Resiliency in the context of HIV/AIDS: A study of community caregivers' perceptions of orphans and vulnerable children in two KwaZulu-Natal districts.

Nabeela Warrasally

Supervised by Ms Phindile Mayaba

Submitted in partial fulfilment of the requirements for the degree of Master of Social Science(Research Psychology) at the Disciplineof Psychology, School of Applied Human Sciences, University of KwaZulu-Natal,Pietermaritzburg

DECLARATION

Submitted in partial fulfilment of the requirements for the degree of the Masters in Research Psychology, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I, *Nabeela Warrasally*, declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.

2. This thesis has not been submitted for any degree or examination at any other university.

3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
   a. Their words have been re-written but the general information attributed to them has been referenced
   b. Where their exact words have been used, then their writing has been placed inside quotation marks, and referenced.

5. This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the References sections.

_____

Nabeela Warrasally
04December 2015

_____

Supervisor: Ms Phindile Mayaba

ACKNOWLEDGEMENTS

I would like to convey a heartfelt thank you to the following individuals for their support, time, encouragement and contributions to this study:

- A sincere appreciation to my supervisor Ms Phindile Mayaba, for her guidance, support, assistance and patience. Without her supervision this study would not have been possible.

- A special thank you to my family for giving me strength when I became overwhelmed during the course of this study and supporting my studies from the very beginning.

- To all of my participants, thank you for allowing me to hear your stories, for being part of this study and for sacrificing your time with the hope that the OVC you care for will benefit from the findings.

- To my husband, thank you for being techno savvy and assisting me in the finer details of this study and not forgetting your continous support.

ABSTRACT

In the context of HIV/AIDS, being orphaned is a reality for 3.8 million of South Africa's children. The Department of Social Development (DSD) has found that OVC in South Africa do not display the same resilience as OVC in other parts of the world. The current study sought to investigate the factors that impact on OVC resilience through the perceptions of community care givers (CCGs) –including an evaluation of existing interventions by the DSD. The study was conducted in asemi-urbanareain eThekwini district and in an urbanarea in uMgungundlovu districtin the KwaZulu-Natal province of South Africa. Participants included twenty-four CCG, four of which were male. A qualitative research design was implemented. Data was collected through focus groups which took place in the relevant districts and was analysed thematically, employing Bronfenbrenner's ecological systems theory. The study found that resilience of OVC was significantly impacted on by factors that exist within OVCs macrosystem and chronosystems. Participants reported that delayed service delivery within governmental departments including the DSD prevent OVC "bouncing back" from adversities. The process of red tape and procedures, after a child has been orphaned, is lengthy and the time in which documents are being processed OVC are left with no food, shelter or money. This has the consequence of OVC residing in situations of dire poverty for long durations of time including OVCs basic needs not being met. The study concludes that the role of CCG in facilitating resilience is imperative to OVC development. However, procedures of red tape and delays of service delivery are the contributing factors to OVC lack of resilience in this context.

Keywords

Orphans and vulnerable children (OVC); Community Caregivers (CCGs); resilience; Department of Social Development (DSD); psychosocial support; Bronfenbrenner's ecological systems theory

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

1.1 Background and context to the research problem

The exponential growth of OVC in sub-Saharan Africa is a result of the HIV/AIDs epidemic which has claimed the lives of 1.5 million people in the year 2013 alone (World Health Organization [WHO], 2015). Ever since the 1990s the number of children in South Africa who have been orphaned has tripled and it is expected that within the next ten years incidence rates of orphanhood will continue to be on the rise (Ardington &Leibbrandt, 2010). Generally, in the context of sub-Saharan Africa the extended family will take on the responsibility of caring for and bringing up the orphaned child (Karim, 2010). However, there is great concern that extended family networks are buckling under the severity of the orphan catastrophe and that an alternative arrangement is required in the face of the increasing number of orphans (Ardington & Leibbrandt, 2010; Karim, 2010). In recent years there has been a shift towards community based care for OVC in the hope of efficiently managing the orphan catastrophe; in the context of South Africa this has given rise to the training of CCG (Makoae, 2015).

OVC are confronted with multiple risk factors, this includes lack of nutrition, poor access to education, minimum social assistance, psychological problems such as depression, anxiety and delinquency (Department of Social Development [DSD], 2010; Tefera & Mulatie, 2014). These factors impact on OVCs level of resilience by placing OVC in situations of multiple adversities. According to the DSD (2010) OVC who are in situations of adversity are less prone to developing mental illnesses if they are the recipients of community based care and support and are aided in attaining a sense of familiarity in their lives (DSD, 2010; Sherr et al., 2016).

In the context of orphanhood resilience is of significant importance as it is a movement away from focusing on individuals weaknesses towards their ability to cope with and overcome adversity (DSD, 2010; Theron & Theron, 2010). The theory of resilience is rooted in overcoming vulnerabilities and therefore directly relates to OVC (Ngonyama, 2013). The development of resilience is fostered via three mechanisms; the first mechanism is found within the individual themselves such as the ability to cope with difficult situations, self-confidence and the ability to adapt to change. The second mechanism refers to the family and

relationship development such as having a supportive social network. The third mechanism extends beyond the family and includes support from teachers, CCG etc. (DSD, 2010; Jameel, Shah & Ganaie, 2016). The facilitation of resilience is vital in the context of South Africa to change the stigma of helplessness that many OVC internalise and to create a situation of self-efficacy and improvement in the lives of OVC (Ngonyama, 2013).

Recent research has found that in some parts of the world orphans and vulnerable children (OVC) develop resiliency because of the multiple forms of support that they receive inclusive of psychosocial support (Kganakga, 2013; Jameel, Shah & Ganaie, 2016). However, the Department of Social Development (DSD) in South Africa has concern, based on their knowledge and findings, that some South African OVC do not display a sense of resilience that is found to be common in OVC in other parts of the world. This is due to OVC in the context of South Africa being placed at multiple risk after the death of a parent including displacement, poverty, lack of access to education, lack of nutrition and lack of social support (Kganakga, 2013; Killian, 2004). Therefore the motivation for this research is to investigate the determinants (including those outlined above) that impact on OVCs resilience development in KwaZulu-Natal, through gaining perspectives from those directly involved in the care and development of OVC such as community caregivers (CCG).

The Regional Psychosocial Support Initiative (REPSSI) as an organisation has adopted a holistic approach to the social issue of OVC by incorporating a collaboration of professionals whose aim is to promote and influence resilience at the various ecosytemic levels of a child's environment and to provide psychosocial support for OVC (DSD, 2010). The importance of collaborating professionals in the care and resilience development of OVC is motivated for by Theron and Theron (2010) who employ an ecological perspective to the development of resilience for OVC. According to Bronfennbrenner a child's immediate family, a tenet of the microsystem level, can serve as a protective factor against the cumulative risk faced by OVC therefore decreasing the child's psychological stress (DSD, 2010). Many OVC are placed in the trust of caregivers whom do not always have the training and knowledge of how to provide psychosocial support and to promote and create an environment of resilience building for children (REPSSI; Makoae, 2015). Through the professionalization of CCG, the DSD aims for the role of CCG to serve as a protective factor against the cumaltive risk faced by OVC resulting in resilience development of OVC. CCGs possess local knowledge of the communities they work in as they are quite often a member of the community. As a result this

makes it easier for CCG to build rapport with community leaders and therefore makes the implementation of interventions more acceptable by the community (Karim, 2010).

REPSSI developed and revised a certificate programme which admits community based workers also known as CCG to obtain a recognised certificate in aid of OVC. The certificate course serves to "professionalise the field of community-based child care, and mainstreaming child protection, psychosocial support and community mobilization principles into their work" (REPSSI, n.d). The sample drawn in this study consists of CCG trained by REPSSI in collaboration with DSD.

The DSD's aim is to develop interventions that can promote resilience for South African OVC and to explore what the gaps are in their existing interventions. One of the ways in which they have achieved this is through the training of CCG so that their skills can be used to care for OVC and promote change in their lives through the facilitation of resilience. It is important to note that resilience is not only achieved through internal characteristics but also through external support in OVCs environment (Jameel et al., 2016). External support can range from government policy on OVC to community based care including CCG.

Therefore this research seeks to explore the resilience or lack of resilience in South African OVC as well as the factors and contexts (internal and external constituents) that influence their ability to be resilient- through the perception of CCG- so as to aid the DSD in fulfilling their obligations made to OVC as was stated by the DSD in 2003 (Appendix 4).

1.2 **Aims and rationale**

The current study was guided by the following main objectives:

- To investigate why some South African OVC may not be as resilient as OVC in other parts of the world according to CCG.
- To explore the perspectives of CCG on how OVC in KZN who are faced with multiple adversities can be assisted to become resilient.
- To determine and highlight the gaps in existing interventions of the DSD for OVC resilience building according to CCG.

Furthermore, the rationale of the current research is a result of the DSD seeking to investigate the causes that prevent OVC in South Africa from displaying resilience in comparison to OVC in other parts of the world (Kganakga, 2013)

1.3 Research questions

- What are the perceptions of CCGs as to why some of South Africa's OVC may not be as resilient as OVC in other parts of the world?
- What are CCG's perspectives on how OVC in KZN, who are faced with multiple adversities, can be assisted to become more resilient?
- What is the role of CCG in building resilience for OVC?
- What do CCG perceive as gaps in the existing interventions of the DSD for OVC resilience building?

1.4 Research methodology

The methodology employed in this study made use of a qualitative research design and was based on the situational need to gain insight into CCG's perceptions through their social engagement and interactions with OVC. The sample used in this study comprised of 24 CCG. Purposive sampling was used to select participants who were involved in the care of OVC in two KwaZulu-Natal districts at the time of the study. This study used focus group discussions as the primary tool of data collection. Focus group discussions was determined as being the best tool to allow for a common understanding of CCG's perceptions, understanding and experiences of OVC resilience which was attained through group engagement and open dialogue.

Thematic analysis was used to analyse data and report consistencies and themes that was central to the data. Ethical considerations were central to the process of this research. Ethical clearance was obtained from the University of KwaZulu-Natal Higher Degrees and Research Ethics Committee. Furthermore, informed consent was obtained from participants prior to their participation in the study. Confidentiality was maintained by not disclosing details of participants that would make them identifiable. An in-depth account of the methodology used in this study is detailed in Chapter 3.

1.5 An outline of the chapters

The following chapter includes a review of the literature with regards to the current status and implications of the HIV/AIDS pandemic in South Africa in relation to OVC. It is important to note that in the context of the current study OVC refers specifically to orphans who have lost either one or both parents due to HIV related diseases therefore placing them at risk in the context of the two districts mentioned. The literature covers an array of policies and legislation put into place by government for the care of OVC it further explores the role of CCG in the care and resilience development of OVC. The theoretical framework of this research draws on Bronfenbrenner's ecological theory (Bronfenbrenner, 1979). There is a focus on the rippling relations extending from the OVC's microsystem to their chronosystems representing a ripple down effect of risk that impedes on OVC resilience development, in the context of the current study.

Chapter 3 provides a blueprint of the methodological procedures carried out in this study. This includes sampling, data collection, data analysis, ethical considerations as well as validity, credibility and generalisability. Chapter 4 presents the findings of the current study and supports findings with relevant excerpts. Chapter 5 presents a discussion of the findings supported by empirical literature. Chapter 6 is the concluding chapter of this study and succinctly summarises the research, addresses some limitations of the study and provides recommendations for future research. Lastly, a reference list, appendices and transcripts of the focus groups are attached.

1.6 Conclusion

OVC in South Africa are at the coalface of the AIDS pandemic, they are left vulnerable and at risk. An initiative to change the plight of OVC has been the incorporation of community based care for OVC. This includes the inclusion of CCG into the support structure of OVC, as initiated by the DSD. Support structures, such as the presence of CCG, are proven to help facilitate resilience in OVC. However, OVC in South Africa still display a poor sense of resilience. This study sought to investigate through the first hand experiences, accounts and perceptions of CCG what measures can be taken to improve OVC resilience, what gaps there are in existing interventions and how do they as CCG see the way forward in resilience building of OVC. The next chapter will review literature in relation to OVC resilience, HIV/AIDS, polices and legislation as well as Bronfenbrenner's ecological systems theory.

CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Introduction

This section reviews currently available literature on OVC in attribution to their resilience development in the context of HIV/AIDS. It will closely look at four imperative aspects of OVC and resiliency, namely; epidemiology, a review of other related studies, a theoretical framework that employs Bronfenbrenner's ecological systems theory and lastly policies and frameworks that guide OVC development in the context of South Africa. The review of literature describes and evaluates the literature and critiques how these factors impact on OVC development.

2.2 Epidemiology

2.2.1 HIV/AIDS globally

HIV/AIDS has taken on a global reach of infection spreading widely and vastly. It is approximated that there are more than 36.9 million people all over the world that have contracted the HI virus, this is a figure inclusive of 2.6 million children (WHO, 2015). Globally governments, countries, organizations and institutes have all in some way contributed to HIV awareness, measures of prevention, plans of treatment and support. These initiatives have proven to reduce the number of HIV infections globally between the years 2000-2015 (UNAIDS, 2015). The global statistics for HIV infection show that newly contracted HIV infections has decreased by thirty- five percent since the year 2000 (UNAIDS, 2015). The most recent global statistics have found that due to an increased global awareness about HIV prevention related matters as well as increased service delivery of ARVs more than 15 million people globally are on HIV treatment which is a significant increase in comparison to the 13,6 million people in June 2014 (UNAIDS, 2015).

However, while the spread of HIV is on a decline 0.8 percent of adults globally are living with a positive HIV status (UNAIDS, 2014). According to the UNAIDS (2014) this number is still unacceptable and by the year 2030 with further initiatives, outreach programmes, service delivery, access to ARVs and education – this percentage should be decreased to zero.

2.2.2 HIV/AIDS in sub-Saharan Africa

The continent of Africa still remains as the mostly highly infected region globally. It is recorded that 68% of global incidence rates are located in the region of sub-Saharan Africa with 25.8 million Africans infected (UNAIDS, 2015). Adult prevalence rates of 17.9% in the continent of Africa differ significantly with adult prevalence in Swaziland at 26.5%, Lesotho at 23.1%and Botswana at 23% (Indexmundi, 2014).

The overall HIV prevalence in South Africa for the year 2012 showed significant differences across provinces. KwaZulu-Natal had the highest prevalence rate of 16.9%, Mpumalanga had a prevalence rate of 14.1%, Free State had a prevalence rate of 14.0%, North West had a prevalence rate of 13.3%, Gauteng had a prevalence rate of 12.4%, Eastern Cape had a prevalence rate of 11.6%, Limpopo had a prevalence rate of 9.2%, Northern Cape had a prevalence rate of 7.4% and Western Cape had a prevalence rate of 5.0% (Shisana et al., 2014). Across South Africa between the years 2002 to 2014 the percentage of people living with HIV has increased from 9% to 10.2% (Statistics South Africa [StatsSA], 2014).

South Africa is ranked fourth in the world in terms of HIV prevalence (Indexmundi, 2014). In the year 2013 it was approximated that 458,933 South Africans died as a cause of HIV (News24, 2014). Due to the prevalence rate of HIV in South Africa, policies have been developed such as the *National Strategic Plan on HIV, STIs and TB 2012-2016*. This strategy seeks to minimize the rate of HIV infection by 50% by the year 2016 (South African National AIDS Council [SANAC], 2011). The strategy seeks to address psychosocial issues around HIV/AIDS by providing necessary treatment, care and support for 80% of the population that is said to be to be infected (SANAC, 2011).

Shisana et al. (2014) reported the recent prevalence rates of HIV in South Africa, disaggregated by sex and age, as follows:

Table 1

Prevalence rates of HIV in South Africa, disaggregated by sex and age

Age Group	Percentage of HIV Infected Citizens	
	Male	Female
0-14 years	2.3%	2.4 %
15-19 years	0.7%	5.6%
20-24 years	5.1%	17.4%
25-29 years	17.3%	28.4%
30-34 years	25.6%	36.0%
35-39 years	28.8%	31.6%
40-44 years	15.8%	28.0%
45-49 years	13.4%	19.7%
50-54 years	15.5%	14.8%
55-59 years	5.5%	9.7%
60 years and older	4.6%	2.4%

What is significant in the statistics in Table 1 above is that the highest prevalence rate for females is in the age of group of 30-34 years and the highest prevalence rate for males is in the age group of 35-39 years. According to Table 1 the most at risk age groups for HIV prevalence ranges between 25-44 years for females and ranges between 30-39 years for males. From this it can be deduced that females are at risk for an extended period of time in comparison to males. This could be due to HIV being a gendered epidemic particularly in sub-Saharan Africa (Shisana et al., 2014).

In the African context, HIV/AIDS has managed to mobilize itself as a gendered epidemic with women presenting high incidence rates. Women contribute 58% of infections (UNAIDS, 2014). Furthermore, research has found that it is more likely for a female to contract the HI virus from sexual intercourse with a male than it is for a male to contract the HI virus from a sexual intercourse with a female (Magadi, 2011). Numerous aspects contribute to females being at increased risk to the HI virus in the context of sub-Saharan Africa. These are inclusive of gender based violence, biological constituents, economic vulnerability, power dynamics and socialized gender roles (Magadi, 2011). These factors may diminish the power

of women in negotiating for safer sex, therefore placing them at a heightened risk for transmission (Magadi, 2011).

Furthermore, the spread of HIV in sub-Saharan Africa is precipitated by mother-to-child transmission during pregnancy as well as breastfeeding, and is exacerbated by pregnant females and mothers being unable to access ARTs (UNAIDS, 2014). However since 2008 the percentage of pregnant women not receiving ARTs has decreased from 67% to 32%, marking a significant improvement (UNAIDS, 2014). Yet, this still has implications for a large proportion of pregnant women in South Africa whereby 10% of pregnant women who are infected with HIV are not receiving ARVs (UNAIDS, 2015). At present, 1.3 million women in sub-Saharan Africa still require treatment to prevent mother to child transmission (UNAIDS, 2015).

2.2.3 HIV/AIDS and its reach on the children of Africa

Children are a significant proportion of the population in sub-Saharan Africa who are at the fore front of the AIDS pandemic. Advancements in preventing new HIV infections in children have been remarkable. In the year 2013 it was found that 240 000 children were the recipients of the HI virus (UNAIDS, 2014). This is a figure that is 58% less than the figure of 580 000 children in the year 2002. A catalytic account for this reduction is the dissemination of ARVs for pregnant women infected by HIV which has avoided just less than 1 million new infections amongst children since 2009 (UNAIDS, 2014). Geographically, Malawi has had the steepest decline rate of children acquiring the HI virus with a decline rate of 67%. Other countries have also seen a drop in newly acquired infection of children by 50% or more. These countries include Ethiopia, Botswana, Mozambique, Zimbabwe, South Africa, Namibia and Ghana (UNAIDS, 2014).

In the spirit of seeing the end of AIDS there is a drive towards achieving an "AIDS free generation" with the goal of children being born free of AIDS as well as a provision of ARVs to those children who are infected by AIDS (UNICEF, 2013). The Global Plan is a strategy devised to eradicate new infections among children by the year 2015 through mobilizing access to ARVs both for pregnant women as well as infected children. However, while the Global Plan has seen the greatest decline of HIV infections for children since implementation there still were 630 children recorded as newly infected per day in some sub-Saharan countries in the year 2012 (UNICEF, 2013).

In spite of advances in HIV prevention and treatment there still remains social implications and devastations for children in sub-Saharan Africa with there being more than 14 million children orphaned due to HIV (UNAIDS, 2014). 90 % of children orphaned due to HIV reside in sub-Saharan Africa (UNAIDS, 2014). This statistic indicates that children in Africa are the most greatly affected group of children in comparison to children elsewhere in the world. In South Africa in the year 2014 it was estimated that 3.5 million children were orphaned due to AIDS with 2.13 million children having a deceased father, 611 000 children having a deceased mother and 812 000 having both parents deceased (Africa Check, 2014).

2.3 OVC Development in Africa

In the context of Africa amidst its devastations of poverty, the epidemic of HIV and AIDS, drought and political unrest most children in Africa are plummeted into a cyclical nature of vulnerability and risk (Loots, Ebersohn, Ferreira &Eloff, 2012). The epidemic of HIV and AIDS has had ripple effects on the lives of African children, exposing them to a multitude of risk factors inclusive of orphanage at crucial years of development, limitations in accessing education, exposure to disease as well as lack of nutrition are yet to name a few of the adversities and risks faced by African children (Ebersohn & Ferreira, 2011). However, it is in the face of risk that the efficacy of resilience is rooted and becomes a mediator in overcoming risk factors (Theron &Theron, 2010).

When contextualizing HIV and AIDS as an epidemic in South Africa, it can be said that AIDS has had distressing consequences of infringing on systems of support that family and community would usually offer to a child, therefore leaving most children orphaned and vulnerable (Loots et al., 2012). It was approximated that in 2007 there were 700 000 more orphan children in Africa in comparison to the amount of orphan children in Africa in the year 2002 (Loots et al., 2012).

2.3.1 Psychosocial issues related to OVC

OVC require psychosocial support due to their experiences of extreme distress, trauma, anxiety and depression. Psychosocial support seeks to assist OVC in coping with emotional trauma and distress (Mwoma & Pillay, 2015; Martin, 2015). Psychological stress influences OVC negatively and has an unconstructive impact on their mental functioning and emotional

wellbeing (Thwala, 2013). Psychosocial support is thus equally essential to material support so that OVC can develop and function normally. Furthermore, psychosocial support "will enable OVC to strengthen their inner resources in order to cope with and overcome the many challenges they face" (Thwala, 2013, p. 106).

Psychosocial issues around HIV and AIDS place OVC in situations of multiple vulnerabilities that negatively impact on their lives (Killian, 2004; Martin, 2015). Being orphaned is merely one of the vulnerabilities faced by children. Killian (2004) referred to the process of psychosocial stressors as the "HIV/AIDS road" (Killian, 2004, p. 41). Some of these stressors include children taking care of a family or community member that is dying from the virus, children who are faced with the death of a loved one, children having to adopt adult roles after the death of a parent including decision making about their future, as well as children having to face their own mortality due to their own HIV status (Mutumba et al., 2015; Killian, 2004).

A study conducted by Kirkpatrick, South, Rojjanasrirat, Novelli and Williams (2014) zoned in on one imperative aspect of providing psychosocial support for OVC in the context of Zambia. This study implemented grief support intervention programmes for OVC, caregivers as well as teachers. The rationale for implementing support groups is "because of their documented effectiveness in promoting positive change in diverse settings" (Kirkpatrick et al., 2014, p.32). The findings from this study showed that OVC self reportedly admitted to greater levels of personal happiness and voiced that other OVC could benefit from such support groups. The key tenets within these groups was a focus on culturally responsive matters, a support group that was facilitated by trained child support specialists and a support group with facilitators that spoke the native language (Kirkpatrick et al., 2014). Similarly, in the Western Cape a support programme was implemented by the DSD for OVC. The programme took place over a 10-week period and consisted of 10 OVC who attended the support group for one to two hours per week. The facilitators of the programme were trained by an organisation called Khululeka (Phillips, 2015). Training involved how to facilitate loss and grief support groups. The findings from this programme revealed that OVC experienced improvement in their self-esteem and confidence and expressed better emotional coping (Phillips, 2015). Furthermore OVC reported that the programme aided them in dealing with their losses as well as how to manage their grief in a healthy manner (Phillips, 2015).

Furthermore, in the context of South Africa there is a high demand for psychosocial service provision for OVC. In recognition of this, PEPFAR along with the DSD, has sustained the Thogomelo Project (Nyberg et al., 2012). This project led to the development of three skills development programmes, namely; "child protection, psychosocial support, and supportive supervision for caregivers and a child protection guidebook and CD-ROM, referral guides, and a caregiver tool kit" (Nyberg et al., 2012, p. 130). These tools are directed toward skills training of caregivers in South Africa and are closely linked with the DSDs child protection priorities which are inclusive of awareness as well as prevention of abuse by the process of identifying and intervening affected families and efficiently managing instances of abuse. This project is important in demonstrating one way forward in combating the deficit of psychosocial provision for OVC in South Africa (Nyberg et al., 2012).

Additionally, Mwoma and Pillay (2015) conducted a study in Soweto and found an alternate solution in combating the deficit of psychsocial service provision for OVC in South Africa. They found that there is a great need to implement psychosocial support for OVC in public primary schools (Mwoma & Pillay, 2015). The rationale for implementing psychosocial support programmes within the schooling context is that the school and educators play a pivotal role in the development of OVC, particularly due to their loss of parental support. Therefore, the educational system is an ideal context to provide psychosocial support for OVC. However, findings suggested that in the context of these schools provision of psychosocial support was limited due to a lack of professionals to provide these services. Educators at these schools suggested that involvement of psychologists, counsellors and social workers to assist in psychosocial support provision was much needed and that with the absence of counselling structures OVC were most likely to grapple with their situations of adversity (Mwoma & Pillay, 2015). This again reiterates the need for a collaboration of professionals to provide a holistic approach towards the enhancement of the lives of OVC (Theron & Theron, 2010).

2.3.2. Placement of OVC after the death of a parent

It is perceived that care for OVC is best suited with members of family after the death of a parent or loved one (Carter, 2013; Mutenheri, 2013). While this holds truth and households of family members is the most common placement for a child after the death of a parent in South Africa, it comes with its limitations due to issues of psychosocial support and financial support (Carter, 2013). Research has found that while OVC are being placed into the care of family it is common place that the elderly are the ones taking on the position of guardian (Carter, 2013; Freeman & Nkomo, 2007; Mutenheri, 2013). At the same time elderly guardians are caring for numerous children, which subsequently is a cause of considerable exertion and stress for them (Mutenheri, 2013). Freeman and Nkomo (2007) found that in the province of Mpumalanga in South Africa, approximately 41.6% of guardians were over the age of 60 years and were guardians to OVC between the ages of 6 to 18 years. They also found that 20.1% of guardians were in the position of caring for OVC who were younger than 6 years of age. Freeman and Nkomo (2007) also reported that over 66.7% of the elderly guardians voiced that they were undergoing "moderate, severe or extreme difficulties" (Freeman & Nkomo, 2007, p. 504) in the process of caring for OVC.

A study conducted by Freeman and Nkomo (2007) found that orphaned children who were HIV seropositive were less welcome into the home of a family or community member after the death of a parent due to issues around stigma as well as having to deal with the terminal illness of the child (Freeman & Nkomo, 2007; Haley & Bradbury, 2015). This has further implications and complications for the psychosocial stressors of the orphaned child leaving them more vulnerable in the face of their adversities (Freeman & Nkomo, 2007).

As a result there are many situations that arise due to OVC being excluded from the acceptance into extended family (Mutenheri, 2013). Daniel and Mathias (2012) brought forth the reality of child headed households and the implications of children taking on multiple roles, including the role of adult.

Daniel and Mathias (2012) researched child headed households in Tanzania. Their findings suggested that more often than not an elder sibling took on the role of caring for a younger sibling(s). Adopting the role of caring for younger siblings presented a role conflict for the elder sibling that they then had to manage (Nziyane & Alpaslan, 2012). Daniel and Mathias (2012) argued that while the OVC in their sample where in positions of extreme vulnerability

due to lack of aid they displayed a sense of resilience that was astounding. Daniel and Mathias (2012) described the resilience of OVC in child headed households as displaying agency in relation to the adverse situations that these OVC are entrenched in. Their resilience was seen in their motivation to seek a better life. They achieved this by utilizing their manual labour, local knowledge and skills in the production of crop which they then sold allowing them to make a profit (Daniel & Mathias, 2012). They also prioritized education while still managing their role of guardian by feeding, caring and clothing their siblings (Daniel & Mathias, 2012). They were able to manage this by collaborating with teachers and asking for time off. Daniel and Mathias (2012) interpreted their achievements as being attainable because they used "their agency, assets and limited social networks to reach these achievements" (p. 199). Interestingly, Maphalala and Ganga (2014) were involved in a study that assessed the developmental experiences of OVC in child-headed households. Their findings show that while there is deviation in developmental experiences between OVC some OVC expressed that being orphaned allowed them a greater connection to the world in relation to meeting "well-wishers who help in paying the school fees and supply support materials that enhance the children's learning" (Maphalala & Ganga, 2014, p. 317). This indicates that in spite of their situations they were able to identify systems of support within their chronosytems and interpreted this as a positive outcome of being orphaned. This demonstrates internal resilience within some of the OVC (Maphalala & Ganga, 2014).

2.3.3. Cultural applications of resiliency

Resilience is generally understood as displaying adaptive behaviour in circumstances of adversity (Theron &Theron, 2010; Ungar, 2008). Theron and Theron (2010) locate resilience in the context of Africa and critique the limitations of resilience promotion in many contexts and for many children. They argue that resilience has to be culturally and contextually rooted which has been negated in previous years of research and is only beginning to unfold as a tenet of resilience building in recent years (Theron &Theron, 2010; Ungar 2008).

A study conducted in South Africa sought to qualitatively explore indigenous understandings of resilient Black South African Basotho youth (Theron, Theron & Malindi, 2012). A finding of the study suggested Black South African Basotho youth's resilience was not influenced by a single significant person in their lives, as is a common feature of resilience in many western settings (Theron et al., 2012). Rather resilience was aligned to their cultural African beliefs of Ubuntu whereby "supportive systems" through the community, spirituality, interdependence

and interconnectedness with nature fuelled their resilience (Theron et al., 2012, p. 15). This is an indication that resilience building for OVC in the context of South Africa is required to be culturally rooted as is also seen as a prerequisite for resilience building by Killian (2004) who highlights the "importance of cultural connections and a sense of history" in resilience building (Killian, 2004, p.48).

Furthermore, the use of folktale in a primary school class setting has been found to help educators to identify areas of need and support for OVC. In a study by Mayaba and Wood (2015) OVC were asked to draw and act out a play as part of an intervention strategy to help identify areas of need and support for OVC. The use of cultural stories in an education setting provided an interactive space for educators to assist learners in areas of their lives that required support aiding in the development of resilience through the incorporation of a culturally situated methods (Mayaba & Wood, 2015).

Previous studies have stressed the significance of child resilience in the context of Africa (Mueller, Alie, Jonas, Brown & Sherr, 2011). Findings suggest that resilient children demonstrate factors such as high self-esteem, self-efficacy and the ability to cope in traumatic situations (Mueller, Alie, Jonas, Brown & Sherr, 2011). On the other hand children with low self-esteem and poor self-efficacy are less likely to be resilient and are therefore more prone to mental illnesses (Ungar, 2011).

A study by Mueller et al. (2011) sought to investigate the effect of a "community-based psychosocial intervention for children affected by HIV and AIDS" (Mueller, Alie, Jonas, Brown & Sherr, 2011, p. 58).The intervention termed MAD (Make a difference) was directed toward boosting children's self-esteem and self-efficacy. This intervention uses art and education as a tool to establish "self-worth (self-esteem), self-concept, empowerment and emotional control (self-efficacy)" (Mueller, Alie, Jonas, Brown & Sherr, 2011, p. 58). Central to these activities are the children having to produce text including 'hero' themed books central to their own lives. Furthermore, there were HIV education activities focused on self advocacy and empowerment (Mueller, Alie, Jonas, Brown & Sherr, 2011). Conclusions from this study through analysis of the material produced by children suggest that social and peer support improves self-efficacy, stigma related to HIV places children at further risk and that violence either through being a victim or witnessing violent acts has a significant impact on levels of self-efficacy (Mueller, Alie, Jonas, Brown & Sherr, 2011).

2.3.4. Caregivers perceptions of resilient OVC

Kerr (2011) conducted a study investigating the perceptions of community caregivers, who are based in South African children's homes, on the resilience displayed by pre-school children. The caregivers identified resilience within children as being located internally as well as externally to the child (Kerr, 2011; Johnston, 2015). They identified that their own role, as caregivers, significantly impacted on the child's ability to be resilient as well as the structures of the institution of care itself. They voiced concerns around the stereotype that children in care centres are less likely to develop normal functionality. However, the caregivers perceived care centres as mediators for children to develop better resilience. They also recognized the importance of integrating internal and external factors so that a sustainable environment for resilience development can be achieved for the child (Kerr, 2011; Johnston, 2015).

There is very little literature documented on the resilience of OVC as perceived by CCG. The expansive knowledge that CCG possess on OVC is an area of research that is largely untapped (Karim, 2010). However, according to Nyberg et al. (2012) communities and community members can supply much needed support to OVC in need, this includes CCG. "Community volunteers remain at the heart of the response, often intervening in ways that formal systems cannot to ensure a child is cared for in a nurturing environment, over the years, many thousands of volunteers – men, women, and youth – have worked for the protection and care of children" (Nyberg et al., 2012, p. 130). Similarly, this is the aim of the DSD in employing CCG for the care of OVC as CCG are embedded within the community and possess local knowledge and understanding of the community and its functionality (Karim, 2010).

2.3.5. Collaborative initiatives towards resilience building of OVC

Awareness for the safety and well-being of children whom are placed at great risk due to the epidemic of HIV and AIDS has resulted in the promotion of resilience for children, specifically in Africa, needing to be more holistically targeted and facilitated, not merely by one field of professionals but through a collaboration of professionals whose concerns lay with the development of children (Theron &Theron, 2010, Ungar, 2008). These would include teachers, psychologists, social workers and institutions of government (Theron &Theron, 2010, Ungar, 2008). As a result the DSD in South Africa has recognized the

devastating effects of HIV and AIDS on OVC and has therefore developed a policy framework for OVC which calls upon government, Non-Governmental Organization (NGOs), organizations as well as civil society to become integrated in the well-being of OVC (Department of Social Development[DSD], 2005).

2.3.6. The context of institutional care for the vulnerable child

A study conducted by Rukundo (2012) researched the resiliency of orphans placed at orphanages in the context of Uganda. Her research elicits the notion that due to failing and collapsing networks of communal acceptance for the orphaned child into the family, orphanages are becoming more valuable and needed as a sustainable environment for OVC (Johnston, 2015). Rukundo (2012) reports on a study that was conducted in Uganda and found that OVC placed at orphanages displayed a general sense of happiness and were satisfied with their situation. However, in the context of Botswana and Malawi, OVC voiced experiencing some restrains. However, 90% of OVC reported that their main concerns were receiving basic needs such as food, shelter and a sense of belonging which was received at the orphanage (Rukundo, 2012).

In spite of the up and coming notion of orphanages being a suitable placement for OVC some researchers still have rooted beliefs that community based care is the most appropriate for the development of OVC (Rukundo, 2012; Ngwenya, 2015)). However, a member of governance in Africa, Hilda Tadria, who is part of the Commission on HIV/AIDS and Governance in Africa voiced her standing by saying, "…both community-based and institutional care can work. What matters is that the children are tracked and monitored properly, to ensure that their rights are respected and their needs are met" (Rukundo, 2012, p. 15).

2.3.7. Social networks as a progressive factor towards resilient OVC

In mind mapping ideas of how to promote resiliency of OVC it is often undermined how important friendship is as a mediator towards positive resiliency outcomes (Agaje, 2008). Skovdal and Ogutu (2012) identified the gap in research of the role friendship plays for OVC in the context of Africa. A study conducted in Lesotho and Malawi suggested that OVC who left their communities after the death of a parent to move in with extended family members

voiced concerns about leaving their friends behind and feeling emotionally cut off because of an additional loss to their parent's death i.e. the loss of friendship (Skovdal & Ogutu, 2012).

Skovdal and Ogutu (2012) conducted a study to determine how OVC cope with adversity through "peer social capital" (Skovdal & Ogutu, 2012, p. 241). Their findings suggest that OVC intentionally formulated friendships with a clear goal of receiving and giving support through situations of difficulty. This finding is indicative of OVC possessing qualities of being able to seek support, which is a key tenet of resilience, as a result the establishment of friendship served as a protective factor against risk for the OVC in this study (Skovdal & Ogutu, 2012). Similarly Agaje (2008) reports that OVC who engage in "warm friendships" are more likely to demonstrate characteristics of resilience (p. 12). OVC with strong peer influences were shown to experiences less emotional symptoms and difficulties in the functioning of their daily lives (Agaje, 2008).

2.3.8. Psychological well-being of OVC

While the pandemic of HIV/AIDS is widely researched, there are still some areas that are under studied. One of these areas is related to the psychological well-being of OVC. OVC, especially in the context of Africa, suffer at the hands of multiple adversities and stressors such as bearing witness to the death of either one parent or both. They may also experience the loss of caregivers and siblings, experiencing isolation due to social issues of stigmatization (Martin, 2015; Ngonyama, 2013). These issues compound OVC's psychological frame of mind placing them under great duress (Martin, 2015). Cluver and Gardner (2007) wrote that OVC are more likely to internalize their problems than externalize them. It is common that research findings suggest that OVC who do not receive support are more likely to develop behaviours impeding on delinquency and juvenile tendencies. However, contrary to this Cluver and Gardner (2007) argue that OVC are more inclined to develop mental disorders such as depression, anxiety and PTSD than involve themselves in unruly behaviours (Cluver & Gardner, 2007). They argue that in order for interventions to be well adjusted in overcoming psychological issues of OVC it is imperative to understand the factors that contribute to their state of mind (Cluver & Gardner, 2007; Ngonyama, 2013).

2.4. Theoretical Framework: The Ecological Perspective and its construction toward a resilient framework for OVC

This section presents an argument of Bronfennbrenner's ecological systems theory and its application towards constructing a framework of OVC resilience development in the context of South Africa. Bronfenbrenner's ecological theory is central to the effects of the environment on an individual's behaviour (Thembela, 2007; Bronfenbrenner, 1979). Bronfenbrenner understands human behaviour as being located in relation to an ecological system. Therefore this framework argues that the development of a person occurs through the interaction between numerous systems as well as the effects of these systems on a person's growth and behaviour (Thembela, 2007; Bronfenbrenner, 1979). The worth of this theory is central to Bronfenbrenner's acknowledgment of the multi-dimensional interaction of influences as well as the multiple spheres of influence on children as well as humanity (Karim, 2010; Bronfenbrenner, 1979). This theory consists of five systemic layers, namely the; microsystem, mesosytem, exosystem, macrosystem and chronosystem (Karim, 2010; Bronfenbrenner, 1979).

The chronosystem is the layer that includes the element of time ranging from historical to developmental contexts (Karim, 2010). The macrosytem consists of customs, laws, policies and cultural values which affect an individual's well-being and development. The exosystem consists of the wider social systems that impact an individual's development in spite of the individual not having direct involvement in it (Karim, 2010; Bronfenbrenner, 1979). The mesosytem is indicative of the interactions between various structures within the microsystem. The microsystem includes an individual's immediate environment including relationships, structures and interactions within the individual's environment. This layer includes family, educational settings and friends (Karim, 2010; Bronfenbrenner, 1979).

2.4.1. The school as a tenet of resilience development

The application of this framework is central to the role education (the school) serves as a facilitator of resilience in the context of children whose other environments such as home are not as sustainable for building resilience due to the complex effects of HIV/AIDS which breaks down usual systems of support such as the family. The schooling environment forming part of Bronfenbrenner's microsystem can play a key role for the development of the OVC that are in South Africa currently (Ebherson & Ferreira, 2011).

Education would be deemed as a process-orientated approach to resilience promotion taking on an ecological perspective (Loots et al., 2012; Ebherson & Ferreira, 2011). This perspective views factors that promote resilience as being located within the individual, the family as well as the larger community consisting of the microsystems, mesosystems, exosytems and macrosystems (Loots et al., 2012). Therefore, the ecological perspective would argue that resilience is not exclusively dependent on the individual and their family but is also promoted through external structures such as schools (Loots et al., 2012; Theron & Theron, 2010). In the context of Africa, schools can become optimized as the best catalyst in resilience development for OVC due to the consequences of HIV/AIDS which has and continues to deplete other systems of support such as the communities and families. As a result the role of schools' utility in resilience promotion for OVC has become central to "resilience discourses" (Loots et al., 2012, p. 598).

Consequently much research has emphasized the importance of including "resilience-building efforts" (Loots et al., 2012, p. 598) within the schooling environments in order to endorse resilience for OVC (Loots et al., 2012). Specific contributors to resilience within the school would include "supportive peers, positive teacher influences, academic success as well as structured physical and social environments" (Loots and Ferreira, 2012, p. 60). However, while endorsing resilience in schools according to the ordered manner as outlined above provides an ideal theoretical foundation towards resilience the practicality of this approach is far from achievable in the context of South Africa amidst the multidimensional hardships faced by schools themselves, particularly schools in rural South Africa (Mampane & Bouwer, 2011).

In the context of South African schools, violence, crime and situations of complexity are central to every day school experiences for children including OVC (Mampane & Bouwer, 2011). Therefore, the mass of learners are faced with the possibility of direct risk within the educational setting and "many contend with the absence of adult supervision and/or an unsafe learning environment" (Mampane & Bouwer, 2011, p. 114). Consequently, learners need a significant amount of safety and resilience in order to overcome the risks and adversities faced by them on a daily basis within their developmental contexts (Mampane & Bouwer, 2011; Wood, Ntaote & Theron, 2011). Mampane and Bouwer (2011) highlight that in order for OVC to be resilient there simply has to be at least one other key individual concerned with the promotion of their resilience that is part of their immediate environment such as a

teacher, caregiver or parent. In the case of OVC it is seen how essential the role of the teacher and caregiver is and how their role becomes central to the child's development of resiliency (Wood, Ntaote & Theron, 2011).

A study conducted by Mampane and Bouwer (2011) at a township school in South Africa concluded that in the context of township schools, resilient children who are perceived as being vulnerable showed great dependency and reliance on the school because they believed that it is school which would contribute to their future life choices and goal attainments (Mampane & Bouwer, 2011). This indicated that school becomes an imperative mediator towards building resilience in vulnerable children and it is seen that the school becomes a significant protective resource for the vulnerable child against risk and adversities that they may face (Mampane & Bouwer, 2011). An added advantage for African contexts is that the school can provide a sense of belonging for OVC where in many cases OVC are excluded from a sense of belonging because of breakdowns in family due to HIV/AIDS, poverty and consequently death (Killian, 2004). It is this sense of belonging that is found to be a central tenet of resilient OVC (Killian, 2004).

2.4.2. Culture as a framework for resilience development.

The concern of how to achieve resilience in a rural South African school can be given a framework through the argument Killian (2004) puts forth. Killian (2004) recognizes that resilience needs to be incorporated culturally at a macrolevel. Therefore to build resilience in schools, the concept of Ubuntu needs to become an integral component of school values and ethos. This reorientation of school values towards "respect, participation and care" within all systems of the community including the school will become a catalyst in which "change, transformation and development" may become mobile and active (Killian, 2004, p. 56).

OVC in Africa are faced with a whirlwind of exposure to risks and adversities. Furthermore they very rarely have systems of support to facilitate resilience within them. Therefore it is imperative that multiple key players collaborate in their strategies to promote resilience for OVC in Africa (Theron &Theron, 2010). An effective way of reaching multiple children simultaneously is through targeting mesosystems such as the school to increase its efficacies in serving as a protective factor against risks for the vulnerable child as well as becoming a mediator in promoting resilience for OVC (Ebersohn& Ferreira, 2011). It is with the hope of

rooting cultural values such as Ubuntu in schools that an integral part of belonging will become a significant facilitator of resilience for the OVC of Africa (Killian, 2004).

2.4.3. Where is it best suited for OVC to be placed? Questioning the role of institutional care and community based care

OVC undoubtedly face many psychosocial stressors. OVC are commonly placed into the care of caregivers who form part of OVCs mesosystems (Ngwenya, 2015). However, the efficacy of caregivers for OVC needs to be evaluated due to the delicate needs of OVC that most of the time is left unfulfilled. This is due to limitations of government and organizations whose training and policies in relation to caregivers of OVC do not postulate sufficient training to the psychosocial needs of OVC (Thembela, 2007).

Governmental initiatives have recently taken on an ecological perspective by introducing at an exosystemic level the need for OVC to be incorporated into a 'normal family structure' so that their development can be optimized (Guvava, 2011). As a result in recent years there has been a shift from institutional care for OVC to community-based care (Ngwenya, 2015). It is with the hope of community-based care that OVC will not be isolated from cultural roots and communities therefore holding onto a sense of familiarity and stability which consequently positively affects their development (Guvava, 2011; Ngwenya, 2015).

In other words relating community based care to Bronfenbrenner's ecological systems theory it is clearly seen that "care interventions" (Guvava, 2011, p. 32) are ineffective if they are applied in seclusion of the child's environment. The theory centralizes the immediate environment of a child which is inclusive of family, school, communities and wider society such as societal norms, morals and values which directly affect a child's development. It is these systems that add to a child's development and involves reciprocal interactions which occur between the child and their many systems (Guvava, 2011).

Problems with institutional care can be seen in that it isolates a child from familiarity such as the community and family therefore depriving a child of family care (Ngwenya, 2015). The benefit with community-based care is that it recognizes, "the co-existence between a child and his/her community or family" (Guvava, 2011, p. 34). Guvava (2011) highlights that HIV/AIDS is an epidemic which cannot be understood, addressed or overcome if it treated as

though it is separate from a child's "family, social, cultural, economic and physical environments" (Guvava, 2011, p.34).

2.5. Policy and Legislative Framework Geared Towards OVC

South Africa has identified the hazardous effects of children orphaned due to the epidemic of HIV and AIDS. Consequently, South African law has incorporated policies around the care, well-being, protection, safety, needs and rights of OVC. In 2002 a declaration was made by South Africa, who is a signatory to the Declaration of Commitment of the United Nations General Assembly Special Session on Children (UNICEF, 2003). One of the declarations was geared towards developing and implementing national policies as well as strategies in order to reinforce parliamentary, family units and communities capabilities towards establishing supportive environments for OVC who are HIV positive (UNICEF, 2003).

This support would include necessary counselling as well as psychosocial support. Prioritizing admittance to school, ensuring OVC are provided with basic needs such as shelter, nutrition, access to health care facilities and social services (The United Nations special session on children, 2003). An imperative contribution of the declaration was to ensure that OVC would be safeguarded against every type of abuse including acts of violence, exploitation, prejudice and child trafficking (DSD, 2005).

2.5.1. Legislation on OVC

South Africa's constitution (section 28) stipulates legislation on the rights of children (DSD, 2005). These rights are formulated based on the principles of children having the right to survival and being safeguarded against all forms of abuse, children having the right to be heard, children's welfare being key in their development as well as the right to their autonomy (DSD, 2005).

While these rights form part of legislation they have become somewhat wayward increasing the lack of their mobility to be implemented. The blame for this can be attributed to the effects of HIV/AIDS which is known to further aggravate the adversities that many children in South Africa face as a daily reality. As a result in recent years the epidemic of HIV and AIDS has caused increased poverty, increased rates of orphanage, increased lack of accessing resources, as well as other contributions that adversely affect children such as increased incidents of rape, abuse, neglect and stigmatization (Maseko, 2014). Therefore many

children's rights' are not and were not being fulfilled. However, due to the recognition of the impact of AIDS, legislation, policies and strategies were adapted so that concern lay to the security and empowerment as well as guardianship of those children whose rights are infringed upon as a cause of HIV/AIDS (Maseko, 2014).

As stated above the constitution is guided by policies and frameworks that guide the rights to OVC protection. Some of these legislations are:

Children's Amendment Act (No 41 of 2007)
This Act is geared towards the safeguarding and protection of children. The Act permits Children's Courts as well as the positioning of Commissioners of Child Welfare and the procedures and measures towards inspecting aspects of abuse and neglect (RSA, 2007). The Act proposes that social work assessments and testimonies are a prerequisite and that the court is entitled to place children that the court deems necessary into alternate forms of care such as foster homes and or adoption. Foster care is the mode of preference for children who are orphaned (Republic of South Africa [RSA], 2007). Foster care is defined as provisional residency for children. This necessitates social work examination, supervision and feedback every two years on a child's situation (RSA, 2007). The Child Care Act supports that children who are abandoned, orphaned or are not receiving support may require the Act to be mobilized therefore placing the child in alternate care (RSA, 2007). In 2003 The Children's Bill centralized the role of the family as well as legal necessities for children suffering either primarily or secondary from HIV/AIDS making available their placement in alternate forms of care (RSA, 2007).

The Employment Equity Act (No 55 of 1998)
This Act vetoes prejudice on the basis of HIV status. This Act is plausible for children who fall between the ages of 15-18 years. It includes caregivers and heads of households (DSD, 2005).

The Medical Schemes Act of No 131 of 1998
This act serves to care for children as well as their caregivers in relation to unjust prejudice due to their HIV/AIDS status (DSD, 2005).

The National Health Act

This act identifies children as categories that are in need of "special attention" (DSD, 2005, p. 29) and therefore makes provision for their free basic health care for those children who fall under the age of six and do not belong to any medical aid. This includes children who are affected by HIV/AIDS (DSD, 2005).

The South African Schools Act (No. 84 of 1996)

The South African Schools Act (No. 84 of 1996) stipulates that children between the ages of 7 and 15 years are obligated to attending school (DSD, 2005). It also stipulates that due to dire conditions certain learners may be excused from paying school fees. Such as those children who are adversely affected by HIV and AIDS and therefore do not receive much support (DSD, 2005).

The pandemic of HIV and AIDS is resulting in an increasing number of orphans. As a result children are left with no caregivers placing them at risk of poverty and diminished care. Many a time children leave school to care for the sick. They suffer from emotional fatigue and take on adult responsibilities at an early age. These circumstances aggravate their vulnerabilities as they are at heightened risk for abuse and require protection. In recognition of this fast paced social pandemic the government implemented legislative acts that serve as a blueprint to the safety, empowerment and care of children who are at great risk for the infringement of their rights due to HIV and AIDS. These laws were implemented to address the rights of children and to enforce child care protection such as making education compulsory so as to limit their vulnerabilities.

2.5.2. Policies and strategies for OVC protection support and care

The *National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS* 2000 (NIP) is a policy that forefronts access to health care facilities and health related information in attribution to prevention, care and support for children affected by HIV/AIDS (DSD, 2003). This plan combined various departments such as the Department of Health (DOH), the Department of Education (DOE) and the Department of Social Development (DSD) in its objective of prevention, care and support.

The DoH contributed to the national *Policy on Testing for HIV* which was implemented in 2010. This policy laid out the conditions for when HIV testing is allowed to take place. It

stipulated the regulations surrounding pretesting as well as post testing methods of counselling (DSD, 2005). It contained the definition as well as the importance of informed consent during the process of HIV testing. While the policy was not explicit in its provisions for consent given by children it did identify 'proxy consent' as a method of informed consent given by a legal guardian of a child. It is important to note that the Child Care Act permits children whom are 14 years of age or older to provide consent for their own health care which would include HIV testing (DSD, 2005).

The DSD's strategic plan for the year 2012-2015 sought to provide social services which shield the disadvantaged and vulnerable as categorized by the South African Constitution and legislation. This included the creation of enabling environments for sustained progress as well as the delivery of integrated, sustainable and quality services in collaboration with all stakeholders devoted to developing a caring society (DSD, 2012). This plan recognized that in spite of the DSD being the driving force behind the provision of social services for groups of people such as those adversely affected by HIV/AIDS, it could not do so in isolation but required the collaboration from other departments.

Furthermore, the DSD has implemented an initiative for the care of youth and children whom are vulnerable (DSD, 2012). This initiative is known as "Isibindi" and is effective through the service provision of child and youth care workers who provide vulnerable children with support at various levels including their homes and communities. This support is provided through safe parks and life skills programmes (DSD, 2012). It is estimated that 1.3 million children would be beneficiaries of this initiative once it is implemented (DSD, 2012).

The National Strategic Plan for HIV, STIs and TB (2012-2016) is a framework that directs the contribution of all collaborators involved in matters related to HIV, sexually transmitted infections (STIs) and TB in South Africa. It outlines goals and strategies for South Africa's response to the named diseases within the allocated timeframe (SANAC, 2012). *The National Strategic Plan for HIV, STIs and TB (2012-2016)* has five goals. These goals include reducing the number of new HIV infections by half, making certain that at least 80% of HIV infected individuals receive ARVs, reducing the number of new TB infections and death by half, making certain that the rights of individuals with AIDS are protected and ensuring that stigma related to HIV and AIDS is reduced (SANAC, 2012).

It can thus be said that legislation, policies and strategies have been derived in collaboration with the needs of the children in South Africa who have become vulnerable due to the epidemic of HIV and AIDS. As a result many of these legislations are footed in the protection and care of those children whom are the most vulnerable. Policies are rooted in prioritizing access for OVC to vital services such as education and health care facilities. Strategies are devised towards awareness and advocacy for the establishment of encouraging dependable environments and settings for OVC. A significant catalyst of mobilizing HIV awareness, prevention and treatment was the strategy of the DSD to incorporate multidisciplinary sectors to maximize their role in support of OVC.

2.5.3. Questioning the future of OVC policy implementation

The question is then asked what can be done to further improve the lives of OVC made vulnerable by HIV and AIDS. In response to this it can be argued that it is the constitutional prerogative to protect and manage the well-being of OVC by establishment of interventions that are revised, monitored and evaluated. This is a process that requires consistency by adapting national policies, legislations, strategies and frameworks that better the position of government to amalgamate these in order to safeguard OVC.

While AIDS is an epidemic that is shared by more than 1 in 4 South Africans it is also an epidemic that is attached to great stigmatization and prejudice (DSD, 2005). In developing policies it is pivotal that social intervention gears itself around changing the perceptions and viewpoints generally associated with HIV and AIDS. The DSD policy framework (DSD, 2005) highlights that interventions need to mobilize members of communities to talk about HIV and AIDS with less restrictions and reservations. Interventions require encouragement of members of communities towards collaborative care and response for OVC. Interventions require a mode of unambiguous protocols and routes of interaction among stakeholders and service providers (DSD, 2005).

According to the *Global Sector Health Strategy on HIV/AIDS 2011-2015* (WHO, 2011) it was proposed that the institute of health needed to utilize its exclusive function in making certain that policies, laws and regulations in all institutes and sectors were maximizing their "national support" (WHO, 2011, p. 29) towards HIV action. With focused attention towards achieving gender equality and safeguarding and endorsing the human rights of vulnerable groups including OVC.

The WHO (2011) also proposed that they will be a key determinant in eliciting more awareness to health related issues and requirements of vulnerable populations such as OVC. They proposed to help classify the function of other sectors and institutes to make certain that these requirements are fulfilled. WHO propositions that they would support nations to outline and reassess existing health policies, legislations and strategies so as to guarantee that health issues around AIDS are sufficiently understood and addressed by the year 2015 (WHO, 2011).

While organizations such as the WHO propose to reassess current policies making them more fit and appropriate for health issues surrounding HIV/AIDS, Zhou (2012) argues that policies geared towards OVC are strongly deficient in their ability to provide psychosocial support for OVC. Zhou (2012) analyses two global frameworks on OVC policy: the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* which was a framework issued in 2004 by UNICEF and was used as an international agreement towards "OVC programming" (p. 12). She also analyses the *Guidelines for the Alternate Care of Children* which is a document developed by the United Nations General Assembly as a manual for informing national policies on OVC safeguarding and social welfare in relation to OVC placement.

 Zhou (2012) argues that in spite of the above mentioned frameworks adequately prioritizing concern around health related issues and placement of OVC they very strongly leave an aspect of great importance, psychosocial support of OVC, unattended to. Zhou (2012) states that "the lack of international guidelines for psychosocial programming has subsequently led to inconsistent country-level policies" (p. 8) and therefore future policies are thought of as being required with great urgency to address the issues surrounding psychosocial support of OVC.

There is minimal research conducted on CCG's views about policies implemented for OVC. However, Karim (2010) conducted a study on CCG who provide psychosocial care for children affected by HIV. The study found that CCG were fervent to provide a holistic approach of care for the OVC, their families and the community in which they offer their services. However, similarly to Zhou (2012) findings from this study suggested that CCG were concerned about the provision of services especially psychosocial services to vulnerable

populations, as these CCG were providing services in just one area. Furthermore, CCG were concerned about how "funding agendas derive the nature of the work and the manner of monitoring and evaluation" (Karim, 2010, p. 1).

Karim (2010) highlights that CCG are confronted with numerous difficulties when working with children who are in situations of adversity. Some of these difficulties necessitate personal characteristics as well as training relevant to the work of CCG. Karim (2010) states that the triumph of psychosocial interventions with OVC is reliant on the capability, enthusiasm and devotion of the CCG as CCG are the middle men between non-governmental organizations and recipients of the services. In spite of monetary funding and the strategizing of initiatives to provide psychosocial support for OVC the implementation of these initiatives by CCG is imperative for the attainment of successful outcomes (Karim, 2010). However, many CCG are not receiving the care and support that is needed for them to provide services to the OVC, families and communities that are severely affected by HIV and AIDS (Karim, 2010).

In conclusion it can be said that psychosocial support provision for OVC is imperative for their mental well-being and recovery. However, training, care and support of those such as CCG who are providing psychosocial support to OVC needs to be prioritized as an urgent need in the delivery of psychosocial support for OVC. This amongst other factors listed above needs to be recognized by government and policy makers and incorporated into legislations, policies and strategies in the future in order to holistically combat HIV and AIDS.

2.6. Conclusion

HIV and AIDS has made many children vulnerable and placed them at great risk of abuse, neglect, violence, poverty and lack of education. The empirical literature above has highlighted the multi-faceted nature of HIV combining a holistic approach of analyzing and combating HIV. This included the epidemiology of HIV globally as well as in sub-Saharan Africa, locating the effects of HIV through Bronfenbrenner's ecological systems theory, zoning in on OVC development in Africa and lastly critically reviewing policies and legislation geared toward the protection of groups affected by HIV and AIDS. The dearth of literature in relation to enhancing the resiliency of OVC from the CCG's perspective led to the undertaking of the current study.

The following chapter will outline the methodology employed in this study. It will include information about the research design, sample, data collection methods, data analysis and ethical considerations.

CHAPTER 3
METHODOLOGY

3.1 Introduction

An imperative aspect of engaging in any research is the issue of methodology. The methodology requires to be addressed at the outset of any study. In simple terms, methodology is a blueprint of how the researcher intends to carry out the proposed research. This chapter discusses information about the research process including the research design, sampling, data collection tools, ethical considerations, data analysis as well as dependability, credibility and transferability of the findings (Denzin & Lincoln, 2011).

3.2 Research design

In this study, a qualitative research design was used. It was found most appropriate to engage in qualitative research due to the aims of the study which prioritised an understanding and interpretation of participants and their perceptions of OVC resilience rather than attempting to establish universal laws and make wide spread generalisations (Karnieli-Miller, Strier & Pessach, 2009). The basis of using a qualitative design was founded by the contextual need to understand participants' perceptions through their everyday social engagements and interactions with OVC (Karnieli-Miller et al., 2009). Furthermore, this approach is founded on the assumption that understanding takes place most meaningfully through an inductive approach of research which results in a generation of data that is detailed, descriptive and is a result of a first-hand account with the participants (Silverman, 2009). As a result it was deemed most conducive to use a qualitative research design as it would best suit the aims of this study.

Qualitative research, being an approach that encompasses multiple perspectives, provided the researcher with the opportunity of engaging in qualitative techniques and data collection methods that aided in her understanding of OVC resiliency in the context of KZN (Terre Blanche, Durrheim & Painter, 2009).Therefore the research questions were most adequately answered through qualitative research methods.

3.3 Sampling

This study used a purposive sampling strategy in selecting participants. Purposive sampling is a common and convenient sampling strategy where participants are grouped according to predetermined criteria related to a specific research question (Trochim, 2006).This sampling strategy was informed by the researcher's decision to access a particular subset of participants (Patton, 2002; Trochim, 2006). This decision was strategically based on the need to access CCG due to their direct involvement in the care and development of OVC. Furthermore, CCG were purposively selected because of their on-the-field-experience with OVC which would inform this research with rich and insightful data. Therefore the eligibility criteria of this study required participants to be current CCG in the districts of kwaMashu and Msunduzi. Furthermore all participants were at the time of the research, enrolled in the REPSSI/UKZN certificate programme.

The sample accessed in this study consisted of community caregivers (CCG). These CCG were actively involved in the care of OVC in relevant districts at the time of which the study took place. At the time of this study, all participants were enrolled in the REPSSI/UKZN Further Education and Training Certificate in Child and Youth Care Work. Participants were selected based on their work of being a current CCG in two districts in the KwaZulu-Natal province. The population of this study was selected from one peri-urban township area, kwaMashu, in eThekwini district and one urban area, Msunduzi, in uMgungundlovu district. These two districts were selected due to logistical reasons such as accessibility for the researcher. Priority was placed on data collection taking place within participants' natural settings instead of a controlled environment (Silverman, 2009). The purpose behind this was to access participants' understanding of their perceptions and experiences of OVC resiliency through direct contact and engagement with participants in their own settings (Silverman, 2009).

Mentors were informed of the researcher's arrival one week prior to data collection. From each district, 12 CCG volunteered to partake in this study after the research objectives and process had been explained. The sample therefore comprised of 24 participants who were divided into two groups of twelve in each district. These focus groups took place two days apart. The first focus group was held in the Msunduzi district and the second focus group was held in the kwaMashu district. There were four male participants and twenty female participants. The male participants were included in this study because males are usually not

perceived as caregivers to children and therefore most research generally does not include their perspective (Ruiz-Cantero et al., 2007). However, this research sought to eliminate gender bias common to research involving child care by including male perspectives on OVC resiliency through working with OVC. It is important to note that the sample of this study represents only a minimal percentage of South African CCG, this is primarily due to this study using a purposive sampling strategy (Trochim, 2006).

All the participants were Black South Africans, whose first language was isiZulu. The participants'age ranged from 19 years to 60 years.

The research team explained to participants their rights in the process of research. Participants were briefed on confidentiality and anonymity. Once all participants understood and signed consent forms to partake in the study the next process of data collection began (Resnick, 2008).

3.4 The interview setting

Throughout the study it was also made clear that resilience cannot be understood in isolation from its context and environment, as contextual factors were found to significantly impact on OVC resilience (Schram, 2006). Therefore this study challenged the assumption of research being more valid if conducted in controlled environments (Schram, 2006).

The focus groups were based on the research aims and rationale outlined above. Furthermore, using a qualitative research design allowed the researcher to engage in describing, sense making and interpretation of the social engagements in the focus groups (Marshal & Rossman, 2011). Focus groups were used as a form of a semi structured data collection tool which resulted in the development of new concepts rather than depending on existing theory (Babbie & Mouton, 2005).

The focus groups in both districts were run in the boardrooms at the Department of Social Development (DSD). These focus groups took place during the time CCG usually meet with their mentors for their learning sessions. The research was conducted at the DSD boardrooms for the convenience of participants as they were already meeting at these sites. The boardrooms provided us with an environment that was interruption free and private allowing for participants to feel free to voice their opinions (De Vos, Strydom, Fouche & Delport,

2002). As mentioned above, participants were predominantly first language isiZulu speaking and the researcher was first language English speaking therefore a translator and note taker who were both fluent in isiZulu and English aided in the facilitation of the focus groups (Thembela, 2007).

3.5. Translation of the research instrument

As mentioned above, isiZulu was the first language of all the participants in this study, as a result it was imperative to translate the research instrument from English to isiZulu (Thembela, 2007). Therefore, the consent form (Appendix 3a) and the interview schedule of the focus groups (Appendix 2a) was translated to isiZulu by an isiZulu speaking lecturer in the Department of Language Studies at UKZN, as well as an isiZulu speaking educational psychologist who also aided the researcher to facilitate the focus groups.

The second translator, who is an educational psychologist, reviewed the translations and adjusted psychological terms so that they were relatable and understandable to participants. This process ensured that inconsistencies were resolved and that translated words retained their meanings, especially psychological terms. The process of translation was important so that participants were able to partake in the research with no language bias, therefore ensuring validity of research (Nes, Abma, Jonsson & Deeg, 2010). Translating the interview schedule was also vital so that concepts could be understandable to participants. Furthermore, the goal of translation was to ensure that participants have a clear understanding of the research process in a language which is familiar and understandable to them (Thembela, 2007). Moreover, the supervisor of this study who is isiZulu speaking reviewed the translations and found the translation to be adequate.

The process of engaging in translation during the focus groups proved to be challenging for the researcher, as this was one of her first experiences engaging in research in a language she was not fluent in. However, having a good isiZulu speaking co-facilitator and note-taker made the process easier and allowed for engagement in the research process with participants more adequately. It was interesting to note that participants would try to accommodate the researcher's lack of knowledge of the isiZulu language and communicate in English when they felt that they could express themselves in English. Furthermore, after data collection, the co-facilitator, note-taker and the researcher, engaged in a debriefing session (Marshal &

Rossman, 2011). This session helped the researcher to clarify terms that required being unpacked. During this session the process of research and the dynamics between participants were discussed, and the process of data analysis began (Marshal & Rossman, 2011).

3.6 Data collection methods

The process of data collection ran smoothly except for a few technical difficulties such as finding a time that was convenient for the researcher, co-facilitator, note-taker, and mentors of the CCG as well as experiencing delays in obtaining ethical clearance. However, once these difficulties were resolved, data collection involved going to the DSD offices in the Msunduzi and kwaMashu areas where two separate focus groups where conducted. The process of data collection began by explaining to participants the goal, aims and purpose of this study (Resnick, 2008). It is important to note that throughout data collection, the research team engaged in a process of translation from English to isiZulu and from isiZulu to English – so that participants and the researcher fully understood the research process.

All data was recorded and transcribed both in isiZulu and English (Thembela, 2007).

3.6.1 Data collection process

This study used two focus group discussions as the primary method of data collection. A focus group is simply a group interview (Babbie & Mouton, 2005). The core of a focus group is the engagement of participants through dialogue with each other and the researcher, which results in the production of explicit data (Krauss, 2005). This engagement stems from a topic of interest that is familiar to participants and the researcher, in this particular study, resilience in OVC (Babbie& Mouton, 2005).Both focus group discussions ran smoothly with no obstacles and each focus group lasted for the duration of two hours. The focus groups ran for two hours to avoid infringing on participants time. Also, all research questions were adequately answered and discussed within this time period.

The reasons for using focus groups in this study were many. Firstly, focus groups allowed the researcher to access many participants at the same time, therefore this method was convenient (Babbie& Mouton, 2005). Secondly, the nature of the research topic did not involve direct questioning about participants themselves therefore there were no concerns about participants' personal issues being discussed in a group. Rather, this study sought to access a common understanding of participants' perceptions, understanding and experiences of OVC

resilience and the best way to achieve this was through group engagements and dialogue (Wibeck, Dahlgren & Oberg, 2007). Thirdly, using focus groups allowed for data to be collected in a participatory method, which will further be elaborated on in this chapter. Fourthly, using a focus group creates an environment of research that is less direct and threatening in comparison to a one on one interview (Wibeck et al., 2007). Therefore participants felt less threatened, at ease and more able to voice their opinions which results in data being more valid.

Using focus groups as a data collection tool allowed for this study to be open-ended, subjective and inductive (Babbie& Mouton, 2005). Data collected was clarified from the perspective and experiences of participants. Participants were also able to contribute other informed aspects of OVC resilience that the researcher would not have been able to access if she had used a standardised quantitative measure (Terre Blanche et al., 2009).

Information from the focus groups was obtained by accessing what participants, through their experiences, perceived as factors that impact on OVC resilience in South Africa. Engaging in focus groups resulted in participants collectively communicating through reciprocal dialogues about factors that impact on OVC resilience (Wibeck et al., 2007). It is through facilitating focus groups that a meaning making process of resilience in OVC in South Africa began to emerge (Krauss, 2005). Furthermore, through engaging in data collection and data analysis a process of reciprocal knowledge gaining transaction for the researcher and participants took place (Krauss, 2005).

Central to the focus groups was the focus group interview schedule (appendix 2a) which was informed by the research questions and the reviewed literature. In order to address question two-nine in the interview schedule, a process of dialogue between participants and the researchers took place. In order to address question one, a partciplan method was introduced (Snyman, 2012). The partciplan method is a technique that facilitates group involvement, speeds up the process of decision making and makes possible group interaction through the use of visual mapping (Snyman, 2012). The rationale behind implementing the partciplan method in addressing question one was due to this question requiring the researcher to evaluate the level of understanding of resilience of each participant. Using this method required following a specific process. The items needed were: three A0 size white papers, the repositionable adhesive spray, notepads, twelve black markers and prestick.

The partciplan method required participants to be seated in a circle. Each participant was given a black marker with a stack of notepads. On the top of one A0 white paper, research question one (appendix 2a) was written down and placed with prestick on a wall clearly visible to all participants. Thereafter participants were given five minutes to silently write down their answers to the question on the notepads given to them. Participants were instructed to write down every answer on a separate notepad and participants could provide as many answers as they felt adequately answered the question. It is important to note, that prior to this activity the researcher enquired whether all participants were able to read and write. However, it is a requirement for the REPSSI/UKZN certificate programme for every CCG enrolled to have completed matric (Grade 12), therefore having the skill to read and write. When participants confirmed their ability to read and write the research team proceeded with this activity and provided participants with the choice of answering in English or isiZulu. Following this, the researcher gathered participant's answers and made known to the participants that the answers collectively became the group's answers. This was done to make certain that no individual participants' answers would be criticised. Furthermore, this also helped to maintain confidentiality (Snyman, 2012).

Once this was done the researcher called out participants written answers and as a group participants' had to collectively agree whether the called out answer adequately and correctly defined resilience. If the answers were collectively agreed upon, they were placed on the white A0 paper. Thereafter, participants collectively grouped answers on the white A0 paper and identified themes which the answers belonged to. This process facilitated participants sharing stories which allowed the research to proceed to the following question.

The focus group discussions and the partciplan methods facilitated discussions and resulted in a generation of data that was rich, detailed, informative, subjective and inductive (McIntyre, 2008). Data collection for each group ran for approximately two hours.

3.7 Data analysis

In terms of analysis, language rather than numerical formats were used in explaining, interpreting, describing and reporting data (Krauss, 2005). As a result it was most sensible to adopt a qualitative data analysis method in this study due to the research questions which

were directed towards perceptions and experiences of CCG in relation to OVC resilience (Krauss, 2005).

The data analysis method adopted in this study is thematic analysis. This involved methodically reading through and organising the translated focus group transcripts, field notes as well as other items such as the A0 paper used in the participlan method (Pierce, 2008; Snyman 2012). This aided in increasing the researcher's understanding of the data and made it possible for her to present and document findings of this study (Pierce, 2008). Furthermore, the process of data analysis required the researcher to work with the data by organising it, splitting it into smaller units, synthesising it, looking for patterns, ascertaining what is significant, what still needs to be learnt and lastly determining what needs to be made known to others (Russel& Ryan, 2009).

Thematic analysis is used to identify, analyse and report consistencies as well as themes that are common to the data (Braun & Clarke, 2006). Furthermore, thematic analysis makes possible organisation, descriptions and interpretations of data (Braun & Clarke, 2006). Thematic analysis is used in uncovering themes found in the data. This process also required interpretation where the researcher actively interpreted the meanings that participants attributed to themes (Attride-Sterling, 2001).

Reading through the data helped the researcher to become familiar and thorough with the content of the data (Saldana, 2009). This process also made it possible for her to code data appropriately, to identify excerpts that demonstrated common patterns and to organise data in a manner that was sensible (Saldana, 2009). The steps that were followed in thematic analysis were greatly informed by Braun and Clarke (2006):

3.7.1 Phase 1: Familiarising yourself with your data.

During this phase the researcher engaged in reading the transcripts multiple times. She took an active role in reading and re-reading the data. This required locating meanings and patterns in the data which was done through the means of note-taking and jotting down ideas that would later inform the development of codes (Braun & Clarke, 2006). The rationale of engaging in this process is highlighted by Braun & Clarke (2006) who emphasise the importance of the researcher familiarising herself with the raw data.

3.7.2 Phase 2: Generating initial codes.

This phase required categorising the transcript into smaller more meaningful units. This was achieved by coding significant excerpts and key words or phrases. Coding was based on an inductive approach to the data and therefore codes were developed based on the most relevant and salient topics that surfaced in the transcript (Saldana, 2009). Coding was done by making notes on the transcripts (Saldana, 2009). The researcher also made use of highlighters to categorise parts of the data, as recommended by Braun and Clarke (2006). The most relevant concepts found in the transcripts were organised into sets of codes. The researcher ensured that these codes were not repetitive but still displayed meaningfulness (Saldana, 2009).

3.7.3 Phase 3: Searching for themes.

After coding of data, important and common themes that displayed relevance to the current study was identified (Attride-Sterling, 2001). These themes were then further broken down into themes that were precise in capturing concepts of the excerpts. During this process certain codes could not be placed within major themes and therefore were put aside under a theme termed miscellaneous (Braun & Clarke, 2006). This phase facilitated a reduction of data placing it into relevant themes that concisely summed up the data (Braun & Clarke, 2006).

3.7.4 Phase 4: Reviewing themes.

All excerpts were reread to determine whether there is consistency in the themes. Thereafter, themes were evaluated to determine whether they were consistent with the overall data set (Guest, MacQueen&Namey, 2012). During this phase additional themes that were missed in initial coding were identified and placed under relevant themes (Braun & Clarke, 2006).

3.7.5 Phase 5: Defining and naming themes.

At this phase each theme was given more detail through analysis (Guest et al., 2012). This involved relating these themes to the broader issues of the research and contextualising each theme through providing narratives shared by participants (Guest et al., 2012). The researcher also ensured that themes did not overlap and become repetitive by investigating the relationship amongst all themes. Doing this aided in determining the existence of sub-themes within each theme resulting in a structure of coherence in presenting the themes. At the end of this phase the researcher was clear about what each theme covers, unpacks and interprets and thus resulted in naming of themes (Braun & Clarke, 2006).

3.7.6 Phase 6: Producing the report.

All themes, concepts and patterns that were identified as significant through analysis were tied up (Braun & Clark, 2006). This was achieved by relating all extracts and themes to the research questions and interpreting them from a theoretical perspective (Braun & Clarke, 2006). Clarity, coherency, non-repetitiveness and conciseness were ensured in presenting the argument of this report (Braun & Clarke, 2006).

Common to all research methods are advantages and disadvantages, the same holds true for thematic analysis. Thematic analysis is a method of flexibility and can be used to address a multitude of epistemologies and research interests (Braun & Clarke, 2006). It is a method that can be learnt efficiently and speedily. It can systematically be used in finding important aspects of data and can provide detailed descriptions of the data, as is seen in the current study. It also goes further than merely describing data and allows the researcher to actively interpret data (Braun & Clarke, 2006). However, there are limitations to using thematic analysis. Thematic analysis, even though widely used, is not regarded as an esteemed method of analysis due to this method being poorly demarcated (Ebrahim, 2012). However, by implementing the methods used by Braun and Clarke (2006) the researcher was able to overcome this and provide analysis that was credible. In the paragraph below the researcher has highlighted how she has rigourously maximized the use of thematic analysis and ensured that analysis was not compromised.

3.8 Credibility, trustworthiness, dependability and transferability

Dependability and credibility are essential in ensuring that the findings of a study are trustworthy and transferable (Silverman, 2006). In qualitative research establishing trustworthiness, dependability, credibility and transferability is complex (Silverman, 2006). Credibility is determined by the extent to which findings are considered to being interpreted correctly (Silverman, 2006). This study maintained credibility through various procedures. Firstly, in order to ensure the process of analysis was rigorous and credible recording of the focus groups was imperative, this process ensured that what participants said was reported correctly and was not distorted (Merriam, 2009). Secondly, recordings were transcribed verbatim and then translated into English. Transcribing was carried out by a professional in the field. These transcripts were then translated by a psychology student who was also played the role of note-taker during data collection and therefore she had an in depth understanding

of the study (Silverman, 2009). She was also fluent in isiZulu and English. Furthermore, this student and the researcher collaborated through the process of analysis so as to ensure the researchers understanding of the data was accurate and not misinterpreted resulting in trustworthiness of data. Engaging in this process aided in analysis being more credible as the researcher had the input of another reviewer (Silverman, 2006). Once all data collected including audio tapes, field notes, transcripts and translations were checked and all material were found to be consistent with each other the researcher engaged in the subsequent processes of rigorous thematic analysis (Guest et al., 2012).

Due to the sample consisting of only Black South African CCG whose first language was isiZulu, this study recognised that a language barrier may exist between participants and the researcher-whose first language was English (Nes et al., 2010). This language barrier may have served to threaten credibility if it was left unaddressed. In overcoming this barrier the researcher contracted a translator and note taker-who were both fluent in isiZulu and English-and accompanied her during data collection (as mentioned above) (Nes et al., 2010). Furthermore, the translator was an educational psychologist therefore having a background in psychology ensured psychological terms which were used in data collection was translated correctly and therefore was understandable to participants (Nes et al., 2010).

Establishing credibility in this study required the researcher to present raw data in the form of relevant excerpts so that the reader could make informed decisions about the accuracy involved in the researcher's interpretation of data (Silverman, 2009). The presentation of excerpts in maintaining credibility is referred to as low inference data and allows the reader to evaluate whether the interpretation of data is "true to the content and intent of the data" (Mahasoa, 2010, p.56).

Findings in this study are not generalisable to a larger population, due to the qualitative and contextual nature of the research (Silverman, 2009). However they are transferable to populations that have comparable features to the sample of this study (CCG in KZN). Transferability is established from the belief that phenomena under study are context-bound and as a result findings from this study can only be transferred to contexts that are alike to the current context under study (Silverman, 2009).

3.9 Ethical considerations

The following ethical considerations and decisions were made in conducting this study.

3.9.1 Permission from relevant authorities

Ethical clearance was obtainedfrom the University of KwaZulu-Natal Higher Degrees and Research Ethics Committee (Appendix 1). Verbal informed consent was obtained from other relevant authorities, such as DSD during deliberations with REPSSI and UKZN(School of Applied Human Sciences). Once this was obtained, the researcher commenced with carrying out the research.

3.9.2. Informed consent

Participation in this study was voluntary. Once participants verbally consented to partaking in this study, they were asked to sign an informed consent form (appendix 3a). Signing the consent form indicated that participants agreed for further use of their data. A clause in the consent form specified that data gained from this study could potentially be used for further research. If participants consented to this, they signed the clause. Furthermore, another clause stated that audio recordings of the focus groups would be transcribed for the use of data in the study. If participants agreed to these conditions by signing the clause they participated in the focus groups (Jefford & Moore, 2008).

3.9.3 Confidentiality

Confidentiality and anonymity were guaranteed by not divulging the details of participants. Participants were allocated with pseudonyms and no identifiable characteristics of participants were made in the research (Jefford & Moore, 2008).

3.9.4 Incentives

Light meals such as sandwiches and juices were offered to participants as an incentive. Participants were clearly informed that sandwiches and juices were offered to them as a gesture of gratitude for giving their time and for their participation in this study. Participants did not incur monetary costs for their participation. However, participation required two hours of participant's time (Collumbien, Busza, Cleland & Campbell, 2012).

3.9.5. Beneficence and non-maleficence

Participants indirectly benefited from participation. This took place via group interactions and discussions with other CCG. Through the process of focus groups participants were able to actively voice and share the difficulties they face as CCG and communicate ways in which they believe– through their experience– that OVC resilience could be improved. Furthermore, through partaking in the focus groups, the participants displayed a sense of hope that findings from this study would be used to benefit OVC and intervene in some of the obstacles they face as CCG.

Participants were not exposed to any harm during the study, neither physical, emotional nor psychological harm (Collumbien et al., 2012).

3.9.6 Storage of data

Data collected will be destroyed after five years from the time of data collection. Data is stored in an electric form in audio format. Transcriptions of audio files are stored as word documents. Data is kept for future use in research, should other researchers or this researcher require doing so (Resnick, 2008).

The above outlined ethical considerations were imperative in ensuring the well-being of participants was upheld. These ethical regulations were adhered to so that participants were not exploited by unethical research and that participants were fully educated of their involvement and role in this study (Resnick, 2008).

3.10 Conclusion

This chapter presented the methodology used for the qualitative design of this study including ethical considerations. It outlined the theoretical basis for qualitative design and specified the practical applications used in this study. The next chapter presents the results found in this study.

CHAPTER 4
RESULTS

4.1 Introduction

This chapter presents data collected through focus groups in this study. The themes that emerged from the focus groups are presented, analysed and discussed. The findings will be presented thematically supported with relevant extracts from the focus groups.

As mentioned in chapter three, the aim of analysing the data from the focus groups is to identify themes relevant to the research questions. The process of finding themes is a "creative research process" that makes it necessary for the researcher to consciously and cautiously make informed decisions about what is really relevant and meaningful in the data collected and subsequent analysis (Thembela, 2007, p. 73). The following section outlines the themes that emerged during the focus groups in relation to the flow of conversation as well as the themes that emerged from each question asked from the interview schedule (Appendix 2a).

4.2. Discussion of themes

The following sections present the themes that emerged from the data: the obligation made to OVC by the DSD, the need for improved shelter for OVC, the problems experienced with food parcels, access to education, psychosocial services, common issues with service delivery, the repercussions of delays in receiving identity documents, social workers' perceived laziness, gaining insight into CCGs understanding of resilience, the role of CCG in facilitating resiliency in the OVC they work with and reviewing current programmes implemented by the DSD and CCG for the care of OVC.

4.2.1. The obligation made to OVC by the DSD

Across both focus groups there were a considerable number of themes which emerged. Most participants acknowledged the attempt of the DSD in meeting some of the needs as stated in the obligation (Appendix 4). However, participants across both focus groups also emphasized significant gaps in the fulfillment of this obligation to OVC. The obligation made by the DSD to OVC is significant to the resilience of OVC because this obligation promises to protect OVC from any potential risk that they as OVC could face after being orphaned, including access to food, shelter, education, protection from abuse and child trafficking. As a result this obligation is paramount to the resilience development of OVC

in South Africa because it is the blueprint of standard of care for OVC in a context where OVC face cumulative risk after being orphaned (DSD OVC Policy, Article 65)(DSD, 2003).

As stated in the *DSD OVC Policy, Article 65,* the obligation promises to deliver services to OVC across various sectors including provision of supportive environments for OVC who are infected and affected by HIV/AIDS (DSD, 2003). The obligation states that supportive environments will be attained through the provision of counseling and psychosocial support, access to school, shelter and nutrition as well as accessibility to health and social services. Furthermore, this obligation promises to protect OVC from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance (DSD, 2003).

All research participants identified that most of the promises in this obligation have not been delivered to OVC. They also identified that the promises which are delivered are constrained in their effectiveness because they are hindered by inefficient service delivery which consequentially impacts on OVC development and protection, resulting in the obligation not being fulfilled. The following provides a detailed thematic analysis of the themes that emerged during data collection using relevant excerpts.

4.2.1.1 The need for improved shelter for OVC

Many of the participants voiced that the OVC they were caring for did not always have safe environments in which they were living. One participant also showed concern that the DSD in some areas did not provide shelter for OVC, according to her experience.

P1: I don't remember any child that they (DSD) have given a shelter from my area.

At the onset of the focus group participants voiced the need for government to build *safety homes* for OVC. The participants in this focus group identified safety homes as a need for shelter because of their witnessing of issues that occur in the current living situation of many OVC. Many OVC are placed into guardianship of extended family, a common occurrence with this living situation is abuse whereby OVC become the recipients of abuse.

> *P2: To build (pause) more buildings, like where children can live safely in a certain place where they can live or stay together, if they can build more homes for them, safety homes. Unlike when they are living with parents sometimes they sometimes get abused, by living with relatives, sometimes not relatives, as they are orphans, if they can have homes, safety homes sometimes they are feel places where children can live safely, more homes for safety.*

Furthermore, participants displayed concerns that even though the OVC they are caring for have shelter, the shelter they are living in is not conducive to their development.

> *P3: No, concerning the children no DSD tries in that regard, but there are some obligations that are left loose like when you visit the homes, the houses we visit you find that in some there is no development; there is no water, no electricity in the houses we visit.*

4.2.1.2 The problems experienced with food parcels

The second theme that emerged as a response to DSD's fulfillment of the obligation was based on DSD's promise of nutrition for OVC. The issue of food parcels was a controversial topic across both focus groups. This topic surfaced numerous times during the focus groups and presented itself as an issue of great concern for the participants.

Placing it in perspective, food parcels are given to OVC for the duration of three months after they have been identified as an orphan or vulnerable child. These food parcels are provided by the DSD and are sometimes distributed at centres that are sponsored by the DSD. The motivation of provision of food parcels for three months is that ideally within these three months OVC should be placed in a foster home or foster care. However, while distributing and receiving food parcels sounds convenient and easy there are a significant amount of concerns that the participants expressed about food parcels. Firstly, the three month duration of food parcels is not sufficient because of the common reality that even after three months OVC are rarely placed in homes. Therefore the consequence is that after three months and the abrupt end of food parcels, OVC generally do not receive nutrition on a daily basis.

> *P3: The food parcels, the three months thing, ey it is difficult, because now if a child applies for a foster [grant] it takes a year or two. Now they give out the parcel for only three months, what saddens me the most as a caregiver is that all the time when the child is trying to apply going up and down trying to get the grant in the meanwhile what helps that child, because during that time, because they only give out food parcels for three months?*

Secondly, participants mentioned that there is a gap in the service delivery of food parcels. The effect of this is that food parcels are not always provided for a continuous three months. As a result OVC have no certainty as to whether they will receive a food parcel for that month.

> *P4: You find the vulnerable people, you talk with them, you take every detail, sometimes they need a food parcel, DSD they promise that food parcel, sometimes they give that food parcel one month, what about the other month and the other month? The people what they eat? That is the problem.*

> *P6: What they say in three months time, whatever you have been trying err err to trying to do, maybe trying to get from home affairs or SASSA by the time everything will be provided for, which is not always true, because sometimes their guardians also have no job and it takes time and after three months they don't want to give more food parcels*

Thirdly, in order to have access to food parcels there is a process of documentation that is necessary. What the participants voiced as a concern is that more often than not there are delays in service delivery that prevent OVC from completing the documents and, furthermore, the processing of these documents is a slow procedure. As a result OVC do not always have the necessary documents to receive food parcels. This means that even though food parcels may be available, OVC who do not have documents are not able to access these food parcels.

> *P5: Okay, here in the organisation that I am with, DSD does provide food parcels. When they have delivered the food parcels, there are some food parcels that will be sent back, because the documents are not complete, so they go back home without food and at home there is no food and then the food will be left there and we end up not knowing where it disappeared to, it does not get to the OVC, but*

the food was available and it just disappears there in the organisation and the OVCs do not get the food.

Fourthly, participants recognised that in addition to food parcels, the DSD have put forth an initiative of *one home one garden.* While this initiative promotes self-sustainability of communities and independence of merely relying on outside assistance for food provision, participants felt that this initiative is also constrained in its effectiveness to provide food for families especially with a large number of members. This is because many families do not always have large enough space in order to grow vegetables. Participants also displayed concern that not all food which is required can be grown at home. However, it was also identified that not all homes that participants visit are involved in the initiative of one home one garden.

> *P7: They say you have to teach them about one home one garden and one home one garden is just that...you can't work with those veggies, because some of them have a small plot for planting their veggies where are they going to get err mealies, beans, samp where all those things err.*

> *P9: Not all of them do one home one garden, but some of them even if it is a place like that door they can do that, but it's just that, it's just that small place to get some fresh vegetables, nothing else which is not enough.*

4.2.1.3 Access to education: Not always an obligation fulfilled

The third emergent theme was related to OVC's access to school. The participants mentioned that school uniforms and school fees are essential for OVC's access to education. The DSD usually provides uniforms for OVC in order for them to attend school. Participants reported that even in delivery of uniforms for OVC there are delays which have the consequence of preventing OVC from attending school. They also mentioned that many OVC do not have money to pay for school fees resulting in their exclusion from school.

When asked what role they as participants play in solving this problem, the participants responded that when they are presented with an issue such as OVC not having school uniforms or not having money to pay for school fees it is a requirement for them to report this to a social worker. However, the process of reporting also seems to experience some delays

and more often than not the participant perceive social workers as not adhering to protocol of following up on the reported case. This perception is mainly due to social workers reportedly not providing feedback to participants about the progression of the case.

> *P8: They don't even attend the school because they do not have school uniform, they don't have school fees, so if we reporting that matter, social workers take their time to attend, so we get stuck there, because we not have money to pay for them.*

> *P13: Yes, they do provide school uniforms, but it also takes so long, because…I don't know whether its bureaucracy or what, but maybe twelve months gone without funding in the organisation, yet the OVC are still waiting without school uniforms.*

> *P 21: On our side or our area our social workers promised to bring the uniform; shoes, shirts, skirts, but eventually we didn't get that from two years ago.*

However, one participant showed acknowledgment of the DSD's role in uniform provisions and suggested that it is because of DSD's active delivery of uniforms that OVC attend school.

> *P7: The DSD is trying by all means to the children to get the uniforms to go to school, and then this makes me happy because needy children get the uniforms to go to school. Many children go to school because of the DSD giving those uniforms.*

4.2.1.4 Psychosocial services: An obligation left unmet but urgently required

The provision of psychosocial services for OVC was a common thread of concern across both focus groups and for all participants. Participants varied in their responses of the role of the DSD in fulfilling their obligation of providing food, shelter and education for OVC. However, in the response to psychosocial support all participants unanimously agreed that this promise was left unmet. Furthermore, all participants strongly saw the need for OVC to receive psychosocial support and voiced that it is through the provision of psychosocial support that many of the problems which stem from being orphaned and vulnerable would be minimised such as OVC resorting to criminal activity, prostitution and drug addiction amongst many other damaging lifestyle choices.

P14: The DSD in their obligation state that they provide psychosocial support skills, but the participants doesn't have that skill to provide that psychosocial support, because in terms of emotional support, there is no such skill that equips participants to enter those dress codes and pass those skills, transfer that skill.

During the flow of conversation in the focus groups, participants were asked if they have any suggestions of how psychosocial support services can be provided for OVC. What followed were participants suggesting that within their training programmes they should be equipped with skills to provide psychosocial support to OVC. Participants expressed that the OVC they care for turn to them as a pillar of support and that if they were better equipped and skilled to provide psychosocial support they (CCG) could become a medium through which psychosocial support is provided for OVC.

P12: Maybe if the department can give us the training of counselling, maybe if they, they educate us more about these things, then it will be much better.

4.2.2 Common issues with service delivery

Another theme that emerged across both focus groups was poor service delivery which negatively impacted on OVC accessing necessary documentation including identity documents. This then, had added implications of OVC not being able to access food parcels and grants, and this hindered their enrolment into schools. All participants across both focus groups displayed a significant amount of frustration at inefficient service delivery. They argued that many of the obstacles that prevented them from doing their job effectively, as participants, stemmed from delays in service delivery.

This is because as participants, they take on an active initiative of helping OVC to access documents so that they can receive food parcels and child/foster grants. However, participants mentioned that very rarely are they able to receive the document they require with ease. Often, applying for these documents requires OVC and their guardians to travel long distances into the nearest town or city where the relevant DSD building is located. This travelling expenditure is high and unaffordable to many OVC and sometimes more than one trip to the department building is required. Therefore, the process of accessing services for OVC places their guardians under greater financial constraints. In unpacking the issues around service delivery many subthemes emerged.

4.2.2.1 The repercussion of delays in receiving identity documents

Participants provided examples of the constraints they face in helping OVC access documentation that is required for OVC to access food parcels, education and grants.

> *P8: Like you need a, a…you made a referral to home affairs for a full birth (certificate), firstly, they will make a, mistake; there are misprints, you will be doing a follow up on that, they say, "no, it hasn't been done, you have to phone Pretoria office" you phone Pretoria office, they say "no, we want a relative of that person, where, where an orphan will get a relative? Sometimes it is a children, young children, when we say young; a small child; 5-6-7 years old that does not have a relative, you are a relative, because you are working with that child, so we get stuck on things like that. Sometimes we find adults, where they have been trying for ID's four, five years now (pause) the same thing the ID doesn't come back. Then they have to pay, where are people going to get that money to pay for ID's, try again, they start afresh doing the same process, next year, same thing, do the same process again!?*

The above excerpt demonstrates the sense of frustration that was common to all participants in the focus groups. Participants argued that the delay in accessing identity documents (IDs) has reciprocal effects on access of food parcels and grants for OVC, resulting in a cyclical nature of poverty, with no escape. They stated that even in their attempts to help OVC access these documents, the procedures of protocol and redtape make it impossible for them to help OVC because it is required that a blood relative be involved in the procedure of accessing an ID or necessary document.

The problem lies in that relatives are not always available therefore this impacts on OVCs access to documents having the effect of preventing OVC from receiving food parcels and grant. Furthermore, participants were concerned that it is often a common reality that the guardians of OVC do not have documents themselves which then poses a further problem of guardians who are available not being able to help OVC access their documents because they themselves do not have IDs.

P16: Another thing that is painful, you find that there is a grandmother who comes from Lesotho and had children here, you find that the mothers of her grandchildren have died because of these diseases that are here, the grandmother is now left with these children and herself does not have an ID and the children have no certificates, you find that in that household, they are very poor, because she cannot even register for the child grant, because she also does not have an ID, now these children cannot get help, you find that the cycle of poverty continues and we can't help her. When we try to go to United, you find that the commission asks us about their relatives, maybe her sister who was at that place, or who does she know from South Africa, you find that not even the children get help. There are so many children with that same problem.

P5: We cannot help an OVC without a guardian and if the guardian has no ID, you have to help the guardian first, so that when she gets the ID, she can now register the children so they may get help, because it is difficult sometimes if the guardian has no ID and then the child has no certificate the children will not get help, there has to be first help the guardian

Furthermore, in a context that is in dire poverty, the expenditure involved in accessing IDs places OVC as well as their guardians into a plight of added financial constraints which they are unable to afford.

P18: The government when it comes to ID's, now that they want to do the new cards, all I see is that they want money, the new cards are R150, they will go and change them again! [Raises voice] whole they are already problems, people cannot even afford the small amount for the existing ID's; they come again to say that another amount must be added. They must look after the OVC, that they OVC should not even pay a cent in that regard, it is slow.

Participants acknowledged that the reasons motivating the *new card system* were to prevent corruption occurring in accessing the child and foster grants. However, they were more concerned about the effects of the card system on the OVC that they were caring for. Placing it in context, this new card system is known as a *smart ID card* and will soon replace the existing IDs in South Africa. The goal of the smart ID card is to reduce identity theft that is a

common occurrence with the current ID. Duplicating a smart ID card will be nearly impossible and therefore curb identity theft (ZDNet, 2013).

> *P17: Yes, we can see that the new card help in that they want to prevent corruption, but sometimes, there are times where vulnerable people get affected more.*

Many of the concerns around the issue of service delivery resulted in participants almost pleading for change in protocol, red tape and speed so that OVC could have more efficient and faster delivery of documents so that they are able to mobilise their dire situations and proceed with their lives after dealing with the adverse situations such as being orphaned. Participants also acknowledged that not only do the inefficiencies in service delivery prevent OVC from accessing food parcels and child grants but it also has psychological effects which result in OVC displaying these psychological traumas through adverse behaviour patterns.

> *P18: I had a problem with a child I was working with, he is thirteen years (13), his mother died while he was still young, and they lived in Portshepstone. He then stayed with her grandmother and when he was used to her, the grandmother died as well. He now has that anger that he is now an orphan, he beats other children, he is trying to relieve stress of all the things he has witnessed. He now stay in Inanda, and they are still waiting for his belongings from Portshepstone and documents to show that he was on foster care in Portshepstone, he has not received it even today. His grandmother used to be his guardian and accessed to the foster grant for him, since she dies from 2010 till now, he does not get any.*

A common problem is that when a child reaches eighteen years of age they fall outside the bracket of being an orphan and therefore are no longer eligible to receive child grant or foster grant. As a result, participants were greatly concerned about the plight of an OVC who reaches eighteen years of age and no longer has access to grant. It was a further concern of the situations in child headed households where when a child reaches eighteen and his/her grants stop it has detrimental effects on younger siblings.

> *P21: Here we work with families that are child headed, sometimes, you see, you will arrive and find that there is no father, no elder, but there is a child who is also just a child, but in a case where they have reached eighteen years, they are taken*

as adults, but they forget that the grant has been closed, so if there was also a small child there who needs to continue and go forward, they cannot do anything, just because the home affairs wants this and that, like when there are no longer parents, they child does not know where they put the things that are needed, they cannot go forward, but they know that they are the key to things (home affairs) to many things, so everything rests upon them, so if they can move, just to move, maybe they can.

4.2.2.2 Social workers' perceived laziness

Participants stated that conflict existed between social workers and participants. This conflict negatively impacts on participants' job performance because they attributed many of the obstacles they faced to social workers being "lazy" and "not doing their job". This resulted in a dialogue of attributing blame to social workers for many of the situations that affected OVC.

Participants complained that their reporting of cases to social workers often has no positive results because the situation of OVC remain unchanged in spite of participants case reports to social workers. However, social workers may also face many of the challenges in doing their job, like participants reportedly face; such as slow service delivery, red tape and protocol that prevents them from creating speedy change in the lives of OVC. Therefore an attribution of blame by participants may be the result of frustration that was so clearly displayed through the process of data collection. Furthermore, the lack of social workers engagement with participants results in participants feeling inadequate in their job performance because very rarely do they receive feedback from social workers. This has psychological effects on participants resulting in them feeling disheartened and hopeless.

> *P21: The process of the social workers is very slow err, their procedures, they don't make follow-ups. We have some serious cases, we report to them, but they do not come back to us and do follow-up and find out if whatever we were reporting is true or we just made it. It always makes our hearts, it breaks us down because there are people that we have to report back to and we know they have a lot of work, but they have to do more than that, because sometimes some of the things they would have prevented from happening. It just goes on and on and on…*

However, while participants attributed blame to social workers being lazy it was also identified that the source of social workers lack of follow up and feedback to participants may be due to an overload of work and not merely social workers being lazy.

> *P11: The social worker, they never do err err properly, never never do the follow-up, we refer to them when we found a problem and we never have a response. Where sometimes we call him and he says "ey I'm busy, I'm busy, make another day".*

> *P15: It's not that all of them (social workers) are lazy, it's because you know, like err job load, they have a lot of work to do.*

> *P13: They are running short of social workers, so since they are running short of social workers, the service is going to be very weak, those they do show that they got potential to do their work, since they are running short, I don't think they will do their work properly.*

This suggests that social workers may have too many cases to deal with which prevents them from seeing through each case properly – resulting in a cyclical nature of added cases without resolving previous cases. In response to this dilemma of lack of feedback and follow-ups, participants were asked what initiative they take in order to overcome this obstacle. One participant responded by stating the following:

> *P15: In actual fact they, well sometimes when you refer you case err to the social worker and they don't respond err we normally report that case to the war room [a place where cases are presented] and then after that, even if the war room does not act on time, we do work with our local counsellors, counsel to err err ward counsel to help. We do have structures, err community structures, we make sure that we, we make them know the the situation then so that when you face with a problem where you are getting blamed of not delivering a service to one of the OVC and you will tell them that I reported to my local war room, to my ward room, I reported to the social worker, no response, I reported to the structure and I reported to the the, to the local council and you mention all of those things and you make sure that each case we write it down, cause it a problem to us, we are the ones goes...visited these houses, so if they have someone to blame, they first*

blame you, "Like you came to us, you discovered this case and you didn't respond, you promised one and two and three and you didn't respond" and we make sure that we work with our local err err, what you call this?.. Stake holders…

The above excerpt suggests that participants take an active and persistent role in attempting to report and resolve the cases of the OVC they are in care of. It also makes clear that the job of a participant can become notoriously frustrating and demanding due to a repeated process of minimal outcome in aid of OVC. Participants also voiced that their role in helping OVC is limited and cannot be carried out efficiently without working in collaboration with social workers.

P8: And some other things need social workers themselves so that is where we get stuck, because some, we cannot do everything for ourselves.

As this discussion evolved participants began to brainstorm ideas of how service delivery could be improved. The perception of one participant was that social workers did not have transport to do home visits and therefore suggested a need for increasing government transportation as well as increasing the number of social workers in the hope that an increased number of social workers would result in efficient resolving of cases, feedback to participants and home visits.

P 23: What could also help is for the government to increase the vehicles, because it will help the social workers to be able to visit homes, that we tell them to go see the problems there and to employ more people, because those that are there are a few [P5 adds: they are over-loaded with work], yes we can blame those that are there, but as people who usually visit them, we can see that they are few. The government should hire more people.

Placing it in perspective, the frustration participants directed towards social workers is because the job of a participant is directly dependent on reporting to a social worker. Therefore, if social workers are not active about resolving cases, proving feedback and engaging in home visits the job of a participants seems to be stunted because they see no progression in the communities and OVC they are working with.

> *P1: What I can say is that the social workers must pull up their socks, because sometimes we get stuck, because of them really, they don't do their work. If they can do that, then they put themselves in our shoes, and do their work, then it will be better.*

The end result of poor service delivery, including reporting, feedback and home visits of social workers as well as accessing documents, has negative repercussions for the reputation of participants in their communities. This is because community members often direct blame to participants when service delivery is delayed, due to participants directly being involved in helping OVC access documents. This results in participants being ostracized from the community and made to carry the burden of inefficient service delivery.

> *P23: It is us who face trouble with the people, because most of the time, the time we leave and when we come back, a person when you first enter the house she/he gets happy hoping that they will get something and things will be better they will have something, you find that when you go and come back empty handed; you do not bring a social worker to do a follow-up, to do home visits, it becomes a problem in all that really, really we are not right on that regard. You know how our people are like, when they want help, they wish that they can get it now, now, now, because to some people it looks like we are the ones who are bringing help, but we are only messengers, not that we will come with that help, we are only taking the information, pass it forward, so when you come again, you arrive with more stories….cause you have taken the information, you come back empty handed, again. For us that is a big issue that they even chase us away (All: yes they chase us) saying that "you see this thing of yours, we don't care anymore".*

Furthermore, as the process of research continued and participants became more vocal, the researcher sensed great conflict that was precipitating on the side of the participants. This conflict was fuelled by misunderstandings about the role of social workers. Participants perceived social workers as needing to engage with participants during their home evaluations in order to experience the realities and adversities that OVC are living in. One participant voiced that if social workers were exposed to the reality of OVC's lives then social workers would be more empathetic to the plight of OVC and as a result would work more efficiently to resolve cases.

P15: Whereas I don't see the work of a social workers as only sitting in the office, it will have more dignity if one day the social worker can get out of the office and come with the participants, and see, come and go see, besides just waiting for the referrals that usually come for intake here, but to just come out, go and see the conditions that we get to see, maybe that will….when they have seen these things, it could change the way they do work.

At the time of data collection, the researcher perceived much of the discussion taking place as participants merely using this time as a way of complaining about social workers. However, in retrospect, through the process of analysis, the researcher has come to realize that much of the problem stems from a lack of communication between social workers and participants.

P12: Another issue that we face is that social workers do not want to befriend us, to come to where we work to hear the kinds of problems we face in communities, they are distant, they only arrive when they are pushed by the officials or the bosses.

P6: They do not want to be our friends, they do not want to give us directions as to what we are supposed to do and how.

As a result participants were indicating a need for a more efficient and closer working relationship between relevant stakeholders such as social workers and themselves. Furthermore, the implication of a lack of communication between social workers and participants has reciprocal effects on processing of documents. This makes the processing of documents delayed which negatively impacts on OVC and their guardians.

P4: Come June when they are trying to meet deadlines and pushed by the officials, they want 'meli' [DSD document] where are we supposed to get that to fill it out to show that we have been going out, because they never gave it to us? They do not want to be our friends, they do not want to give us directions as to what we are supposed to do and how, when this happens, you send the old lady to the offices to process the child foster and you tell her what you know about the documents to bring, when she gets there, she is sent back because of a small thing, the she has to go back again, why is she not written for what things she needs to bring tomorrow? So that all her things are complete, she is sent back for one thing, tomorrow again they say the

same thing. What is the old lady travelling with, because she does not have the money?

The miscommunication between social workers and participants results in a cyclical nature of enhancing poor service delivery due to participants not being fully informed of the documents that are required for OVC. This has the effect of further delaying access to identity documents which then hinders access to food parcels and grants.

4.2.3. Gaining insight into CCG's understanding of resilience

Gaining insight into participants' understanding of resilience was imperative to understanding what this study was seeking to explore, i.e., the resiliency of OVC in the context of HIV/AIDS, through the perception of participants. The responses of participants suggested that it was difficult for some participants to articulate their understanding of resilience, especially participants in one of the districts, which the resesarcher is unable to disclose due to confidentiality. However, it was with more ease that participants shared stories and experiences of OVC that they perceived to be resilient or not, which will be explored later on. Overall the themes that emerged indicate that most participants had a satisfactory level of understanding resilience with the exception of one or two participants who incorrectly defined resilience. To assess this, participants were asked to all contribute key words that explained the term resilience (see Appendix 5).

From this list participants were asked to collectively group words that they thought to be correct and could be categorised together and thereafter to provide an explanation for their categorisation. District 1 categorised the following:

- Friendly, humbleness, sympathy, love and care, respect, helpful and support
- Psychosocial support, manage, cope, ability, reliable, support, strong, confident, brave and positive

The following excerpts provide an explanation of their categorisations.

> *P11: What I can say positive, if you are a resilient, no matter what happened in your life, but you must tell yourself that it is not the end of the world, something good can come, after the hardship and the problems, so you have to be positive in life no matter what happened.*

> *P15: I can say about orphan children, I think you need to be positive, you don't need to see a way back if you see the hard situations, then you go back, so you need to go forward.*

> *P2: For positive, some things we experience them and something good came out of those experiences, so its err, you have to stay positive, no matter, no matter you don't have parents but we have to encourage them that something good will come out of them, even if they don't have parents, they can be something good, they can become whatever that they want to become.*

Even though participants identified the term sympathy as a characteristic of resilience, some participants disputed this by responding with the following excerpts.

> *P3: We don't need to be sympathise with them, we need to be empathise their problem.*

> *P8: Empathy is what we have as people, but now that we have been taught, we can now empathise not sympathise, but because we are human we do have sympathy, because you are a person because of other people [Zulu Proverb] so you sympathise, but when it comes to work, you do not sympathise you empathise.*

> *P6: To manage you have to tell that person that whatever it is, it will be okay, you will manage after that, you need to put yourself in their shoes, and give them the positive life.*

In summarizing the participants' understanding of resilience, they attributed the term resilience to their own facilitation of resilience rather than resilience being an attribute located within OVC. As a result many of the above excerpts explain resilience from the perspective of how they as participants aid in resilience development of OVC.

In retrospect to the system of categorizing words collectively, it was realised that this process did not adequately allow for accessing participants understanding of resilience in the Msunduzi group. This is because participants were not able to efficiently group words that belonged together, while this may have been a flaw in facilitation it was thought that it would

be a better outcome if participants in the district 2 were merely asked to select five key words from the list that they brainstormed which they felt best defines resilience according to their understanding.

Therefore from the list of key words, participants in district 2 collectively selected five words that they thought best defined resilience. These words were:

- Strong, trust, manage, cope and caring

The following excerpts provide an explanation for participants' selection of these words.

Strong

> *P16: Strong mmh, just to talk, just to manage, you can be able to talk about your problem, just you do not think about the problem every time, just to be strong.*

> *P11: I think I'm choosing strong, because under any situations, a person who is resilience can be strong, must stand any situation that comes to her or him. Every person who is resilient is strong has to be strong, because he can change the situation from situation to another situation or to a better situation, can change things in her way or his way to a better situation, because he is resilient, he is strong.*

> *P15: To be strong to face any difficult challenges and conquer them.*

The term strong was used by participants to express emotional strength of OVC inspite of situations of hardship. This term was a defining factor of resilience for CCG in relation to the OVC they work with.

Trust

> *P12: It is important that a person presented with a problem it is important that I keep it a secret and not tell others, so that the person trusts me and I must be trustworthy in things like that.*

> *P17: To have trust, the person who is being helped, the OVC, must have the trust of the person who is helping him and that indeed they will help him. To have trust that he*

will get help, because once you lose trust then he will not believe that he may be helped.

P21: And again err that person or OVC need to be trust worthy or sometimes to believe, to believe in yourself to believe in yourself, like if you are resilience then you are able to believe or to trust what you are going through, to trust that ay no, I have victory on this, I have to conquer then to be able to believe in yourself.

P22: For trust, let me make an example; if a child loses a mother, a father, to be removed from the home to another area or location, then that child loses trust, but if she gets support, she can bounce back and become resilient and be able to trust the new siblings that she stays around with, but if she is still not resilient, cannot trust anybody.

The term trust was interpreted as a significant constituent of resilience building for OVC by CCG. This term was construed as an important characteristic for CCG to possess in aiding resilience building of OVC.

Manage

P22: Maybe manage is when the orphan tells you about his situation and his troubles then you try to counsel the child put him in the picture that they must not lose hope. As he is still growing up and the years go by, his life will not end there, where he is troubled. He ends up being able to manage that yes my life will not end here, life goes on and on, you can manage that the child ends up, maybe he did not like school, he goes back and he is alright, all because you explained to him and showed him how important he is.

P15: To manage the situation that you are facing.

P12: It is to cope in different things when situations are difficult.

P11: To add on what [P5] has just said, I have been working with OVCs for over ten years; they have got strong coping mechanism, the fact that she is still alive. You find other living in a shack, the rain enters and water, but they tell you the truth, the story

of that place. So you can see that she can manage, I would not be able to live there,
but she can withstand that situation, so they manage.

The term manage was used by CCG as a synonym for the term cope. CCG referred to OVC as managing in their situations of adversity and interpreted this as a charactersitc of OVC being resilient.

Cope

> *P13: Err this word is powerful, this word, it helps us as we are participants. Is to cope,*
> *is to cope with the challenges that you are facing with them in anywhere this, in the*
> *families in our communities around, it is powerful to help with in our community.*

> *P15: Even a child is in a bad situation, but it manage to cope with school, maybe at*
> *school he gets better results.*

> *P18: The coping mechanism it relies on us as participants, without u they can't cope.*

The term cope was the most accurate definition of resilience that was used by partcipants in describing resilience of OVC. Participants attributed coping not only to OVC but to themselves as CCG coping with the situations of OVC that they have to deal with.

Caring

The word care, even though not explicitly related to resilience by participants, was emphasised in its importance toward facilitating OVC resilience. The act of caring was initiated by participants through their engagement in listening to OVC and making them feel important.

P13: It is listening that makes him [OVC] aware that he is also important, because what can
I say?...Many people do not care about vulnerable children and treat them as
nobody's in the community.

The participants' explanations of what resilience is demonstrate that they had previously been educated about resiliency. Their definitions show a well conceptualised understanding of resilience. Evident in participants' definition of resilience is that participants defined

63

resilience in terms of their active contribution to aiding OVC resiliency development. Their role as participants was interpreted as a catalyst in OVC becoming resilient. This is important because it suggests that participants are active in providing psychosocial support for OVC in spite of them being untrained in the field of psychosocial support. Furthermore, this emphasizes the need for participants to be trained in psychosocial support so that they can become more skilled in providing psychosocial support.

4.2.4. The role of CCG in facilitating resiliency in the OVC they work with

Based on the participants' definition of resilience it was clear that participants were aware of resilience and it was even clearer that they saw themselves as active contributors to facilitating the development of resilience in the OVC they work with. This study aimed to further explore the mechanisms that participants used in facilitating resilience in OVC. Through prior discussions in the focus groups it was seen that participants faced numerous obstacles in doing their job efficiently, therefore it was of interest to this research to understand how participants facilitated resilience in spite of OVC living in situations of dire adversities, of which participants spoke of throughout the focus groups.

In response to the role participants play in facilitating resilience in OVC, the participants shared many personal stories and experiences. These stories also suggested that participants were able to incorporate the characteristics of resilience (as earlier defined by them) such as trust, cope, strong, support, manage and care. These stories further helped in gaining perspective of why participants selected those particular words in defining resilience. Below, are a few excerpts which were thought to best demonstrate how participants reached an understanding of resilience through their practical experiences of working with OVC.

> P14: Okay, let me refer err to my OVC story, it was on Saturday, err one of my orphans was beaten by one of the relatives here at kwaMashu. The reason why err that person beat my child was because she was suspecting that this child stole her cell phone. She just beat this child in a way that the child phoned me at night and say "my auntie beat me and then I can't even sleep right now" I spoke to this child and I say to him "you know let us deal with the situation and see how bad your wound is then after that we will have to come back and talk to your auntie". The fact that this child cope to go back home and become and normal child out of the situation then I began to understand that more than anything he was not sleeping at that time, it was

ten at night when he called me, but the following day when I called his brother "where is [Phillip]?" he just said "no, he is playing outside" coping and managing in a situation is playing with the stripes and wounds and you know, he was coping and he was managing to play out of that situation. I asked him to go to the clinic and then they found this person was beaten up in a bad way, but the challenge that I have is that her err his auntie found out that it was not him who stole a cell phone. It was an elder child who stole the cell phone, in a way that he went with him to his school and asked the teacher "did this child came with a cell phone?" and the teacher said no he is not a person who comes with cell phones here and then she did not even believe him at that time and when they went back home she found that oh! It wasn't him and she didn't even say sorry to this child and the child is coping right now. He is at school and he managed to play like things are normal yet he is not hating his auntie.

This story reiterates the situation of adversities that OVC experience, in this case physical abuse. However, in the extreme situation of abuse that this OVC found himself in, he was able to identify a system of social support i.e. the participants. Furthermore this participants was able to establish a relationship with the referred to OVC such that the OVC identified a relationship of trust that existed between the participants and himself which allowed him to call the participants. This signifies the role played by participants as systems of support. Furthermore this signifies the resilience of the referred to OVC because he was capable of identifying a source of support in his situation and he was able to utilise this support. According to this participant this OVC demonstrated coping mechanisms because he was able to continue with his daily activities in spite of him being abused.

> *P 17: Uhm the main key that we use we first build a relationship with these children, so that they can be able to communicate with us easily and expect us in times of need that is why it is easy for them, if they are facing any err difficult challenges, it is easy for them to call us, before calling anybody, because they know that the only person who will cope better with me is the participants. So building a relationship with them is the main key.*

> *P18: You must not take the child as only just a child, firstly you must have respect, do not be unapproachable.*

65

> *P16:Like I have explained my sister, that we are very helpful in the community, we have children who come and explain to us as participants who are known in the community, then he tell you his situation and his problem and you listen to that child, it is listening that makes him aware that he is also important.*

The above excerpts infer that participants are taking an active role in aiding OVC resilience development. Participants were able to identify that in order for OVC to be resilient a relationship of trust is required. This relationship of trust is established through participants showing respect to OVC, listening to OVC and facilitating communication. Participants acknowledged the need to provide a sense of belonging for OVC which requires listening, respect, trust and communication.

> *P16: Sometimes you can't do anything, because you don't have any, just sitting and listening, talking, talking, talking, by the time you're talking is continued, continued you can see that he is starting to smile and then without doing anything, just listening to them.*

Participants also identified that their scope of aiding in facilitating resilience is limited and that sometimes all they can do is listen to the OVC and talk with them. It is through participants' experiences of working in these contexts that they have found merely talking and listening to OVC is an imperative mechanism in aiding OVC to better cope, manage and deal with their situations of adversities.

> *P15: If I can just pick from one of the children that I have worked with, there is a child who has managed to stay in a place that is very small, like a size of a toilet. It was a place built for material for a site like wheel barrows. He stayed there, because his guardian had passed on. He was adopted by this sister (nun) at King George, there came a time when she passed on, she had her own biological children and they chased away the adopted child, so it cost him to go about looking for a place to stay and he found that farm with the small place to stay, it is very mall and he lives in this big site around him and because I am doing work err dealing with orphans, I was called by my children and they said to me "mom, there is a child here who is in high school in grade ten can you please come and see his situation" and his problem is*

that the teachers have tried and failed to help him then I went to the school and I found out that the child was living at that place, because he was chased away, because his mother who adopted him had passed on and the biological children of that mother did not want him. The mother had also written the child in her will and so her children refused with the child's certificate, they refused with everything they don't want him to receive anything. So we managed to take the child out of that place, he was attending school from that small house he got dressed there and did everything there. There were no rooms and no stove to cook on but he survived, he would go and fix other people's stoves, get money and buy bread, he survived in that small house, he managed to live in a place, we did not even know how he survived. I reported this to my organisation and they took him to the church where he lives now. He is now in grade twelve, he was doing grade ten that time.

P15: I can say that we can help the child to be strong and stand and be able to cope, because, for example we took that boy from a small house and he found a good room, after that he showed us his talents, we saw his hidden talents. Everything that has to do with electricity, he can do and fix it. Now the time we praise him telling him that he is doing well, "what you are doing is right, keep it up" he gets the confidence, which is saying yes he can do something, so he believes that yes, I can survive, you see. Children love to be praised about the things that they are doing.

The above story suggests that this participant was able to be empathetic towards the situation of homelessness that the OVC referred to above was facing. Furthermore, she was able to aid the OVC in finding shelter at the church. This participant also identified coping skills within this OVC because in spite of him being shunned from his adopted family, he managed to continue with school. In addition to continuing with school this OVC utilised the electrical skills he had previously learnt which allowed him to earn money for his survival. This participant interpreted the coping ability found in this OVC as one that suggested him to be resilient in spite of his situation of extreme difficulty.

While many participants shared positive stories of OVC demonstrating resilience, a few participants identified that not in all cases do OVC demonstrate resilience. Participants also voiced that in many situations, they as participants cannot identify the problems that OVC

face and at times – even though participants are working with OVC– some OVC are still involved in detrimental behavioural activities that result in criminal behaviour.

> *P12: Ya, ya, because you know sometimes you know you deal with the OVC and then some of them find it hard to open up to you. So it is even harder for us to assist them and to really help that child in terms…it is even hard to identify the problem of the OVC not unless you create that confidence and that relationship until you get to the point and know what exactly does this child needs. Sometimes some of them, they get arrested with you involved, with you helping them err they found themselves in prison yes.*

> *P5: You find that those who do not show resilience are involved in drug abuse as you have seen them around being street kids.*

> *P8: And also that maybe others cannot accept or face that they are orphans, you then he will see his friends wearing Carvella and clothes that have labels you see now he will also want those things, he will get them from who? You see he then ends up stealing, just because he wants these things. He demands thing, his will obviously not do his schoolwork well, because he does not want to accept that his situation at that time is…maybe if something were to happen, he will say "it should happen to me, because I am an orphans, my mother and father died" and he does not even think that he can do something for himself. He starts abusing alcohol; he steals and does every bad thing.*

> *P9: For some you find out that they have neglected themselves, they just get babies in order to get money they just get pregnant.*

The above excerpts bring forth the reality that many OVC do not display qualities of resilience, and are overwhelmed by the situations they find themselves in as a result of orphan-hood and vulnerability. The repercussions of this is that OVC sometimes engage in behaviour that has severe repercussions for their future, such as falling pregnant, drug addiction and stealing. As a result participants identified that OVC are experiencing many psychosocial issues and require interventions in aid of overcoming and 'bouncing back' from their adverse situations. Participants expressed that the foundation of creating change in

resilience of OVC was dependent on DSD conducting field research on the plight and issues common within the communities participants work in.

> *P3: The first thing the DSD should do is the home visit in order to know and understand what is going on out there.*

> *P6: As my colleague has just said, they [DSD] must visit so that they can see what is needed, because we see things.*

4.2.5 Reviewing current programmes implemented by the DSD and CCG for the care of OVC

Participants were asked to provide feedback on DSDs current programmes for OVC development and care. The outcome of this question was largely laden with participants not reviewing current programmes but rather suggesting the niche in programmes offered by DSD as well as what programmes DSD should be strategising toward, according to the experiences of participants. The excerpts below highlight common suggestions from participants across both districts.

> *P 19: I was thinking that they can build us rehabilitation centres next to where we live, because we have a drug problem in the community and it takes a long time for things like these to be solved. When you meet a person who is drug addicted, when you try to take him to rehab, you find that it is already full, things like that. I would like that in our nearest areas that they build rehab centres, places to learn and places to play sports in so that the children can keep themselves busy, doing crafts, sewing, thing like that*

> *P 11: maybe I would be happy if the DSD during the week, from Monday to Friday, that one day, a social worker come out, even though the children have the grant, to go and see how they are really. Do they eat well, do they study well, and what bothers them?*

> *P 5: I think that the DSD also needs to reconsider their service in terms of providing social support for the OVCs, for example if they can have a program that is uniformed in all NGOs that they are working with maybe during school holidays to have that program that maybe has two weeks or one week sessions where these OVCs can be taken to give enough free space to share their emotions, maybe they could hire and a person to*

facilitate the program or maybe they can train some participants in those skills and deploy those NGOs so that they can see and can monitor those OVCs otherwise they would say they are proving psycho-social support of which is not in reality, in practicality.

Secondly, in response to the question of programme implementation participants began to discuss the programmes that they as participants have put into place for OVC. Many of these programmes were sport related activities that participants encouraged OVC to be involved in.

P15: You and your area can start with the children you work with, maybe that as you work with them you find that oh, most of them like soccer, and others maybe love netball then you can group them. You now know that maybe on Tuesday, you will see the netball group, and on Thursday you will the soccer group. You do this yourself, and then when you see that this activity is loved by the children, then you can start challenging the next person's area to have competitions and then it goes forward as time goes by and then we see that we are moving forward, we carry on until it gets adopted throughout the area

P 8 : you know that the child is abused at home, there is no body, he is stressed, knowing that when he has to come back, he thinks about what he is going to eat and all that, but during the time when he is playing, he can see other children, seeing that he is not alone, he is not the only one with a problem there are other who also have problems, but still they are living, you can live and he gets to also do the same, because his body needs to exercise

P8: no, you see the we do not have other things like the play grounds, we don't have them, we are still doing it ourselves, maybe you know a neighbour who works at the department of sports, and then we ask from them to donate for us, to bring us the soccer ball and the gear, same as the ward committees; there is one from health, one from sports, one from agriculture we ask the resources relevant to each department for each of them to help us here and there, but we still need other things that will make us develop

P 17: I am running my program every month, there is a swimming pool and we do an awareness campaign against HIV and AIDS I advise children, I am together with the ward committee Fikile, who lives in my area, and we do this every month

4.3 Conclusion

This chapter presented the results of the current research. The results were supported by relevant excerpts. The following chapter will discuss the results based on empirical literature.

CHAPTER 5
DISCUSSION OF RESULTS

5.1 Introduction

This study on the resilience of OVC in the context of HIV/AIDS aimed to explore the factors that impact on OVC resilience − in two districts in the KwaZulu-Natal province of South Africa − through the perceptions of CCG. The study examined the perceptions and experiences of CCG in relation to their direct involvement in the resilience development of OVC they work with. Furthermore, this study investigated the factors that inhibit the development of resilience in OVC, a review of the current programmes implemented by the DSD for the care of OVC, and how CCG propose to enhance resilience development of OVC in KZN. This chapter discusses the findings that emerged in the data of this investigation.

5.2 The obligation made to OVC by DSD: An obligation not adequately fulfilled

The findings of the current study suggest that the DSD's obligation to provide OVC who are infected and affected by HIV/AIDS with supportive environments including access to school, shelter and nutrition, psychosocial support as well as accessibility to health and social services(DSD OVC Policy, Article 65)(DSD, 2003, p. 9) is an obligation that is not adequately fulfilled. Participants voiced that the greatest obstacle OVC face in attending school was a lack of service delivery of school uniforms and a lack of finances to pay school fees. These were the factors that significantly impacted on OVC enrolment and attendance of school.

According to Khanare (2012) the school is an imperative external resource that fosters resilience within children especially in a rural context of high HIV prevalence such as the context of the current study. Contextualising and promoting resilience in Africa has taken on many approaches (Ebersohn & Ferreira, 2011). One of these approaches occurs within systems of education and is perceived as having significant usefulness (Ebersohn & Ferreira, 2011). Teachers and schools become an extended family to a child, contributing to their development, well-being as well as their psycho-social needs (Ebersohn & Ferreira, 2011), addressing many of the problems that OVC in this study are experiencing. However, through the process of difficulties and risk faced by the child, the role of the teacher and school becomes more crucial to the development of their resilience (Ebersohn & Ferreira, 2011). Loots et al. (2012) report that systems of education specifically educators and schools could serve as mediators towards resilience by "providing school-based psychosocial support to

vulnerable individuals" (Loots et al., 2012, p. 57) such as those orphaned by the devastations in Africa like HIV and AIDS (Loots et al., 2012).

This highlights the importance of bridging gaps that prevent OVC in this study from accessing education as education plays a pivotal role in healthy resilience development of a child as found by Ebersohn and Ferreira (2011) as well as Loots et al (2012).

In South Africa, initiatives have been taken to address and minimise the obstacles that prevent OVC from attending school, such as the obstacles mentioned by participants in the current study. One such initiative implemented by Hope Worldwide South Africa (HWWSA) is an OVC programme in collaboration with other organisations such as the Rotary International. These programmes have reached 5076 OVC and provided them with access to school uniforms, stationary, tuition in various subjects and amongst the most needed a wavering of school fees (Chin'andu, Njaramba, Welty-Mangxaba, 2008). While their programme can be commended, it is imperative to acknowledge that there still are a significant number of OVC who require educational support and are not receiving it (Chin'andu, Njaramba, Welty-Mangxaba, 2008) some of which include the OVC participants work with. Furthermore, *The National Draft Strategic Plan* (2013-2017) (Department of Social Development, 2012) highlights that according to the SA Schools Act (Act No 84 of 1996) (RSA, 1996) all children who are on social grants are at liberty of school fee wavering. In order to receive school fee wavering all that is required is an affidavit and presentation of their SASSA card to provide evidence that they are receiving a grant (Department of Social Development, 2012). However in the context of the current study participants explained that accessing documents that would allow wavering of school fees is not always attained easily or attained at all therefore preventing OVC from accessing education. This infringes on the DSDs obligation of OVC access to education.

Participants displayed great concern for the situation of hunger and deprivation that many OVC face especially at the crucial time after they have been orphaned. An initiative adopted by the DSD is to provide OVC with food parcels for the duration of three months after they have been orphaned. The rationale for this duration is that ideally within three months OVC should be placed in a foster home or foster care. However, the procedure of accessing food parcels is notoriously difficult resulting in OVC not having access to food parcels, as mentioned by participants. Accessing food parcels requires OVC to have documentation such

as a birth certificate or ID. The procedure of accessing these documents is slow and lengthy and involves red tape. Therefore in the duration of accessing necessary documentation OVC are left with their basic need of nutrition unmet. While there is a vast amount of literature on initiatives that are put into action for OVC care including access to food parcels, foster grants and free education-amongst others-not much literature evaluates the efficacy of these initiatives; how they benefit OVC; how they can be improved; and what are the constraints of these initiatives (Grady et al., 2008).

A study conducted by Skinner, Sharp, Jooste, Mfecane and Simbayi(2013) found that 8% of orphans in the area of Kanana in the North West province of South Africa did not have birth certificates and experienced the same difficulty in accessing grants as did the participants in the current study. This highlights that the problems associated with not having a birth certificate are not isolated to OVC in KZN but are also experienced in other provinces. Skinner et al. (2013) quantified OVC access to food and found that 51% of OVC in Kanana did not have access to food for at least one day in a week infringing on OVCs basic rights of nutrition and compromising the DSDs obligation made to OVC. This reiterates that the problem of poor access to food for OVC extends beyond the group of participants in the current study and highlights the need for governmental intervention.

The current study found that the provision of psychosocial services for OVC has not been sufficiently provided, and this is urgently required for the facilitation of OVC resilience. A study by (Martin, 2015) whose aim was to explore issues pertaining to psychosocial support provision for OVC found that OVC psychosocial support was not only related to their own internal resilience but was also linked to factors outside of the child such as caregivers psychosocial support as well as caregivers not having adequate psychosocial support to deal with taking care of OVC. These findings confirm the concerns of participants in this study who expressed that as CCG they were not provided with psychosocial support or equipped with the psychosocial skills required to care for OVC or to provide OVC with psychosocial support. Martin (2015) delves into the impact of caregivers not receiving psychosocial support and terms this "caregiver burnout" (p. 26) which many of the participants clearly demonstrated by stating that as CCG they did not receive much government psychosocial support and expressed frustration related to their job. However, in the relevant districts participants developed their own psychosocial support networks by sharing problems with other CCG therefore creating their own support networks. There is gap in research in relation

to self-formed psychosocial support networks for CCG. However, participants voiced that in their own experience these psychosocial support networks helped them to better cope with the stressors of being a CCG therefore better enabling participants to provide support to OVC.

5.3 The impact of slow/delayed service delivery on OVC

The findings of the current study revealed that slow service delivery is a risk factor that contributes most significantly to OVC's lack of resilience and development. Slow service delivery has negative implications for the OVC in terms of accessing food parcels, shelter, foster grants and education, impacting on their basic needs of survival and compromising the DSDs obligation made to OVC, as mentioned by participants. In spite of service delivery having significant impacts on vulnerable populations in South Africa there is a gap in empirical literature and research pertaining to this issue. Neswiswa (2014) provides a practical framework of how service delivery in South Africa can be improved. The foundation of the movement towards efficient service delivery is linked to systematic monitoring systems of services across departments that have a direct influence on OVC such as the department of education, health and social development. Without implementing systematic monitoring systems the service provision in South Africa will remain incompetent (Neswiswa, 2014) and OVC will continue experiencing difficulty in accessing necessary documents in order to receive grants, food parcels, shelter and access to education. Systematic monitoring systems is also necessary, according to Neswiswa (2014), for the improvement of "data collection systems, analysis and dissemination" (Neswiswa, 2014, p.32) which can influence progress in other important areas including "government, civil society organizations and within the community" (Neswiswa, 2014, p.32). This progress can also extend to the care of OVC.

According to PEPFAR (2012) the assessment of services provided to OVC is necessary to make certain that OVCs needs are being fulfilled. "PEPFAR (2006:10) notes that effective services must result in a reduction in vulnerability and an improvement in the wellbeing of OVC" (Neswiswa, 2014, p. 24). While this underlines the epitome of service delivery for OVC participants expressed a different reality of OVC service delivery which further places OVC into vulnerabilities such as lack of food, inability to access grants, education, food parcels and shelter. This again reiterates the need for systematic monitoring systems of

services in South Africa which will curb the barriers faced by OVC in having the DSD's obligation met (Neswiswa, 2014).

5.4 CCG's understanding of resilience

An imperative aspect of this study was to gain insight into participants understanding of resilience and their role in resilience development of the OVC they work with. Findings suggest that in both districts participants had a good conceptual understanding of resilience and saw themselves as playing an active role in the resilience development of the OVC they work with. (Karim, 2010) confirms this finding by stating that CCG play an integral role in the psychosocial development of OVC including resilience building. However, Karim (2010) highlights the limits of CCG's care for OVC due to a lack of integration between systems of care for OVC. Karim's (2010) finding is supported by participants who emphasized the breakdown between various stakeholders who care for OVC such as poor communication between social workers and CCG as well as various government departments such as the DSD and the DoE and how this breakdown has negative impacts on CCG's scope to adequately care for OVC.

Current findings suggest that the OVC participants work with are in situations of compounding adversities including poverty, food insecurity, psychological distress, abuse and experience constitutional rights not being met, placing OVC at increased cumulative risk. Findings reveal that within these situations of cumulative risk the resilience of OVC varies from OVC to OVC and is therefore not the same for every OVC. This finding links back to one of the earliest theorizations of resilience which outlined the principle of resilience as a child possessing personal qualities and characteristics that facilitate bettering coping mechanisms in the face of adversities (Saklofske et al., 2013), therefore locating resilience as intrinsic and not merely as a process or extrinsically located (Embury, 2013). This provides an explanation as to why some participants identified certain OVC as demonstrating resilient characteristics while other OVC who are in similar situations showed minimal resilient development.

Furthermore Skovdal & Daniel (2015) conducted a study on OVC in Sub-Saharan Africa who were exposed to cumulative risk such as adapting to life after death of a parent and adjusting to new living arrangements. The findings of this study revealed that OVC, "are not passive victims who sit and wait for help, but are competent social actors who actively cope

with difficult social circumstances through skill and ingenuity" (Skovdal & Daniel, 2015, p. 160). This finding is similar to findings in the current study whereby participants narrated stories of OVC resilience in spite of adversities. These narrations included stories of OVC being able to identify systems of support and actively seeking help from these systems including CCG as well as OVC showing resilience in pursuing school in spite of experiencing major psychological distress such as being shunned from adopted family members as was narrated by P15.

In the current study the social support structure of CCG appears to have a direct impact on increasing resilient factors of OVC. The presence of CCG as a form of social support for OVC has proven to stimulate resilient factors within OVC as was demonstrated in the narratives of participants particularly facilitated by the role of CCG as listener and carer of OVC (Salami, 2010). The system of care-giving serves as a protective factor against the cumulative risks that many OVC in this study experience. In many cases the presence of CCG provided a platform through which dialogue could exist for OVC. Effective communication or the opportunity for communication between CCG and OVC is interpreted as a coping strategy which impacts the resilience development of OVC. The coping mechanism of communication is of vital importance in the context of the study where many OVC are left with no place for expression or communication due to the breakdown in family networks. CCG to some extent addressed the gap of communicational breakdowns facilitating a sense of OVC being heard and reciprocally impacted OVC resilience development. There is not much research that directly explores the psychological resilient development affects of communication between CCG and OVC. However, existing research including a study conducted by (Wang, Li, Barnett, Zhao & Stanton, 2012) found that trusting relationships such as the relationships established between CCG and OVC in the current study is found to be a "proximate protective factor" (Wang et al, 2012, p. 1435) in other words the relationship between CCG and OVC serves as a protective factor aiding in resilience building of OVC as is demonstrated in the current study.

5.5. Reviewing current programmes implemented by the DSD &CCG for the care of OVC

The DSD has recognised many of the identified issues found in the current research including the need for improved interventions for the care of OVC. *The Draft National Strategic Plan* (DSD, 2012) is focused on ensuring early intervention programmes to caregivers and children including OVC in South Africa. Their mission is aligned with ensuring provision of inclusive social services targeted towards the protection of OVC based on the South African legislation. A fundamental goal or strategy implementation from the National Strategic Plan (2013-2017) (DSD, 2012) is that there is an urgent need for amendment of the Social Assistance Act (Act No 13 of 2004) in order for guardians of OVC to access social grants speedily (DSD, 2012). The implication for this amendment in relation to the current research is that many of the cumulative risk OVC experience particularly at the crucial time after being orphaned will be controlled/ minimised because OVC will ideally be able to manage addressing their basic needs such as food security, accessing shelter and education. Reciprocally this should address some of the baseline risk factors that OVC in this study experience.

As part of resilience development strategies, CCG often voiced that sports related activities can be used as a medium for resilience development of OVC. According to Jeanes (2011) sport is increasingly being used as a "development tool" (Jeanes, 2011, p. 388) to address psychosocial issues, health concerns and hazardous behaviours within youth with the ultimate goal of reaching social change.

Findings from a study conducted by Jeanes (2011) suggested that vulnerable youth who are involved in sports related activities interpreted engaging in sport as a support structure. Sport provides vulnerable youth with the opportunity for developing friendships with other youth in similar situations, therefore creating a sense of belonging, togetherness and trust (Jeanes, 2011). Sporting activities creates a system of cohesion and togetherness in a context where many OVC are left vulnerable and alone. The process of engaging in sport produces a platform for OVC to interact with other OVC in similar situations in a constructive non-threatening manner. This serves as a mediating factor towards reducing risk and promoting resilience for OVC (Jeanes, 2011).

Through CCG narratives it is highlighted that certain OVC engage in behaviour which is hazardous to their development as a result of the many risks and psychological trauma that OVC experience. CCG in this study identified OVC engagement in sport as imperative to OVC resilience development. CCG insight into the resilient building potential of sport is consistent with many studies which report that engaging in sporting activities has the positive outcome of reducing psychological stress which leads to anxiety, depression and tension which is common to many OVC in this study (Bailey, 2005).

5.6 Conclusion

In conclusion, this study has provided a detailed qualitative analysis of resiliency in the context of HIV/AIDS in the KwaMashu and Mngondluvo districts of KwaZulu-Natal. The data that emerged suggests that even though there is government support, intervention and policy in favour of OVC there still remains huge deficits in OVC optimizing government structures. This is mainly linked to breakdowns within systems of government such as slow service delivery which has reciprocal affects on DSDS obligation made to OVC not being met therefore negatively impacting OVC resilience development. This finding proves to be the most significant factor that impacts OVC resilience and serves to inhibit OVC resilience development.

However, data from the current study suggests that CCG play an influential role in the resilience development of OVC. CCG provide a baseline support structure for OVC that they would otherwise not have. CCG are ideally meant to be catalytic in ensuring OVC have access to shelter, food and education, however data from the current study suggests that CCG often face many obstacles in providing support for OVC due to breakdowns within government systems of support as well as lack of government support. This highlights the need for future research to evaluate the efficacy of government interventions for the care and support of OVC including addressing the needs of CCG so that they are better able to care for OVC.

6.1 Introduction

This is the concluding chapter of the current study. This chapter will provide a succinct conclusion of the current research. This chapter will also provide recommendations for future research. Recommendations will address some of the encountered limitations in this study as well as gaps that surfaced.

6.2 Conclusions Drawn in Relation to the Research Questions

The following are conclusions drawn from the findings of the study in relation to the research questions:

6.2.1 CCG's perspectives on why OVC in South Africa may not be as resilient as OVC in other parts of the world

According to CCG, many of the OVC they work with experience their basic rights not being met as a result OVC face multiple adversities after being orphaned. The CCG are aware of and recognise the obligation made by the DSD to OVC. However, CCG report that there are many obstacles that prevent or make it difficult for OVC to access the services promised by the DSD in the obligation. In most cases service delivery is slow and cumbersome and involves red tape which delays the process of OVC accessing necessary documents to obtain food parcels, education and shelter. In the interim OVC are left with no food, shelter or access to education therefore placing them at great risk with minimum support structures.

According to CCG, the process of inefficient and slow service delivery is a significant factor that impacts on OVCs levels of resilience on a macro level and it translates too many OVC being left destitute after being orphaned. Furthermore research shows that in the absence of a primary caregiver the schooling environment becomes more crucial to the development of a child's resilience (Ebersohn &Ferreira, 2011). This reiterates the problem OVC in this study face because they are unable to access support structures that promote resilience such as the school, therefore making it difficult for them to demonstrate resilience.

6.2.2 CCG's perspectives as to how OVC who are faced with multiple adversities in KZN can be assisted to become more resilient

The CCG identified lack of shelter as the first risk factor OVC face. They suggested the need for building *safety homes* for OVC to be protected and cared for. Furthermore, OVC who do have shelter are living in environments that are not conducive to their optimal development as they do not have running water or electricity. Therefore according to CCG if OVC are placed in *safety homes* it will be easier for the DSD to monitor their living arrangements.

Secondly, psychosocial service provision is an imperative aspect to OVC overcoming adversities and reaching a point of mental well-being as a result CCG requested training so that they can offer psychosocial services to OVC. Thirdly, a significant influence exacerbating OVC adversities is the issue of slow service delivery. Due to poor service delivery OVC are placed in a worse situation than they were prior being orphaned as it is difficult for them to access food parcels and education. CCG argued that better monitoring of service delivery by the DSD will help to curb this issue and subsequently lessen the adversities experienced by OVC.

Lastly, in order for those working first hand with OVC such as CCG to be effective at their jobs there is a need for improved communication between all stakeholders involved in the care of OVC such as relevant government departments and social workers. CCGs argued that if all stakeholders worked together in a collaborative manner with efficient communication then there would be a common understanding of how to minismise the adversities experienced by OVC and all stakeholders would reach a common goal for the care and protection of OVC.

6.2.3 The role of CCG in building resilience for OVC

The CCG saw themselves as catalytic to the resilience development of OVC they work with. They demonstrated genuine care and concern for the OVC. Due to their close working relationship with OVC they saw potential in their role of caregiver to assist OVC in resilience building. The CCG identified a gap in psychosocial support provision to OVC- which is greatly needed to ensure mental well-being of OVC (Thwala, 2013). The CCG admitted to providing psychosocial support to the OVC they are in care of. However they voiced concern that they were not trained to provide psychosocial support and therefore were unsure of the effectiveness of their lay psychosocial support provision. In brainstorming ideas of how to

facilitate resilience in OVC, CCG showed willingness to receive training on psychosocial support so that they would have the necessary skills to provide psychosocial support for OVC. According to Thwale (2013) psychosocial support is vital in strengthening OVCs inner resources to help them better cope with and overcome the hardships they are faced with, in other words psychosocial support is essential to the resilience development of OVC.

6.2.4 CCG's insights into the gaps in interventions of the DSD for OVC resilience building

CCG highlighted an array of psychosocial issues that the OVC they work with experience. As a result CCGs put forth ideas of interventions they saw fitting for the specific problems within the communities they worked in. The first identified problem was the issue of drug exploitation and the need for establishing rehabilitation centres within the community. Included in the rehab centres should be stimulating activities and skills building opportunities so that the children are occupied and mentally stimulated.

Secondly, CCG pointed out the need for closer monitoring by the DSD of the services they offer to OVC and whether these services are achieving the desired outcomes. CCGs mentioned that the DSD have programmes during school holidays that are aimed at providing psychosocial support to OVC. However, CCG voiced that these programmes are not always efficiently run and therefore OVC do not always benefit from them.

Thirdly, CCG unanimously agreed that sport is an important aspect of resilience development as it provides an outlet for the OVC, a sense of belonging and helps OVC to establish friendships as well as to stay out of unruly activities. However, CCGs are restricted in their ability to progress with sports development for OVC as they do not always have equipment for sport. Therefore CCGs request the government departments to become more involved in sports development within their communities. Sport is proven to be effective as a support structure for vulnerable youth as sporting activities provides a space for OVC to engage with other OVC in a productive non-hostile context (Jeanes, 2011). This provides a mediating factor to minimising risk and developing resilience for OVC (Jeanes, 2011).

6.3 Implications for theory, policy and practice

The findings and conclusions drawn from the current study have the following:

There is a need for:

- Improved implementation, monitoring and execution of service delivery that affects OVC accessing necessary documentation in order to receive grants, food parcels, shelter and education is needed.

- Training of CCG to provide OVC with psychosocial support.

- Building of *safety homes* for OVC to be protected and safe from abuse.

- Collaboration of various stakeholders who are concerned with the care of OVC so that there is a mutual understanding of the strategies to assist OVC in overcoming their adversities.

- Incorporation of sporting activities as a risk reducing factor for OVC based on the communities that OVC reside in.

- Assistance from governmental departments to aid CCG in acquiring equipment for OVC sporting activities.

- Development of rehabilitation centres for OVC within the communities.

- The core of adversities experienced by OVC is worsened by factors that lie outside their control and within the chronosystem. As a result in order for resilience of OVC in South Africa to be improved government structures need to evaluate and assess existing interventions efficacies and devise new better monitored interventions for the care and protection of OVC.

- Research aimed at receiving local knowledge from those directly involved in the care of OVC, such as CCG, will aid in developing interventions that are practical, doable, needed and will result in social transformation for OVC.

6.4 Limitations of the current study

The current study is limiting in its applicability to other contexts as the sample was drawn from two specific districts in KwaZulu-Natal. Therefore findings cannot be generalized to populations outside of these two districts.

Furthermore, all of the participants were first language isiZulu speaking. This may have caused a language barrier between the researcher and participants as the researcher is first language English speaking. This barrier was addressed by the use of bilingual co-facilitators

to minimize any language misinterpretations but there is no certainty that data was not lost in translation.

It was difficult to locate empirical literature against which findings of the current study could be deliberated as it seems that not much existing literature focuses on CCG and their influence in resilience development of OVC. However, at the same time this implies that there is a need for future research to focus on this gap in literature.

6.5 Recommendations for future research

Firstly, future research may address some of the limitations encountered in the current study. This includes carrying out similar research in other parts of South Africa so as to collaborate a more representative sample. This will serve to further validate findings from the current research and increase its generalisability, if future findings are similar.

Secondly, the current study has found that there are huge gaps in empirical literature that evaluates the efficacy of government initiatives that are put into place for the care of OVC in the context of South Africa. While there are policies, legislation and initiatives that outline the standard of care for OVC not much literature evaluates; how effective these initiatives, policies and legislation are when practically utilized or put into motion. Therefore future research could address this gap.

Thirdly, future research could explore the benefits of resilience on OVC care when CCG are better equipped and trained in psychosocial support services.

Fourthly, there is a need for improved communicational platforms between stakeholders that care for OVC extending from OVCs mesosytems (CCG) to the chronosystems (government), so that there can be better collaboration in the DSD fulfilling their obligation made to OVC. Future research could research methods, tool and resources that facilitate efficiency between various stakeholders for the care of OVC.

6.6 Conclusion

In the context of HIV/AIDS, resilience development for OVC is significantly impacted on by numerous factors that lie outside the control of OVC. The current study explored CCG's perceptions of factors that impede on the development of resilience in OVC in the

KwaMashu and uMgungundlovu districts of KwaZulu-Natal. In the review of literature it was found that not much research has focused on the role of CCG in facilitating resilience of OVC. However, findings in the current study suggest that CCG play an integral role in facilitating resilience of OVC mainly by providing OVC with a support system that OVC would otherwise not have. However, simultaneously CCG face many obstacles in doing their job due to slow service delivery which has rippling effects on OVC not having the obligation made by DSD to them fulfilled. Therefore, CCG in the current study report that many of the factors that impede resilience development for OVC stem from their basic needs and rights not being met such as not being able to access food parcels and not receiving education because of inability to attain necessary documents for school fee wavering and to access food parcels. In conclusion the current study found that in spite of there being policies, legislation and initiatives put into place for the care of OVC by government and government departments like the DSD these policies, initiatives and legislations need to be evaluated in their relation to their efficacy and revised accordingly.

REFERENCES

AfricaCheck (2014). *How many orphans are there in South Africa?* Retrieved from https://africacheck.org/factsheets/factsheet-how-many-orphans-are-there-in-south-africa/

Agaje, S.W. (2008). *Resilience among children exposed to traumatic loss* (Unpublished master's thesis). University of Oslo.

Ardington, C., Leibbrandt, M. (2010). Orphanhood and Schooling in South Africa: Trends in the vulnerability of orphans between 1993 and 2005. *Journal of economic, culture and development change, 58 (3*), 507-536. doi: 10.1086/650414

Attride-Stirling, S. (2001). Thematic networks: An analytical tool for qualitative research *Qualitative Research, 1*(3), 385- 405.

Babbie, E., & Mouton J. (2005). Qualitative studies. In E. Bobbie & J. Mouton. (2005). (Eds.). *The practice of social research* (pp.269-311). Cape Town: Oxford University Press.

Bailey, R. (2005). Evaluating the relationship between physical education, sport and social inclusion. *Educational Review, 57*(1), 71-90. doi:10.1080/0013191042000274196

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,3*(2), 77-101. doi: 10.1191/1478088706qp06309

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Harvard University Press

Carter, B.J. (2013). *A contextually appropriate protocol in social work for the assessment of prospective foster parents in South Africa*(Unpublished masters thesis). University of Johannesburg, Johannesburg.

Chin'andu, A., Njaramba, P., &Welty-Mangxaba, J.W. (2008). *HOPE worldwide South Africa OVC programmes*. Retrieved from http://www.cpc.unc.edu/measure/our-work/ovc/ovc-program-case-studies/ovc-case-studies-sa/Hope%20WorldwideSA-%20SR-842-H3.pdf

Cluver, L., & Gardner, F. (2007). The mental health of children orphaned by AIDS: A review of international and southern African research. *Journal of Child Adolescence and Mental Health, 19*(1), 1-17. doi: 10.2989/17280580709486631

Collumbien, M., Busza, J., Cleland, J., & Campbell, O. (2012). *Social science methods for research on sexual and reproductive health.* World Health Organisation: WHO Press.

Daniel, M., & Mathias, A. (2012). Challenges and coping strategies of orphaned children in Tanzania who are not adequately cared for by adults. *African Journal of AIDS Research, 11*(3), 191-201. doi: 10.2989/16085906.2012.734978

Denzin, N., & Lincoln, Y. (Eds.). (2011). *Handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Department of Social Development (DSD). (2003). *Children affected by HIV/AIDS in South Africa a rapid appraisal of priorities, policies and practices*. Retrieved from http://www.unicef.org/southafrica/SAF_resources_safethechildren.pdf

Department of Social Development (DSD). (2005). *Policy framework on orphans and other children made vulnerable by HIV and AIDS South Africa*. Retrieved from http://www.sarpn.org/documents/d0002008/Policy-Framework_OVC_Jul2005.pdf

Department of Social Development (DSD). (2010). *Annual report for the year ended 31 March 2010*. Retrieved from http://www.gov.za/sites/www.gov.za/files/DSD%20ANNUAL%20REPORT%202010_v2.pdf

Department of Social Development (DSD). (2012). *Strategic plan 2012-2015*. Retrieved fromhttp://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=283&Itemid=39

De Vos, A. S., Strydom, H., Fouche, C. B.,&Delport, C.S.L. (2002). *Research at grassroots for the social sciences and human services professions* (2nd ed.). Pretoria: Van Schaik.

Ebersohn, L., & Ferreira, R. (2011). Coping in an HIV/AIDS dominated context: Teachers promoting resilience in schools. *Health Education Research*, *26*(4), 596-613. doi: 10.1093/her/cyr016

Ebrahim, M.A. (2012). *Thematic analysis: A critical review of its process and evaluation.* Retrieved from: http://www.westeastinstitute.com/wp-content/uploads/2012/10/ZG12-191-Mohammed-Ibrahim-Alhojailan-Full-Paper.pdf

Freeman, N., &Nkomo, M. (2006). Assistance needed for the integration of orphaned and vulnerable children? Views of South African family and community members. *Journal of Social Aspects of HIV/AIDS, 3*(3)*, 503-509. doi: 10.1080/17290376.2006.9724877

Guest, G., McQueen, K., & Namey, E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: Sage.

Guvava, D.D. (2011). *Reconceptualising 'care' for vulnerable children in the context of HIV/AIDS: A case study of Cotlands*(Unpublished masters thesis). University of Witwatersrand, Johannesburg.

Hayley, J.F., & Bradbury, J. (2015). Child-headed households under watchful adult eyes: Support or surveillance? *Journal of childhood, 22(3)*, 394-408. Doi: 10.1177/0907568214548282

Indexmundi (2014). *HIV/AIDS adult prevalence rate*. Retrieved fromhttp://www.indexmundi.com/g/r.aspx?t=50&v=32

Jameel, S.N., Shah, S.A., & Ganaie, S.A. (2015). Perceived social support and resilience among orphans: A systematic review. *The international journal of Indian psychology, 3(1)*, 77-82. Retrieved from: http://oaji.net/articles/2015/1170-1449829063.pdf

Jeanes, R. (2011). Football's coming home: A critical evaluation of the Homeless World Cup as an intervention to combat social exclusion. *International Review for the Sociology of Sport*. doi: 10.1177/10126902141428391

Jefford, M.,& Moore, R. (2008). Improvement of informed consent and the quality of consent documents. *The Lancet Oncology, 9*(5), 485-493. doi: 10.1016/S1470-2045(08)70128-1

Johnston, E. (2015). *Orphans' hope: An evaluation of residential orphan care in Malawi Africa* (Unpublished master's thesis). Southeastern University, Lakeland.

Karim, F. (2010). *An exploration of the concerns and motivations of community caregivers working with children in adversity* (Unpublished master's thesis). University of KwaZulu-Natal, South Africa.

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research*, *19*(2), 279-289. doi: 10.1177/1049732308329306

Kerr, A.J. (2011*). Caregivers' perceptions of displayed resilience among pre-school aged children living in a South African children's home* (Unpublished masters thesis). University of Wits, Johannesburg.

Kganakga, M.C. (January, 2013). An overview of the HIV OVCY programme in South Africa.Keynote address for the Workshop on*"Supporting and Caring for OVCY: The South African Context"*, REPSSI/UKZN Community-Based Work with Children and Youth, Pietermaritzburg, South Africa.

Khanare, F. (2012). School children affected by HIV in rural South Africa: Schools as environments that limit or enable coping. *African journal of AIDS research, 11*(3)*, 251-259. doi: 10.2989/16085906.2012.734985

Killian, B. (2004). Risk and resilience. InPharoah, R. (Ed). *A generation at risk? HIV/AIDS, vulnerable children and security in Southern Africa.* Retrieved fromhttp://www.iss.co.za/pubs/Monographs/No109/Chap3.htm

Kirkpatrick, S.M., South, B.J., Rojjanasrirat, W., Novelli, K.W.,& Williams, L.A. (2014). Perceptions of orphans' grief support program in Zambia. *Clinical Nursing Studies, 2*(4)*, 30-38. doi: 10.5430/cns.v2n4p30

Krauss, S.E. (2005). Research paradigm and meaning making: A primer. *The Qualitative Report*, *10*(4), 758-770. Retrieved from:http://www.nova.edu.ssss/QR/QR10-4/krauss.pdf.

Loots, T., Ebersohn, L., Ferreira, R., & Eloff, I. (2012). Teachers addressing HIV and AIDS related challenges resourcefully. *Southern African Review of Education*, *18*(1), 56-84. Retrieved from: http://repository.up.ac.za/bitstream/handle/2263/19626/Loots_Teachers(2012).pdf?sequence=1

Magadi, M.A. (2011). Understanding the gender disparity in HIV infection across countries in sub-Saharan Africa: evidence from the Demographic and Health Surveys. *Journal of Sociology of Health and Illness, 33*(4), 522-539. doi: 10.1111/j.1467-9566.2010.01304.x

Makoae, M.G. (2015). *Experiences of caregivers implementing HIV and AIDS services within community based organizations (CBOS)* (Unpublished thesis). University of Free State.

Mampane, R., & Bouwer, C. (2011). The influence of township schools on the resilience of their learners. *South African Journal of Education, 31*(1)*, 114-126. Retrieved fromhttp://www.sajournalofeducation.co.za/index.php/saje/article/view/408/229

Maphalala, M.C., & Ganga, E. (2014). Developmental experiences of OVC in child-headed households and the impact og cognition and learnjng. *Mediterranean journal of social sciences, 5(3)*, 312-323. doi: 10.5901/mjss.2014.v5n3p312

Marshall, C., & Rossman, G.B. (2011). *Designing qualitative research* (5th ed). Thousand Oaks, CA: Sage Publications.

Martin, C. (2015). *Caregiver perspectives on psychosocial support programming for orphans and vulnerable children in South Africa: A non-governmental organization case study* (Unpublished master's thesis). University of Ottawa, Canada.

Maseko, P.Z. (2014). *An exploration of the needs and services provided to orphan and vulnerable children affected by HIV and AIDS in Richmond, KwaZulu-Natal, South Africa.*(Unpublished masters thesis). UNISA, South Africa.

Mavhandu-Mudzusi, A.H., Sandy, P.T., &Francis, T.K. (2014). Factors contributing to intergenerational sexual relationships among refugee girls in the city of Tshwane, South Africa. *Mediterranean Journal of Social Sciences, 5*(20), 2876-2884.doi: 10.5901/mjss.2014.v5n20p2876.

McIntyre, A. (2008). *Participatory action research*. Thousand Oaks, CA: Sage.

Mayaba, N.N., & Wood, L. (2015). The value of using folktale as an intervention tool to enhance resilience for children orphaned and rendered vulnerable by HIV and AIDS. *Education as change, 19(1)*, 10-35. doi: 10.1080/16823206.2015.1024143

Merriam, S. (2009). *Qualitative research: A guide to design and implementation* (2nded.). San Francisco, CA: Jossey-Bass.

Mohasoa, I.P. (2010). *Substance abuse amongst male adolescents*(Unpublished master's thesis). University of South Africa, Pretoria.

Mueller, J., Alie, C., Jonas, B., Brown, E., &Sherr, L. (2011). A quasi-experimental evaluation of a community based therapy art intervention exploring the psychosocial health of children affected by HIV in South Africa. *Tropical Medicine and International Health journal, 16*(1)*, 57-66. doi: 10.1111/j.1365-3156.2010.02682.x

Mutenheri, H. (2013). *A formative evaluation of the James House Programme for orphans and vulnerable children* (Unpublished master's thesis). University of Cape Town, Cape Town.

Mutumba, M., Bauermeister, J.A., Musiime, V., Byaruhanga, J., Kiweewa, F., Snow, R., & Tsai, A.C. (2015). Psychosocial challenges and strategies for coping with HIV among adolescents in Uganda: A qualitative study. *Journal of AIDS patient Care and STDs, 29*(2), 86-94. doi: 10.1089/apc.2014.0222

Mwoma, T., & Pillay, J. (2015). Psychosocial support for orphans and vulnerable children in public primary schools: Challenges and intervention strategies. *South African Journal of Education, 35*(3), 1-9. doi: 10.15700/SAJE.V35N3A1092

Nes, F.V., Abma, T., Jonsson, H.,&Deeg, D. (2010). Language differences in qualitative
research: Is meaning lost in translation? *EuropeanJournal of Ageing, 7*(4), 313-316.
doi: 10.1007/510433-010-0168-y

Neswiswa, K.G. (2014). *Evaluating the effectiveness of psychosocial services rendered by the
Godisanang OVC programme in Rustenburg* (Unpublished master's thesis).
University of South Africa, Pretoria.

News24. (2014). *HIV third leading cause of deaths in SA*. Retrieved
from:http://www.news24.com/SouthAfrica/News/HIV-third-leading-cause-of-deaths-
is-SA-20141202

Ngonyama, L.G. (2013). *Exploring community resilience strategies on challenges faced by
orphans and vulnerable children affected by HIV and AIDS in Ekurhuleni
Metropolitan Municipality, Gauteng* (Unpublished master's thesis). University of
South Africa, Pretoria.

Ngwenya, M. (2015). *An investigation into challenges faced by community-based
interventions for orphans and vulnerable children in Mutare, Zimbabwe* (Unpublished
master's thesis). University of South Africa, Pretoria.

Nyberg B.J., Yates D.D., Lovich R., Coulibaly-Traore D., Sherr L., Thurman T.R., Sampson
A., & Howard B. (2012). Saving lives for a lifetime: Supporting orphans and
vulnerable children impacted by HIV/AIDS. *Journal of Acquired Immune Deficiency
Syndromes, 60*(2)*,* 127-135. doi: 10.1097/QAI.0b013e31825da836

Nziyane, L.F., & Alpaslan, A.H. (2012). The realities of orphaned children living im child-
headed households. *Journal of social work, 48(3)*, 290-307. Doi: 10.15270/48-3-86

O'Grady, M., Njaramba, P., Sebastian, B., Ching'andu, A., Oti, S., Selvaggio, P.M., Welty-
Mangxaba, J., & Thurman, R.T. (2008). *OVC programmes in South Africa funded by
the U.S President's Emergency Plan for AIDS Relief (PEPFAR)*. Retrieved
from:http://www.cpc.unc.edu/measure/our-work/ovc/ovc-program-case-studies/ovc-
case-studies-sa/Summary-SR0842-SUM-v2.pdf

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks,
CA: Sage.

Pierce, R. (2008). Analyzing qualitative information: Classifying, coding and interpreting
information. In R. Pierce, *Research methods in politics*(pp. 241-262). London: SAGE
Publication.

Phillips, L. (2015). An outcome evaluation of psychosocial services provided to orphans and
vulnerable children in the Western Cape. *Western Cape Government, DSD*. Retrieved

from:https://www.westerncape.gov.za/sites/www.westerncape.gov.za/files/an_evaluat
ion_of_psycho_social_services_for_ovc_aug_2015_0.pdf

Republic of South Africa (RSA). (2007).*Children's amendment act, no.41 of 2007*. Pretoria:
Government Printers.

Resnick, D.B. (2008). Environmental health research involving human subjects:
Ethicalissues.*Environmental Health Insights*, *8*(2), 27-34.

Ruiz-Cantero, M.T., Vives-Cases,C., Artazcoz, L., Delgado, A., Calvente, M., Miqueo, C.,
Montero, I., Ortiz, R., Ronda, E., Ruiz I.,& Valls, C. (2007).A framework to analyse
gender bias in epidemiological research. *Journal of Epidemiological Community
Health, 61*(2), 46-53. doi: 10.1136/jech.2007.062034

Rukundo, P. (2012). *Children orphaned by AIDS who live in orphanages in Uganda: What
enables them to thrive*? (Unpublished masters thesis). University of Bergen, Norway.

Russell, H.,& Ryan, G. 2009. *Analyzing qualitative data: Systematic approaches*. California:
Sage Publications.

Saklofske, D.H., Nordstokke, D.W., Embury, S.P., Crumpler, T., Nugent, S., Vesely, A., &
Hindes, Y. (2013). Assessing personal resiliency in young adults: The resiliency scale
for children and adolescents. In Embury, S.P. & Saklofske, H.D. (Eds.). *Resilience in
children, adolescents and adults: Translating research into practice* (pp. 189-198).
New York:SpringerScience &Business Media.

Salami, S.O. (2010). Emotional intelligence, self-efficacy, psychological well-being and
students' attitudes: Implications for quality education. *European Journal of
Educational Studies, 2*(3)*, 247-257.

Saldana, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, CA:
Sage.

Schram, T. H. (2006). *Conceptualizing and proposing qualitative research* (2nd ed.).
New Jersey: Pearson Prentice Hall.

Sherr, L., Yakubovich, A.R., Skeen, S., Cluver, L.D., Hensels, I.S., Macedo, A., &
Tomlinson, M. (2016). How effective is help on the doorstep? A longitudinal
evaluation of community based organization support. *PLoS ONE, 11 (3),* 1-12. doi:
10.1371/journal.pone.0151305

Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D.,
Onoya, D. (2014).*South African national HIV prevalence, incidence and behaviour
survey, 2012*. Cape Town: HSRC Press.

Silverman, D. (2006). Credible qualitative research. In D. Silverman, *Interpreting qualitative data*(pp. 271-316). London: SAGE Publications.

Silverman, D. (2009). Evaluating qualitative research. In D. Silverman, *Doing qualitative research*(pp. 292-308). London: SAGE Publications.

Skinner, D., Sharp, C., Jooste, S., Mfecane, S., & Simbayi, L. (2012*). A study of descriptive data for orphans and non-orphans on key criteria of economic vulnerability in two municipalities in South Africa.*doi: org/10.4102/curationis.v36i1.105

Skovdal, M.,& Daniel, M. (2012). Resilience through participation and coping-enabling social environments: The case of HIV-affected children in sub-Saharan Africa. *African Journal of AIDS Research, 11*(3), 153-164. doi: 10.2989/16085906.2012.734975

Skovdal, M., &Ugutu, V.O. (2012). Coping with hardship through friendship: The importance of peer social capital among children affected by HIV in Kenya. *African Journal of AIDS Research, 11*(3)*,* 241-250. doi: 10.2989/16085906.2012.734983Snyman, M.A. (2012).*Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence* (Unpublished master's thesis). University of Stellenbosch, Stellenbosch.

Statistics South Africa. (2014). *Mid-year population estimates*. Retrieved from: http://www.statssa.gov.za/publications/P0302/P03022014.pdf

Tefera, B., & Mulatie, M. (2014). Risks, protection factors and resilience among orphan and vulnerable children in Ethiopia: Implications for intervention. *International journal of psychology and counselling, 6(3),* 27-31. doi:10.5897/ijpc2013.0241

Terre Blanche, M., Durrheim, K., & Painter, D. (Eds). (2009). *Research in practice: Applied methods for the social sciences* (2nded). Cape Town: UCT Press.

The South African National Aids Council (SANAC). (2012). *The national strategic plan for HIV, STIs and TB (2012-2016)*. Retrieved fromhttp://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/SANACCallforNominations/A5summary12-12.pdf

The United Nations Children's Fund (UNICEF). (2003). *The United Nations special session on children*. Retrieved fromhttp://www.unicef.org/specialsession/docs_new/documents/SSC-anniversary-report.pdf

Thembela, L.P. (2007). *An evaluation of a psychosocial support intervention for vulnerable children* (Unpublished doctoral thesis). University of Zululand, Kwa-Dlangezwa.

Theron, L.C., & Theron, M.C. (2010). A critical review of studies of South African youth resilience, 1990-2008. *South African Journal of Science, 106*(7), 1-8. doi: 10.4102/sajs.v106i7/8.252

Theron, C.L., Theron, A.M.C., Malindi, M.J. (2012). Towards an African definition of resilience: A rural South African community's view of resilient Basotho youth. *Journal of Black Psychology, 1*(1)*,* 112-120. doi: 10.1177/0095798412454675

Thwala, S.K. (2013). The role of culture in psychosocial development of orphans and vulnerable children. *International Journal of Adolescence and Youth, 18*(2), 105-121. doi: 10.1080/02673843.2012.665169

Towards an AIDS Free Generation (2013). *Sixth stocktaking report*. Accessed from:http://www.unaids.org/sites/default/files/media_asset/20131129_stocktaking_report_children_aids_en_0.pdf

Trochim, W.M.K. (2006). *Non-probability sampling*. Retrieved from:http://www.socialresearchmethods.net/kb/sampnon.php

UNAIDS. (2015). *Core epidemiology*. Retrieved from http://www.unaids.org/en/resources/documents/2015/20150714_coreepidemiologyslides_ppt

UNAIDS. (2015). How AIDS changed everything: 2014 global statistics. Retrieved fromhttp://www.unaids.org/sites/default/files/media_asset/20150714_FS_MDG6_Report_en.pdf

UNAIDS. (2014). *Global statistics*. Retrieved fromhttp://www.unaids.org/en/resources/campaigns/2014/2014gapreport/factsheet

UNAIDS. (2014). *The Gap Report*. Retrievedfromhttp://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

Ungar, M. (2008). Resilience across cultures. *The British Journal of Social Work, 38(2)*, 218-235. doi: 10.1093/bjsw/bcl343

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry, 81(1)*, 1-18. doi: 10.1111/j.1939-0025.2010.01067.x

U.S. Presidents Emergency Plan for AIDS Relief. (2012). *Guidance for orphans and vulnerable children programming*. Retrieved from: http://www.pepfar.gov/documents/organization/195702.pdf

Wang, B., Li,X., Barnett, D., Zhao, G., &Stanton, B. (2012). Risk and protective factors for depression symptoms among children affected by HIV/AIDS in rural China: A structural equation modeling analysis. *Journal of Social Science & Medicine, 74*(9)*,* 1435-1443. doi: 10.1016/j.socscimed.2012.01.007

Wibek, V., Dahlgren, M.A.,& Oberg, G. (2007). Learning in focus groups an analytical dimension for enhancing focus group research. *Qualitative research,7*(2), 249-267. doi: 10.1177/14687941078

Wood, L., Ntaote, G.M., & Theron, L. (2011). Supporting Lesotho teachers to develop resilience in the face of the HIV and AIDS pandemic. *Journal of teacher and teacher education, 28(2012)*, 428-439. doi: 10.1016/j.tate.2011.11.009

World Health Organisation (WHO). (2015).*Global health observatory (GHO) data*. Retrieved from http://www.who.int/gho/hiv/en/

World Health Organisation (WHO). (2011). *Progress report 2011: Global HIV/AIDS response*. Retrieved fromhttp://www.who.int/hiv/pub/progress_report2011/en/

Zhou, G. (2012). *Understanding the psychosocial wellbeing of OVC: The intersection of research and policy. (Unpublished* masters thesis). Duke University, Durham.

APPENDIX 1: LETTER GRANTING ETHICAL APPROVAL

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

5 July 2013

Mr Nabeela Warranally 208527650
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Protocol reference number: HSS/0478/013M
Project title: Resiliency in the Context of HIV/AIDS: A study of Community Caregivers' Perceptions of Orphans and Vulnerable Children in two KwaZulu-Natal Districts.

Dear Ms Warranally

Expedited Approval

I wish to inform you that your application has been granted Full Approval.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr S Singh (Deputy Chair)

/pa

cc Supervisor: Ms Phindile Mayaba
cc Academic Leader Research: Professor D McCracken
cc Post Graduate Administrator: Mr Sbonelo Dума

INSPIRING GREATNESS

APPENDIX 2a: ENGLISH INTERVIEW SCHEDULE FOR FOCUS GROUP

1. Participlan method

   Do you know what resilience is?

   - o If yes, what is your understanding of resilience?

     Participants to be seated in a circle. Each participant is given a black marker with a stack of notepads. On the top of one A0 white paper, the research question- do you know what resilience is?- is written down and placed with prestick on a wall clearly visible to all participants. Thereafter participants are given five minutes to silently write down their answers to the question on the notepads given to them. Participants are instructed to write down every answer on a separate notepad and participants could provide as many answers as they felt adequately answered the question. Following this, the researcher gathers participant's answers and makes known to the participants that the answers collectively become the group's answers. This is done to make certain that no individual participants' answers will be criticised.

     Once this is done the researcher calls out participants written answers and as a group participants' have to collectively agree whether the called out answer adequately and correctly defines resilience. If the answers are collectively agreed upon, they are to be placed on the white A0 paper. Thereafter, participants collectively group answers on the white A0 paper and identify themes which the answers belong to. This process will facilitate participants sharing stories and allows the research to proceed to the following question.

2. What are your experiences of resiliency in terms of working with OVC?
3. How do you see resiliency being facilitated in your line of work?
4. What are the programmes that the DSD offers to help facilitate resilience of OVC?
5. Do any of the programmes offered by the DSD aid in facilitating resiliency of OVC?
   a. If not, how do you think, based on your experiences, that they can be improved?
6. In your line of work, have you received support from other stakeholders excluding the DSD? Example, community members?
7. Do you think the OVC you are working with display resilience or not?

    a. If yes, what have you observed about the OVC you work with that allows you to say they are resilient?

    b. If no, what have you failed to see in OVC that makes you say they are not resilient?

8. Through your experiences and expertise, how do you think the DSD can improve on its programmes to build resiliency for OVC?

9. Do you have any other informed ideas or contributions about how resilience can be promoted for OVC in the context of KwaZulu-Natal?

INGXOXO NABANTU ABATHILE

Ngokwazi kwakho, ngabe isibopho esenziwa Umnyango Wezokuthuthukiswa Komphakathi ezintandaneni nakwizingane eziphila ngokukhubazeka safezwa yini, kuliphi izinga?

Ucabanga ukuthini ngezibopho ngokombono wakho; uma zingakafezwa zingafezwa u-

-Uhulumeni

-Osonhlalakahle

-Umphakathi

-Abanakekeli bomphakathi

-Izinhlangano zomphakathi?

Ngabe kukhona yini okunye okumayelana ezingane Eziphila Ngokukhubazeka ngokwakho ukubona nasolwazini lakho okudinga ukwenziwa uma kukhona ngobani?

Ngokwazi kwakho yiziphi izinto ezivimbela Izingane Eziphila Ngokukhubazeka ukuba zithole ukuthuthukiswa okusezingeni eliphezulu?

Ngabe uyazi ukuthi yini ukubhekelela?

-Uma wazi, uthi kuyini?

Ukubona ukubhekelela kukuliphi izinga lapho usebenza khona?

Yiziphi izinto ezenziwe Umnyango Wezokuthuthukiswa Komphakathi ukusiza ukugqugquzela ukubhekelelwa nokuthuthukiswa Kwezintandane Nezingane Eziphila Ngokukhubazeka?

Ngabe izinto ezenziwe Umnyango Wezokuthuthukiswa Komphakathi ukusiza ukugqugquzela ukulashwa ngokushesha nokuthuthukiswa Kwezintandane Nezingane Eziphila Ngokukhubazeka kwaba nosizo?

-Uma zingasizanga, ucabangani, ngokwazi kwakho kungathuthukiswa kuphi?

Lapho usebenzela khona, usuke wathola ukuxhaswa ngabanye abantu ngaphandle Komnyango Wezokuthuthukiswa Komphakathi? Isibonelo, amalunga omphakathi?

Ucabanga ukuthi Izintandane Nezingane Eziphila Ngokukhubazeka osebenza ngazo ziyajwayelana nesimo?

> -Uma uvuma, ikuphi osukubonile Ngezintandane Nakwizingane Eziphila Ngokukhubazeka osebenza ngazo obona ukuthi ziyajwayelana nesimo?
> -Uma uphika, ikuphi ongakubonanga Kwizintandane Nezingane Eziphila Ngokukhubazeka ukuthi azijwayelani nesimo?

Ngosewakewakubona nangokolwazi lwakho, ucabanga ukuthi Umnyango Wezokuthuthukiswa Komphakathi ungenza kanjani kangcono ezintweni ozenzayo ukwenza zijwayelane nesimo Izintandane Nezingane Eziphila Ngokukhubazeka?

Ngabe unayo eminye imibono noma ongakusho ukuthi ukuze zijwayelane nesimo Izintandane Nezingane Eziphila Ngokukhubazeka kumele kuthuthukiswe kanjani ngeKwaZulu-Natali?

Ucabanga ukuthi abanye abaqeqeshiwe ababambe iqhaza ekunakekeleni Izintandane Nezingane Eziphila Ngokukhubazeka (Abasebenza ngezingqondo zabantu, osonhlalakahle nabanye) bangasiza kanjani ekugqugquzeleni ukuthuthukiswa nokulashwa kwezintandane neZingane eziphila ngokukhubazeka?

Ulibona linjani iqhaza lakho Njengomnakekeli Womphakathi ekuthuthukiseni Izintandane Nezingane Eziphila Ngokukhubazeka?

APPENDIX 3a: ENGLISH CONSENT FORM FOR FOCUS GROUP

School of Applied Human Sciences
Discipline of Psychology
P/Bag X01 Scottsville
PIETERMARITZBURG, 3209
South Africa
Phone: +27 33 2605371
Fax: +27 33 2605809
Cell: 082 447 9092

 To whom it may concern

Resiliency in the Context of HIV/AIDS: The Community Caregivers' Perceptions of Factors that Impede on the Development of Resilience in Orphans and Vulnerable Children in the eThekwini and uMgungundlovu districts, KwaZulu-Natal.

My name is Nabeela Warrasally and I will be conducting a research project towards my Masters Degree in Psychology at the University of KwaZulu-Natal. I would like to ask for your consent to participate in my research project. The project aims to determine the perceptions of those directly involved in the care of orphans and vulnerable children (OVC) (caregivers, social workers and psychologists) and how their expertise, knowledge and experiences determine what the factors are that impede on OVC resilience. By conducting this research I am interested in investigating what the gaps are in existing interventions of resilience building for OVC so as to inform a holistic approach to resilience building for OVC in the context of KwaZulu-Natal. You have been identified as someone who meets the criteria of the study as laid out by the researcher. The criteria include that you are a caregiver who is involved in the care or development of OVC in the context of KwaZulu-Natal.

Involvement in this project will require that you participate in a focus group of 10-12 caregivers. The focus group interview should take no longer than 2 hours. This will be carried out by me, the researcher. The results of the study will be released in my Masters dissertation and may also be presented at a conference or an open-day for the presentation of all Masters research projects, of which you are invited to join. It will also be archived at the Cecil Renauld Library at the University of KwaZulu-Natal. No personally identifiable details will be released, only averaged information. I would also like to ask your consent to the focus group interview being audio recorded and later transcribed by me, the researcher, or an independent body, so as to have an accurate record of your responses.

Please understand that **your participationis voluntary** and you are not being forced to take part in this study. However, your participation would be much appreciated as it would contribute a great deal towards the research involved in improving the resilience of OVC in the context of KZN. If you choose not to partake in this research you will not be affected in any way whatsoever. You are also free to withdraw at any stage of the research without any penalties incurring and **you will not be prejudiced in any way**.

The identity of all participants, including yours, will remain **confidential** with no identifying information included in the completed research report. Only the researcher will have access to the information.

You will be compensated with R50 to cover the travelling costs of attending the focus group. Snacks will be served for your participation in this research as a show of thanks for your time and enthusiasm in my study as I am very grateful to you for this.

If you have any further questions or concerns about this study please feel welcome to contact me on my email address, 208527650@ukzn.ac.za and I will be of assistance whenever and wherever possible. Please note that if you are concerned in any way about the results of the study, please note that I shall try in any way possible to assist you and offer any support that you may need.

Sincerely

Nabeela Warrasally   Phindile Mayaba
Researcher   Supervisor
Psychology Honours student   Lecturer in the Discipline of Psychology
208527650@ukzn.stu.ac.za   mayabap@ukzn.ac.za

---tear off---

CONSENT
I hereby confirm that I understand the contents of this document and the nature of the research project, and I agree to participate in the research project.

I understand that my answers will remain confidential and that I am at liberty to withdraw from the project at any time should I so desire.

In addition to the above, I hereby agree to the audio recording of the focus group. I understand that these recordings will be kept securely in a locked environment and will be destroyed or erased once data capture and analysis are complete. I also agree to the results of this study being used for future research.

SIGNATURE   DATE

IFOMU LEMVUME YABANTU OKUZOKHULUNYWA NABO

School of Applied Human Sciences
Discipline of Psychology
P/Bag X01 Scottsville
PIETERMARITZBURG, 3209
South Africa
Inombolo yethelefoni : +27 33 260 5371
Ifeksi :+27 33 260 5809
Inombolo yeselula: 082 447 9092

Noma ngubani ozoyamukela

Ukubhekana neHIV/
AIDS: Okucwaningwayo ukuze kuqondwe ngabanakekeli bomphakathimayelana
Nezintandane Nezingane Eziphila Nokukhubazeka kwizifunda
ezimbilizaKwaZuluNatali.

Igama lami nginguNabeela Warrasally ngizobe ngenza ucwaningo lweziqu zami zeMasterskwiPsychologyeYunivesithi YakwaZuluNatali.Ngizocela imvume yakho ukuba ube yingxenyeyocwaningo. Inhloso yocwaningo ukuqonda labo ababambe iqhaze ekunakekeleni IzintandaneNezingane Eziphila Ngokukhubazeka Njengabanakekeli Bomphakathi nokuthi ubungcweti, ulwazinesabake bahlangabezana nako bunika ziphi izinto kwizintandane nezingane eziphila ngokukhubazeka.Ngokuqhuba lolu cwaningo ngithanda ukuphenya ukuthi yiziphi izikhala ezikhona ekwakheni uzinzoukuthi Izintandane Nezingane Eziphila Ngokukhubazeka bese kuzokwazi ukuthi zivalwe zijwayelanenesimo Izintandane Nezingane Eziphila Ngokukhubazeka ngokweKwaZuluNatali.Ukhethiwenjengomuntu onako okudingekayo kulolu cwaningo ngokomcwaningi. Uhlelo luhlanganisa ukuthiungumnakekeli okhona ekunakeleleni noma ekuthuthukiseni Izintandane Nezingane EziphilaNgokukhubazeka ngokwendlela yaKwaZuluNatali.

Ukubandakanyeka kulolu cwaningo kuzodinga ukuthi ubambe iqhaza kubanakekeliabalishumi kuya kwabayishumi nambili abazobamba iqhaza. Imibuzo ezobuzwa engxoxweni akumele ithathe ngaphezu kwamahora amabili.Loku kuzokwenziwa yimina, umcwaningi. Imiphumela yocwaningo izosetshenziswa kwiMastersyamifuthi ingathulwa kumhlangano wokubuzana noma kusuku oluvulelekile lokhethula zonke iziquzeMasters,ovumelekile ukuba ube yingxenye yako. Futhi kuzogcinwa kwisigcinalwazi esibizwangokuthi iCecilRenauld eYunivesithi yaKwaZuluNatali.Alukho ulwazi ngomuntu ngamunyeoluzokhishwa, ngaphandle kolwazi oluvamile ukutholakala. Ngifisa nokuthola imvume yakho ukuthiingxoxo esibe nayo ukuba irikhodwe bese ukuhamba kwesikhathi ngiyisebenzisa mina, umcwaningi,ozimele, ukuze ngibe nokuyikona kona okushilo.

Ngicela ukuba uqonde ukuthi **ukubamba iqhaza kungokuthanda kwakho awuphoqiwe** ukuba yingxenyekulolu cwaningo. Nokho, ukubamba iqhaza kuzothokozisa njengoba kuzosiza ukuthuthukisaokuhlanganisa ucwaningo Ngezintandane Nezingane Eziphila Ngokukhubazeka ngokwendawoyakwaZuluNatali.Uma ukhetha ukungabi yingxenye yalolu cwaningo ngeke wenzakalelwe yilutho.Uvumelekile ukushiya phakathi noma ngabe yinini kulolu cwaningo kungabi nankinga futhi **ngekekukulimaze ngalutho**.

Ulwazi ngabantu bonke ababambe iqhaza, kulolu cwaningo kanye nawe, kuzoba **imfihlo**ngokungabandanyekekikokuchazwa kolwazi ekuphothuleni lolu cwaningo. Umcwaningi kuphela ozoba nemvume olwazini.

Uzonikezwa imali engango uR50ukuze ubhekane nezindleko zokuya lapho kuhlanganyelwa khona. Ukudla okuncaneuzokuthola ngokubamba iqhaza kulolu cwaningo ukukubonga ngesikhathi sakho nomdlandlaocwaningeni lwami ngoba ngibonga kakhulu.Uma uneminye imibuzo noma okuthile ngalolu cwaningo khululeka wamukelekile ukungithinta kuleli khelileemeyili,208527650@stu.ukzn.ac.za futhi ngizokusiza noma ngabe yinini noma ngabe yikuphi.

Ngicela uqaphele ukuthi uma kukhona ofuna ukukusho noma ngayiphi indlela ngemiphumela yalolucwaningo, ngicela uqaphele ukuthi ngizozama noma ngayiphi indlela ukukusiza noma ngani okudingayo.

Ozithobayo

Nabeela Warrasally	Phindile Mayaba
Umcwaningi	Umqondisi wocwaningo
Umfundi owenza iziqu zeMasterskwiPsychology	Umfundi kwisikole sePsychology
208527650@stu.ukzn.ac.za	mayabap@ukzn.ac.za

--sikalapha--

UKUVUMA

Ngiyavuma ukuthi ngiyakuqonda okuqukethhwe yilo mbhalo nendlela eliyilo lolu cwaningo, futhingiyavuma ukubamba iqhaza kulolu cwaningo.

Ngiyakuqonda ukuthi izimpendulo zizoba imfihlo futhi ngikhululekile ukuyekela ukuba yingxenyeyocwaningo noma engabe yinini.

Ukungeza kokungenhla, ngiyavumelana nokurikhodwa kwakho. Ngiyakuqonda ukuthi lokhuokuzorekhodwa kuzobekwa endaweni evikelekile ezokhiywa bese kuyacishwa noma kulahlwe umasekuqediwe ukuthatha ulwazi kuko. Ngiyavuma futhi ukuthi imiphumela yalolu cwaningo isetshenziswekucwaningo lwangomuso.

ISAYINI   USUKU

APPENDIX 4: OBLIGATION MADE BY DSD TO OVC AS STATED BY DSD IN 2003

This obligation is to:

Build and strengthen governmental, family and community capacities to provide supportive environments for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance. (DSD OVC Policy, Article 65)(DSD, 2003 p. 9).

APPENDIX 5: Resilience as defined by participants

Resilience as defined by participants

Characteristics	Msunduzi	KwaMashu
Strong	x	x
Humble	x	
Talk and be happy		
Hospitality	x	
Try, help and voluntary		
Sympathy	x	
Care	x	x
Cope	x	x
Friendly	x	
Play and stop crying		x
Normal life		x
Psychosocial support	x	
Manage	x	x
Empathy	x	
Help others		x
Confidence		x
Positive	x	
To do things better than before		x
Children coping		x
Independent and responsible		x
Warm	x	
Able to cope	x	
Cope and communicate with others		x
Confidentiality	x	
Ability	x	
Support	x	
Brave	x	
Trust		x
Development		x
Reflective and acceptable		x
Patience	x	
Share, able to face and solve big challenges		x
Psychosocial support	x	
Talk and be happy		x
Manage problems		x
Potential	x	
Speak or talk	x	
Hard worker	x	
Too face difficult situations in life	x	
Never give up and try by all means		x