteen years old. She has everything, but no love. They always fight in their house. Her mother married her father because he has money. She hides her problem. She likes to show off.

INTERVIEWER: Can you share a story about how you have managed to overcome challenges you face personally, in your family, or outside your home in your community?

PARTICIPANT B: When I was nine years old, I lost my mother. That was very difficult for me. I lost my backbone. But I prayed to God. I also accepted my situation. I talked to other people. At first I could not eat or sleep. Today, I know I'm not the only one with problems. But God knows His purpose. Also when my father used to beat me, I didn't care. Today I face my problems and I fight my problems. I always look at the positive side.

ADDENDUM G

INTERVIEW 3

INTERVIEWER: Before we start with the questions, tell me something about yourself.

PARTICIPANT C: I am 14 years old. I still go to school. I'm in grade 9. I am a Zulu.

INTERVIEWER: Can you tell me what would I need to know to grow up well here?

PARTICIPANT C: You need to be happy. Being happy helps you to cope.

INTERVIEWER: That's good. Tell me, what role do religious organizations then play in your life?

PARTICIPANT C: I go to church every Sunday. It helps me to cope.

INTERVIEWER: Which church do you go to?

PARTICIPANT C: Twelve Apostles. Yes.

INTERVIEWER: That's good. What do the other members of your family think of the way you live your life, such as your beliefs and going to church?

PARTICIPANT C: They are happy about my life. They are proud.

INTERVIEWER: Good. How do you handle change, both at an individual level, and the changes taking place for everyone in your community?

PARTICIPANT C: Change brings difficulties, but I will still cope.

INTERVIEWER: Okay, that's good. Tell me how you contribute to your community?

PARTICIPANT C: I want to uplift my community. I teach my friends how to do gumboot dancing. We enjoy it. It's nice.

INTERVIEWER: Oh, yes. Thank you very much for the dance you gave me this morning. I really enjoyed it. Now tell me, what is it like for you when people around you succeed?

PARTICIPANT C: I feel good for them. I am not jealous.

INTERVIEWER: Do you have a life philosophy and would you like to share it with me?

PARTICIPANT C: Just be happy.

INTERVIEWER: Excellent. Tell me something about your culture. Can you describe it? What day to day activities are part of your culture and how are things done in your community?

PARTICIPANT C: Our culture teaches us to have respect for everybody.

INTERVIEWER: Okay. Tell me, how do you describe people who grow up well here despite the many problems they face?

PARTICIPANT C: They are hard working. They are independent. They laugh a lot.

INTERVIEWER: Excellent. What does it mean to you, your family and to your community, when bad things happen?

PARTICIPANT C: I don't know. Other people don't care.

INTERVIEWER: Can you tell me what some of the bad things are?

PARTICIPANT C: Fathers beating mothers. We have crime.

INTERVIEWER: What kind of crime?

PARTICIPANT C: People who rape. They murder other people. We also have people begging.

INTERVIEWER: What do the people say when these bad things happen?

PARTICIPANT C: They talk about it. They ask for help.

INTERVIEWER: What do they say?

PARTICIPANT C: They say "shame". It is a pity.

INTERVIEWER: Who talks about these things most?

PARTICIPANT C: All the people talk about it.

INTERVIEWER: Who is likely to come up with the solution to the problems when they occur?

PARTICIPANT C: The police department.

INTERVIEWER: What do other people think of these solutions?

PARTICIPANT C: They think that they do a good job. The people are afraid of the police.

INTERVIEWER: Can your give me examples of the solutions?

PARTICIPANT C: When people beg at night, like when they come to our homes, asking for money, and when there is violence, sometimes the police interferes.

INTERVIEWER: Can you tell me, what kinds of things are most challenging for you growing up here?

PARTICIPANT C: Yes. Parents always fighting.

INTERVIEWER: That must be bad. Are there any job opportunities for people your age?

PARTICIPANT C: No.

INTERVIEWER: Are you or people you know exposed to violence?

PARTICIPANT C: Yes, when I play with my friends.

INTERVIEWER: How do you avoid this in your family, community, and when with peers?

PARTICIPANT C: I'll stop my friends when they want to fight.

INTERVIEWER: How does the government play a role in providing for your safety, your recreation needs, housing, and jobs now and when you are older?

PARTICIPANT C: The government provides us with a house. They give us safety. But there is no work. There is no recreation.

INTERVIEWER: Do you have opportunities to experience meaningful rites of passage?

PARTICIPANT C: Yes. I feel free to do anything. I am not at risk.

INTERVIEWER: How tolerant is your community of problem behaviours among people your age?

PARTICIPANT C: Sometimes they are tolerant.

INTERVIEWER: What are some of these behaviours?

PARTICIPANT C: When children run away from home. Or when we do not do our parents any favours.

INTERVIEWER: Do you feel safe and secure here?

PARTICIPANT C: No. At night the older boys intimidate you on the street.

INTERVIEWER: How do others protect you?

PARTICIPANT C: My mother protects me. My father is absent most of the times. My mother always asks me how I feel.

INTERVIEWER: Do you feel equal to others?

PARTICIPANT C: Yes.

INTERVIEWER: Are there others you do not feel equal to and how do these people make you feel?

PARTICIPANT C: No. I feel equal to everybody.

INTERVIEWER: Good. Do you have access to school and education and any other information you need to grow up well?

PARTICIPANT C: Yes I go to school and I get some information from a social worker. But I'm not sure about university, because I don't have money.

INTERVIEWER: Who provided you with access to getting a school education?

PARTICIPANT C: My parents.

INTERVIEWER: What do you do when you face difficulties in your life?

PARTICIPANT C: I run away from the situation and play with my friends.

INTERVIEWER: Oh, that's interesting. Now, what does being healthy mean to you and others in your family and community?

PARTICIPANT C: Growing well. Being able to eat.

INTERVIEWER: Can you describe the way your parents or caregivers look after you?

PARTICIPANT C: They want to make me happy, but they can't, because there's no money. But they do provide me with food and clothes and transport. They give me taxi money

INTERVIEWER: How does your family express themselves and what do they think of you?

PARTICIPANT C: They talk to me sometimes. They think I'm going to be something one day. They are proud of me.

INTERVIEWER: How does your family monitor you, or keep track of what you are doing?

PARTICIPANT C: I always tell them where I'm going.

INTERVIEWER: How do you know how to act with other people?

PARTICIPANT C: I just want to make them laugh. It comes from myself.

INTERVIEWER: How well do you do socially?

PARTICIPANT C: Good. I like to be with my friends and play.

INTERVIEWER: Are you thought of well by others? Are you popular or liked?

PARTICIPANT C: I am popular. I am well liked.

INTERVIEWER: That's nice. Do you have a role model and can you describe him or her?

PARTICIPANT C: Yes. Thabo Mbeki. Because he's trying to do good for other people. He's a good person. He is also serious.

INTERVIEWER: That's very good. Do you have other meaningful relationships with people at school, home, or in your community?

PARTICIPANT C: Yes, my youngest sister. We talk about everything.

INTERVIEWER: How old is she?

PARTICIPANT C: She's fourteen.

INTERVIEWER: What do you do, and others you know do, to keep healthy, mentally, physically, emotionally and spiritually?

PARTICIPANT C: We play soccer and golf. Singing also helps and dancing. We go to church.

INTERVIEWER: Are you assertive? How do you show this?

PARTICIPANT C: Yes, I am. I tell people what I want. They accept it sometimes. If they don't, I ignore them.

INTERVIEWER: Can you describe your ability to solve problems?

PARTICIPANT C: I can handle ordinary problems, but not serious problems.

INTERVIEWER: Serious problems, like?

PARTICIPANT C: Things that only grown ups can solve, not kids like me.

INTERVIEWER: Are you better or worse than others at solving your problems and how do you know this?

PARTICIPANT C: I am better. I know this because sometimes I give advice.

INTERVIEWER: Do you have a sense of control over the world?

PARTICIPANT C: Yes, I am in control of my life. It is a good feeling. I don't want to be controlled. I only want to give advice.

INTERVIEWER: How much uncertainty are you able to live with?

PARTICIPANT C: I want certainty. I want answers.

INTERVIEWER: Do you value self-awareness and insight?

PARTICIPANT C: Yes. It's good to know yourself.

INTERVIEWER: How does this affect your life and what you do day to day?

PARTICIPANT C: It doesn't affect my life.

INTERVIEWER: Would you describe yourself as optimistic or pessimistic about life?

PARTICIPANT C: I am optimistic. Yes, optimistic.

INTERVIEWER: Do you have personal goals and aspirations and what are these?

PARTICIPANT C: Yes, I want to be a social worker. I want to help people with their problems. I want to be rich and have a good life.

INTERVIEWER: How much can you be independent and how much do you have to rely on others in your life for your survival?

PARTICIPANT C: I am independent. But I need many people to survive. I need everyone. I don't want to survive on my own.

INTERVIEWER: How much do you use substances like alcohol and drugs?

PARTICIPANT C: I don't use it at all. I don't smoke. I feel good about it.

INTERVIEWER: What do others around you think about this?

PARTICIPANT C: They think I'm stupid because I don't want to do wrong things.

INTERVIEWER: What role does humour play in your life?

PARTICIPANT C: Oh, I love laughing. It plays a big role in my life.

INTERVIEWER: Can you share with me a story of another child who grew up well in this community despite facing many challenges?

PARTICIPANT C: Yes. My friend is always hungry. His mother does not buy food. But he is coping good. He is playing and being happy.

INTERVIEWER: Can you share a story about how you have managed to overcome challenges you face personally, in your family, or outside your home in your community?

PARTICIPANT C: I saw Zola. He advised people not to look at bad things all the time. I pretend that things are not as bad.

ADDENDUM H

GROUP INTERVIEW

INTERVIEWER: When we compare the children here, how do they compare with children from other sites? How do the experiences of other children compare with the experiences of children here?

PARTICIPANT D: The community here doesn't offer the same opportunities as in other communities. In other communities there are drama workshops, AIDS workshops, meetings for alcoholics, information about drugs, and organizations that help people with AIDS.

PARTICIPANT E: Yes, in Cape Town, for instance, they have better living standards. They have nice house and buildings. In KwaZulu Natal they have better schools than here in Daveyton. They have special buildings for orphans and help for the orphans. There the orphans get clothes and beds to sleep in. Even in Soweto things are better. There they know where to find help.

INTERVIEWER: How would children here handle the problems these other children face?

PARTICIPANT D: I don't think the other children would be able to cope here. I think the children from this site would be able to handle any problems other children face.

INTERVIEWER: What advice would you give to these other children?

PARTICIPANT F: I would tell them help is coming, they mustn't rush things. They must live life one day at a time and pray to God. There will be some people in the community who will share.

INTERVIEWER: : What patterns do you see in how these other children cope with life's problems?

PARTICIPANT D: They are helpful. They believe in God. Religion is important to them.

PARTICIPANT F: They try to go to school. They know that they have a future. They deal with their problems. Faith in God makes them cope. They know that someone cares. They do not quit. They want to be the best. They are youth who listen to a message and take it seriously. They volunteer to run activities with youth in and around the local communities.

PARTICIPANT E: They live lives without drugs and alcohol. A life free of drugs, free of promiscuity, and free of crime. They choose education. They bring smiles to sad faces.

PARTICIPANT G: And they talk to their friends, you know, share secrets. Be positive

PARTICIPANT H: You know, they go to school. Everyone should go to school.

PARTICIPANT I: Apart from enjoying your school years, one should live one's dreams. The successful children have the drive to succeed. And they talk about their problems openly.

PARTICIPANT J: They spend lots of time praying. Their faith in God inspires them. Things that seem impossible to achieve seem easier.

INTERVIEWER: Are there specific themes, or aspects of their lives, that protect these other children from the challenges they face?

PARTICIPANTS E, F, G, H, J: Yes. They get an education. They believe in God and themselves. They help other people. They feel good about themselves.

INTERVIEWER: What are the challenges of the community?

PARTICIPANTS D, F, G, H, J, I: Oh, many. Especially poverty, HIV/AIDS, hunger and starvation, single parent homes, unemployment and no help from the government. Also the stigma of not being able to pay school fees and school clothes. They need shelter. There are no jobs. Children are having sex at younger ages. They are promiscuous. There's lots of alcohol abuse, violence, abortion, crime. Pollution is also a problem. Parents find it hard to talk openly about sex.

INTERVIEWER: What are the things that help the youth cope?

PARTICIPANTS D, E, F, H, J: There is some hunger relief in the form of food parcels. Some people are helped to grow vegetable gardens. They are sent to school. They get special care from social workers. They need to learn and go to school. They must learn to look after themselves. They need life skills.

INTERVIEWER: What do you understand resilience is?

PARTICIPANTS D, E, F, G, H, I, J: Coping. Being able to go on with life although it is very hard. Making a success of their lives. Being successful. Having hope.

ADDENDUM I

POETRY BY RESILIENT ORHANS

LOVE

Love is God

Without love there is no life

Having that little something to hold.

Having that beauty

Sharing what you achieve from love.

Sharing that small little food with your family

Love is like the sun coming out of the clouds, and

Warming your soul

The soul that gives you life

That love is when your parents give birth to you

And then raise you from poverty

But having their love is everything

Love is hope

Hoping that someday my family will be there

Going East to West

Going North to South

Whatever you wish for in life

Your inner part is nothing,

Without love to fulfil everything.

Even though you have nothing to eat.

Love is trust

Trusting that God shall give you power

Power to go forward

Forward that means a wonderful future

Future that will cause your life to be beautiful

Beauty which you have from mother nature

Having nothing to drink or eat but love

That makes you wake up and do something

For your life even working at your age

But it's not over until God says so