STRATEGIES TO PROVIDE HOLISTIC CARE AND SUPPORT TO CHILDREN WHO ARE AIDS ORPHANS LIVING IN TOWNSHIP COMMUNITIES

BY

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This thesis is dedicated with love and affection to "JULIANS' CHILDREN" in honour of my brother

JULIAN MARK FROOD.

I commend this journey to you both.

May you find and live in renewed purpose hope and love and leave a legacy worth celebrating

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"Whatever you do in thought and word and deed, let it be unto the Lord" Colossians Ch. 3 v17

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ABSTRACT

The human immunodeficiency virus/acquired immune-deficiency syndrome pandemic (HIV/AIDS) continues to increase in prevalence worldwide, particularly in South Africa. “AIDS, (Acquired Immune Deficiency Syndrome), has devastated the social and economic fabric of African societies, made orphans of a whole generation of children and become the epicentre of the HIV/AIDS pandemic” (Fassin, 2007: 76). Like the virus itself, the AIDS crisis mutates rapidly. Children who are AIDS orphans living in South Africa, as in other African countries, suffer from recurrent psychological trauma. It starts with the illness and death of their parents and is followed by cycles of poverty, malnutrition, stigma, exploitation, sickness and often sexual abuse. The figures concerning those affected, which are staggering, offer various predictions regarding the number of orphans left in the wake of the pandemic. Between 1990 and 2003, the number of orphaned children rose from fewer than 1 million to more than 12 million in sub-Saharan Africa (UNICEF, 2005: 68).

South Africa is severely affected by the AIDS pandemic, with the largest number of HIV infections in the world, a total of 5.7 million (RSA, 2010: 10), affecting approximately 3.2 million women and 280 000 children aged from 0 to14 years. There is a significant variation in HIV prevalence per province, with the Eastern Cape (EC) reportedly having an average prevalence rate of 28%. Hence South Africa is likely to be the country with highest percentage of children orphaned by AIDS within its population. Orphanhood is a major consequence of the AIDS pandemic in South Africa with an estimated 2.2 million AIDS-orphaned children, 11,188 per 100,000 by 2015. Most children who are AIDS orphans living in township communities live predominantly uncared for and unsupported.

Therefore the purpose of this research study was to develop strategies to provide care and support to children who are AIDS orphans living in township communities. To achieve the purpose of this research study, a qualitative, exploratory, descriptive and contextual design was used by the researcher to gain insight from health and social care practitioners who render care and support to children who are AIDS orphans living in these communities. The data from in-depth interviews with the health and social care practitoners was used by the researcher to develop strategies to provide care and support to children who are AIDS orphans living in township communities. The study comprised the following four phases:

Phase One: During this phase, the researcher will present an overview of the current legislative framework policies at an international, national and provincial level, regarding the the rights of children living in South Africa.

Phase Two: During this phase data from two research populations were collected and analysed. As the research process of this study dealt with two groups of participants, namely in group one health care practitioners and group two comprised social workers and psychologists, who work in the township communities to provide care and support to children who are AIDS orphans living in these communities. The researcher discussed each group separately in the discussion of phase two of the study.

Phase Three: Comprised the themes identified in the data gathered from the transcribed in-depth interviews, the field notes as well as the reflective journals were cross-validated to ensure trustworthiness of the data which was then organised into a conceptual framework. The conceptual framework was used to clarify the relationships of the concepts and the themes identified during the research process and also used to link the gathered data to previously established models and theories (Schneider, 2004: 133).

Phase Four: The last phase of the research design, focused on the development of the "Steps of progression strategies" to provide holistic care and support to children who are AIDS orphans living in township communities. This was done making use of the themes identified during data analysis and the literature sources used throughout this research process. The evaluation criteria of Chinn and Kramer (2008: 237-248) were used to evaluate the strategies.

It is therefore concluded that the researcher succeeded in achieving the purpose of this study because strategies which were understandable, clear, simple, applicable and significant to nursing practice have been developed for use by the Department of Health and Department of Social Development as well as primary health and social care practitioners to provide holistic care and support to children who are AIDS orphans living in township communities in South Africa.

LIST OF ACRONYMS ABBREVIATIONS USED IN THIS RESEARCH PROJECT

AIDS	Acquired Immune Deficiency Syndrome
ACRWC/ ACC	African Charter on the Rights and Welfare of the Child also known as African Children's Charter
AYC	African Youth Charter
CHH'S	Child Headed Households
CRC	United Nations Convention on the Rights of the Child
CRC-OPSC	Optional Protocol of the Convention on the Rights of the Child on the sale of children, child pornography and child prostitution
CRPD	Convention on the Rights of People with Disabilities
CSG	Child Support Grant
DEDEA	The Department of Economic Development, Environmental Affairs
DOH	Department of Health
DSD	Department of Social Development
DWCPD	Department of Children and People with Disability EC Eastern Cape
FCG	Foster Care Grant
FRTI	Faculty of health sciences research technology and innovation committee
HIV	Human Immuno Deficiency Virus
IFSW	International Federation of Social Workers
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic Social and Cultural Rights

MDG	Millennium Development Goals
MDT	Multi-Disciplinary Team
MA	Master’s Degree
NPA	National Plan of Action for Children
NEPAD	The New Partnership for Africa’s Development
NPAC	National Plan of Action for Children
NMB	Nelson Mandela Bay
NGO’S	Non-Governmental Organisations
NIMART	Nurse Initiated management of Anti Retro Viral Therapy
NIP	National Integrated plan for children infected by HIV/AIDS
NMMU	Nelson Mandela Metropolitan University
NPAC	National Plan of Action for Children
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PhD	Doctorate of Philosophy
RSA	Republic of South Africa
SANC	South African Nursing Council
UDHR	The Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

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CHAPTER ONE

OVERVIEW OF THE STUDY

“There can be no keener revelation of a society’s soul than the way in which it treats its children” Nelson Mandela (DWCPD, 2012-2017: 1)

1.1 INTRODUCTION AND BACKGROUND

“Pain.... I feel pain; I see pain; I touch pain; I live pain ... pain has become my friend, part of my life. Pain is in my thoughts; it’s in my dreams; it is always with me. I am an orphan because my parents died of AIDS. I have lost my life, my hope, my future, my heart because of pain. I see pain every day; I see pain in the eyes of my grandmother in my brothers and in my sisters. I see pain in others. I see the pain of grief and hopelessness. I see the pain of sorrow and despair. AIDS causes pain in those who die and pain in those who live. Will this pain ever stop? Will it ever go away? Will it ever be ripped out of my life, out of my heart? I don’t want this pain anymore! I want this pain to stop and never come back again. I say to this pain “Pain out! Pain out! I don’t want you anymore! I don’t want you to take my future”. These are the words of Ayanda (2011), an AIDS orphan from Kwazakhele Township, Nelson Mandela Bay (NMB), Eastern Cape Province (EC).

“Today I felt hopelessness. I tried to assist a 14-year-old girl who is an AIDS orphan. She has no birth certificate for her younger sister; no money for transport to go to Home Affairs to make an application for a birth certificate and no food in her home. I gave her some of my personal money to buy food for her family and get a taxi to home affairs. It takes so long for the grants to come through. The last foster care grant which I assisted in the application of took three years to be awarded. These children orphaned by AIDS are left destitute when their parents die. They have no money and only get food which is given to them by other people living in poverty in the townships. The only thing I can do is to refer them to Non-Governmental Organisations (NGO’s) working in the townships, assist them in applications for child support grants, disability grants and foster care grants and give them money for food and transport. There are so many children in this position. It’s hopeless”. This was told to me by Gimani (2010), a social worker in Kwazakhele Township, Nelson Mandela Bay (NMB), Eastern Cape Province (EC).

“AIDS, (Acquired Immune Deficiency Syndrome), has devastated the social and economic fabric of African societies, made orphans of a whole generation of children and become the epicentre of the HIV/AIDS pandemic (Fassin, 2007: 27). Like the virus itself, the AIDS crisis mutates rapidly. Children who are AIDS orphans living in South Africa, as in other African countries, suffer from recurrent psychological trauma. It starts with the illness and death of their parents and is followed by cycles of poverty, malnutrition, stigma, exploitation, sickness and often sexual abuse. The figures concerning those affected, which are staggering, offer various predictions regarding the number of orphans left in the wake of the pandemic. Between 1990 and 2003, the number of orphaned children rose from fewer than 1 million to more than 12 million in sub-Saharan Africa (UNICEF, 2005: 68).

The challenges are significant: According to the UNAIDS/World Health Organization 2008 Report on the Global AIDS Epidemic, by the end of 2007, HIV/AIDS had left behind 15 million AIDS orphans (UNAIDS, 2008: 4).

The AIDS pandemic in Africa is reducing life expectancy, increasing mortality, reducing fertility, leaving more men alive than women and producing millions of AIDS orphans. Unless a medical miracle occurs, almost all the 24 million Africans infected with the virus at the beginning of 2000 will die. Each day 6000 Africans die from HIV/AIDS and a further 11,000 are infected with HIV” (Meintjes and Guise, 2006: 19).

South Africa is severely affected by the AIDS pandemic, with the largest number of HIV infections in the world, a total of 5.7 million (RSA, 2010: 10), of whom approximately 3.2 million are women and 280 000 children aged from 0-14 years. There is a significant variation in HIV prevalence per province, with the Eastern Cape Province (EC) reportedly having an average prevalence rate of 28%. Hence South Africa is likely to be the country with highest percentage of children orphaned by AIDS within its population. Orphanhood is a major consequence of the AIDS pandemic in South Africa with an estimated 2.2 million AIDS orphaned children 11,188 per 100,000 by 2015 (Hayman and Kidman, 2009: 34).

The term “AIDS orphan” is defined as any child under the age of 18 years who has lost one or both parents to HIV/AIDS. According to the United Nations International Children’s Fund (UNICEF, 2011: 1), an estimated 15.7 million children, that is 30% of 53 million anticipated orphans from all causes in sub Saharan Africa, had lost either one or both parents to HIV/AIDS by 2010. The Joint United Nations’ Programme on HIV/AIDS (UNAIDS, 2009: 12) estimates that there were 1.8, million orphans living in South Africa by the end of 2008. The statistics for AIDS orphans are calculated using assumptions such as the average number of children per mother, a reduction in fertility rate and an increase in the number of infant deaths caused by HIV/AIDS. In 2007 alone, 30 million to 36 million people were living with HIV/AIDS worldwide, 2.2 to 3.3 million people became infected with the virus and 1.8 million to 2.3 million people died of HIV-related causes (UNAIDS, 2008: 2).Therefore many more children could be faced with becoming orphans.

So the devastation continues. Data from the United States Agency for International Development (USAID) suggests that 19 sub-Saharan countries had a combined total of 40 million orphans in 2010, due to HIV/AIDS. The statistics demonstrate that one in every three *children orphaned by HIV/AIDS is younger than 5 years of age. Studies by UNICEF (2009) also* demonstrate that when a family member dies of HIV/AIDS, the income of the family falls by between 50 and 65%, whilst expenditure on healthcare quadruples. The orphans are the first to be denied their education when their extended families cannot afford to educate them (UNICEF, 2011: 17-18).

Africa is home to 77% of the world's 15 million orphans as a result of HIV/AIDS (UNAIDS, 2008: 3). Before AIDS approximately 2% of all children in developing countries were orphaned (Foster, 2006:12). After AIDS became pandemic the estimated number of maternal, paternal and double orphans due to AIDS in Malawi, South Africa and the republic of Tanzania rose from 1.2 million in 2001 to 2.9 million in 2007 (UNICEF, 2011: 41). The startling reality of these figures hits home when one realizes that 9 out of 10 children in 2010 who have been orphaned lost both parents to HIV/AIDS.

In 2008, South Africa had the highest number of people infected globally with HIV/AIDS, estimated at 5.3 million, including 220,000 children under 15 years (UNAIDS, 2009: 57). This means that South Africa will ultimately have the highest number of orphaned children on the African continent. In 2010, 16% of all children living in South Africa were AIDS orphans. This was predicted by UNICEF, (2004) and UNAIDS, (2007). According to current statistical data there are currently 1.9 million children orphaned by AIDS living in South Africa (UNICEF, 2011: 3).

Children who are AIDS orphans living in South Africa, as in other African countries, suffer from recurrent psychological trauma, which starts with the illness and death of their parents, (van Dijk, 2008: 27). The majority of orphaned children in Africa live in impoverished households (UNAIDS, 2009: 4) and there will be significant costs incurred in caring for these children in the long term. If no mechanisms are put into place, such costs will include an increase in the number of children living on the street, increased numbers of children living in child- headed-households,(CHH's), increased levels of juvenile delinquency, reduced literacy and consequentially a huge economic burden will be placed upon the state.

Blanket statements about the role of the extended family in Africa as a safety net and assumptions that relatives will be ready and able to assist orphans in need, should be treated with caution. The extended family networks that have traditionally supported vulnerable members have been overstretched by the ravages caused by HIV/AIDS (UNAIDS, 2009: 3). The extended family's resources are worn down by AIDS and at the same time, the numbers of orphans are increasing. Children who are unfortunate enough to slip through the net of extended family support are especially vulnerable to disease, malnutrition, illiteracy, exploitation and also the risk of HIV/AIDS infection themselves. As the traditional family structures break down in the pandemic, the suffering of grandmothers and grandchildren increases as "parents watch their children die and children watch their parents die" (van Dijk, 2008: 57).

As the numbers of orphaned children in a community increase and uncles and aunts also die prematurely of AIDS, the traditional and first choice of caregivers becomes unavailable and ailing grandparents are therefore recruited to childcare. Grandparents are often the last resort as caregivers and agree to take the AIDS orphans into their homes as all other relatives refuse. In some cases, however, what happens is that the burden of care for the frail grandparents falls to the younger orphans and so their childhood is lost in a heap of grief and mounting responsibility (Kiggundu and Theron, 2009: 19).

With the demise of grandparents and the realities of a migrant labour force the inevitable has occurred in that there are now increased numbers of children living on the street and increased numbers of orphan children living in child- headed households (CHH's) (van Dijk, 2008: 42). In communities where the prevalence of HIV/AIDS has severely affected the community, the number of CHH's has risen. Considering that South Africa has the highest HIV-infection rate on the continent of Africa, these statistics can be assumed to be far worse than were previously thought as children are made vulnerable when AIDS affects their families. Time and money resources are depleted in households where children are "left to care for chronically sick parents" (Hayman & Kidman, 2009:34). In South Africa no reliable statistics exist regarding the number of CHH's. Some argue that the numbers are low (Meintjes and Guise, 2006: 415), whilst others describe the number of child-headed households as "escalating" or "overwhelming" (van Dijk, 2008: 43).

Children who are caring for sick and dying parents are often overburdened by grief and responsibility. In many households children are the sole carers for their parents who are dying of AIDS. Children and young people who are caring for their sick and dying parents are "largely invisible to policymakers" (Cluver and Gardner, 2007: 2).

The HIV/AIDS pandemic has become one of the most critical challenges that threaten the realisation of children's rights in South Africa. The problem is compounded by the increase in the number of OVC, mainly due to the high rate of deaths among parents and caregivers. While HIV/AIDS dramatically increases the population of orphans and vulnerable children, it also reduces the number of traditional caregivers and the number of breadwinners in families. AIDS undermines the ability of the very people who are best equipped to raise orphans or to contribute to their upbringing. The realisation of the rights of orphans and other children made vulnerable by HIV/AIDS and the progression of the social development agenda to restore their dignity and well-being requires a collective effort from the government, the business sector, civil society and the strengthening of community responses. On the 29th November 1989, South Africa along with other nations ratified the United Nations Convention on the Rights of the Child (UN, 2011: 2). Article 4 of the UNCRC reads as follows: "Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. When countries ratify the convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the convention in these areas are being met. They must help families protect children's rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones. Such legislative changes are not imposed, but come about through the same process by which any law is created or reformed within a country" (UN, 2011: 2), Article 4 of the United Nations Convention.

The Children's Act of South Africa 2005 was signed by the President of South Africa on the 19th June 2006. The objectives of the Act were to give effect to the rights of children as in section 28 of the constitution of South Africa, influenced by the ratification of the UNCRC by the South African government. The objectives of the Children's Act are to:

1. set out principles relating to the care and protection of children,
2. define parental responsibilities and rights,
3. make further provisions regarding children's courts,
4. provide for the issuing of contribution orders,
5. make new provision for the adoption of children,
6. provide for inter-country adoption,
7. give effect to the Hague Convention in Inter-country adoption,
8. give effect to the Hague Convention on International Child Abduction,
9. provide for surrogate motherhood,
10. identify new offences relating to children and

11. provide for matters connected therewith concerning the rights of the child in South Africa.

Section 28 of the South African constitution provides for the rights of children in South Africa. Children's Rights are underpinned by four major principles:

- the right of the child to survival, development and protection from abuse and neglect
- the right to have a voice and be listened to
- that the best interests of the child should be of primary consideration
- the right to freedom from discrimination.

In 2005 the government of South Africa also released a policy framework for orphans and other children made vulnerable by HIV/AIDS in South Africa, the motto of which was "Building a caring society together" (DSD, 2005: 1). The policy framework reflects the collective commitment of government, faith-based organizations, community-based organizations, civil society and the business sector; and serves as a guiding tool to all people involved in HIV/AIDS and the children's sector. It seeks to reinforce the existing commitments and efforts to create a supportive and enabling environment for children, conducive to their health and welfare. To this end the government continues to foster intergovernmental cooperation and also enlist the support of donors of both local and international development agencies. These partnerships will ensure that policies and plans are being translated into realities that will benefit orphans and vulnerable children in their communities" (DSD, 2005: 3). On page four of this policy document the Minister of Social Development, Dr Z.S.T Skweyiya, writes: "It is the constitutional obligation of the state to protect and ensure the well-being of OVC's through programmatic intervention" (DSD, 2005: 4).

The programmatic intervention is difficult to evaluate as, whilst there is a policy framework in place there are no overall comprehensive strategies to govern the care and support of children who are AIDS orphans living in the townships. Much of the response is left to individual provinces to implement and falls heavily on the NGO sector. The overall objective of the policies are clear, namely, "to promote a supportive environment in which orphans and other children made vulnerable by HIV/AIDS are adequately cared for and supported and protected to grow and develop to their full potential" (DSD, 2005: 4).

The National Action Plan, which builds on the foundations of this policy framework, creates and promotes a supportive environment in which orphans and other children made vulnerable by HIV/AIDS are adequately cared for, supported and protected holistically to grow and develop to their full potential. This national action plan is supported internationally by the United States Government through the President's Emergency Plan for AIDS Relief

(PEPFAR), (Beverly et al., 2012: 2) Under the leadership of the United States ambassador PEPFAR supports the national action plan for OVC and other children made vulnerable by HIV and AIDS, the national guidelines for social services to children infected and affected by HIV/AIDS and the National Strategic Plan (NSP). The NSP is the current HIV/AIDS plan in use in South Africa. This plan follows on from the NSP of 2000-2005 and from the Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment, 2004. The NSP currently represents the country's multi-sectoral response to the challenge of HIV infection and the wide-ranging impacts of AIDS (DoH, 2007: 3). The HIV & AIDS and STI Strategic Plan for South Africa (NSP), 2007-2011 and (NSP) 2012-2016 aims to reduce the rate of new HIV infection by 50% by 2015, thereby reducing the impact of HIV/AIDS on individuals, families, communities and society. This is to be achieved by expanding access to appropriate comprehensive treatment, care and support to 80% of all HIV-positive people and their families by 2016 (NSP, 2012-2016:10).

The objectives of the national policy framework for orphans and other children made vulnerable by HIV/AIDS provide a framework to:

1. ensure coordinated action at national, provincial, district and local level to realise the rights of orphans and other children made vulnerable by HIV and AIDS, their caregivers, families and communities,
2. ensure that legal, policy and institutional frameworks for the protection and promotion of the rights of affected children are implemented at all levels and
3. provide an overarching framework to support stakeholders in the development of comprehensive, age-appropriate, integrated and quality responses to orphans and other children made vulnerable by HIV and AIDS.

The six key strategies, which will assist in developing comprehensive, integrated and quality responses for orphans and other vulnerable children at programmatic level are to:

1. strengthen and support the capacity of families to protect and care,

2. mobilise and strengthen community-based responses for the care, support and protection of orphans and other children made vulnerable by HIV and AIDS,

3. ensure that legislation, policy; strategies and programmes are in place to protect the most vulnerable children,

4. assure access for orphans and children made vulnerable by HIV and AIDS to essential services,

5. raise awareness and advocate for the creation of a supportive environment for orphans and vulnerable children (OVC); and
6. engage the civil society sector and business community in playing an active role to support the plight of orphans and children made vulnerable by HIV/AIDS.

The last strategy could be seen as crosscutting in that it supports the implementation of the other strategies. The implementation of these strategies is vital to ensuring South Africa's achievement of the millennium development goals and the United Nations General Assembly Special Session's (UNGASS) declaration of commitment on HIV/AIDS. According to the Eastern Cape government's website, the listing of available programmatic responses lies in essence with the NGO sector. On the website the researcher found a list of NGO's working with OVC in the township communities and some contact details; but the only other data regarding the care and support of OVC was in information regarding application for government grants, namely the Foster Care Grant (FCG), Child Support Grant (CSG) and the Care Dependency Grant (CDG). "The policies to eradicate child poverty and to support OVC are mainly the responsibility of the national and provincial departments of social development, whose role is defined both in the constitution and in the white paper for social development" (van Dijk, 2008: 99).

There has been a paradigm shift in the approach by the South African government away from a welfare approach towards a more developmental approach, Streak, 2005; cited in van Dijk (2008: 99) regarding the care and support of OVC. The concept of a "developmental approach emerged from the world summit for social development in 1995. The Minister of Social Development when explaining the paradigm shift to a developmental approach has argued that "people need to be taught how to be self-reliant" (van Dijk, 2008: 99).

In 2000 three government departments, (Health, Social Development and Education) launched a special plan for children affected by HIV/AIDS, called the National Integrated Plan for children infected and affected by HIV/AIDS (NIP). The NIP was approved in 2000 by the South African cabinet (Sloth–Neilson, 2004: 22). The aim of this plan is to "ensure access to appropriate and effective integrated system of prevention, care and support services for children infected and affected by HIV/AIDS" (van Dijk, 2008: 99). The key features of NIP are, life skills education, counselling and testing and home and community-based support (HCBCS).

"Community-based care is defined as the care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities" (van Dijk, 2008: 100). The department of social development is limited to providing finance, policy guidance and advice but the actual care and support depend solely on foster families, volunteers and social workers. Despite honourable intentions of the South African government, the implementation of policies has been left largely to the NGO sector, Sloth and Nelson, 2002, cited in van Dijk, (2008: 100). In order for this approach to work there needs to be extensive funding. One of these elements is HCBCS and should be seen as one element of an integrated national response to the care and support of children orphaned by HIV/AIDS (UNICEF, 2008:49).

The National Plan of Action for Children (NPAC), (DWCPD, 2012-2017: 2) claims to bring together existing international and national priorities for the survival, protection development and participation of the children in South Africa in one coherent framework. The NPAC is also seen as a major initiative to monitor progress with the implementation of the UNCRC. This will be discussed in more detail in chapter three of this study (DWCPD, 2012-2017: 3).

There is clearly an intention by the South African government to improve care and support to OVCs living in the township communities, the overall objective of care and support to children living as OVCs is “to promote a supportive environment in which orphans and other children made vulnerable by HIV/AIDS are adequately cared for and supported and protected to grow and develop to their full potential” (DSD, 2005: 4). There is currently no overriding government policy governing the provincial care and support of orphans and vulnerable children affected in the HIV/AIDS pandemic. The lack of a coordinated and well-resourced response to provide care and support to children who are AIDS orphans living in the townships leads to both disparity and tension between intentions stated by the government and the implementation of programmatic responses to provide care and support to children who are AIDS orphans living in the townships.

1.2 PROBLEM STATEMENT

Whilst on a visit into the township communities in 2013, the researcher spoke with a young African girl of 14 years who was coming out of her shack carrying a bucket full of urine which she was about to empty. She had washed her mother, cooked for her siblings, cleaned the house and was cleaning the yard. She had been caring for her sick mother for 9 months. At the age of 14 years she had responsibility for the care of her dying parent and also the responsibility to care for her younger siblings. We sat in the shack with her and listened to her story. Tears rolled down her face as she spoke of the reality of her life. She took us in the bedroom to meet her mother, who was weak and ailing but very well cared for by her devoted daughter. A childhood had been lost and a grief too great to bear such a responsibility was so crushing that a human spirit was broken in one so young.

The researcher will highlight the problem statement in the following comments made by children who are AIDS orphans living in townships, primary healthcare practitioners, social workers and psychologists who provide these vulnerable children with care and support.

Statement one

“After my mother did die we were much stressed and became very sick. My sister and I did have a bad cough and my brother did have diarrhoea. We did go to the clinic. The Sister did help us by giving us medication but the real problem is we do have no food and money for shoes to go to school. When my mother did die the money we have did die too. I went to a social worker but she can’t help me because we do not have any money to go to the Home Affairs to get birth certificates. We are desperate for help. What we do need is food. The social worker said she will bring a food parcel to us in a few days. Our neighbour does help us with some food. Till then we are desperate. These are the words of Sindiswa (2010), an AIDS orphan from Kwazakhele Township, Nelson Mandela Bay (NMB), and Eastern Cape (EC).

Statement two

“When my Sister died I took her two children to come and live with me. The social worker visited and we made a grant application for two Foster Care Grants for them. It took 2 years for the grants to be approved. This was difficult to us and did cause tension in my family as we had school fees to pay and food and money for clothes. It was very difficult and did cause much stress to us because our own children did suffer”. These are the words of Sinazo (2010), an AIDS orphan from Zwiede Township, NMB, EC.

Statement three

“We are unable to give assistance to the orphans who come to us for help. They are desperate for food, for love, for financial help. We can give them medication for their illness but we can’t help them as they need to be helped. This causes us to feel hopeless and overwhelmed. Some of them are very young. The nurses here in the clinic do what they can to help. They buy bread and mealie meal for the most desperate children from their own pocket but it isn’t enough”. This was told to the researcher by Gimani, a primary healthcare practitioner (2010), working with AIDS orphans, in a primary healthcare clinic, in Ibhayi, NMB, EC.

Statement four

“There are many days in the clinics that are very terrible. Today I saw a boy who was 11 years old. He was an AIDS orphan. He was sick with TB because of the poverty in his home following the death of his mother because of AIDS. We are helpless to help these orphans because we have no money to help them to buy food or to go to school. They are without hope. It’s as if their lives have ended”. This was told to the researcher by Yoliswa, a primary healthcare practitioner (2011), working in a primary healthcare clinic, Ibhayi, NMB, EC.

Statement five

“I was excited on completion of my Masters Degree in Psychology. I started working as a community service psychologist in the townships and thought I would be in a position to alleviate the psychological distress children suffer on becoming orphans. However I was distressed to find there were no resources such as toys or material for drawing to help me to assist children suffering from psychological distress. In fact my main function was to help children living as AIDS orphans to apply for grants. My function was more as a social worker than a psychologist”. These are the words of Mr Smith (2012), a psychologist, in a satellite office in Kwazakhele Township, NMB, EC.

Statement six

“I trained as a social worker because I believed I could help people in distress. Now I send hungry children away to their homes because they don’t have birth certificates or death certificates available to help me apply for grants for them. These children are destitute. It breaks my heart but how can I keep giving them money out of my own pocket? I refer them to NGO’s to give them immediate assistance. Mrs Matthews (2012), a social worker in Kwazakhele Township, NMB, EC reported this to the researcher.

There is tension between the legislative policy frameworks concerning the care of orphans and other children made vulnerable by HIV/AIDS in South Africa and the care and support provided to children who are AIDS orphans living in townships. The above comments illustrate experiences that highlight this tension. Primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists experience difficulty when providing care and support to children who are AIDS orphans living in the townships. Yet the overall objective of the legislative policy frameworks guiding the care and support of children who are AIDS orphans living in townships is to uphold the following statement made by the South African government: “It is the constitutional obligation of the state to protect and ensure the well-being of OVCs through programmatic intervention” (DSD, 2005: 40). Whilst there is government policy in place to direct the course of action of the South African government regarding the care and support for orphans and vulnerable children, the strategies or overall plan to achieve these aims of government would seem to lack operationalisation and the responsibility is predominantly taken by the NGO sector.

The researcher is a paediatric nurse from the United Kingdom and a primary healthcare practitioner who has experience of working in primary healthcare clinics in the townships in South Africa: and is also the director of a Non-Governmental Organisation (NGO) assisting widows and orphans living in the township communities of the Nelson Mandela Bay (NMB) The researcher also has experience of working in a primary healthcare capacity with AIDS orphans in Uganda, Zambia and Lesotho. Whilst working as a volunteer at the House of Resurrection Haven in South Africa and subsequently as a primary healthcare practitioner in the primary healthcare clinics in the Nelson Mandela Bay, the researcher gained experience in the care and support of children who are AIDS orphans. It was during this time that the researcher became aware of the extent of the AIDS pandemic and how death, abandonment, rejection, socio-economic hardship and poor health plagued the lives of children who had been left as AIDS orphans. On the completion of studies at Master's Degree level and through working as an NGO director, the researcher began to think more about developing strategies to provide care and support for children who are AIDS orphans living in townships.

The research questions that arise from the problem statement are:

What are the current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa?

What are the experiences of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists in providing care and support to children, who are AIDS orphans living in the townships?

What strategies should be in place to enable primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to provide care and support to children who are AIDS orphans living in the townships?

1.3 PURPOSE OF THE RESEARCH

The purpose of this qualitative study is to analyse international, national and provincial legislative policy frameworks concerning the rights of children living in South Africa and to explore and describe the experiences of primary healthcare practitioners in primary healthcare clinics, social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships. The information obtained will be used by the researcher to develop strategies which could be embraced by the Departments of Health and Social Development to enable primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to provide holistic care and support to children who are AIDS orphans living in the townships.

1.4 RESEARCH OBJECTIVES

A research study usually has a “broad statement of purpose expressed as an aim and then some more specific statements, expressed as objectives, which address different aspects of the aim (Gerrish and Lacey, 2006: 85) and which are clear, concise, declarative (Burns and Grove, 2009a: 165) and give an indication of what the researcher wishes to achieve in the research (Babbie and Mouton, 2009: 101).

1.5 OBJECTIVES OF THE STUDY

The objectives of this proposed research study are to:

- explore current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa
- explore and describe the experiences of primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS orphans living in the townships,
- explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships,
- create a conceptual framework for the care and support of children who are AIDS orphans living in townships and
- develop strategies that could be embraced by the Departments of Health and Social Development to enable primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists to facilitate care and support to children who are AIDS orphans living in the townships.

1.6 CLARIFICATION OF CONCEPTS

It is necessary to ensure clarity when making reference to the main issues and concepts in this study due to the multiplicity of interpretations of concepts which are possible in the human health sciences (Garbers, 1996: 290). Several concepts have been identified as requiring clarification for this study.

- **AIDS orphan**

According to UNAIDS, an AIDS orphan is defined as an HIV-positive or-negative child who, prior to the age of 15 years, has lost either mother or both parents to AIDS (UNAIDS, 2009: 1). For this research study, considering that the constitution of South Africa defines a child as a person being under the age of 18 years, the researcher will consider a child orphaned by AIDS as being a person below the age of 18 years who has lost either one or both parents to AIDS or AIDS-related symptoms.

- **Children**

There is no single law that defines the age of a child across the world. The United Nations Convention on the Rights of the Child (UNCRC), ratified by the South African government in 1991, states that a child “means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.” (Article 1, Convention on the Rights of the Child, 1989). The constitution of South Africa defines children as being persons under the age of 18 years, therefore for this research study, children will be considered as persons below the age of 18 years.

- **Conceptual framework**

The Concise Oxford English Dictionary (Soanes and Stevenson, 2008: 296) defines conceptual as “relating to, or based on, mental concepts” since a concept is “an idea or mental picture of a group or class of objects”. According to Holloway (2008a: 43), “the production and development of concepts is a characteristic of qualitative research” and the generation of concepts is an essential feature of qualitative research, as are links between concepts, which are required as components of theory, in the context of this research. The word “framework” itself is, according to the Concise Oxford English Dictionary (Soanes and Stevenson, 2008: 536), “an essential supporting or underlying structure”. In this study the conceptual framework will refer to the themes analysed from the data collection which will then form the basis of the development of the strategies.

- **Primary Healthcare Clinics**

In South Africa primary healthcare services developed over many years, even before the Alma Ata Conference in 1978 when Primary Healthcare was propagated by WHO (Hattingh et al., 2006: 60). The concept of Primary Healthcare was defined at Alma Ata as “essential care which is based on scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in their community, through their full participation and at a cost that the community and country can afford"   (Hattingh et al., 2006: 60-61). It is further defined as "the first level of contact of individuals, the family and the community with the national health system, bringing healthcare as close as possible to where the people live and work; and constitutes the first element of a continuing healthcare process" (Hattingh et al., 2006: 61). What is also relevant is that primary healthcare and clinics have often been slated due to being perceived as second-class care centres with 'poor' medicine for poor people, where funding has usually been insufficient and inconsistent, leading to restricted primary healthcare interventions and reinforcing a culture of survival in developing countries (Hattingh et al., 2006: 60). Primary healthcare clinics should be, "available, accessible and affordable, where minor illnesses and, where required, more serious illnesses should be treatable, a one-stop service for communities who need comprehensive and continuous care" (Lundy and Janes, 2009: 135).

- **Township**

In South Africa, the terms township and location usually refers to the (often underdeveloped) urban living areas that, from the late 19th century until the end of Apartheid, were reserved for black South African People. Townships were usually built on the periphery of towns and cities. Townships are traditionally poor with unstable infrastructure. (Houser, 2008:21). This study will be conducted in the townships, in the Nelson Mandela Bay Health District (NMBHD), which is situated in the Western Region of the Province of the Eastern Cape (PEC), South Africa. The PEC has a population of 6, 7 million people which is 13, 5% of the national total, making the PEC the third largest province in South Africa (StatsSA, 2011: 4). Further details regarding townships will be presented in the contextual description of this proposed research study.

- **Primary healthcare practitioner**

This person is a professional nurse working in the primary healthcare clinics, an individual authorised to practise and capable of practising nursing or midwifery in his/her right by virtue of registration in terms of section 16 of the Nursing Act, 2005 (SA, 2005). Such a person is accountable for evaluating a patient's situation on the basis of knowledge and skill, taking decisions with discretion and acting in accordance with such decisions, South African Nursing Council Terminology List: (SA, 2005: 30). Professional nurses meeting these requirements act as independent practitioners in their own right and are expected to accept full responsibility and accountability for their actions.

- **Social Worker**

The social work profession promotes social change, problem-solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. In this research study refered to as a social care practitioner.

Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives and prevent dysfunction. Professional social work is focused on problem-solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and communities they serve. Social work is an interrelated system of values, theory and practice which grew out of humanitarian and democratic ideals; and its values are based on respect for the equality, worth, and dignity of all people (Adopted by the IFSW General Meeting in Montréal, Canada, July 2000).This international definition of the social work profession replaces the IFSW definition adopted in 1982. It is understood that social work in the 21st century is dynamic and evolving, and therefore no definition should be regarded as exhaustive.

- **Psychologist**

This is a professional person who has completed a programme of study in Psychology and is engaged in research, clinical treatment, teaching or other applications of Psychology. Psychologists specialise in diagnosing and treating diseases of the brain, emotional disturbance and behaviour problems. Since psychologists can only use talk therapy as treatment; they will refer clients to a psychiatrist or other medical doctor to be treated with medication if this is what is professionally required. Psychologists may have a master's degree (MA) or doctorate (Ph.D.) in psychology; but may also have other qualifications, including Board certification and additional training in another type of therapy and may also have completed a programme of study in psychology and be engaged in research, clinical treatment, teaching or other applications of psychology (Curry, 2012: 1).

- **Care and Support**

Care and support are “based on an active concern for the well-being of others and ourselves” (Green et al., 2003: 17). Children who are AIDS orphans living in the townships require care and support because they are vulnerable and face many challenges. “The aim of the framework policy in South Africa regarding the care and support of orphans and vulnerable children is to provide programmatic initiatives to promote a supportive and caring environment in which orphans and other children made vulnerable by HIV/AIDS are adequately cared for and supported and protected to grow and develop to their full potential” (DSD, 2005: 4). According to the Concise Oxford English Dictionary (Soanes and Stevenson, 2008: 1448), support means to “bear all or part of the weight of; give assistance, encouragement or approval to; be actively interested in” and need was previously defined essential or necessary care. Children who are AIDS orphans living in the townships require both care and support. Such children should be receiving support and care from health and social care professionals trained and appointed by the South African government to operatonalise their policy framework for caring for and supporting children who are AIDS orphans living in the townships and who require a continuum of care and support which can respond to their changing needs over the course of their transition into adulthood and to “fulfil their potential”. Care and support in the context of this research study will be considered as any assistance given to children by primary healthcare practitioners, social workers and psychologists to provide physical, emotional psychological or spiritual care and support to assist children who are AIDS orphans living in the townships.

- **Strategy**

A strategy is a plan designed to achieve a particular overall aim and the art of planning toward generating a successful outcome (Liddel-Hart, 2012: 4).

1.7 THEORETICAL PARADIGMATIC PERSPECTIVE

A paradigm is “a set of laws, theories, methods and applications that form a scientific research tradition” (McBurney and White, 2007: 24). These are used by the qualitative researcher, who is termed a philosopher in the sense that he/she is “guided by highly abstract principles” Bateson, in Denzin and Lincoln, (2003: 33), which culminate in the overall view of the qualitative researcher regarding how he/she “sees the world and acts in it” (Denzin and Lincoln, 2003: 33). A paradigm then is defined as a “particular way of viewing a phenomenon in the world” (Burns and Grove, 2009a: 53), which lends itself to a quest for understanding the study topic and for in-depth inquiry (Henningh et al., 2004: 3).

Theoretical frameworks are a collection of concepts, maps and or conceptual models that depict a piece of theory that is to be examined as the basis for a research study. In general the theoretical framework is the basic structure of the ideas to be tested for the study (Houser, 2008: 169).

The development of the theory “An anthropological nursing science: Nursing Accompaniment theory" was strongly influenced by the existential-phenomenological and personological world and life view of Western-European philosophers of the nineteenth and twentieth century, as well as by developments in the fields of philosophical anthropology and fundamental agogics in South Africa during the seventies (Kotzé, 1998: 2). The theoretical framework for this study is found in WJ Kotzé’s theory on Nursing Accompaniment (Kotzé, 1998: 3-14). Her paradigm perspective provides the foundation from which all aspects of this study will be developed and viewed.

1.7.1 Metaparadigms

For the purpose of this research study, there are four metaparadigms requiring explanation in order to understand the experiences of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists who have a professional role in providing care and support to children who are AIDS orphans living in townships.

1.7.2 Man

Man in this study, refers to children who are AIDS orphans living in the townships, primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists who have a professional role in providing care and support to children who are AIDS orphans living in townships. Man is seen as a multi-dimensional (holistic) being. Kotzé (1998: 2) points out that her philosophical and anthological convictions prompt her to see man as being continually concerned with norms, constantly choosing between right and wrong and as an open being, continually changing. The multi-dimensional, inseparable, body-psyche-spirit is in a continuous dynamic relationship with the surrounding world (both known and unknown), with time, with fellow-beings and with God. In this research study the researcher wants to acknowledge that the care and support given to children who are AIDS orphans living in townships is multidimensional, namely that care and support encompass physical, emotional, spiritual and practical care and support.

1.7.3 World

This term refers to the world in which man exists. The objective or external world is the world of which he is only vaguely aware and of which he has little knowledge (Kotzé, 1998: 10). As man explores and gets confronted with certain aspects of his external world, he may get a grip on it, build a relationship with it and so make it part of his “life world”. For primary healthcare practitioners, working in primary healthcare clinics, social workers and psychologists, embracing the “life world” of children who are AIDS orphans living in the townships is challenging and at times overwhelming. Within this proposed study the “external world” refers to; primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists who are engaging the “life world” of children who are AIDS orphans living in the townships and their experiences of providing care and support to these vulnerable children.

The subjective world or “life world” refers to that part of the world that man has made his own. In this world he knows he is safe, secure and wanted (Kotzé, 1998: 11). The subjective world consists of the personal world, interpersonal world, world of co-existence and time. When primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists provide care and support to children who are AIDS orphans living in the townships their “life world alters” as they embrace a challenge which requires adaptation. What was familiar may become daunting they as professionals try to provide care and support to children who are AIDS orphans living in the townships, in very challenging circumstances.

1.7.4 Health

Kotzé’s (1998: 12) metatheoretical statement on health is in line with the definition of the World Health Organization (WHO). It is also seen as a dynamic process in which a person, sick or healthy, must maintain himself as a multi-dimensional being in his relationships, not only in his physical but also in his social environment (Kotzé, 1998: 13). Health is thus a relative concept, an adjustment and a process. It has the potential of illness when one is well and wellness when one is ill. The relative concept of illness or wellness is affected by the quality of man’s relationship with world, time, fellow-beings and God (Kotzé, 1998: 4). Health in this research study would be considered as how primary healthcare practitioners in primary healthcare clinics, social workers and psychologists, remain healthy and provide assistance, physically emotionally and spiritually in the form of care and support to children who are AIDS orphans living in the townships.

1.7.5 Nursing

According to Kotzé (1998: 4), nursing is an interpersonal event, with accompaniment as an integral part of it. Kotzé's theory of Nurses' accompaniment flows from her philosophical belief based on the premise that nursing is a phenomenon that is only possible on a human level. It occurs between a person in need of help and supportive guidance (i.e. the accompanied) and the person with the necessary knowledge and skills to provide that support, assistance and guidance (i.e. the accompanier). In order to be effective, the relationship requires an environment of "trusting, knowledge/understanding, togetherness" (Kotzé, 1998: 10).

Accompaniment is described as a "deliberate, systemic intervention by the nurse (healthcare practitioner) to assist the patient/client to overcome the need of help and support, to recovery or self-reliance and the acceptance of responsibility for the purpose of giving meaning into personal life even in terminal situations" (Kotzé, 1998: 3). In this research study the accompanier is considered to be the primary healthcare practitioner working in primary healthcare clinics, social workers and psychologists and the accompanied, children who are AIDS orphans living in townships.

1.8 RESEARCH DESIGN AND METHOD

As this study will be used to generate new knowledge regarding a particular human experience, a qualitative research design will be used. The researcher plans to explore and describe the experiences of healthcare practitioners working in primary healthcare clinic's, social workers and psychologists working in satellite offices based in the township communities who provide care and support to children who are AIDS orphans living in the township communities. The research design and method will be briefly described in this chapter with a comprehensive description being presented in Chapter Two.

1.8.1 Research Design

The research design is a blueprint or a plan defining how the research will be conducted (Babbie and Mouton, 2008: 72) . For this research study the research design will be a qualitative, explorative, descriptive and contextual in nature, in order to achieve the research objectives.

1.8.1.1 Qualitative Research

Metaphorically qualitative research is an intricate fabric composed of minute threads, many colours, different textures and various blends of material. The fabric is not explained easily or simply. “Like the loom on which fabric is woven, general world views and perspectives hold qualitative research together” (Creswell, 2009: 26).

Qualitative research, with its roots in anthropology, philosophy and sociology, is used as a method for studying the ways in which people make sense of their world and their experiences (Holloway, 2008a: 8). Qualitative research is an umbrella term for a number of different approaches; but each of them is based on interpreting social reality and the lived experiences of a human being (Holloway, 2008a: 3). The social, cultural, political and physical environments may be similar for many people; but will affect each person in an individual way (Holloway, 2008a: 4). Descriptions given by humans are used as a way of increasing knowledge concerning the human experience (Creswell, 2009: 27). A researcher making use of qualitative methods is able to explain the relationships between these environments and the individual by analysis of the stories they tell. In this research study, health and social care practitioners describe their unique experiences in their own social, cultural political and physical environments Health and social care practitioners were asked to describe their experiences of providing care and support to children living as AIDS orphan in the township communities.

1.8.1.2 Exploratory Study

An exploratory study is designed to increase knowledge within the field of study (Welman et al., 2010: 15).

A study is exploratory when it tries to uncover relationships and dimensions of a phenomenon by investigating the manner in which the phenomenon manifests itself to any other related areas in order to obtain a better understanding of the phenomenon (Babbie and Mouton, 2008: 56). Exploratory research by its nature explores the research question about which little is yet known in order to uncover generalisations, which means the researcher departs from a point of reference of “not knowing” (Burns and Grove, 2009b: 83). The researcher wants to become familiar with the experiences of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships. Therefore exploration is needed. The experiences will generate new knowledge which in turn will lead to an improved understanding of those experiences.

1.8.1.3 Descriptive Study

Descriptive designs are “crafted to gain more information about characteristics within a designated research study” (Burns and Grove, 2009a: 214). A descriptive design refers to the accurate portrayal of the lives of particular individuals or real-life situations, for the purpose of discovering new meaning and describing what exists by categorising the information generated from the study (Burns and Grove, 2009a: 215). In this proposed study the researcher would like to describe the experiences of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists who provide care and support to children who are AIDS orphans living in townships.

1.8.1.4 Contextual Study

The qualitative researcher has a “preference for understanding events, actions, and processes in their context” (Babbie and Mouton, 2008: 272), the context then provides for interpretive meaning, using the culture of the participants, situations that they find themselves in and the environment, so that meaning can be “put together and packaged, as it were, through nonverbal, usually non-linear, and ‘invisible’ features of context, often commonsensical referred to as tone, emotion, history or experience” (Denzin and Lincoln, 2003: 307). The total context of the participants’ lives will affect the findings and are thus important aspects to be considered (Holloway and Wheeler, 2002: 11).

The context involves situating the object of the study or the phenomenon of a study within its immediate setting (Creswell, 2007: 67). Context implies the conditions and situations of an event. It aims at focussing on the specific set of priorities that pertain to a phenomenon. The approach to this study will be contextual. The context for this proposed research study will be the township communities of Nelson Mandela Bay where children who are AIDS orphans need to access care and support from primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists working from satellite offices in the townships. More detail regarding the context will be provided in Chapter Two of this study.

1.8.2 Research Method

Creswell (2009: 15) states that research methods involve “forms of data collection, analysis and interpretation that researchers propose for their studies” which, according to Babbie and Mouton (2009: 74), consist of the systematic, methodical and accurate execution of the research design. In the research method classes of techniques, skills and instruments are used to execute specific tasks in the research process (Babbie and Mouton, 2009: 36).

The research methods for this study will be carried out in four phases. The first phase consists of an analysis of International and South African government’s legislative policy frameworks concerning the rights of children living in South Africa. Phase two includes the sampling procedure and participants, the data collection process and data analysis. A comprehensive literature control forms part of phase two. Phase three consists of the compilation of a conceptual framework. This conceptual framework will be used during the formation of strategies. Phase four is the development of strategies, that will be developed to provide care and support to children who are AIDS orphans living in the township communities; making use of the themes identified during data analysis and with the literature sources.

1.8.2.1 PHASE ONE

During this phase, the researcher will present an overview of the current legislative framework policies at an international, national and provincial level, regarding the the rights of children living in South Africa. The researcher will do this through an extensive review of current literature using a range of books, available data bases, peer review journals, and discussion with experts. This will be presented in chapter three of this research study in order to place the care and support of children orphaned by AIDS living in the townships within the legislative, policy framework currently in place in South Africa, through which care and support to these vulnerable children is provided.

1.8.2.2 PHASE TWO

During phase two data from two research populations was collected and analysed. As the research process of this study deals with two groups of participants, the researcher will discuss each group separately in the discussion of phase two of the study.

1.8.2.2.1 Research Population One

According to Polit and Beck (2010: 306), “A population is the entire aggregation of cases in which the researcher is interested”. Therefore, population refers to a particular type of individual who is the focus of the research and who meets the sampling criteria (Burns and Grove, 2009a: 342-344). The research population one of this study was chosen from PHC clinics where primary healthcare practitioners work to provide care and support to children who are AIDS orphans living in the townshps . The first research population will comprise:

- primary healthcare practitioners working in primary healthcare clinics in Nelson Mandela Bay Municapalities, who provide care and support to children who are AIDS living in townships;
- who are primary healthcare practitioners who have formal registration with SANC; and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

Sampling

During the course of this study, the researcher will make use of criterion-based-purposive sampling for both research populations. This sampling strategy was chosen by the researcher in order to conduct a detailed exploration of how primary healthcare practitioners in primary healthcare clinics, social workers and psychologists experience providing care and support to children who are AIDS orphans living in townships. Purposive sampling is used in qualitative research. The researcher selects individuals for the study because they can purposefully inform an understanding of the research problem and central phenomenon in the study (Creswell, 2007: 125). Purposive sampling is based on the assumption that the researcher's knowledge about the population can be used to handpick the participants to be included in the sample. Criterion sampling works well when "all of the individuals studied represent people who have experienced providing care and support to children orphaned by AIDS living in townships". Purposive sampling is precisely as its name suggests. Members of a sample are chosen with a purpose to represent a type of key criterion. All the research populations used in this research study were selected in this manner. The first is to ensure that all key constituents of relevance to the subject matter are selected for the study. The second is to ensure that within the criteria some diversity is included so that the impact of the characteristics concerned can be explained. Although purposive sampling selection involves deliberate choices it does not, however, suggest any bias in the nature of the choice made. "The process of purposive sampling requires clear objectivity so that the sample stands up to independent scrutiny" (Ritchie and Lewis, 2003: 74).

Gate Keepers

Formal permission is important in the undertaking of any research study and is required so that both the researcher and participants are protected. In order to gain access to study participants at research sites, the agreement of individuals in authority is required. These individuals who are termed 'gatekeepers' (Creswell, 2009: 90), are the people who have the power to grant or withhold access to a setting or participants. They may be located in different places and layers in the hierarchy of the institution; and the researcher needs to give adequate details of dissemination and publication so that the gatekeepers are informed and willing to enable the research study to be undertaken. This is particularly the case in healthcare settings where gatekeepers might be sensitive regarding the findings of research, or that there disruption to care and support provided by the requested participants (Holloway, 2008a: 107).

In this research study the gatekeepers were the District Manager for the Department of Health in Nelson Mandela Bay District and the Executive Director for Public Health of the Nelson Mandela Bay Health District in order to enter the PHC clinics to be used in this study. The District Manager and the Executive Manager will therefore be approached first by means of a formal written request (see Appendix B, C and F). A formal request in writing was also sent to the primary healthcare practitioner managers, in the clinics where the proposed research interviews were conducted (see Appendix E).

Appointments for in-depth interviews were arranged telephonically or by e-mail with the participants or in person; and informed consent forms were supplied to each participant (see Appendix A and D). This was done as soon as the right to entry to the site has been obtained from the Faculty Research, Innovation and Technology Committee, Research Ethics Committee- Human, the District Manager for the Nelson Mandela Bay Health District office and the Executive Director for Public Health of the Nelson Mandela Bay Health District, in order for the researcher to enter the PHC clinics and satellite offices which were used in this study (see Appendix G, H, I and J).

Data Collection Method

In qualitative research data collection involves the gathering of information through a variety of data sources, for instance, observation and interviews. Often the term ‘generating’ data is used in qualitative data rather than ‘collecting’ data (Holloway, 2008a: 64-65). The fundamental aim of planning qualitative research is to position the researcher close to the participants so as to gain access to and describe, personal experiences and interpret their meanings in specific settings (Muller, 2009: 15). For the purpose of this study, the researcher has chosen in-depth interviews with both groups of participants in order to obtain the relevant research data.

“The qualitative one-on-one interview is often called a ‘conversation with a purpose’ Burgess, 1984:102 quoted in (Holloway, 2008a: 134); and reflects the researcher’s agenda though it is intended to obtain the perspectives of the participants (Holloway, 2008a: 134). In-depth interviews are one of the most favoured data-collection methods used in qualitative research whereby the researcher aims to gain the perspectives, feelings and perceptions from the participants and/or their description of the phenomenon being studied (Holloway, 2008a: 134). In-depth interviews are unstructured interviews which are used when the researcher wishes to find out how something works or to explore the personal experiences of an interviewee where the interviewer has little or no prior sense of what are key issues or events for them (Gibson and Brown, 2009: 90). The in-depth interview is managed by the researcher in a way that allows the participants to discuss their practices and/or activities within the chosen setting whilst ensuring that the interviewer directs the in-depth interview according to areas of interest or relevance to the study, which is achieved by the researcher probing areas that are regarded as relevant (Gibson and Brown, 2009: 90). The researcher has chosen this method for data collection because she intends to collect rich and in-depth data that may become the basis for theorising.

The researcher informed the participants that the data-collection method was in the context of the participants' place of work. Permission was requested from the participants to use a tape recorder to record the in-depth interviews, prior to interviewing. This will enable the researcher to record the exact words of the interview, inclusive of questions, so that she does not forget important answers and words whilst she is maintaining eye contact and paying attention to what the participants are saying during the interview. Unstructured in-depth interviews are typically undertaken as a means of working out what might be interesting; therefore the researcher analysed the interview directly after conducting it and reflection was contextual in nature, during which the researcher considerd the list of topics covered in the interview; ways in which she played a role in the development of the conversation, how the interview compared in content to other interviews that may have been conducted; and how the answers to these questions can enhance future interviews (Gibson and Brown, 2009: 90-91).

According to Holloway (2008b: 134), unstructured in-depth interviews begin with a broad, open-ended question within the broad area of the study. The questions asked in this section of the study were for research population one participants. The following questions were posed to participants in this group:

How do you experience providing care and support to children who are AIDS orphans living in the township communities?

What recommendations would you like to make to improve the quality of care and support provided to children who are AIDS orphans living in the townships?

The researcher will continue interviewing primary healthcare practitioners in primary healthcare clinics until data saturation is reached (Strauss and Corbin, 2002: 361). According to Polit and Beck (2010: 567), data saturation refers to the “collection of qualitative data to the point where a sense of closure is attained because new data yields redundant information”.

1.8.2.2.2 Research Population Two

The second group of participants in this research study were social workers and psychologist based in satellite offices in the NMB providing care and support to children who are AIDS orphans living in the townships. The selection criteria will therefore be:

- social workers and psychologists working in satellite offices in the Nelson Mandela Bay Metrapole providing care and support to children who are AIDS orphans living in townships,
- have formal registration with their associated professional body; and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

Data Collection Method

Data from this research population will also be collected in the form of unstructured in-depth interviews as previously described. This will allow participants to use their own words and develop their own thoughts. Allowing participants to “speak their minds” is a good way of discovering detail about complex issues (Denscombe, 2010: 34). According to Jolley (2010: 4), the in-depth unstructured research interview enables a less structured and more flexible and comprehensive gathering of data. In-depth interviews are usually employed in exploratory studies (Welman et al., 2010: 7).

The following questions were posed to participants in this research population

How do you experience providing care and support to children who are AIDS orphans living in the township communities?

What recommendations would you like to make to improve the quality of care and support provided to children who are AIDS orphans living in the townships?

Sampling

The researcher will also use criterion-based purposive sampling for the selection of participants for research population two as previously described. This will allow the researcher to select individuals for this research population who can purposefully inform the researcher from their understanding of the central phenomenon being studied.

Gate Keepers

The gate-keepers for this aspect of the proposed research study were the manager of the school feeding programme through which social workers are placed in satellite offices in townships to provide care and support to children who are AIDS orphans living in townships in Nelson Mandela, Bay: and the manager for the placement of masters degree students on their internship programme based at NMMU. Psychology students on this internship programme are based in satellite offices also in the township communities where they provide care and support to children who are AIDS orphans living in the townships.

Pilot Study

A pilot study was undertaken by conducting two interviews with two of the following participants; either a primary healthcare practitioners working, in primary healthcare clinics, a social worker or psychologists providing care and support to children who are AIDS orphans living in townships. The aim of the pilot interviews was to identify and determine that the questions posed and the data gathered is useful and usable and to establish that the research interview technique used by the researcher was correct. In this manner corrections could be made by the researcher before conducting further interviews with participants selected for this research study (Geense et al., 2013: 3).

Field Notes

Researchers using observation and case-study methodologies often start with some general question in mind but without specific categories of behaviour defined, it is important to make notes of all observations and how these were interpreted at the time in order to help the researcher remember relevant issues. It is not possible to remember details later, so the researcher should be diligent in the completion of field notes after each interview (McBurney and White, 2007: 233). Field notes are both a description and reflection and contain speculations, analytical comments and other thoughts of the researcher (Holloway, 2008a: 97).

Many qualitative researchers use a reflective journal or personal diary, to document personal experiences, reflections and progress in the field (Holloway, 2008a: 97). Bracketing, which means to identify and hold in abeyance preconceived beliefs and opinions about the subject being studied, needs to be utilised by the qualitative researcher in order to describe accurately the participant’s experiences. Although it is difficult to achieve fully, bracketing is necessary in order for the researcher to try to bracket out presuppositions so that data can be confronted in pure form (Polit and Beck, 2010: 268). Reflective journals form part of an audit trail in qualitative research and are an important means to enhance rigour, whereby the researcher's intentions and dispositions are recorded (Polit and Beck, 2010: 498).

Data Analysis

The individual interviews were digitally recorded and transcribed, producing a verbatim report of the interview and proceedings for analysis. By combining the data from the transcripts with the field notes, a rich source of information was created which could provide an in-depth picture of the experiences of primary healthcare practitioners, social workers and psychologists experiences regarding the provision of care and support to children who are AIDS orphans living in the townships.

Literature Control

Literature control is an important phase of the study in which the data collected is compared with existing research findings. This enables the researcher to place the findings in the context of the existing general scientific knowledge. Analysis of the literature on the subject takes place together with, or following, data analysis, assisting in the interpretation and validity of the findings (Streubert and Carpenter, 2011: 158).

1.8.2.3 PHASE THREE

The themes identified in the data gathered from the transcribed in-depth interviews, the field notes as well as the reflective journals were cross-validated to ensure trustworthiness of the data which will then be organised into a conceptual framework. The conceptual framework is used to clarify the relationships of the concepts and the themes identified during the research process and also used to link the gathered data to previously established models and theories (Schneider, 2004: 133). The structure of the conceptual framework for the care and support of children who are AIDS orphans living in the township communities will depend upon the data analysis. The data analysis will also indicate the strategies to be developed to facilitate the care and support of children who are AIDS orphans living in the township communities.

In the development of a conceptual framework the researcher will utilise the six vantage points of surveying activity together with the six aspects of activity as listed by Dickoff, James and Weidenbach (1968: 422).

- Agency- Who or what performs the activity?
- Patiency or recipiency- Who or what is the recipient of the activity?
- Framework- In what context is the activity performed?
- Terminus- What is the end point of the activity?

- Procedure- What is the guiding [procedure, technique or protocol of the activity?
- Dynamics – What is the energy source for the activity?

These six aspects of activity will serve as an organising principle. It is important to create conceptual meaning by addressing the relationship between concepts and scientific progress and development or advancement of various fields of study in order to ensure that the concept continues to explain adequately the phenomena relevant to each discipline (Rogers and Knafl, 1993: 25-26). Conceptual problems can occur when confusing terminology or ambivalent words are used to characterize certain situations or phenomena; therefore in order to create conceptual meaning it is necessary to ensure that a tentative definition of the concept is made in order to reflect the use of the concept in the particular context (Rogers and Knafl, 1993: 74); and a set of tentative criteria for determining if the concept exists in a particular situation is also required in order to create conceptual meaning (Rogers and Knafl, 1993: 74).

1.8.2.4 PHASE FOUR

This phase will involve the development of strategies to provide care and support to children who are AIDS orphans living in the townships. The recommended strategies were developed from the data obtained during the interviews conducted with the participants, the field notes and the reflective journal and will also depend upon the themes which will have been identified from the data analysis.

1.9 TRUSTWORTHINESS

Trustworthiness is established by a variety of constraints or criteria of evaluation to ensure that it is both credible and valid for professional practice (Shenton and van Rensburg, 2004: 62). Trustworthiness is established by a variety of constructs or criteria of evaluation to ensure that the information gathered is both credible and valid for professional practice (Polit and Beck, 2010: 537). These constructs are credibility, transferability, confirmability and dependability. The subject must be accurately identified and described and the findings should be able to be transferred to other similar situations. Regular auditing is required and the findings should be consistent and accurate. Guba’s model of trustworthiness, (Guba and Lincoln, 1989: 215), was used to ensure that a high level of trustworthiness was achieved. The process used to ensure that this was reached and maintained will be described in greater detail in Chapter Two.

1.10 ETHICAL CONSIDERATIONS

Ethical research is essential for the generation of sound empirical knowledge and for the protection of the participants involved in the research study. What does good ethical conduct in research involve? This is a question that researchers philosophers lawyers and politicians have debated for years (Burns and Grove, 2009b: 103).

Ethical guidelines are standards which are used to judge the conduct of the researcher and to assess the extent to which ethical principles are adhered to. The ethics of science concerns the rights and wrongs in the conduct of research. Because scientific research is a form of human conduct it follows that such conduct has to conform to generally accepted norms and values (Burns and Grove, 2009a: 101). Such guidelines seek to prevent the researcher from engaging in scientific misconduct, such as distorting and inventing data, plagiarism, failing to maintain confidentiality and privacy of participants, forcing people to be involved in research and for not executing the study properly (Burns and Grove, 2009a: 102).

“The ethical practice of social research with human participants is a complex and demanding responsibility. Throughout the social research process from initiation to completion, ethical issues will exist and emerge, often raising moral dilemmas that are not easily resolved” (King and Horrocks, 2010: 103). However, despite the dilemmas, the Belmont Report identified three ethical principles as relevant in the conducing of medical or behavioural research. Respect for persons, holds that a person has the right to self-determination and freedom or not to participate in research; the principle of beneficence requires the researcher to do good and “above all” to do no harm and the principle of justice holds that human participants should be treated fairly (Burns and Grove, 2009a: 188). The following ethical principles were adhered to throughout this research study:

- **PRINCIPLE OF BENIFICENCE**

  Harm arising from poorly conducted research could range from physical harm to emotional distress, which is why beneficence is an essential ethical principle in research (Hansen, 2006: 35). According to Barrett and Coleman (2009: 565), participants should be treated in an ethical manner by respecting their decisions, protecting them from harm and safeguarding their wellbeing. This is ensured through the wide range of laws, regulations and professional codes of practice, all of which are devised to protect the rights and interests of all participants in research studies.

  The researcher ensured that no participant was subjected to any harm, exploitation or risk. This was done through obtaining informed consent, recognising that all research participants were autonomous, that they had the right to refuse to participate in the research study, and that they could withdraw from the research study at any time (see Appendix A and D). The research study had no actual risk factors and anonymity was maintained; thus there was no risk of participants being identified or victimised in the event of negative comments being made regarding the data collected or the research study. This research study will benefit the participating individuals and society in general by contributing to the body of knowledge through the development of strategies to provide care and support to children who are AIDS orphans living in the township communities.

- **PRINCIPLE OF RESPECT FOR HUMAN DIGNITY**

This principle includes the right to self-determination and the right to full disclosure, which essentially means that humans should be treated as autonomous agents, capable of controlling their own activities and destinies. The right to self-determination indicates that potential participants can voluntarily decide whether to take part in the study, without the possibility of prejudicial treatment (Polit and Beck, 2012: 154). The researcher therefore ensured that all participants had the right to decide to terminate their participation at any stage, to refuse to give information and to ask for clarification about the purpose of the study. No participant was coerced into taking part in this study at any stage.

In order to make an informed, voluntary decision regarding participation in this study, participants required full disclosure, which means that the researcher fully described the nature of the study as well as the stated right to refuse participation. This included outlining the researcher’s responsibilities (Polit and Beck, 2012: 154). The researcher consequently disclosed fully to the participants the nature of the research and gave each participant the opportunity to refuse to participate in the study, while simultaneously outlining the risks and benefits that could occur as a result of their participation. The right to full disclosure and the right to self-determination are the two major elements on which informed consent is based (Polit and Beck, 2012: 154). The researcher therefore ensured that the participants had adequate information about the research study, were capable of understanding the information and had the power of free choice, enabling them to consent voluntarily in the research or decline participation. Accordingly the participants were requested to give their consent in writing (see Appendix D), after reading the information letter for participants (see Appendix A).

- **PRINCIPLE OF JUSTICE**

This includes the participants’ right to fair treatment and their right to privacy, which encompasses the equitable distribution of benefits and burdens of research (Polit and

Beck, 2012: 155). The researcher therefore ensured that there was a fair and non-discriminatory selection of participants and non-prejudicial treatment of individuals who declined to participate or who withdrew from the study (Watson et al., 2010: 132). The researcher also honoured all agreements and adhered to the procedures outlined in advance and was also respectful and courteous at all times.

Anonymity and confidentiality were adhered to, this being ensured by not using names or other identifying data relating to participants and institutions. The researcher accordingly ensured that no link could be made with the data obtained and a particular participant (Watson et al., 2010: 283).

Dissemination of qualitative research is the process of distributing information and knowledge so that it can reach the audience or readership for which it is intended (Holloway, 2008a: 76), and can take the form of, writing articles for academic journals, publishing a book or chapter, giving presentations at conferences or other media such as audio or videotapes. For the purposes of this research, the results will be disseminated by submitting a written report and supplying a copy to the NMMU library. Three articles will also be written for peer-reviewed journals and papers will be presented at various appropriate conferences.

1.11 STRUCTURE/FORMAT OF RESEARCH REPORT

The research study is divided into seven chapters and the format is:

Chapter 1:	Overview of the study
Chapter 2:	Research design and method
Chapter 3:	An overview of international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa
Chapter 4:	Discussion of results and literature control
Chapter 5:	Development of conceptual framework
Chapter 6:	Description of strategies
Chapter 7:	Conclusions, limitations and recommendations

1.12 CHAPTER SUMMARY

HIV/AIDS pandemic is devastating the lives of many children who become destitute AIDS orphans. Their lives hopeless and full of adversity. It is imperative that informed programmatic implementable strategies are in place at national, provincial and household levels to eliminate growing child-headed households and street children populations. On becoming AIDS orphans, children are vulnerable physically, emotionally, psychologically educationally and nutritionally. Informed well-implemented strategies to govern the response of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists can stabilise the lives of these vulnerable children and can assist these children away from a life of destitution into a life where they can be cared for, supported and mentored to reach their “full potential” and therefore add value to their communities and their nation.

In this chapter the researcher has presented an overview of the research study. This overview will be presented fully in subsequent chapters.

CHAPTER TWO

RESEARCH DESIGN AND METHOD

The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.” Albert Einstein

2.1 INTRODUCTION

In Chapter One, the researcher presented an introduction to the research problem together with an overview of the study and a description of the research problem and research objectives. A brief orientation concerning the research design and method was also provided.

In this chapter the purpose of the study together with the research method and design will be presented. A description of the research strategy, the data-collection process and the sampling method, data analysis and ethical considerations as well as trustworthiness will be provided in greater detail.

2.2 BACKGROUND TO THE STUDY

"Safety and security don't just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear (Mandela, 2002: 1).

“AIDS (Acquired Immune Deficiency Syndrome) has devastated the social and economic fabric of African societies and made orphans of a whole generation of children and has become the epicentre of the HIV/AIDS pandemic (Fassin, 2007: 27). South Africa is severely affected by the AIDS pandemic, with the largest number of HIV infections in the world, a total of 5.7 million (DoH, 2010a: 10). Children who are AIDS orphans living in the townships in South Africa, as in other African countries, suffer from recurrent psychological trauma, which starts with the illness and death of their parents, (van Dyk, 2008: 27). The majority of orphaned children in Africa live in impoverished households (UNAIDS, 2011: 4) The HIV/AIDS pandemic has become one of the critical challenges that threaten the realisation of children’s rights in South Africa.

The problem is compounded by the increase in the number of OVC, mainly due to the high rate of deaths among parents and caregivers. While HIV/AIDS dramatically increases the population of orphans and vulnerable children, it also reduces the number of traditional caregivers and the number of breadwinners in families. AIDS undermines the ability of the very people who are best equipped to raise orphans or to contribute to their upbringing. The realisation of the rights of orphans and other children made vulnerable by HIV/AIDS; and the progression of the social development agenda to restore their dignity and well-being requires a collective effort from the government, the business sector, civil society and the strengthening of community responses. On the 29th November 1989 South Africa along with other nations ratified the United Nations Convention on the Rights of the Child (UNCRC). The NPAC 2012-2017 is a comprehensive, overarching plan which brings together governments regarding the recognition of children's rights in South Africa. The NPAC does however not seek to duplicate or replace plans related to children that have already been created by National and Provincial Government Departments or local Municipalities, but rather seeks to provide a mechanism that enhances collaboration and mainstreaming of children's rights by providing a holistic framework for the integration of programming organisation and implementation of intersectoral programmes for the betterment of the situation of children living in South Africa (DWCPD, 2012: 27). There is currently no overriding government policy regulating the provincial care and support for orphans and vulnerable children affected by the HIV/AIDS pandemic. The lack of a coordinated and well-resourced response to provide care and support to children who are AIDS orphans living in the townships leads to both disparity and tension between intentions stated by the government and the implementation of programmatic responses to provide care and support to children who are AIDS orphans living in the townships.

The demographics of the participants of this research study are explained fully below in order to give clarity regarding the detail, pertaining to each profession.

- **Primary healthcare practitioners**

  According to Human Resources for Health South Africa , when one looks at the primary healthcare practitioners per 10,000 population table for the public sector in South Africa: there are 3.70 medical practitioners per 10,000 population in South Africa, 2.33 pharmacists and 18.52 primary healthcare practitioners, all per 10,000 population (Human Resources for Health South Africa, 2012/13-2016/17: 31). The Eastern Cape has the second lowest number of healthcare professionals in South Africa with a total (public and private) of 44.38 per 10,000 population. The majority of the medical practitioners and pharmacists work in the private health sector, while the majority of primary healthcare practitioners work in the public sector (Human Resources for Health South Africa, 2012/13-2016/17: 31); hence the numbers of primary healthcare practitioners, as opposed to other health professional categories, working in PHC clinics, is very low.

- **Social Workers**

  The total number of social workers registered with the South African Council for Social Service Professions (SACSSP) as at March 2012 was 16 740. This number includes social workers that work for the Government, non-profit organisations (NPOs) or the private sector, as well as those that are no longer in practice but retain their registered status. Of these social workers, only 6 655 (40%) are employed by the Government and 2 634 (16%) by NPOs. This leaves 7 451(45%) registered social workers that are either employed in the private sector or are not practising. The national population-to-social-worker ratio is thus 5 446-to-1, with the lowest provincial ratio being in the Eastern Cape at 4 903 to 1 and the highest in the Free State at 5 935-to-1. According to the Department of Social Development (DSD), the current international norm for population-to-social-worker ratio is 5 000-to -1. In its Integrated Service Delivery Model developed in 2005, the desired caseload per social worker is 60 cases, but the Minister of Social Development, Bathabile Dlamini, concedes that owing to high levels of poverty, deprivation and a high incidence of HIV/AIDS, the actual caseload per social worker is far higher (Moloi, 2012: :1).

- **Psychologists**

  Human resources for mental healthcare in South Africa are desperately inadequate. A recent national survey revealed that, per 100,000 population, the country has only 0.28 psychiatrists, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists and 10 nurses. Thus, as far as psychiatrists are concerned, South Africa has fewer than 30% of the number required to comply with national norms of 1 per 100,000 population. Furthermore, this figure (0.28 per 100,000 population) falls far below the average for other middle-income countries (which is approximately 5 per 100,000 population) and even further below the average for high-income countries (which is approximately 15 per 100,000 population). Furthermore, most mental primary healthcare practitioners tend to be located within urban centres, leaving large rural regions of the country without such services. For example, of the 32 psychiatrists working in the public health sector in Kwa-Zulu-Natal Province, only 6 are located outside of the major cities (Pillay and Barron, 2011: 47).

Recruitment of students into clinical psychology training programmes is generally not difficult, considering that the demand for professional training far outweighs available places. It is safe to estimate that the total number of training seats nationally is fewer than 150 per annum. However, universities generally find that they are oversubscribed, receiving between 10 and 20 times more applications than they can accommodate. One of the offshoots of this highly competitive application process is the commitment and effort required by aspirant students, many of whom actively seek out mental health–related volunteer work in order to strengthen their applications. While selection criteria vary across universities, indices such as academic excellence, reflexivity, life experience and a community orientation are used in an attempt to recruit the most appropriate students to enter the profession. Given the gross under-representation of black clinical psychologists as a consequence of higher education institutions' recruitment policies during apartheid, issues of equity and redress are also considered in the selection process. Although all universities have to take cognisance of this factor as a selection variable, it has been argued that a much more deliberate and concerted focus is needed nationally if this problem is to be meaningfully addressed (Pillay and Barron, 2011: 27).

2.3 PURPOSE OF THE STUDY

This study analysed international, national and provincial legislative policy frameworks concerning the rights of children living in South Africa and explored and described the experiences of primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists based in satellite offices who provide care and support to children who are AIDS orphans living in the townships. The information obtained was used by the researcher to develop strategies which could be embraced by the Department of Health and Social Development to enable primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to facilitate care and support to children orphaned by AIDS living in the townships.

2.4 RESEARCH OBJECTIVES

In order to obtain the answers to the research questions described in Chapter One the following objectives for the study were decided on to:

- explore the current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa,
- explore and describe the experiences of primary healthcare practitioners working in primary healthcare clinics in providing care and support to children who are AIDS orphans living in the townships.
- explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships;

- create a conceptual framework for the care and support of children who are AIDS orphans living in townships; and
- develop strategies that could be embraced by the Department of Health and Social Development to enable primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to facilitate care and support to children who AIDS orphans living in the townships.

2.5 RESEARCH DESIGN AND METHOD

Research methodology is most often described as the overall philosophy underpinning research, whereas research methods are the practical guidelines or techniques used to produce research (Proctor et al., 2010: 4). Conversely research methods consist of the systematic, methodological and accurate execution of the research design (Rebar et al., 2011: 29).

According to Babbie and Mouton (2008: 107) "a research design is defined as a set of guidelines and instructions to be followed in addressing the research problem. Qualitative research is an umbrella term for a number of diverse approaches which seek to understand by means of exploration, human experience, perceptions, motivations, intentions and behaviour. To care for people and to promote or change behaviour requires an in-depth understanding of concepts such as experience, belief motivation and intention In order to understand people, one should listen to and observe them (Parahoo, 2006: 63).

The researcher of this study chose to utilise a qualitative framework as the purpose of the study was to create further knowledge regarding a particular human experience. A qualitative research study can be further defined, according to Burns and Grove (2009a: 44), as a systematic, subjective approach used to describe life experiences and give them significance. The aim of this study was to present an overview of international, national and provincial legislative policy frameworks concerning the rights of children living in South Africa and to explore and describe the experiences of primary healthcare practitioners in primary healthcare clinics, social workers and psychologists in satellite offices in the township communities who provide care and support to children who are AIDS orphans living in the townships; therefore the researcher used a qualitative, exploratory, descriptive, and contextual approach.

2.5.1 Qualitative research

“Metaphorically qualitative research is an intricate fabric composed of minute threads, many colours, different textures and various blends of material. This fabric is not explained easily or simply. Like the loom on which fabric is woven, general world views and perspectives hold qualitative research together easily (Creswell, 2007: 36). Qualitative research approaches are based upon a world view that is holistic and may draw upon the following concepts:

- multiple construct realities;
- the knower and the known are inseparable and knowledge is co- constructed;
- inquiry is value bound;
- all generalisations are bound by time and context (Burns and Grove, 2009a: 73); and
- the reasoning process used in qualitative research involves perceptually putting pieces together to make wholes from which process meaning is produced. Because perception varies with the individual, many different meanings are possible (Burns and Grove, 2009a: 73).

2.5.2 Exploratory study

The main aim of exploratory research is to gain a deeper understanding of a person, situation or phenomenon or to gain a basic familiarity with the subject of the study (Babbie and Mouton, 2008: 80). Exploratory studies are valuable for obtaining, insights, understanding and meanings regarding a subject which may appear to be familiar such as children who are AIDS orphans living in the townships (Polit and Beck, 2010: 22). The new insights obtained may have relevance to an entire subject or to only one aspect of the subject. As knew knowledge is gained, an exploratory study may also guide the researcher to identify further aspects of the research which may require investigation and research.

The term “exploration” in qualitative research can best be understood using an analogy of an explorer in a strange land or in uncharted territory. The exploration is undertaken to “discover” new lands, people or customs and to learn from them. The rationale for the use of exploration in this way is based on the assumption that researchers can only understand perception and behaviour from participants’ own perspectives, in their own words and in the context in which they live and work; and that there can be varied interpretations of the same phenomena. Ultimately the purpose of exploration is to gain a better understanding of how people think and their behaviour as individuals or as part of a group (Parahoo, 2006: 63).

2.5.3 Descriptive study

Descriptive study designs are crafted to gain more information about the characteristics within a particular field of study, the purpose of which is to provide a picture of situations as they happen naturally (Burns and Grove, 2009a: 237). A descriptive study adds richness to the results of a research study as it increases the understanding of the particular subject because the researcher often goes on to explain the reason for the particular phenomenon observed and its implications (Babbie and Mouton, 2008: 81).

Descriptive designs are used to answer research questions that seek to describe phenomena of interest as accurately as possible (Rebar et al., 2011: 189) and particularly about which little theoretical or factual knowledge is available (Parahoo, 2006: 184). Descriptive methods are also used to try to predict behaviour (Welman et al., 2005 :23). The descriptiveness of the research allows for a rich and dense account of the verified interconnection between concepts and their relationships (Denzin and Lincoln, 2011: 27). Therefore a descriptive design was appropriate for this research study because very little information was available regarding primary healthcare practitioners in primary healthcare clinics, social workers and psychologists in providing care and support to children who are AIDS orphans living in the townships.

A description was therefore provided regarding how primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists experience providing care and support to children who are AIDS orphans living in the townships. The exploratory objective of the research provided the researcher with an opportunity to place data collected into themes and subthemes, place these themes and subthemes within the existing body of knowledge and to develop strategies which could be used or embraced by the Department of Health and Social Development to enable primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to provide care and support to children who are AIDS orphans living in the townships (Babbie and Mouton, 2008: 81).

2.5.4 Contextual study

In a qualitative study, an understanding of the background and the natural context in which the participants find themselves, adds greater meaning to the phenomena observed (Babbie and Mouton, 2008: 272). It is important for the researcher to give attention to the views of the participants regarding their environment, which may be physical, geographical, economic, political, social or cultural. This is also known as a holistic research as the background and the context of the study play an important role in the interpretation of the results obtained during the research process (Babbie and Mouton, 2008: 272).

“In the truest sense, the person is viewed as having no existence apart from the world and the world as having no existence apart from people. Each individual and his or her other world are said to co-constitute one another” (Welman et al., 2005 :191).

The context refers to the socio-cultural, historical and temporal environment in which the research is situated; and includes the conditions in which it occurs, which is important because the above components can affect the way people think and act and therefore influence research enquiry (Holloway, 2008a: 51). This study was conducted at PHC clinics, and satellite offices in the township communities where primary healthcare practitioners, social workers and psychologists work to care and support children who are AIDS orphans living in the township communities.

Nelson Mandela Bay Metrapole (formally known as Nelson Mandela Metropole) lies in the Western region of the Eastern Cape Province. Most of the Eastern Cape is rural with only a few larger towns and cities. The legislative capital of the Eastern Cape Province is Bhisho which is 240 Km from Nelson Mandela Bay, and which is commonly regarded as the “economic capital of the region” (DoH, 2010a: 4).

The Nelson Mandela Bay Health District (NMBHD), which is situated in the Western Region of the Province of the Eastern Cape (PEC), South Africa, has a population of 6.8 million people, which is 13.50% of the national total, making the PEC the third largest province in South Africa (StatsSA, 2011: 3).

According to the mid 2011 estimates from Statistics South Africa, South Africa’s population is 50.6 million, with black Africans in the majority making up 79.5% of the population (StatsSA, 2011: 3). Approximately 945,479 people live in Nelson Mandela Bay (NMB), which is one of six metropolitan areas in South Africa. Nelson Mandela Bay Metrapole is located on the shores of Algoa Bay and consists of the cities of Port Elizabeth, Uitenhage and Despatch. It covers an area of 1,845 square kilometres, 4% of which is rural. Approximately 250, 668 of the above population are children under the age of 14 (DEDEA, 2008: 111).

The socio-economic profile of the Eastern Cape is marked by widespread and inherent poverty, racial, class and geographical inequality and profound backlogs in public services (Eastern Cape Department of Economic Development and Environmental Affairs (DEDEA, 2008: 13). The populations in the areas that are serviced by the PHC clinics and satellite offices live in informal settlements, made up of tightly clustered shacks and in formal areas termed ‘townships’. A shack is a roughly assembled hut or cabin made from wood and cardboard with corrugated iron for roofing. Approximately 13.7% of the potential participants of this study live in this type of housing (StatsSA, 2011: 17).

People living in these areas have limited access to water supplies and lack sanitation, with only 46.7% of the population having piped water in their dwellings and 60% with a flush or chemical toilet (StatsSA, 2007: 17-20). StatsSA (2011: 9) indicated that approximately one in four households in the Eastern Cape (25.0%) registered household consumption expenditure of less than R16, 406.28 per annum. Correspondingly 25.7% of all households indicated that their standard of food consumption was less than adequate (StatsSA, 2011: 16) . The majority of local residents are Xhosa-speaking and adhere to traditional Xhosa cultural norms and practices, including traditional healing and ancestor worship (van Wyk, 2011: 54-57).

The children living in these communities attend these local PHC’s where primary healthcare practitioners render care and support to them and the satellite offices where social workers and psychologists work to provide care and support to these vulnerable children. The clinics and satellite offices in which the researcher performed interviews are situated among people in the Eastern Cape living in extremely low socio-economic conditions. As an example, only an estimated 6% of individuals of working age are currently employed in the Eastern Cape. There is no doubt that many people in the Eastern Cape are living under extremely poor conditions (Loeb et al., 2008: 319).

Primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists working in satellite offices in the township communities were interviewed in this research study.

2.6 RESEARCH METHOD

The research method comprises the systematic, methodological and accurate execution of the research design (Rebar et al., 2011: 29). Research methods describe the overall process of how the researcher implemented the research study, including who was involved in the study and how the data was collected. The research process consists of four phases which cover all aspects of collecting the data, analysing the data and the creation of a conceptual framework and strategies which can be used by the Department of Health and Social Development to assist primary healthcare practitioners in the primary healthcare setting, social workers and psychologists who provide care and support to children who are AIDS orphans living in the township communities.

2.6.1 Phase One: An overview of interational, national and provincial legislataive and policy frameworks concerning the rights of children living in South Africa

This will be presented in Chapter Three of this research study. The researcher conducted and extensive literature review with regard to this specific subject. A literature review is an in-depth evaluation of previous research (Coughlan et al., 2013: 1) and can also be described as the process of reading, analysing, evaluating and summarising scholarly materials concerning a specific topic. In the instance of this research study the researcher performed a literature review in order to answer the following research question: What are the current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa.

A literature review can also be described as "a systematic, explicit and reproducible method for identifying, evaluating and synthesising the existing body of completed and recorded work produced by researchers, scholars and practitioners"(Flick, 2009: 22).

A literature review must do these things:

- be organised around, and related directly to, the thesis or research question that the researcher has developed;
- synthesise results into a summary of what is and is not known;
- identify areas of controversy in the literature; and
- formulate questions that need further research.

In writing the literature review, the purpose of the researcher is to convey the knowledge and ideas established regarding the posed research question or topic. The literature review must be defined by the guiding concept. In this instance the guiding concept is the research question posed not just a descriptive list of the material available or a set of summaries. Therefore, concerning this research study the researcher performed a literature review regarding the current international, national and provincial legislative and policy frameworks concerning the rights of children living South Africa.

2.6.2 Phase Two: Data-collection and analysis

Qualitative researchers strive for “Understanding” those deep structures of knowledge that come from visiting participants personally, spending extensive time in the field and probing to obtain detailed meanings (Creswell, 2007: 201). The data collected must be truthful, relevant and focused on the overall purpose of the study. The data-collection process should be recorded in detail to provide an historical record as a form of quality assurance (Polit and Beck, 2008b: 340; Polit and Beck, 2008a). In a qualitative research study, field notes assist in quality assurance as well as increasing the richness of the data collected (Polit and Beck, 2008a: 406).

Data collection forms the basis of a research study and should be done as methodologically and precisely as possible in order to obtain the most reliable results. In this study, data was collected and analysed from two research populations. The first research population consisted of primary healthcare practitioners in primary healthcare clinics in Nelson Mandela Bay Metrapole, who provide care and support to children orphaned by AIDS living in townships and who have formal registration with SANC as a primary healthcare practitioner. The data-collection method used involved using in-depth interviews and filed notes (Babbie and Mouton, 2008: 289). The second research population comprised social workers and psychologists who were in satellite offices in the township communities and who had experience of caring and supporting children who were AIDS orphans living in the township communities. Data collection is described by Creswell (2007: 118) as “a series of interrelated activities aimed at gathering good information to answer emerging research questions”. It is therefore important to find the right people or places to study and to gain access to, and develop rapport with, participants so that they provide useful data (Creswell, 2007: 118).

a). Research population sampling

The research population is a subset of the target population from which the sample will be taken (Proctor et al., 2010: 142-143). In other words, the researcher recruited participants who fitted the inclusion criteria and who were accessible to the researcher. The research population for this study comprised two groups, namely, primary healthcare practitioners working primary healthcare clinics in Nelson Mandela Bay Metrapole, who provide care and support to children who are AIDS orphans living in townships and social workers and psychologists in satellite offices in the township communities who provide care and support to children who are AIDS orphans living in these communities.

Sampling involves selecting a group of people, events and behaviours or other elements with which to conduct a study (Burns and Grove, 2009a: 343). A sample is defined as a smaller group, or a subset of a group, of interest that is studied in research in order to gain knowledge about other similar patients or people (Rebar et al., 2011: 31). According to Richards (2010: 36), the sampling strategies of qualitative research are guided by the underlying principles of gaining fluid, rich, complex, naturalistic and holistic information.

Purposive sampling is a strategy which uses the researcher's knowledge of the population and its components to select the cases that will be included in the sampling. In this way the researcher was able to choose research subjects that were regarded as representative of the population (Lobindo-Wood and Haber, 2010: 228). Holloway (2008a: 212) indicates that the selection of the participants is criterion-based. In other words, the researcher chooses certain criteria on which the selection of the sample is based. The primary healthcare practitioners and social workers were selected for this research study in this manner. The researcher had to use snowball sampling however to select psychologists as participants for this research study.

The snowball-sampling method allowed the researcher to identify participants who met the predetermined criteria. It is a general qualitative sampling technique. The snowball-sampling technique is modelled after "contact tracing" in public health, in which one individual names all the other individuals who were associated with a specific event. The snowball-sampling outreach strategy finds an Individual (the "source", also referred to as the "seed") who has the desired characteristics and uses the person's social networks to recruit similar participants in a multistage process. After the initial source helps to recruit respondents, the respondents then recruit others themselves, starting a process analogous to a snowball rolling down a hill. Thus, the semi-self-directed, chain-referral, recruiting mechanism is able to reach the hard-to-reach target group in a more pragmatic and culturally competent way (Saddler et al., 2010: 371).

Two research population groups were included in this study, namely primary healthcare practitioners in primary healthcare clinics in Nelson Mandela Bay Metrapole, who provide care and support to children who are AIDS living in townships and social workers and psychologists in satellite offices in the township communities providing care and support to children who are AIDS orphans living in the townships. Accordingly the sampling was implemented as follows:

- **Group 1**: **Primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS living in the township communities**

Purposive sampling was used because the quality of the information obtained per sampling unit is considered more important in qualitative research than numbers (Hansen, 2006: 52). Qualitative research requires in-depth study and smaller samples, chosen from the researcher's knowledge of the population (Babbie and Mouton, 2008: 166). The researcher interviewed all of the primary healthcare practitioners in the PHC clinics where they worked. The interviews took place in five PHC clinics in the township communities of Nelson Mandela Bay Metropol. The criteria for inclusion of this group of participants included:

- primary healthcare practitioners working in primary healthcare clinics in Nelson Mandela Bay Metrapole, who provide care and support to children who are AIDS living in townships;
- who are primary healthcare practitioners who have formal registration with SANC; and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

Data saturation was achieved after interviewing ten primary healthcare practitioners working in PHC who care and support children who are AIDS orphans living in the townships.

- **Group 2: Social Workers and Psychologists in satellite offices in the township communities providing care and support to children who are AIDS orphans living in the townships communities**

Data saturation was reached after interviewing eight social workers and six psychologists for this research study. All social workers and psychologists were interviewed in their satellite offices in the township communities in Nelson Mandela Bay Metrapole; where they work to provide care and support to children who are AIDS orphans living in the township communities. The criteria for inclusion of this group of participants included:

- social workers and psychologists working in satellite offices in the Nelson Mandela Bay Metrapole providing care and support to children who are AIDS orphans living in townships,
- have formal registration with their associated professional body; and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

.The sample size for Group 1 and Group 2 was determined by data saturation from the individual in-depth interviews, which was reached after ten interviews with primary healthcare practitioners, eight interviews with social workers and six interviews with psychologists. Data saturation was evidenced by the examination of data that yielded only a recurrence of material that had already been discovered, coded and integrated, so that a full picture of the theoretical ideas emerged (Holloway, 2008a: 215).

b) Entry to site

It is important to obtain formal permission in order to gain entry into the sites chosen by the researcher, which is termed " gain entry" and involves negotiation with those who have authority to permit entry into their domain (Polit and Beck, 2010: 78). Researchers negotiate with "gatekeepers", so termed because they are the people who have the power to grant or withhold access to the chosen setting. There may be any number of gatekeepers at various places and levels in the hierarchy of an organisation. The researcher should ask not only the person directly in charge but also all others who hold the power to stop and start the data collection pertaining to the research (Polit and Beck, 2010: 107).

The gatekeepers in this research study who were directly in charge of the PHC's and satellite offices, and who could allow the researcher access to both research populations of participants included the district manager of Nelson Mandela Bay who is in charge of the provisionally run clinics, the Nelson Mandela Bay Municipal Management which controls the Municipal clinics in the district and the Epidemiological Research & Surveillance Management of the Eastern Cape Department of Health, who has overall control of all the clinics both provincial and municipal. The district manager for the Department of Social Development was also contacted, requesting permission to undertake the study. These gatekeepers were supplied with a letter from the researcher after they had been contacted by the researcher via e-mail (see Appexdix B, C and F). Once permission had been received from the abovementioned management structures (see Appendix H, I and J), the clinic managers at each PHC and the managers of the satellite offices of the social workers and psychologists were then approached by the researcher regarding gaining their permission to undertake the research study (see Appendix E). The PHC managers and the managers of the satellite offices of the social workers and psychologists were in a position to allow the researcher access to both research populations. Following the approval of these managers the researcher then met with primary healthcare practitioners, social workers and psychologists who had experience of providing care and support to children who are AIDS living in the township communities.

According to Holloway (2008a: 107), the researcher should negotiate with gatekeepers using diplomacy and honesty, and by disclosing the path and the purpose of the research study. This is especially pertinent in healthcare settings, where gatekeepers might be sensitive to the findings of the research, which could be critical concerning their own fields of expertise.

c) Data Collection

Data collection in this study involved using in-depth individual interviews and field notes (Babbie and Mouton, 2008: 289). How the researcher manages the data-collection process will greatly affect the ease with which the data is analysed, hence the need for high-quality data-collection methods to ensure accuracy of the research conclusions (Streubert and Carpenter, 2011: 33-34). Data collection is described by Creswell "as a series of interrelated activities aimed at gathering good information to answer emerging research questions. It is therefore important to find the right people or places to study and to gain access to, and develop rapport with, participants so that they can provide useful data" (Creswell, 2007: 118). Data collection for this study was conducted from the beginning of May till the end of July 2012, and comprised these steps.

- **Gaining access and making rapport**

For the purpose of this study, the researcher has chosen in-depth individual interviews, of which the intent is to explore openly the understanding and experiences of the study participants in order to obtain the pertinent research data (Rebar et al., 2011: 151). In-depth individual interviews are also referred to as one-to-one interviews and are intended to obtain the perspectives of the participants (Holloway, 2008:134). According to Rebar et al, (2011: 151), this form of data collection is dependent on the participants' open sharing of their thoughts, feelings and experiences in order to allow the researcher to construct a description of the variable(s) under study. The researcher selected this method of data collection because she required rich in-depth data that could create a basis for theorising (Burns and Grove, 2009a: 510).

In-depth interviews were therefore utilised by the researcher in order to collect relevant information from the participants in Group 1, the primary healthcare practitioners in the PHC's, and Group 2 which consisted of social workers and psychologists working in satellite offices in the township communities providing care and support to children who are orphaned by AIDS living in the township communities. These groups were chosen according to purposive sampling and snowball sampling as previously described in this chapter.

The researcher arranged the date and time of the interview with each of the participants from Group 1 per clinic to minimise disruption of the workday. The participants were interviewed during their lunchtime or at the end of their working day or in the working day because the clinic managers had arranged interviews between the researcher and the primary healthcare practitioners. All participants were given a letter to read which informed them in full regarding the purpose and objectives of the research study and focused on their rights regarding participation in the study (see Appendix A).

- **Recording information**

Permission was requested from the participants to use a digital recorder onto which the interviews were recorded; this permission having been sought prior to the start of each interview (see Appendix D). This was necessary to enable the researcher to record the exact words of the interview, inclusive of questions and exclamations, in order that everything that took place in conversation and interaction between the researcher and participant was recorded. Using a digital recorder enabled the researcher to have eye contact with the participants and to pay close attention to what was said by the participants.

- **In-depth interviews**

According to Holloway (2008a: 134), unstructured interviews start with a broad open-ended question within the topic area. The first question was answered by means of a literature review and the subsequent questions were posed to both Group one (primary healthcare practitioners in primary healthcare clinics) and Group two (social workers and psychologists in satalite offices).

How do you experience providing care and support to children who are AIDS orphans living in the townships communities?

What recommendations would you like to make to improve the quality of care and support provided to children who are AIDS living in the townships?

- **Prompting**

According to Holloway (2008a: 135), the researcher can use prompts to develop ideas that will be useful in the search for elaboration, meaning or reasons. Prompts are considered interventions that seek to clarify, for the interviewee, the kind of information a question is seeking to gather. Prompts are usually used where the participants have expressed uncertainty or lack of comprehension about an initial question (King and Horrocks, 2011: 40). The researcher used prompting to encourage the participants to explore in greater depth and to reveal more detail and description of their experiences.

Therefore the researcher rephrased and repeated words used by the participants to encourage them to continue with their stories.

- **Probing**

Probes, which are used to assist the participants to give more detail in their storytelling, are usually applied in the form of follow- up questions that encourage participants to expand on their initial answers (King and Horrocks, 2011: 40). By using probing, the researcher was able to obtain the fullest account possible from each participant. The researcher therefore used probing when more clarity was required and applied this by asking questions and comments such as “ In what way?” and “ Can you tell me more about that?”, which assisted in gaining more understanding of the participants’ responses (King and Horrocks, 2011: 40).

- **Resolving field issues**

The researcher included methodological notes in this section as a form of resolving field issues, in that keeping methodological notes provided a framework to assist her to keep the methodology in mind, which included instructions to self (Babbie and Mouton, 2008: 501). There were numerous field issues that the researcher had to resolve, such as locating some of the satellite offices, participants who became emotional whilst being interviewed and difficulties related to entry and access, such as the length of time involved in follow-up and the receipt of letters of permission to enter the site, all of which the researcher had to contend with in order to collect the data required to complete the study (Creswell, 2007: 138). The researcher was however able to resolve field issues adequately as they arose, in order to complete the data collection process successfully.

- **Storing data**

All data collected in this research study was dated, labelled and checked immediately following the research interview in order to re-establish that the data collected had been captured on the recording device; in order to ascertain whether the research interview needed to be conducted again. The researcher made contextual notes before the interview and field notes following the research interview while the events were still fresh in her mind (Holloway, 2008a: 97). The transcripts of the interviews were stored on two separate computers as well as on copies of the digital recordings, so that they were available should the need arise to check data.

d). Bracketing

Bracketing requires that the researcher should remain neutral with regard to belief or disbelief regarding the aspects of the phenomenon being studied. The researcher therefore needed to identify any preconceived notions she might have had regarding the phenomenon. All pre-existing ideas, notions or facets have to be placed to one side or separated from the researcher's self during this study (Creswell, 2007: 58-59). Bracketing is considered a cognitive process of consciously not making judgements about what is heard or observed previously, in order to remain open to data as it is revealed (Streubert and Carpenter, 2011: 27).

Bracketing is an interactive process and part of the researcher's reflective journey, which was assisted by the keeping of a diary of personal thoughts and feelings by the researcher in order to clarify her ideas. Once the researcher was clear about her own thoughts and ideas, she was able to set them aside, in other words being consistently aware of what she believed and consciously striving to keep this separate from what was shared by each participant during the interviews. By conducting this type of self–disclosure, the researcher was able to remain aware when data collection and analysis reflected his or her personal beliefs rather than the participants' beliefs (Streubert and Carpenter, 2011: 27).

Bracketing in this research study was particularly important because the researcher had worked in the township communities as a primary healthcare practitioner providing care and support to children who were AIDS orphans living in these communities. The researcher also founded and manages an NGO to provide care and support to children who are AIDS orphans living in the township communities, and has read extensively concerning the effects of the HIV/AIDS pandemic on orphaned children living in these communities. Accordingly, it was very important for the researcher to be aware of and critically self-reflect on, the influence of her own background, perceptions and interests as previously mentioned. Therefore, a field journal was also kept to describe and interpret her behaviour and experiences within the research context in order to become aware of biases and preconceived assumptions. If biases or preconceived assumptions had been evident, the researcher would have altered the way in which the data was collected. For example, she could have appointed somebody else to collect the data to enhance the credibility of the research (Polit and Beck, 2012: 175).

e). Field notes

Filed notes which are accounts of the interview process, can take a variety of forms and are produced during the interview or afterwards, depending on the practicalities of the setting and other forms of data collection being used. When used alongside other methods of data collection, field notes are more of an analysis than a description of the interview. Accordingly, the researcher was particularly interested in recording interesting characteristics related to the setting and the participants, and any other phenomenon she deemed important to the research study (Gibson and Brown, 2009: 105).

Basic information, such as the researcher's own biases, reactions and problems encountered during the interview, are also recorded in the field notes for future usage (Holloway, 2008a: 99). Because field notes are a record of the observations made by the researcher during each interview, they should be recorded as soon as possible after the interview to ensure accuracy. The researcher also had to bear in mind that the security and confidentiality of the field notes were essential. The researcher therefore wrote up field notes in the field journal every night after collecting information, in order to make sense out of all that had been observed during the interviews. The field notes which were described and dated, and assisted the researcher with self-reflection, as explained in the previous section dealing with bracketing (Watson et al., 2010: 387). The researcher also used the field notes to remind herself of particular interesting features of the setting that could be verified on the recording or any ideas that might be relevant while working through the data (Gibson and Brown, 2009: 105).

f). Pilot study

Holloway (2008a: 187) refers to a pilot study as a small-scale trial run of a larger proposed research project, using the same research approach and a smaller number of participants chosen according to the same criteria as those of the actual study. Holloway (2008:188) highlights the advantages of the researcher conducting a pilot study as:

- helping with refining the interview guide;
- assisting in improving the interviews and observations;
- helping the researcher to become more confident;
- enabling the researcher to practice and to anticipate potential problems; and
- assisting in allowing the researcher to predict the potential costs of the study.

The pilot study was performed in the same way as the main study. A pilot, in-depth individual interview was conducted with a primary healthcare practitioner a social worker and a psychologist to enable the researcher to have a practice run of the research questions and interview method. Informed consent was obtained prior to data collection, after which data was recorded and transcribed. No changes were made to the questions posed to the participants after the pilot study; therefore the information obtained from the pilot study was included in the data analysis.

g). Data analysis

“Data analysis is not off the shelf, rather it is custombuilt, revised and choreographed” (Creswell, 2007: 150). Qualitative research is infinitely creative and illustrative, meaning that the researcher does not simply leave the field with masses of data to write up the findings easily. “Qualitative interpretations are constructed” in that the researcher as interpreter uses notes and documents from the field to create a working interpretive document that encompasses the writer’s attempts to make sense out of what has been learnt. This ultimately leads to the public text or the final tale (Denzin and Lincoln, 2011: 14).

Coding and categorising were implemented during and after collection of data as an analytical tactic, because coding is analysis in qualitative research (Saldana, 2010: 7). A code is described as a “word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for the portion of language-based or visual data” (Saldana, 2010: 3). An important aspect of thematised analysis involves working out the relationships between code categories and the significance of such relationships as they relate to the development of theoretical conceptions and statements (Gibson and Brown, 2009: 138).

The coding process and data analysis were conducted according to the steps suggested in Creswell (2007: 150), in which the analysis process is considered to conform to a general contour, best represented in a “spiral Image”, which he terms the “data analysis spiral”. Creswell (2007: 150) is of the opinion that to analyse qualitative data, the researcher should engage in a process of moving in “analytical circles rather than using a rigid straight-line approach. The researcher would therefore enter the process with the data he or she has collected and exit with an account, theory or narrative, having touched on the various facets of analysis and circle around until the end result is achieved. The data analysis spiral was used to guide the analysis of this study (Creswell, 2007: 150-155). It comprises the following progressive phases of increasing complexity and meticulousness of analysis.

- **Data management** which is this first loop in this spiral, begins the process. This involves organising the data into files that can be retrieved when data analysis begins. The researcher may choose from various methods of data organisation
- The next step in the process is **reading and memoing** during which the researcher gets a sense of the whole database by reading the transcripts in their entirety. Writing memos in the margins assists in this preliminary process. By reading and listening to

the transcripts concurrently with the field notes, the researcher is able to "hear" what the participants said. At this stage, initial categories could be formulated from the initial coding of data.

- The researcher continues analysis by moving onto the next part of the spiral, which is termed **describing, classifying and interpreting**. In this stage codes and categories are developed that are described in detail so that the researcher provides an interpretation of the data. These categories of information are examined and sorted during the process of continually reviewing the database until the researcher can work towards limiting the categories to between 25 and 30. This will assist in ultimately reducing the volume of data generated during the study to a workable five to six themes. **Classifying** is the stage of analysis during which the themes and sub-themes are developed following further examination of the information available. **Interpretation** involves making sense of the data, using hunches, insights and intuition, plus a construct or an idea, or a combination of all of the above, which can lead to promoting and encouraging interpretation. During this part of the process the researcher steps back to allow a larger or deeper meaning to be formulated of the situation being researched.
- In the final phase of the spiral, which is termed **visualising and representing,** the data is presented. This can be done in text, tabular or figure form or a combination of these. During the phase an in-depth picture of the study is presented, which can be various forms, for example narration, a visual model or theory.

The researcher used the services of an independent coder, while the researcher herself also analysed the data. The use of an independent coder is to assist in the exclusion of biases by the researcher and to control potential haphazardness with the data analysis (Saldana, 2010: 27). The interviews were analysed according to the protocol used by the researcher. Transcripts were made of the recorded interviews and sent to the independent coder. A letter explaining the requirements of the researcher regarding the independent coding process were included (see Appendix K and L).

The data analysis occurred independently and the researcher and the independent coder met after the completion of the individual analysis for consensus discussions. These discussions assisted in reducing the data to categories and sub-categories and main emergent themes (Creswell, 2007: 153). The use of the independent coder ensured triangulation of the data. Triangulation refers to the use of multiple methods for data collection and data interpretation, which allows the data in the study to connect in an accurate and impartial representation of reality (Streubert and Carpenter, 2011: 350-359).

h.) Literature control

A literature control was done to place the findings and results of the analysis within the context of existing theoretical literature (Burns and Grove, 2009a: 91). The literature consulted covered all aspects of children who are AIDS orphans living in the townships communities in South Africa while statistical publication related to these varying aspects and community and health issues related to children who are AIDS orphans living in the townships in South Africa. Other aspects were guided by the emergent themes that emanated from the data (Burns and Grove, 2009a: 90-91). The central themes and sub-themes were identified from the data analysis and validated by the examination of the literature. The literature control was wide-ranging and continued throughout the data-gathering and analysis phases of the study (Chinn and Kramer, 2008: 267).

2.6.3 Phase Three: Development of a conceptual framework

Phase Three of the study being the compilation of a conceptual framework. A conceptual framework defines the main areas of the research study and clarifies the relationships between the concepts and themes identified during the research process (Lobindo-Wood and Haber, 2010: 61). It defines the ideology used in the study and aligns it with the methodology and the research setting. The conceptual framework also helps depict the relationship between the methodology and research setting and participants.

The main concepts of the study which emerged during the process of identifying concepts, were determined from the data and fieldwork that was conducted during the process of data collection. Afterwards the main and related concepts were classified and defined (Dickoff et al., 1968: 415-435). Chinn and Kramer (2008: 186) state that creating conceptual meaning creates a tentative definition of the concept and a set of tentative criteria for determining whether the concept exists in a specific situation.

The Walker and Avants (2011: 163-164) approach to the definition and classification of concepts involves a detailed review of both dictionary and subject literature definitions of main concepts. The dictionary definitions listed and described the attributes of each concept, and therefore provided their diverse uses. Subject literature provided theoretical definitions and gave the researcher a way of expressing the richness of the concept within the theory, thus offering wider sources of meanings of the concepts within the relevant field of study (Walker and Avant, 2011: 164).

The related concepts were classified according to the survey list of Dickoff et al. (1968: 423) which calls attention to “significant aspects of activity and to certain dimensions, knowledge or other resources relevant to activity". The survey list, which assisted in "revealing different features are point of view shifts", comprises the following steps:

- Agency (Who or what performs the activity?);
- Patiency or recipiency (Who or what is the recipient of the activity?);
- Framework (In what context is the activity performed?);
- Terminus (What is the endpoint of the activity?);
- Procedure (What is the guiding procedure, technique or protocol of the activity?); and
- Dynamics (What is the energy source for the activity-whether chemical, physical, biological, mechanical or psychological?).

These six aspects of activity served as an organising principle.

These steps described above are used as a survey list when describing a particular situation or problem and to give direction for the activities or strategies required to address the problem. The survey list is used to identify the agent who carries out the strategies, who are the recipients of the strategies and in what context they will be carried out. The survey list is also used to identify the guiding procedures and dynamics of the strategies as well as the proposed outcome which is for children who are AIDS orphans living in the township communities. By making use of the survey list, it is possible to identify the dynamics required for activities to take place as well as the procedures which are required to guide them. When presenting the conceptual framework in chapter four, the researcher will make use of the survey list as a cogitation map to aid description.

2.6.4 Phase Four: Description of the strategies

Consists of the compilation of strategies to assist primary healthcare practitioners in the primary healthcare clinics, social workers and psychologists in providing care and support to children who are AIDS orphans living in the townships communities. These strategies were created using a conceptual framework.

On completion of Phases One and Two of the research process, the collected data was analysed and interpreted, resulting in the compilation of a conceptual framework. Strategies were then compiled to assist the DoH, DSD, primary healthcare practitioners, social workers and psychologists in the care and support of children who are AIDS orphans living in the township communities. The recommended strategies were based on data obtained during the interviews conducted with the participants in the study and from examination of the reflective journals. The strategies were dependent upon the themes which were identified in the data. During the research process it became apparent that, for the primary healthcare practitioners, social workers and psychologists to implement strategies at a functional level, certain prerequisites had to be in place on a grand strategy level. The resulting strategies are, therefore, presented on both grand and functional levels. The strategies were submitted to an expert panel consisting of the following people: primary healthcare practitioners, social workers, psychologists, educators and a research academic with research experience in caring and supporting children living as AIDS orphans living in the township communities.

2.7 MEASURES TO ENSURE TRUSTWORTHINESS AND AUTHENTICITY OF THE STUDY

A research study is considered authentic when the strategies are appropriate, fair, and faithfully show a range of realities (Polit and Beck, 2012: 584). Authenticity is acknowledged in a report when it conveys the feeling and tone of aspects of participants' lives as they are experienced. A text is considered to portray authenticity when it allows readers to truly experience the lives being described sincerely leading to heightened sensitivity regarding the issues being illustrated (Polit and Beck, 2012: 585). The researcher therefore endeavoured to portray a sense of mood of the participants interviewed, together with their feelings, language and the context of their lives, in order to reinforce authenticity in this study. The researcher achieved this by showing fairness to all participants and gaining their acceptance throughout the study. Informed consent was obtained from all participants and was applied as an ongoing, transactional process referred to as "process consent" which means that the researcher continually renegotiates consent in order to allow the participants to play a collaborative role regarding their involvement of the study (Polit and Beck, 2008b: 177).

According to Lincoln and Guba (1985) and (Polit and Beck, 2012: 584), credibility, dependability, confirmability and transferability ensure the trustworthiness of qualitative research. Trustworthiness in qualitative research is demonstrated through the researcher's attention to, and confirmation of information discovery to represent accurately the participants experiences (Streubert and Carpenter, 2011: 48). In terms of truth value, the issue is whether the researcher has established confidence in the truth of the findings for the participants and the context in which the study was carried out (Polit and Beck, 2012: 585). Truth value within the qualitative paradigm was obtained in this study by discovering the experiences of primary healthcare practitioners in primary healthcare clinics, social workers and psychologists based in satellite offices, who provide care and support to children who are AIDS orphans living in the townships.

Reliability is defined in terms of consistency by using in-depth individual interviews to gather a range of experience (Polit and Beck, 2012: 585). The researcher implemented the principle of consistency by using in-depth interviews to gather a range of experience (Polit and Beck, 2012: 585). The researcher implemented data triangulation in order to use multiple sources, methods and theories to provide corroborating evidence that would shed light on each theme or perspective discussed in this study (Creswell, 2007: 208).

The researcher will make judgements of trustworthiness possible through developing the following criteria:

2.7.1 Credibility

Credibility corresponds to the notion of internal validity (Bassett, 2004: 108). According to Streubert and Carpenter (2011: 48), credibility includes activities which increase the probability of convincing and reliable findings being produced by the researcher. The researcher must ensure that her findings are compatible with the perceptions of the participants (Streubert and Carpenter, 2011: 48) . Credibility was ensured through prolonged and varied field experience, the interviewing process, peer review, reflexivity and triangulation.

The researcher ensured prolonged and varied field experience by spending time establishing rapport with the participants before commencing the interview so that the participants could establish a relationship with the researcher. The researcher also stayed for a while following the research interview because the participants always continued to talk following the end of the research interview. This was important because as rapport between the researcher and the participant continued, the participant volunteered increasingly sensitive information.

Credibility was enhanced during the interview process through the researcher rephrasing, repeating or elaborating upon the questions asked. Peer review on the other hand, took place through discussing the research process and findings with impartial colleagues. These discussions took place with research students who had completed their PhD’s, the researcher’s two promoters and the researcher’s independent coder who had experience with qualitative research methodologies.

One of the strategies for credibility that greatly enhances the quality of the research is triangulation, which includes the use of various sources to draw conclusions about what constitutes the truth (Polit and Beck, 2012: 175). In this study, triangulation of data-gathering methods and sources were utilised to ensure trustworthiness. In-depth individual interviews were used to collect data which was then obtained from two groups of participants, primary healthcare practitioners working in primary healthcare clinics (Group 1): social workers and psychologists (Group 2) working from satellite offices in the township communities. Additionally, consensus was reached between the research participants and the researcher, including an independent panel of experts and an independent coder. The strategies were submitted to an expert panel consisting of the following people: primary healthcare practitioners, social workers, psychologists, educators and a research academic with research experience in caring and supporting children who are living as AIDS orphans in the township communities.

2.7.2 Transferability

According to Polit and Beck (2012: 197) transferability is linked to generalisability: namely the extent to which qualitative study findings can broadly be applied to other groups and settings. Therefore the knowledge gained through this study was relevant in another similar study; and those that carried out the research in another context were able to apply certain concepts that were originally developed through this research study (Polit and Beck, 2012: 197).

Another way of viewing transferability is to contemplate the data itself rather than the actual topic of the research. Accordingly, a thick description of the context, participants and findings is provided by the researcher in order to allow others to assess whether the amount of information provided about the study contexts is at a sufficient level to support transferability (Polit and Beck, 2012: 197). According to Lincoln and Guba (1985) and (Polit and Beck, 2012: 525), the main work of transferability is carried out by the readers of the research study, who determine the extent to which conceptualisations and findings apply to new situations and then they ‘transfer’ the research.

Applicability refers to the degree to which the findings of the research can be transferred to or are appropriate in, another setting or groups. The researcher’s responsibility is to provide sufficient descriptive data so that those reading the study can evaluate the applicability of the data to other contexts, as stated previously. In this study, transferability was achieved by purposive sampling of primary healthcare practitioners working in the primary healthcare clinics and social workers working in satellite offices in the township communities and snowball-sampling of psychologists in satellite offices working in the township communities (Babbie and Mouton, 2008: :277), and also through dense description of the research results, supported with quotations from the participants (Polit and Beck, 2012: 585).

2.7.3 Dependability

According to Streubert and Carpenter (2011: 49), dependability is a criterion encountered only after establishing the credibility of the findings. Triangulation of methods contributes to the dependability of the findings. The strategies that were used to ensure trustworthiness included thick description, triangulation and peer review. An independent coder was used to enhance dependability.

A dense description of the methods used in the study provided information regarding how the study could be replicated within the uniqueness of the context. Therefore the methodological approach was explained in detail; and the research findings related to the experiences of the participants and the knowledge generated, were all presented as accurately as possible (Babbie and Mouton, 2008: :278). The feedback obtained from the expert panel and peer scrutiny further ensured confidence in the dependability of the study (Babbie and Mouton, 2008: :278).

Dependability refers to the stability of data over time. In other words, the researcher must describe all changes in the conditions and the design that occurred during the study. A dependability audit was established when the process, and the products, were fully described by the researcher. In providing a full description of the data collection and data analysis, the researcher assisted other researchers by offering an audit trail of the steps of knowledge generation-specific to the study, thereby ensuring dependability.

2.7.4 Confirmability

Confirmability is a process criterion whereby an audit or decision trail is set down by the researcher in order to confirm the findings. Those following the process should be able to follow the path taken by the researcher in order to understand how she arrived at the constructs, themes and their interpretation. The researcher was therefore required to ensure that the product, data, findings, interpretations and extrapolations, as well as the recommendations and strategies, were confirmable (Babbie and Mouton, 2008: 278). Thus the researcher illustrated as clearly as possible the evidence and thought processes that led to the conclusions reached (Streubert and Carpenter, 2011: 49), in order to establish researcher credibility that could enhance confirmability (Polit and Beck, 2012: 600).

Confirmability included the decisions taken by the researcher based on the data the reflexive or field journal produced, which was done to optimise the objectivity or neutrality of the data (Polit and Beck, 2012: 599) since confirmability exists within the characteristics of the data, therefore the thorough use of literature provided a theoretical basis of the study to validate confirmability (Polit and Beck, 2012: 599).

The researcher presented evidence of the data construction and synthesis through the themes that were developed, the literature and the quotations to support the findings, all of which were reflected in the development of the strategies (Babbie and Mouton, 2008: :278). Triangulation of methods, sources and reflexivity, which refers to critical self-reflection by the researcher to ascertain the presence or absence of biases, preferences and preconceptions, were all used to ensure trustworthiness.

2.8 ETHICAL CONSIDERATIONS

Wood and Ross-Kerr (2011: 293) maintain that there are ethical implications at every stage of the research process, which are there to protect the rights of the participants, especially children. The research proposal was therefore submitted to the Faculty of Health Sciences Research Technology and Innovation Committee (FRTI) at Nelson Mandela Metropolitan University (NMMU) for approval (see Appendix G). The researcher requested permission in writing from the Directorate of Epidemiological Research and Surveillance Management at the Eastern Cape Department of Health, in order to conduct research in the PHC clinics in Nelson Mandela Bay municipal area. The researcher then requested permission from the management of the District Health Services, both provincial and municipal, namely, the district manager (provincial) and the manager in charge of Municipal Health Services, who were both approached by means of a formal written request (see Appendices H, I and J), so that they were personally informed about the researcher's presence in the PHC clinics under their direct jurisdiction. The researcher also sought permission from the director of the department of social development and the manager of the satellite offices.

Informed consent was obtained from the research participants by issuing each participant with a letter (see Appendix A and D) that explained to them in full what the purpose and objectives of the research study were. Each participant was given time to read the letter. The consent forms were signed by each participant. The following ethical principles were observed throughout this study in order to protect the participants from any harm.

Research requires not only expertise and diligence but also honesty and integrity (Burns & Grove, 2009:184). There are fundamental obligations, standards or guidelines that the researcher has to adhere to in conducting research. They are as follows: a) Informed consent, b) No deception, c) Right to withdraw, d) Debriefing and e) Confidentiality and anonymity (King and Horrocks, 2010: 104).

- **No Deception**

Deception in research can violate a participant's right to self-determination. That is the ethical principle based upon the respect for persons (Burns and Grove, 2009a: 188). Deception is the misrepresentation of information or the giving of information in an incorrect manner in order to make another person believe what is not true which is a violation of the respect to which each person is entitled and a breach of ethical standards in the conducting of research (Burns and Grove, 2009a: 190). The researcher was aware of her responsibility to ensure the participants receive the correct information regarding the research study and were not misinformed at any stage during the research process.

- **No harm to participants**

The right to protection from discomfort and harm is based upon the ethical principle of beneficence, which holds that one should "do good" and above all do "no harm". Participation in research is voluntary and as such those participating in the research study have the right to withdraw at any time throughout the study without giving any reason. Interviews with participants often cause emotional reactions. The aim of the interview, however, is to gain information and not "elicit extreme emotional responses from participants" (King and Horrocks, 2010: 115). An ethical researcher must be prepared, at any time during the research, to terminate the research if there is reason to suspect that continuation would result in undue stress to the participant. Therefore all the participants involved in this research study were protected from both physical and emotional harm at all times, were well informed about the possible impact of the study; and were given the choice of withdrawing from the study at any stage, if they wish to do so. If the researcher becomes aware of any prospect of physical or emotional harm befalling the participants, there is an ethical duty to change the focus of the study to reduce the risk of exposure to participants. The principle of self-determination was adhered to throughout this research study. The right to self-determination is based on the principle of respect for persons and the understanding that participants are autonomous agents (Burns and Grove, 2009a: 189). This means the participants have the right to decide voluntarily whether to participate in the study without the risk of incurring any penalties or prejudicial treatment. It also means that the participants have the right to refuse to give information and can also ask for clarification regarding the purpose of the study or specific questions.

- **Informed consent**

Obtaining informed consent from human subjects is essential for the conduct of ethical research. Consent is the prospective participant's agreement to participate in a research study, which the participant reaches after assimilating essential information (Burns and Grove, 2009a: 201). The Nuremberg Code defines informed consent as: “the voluntary consent of the human subject is absolutely essential.” This means that the person involved should have the legal capacity to give consent and should be so situated as to be able to exercise free power of choice, without the intervention of any element or force, fraud deceit duress, overreaching or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision Nuremberg Code cited in (Burns and Grove, 2009a: 203). The issue of informed consent is about being open, truthful and respectful of people’s right to choose (King and Horrocks, 2010: 106). All the participants in this study were given the opportunity to make an informed decision about whether to take part in the research study and also to withdraw at any stage. It is considered unethical to include anyone who is unwilling in the research study

- **Privacy**

Privacy is “an individual’s right to determine the time, extent and general circumstances under which reporting personal information was shared with, or withheld from others. This information consists of one’s attitudes, beliefs, behaviours opinions and records” (Burns and Grove, 2009a: 195). In upholding privacy the researcher seeks to uphold the value of the participant’s dignity since invading privacy might cause loss of dignity, friendships or employment or create feelings of anxiety, guilt, embarrassment or shame. The researcher did prevent an invasion of the participants’ privacy through upholding the participants’ right to anonymity and confidentially. On the basis of the right to privacy, the participant has the right to anonymity and the right to assume that the data collected is kept confidential (Burns and Grove, 2009a: 109).

- **Confidentiality and Anonymity**

In the literature relating to ethics, confidentiality is commonly viewed as equivalent to the principle of privacy. Therefore to ensure someone’s confidentiality appears to suggest that what is said in the qualitative interview will remain private and not be repeated (King and Horrocks, 2010: 116). In the undertaking of qualitative research this can’t be what is meant since the research findings will be reported by the researcher and outcomes published. Rather than ensuring confidentiality as researchers we seek to offer anonymity when using the data generated, using qualitative interviewing (King and Horrocks, 2010: 117). “Anonymity refers to concealing the identity of the participants in all documents relating from research therefore actively protecting the identity of the research participants” (King and Horrocks, 2010: 117).

According to the British Sociological Associations, Statements of Ethical Practice 2004 cited in King and Horrocks (2010: 117) the following guidelines are issued with regard to confidentiality, privacy and anonymity. According to this association guideline 34 and 35 read respectively:

(34) The anonymity and privacy of those who participate in a research process should be respected. Personal information concerning research participants should be kept confidential.

(35) Where possible, threats to the confidentiality and anonymity of research data should be anticipated by researchers. The identity and research records should be kept confidential whether or not an explicit pledge of confidentiality has been given.

When participants agree to be interviewed they have the right to expect that the data their research interviews produce will be handled with due respect and discretion: participants do also expect their interview data to be made available for general consumption. The data is generated for a specific purpose and no other use of that information should be made available without discussion and permission from the participants. With the introduction of the Data Protection Act 1998 which came into effect on 1st March 2000 consideration of anonymity and confidentiality has gone the moral and ethical domain and there are also legal implications. With the fundamental principle of the act being the protection of the rights of individuals in respect to personal data being held about them, this also includes research data (King and Horrocks, 2010: 109). Reading of the data generated in the research interview with regard to confidentialituy should be straightforward: in that the data was kept secure and known in its raw state to the participants the researcher and the research team. The interviews in this study were numbered in the following manner eg. participant 1 etc. The keeping of names and personal details was known only to the researcher. This information was stored on a security code protected computer. The use of pseudonyms was used by the researcher who did replace the participants name with an alternative ones.

- **Anonymity**

Anonymity exists if the participants' identity cannot be linked, even by the researcher, with the participants' individual responses (Burns and Grove, 2009a: 196). As already mentioned, the use of pseudonyms replacing the participants' names with alternative ones is a great way in the research process of reducing the identifiability of the participants. Another is the use of coding and recoding or "anonymising the data" (King and Horrocks, 2010: 119). In the data analysis phase of the research process data gathered during the research interview was coded and recoded and linked to themes and categories rather than to particular participants. In this manner it is more difficult to identify a particular interview with a participant's entire life story. The process of coding and re coding has already been presented in a precious section of this chapter.

- **Debriefing**

Debriefing sessions were conducted after the research, during which time the participants had the opportunity to work through their experiences and the aftermath thereof. These sessions had the purpose of rectifying any misinterpretation which may have arisen in the minds of the participants taking part in the research study.

The researcher acknowledges the right of the community and the science community to quality research, which was ensured by the researcher. The researcher adhered to the highest standards of research planning, implementing and reporting. All efforts were made by the researcher to remain neutral and unbiased throughout the study through "bracketing" her own views, beliefs and experiences. The research was undertaken honestly with no evidence being manipulated. Conclusions and findings are fully reported. All inputs from the participants are acknowledged. Acceptable procedures and scientific methods were upheld at the highest level and with good regard.

2.9 CHAPTER SUMMARY

The above discussion is an in-depth description of the research design and methods used to conduct this research. The purpose and research objectives are stated within the context of the research and the ethical principles are outlined and debated. A description of the proposed process for the development of strategies to provide care and support to children who are AIDS orphans living in the townships is outlined in this chapter.

CHAPTER THREE

AN OVERVIEW OF CURRENT INTERNATIONAL, NATIONAL AND PROVINCIAL LEGISLATIVE AND POLICY FRAMEWORKS CONCERNING THE RIGHTS OF CHILDREN LIVING IN SOUTH AFRICA

“There can be no keener revelation of a society’s soul than the way in which it treats its children” Nelson Mandela (Mabe, 2011:1).

3.1 OVERVIEW

The status and well-being of children speaks volumes about the values and quality of life in any society. South Africa’s ratification of international treaties since 1995 relating to children’s rights, obligates the country to ensure that its domestic legislation is in harmony with international laws and commitments. South Africa has a rich legislative and policy environment with many national laws which have been developed since 1994 and give effect to the country’s constitutional obligations and the promotion, protection of children’s rights.

South Africa is signatory to numerous international treaties and agreements, such as the Universal Declaration on Human Rights, the International Convention on Civil and Political Rights, the United Nations Convention on the Rights of the Child and the Millenium Declaration, of which the Millenium Development Goals are the targets for achievement. The domestication of treaties and implementation through programmes and services are the expression of a government’s commitment to give effect to all that has been agreed upon (Ramodibe, 2011 :1). It has been well documented by the Government of South Africa that “giving expression to such treaties and commitmenents will certainly enhance children’s rights” (Ramodibe, 2011 :1).

“Every child has the right to have his/her dignity protected and respected”(National Plan of Action for Children NPAC) 2012-2017, Department of Women and Children and People with Disabilities (DWCPD, 2012-2017: 13). The realisation of children’s rights is not only fundamental for their development and well-being but also pivotal to creating the world envisioned by the Millenium Declaration-a world of peace, equity, security, freedon respect for the environment and shared responsibility,in short, “a world fit for children” (NPAC, 2012-2017: DWCPD: 14).

Children are resillient in times of adversity; yet their vulnerability within families and society should not be underestimated. Since the advent of democracy in South Africa, the discourse on children’s rights has focused on the realisation of imperatives that recognise children’s vulnerabilities. The intention of this lies within the constitution of South Africa and in the Bill of Rights; with a particular emphasis on children’s rights. “It is the South African’s Government’s obligation to protect and promote the survival, development and well-being of children to attain a good quality of life” (Ramodibe, 2011:1). As such the South Africa Government’s philosophy regarding the realisation of the rights of children living in South Africa is: “that the fulfilment of children’s rights does not happen in isolation of the broader macro-components of governement policy; thus it is essential that mainstreaming of children’s rights be regarded as a central principle of the current NPAC” (DWCPD, 2012-2017: 11).

The purpose of this chapter is to present the current international, national and provincial legislative and policy frameworks regarding the rights of children living in South Africa. This will be represented below under the following five headings.

- Introduction and background of development on children’s rights internationally
- International treaties, conventions declarations and protocols ratified by the South African Government
- Regional treaties ,covenants, declarations and protocols signed by the Government of South Africa
- Domestic legislation within South Africa regarding the rights of children living in South Africa
- Domestic legislative changes 2011/2012 within South Africa which have affected the rights of children

3.2 INTRODUCTION AND BACKGROUND

The ultimate test of a moral society is the kind of world that it leaves to its children.”
Dietrich Bonhoeffer (UN, 2012:2).

“The only international language is a child’s cry**”** Eglantyne Jebb (Mulley, 2009: 56). Eglantyne Jebb was a British social reformer and founder of the “Save the Children” organisation, the first truly effective international aid organization. In 1923 Eglantyne Jebb drafted a declaration of the Rights of the Child. These five simple statements were endorsed by the League of Nations in 1924. In 1925, the first International “Child Welfare” congress was held in Geneva. Eventually an extended, seven-statement declaration became the UN’s “Rights of the Child” statement now ratified by all countries on earth except the United States and Somalia. The Declaration was widely discussed and supported by organisations and governments. An expanded version would be adopted by the United Nations in 1959 and it was one of the main inspirations behind the 1989 UN Rights of the Child.

We set out to save the lives of children; but if we remain true to this ideal of international co-operation, we may make a worthy contribution to the task of saving the soul of the world." Eglantyne Jebb in (Mulley, 2009: 22).

Jebb believed that the rights of a child should be especially protected and enforced, when drafting the first stipulations for children’s rights contained in five simple statements in the Rights of the Child follows below (Mulley, 2009: 27):

1. The child must be given the means requisite for its normal development, both materially and spiritually.
2. The child that is hungry must be fed, the child that is sick must be nursed, the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succoured.
3. The child must be the first to receive relief in times of distress.
4. The child must be put in a position to earn a livelihood and must be protected against every form of exploitation.
5. The child must be brought up in the consciousness that its talents must be devoted to the service of its fellowmen.

The principles, in the form of the “Rights of the Child”, have also been fully embraced by the United Nations. Few people have left such a positive legacy for the world’s social well-being. It is important then that aid to the child should (Mulley, 2009: 149):

- be given in a planned, scientific manner;
- be preceded by careful research;
- be directed towards families;
- be given on the basis of need and not any sectarian basis;
- be constructive, self-sustaining;
- stimulate self-help; and
- be pioneering and able to develop models for others to follow.

The Declaration of the Rights of the Child is the name given to a series of related children's rights proclamations drafted by Save the Children founder, Eglantyne Jebb in 1923. There is “no trust more sacred than the one that the world holds with children and no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace" Kofi Annan (UN, 2012:1).

3.3 INTERNATIONAL: TREATIES CONVENTIONS, DECLARATIONS AND PROTOCOLS, RATIFIED BY SOUTH AFRICA CONCERNING CHILDREN'S RIGHTS

The protection of human rights is one of the main aims of international law which can be described as the rules and principles that bind states in their relations with one another and, in relation to human rights law, place obligations on the state towards its citizens. Since the Second World War it has become clear that international law also extends to individuals which is evident from the acceptance of the Universal Declaration of Human Rights in 1948 (UDHR). The declaration was followed by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Economic Social and Political Rights (ICCPR). These three instruments form the international Bill of Rights, which strives to protect the individual's human rights if a state as such fails to protect such rights.

Prior to 1993 South Africa followed the principle of parliamentary sovereignty according to which Parliament could pass legislation that was contrary to international human rights standards and that violated human rights. With the enactment of the 1993 constitution and the justiciable Bill of Rights , international law came to play an important role in the interpretation of human rights for two reasons. Firstly, international law makes provisions similar to those found in the Bill of Rights and as a result of the numerous debates concerning the interpretation of these rights in the international community, there is still vast literature on the interpretation of these rights. Secondly courts are obligated by the constitution of South Africa to consider international law when interpreting the Bill of Rights. On creating a democratic society based upon human dignity, equality and freedom children already protected through international law instruments were afforded protection in the 1993 and 1996 constitution.

Following the Second World War, the United Nations and various other international organisations recognised the protection of human rights in various treaties. These treaties protect citizens' rights against possible infringement on the side of the state. South Africa was isolated from the development that occurred in international human rights law due to the system of apartheid. When South Africa became a democracy in 1994, international law had to be made part of South African law so that South Africa could once again take its place within the international community therefore, the constitution of 1996 contains various sections that deal with international law and its place in the South Africa legal system. In particular, Section 39(1) (b) of the constitution places an obligation on courts, tribunals and forums to consider international law when interpreting the Bill of Rights contained within the constitution of South Africa.

With the formation of the Union of South Africa in 1910 the principle of sovereignty of Parliament was incorporated in South African law. Before 1994, various human rights were violated that were decreed by Parliament. There was no Bill of Rights or other legislation available to either citizens or courts to protect citizen’s human rights against the power of the state. As the Appellate Division stated in 1934, “ Parliament may make the encroachment it chooses upon the life, liberty or property of any individual subject to its sway, and It’s therefore the function of courts law to enforce its will ”(Sachs, 1934: 37).

“We have confronted and successfully dealt with some of the toughest, most intractable challenges of our time - challenges that have left other societies in ashes. We are problem solvers. We are pragmatists. We work by consensus. And we prefer long-term solutions to quick, expedient fixes. But we are still revolutionaries: we want to hand succeeding generations a truly better world " (Barbara Masekela, South African ambassador to the United States 2012).

The protection of human rights is one of the main aims of international law.

There are nine core international human rights treaties that promote children’s rights, which are:

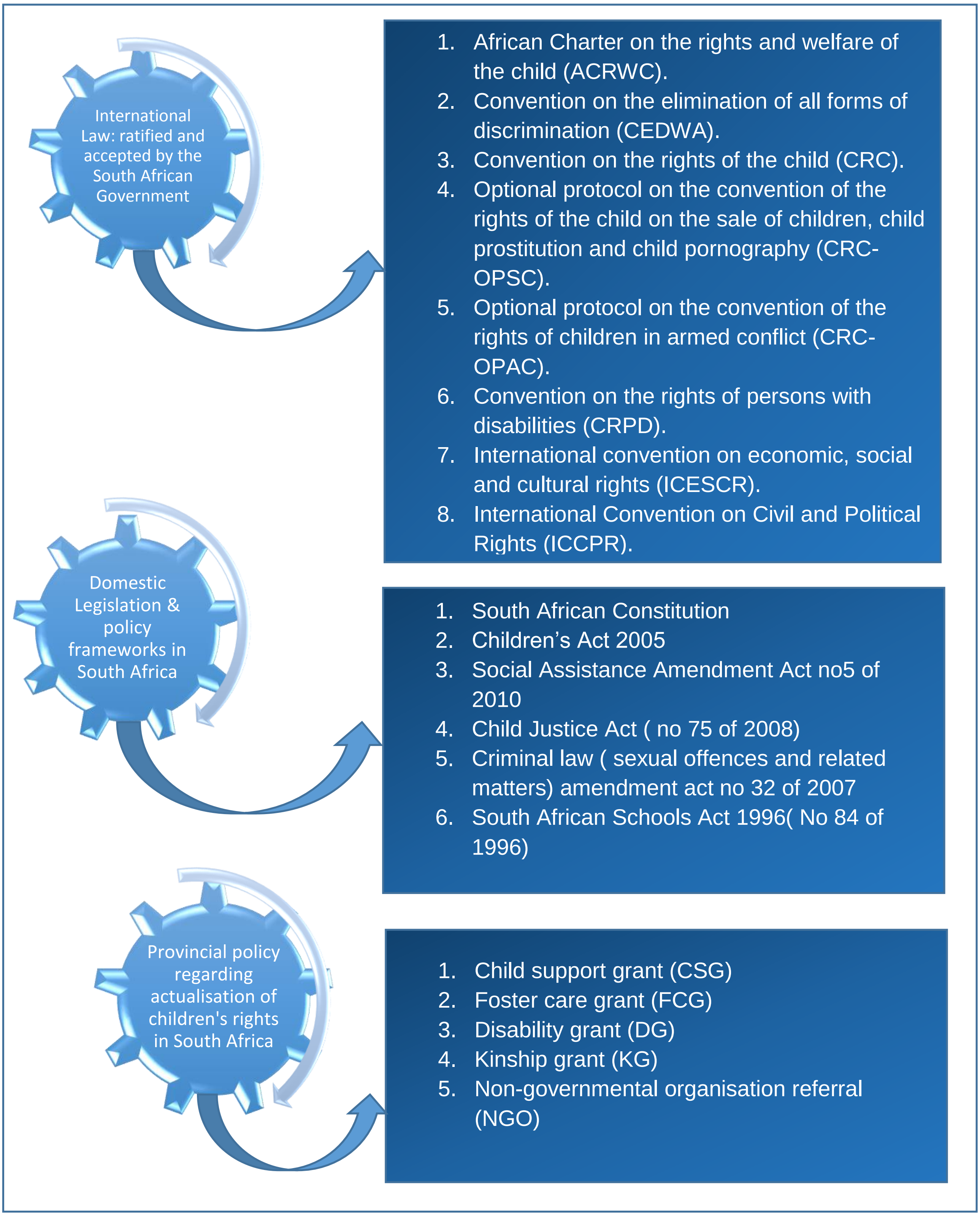
- African Charter on the Rights and Welfare of the Child: ACRWC
- Convention on the Elimination on all Forms of discrimination Against Women (CEDWA)
- Convention on the Rights of the Child: CRC
- Optional Protocol to the Convention on the Rights of the Child on the sale of Children, child prostitution and child pornography: CRC-OPSC
- Optional Protocol on the Convention on the Rights of the Child on the involvement of children in armed conflict: CRC OPAC
- Convention on the Rights of Persons with Disabilities: CRPD
- International Convention on Economic, Social and Cultural Rights: ICESCR
- International Convention on Civil and Political Rights: ICCPR
- Minimum Age Convention: MAC 1973 (No. 138)
- Worst Forms of Child Labour Convention: 1999 (No. 182). WFC

Since the adoption of the Universal Declaration of Human Rights in 1948 all member states have ratified at least one core international human rights treaty and 80% have ratified at least four or more. Each of these treaties has established a committee of experts to monitor implementation of the treaty provisions by its state's parties. Some of these treaties are supplemented by optional protocols dealing with specific concerns. These are made in accordance with the provisions of the treaty which each monitors. The Office of the High Commissioner of Human Rights (OHCHR) assists treaty bodies in harmonising their working methods and reporting requirements through their secretaries.

In addition to the International Bill of Rights and the core human rights treaties, there are many other universal instruments relating to human rights. The legal status of these instruments which varies, can take the form of declarations, principles, guidelines, standards rules and recommendations. All of these have no legal binding effect; but each instrument has an undeniable moral force and provides practical guidance for states in their conduct. Covenants, statutes, protocols and conventions are legally binding for those states that ratify and accede to them. Examples of this for South Africa would be the UNCRC and the United Nations Millennium Declarations which will be discussed further on in this chapter.

Figure 3.2 : Demonstrating intersection of International, National and Provincial legislative and policy frameworks in South Africa concerning Children's Rights.

Figure 3.1: Demonstrating intersection of International, National and Provincial, legislative and policy frameworks in South Africa concerning Children's Rights.



International Law: ratified and accepted by the South African Government

1. African Charter on the rights and welfare of the child (ACRWC).
2. Convention on the elimination of all forms of discrimination (CEDWA).
3. Convention on the rights of the child (CRC).
4. Optional protocol on the convention of the rights of the child on the sale of children, child prostitution and child pornography (CRC-OPSC).
5. Optional protocol on the convention of the rights of children in armed conflict (CRC-OPAC).
6. Convention on the rights of persons with disabilities (CRPD).
7. International convention on economic, social and cultural rights (ICESCR).
8. International Convention on Civil and Political Rights (ICCPR).

Domestic Legislation & policy frameworks in South Africa

1. South African Constitution
2. Children’s Act 2005
3. Social Assistance Amendment Act no5 of 2010
4. Child Justice Act (no 75 of 2008)
5. Criminal law (sexual offences and related matters) amendment act no 32 of 2007
6. South African Schools Act 1996(No 84 of 1996)

Provincial policy regarding actualisation of children's rights in South Africa

1. Child support grant (CSG)
2. Foster care grant (FCG)
3. Disability grant (DG)
4. Kinship grant (KG)
5. Non-governmental organisation referral (NGO)

Figure 3.2: Detail concerning International, National and Provincial legislative and Policy frameworks in South Africa concerning children’s rights.

3.3.1 The Universal Declaration of Human Rights

Human rights are rights to which all human beings are entitled merely by virtue of being human. Such rights neither have to be earned nor are they dependent on any particular social status. Quite simply they are concerned with asserting and protecting human dignity and are ultimately based upon a regard for the intrinsic worth of the individual. This is an eternal and universal phenomenon and is also true for Nigerians, Malays, or to Englishmen and Americans (Kaime, 2009: 19).

"Where, after all, where do universal human rights begin? In small places, close to home- so close and so small that they cannot be seen on any maps of the world. Yet they are in the world of the individual person; the neighbourhood he lives in; the school or college he attends; the factory, farm, or office where he works. Such are the places where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without a concerted, citizen action to uphold them close to home, we shall look in vain for progress in the larger world" on February 16, (UDHR, 1948: 1) Eleanor Roosevelt.

Prior to the interim constitution of South Africa in 1993 Parliament in South Africa was supreme in the sense that it could pass legislation without fear that the substance of that legislation could be tried in a court of law. According to Murieinik the dawning of the new constitutional era in South Africa, with the supreme constitution and an entrenched Bill of Rights, represented a bridge from a culture of authority towards a culture of justification (Murieinik, 1993: 48). Before 1994 various human rights were violated by numerous laws that were promulgated by Parliament.

The human rights movement that is the collection of norms, processes and institutions addressing the relationships among individuals, the state and communities is generally taken to have been born following the abominations of World War Two. The normative foundation of the movement is the Universal Declaration of Human Rights (UDHR). The UDHR and two other key instruments, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic and Cultural Rights (ICESCR), form the so- called International Bill of Rights, the cornerstone of the human rights movement. In 1990, when Nelson Mandela was released after almost three decades in prison, the push for political change in South Africa had become an international human rights project.

The construction of the post-apartheid state represents the first deliberate and calculated effort in history to craft a human rights state, a policy that is primarily animated by human rights norms (Mutua and Makau, 1997: 67). The dramatic rebirth of the South African state marked by the 1994 democratic elections has arguably been the most historic event in the human rights movement since its emergence some fifty years ago (Mutua and Makau, 1997: 63). In expressing this “universally” human rights are enshrined in the constitutions of every one of today’s 170 states, old and new; religious and secular and atheist; Western and Eastern” (Mutua and Makau, 1997: 64). Internally human rights have dominated virtually every aspect of the recreation of the democratic, authoritarian and totalitarian; market economy, socialist and mixed, rich and poor.

These precepts are dominated and evidenced by the completeness of the rights enumerated in the new constitution of South Africa adopted by the constitutional assembly in May 1996 and signed by President Mandela into law on Dec 10th 1996. The new constitutional order draws extensively from international law including human rights law. It provides that international agreements, which include human rights treaties and international customary law, are binding law unless they contradict the Constitution or other laws passed by Parliament. The new state of South Africa subsequently signed and ratified many of the international human rights instruments: Convention for the Elimination of all forms of Discrimination against Women (CEDAW) and the Convention of the Rights of the Child (CRC) and the country also signed the ICESCR and ICCPR.

The effect on South Africa of signing the international declaration and other international treaties is the influence of these declarations and treaties on domestic law and legislation within South Africa. “The constitution of South Africa itself, consciously and explicitly draws from international human rights law”. The Bill of Rights in the constitution of South Africa resulted from the careful analysis of international and comparative law in the light of the specific South African needs.

The modern state of South Africa is the primary guarantor of human rights, while it is simultaneously the target of the international human rights law prescribing the standard of treatment of individuals by their governments.

The new constitution does not differ substantially from the interim one although it adds to and strengthens institutions created to promote and protect human rights and further illuminates economic and social rights. The constitution has the strongest Bill of Rights of any constitution in the entire world. Its equal protection clause prohibits the discrimination on almost all conceivable grounds, including sexual orientation as well as race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, language or birth (Mutua and Makau, 1997: 63).

The international human rights movement was strengthened in 1948 when the United Nations General Assembly adopted the Universal Declaration of Human Rights (UNDR). "The General assembly proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observances, both among the peoples of Member states themselves and among the peoples of territories under their jurisdiction" (United Nations General Assembly, 1948:1). The constitution of South Africa will be presented further on in this chapter with the focus on the Bill of Rights which directly affects the welfare of children living in South Africa.

Understanding the background to the development of the constitution in South Africa is foundational in understanding how domestic legislation concerning the realisation of the rights of children in South Africa has its roots firmly in international law.

3.3.2 International Convention on Civil and Political Rights (ICCPR)

"Human rights are inscribed in the hearts of people; they were there long before lawmakers drafted their first proclamation" (Mary Robinson, United Nations High Commissioner for Human Rights, 1997-2002).

The ICCPR was adopted and opened for signature, ratification and accession by the General Assembly's resolution on the 16th December 1996 and entered into force on 23rd March 1976. This followed almost two decades of negotiations and rewriting. In 1976, after being ratified by the required thirty five States, it became international law.

The preamble of the covenant notes the recognition of the inherent dignity and the equal and inalienable rights of all members of the human family, which is at the foundation of freedom, justice and peace in the world. The covenant promotes the following rights:

- The right to legal recourse when an individual's rights have been violated, even if the violator was acting in an official capacity
- The right to life
- The right to liberty and freedom of movement.
- The right to equality before the law

- The right to presumption of innocence until proven guilty
- The right to appeal a conviction
- The right to be recognised as a person before the law
- The right to privacy and protection of that privacy by law
- Freedom of thought, conscience and religion
- Freedom of opinion and expression
- Freedom of assembly and association.

The right for people to choose freely whom they will marry and to found a family. The covenant requires that the duties and obligations of marriage and family be shared equally between partners. It guarantees the rights of children and prohibits discrimination based on race, sex, colour, national origin or language.

The covenant forbids the following:

- Torture and inhumane or degrading treatment
- Slavery or involuntary servitude
- Arbitrary arrest and detention, and debtors prisons
- Propaganda advocating either war or hatred based on race, religion, national origin, or language
- Restriction of the death penalty to the most serious of crimes, guarantees condemned people the right to appeal for commutation to a lesser penalty, and forbids the death penalty entirely to persons below the age of 18 years of age.

The covenant permits governments to suspend temporarily some of its rights in the case of Civil emergency only and also ratifies the United Nations Human Rights Commission (UNHRC). This was regarded as the United Nations principle mechanism and international forum concerned with the promotion and protection of Human Rights. It has however subsequently been replaced by the United Nations Human Rights Council in 2006.

Equality and non-discrimination are the most widely recognized human rights in law and they have great potential to complement social rights. Article 2 in both the ICCPR and the ICESCR contains a similar non-discrimination provision, requiring state parties to respect and ensure the rights in the Covenants without distinction on the basis of these same enumerated grounds, including “property” or economic status.

It reads as follows: “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.” In this respect the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property birth or status.

Discrimination can be defined as any distinction, exclusion, restriction or preference which is based upon any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons on an equal footing of all rights and freedoms (Langford, 2008: 5).

The Bill of Rights within the South African constitution reflects much of the ICCPR as it contains a similar non-discrimination provision, requiring state parties to respect and ensure the rights in the Covenants without distinction on the basis of these same enumerated grounds, including “property” or economic status. The ICCPR may help frame litigation, advocacy strategies and government policy where there is constitutional ambiguity (Langford, 2008: 4). The ICCPR makes contributions to the South Africa Constitution in 2 ways:

- Non-discrimination provisions in the International Bill of Human Rights prohibit discrimination the basis of “property” or “economic status,” which is a frequent ground for denying poor people equal access to healthcare, education, housing and social assistance.
- One-to-one equality, already recognized for civil and political rights, ought to be extended to social rights, including the right to healthcare. Both avenues are well grounded in the text, the history and the overall framework of the International Bill of Human Rights, and both avenues lead toward the universal provision of healthcare, education, housing and welfare on an equal basis for all.

3.3.3 International Covenant on Economic Social and Cultural Rights (ICESCR)

Almost 18 years after the South Africa Government signed the ICESCR, cabinet has approved that South Africa will ratify the ICESCR. The important decision to ratify means that the ICESCR will be legally binding in South Africa as of October 2012. “The ICESCR is a key international treaty which seeks to encourage State Parties to address challenges of inequality, unemployment and poverty, which are critical to the strategic goals of governments”. South Africa’s current ratification of the ICESCR will signal South Africa’s commitment to be legally bound by the full range of human rights recognised under international law (Dugard, 2005: 1). This move to ratify the ICESCR is an important step towards creating an harmonious roadmap for the realisation of socio economic rights for all in South Africa (Dugard, 2005:1).

The recommendations by the cabinet to ratify the ICESCR will be in line with section 231(2) of the South African constitution. The Covenant forbids the exploitation of children and requires all nations to cooperate to end world hunger. States are to submit annual reports on progress in providing for these rights (ICESCR, 1991: vol 993).

Article 9 (1): “The State Parties recognise the right of everyone to social security” (ICESCR, 1966: 7), Article 10 (1); “The widest possible protection and assistance should be accorded to the family: which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses” (ICESCR, 1966: 7).

Article 10 (3): “ Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of percentage or other conditions. Children and young people should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set limits below which the paid employment of child labour should be prohibited and punishable by law” (ICESCR, 1966: 7).

Article 11 (1) “The State Parties to the present Covenant, recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing, housing and to the continued improvement of living conditions. The State Parties will take appropriate steps to ensure the realisation of this right, recognising to this effect the essential importance of international cooperation based upon free consent” (ICESCR, 1966: 7).

Article 12 (1): “The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (ICESCR, 1966: 8).

Article 13 (1) “The State Parties to the present Covenant recognise the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerate friendship among nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace"(ICESCR, 1966: 8).

It has long been recognized that an essential element in protecting human rights was a widespread knowledge among the population of what their rights are and how they can be defended, (Boutros Boutros-Ghali, Sixth UN Secretary-General, 1992-1996).

When one looks at the articles within the ICESCR it is clear to see how articles within the ICESCR are contained in the Bill of Rights within the constitution of South Africa. The ICESCR states: "The State must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of each of these rights." Article 26 (2) and 27 (2).This qualification is similar to article 2 of the International Covenant on Economic, Social and Cultural Rights (1966) which describes the nature of States parties' obligations in relation to the Rights recognised in the Covenant. However, other economic and social rights such as the right to basic education and the socio-economic rights of children are not subject to the same qualification and are thus more directly enforceable. The way the socio-economic rights are framed in the Bill of Rights suggests that they should not be regarded as commodities to be dispensed by the State, free of charge to a passive citizenry. The State's primary duty is to create an enabling environment through which people can gain "access to" the various rights. An enabling environment has the following key element, namely, ensuring that resources, services and opportunities are made available without unfair discrimination.

The overarching effect of ratification of this convention will be the obligation of the State of South Africa to promote the universal respect for, and observance of, human rights and freedoms (Abrahams and Matthews, 2011: 24).

3.3.4 The United Nations Convention on the Rights of the Child (CRC)

The principles of the CRC have played a significant part in the promotion of the rights of children in the entire world as well as in shaping various forms of international cooperation in this sphere (Kaime, 2009:14).

After a decade of preparatory work, the United Nations (UN) adopted in 1989 the Convention on the Rights of the Child (CRC). Among the human rights instruments that make up the UN human rights system the CRC stands unique. Never before has a human rights instrument promoted under the auspices of the UN has so many states participating at the signing ceremony. Never before has a human rights treaty gone into force within months after the UN General Assembly has adopted it, and never before has a human rights instrument been so universally ratified. This overwhelming normative consensus affirms a shared and welcome global recognition of the rights of the child. It indicates increasing support and acceptance by the world community of the need to promote and protect the rights of the child. Furthermore the adoption of the CRC represents on the part of the world community that the rights of certain categories of people are best protected in the single instrument designed for that purpose (Kaime, 2009: 1).

The Convention on the Rights of the Child is the first legally binding international instrument to incorporate the full range of human rights; civil, cultural, economic, political and social rights. In 1989, world leaders decided that children needed a special convention just for them because people under 18 years old often need special care and protection that adults do not. The leaders also wanted to make sure that the world recognized that children have human rights too.

The Convention sets out these rights in 54 articles and two optional protocols. It spells out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. The four core principles of the convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. Every right spelled out in the Convention is inherent to the human dignity and harmonious development of every child. The Convention protects children's rights by setting standards in healthcare; education; and legal, civil and social services.

By agreeing to undertake the obligations of the Convention (by ratifying or acceding to it), national governments have committed themselves to protecting and ensuring children's rights and they have agreed to hold themselves accountable for this commitment before the international community. States parties to the Convention are obliged to develop and undertake all actions and policies in the light of the best interests of the child.

Governments that ratify the Convention or one of its Optional Protocols (Optional Protocol on the involvement of children in armed conflict : Optional Protocol on the sale of children, child prostitution and child pornography) must report to the Committee on the Rights of the Child, the body of experts was charged with monitoring States' implementation of the Convention and Optional Protocols. These reports outline the situation of children in the country and explain the measures taken by the State to realize their rights. In its reviews of States’ reports, the Committee urges all levels of government to use the Convention as a guide in policymaking and implementation and because the protection of human rights is by nature a permanent and endless process, there is always room for improvement.

“The Convention is not only a visionary document. We are reminded daily that it is an agreement that works – and its utility can be seen in the everyday use to which I have seen it increasingly being put by country after country, in policy, in practice and in law," Carol Bellamy told a gathering in Stockholm in 2002 as Executive Director of the United Nations Children's Fund, (UNICEF, 2002:22). The extent to which international instruments and laws are able to improve the lives of children across the world is dependent on the extent to which state parties implement them and adopt them into domestic policy and measures to comply with the relevant obligations (Sloth-Nielsen, 2007 :338).

The CRC was adopted and opened for signature, ratification and accession by the United Nations General Assembly resolution 44/25 on the 20th November 1989 and entered into force on 2 Sept 1990, in accordance with article 49. Most countries rapidly acceded to the treaty across the world. This rapid progress towards ratification signalled the rights which have contributed towards the protection of children. South Africa signed the treaty in 1993 and ratified it in1995.

The preamble of the CRC sets out the civil, political, economic, social and cultural rights of children. The convention also reaffirms the fact that children, because of their vulnerability, require the following:

- Legal and other protection before and after birth.
- Respect for the cultural values of the child’s community.
- Special care and protection. Special emphasis is placed on the primary caring and protective responsibility of the family.
- International cooperation in securing children’s rights.

The protection, ensured within the CRC, includes the protection of children from abuse and neglect and interventions required to investigate and prevent child abuse. In addition, more specialised children’s provisions are also provided for in the CRC and concerned children’s decision making forums that include either local or more specialised courts. The CRC forbids the use of capital punishment for children. This convention also has two optional protocols which were subsequently adopted by the General Assembly in 2000 and which are applicable to States who signed and ratified the CRC; given the importance of the CRC in shaping the rights provisions for children in South Africa (see Appendix N).

National, Provincial and local spheres of government must take responsibility for promoting the rights and addressing the needs of children. Section 28 of the Bill of Rights in the South African Constitution provides that every child has the right to basic nutrition, shelter, basic healthcare services and social services and to be protected from maltreatment, neglect, abuse or degradation. “Taking up this call the Government of South Africa must take up the call to guarantee a better life for the children of South Africa” (Mabe, 2011: 3).

South Africa has enshrined children’s rights in the constitution (ACT 108 of 1996), the supreme law of the country that was designed to respect, protect, promote and fulfil the rights of all people in the country. The commitment resonates strongly with international principles. In doing so governments have an obligation to protect and promote the survival, development and well-being of children, which ultimately affects their quality of life. South Africa’s National legislation concerning the rights and welfare of children will be presented in the following section of this chapter.

Given the extensive scope of the CRC, it is useful for explanatory and analytical purposes to classify the rights into categories. In this regard it has been suggested that the CRC may be concerned to with the four P’s.: the participation of children in decisions affecting them, the protection of children from all forms of discrimination, prevention of harm to children; and the provision of assistance for their basic needs (Kaime, 2009: :15).

3.3.5 Millenium Development Goals (MDG).

“There is more to do for the mother who watches her children go to bed hungry – a scandal played out a billion times each and every night. There is more to do for the young girl weighed down with wood or water when instead she should be in school” (UN, 2012: 2).

In September 2000, 189 member states of the United Nations came together at the Millennium Summit and adopted the Millennium Declaration, including commitments to poverty eradication, development and protecting the environment. Many of these commitments were drawn from the agreements and resolutions of world conferences and summits organized by the United Nations during the preceding decade. A year later the UN Secretary General’s Road Map for implementing the Millennium Declaration formally unveiled eight goals, supported by 18 quantified and time-bound targets and 48 indicators, which became known as the Millennium Development Goals (MDG’s). The MDG’s focus the efforts of the world community on achieving significant, measurable improvements in people's lives by the year 2015. They establish targets and yardsticks for measuring results, not just for developing countries but for the rich countries that help fund development programmes and for the multilateral institutions that help countries implement them.

“The MDG’s were never meant to be a one-way street – something that rich countries do for poor ones. Quite the contrary: our long-standing work for development in general has always been based on global solidarity – on a shared interest – on a powerful sense of community and linked fates in an interconnected world.” (Secretary-General Ban Ki-moon, in his closing remarks to the MDG Summit, 22 September 2010).

Three Years to the deadline, progress can be reported on regarding the MDG’s. agreed to by world leaders over a decade ago, for they have achieved important results. Working together, governments, the United Nations family, the private sector and civil society have succeeded in saving many lives and improving conditions for many.

The United Nations Millennium Declaration was adopted by the General Assembly resolution 55/2 on 8th Sept 2000. In terms of the declaration, states have a collective responsibility to uphold the principles of human dignity, equality and equity at a global level. The real value of the Millennium Development Goals (MDG’s) lies within the set time frames for the realisation of these goals. There are eight MDG’s which are listed below in figure 3.3.

Examples of these set time frames with direct relevance to the context of this research subject will now be presented. For the first time since the World Bank started to monitor poverty trends, both the number of people living in extreme poverty and the poverty rates fell in every developing region, including sub-Saharan Africa, where the rates are highest. In the developing regions the proportion of people living on less than $1.25 per day fell from 46% in 1990 to 24% in 2008. In 2008 about 110 million less people than in 2005 lived in conditions of extreme poverty. The number of extreme poor in the developing regions fell from over 2 billion in 1990 to fewer than 1.4 billion in 2008 (MDG:2012:2).

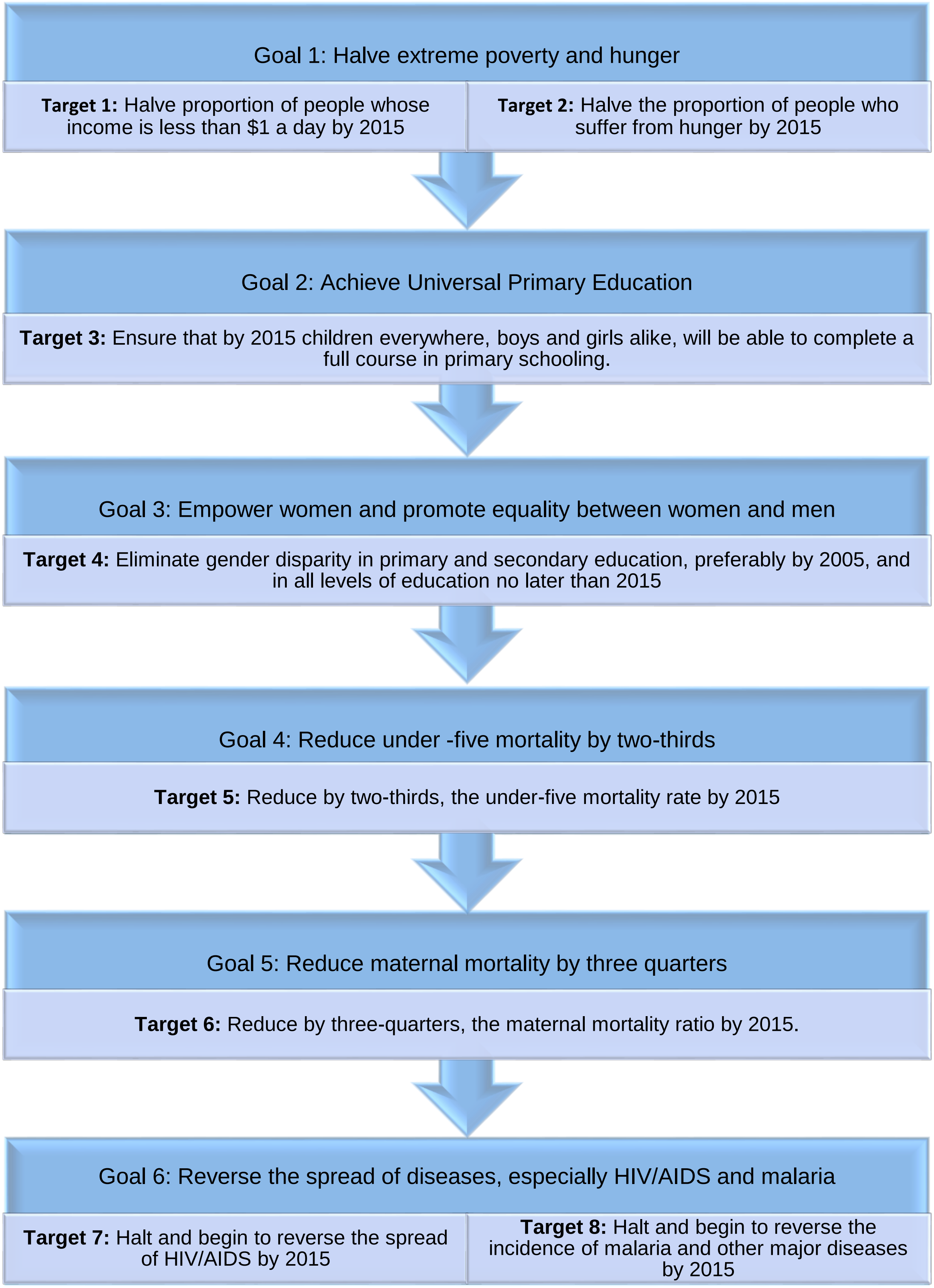
Enrolment rates of children of Primary School age increased markedly in sub-Saharan Africa from 58 to 76% between 1999 and 2010. Many countries in that region succeeded in reducing their relatively high out-of-school rates even as their primary school age populations were growing. There were also improvements in child survival statistics. Despite population growth, the number of under- five years deaths worldwide fell from more than 12 million in 1990 to 7.6 million in 2010; and progress in the developing world as a whole accelerated. Sub Saharan Africa- the region with the highest level of under-five mortality- has doubled its annual rate of reduction , from 1.2% a year over 1990-2000 to 2.4% during 2000-2010.

At the end of 2010, 6.1 million people were receiving antiretroviral therapy for HIV or AIDS in developing regions. The total constitutes an increase of over 1.4 million people from December 2009 and is the largest one-year increase ever. The 2012 target of universal access, however, was not reached. There have been important improvements in maternal health and reduction in maternal deaths; but progress is still slow. Reductions in adolescent childbearing and expansion contraceptive use has continued but at a slower pace since 2000 than over the decade before. Despite a reduction in the proportians of urban populations living in slums, the absolute number has continued to grow from a 1990 baseline of 650 million. An estimated 863 million people now live in slum conditions. Hunger too remains a global challenge. The most recent Food and Agricultural Organisation (FAO) estimates of undernourishment set the mark at 850 million living in hunger in the world between 2006 and 2008 which is 15.5% of the world's population. The continuing high levels reflect the lack of progress on hunger in several regions even as income poverty has decreased. Progress has also been slow in reducing child under-nutrition. Close to one third of children in Southern Asia were underweight in 2010.

"Between now and 2015, we must make sure that promises made become promises kept. The consequences of doing otherwise are profound: death, illness and despair, needless suffering (United and Nations., 2012 :17), lost opportunities for millions upon millions of people" (MDG report, 2012:17). There is recognition by the UN leaders that in addition to separate responsibilities to our individual societies, there is a collective responsibility to uphold the principles of human dignity, equality and equity at a global level. The leaders of the UN recognise that they have a duty to all the world people, especially the most vulnerable and, in particular,children of the world to whom the future belongs.

Article 26 of the United Nations Millennium Declaration reads as follows: "We will spare no effort to ensure that children and all civilian populations that suffer disproportionately the consequences of natural disasters, genocide, armed conflicts and other humanitarian emergencies are given every assistance and protection so that they can resume normal life as soon as possible :to encourage the ratification and full implementation of the CRC and its optional protocols on the involvement of children in armed conflict and of the sale of children, child prostitution and child pornography."

Reliable and timely data and internationally comparable data on the MDG's indicators are crucial for devising appropriate policies and interventions needed to achieve the MDG's and for holding the international community to account. In the subsequent sections of this chapter the researcher will present data specifically with regard to South Africa. It remains clear from the above that there is still much to be done not only in South Africa but also worldwide regarding policy implementation and evaluation thereof to effectively meet the MDG's and statistically to be able to demonstrate progression within countries towards the actualisation of these goals in 2015.



Goal 1: Halve extreme poverty and hunger

Target 1: Halve proportion of people whose income is less than $1 a day by 2015

Target 2: Halve the proportion of people who suffer from hunger by 2015

Goal 2: Achieve Universal Primary Education

Target 3: Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course in primary schooling.

Goal 3: Empower women and promote equality between women and men

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Goal 4: Reduce under -five mortality by two-thirds

Target 5: Reduce by two-thirds, the under-five mortality rate by 2015

Goal 5: Reduce maternal mortality by three quarters

Target 6: Reduce by three-quarters, the maternal mortality ratio by 2015.

Goal 6: Reverse the spread of diseases, especially HIV/AIDS and malaria

Target 7: Halt and begin to reverse the spread of HIV/AIDS by 2015

Target 8: Halt and begin to reverse the incidence of malaria and other major diseases by 2015

Goal 7: Ensure environmental sustainability

Target 9: Integrate principles of sustainable development into country policies and reverse the loss of environmental resources

Target 10: Halve the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015

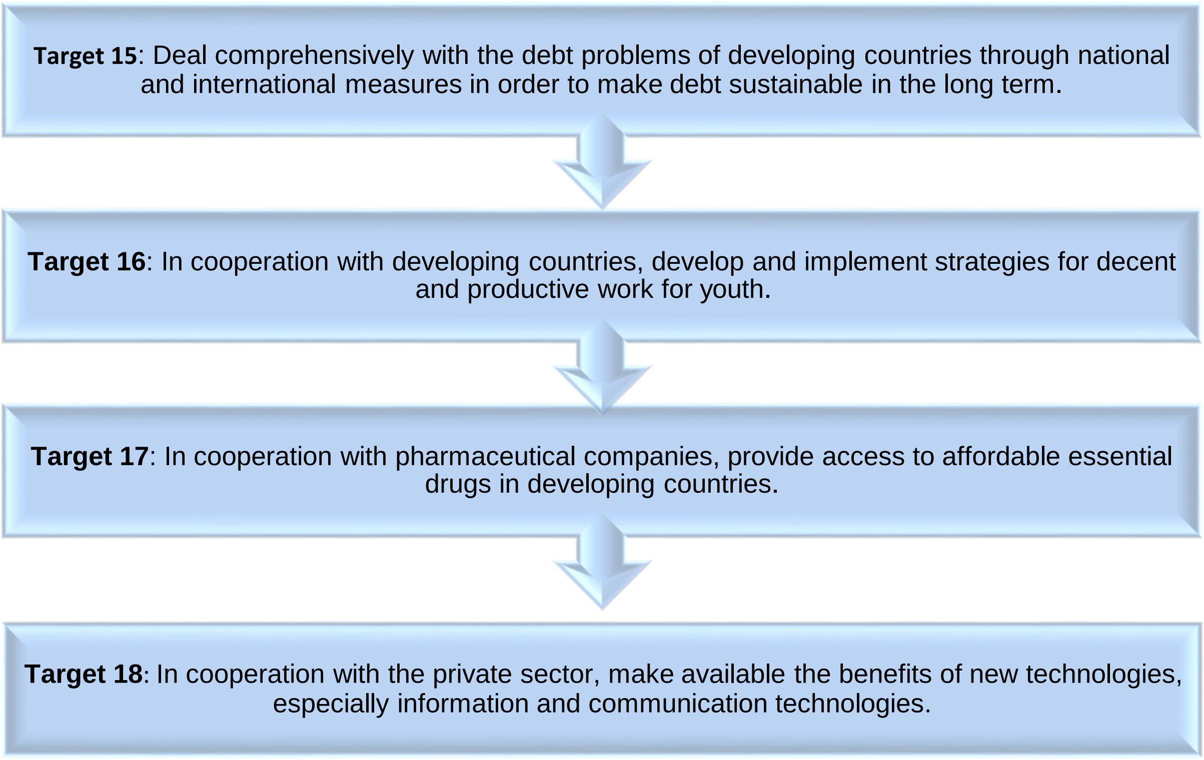
Target 11: Significantly improve the lives of slum dwellers by 2020

Goal 8: Create a global partnership for development, with targets for aid, trade and debt relief.

Target 12: Develop further an open rule- based predictable, nondisc riminatory trading and financial system (includes a commitment to governance, development, poverty reduction, both nationally and internationally).

Target 13: Address the special needs of the least of the developed countries , including tariff and quota-free access for least developed countries exports, enhance programme of debt relief for heavily indebted poor countries (HIPC's) and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction

Target 14: Address the special needs of landlocked developing countries and small island developing States (through the program of Action for the Sustainable Development of Small island Developing States and 22nd General Assembly provisions).



Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.

Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.

Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communication technologies.

Figure 3.3: The Millennium Development Goals (UNICEF, 2011: 22).

Despite the threat of global terror hanging over all of us, there is only one path: to pursue the Millennium Development Goals with fresh resolve – confronting violence, bigotry and hatred with the same determination that we attack the causes from which they spring – conflict, ignorance, poverty and disease. The world we seek, where every child can grow to adulthood in health, peace and dignity – in short, a world fit for children – has remained a dream for more years than we can count. But we at UNICEF are convinced that working together with committed partners, and with an appropriate plan of action and a commitment to resources, we can make that dream a reality for each and every child on earth." (MDG: 2012:2).

3.4 REGIONAL TREATIES, CONVENTIONS, DECLARATIONS AND PROTOCOLS.

3.4.1 African Charter on the Rigths and Welfare of the Child (ACRWC) also known as the African Children's Charter (ACC)

Africa is the only continent with a region-specific child rights instrument. The African Charter on the Rights and Welfare of the Child (ACRWC) is an important tool for advancing children's rights. While building on the same basic principles as the UN Convention on the Rights of the Child, the African Union Children's Charter highlights issues of special importance in the African context.

The preamble of the ACRWC makes two important statements regarding the instruments conception of the rights and welfare of children.

- It identifies the Children's Charter foundation as a principle of international law on the rights and welfare of children contained within the declarations, conventions other instruments of the Organisation of African Unity and the UN. Significantly the ACRWC also known as the African Children's Charter (ACC) specifically mentions the CRC and the declaration ascribed to international human rights norms, in general and children's rights in particular, surpass or do not acknowledge African traditional values and conceptions of human rights.
- The ACC,however, says that the concept of the rights and welfare of the child should be inspired and characterised by the virtues of African cultural heritage and historical background and the values of African civilisation. Thus the rights and welfare of children which are derived from universal sources must be alive in the reality of the African child.

The 1924 Declaration, which was also known as the Declaration of Geneva, proclaimed that "mankind owes to the child the best it has to give"

Whatever the diversity amongst third world countries is in their traditional belief systems, individuals still perceive themselves in terms of their group identity. Who and what an individual is, has been conceptualised in terms of a particular kinship system, the clan, the tribe, the village, whatever the specific cultural manifestations of the underlying prevailing worldview. Consequently any theory of human rights must take into account this reality if it is to be of any use to Africans. It is against this backdrop of discourse that the ACRWC was conceived and entered into force. Human rights are not peculiarly bourgeois or western and without relevance to Africans. There is merit in acknowledging universal norms; nevertheless approaches for the legislation and implementation of children rights can be enriched by the "African cultural experience".

What is important to acknowledge is that, despite accepting the provisions of the CRC, African states also sought to draft provisions of an instrument on the rights of the child which reflected African concerns. The idea to adopt an instrument on the rights of the child originated from a desire to address certain peculiar problems which had not been addressed in the CRC.

Among the concerns were:

- the situation of children living under Apartheid,
- disadvantages facing the African girl,

- the African concept of the community responsibilities and duties,
- the role of the extended family in the upbringing of children,
- the use of children as soldiers and
- the problem of internal displacement arising from civil wars and internal insurrections.

Ultimately the provisions of the ACC are about influencing the child - rearing practices of African families with a view towards improving children's general welfare. The implementation of these articles presented in the ACC is imperative to satisfy these preconditions in order for children to achieve their dignity and realise their full potential so that they can continue to be met as children grow up.

The preamble of the ACRWC declares that, the African member states of the Organisation of African Unity, parties to the present Charter entitled "African Charter on the Rights and Welfare of the Child are" noting with concern" that the situation of most African children remains critical due to the unique factors of their socio - economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger; and on account of the child's physical and mental immaturity he/she needs special safeguards and care. They are "recognising that the child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding. They are also "recognising" that the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, moral and social development; and requires legal protection in conditions of freedom, dignity and security.

They are "taking into consideration" the virtues of the African civilisation, which should inspire and characterise their reflection on the concept of the rights and welfare of the child, "considering" that the promotion and protection of the rights and welfare of the child also implies the performance of duties on the part of everyone.

They are "reaffirming adherence" to the principles of the rights and welfare of the child contained in the declaration, conventions and other instruments of the Organisation of African Unity, in the UN and in particular the CRC: the heads of state and government's declaration on the rights and welfare of the African child:

Considering that this research study concerns AIDS orphans living in the African context the only Article that will be presented fully is article 25 which is titled "Separation from parents". It reads as follows.

1. Any child who is permanently or temporarily deprived of his family environment for any reason shall be entitled to special protection and assistance:
2. State parties to the present Charter:
    (a) Shall ensure that the child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interests cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include, among others, foster placement or placement in suitable institutions for the care of children; and
    (b) Shall take all necessary measures to trace and re-unite children with parents or relatives where separation is caused by internal and external displacement arising from armed conflicts or natural disasters.
3. When considering alternative family care of the child and the best interests of the child, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious or linguistic background (ACRWC, 1999:12).

The ACC affords a platform for addressing the human rights concerns of African children. It does so in a manner that is not only in keeping with current developments at international law, but is also sympathetic to local context. The ACC is not a panacea to the many problems that African children face; it offers the possibility of creating innovative solutions that could alleviate a number of those challenges. The challenge of governments is to unlock the Charters potential and to bring many benefits to African children and their families by not only working on its existing legitimacy, but also in the extension of its legitimacy. The collaboration, participation and innovation of all involved in child work, including children themselves, is the key to developing a framework for the rights and welfare of the child that is not only effective, but also acceptable.

3.4.2 African Youth Charter (AYC)

The vision of the ACY is "Integrated and sustainable youth development, conscious of the historical imbalances and current imbalances and current realities, to rebuild a non-racist and non-sexist democratic South Africa in which young people and their organisations not only enjoy and contribute to their full potential in social and economic and political spheres of life but also recognise and develop their responsibilities to build a better life for all" (ACY; 7, 2009). "A Nation that does not take care of its youth has no future and does not deserve one" (Mantoto, 2009:1).

South Africa ratified the African Youth Charter on 28 May 2009 and deposited the instrument of ratification with the Commission of the African Union (AU) on 8 July 2009. It has been projected that by 2020 on the African continent that 3 out of 4 people will on average be 20 years old. This in turn leads to projections of approximately 10 million young African youth arriving onto the labour market each year. It seems therefore crucial that the South African Government along with other African governments has key policies in place implemented and monitored to support, develop and protect this important, yet vulnerable population group within their countries.

The African Youth Charter represents a strategic framework for the development of a youth policy at national and regional levels: The AYC places an obligation on State parties to develop a comprehensive and coherent national youth policy as well as obligations that signatory states need to abide by when developing and implementing their respective youth policies.

Referring to the rights, freedoms and duties of the African youth, the African Youth Charter is the first legal framework provided to Africa, by the relevant actors in the youth area, to support national policies, programmes and actions in favour of youth development. The document was adopted by Heads of States and Governments and recommended for ratification and implementation.

In South Africa, the concept of youth development has been shaped by the long history of struggle against apartheid. Throughout South Africa’s history, young people have acted as drivers of change and have participated actively in the development of a socially inclusive and economically empowering society. Youth development is therefore guided by the vision of a non-racest non -sexist democracy that is being built through transformation, reconstruction and development. The current National Youth Policy (NYP) in South Africa finds its roots in the AYC.

To highlight the intention of the NYP (2009-2014) is to demonstrate that another aspect of South African legislation concerning the care and well-being of children again finds its roots embedded in international law.

“The vision of the NYP 2009-2014 as is written in the NYP (2009-2014) is as follows: “to develop integrated, holistic and sustainable youth development, conscious of the historical imbalances and current imbalances and current realities to build a non-sexist, non-racist, democratic South Africa in which young people and their organisations not only enjoy and contribute to their full potential in the social economic and political spheres of life but also recognise and develop their responsibilities to build a better life for all” (NYP, 2009-2014:7).

The heads of State and Government at their 12th Ordinary Session held in Addis Ababa, declared the years 2009-2018 as the decade of youth development in Africa and also endorsed at their last summit held in Sirte, Libya, a proposal to declare the year 2010 as the International Year of Youth. “Thus with the entry of the AYC into force, the next ten years will be dedicated to its implementation, which will inevitably improve the status of young people on the continent and help address the serious deficits among this age cohort,” Dr. Agossou explained, adding that, with the entry into force of the AYC, comes the challenge of implementation. This, she said, is the point where the main challenges begin.

There are various challenges to monitoring the implementation of AYC, such as:

- the multiplicity of departments responsible for implementing the charter’s provisions and the lack of an existing framework for monitoring and data collection and
- the responsibility for implementing the provisions of the AYC cutting across various government departments: health, education, security, juvenile justice, etc. This means that an understanding of progress in implementing the AYC will require strong interdepartmental cooperation at national level to ascertain the proportion of youth between the ages of 15 and 35 benefiting from their services before collation and aggregation at regional level.

Above all, what is most crucial is to implement the charter to improve the situation of youth. Implementation would require an affective coordination system for national resources related to youth. Such a framework will need to consider painstakingly all sources of ‘youth resources’ at national level, including those earmarked for traditionally ‘non-youth’ departments like defence. This is crucial amidst claims that the ‘youth sector’ is the most under-funded area. Another important point is to use evidence of ‘what works’ as the basis for youth policy and practice.

The necessity of having a charter developed for the African youth was stated in the African Union Strategic Planning 2004-2007 to ensure that youth issues were embedded in a legal framework, taken seriously and given with the deserved attention and care. The drafting process took place between September 2005 and May 2006 through a very interactive approach, engaging African youth leaders, youth experts from Ministries, Ministers of youth affairs, partners and all interested stakeholders. This process was finalized with the adoption of the document by the African Heads of State and Government on 2 July 2006 in Banjul, Gambia.

The African Youth Charter, which came as an institutional and legal response to youth development and empowerment in Africa with the objectives to:

- facilitate the institutionalisation of youth participation in political debates, decision-making and development processes at national, regional and continental levels; on a regular and legal basis and for positive and constructive contribution.
- contribute to the strengthening of the capacity building programmes for young leaders in Africa.
- open the possibility of dialogue and more opportunity for exchange on youth development issues and facilitates relevant actions for improvement through education, training and skills development.

The African Youth Charter addresses, among others, the following areas for major and concrete actions for change:

- Education, skills and competence development
- Employment and sustainable livelihoods
- Youth leadership and participation
- Health and Welfare
- Peace and security
- Environment protection
- Cultural and moral values

Since January 2012 two more countries have ratified the AYC and must deposit their respective instrument of ratification to the AUC legal office before being counted (Tanzania and Central African Republic). Twenty eight African countries have ratified the Charter since 13 July and 2011, 39 countries have signed it. Many African governments are implementing the AYC by putting into place national youth policies and youth programmes. This is certainly the case in South Africa with the afore-mentioned NYP 2009-2014. Really the overall purpose of the AYC and the resulting national legislation is in the acknowledgment of the enthusiasm of youth to participate actively at local, national, regional and international levels in order to determine their own development and the advancement of society at large.

Among many other things, youth leaders and youth organisations can do the following to implement the ratification of the AYC.

1. Contribute to dissemination and popularization of the charter, and work with Ministries of youth to promote the understanding of the content of the charter among youth at all levels (schools, workshops, churches, etc.) in particular through

    - translation into local languages and large distribution;

- specific workshops and meetings with specific targets to facilitate popularisation of the Charter;
- national activities or festivals for the launching of the Charter, with media involvement;
- communication and information sessions in schools and universities for students and teachers;
- public rallies, competitions, and marches for country wide information and action; and
- advocacy meetings with officials and decision-makers.

2. Work with parliamentarians, especially those dealing with education, youth development or any related areas, to advocate for the ratification of the charter, through

    - special programmes with media involving youth organisations and government;
    - celebration of the African Youth National Day and any other cultural and artistic productions and events; and
    - celebration of the Year of African Youth.

3. Support the post ratification process by advocating for the implementation of the charter, through creation, improvement and reinforcement of partnerships with the public and private sectors, Diaspora, NGOs, and international institutions.

4. Support the ministerial work in reporting on progress made in countries, via,

    - websites for interactive entertainment, social media and ICT facilities, and TV and radio programmes;
    - advocacy material: posters, t-shirts, etc. All this will facilitate the domestication of the Charter, including its ratification where not yet done and the implementation of policies, programmes and plans of action for youth development.

UNESCO is one of the major UN Organizations that can work very closely not only with the African Member States on the issues of building their institutional capacity to respond efficiently and implement all development frameworks, but also with the young leaders of youth organizations in relation with government and civil society to assist in skills development and leadership building.

The support of United Nations Educational Scientific and Cultural Organisations (UNESCO) will enhance the efforts of African countries to ratify and implement the African Youth Charter. In conducting in-country advocacy activities, the youth will appreciate the support of UNESCO, for example, in the production of advocacy and communication materials, media events, workshops for the dissemination of the contents and translation of the Charter into local and vernacular languages.

There has been some seeming confusion about how to implement the Charter. Some countries have proposed to develop separate implementation frameworks for the Charter, while others have indicated that the provisions of the Charter have been integrated into their respective national youth policies. However, the presentation by South Africa's National Youth Commission points in the right direction: the Charter must be implemented within the framework of existing policies at national level, especially the National Youth Policy. Other policies to be adapted include the constitution as well as national policy frameworks on human rights, health, education, employment and various others.

If the implementation of the Charter is integrated into other national policies in this way, countries will incur little or no extra budgetary costs. Statutory budgetary allocations in the different sectors are often intended to provide services to the entire population. However, in implementing the provisions of the Youth Charter, each sector must keep in mind the need to create specific services for young people between ages 15-35 within that sector. Health services must take into account the need for this age bracket to access tailor-made reproductive health services including abortion services, advice on contraception and access to HIV medicines. Ensuring that services are tailor-made requires that the regular training received by service personnel takes into account training for these youth-specific issues without creating new programmes. For education and skills development training, these services are mainly targeted at the youth; however, more needs to be done to ensure that curriculum meets market demands, but these can be done within the broad framework of education sector reforms.

One critical question has been asked over and over again: is the African Youth Charter the solution to Africa's youth development problems? The answer is both "yes" and "no". The very minimum the Charter provides the basis for young people to advocate for their rights and it will serve as the guiding framework for youth development. Broadly, the Charter will also serve the means to guide long-term planning on youth development. Already, the declaration of the years 2009-2018 as the decade on youth development in Africa will assist many member states to think long-term in their youth development planning. Many member states have national planning horizons set quite far in the future (for example, 2016 for Botswana, 2020 for Nigeria, Rwanda and Malawi or 2030 for Zambia); thus the Charter will assist these countries to integrate youth issues within their long-term national development frameworks. A plan of action for the years 2009-2018 is also being developed by the AU Commission as a means to advance the implementation of the Youth Charter over the next decade, this will in a significant way provide further guidance to the work of member states.

The African Youth Charter is a practical step towards the full empowerment and development of Africa's youth, who constitute around 20 percent of the continent's population. While the diverse efforts to ensure that the Charter is implemented are being undertaken, it is important for all stakeholders to appreciate clearly the importance of investing in youth, not just regarding them as a burden to society but as a resource for development. Only when the youth are well served can the future of any nation be fully guaranteed (Manto, 2009 - 2014 :3).

3.4.3 The New Partnership for Africas Development (NEPAD)

In a global economy worth over $ 30 trillion, it is clear that the necessary resources and the know-how to reach every child are well within our grasp," Carol Belemy told a gathering in Stockholm in 2012.

The New Partnership for Africa's Development (NEPAD), an African Union strategic framework for pan-African socio-economic development, is both a vision and a policy framework for Africa in the twenty-first century. NEPAD is a radically new intervention, spearheaded by African leaders, to address critical challenges facing the continent: poverty, development and Africa's marginalisation internationally.

The New Partnership for Africa's Development is a pledge made by African leaders, based upon a common vision and a firm and shared conviction. The leaders have a pressing duty to eradicate poverty and to place their countries individually and collectively on a path of sustainable growth and development; and at the same time to participate actively in the world economy and the body politic. The programme is anchored on the determination of Africans to extricate themselves and the continent from the malaise and underdevelopment and exclusion in a globalising world (Abrahams and Matthews, 2011: 31).

NEPAD is a mandated initiative of the African Union as well as being a framework process within the African Union. This adoption of NEPAD is considered as one of the most important developments of recent times for its conception of a development programme placing Africa at the apex of the global agenda, by:

- creating an instrument for advancing a people-centred sustainable development in Africa based on democratic values;
- being premised on recognition that Africa has an abundance of natural resources and people who have the capacity to be agents for change and so hold the key to her own development; and
- providing the common African platform from which to engage the rest of the international community in a dynamic partnership that holds real prospects for creating a better life for all.

The primary objective of NEPAD is to eradicate poverty in Africa and to place African countries both individually and collectively on a path of sustainable growth and development thus halting the marginalisation of Africa in the globalisation process. At the core of the NEPAD process is its African ownership, which must be retained and strongly promoted, so as to meet the legitimate aspirations of the African peoples. While the principle of partnership with the rest of the world is equally vital to this process, such partnership must be based on mutual respect, dignity, shared responsibility and mutual accountability. The expected outcomes are:

- economic growth and development and increased employment;
- reduction in poverty and inequality;
- diversification of productive activities;
- enhanced international competitiveness and increased exports; and
- increased African integration.

“The good and great thing about NEPAD is that it actually says. “Here we are, and we’re standing on our own two feet as Africans. We are prepared to engage the world on the terms of the world.” (Lund, 2008:1). Hence African leaders will take joint responsibility for a range of issues that will aid development on the continent of which the following will have a direct bearing on children:.

- Strengthening mechanisms for conflict prevention, management and resolution at the regional and continental levels, and to ensure that these mechanisms are used to restore and maintain peace.
- Promoting and protecting democracy and human rights in their respective countries and regions, by developing clear standards of accountability, transparency and participatory governance at national and sub national levels.
- Restoring and maintaining macroeconomic stability, especially by developing appropriate institutional frameworks to achieve these standards.

- Revitalising and extending the provisions of education, technical training and health services, with high priority given to tackling HIV/AIDS, malaria and other communicable diseases.
- Promoting the role of women in social and economic development by reinforcing their capacity in the domains of education and training;
- By the development of revenue-generating activities through facilitating access to credit and by assuring their participation in the political and economic life of African countries.
- Building the capacity of the states in Africa to set up and enforce the legal framework as well as maintain law and order.

In conclusion the MDG's and NEPAD share common values with human rights instruments and their value lies in that they set time frames for the realisation of those rights. When NEPAD was drawn up in 2001, African leaders incorporated the MDG's into the plan. As such African youth leaders identified conflict, HIV and AIDS, poverty and corruption as the main obstacles for Africa in achieving progress. Thus given the challenges facing youth and children in Africa, it will be imperative that strategies and programmes devised to achieve the afore-mentioned goals, take into consideration the needs of children and youth (Abrahams and Matthews, 2011: 32).

3.5 DOMESTIC LEGISLATION

An historical perspective of the child rights movement in South Africa provides an important contextual background for understanding the evolution of child rights in the country and therefore domestic legislation concerning the rights of children in South Africa. Notions of childhood and child rearing manifested itself amidst a myriad of value systems, norms, cultural and religious beliefs within the population of South Africa. Significant events that shaped the outcomes of children's rights in South Africa will be now be described.

"Every generation of children, in fact, offers mankind the possibility of rebuilding his ruin of a world" (Mulley, 2009: 47). During the apartheid era in South Africa children's rights were grossly violated and as such, large numbers of children were arrested, imprisoned and held in custody for participating in political activities (Skelton, 1999:3). Between the mid 1970's and early 1990's, Non-Governmental Organisations (NGO's) and Community based Organisations (CBO's) have played a significant role in the growth of child rights activism in South Africa , the focus of which was largely concentrated on children in an Apartheid context.

In the 1980's and 1992, international and national conferences in and around South Africa focused upon the impact of apartheid on the lives of children, women and families in South Africa. In 1987, a Radda Barnen –sponsored conference entitled "Children, Repression and the Law in apartheid South Africa" was held in Harare, Zimbabwe. The conference served as an important event for the international mobilisation on the issue of the worsening plight of children in the country. In 1987 in Harare Radda Barnen sponsored a conference in conjunction with other international conferences and efforts provided an opportunity and challenge to the African National Congress (ANC), in exile, and the Mass Democratic Movement, to advocate strongly for the protection, survival and development of children's rights in South Africa. Publications in the 1980's such as UNICEF's " children on the frontline: the impact of apartheid, destabilisation and the welfare of children in South and Southern Africa, significantly motivated organisations to lobby and campaign more for children's rights in South Africa. In April 1990 following a number of mass democratic movement initiatives, NGO's from South Africa and United Nations Children's Fund (UNICEF), the National Committee on the Rights of the Child (NCRC) was formed in Botswana. The NCRC was an umbrella body of more than two hundred NGO's and CBO's working with children in South Africa.

The NCRC became the first national organisation in South Africa to promote the rights of children, recognising in collaboration with UNICEF, the need for a situational analysis of women and children in order to determine their needs.

During 1991 and 1992, the time of the Convention for the Democratic South Africa (CODESA) negotiations, the NCRC addressed the major political national parties in the country on the need for the Government of national unity to prioritise the rights of children. The NCRC highlighted the fact that during the transition period, the situation of children had not been prioritised. Subsequently, children submitted the South African Children's Charter to participants at CODESA. The South African Children's Charter was based upon a document drawn up by those children who participated in the May 1992 children's summit organised by Molo Songololo of the NCRC social mobilisation effort. The summit comprised children from different backgrounds from across the country that discussed and debated the problems they faced as children.

In June 1992, an international conference on children's rights was held in Cape Town where the Charter was presented again. This conference highlighted the huge inequalities that existed between racial groups in South Africa because of the application of the apartheid Laws. Participants at the conference argued that children's rights were only achievable through the ending of the apartheid system of government, the election of a democratic government and the drawing up of a new constitution for the country. “The NCRC played a critical role in seeing children’s rights entrenched in the constitution of South Africa” (Knutson, 1998:32). The Interim constitution, which was adopted in 1993, made provisions for the inclusion of the protection of children’s rights. The result of this is section 28 of the Constitution, which refers specifically to children‘s civil and socio-economic rights. This section of the constitution gives children the right to a name, citizenship, care and protection, in addition to all other rights safeguarded in the Bill of Rights.

“Children and Women in South Africa: a situational analysis” was a significant piece of work, highlighting the plight of children and women in terms of education and health, nutrition, violence and abuse. One of the objectives of the situatinal analysis was to provide a baseline data on the situation of children in South Africa. This analysis found that there were major data constraints which, included the under-enumeration in the national statistics of the black population, especially of those residing in the independent home lands. The methods of collecting, reporting and classification of data resulted in under-reporting and poor quality of data especially with regard to vital statistics; and national policies had an effect on the reliability of the data.

The NCRC and UNICEF used the launch of the publication to call for the National Programme of Action for children (NPA) which was based on the Agendas for Action of 1990, Declaration and Plan of Action of the World Summit of Children and on the Convention on the Rights of the Child. The launch of this NCRC /UNICEF report was followed by a 2-day conference held in Thembisa entitled “The State of the African Child: an Agenda for Action”. The Thembisa Declaration was adopted on the 19th June 1993. The NCRC and UNICEF were mandated to oversee and follow up on the recommendations from the Thembisa Declaration the goal being for the establishment of a National Forum for children as well as a National Action Plan (NPA) for children. “When the lives and the rights of children are at stake, there must be no silent witnesses” (UN, 2011: 11).

The development of children’s rights in South Africa took a huge leap forward in 1993 when former presidents of South Africa, F.W de Klerk, and Nelson Mandela jointly signed the 1990 Declaration and Plan of Action of the World Summit for Children and the United Nations Convention of the Rights of the Child (CRC). In Sweden guided by its Thembisa mandate, the NCRC began to work on the outline of the national programme for Action for Children of South Africa. In February 1994, a conference was held to discuss the NPA outline. The outcome of this conference was that recommendations were made as to the way forward regarding the establishment of a NPA; particularly regarding the structure and the processes required and the consultative mechanisms and technical resources that would be required and that a NPA task team was assembled and made responsible for preparing the NPA outline for the presentation to the South Africa Government in June 1994.

The NPA (National Plan of Action for Children) was developed after the ratification of the United Nations Convention on the Rights of the Child. The NPA sought to ensure that the South African Government's policies were child-friendly. On the 16th June 1994 the President Mandela was presented with an outline of the NPA. At this time he promised not only to put children first, but also that the newly elected government would prioritise children's rights at the highest level.

The former president established the inter-ministerial cabinet committee's and steering committee's consisting of Director Generals from the Department of Health, Justice, Education, Welfare, Water Affairs and Forestry, the NCRC and UNICEF. Other structures which later came on board included the national Youth Commission, the South African Human Rights Commission representatives from the nine provinces the Department of Finance and Foreign Affairs and the Office of the President. They were tasked with developing and ensuring the implementation of the NPA framework: "...in serving the best interests of children, we serve the best interests of all humanity" (Bellamy, 2011: 5).

At another level, the Reconstruction and Development Programme (RDP), headed by Jay Naidoo, focussed on promoting growth and addressing the poverty and the inequalities of apartheid. A Childrens rights officer was seconded from the NCRC to work at the RDP office in order to ensure that children's issues were part of the RDP.

Hence the Government of National Unity afforded recognition to children's rights within the framework of the Reconstruction and Development Programme. "South Africa faces an enormous task in building a caring society. It is a national task that calls for the mobilisation of the whole nation into a united people's action, into a partnership with Government for progressive change and a better life for all, for a common effort to build a winning nation" (Thabo Mbeki President, Republic of South Africa 2000).

The RDP commissioned the National Institute of Economic Policy (NIEP) to undertake a second situational analysis of children in South Africa. The report provided a comprehensive description of children and poverty in terms of the effects of apartheid, access to health services, education, housing, water, food security and land. It also highlighted the lack of empirical data pertaining to children's issues and argued that a major constraint was the lack of reliable, representative national and provincial data on children especially data on black African children in South Africa (NIEP 1996:10). The report also concluded that without reliable and representative data, the development of specific service delivery programmes was problematic (NIEP, 1996: 10).

In 1998 the NPA co-ordination was moved from the Department of Health to the Office of the Deputy President. This relocation of the NPA was seen as a necessary and significant step towards the mainstreaming of children's rights and issues into the work of the government departments (Abrahams and Matthews, 2011: 16). The mainstreaming approach calls for each Government Department to prioritise children's issues in its budget, work-plan and programmes.

In 1999 following the second of the democratic elections, the Children's Desk was relocated to the Office of the President and was then known as the Office on the Rights of the Child (ORC). The ORC was tasked with working with stakeholders and NGO's to improve children's well-being and to promote the rights of children in South Africa. The ORC worked closely with the National Programme of Action steering committee. In addition it also played an advisory role, by advising the President and his office on the situation and needs of children in the country.

In 2009 the office on the Rights of the Child was relocated to a new department called the Department of Women, Children and Persons with Disabilities. The purpose of the programme dealing with the promotion of Children's rights is to ensure the realisation of children's rights and responsibilities by:

- providing, leadership and support for planning, coordination, oversight and comprehensive reporting in the National children's Rights and Responsibilities Programme;
- developing and maintaining a children's rights and responsibilities mentoring and evaluation framework;
- developing and managing catalytic projects for children's rights and responsibilities;
- facilitating public and private partnerships in the interests of children; and
- participating in sectoral coordination and national children's rights forums (Abrahams and Matthews, 2011: 17).

"Children's rights have found their expression in law and policy reform" (Abrahams and Matthews, 2011: 17). In South Africa post -1994, with a surge of new laws in South Africa and old laws being repealed, this transformation is in keeping with international trends. A key legislative development in which the child's rights movement has been "vociferous" with the initiation of the Children's Act and the Child Justice Act. Civil society lobbied Parliament at length during the associated law reform process; but the implementation of legislation still remains a challenge for Government. In this regard, Parliament has a particular role to play in terms of its oversight and accountability function.

“Children are the future of our country and essentially rely on adults to nurture and take care of them” (Yaqub, 2009: 2). As a result, the South African Constitution, as the supreme or highest law in the country, insures that children, as citizens of the country, enjoy all the same rights as their fellow adult citizens; however, those that are under the age of 18 are afforded special rights. Most government departments have special programmes that endeavour to protect and maintain the rights of children, either directly or indirectly, in order to comply with the Constitution.

Through this principle of mainstreaming South African government departments incorporate children’s issues into the respective policies, priorities, outcomes and delivery agreements. The government calls upon each department to reflect its commitment to South African children with corresponding strategic plans, operational plans, policy, budgetary allocations, monitoring and evaluation systems (DWCPD, 2012-2017: 11). Mainstreaming requires a re-conceptualisation on how children’s issues are addressed and operationalised by government. By and large children are often thought of as only the concern of the welfare, education and /or health sector, however, all government departments have an important responsibility towards the promotion, protection and fulfilment of children’s rights.

Many government departments focus on the service they are delivering and not on the ones to whom they are delivering the service. If the citizen on the receiving end is to be considered then it is clear that children are part of the process of service delivery, for they require and should receive services from every single government department in South Africa. This approach is the foundation of the NPAC 2012-2017 and it is essential to ensure its sustainability, coherent implimentation and effective monitoring of children’s rights in South Africa. For example, the Department of Transport is responsible for roads within the country. In order for a child to get to school or hopsital she or he requires the use of the road within the country. So as one considers the roads being used so too should be considered the method of transport being used on that road. Is public transport available for the child to use? Is the public transport affordable for that child to use? Thinking about service delivery in this way clearly illustrates that children are served and affected by this department. Every government department has a responsibility to children, and must reflect that responsibility in the delivery of their services, and through a concrete budgetary commitment (DWCPD, 2012-2017: 11).

Children living in South Africa have been afforded outstanding constitutional, legislative and institutional provisions for their survival, development, protection and participation. As a result there is growing evidence that progressive gains are being made in their everyday lives. This fact has been affirmed through the recent consultation processes that were conducted countrywide in preparation for South Africas periodic reports that are due in to the United Nations Committee on the Rights of the Child (UNCRC) and the African Union Expert Committee on the Rights and Welfare of Children (ACRWC).

The national consultations here also indicated that there remain enormous challenges and that extensive dedicated work here is still required to ensure that all South African children have a healthy start, in order to achieve their potential; protected from all forms of harm and grow up in family environments that assist them. So the emphasis is on their every day. wellbeing and happiness.

The consultative process of the afore-mentioned reports included a two-phased process. During the first , February to June 2012, government departments responded to the specific questions in the formal guidelines provided by the United Nations and the African Union. The questions in the guidelines are formatted in such a way that governments must respond directly to the questions in relation to the progress made since the previous report. Accordingly government departments were requested to report on the following areas:

- General measures of implementation
- Definition of a child
- General Principles relating to the rights of the child
- Civil rights and freedoms
- Family environment
- Basic health and welfare
- Education, Sport, Leisure and cultural activities
- Special Protection measures in the State of Emergency; conflict groups.

In addition the ACRWC requires special focus on the following areas:

- Responsibilities of the Child- Article 31 For example children's duty towards their families, community and country
- Harmful social and cultural practices, Article 21 (child marriage)
- Children of imprisoned mothers Article 30
- Children who need special protection on account of being in risky or vulnerable conditions (children in street/orphaned and vulnerable).

The Department of Women, Children and People with Disabilities (DWCPD) collated the reports from government departments and other relevant government documentations into one discussion document which formed the basis for the second phase of the consultation and which involved interactions and consultations with governement departments and civil society organisations in the nine provinces of South Africa. .

The provincial consultations were hosted during July to September 2012 by the offices of the Premiers or the offices that are responsible for coordinating the children's sector in the respective provinces. Provincial government departments, municipalities and non-governmental organisations all participated in the consultative processes. The views of the children were heard during the National Children's Parliament. The Nelson Mandela Children's parliament is an annual event in partnersahip with the Nelson Mandela Children's Fund and a host province

During October and November 2012, the DWCPD presented the report to the National Government departments and the following government clusters: International, cooperation Goverrnance and Administration, Social Cluster,Justice, Crime and Security.

Cabinet approved the release of the report to Parliament and the general public on the 5 th December 2012 and Parliament was to consider the report and provide feedback to the Minister of Women, Children and People with Disabilities by 31st March 2013. The significance of this report cannot be underestimated as it is the only report submitted to the UN since 2002. This report is significant as it quantifies the impact interventions have made regarding the realisation of the rights of children living in South Africa.

With relevance to article 20, with regard to " Children deprived of a family environment" and therefore directly relevant to this research study, the report by DWCPD from 1998 to June 2012 reads as follows:

- In line with the guidelines for the alternnative care of children annexed to General Assembly resolution 64/142 of 18 December 2009, South Africa has developed comprehensive child welfare and protection policies which include provisions for a range of alternative care options, for emergency, short term and long term care. Alternative care options in South Africa include adoption, foster care, child and youth care centres and temporary safe care.
- Placement in alternative care which is done via a children's court, must include a documented permanency plan which takes into account the child's age and developmental needs and is aimed at achieving stability in the child's life. An order placing a child in alternative care lapses two years after the date on which it was made or any shorter period specified in the order. A children's court can extend an order for

a maximum period of two years at a time depending on the individual circumstances of each child.

- Recognising, that early placement in family-based or family-like care is particularly important for very young children, the act requires that for any very young child who has been orphaned or abandoned adoption must be made available for in the prescribed manner and within a prescribed period except when this is not in the best interests of the child.
- In line with the Guidelines for the alternative care of children annexed to the General Assembly Resolution 64/142 of 18 December 2009, SA has established a regulatory framework for the admission of a child to an alternative care setting, the registration and management of alternative care institutions and the training of individuals involved in the provision of alternative care. All child and youth care centres must be registered with the provincial DSD and must be managed in accordance with the criteria of the Children's Act (2005), including compliance with a quality assurance process involving internal and independent assessors. Minimum qualification requirements have also been prescribed for child and youth care workers.

- The DSD is currently conducting an audit of all unregistered child and youth care centres nationally in order to assist them in complying with the prescribed norms and standards and enabling them to become registered. It is also in the process of improving its data management systems to strengthen their database of all facilities working with children.
- In response to the last country report, the Committee expressed its concern (concluding observation 25) about an insufficient number of alternative care facilities in previously disadvantaged communities. In the 2011/12 financial year, there were 355 alternative care facilities (253 children's homes, 42 places of temporary safe care and 60 shelters for street children) in SA accommodating 21 047 children, while bed capacity in those facilities was 24 495. While this suggests that current capacity is able to meet the demand for residential care, it is not clear to what extent the necessary capacity is available in areas of greatest need. Close to half of children (45%) are admitted to registered child and youth care centres because of abandonment or neglect.
- In line with concluding observation 25, SA has instituted training for social and welfare workers on alternative care. Ongoing capacity building is being undertaken in all provinces.
- In an effort to accommodate more children in family-like environments as closely aligned as possible to the child's ethnic, religious, cultural and linguistic background,

the Children's Act (2005) expands provision for foster care. It defines three types of foster care placements: (1) with a person who is not a family member of the child (traditional foster care), (2) with a family member who is not the parent or guardian of the child (related foster care) and (3) in a registered cluster foster-care scheme (a house-mother with a maximum of six children). Foster parents are entitled to financial support in the form of the Foster Child Grant.

- The number of children receiving the Foster Child Grant in South Africa has increased dramatically in the period under review from just over 215,000 in 2004, to 510,298 in 2010. The value of the foster grant has also increased over this period, from R530 per child per month in 2004 to R740 per month in 2011.
- The rapid increase in foster care placements has unfortunately created an enormous administrative burden on social workers and courts, resulting in large backlogs and lapsed foster care orders. In 2011, there were about 84 000 reported cases of foster care waiting to be finalized and between April 2009 and March 2011, over 110,000 foster care orders lapsed resulting in the loss of the grant to these foster parents. The provincial consultations highlighted this as a key concern amongst participants. A recent court judgment on this matter called for a comprehensive legal solution to be found to prevent qualifying families from losing their grants and to address the underlying problems by the end of 2014. In the meantime there is a moratorium on future lapsing and the court called for the reinstatement of all foster care grants and foster care orders that have lapsed since April 2009. Significant efforts have been made to address these backlogs successfully through national and provincial foster care project plans. Activities include the establishment of provincial task teams, the allocation of dedicated staff and the provision of capital resources, staff training, regular feedback meetings and intersectoral collaboration.
- Many foster care placements are with relatives who are caring for children who have been orphaned. The High Court recently ruled that any caregiver with a legal duty of support in relation to the child is no longer eligible for the foster child grant. The implications of this ruling for relatives fostering children are unclear.
- Within South Africa, no child should be without the support and protection of a legal guardian or other recognized responsible adult or competent public body at any time. The High Court is the upper guardian of all minors in South Africa. On the death of one parent, the surviving parent becomes the sole guardian. In all other instances, a guardian is only appointed by will or by the High Court.
- In the case of unaccompanied or separated foreign children, Section 28 of the Constitution places a duty on the State to protect and provide for these children in the

same way as any other child. No unaccompanied foreign children can be deported without first being the subject of a Children's Court enquiry (DWCPD and UNCRC, 2012a: 44)

- "A country which doesn't protect the development of its children has no future" (Ramodibe, 2012: 2). Every government department has a significant role to play as duty bearers of children's rights to ensure that the quality of the lives of children within the country is improved. "Notwithstanding, in terms of the work undertaken by the Executive to deliver the rendering of services that would benefit more children, more still needs to be done" (Ramodibe, 2012: 2). Children as rights holders are entitled to live decent lives. Policies have been developed to foster the well-being of children and they must be visible. For them to become visible a holistic integrated approach is required.

The South African Government has made progressive advancements in its protection of children through its law. It has ratified the CRC and the ACRWC. It has also made provision for children's rights in its national constitution. The South Africa government has recently put into operation the Children's Act, the Criminal Law (Sexual Offences and Related matters) Amendment Act and the Child Justice Act (Skelton, 2012: 7). In this section of this chapter the researcher will present the following legislation with regard to the actualisation of children's rights in South Africa, The South African Constitution; Sexual Offences and Related matters Act (No 32 of 2007); Children's Act (No 38 of 2005) as amended by Children's Amendment Act (No 41 of 2007); Child Justice Act (75 of 2008); Social Assistance Amendment Act (No 5 of 2010) and the South African Schools Act (No 84 of 1996).

1987 - Radda Barnen sponsored a conference "Children, Repression and the law in apartheid South Africa" held in Harare, Zimbabwe.

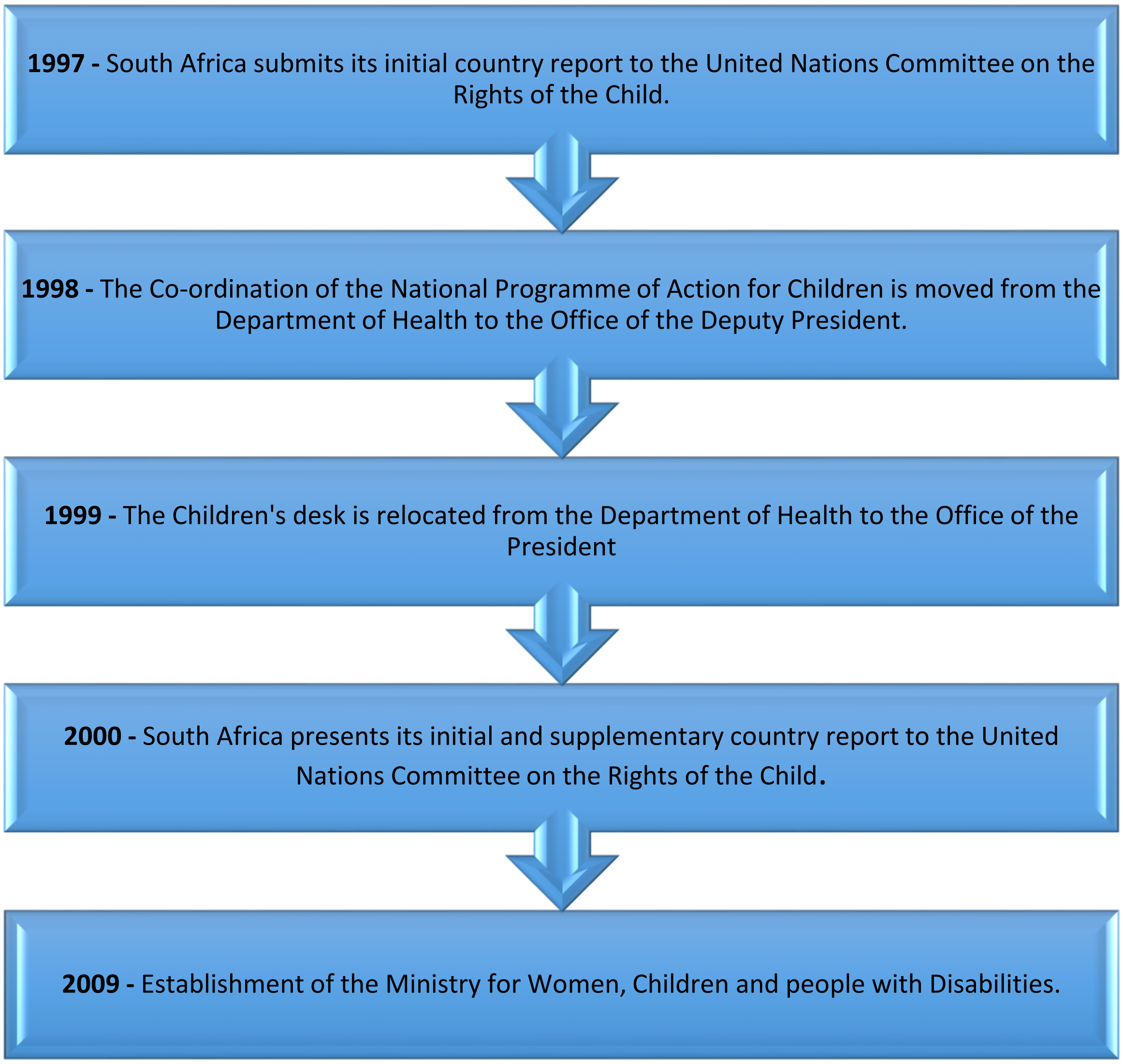
1990 - National Committee on the Rights of the Child (NCRC) is formed in Botswana, following a number of meetings between members of the Mass Democratic Movement, NGO's from South Africa and UNICEF.

1992 - Children's summit is organised by Molo Songololo,and Children's Charter adopted. International Conference on Child Rights held in Cape Town.

1993 - Interim Constitution adopted and provisions made for the inclusion of the protection of children's right's in the country NCRC (National Children's Right’s Committee)and UNICEF launches the publication " Children and Women in South Africa : A Situational Analysis." F.W. de Klerk and Nelson Mandela jointly sign the 1990 declaration and Plan of Action of the World Summit for Children and the Convention on the Rights of the Child.

1994 - President Mandela is presented with an outline of the National Programme of Action for Children at Orlando Stadium in Soweto by National Programme of Action Task Team.

1996 - Cabinet approves the formation of the National Programme of Action for Children. " Children, Poverty and Disparity Reduction: Towards fulfilling the Rights of South Africa’s Children published by the National Institute for Economic Policy/Reconstruction and Development programme



1997 - South Africa submits its initial country report to the United Nations Committee on the Rights of the Child.

1998 - The Co-ordination of the National Programme of Action for Children is moved from the Department of Health to the Office of the Deputy President.

1999 - The Children's desk is relocated from the Department of Health to the Office of the President

2000 - South Africa presents its initial and supplementary country report to the United Nations Committee on the Rights of the Child**.**

2009 - Establishment of the Ministry for Women, Children and people with Disabilities.

Figure 3.4: Representation of the history of the progression of children's rights in South Africa (Hall et al., 2012b: 12).

3.5.1 South African Constitution (ACT 108 OF 1996)

"We, the people of South Africa, recognise the injustices of our past; honour those who suffered for justice and freedom in our land; respect those who have worked to build and develop our country; and believe that South Africa belongs to all who live in it, united in our diversity." From the preamble to the constitution of South Africa; (RSA, 1996: 1).

The constitution is a law agreed upon by the people's representatives which set's out how the state will be constituted and run, the rights and responsibilities as citizens and the creation of particular institutions to support and safeguard the democracy.

South Africa has enshrined children’s rights in the constitution (Act 108 of 1996), the supreme law of the country. That was designed to respect, protect and promote and fulfil the rights of all people in the country, the commitment resonates strongly with international principles. In doing so governments have an obligation to protect and promote the survival, development and well-being of children, which ultimately affects their quality of life.

National, Provincial and local spheres of government must take responsibility for promoting the rights of and addressing the needs of children. Section 28 of the Bill of Rights in the South African Constitution provides that every child has the right to basic nutrition, shelter, basic healthcare services and social services and to be protected from maltreatment, neglect abuse or degradation (see Appendix O). “Taking up this call the government of South Africa must take up the call to guarantee a better life for the children of South Africa” (Mabe, 2011: 3).

"South Africa is a country in which one can expect the unexpected. An inspiration for all. What made it possible was the determination of the people of South Africa to work together to transform bitter experiences into the binding glue of a rainbow nation" (UN Secretary General Kofi Annan 2012).

The South African Constitution contains a number of socio-economic rights that only apply to children. In terms of section 28 (1) (c) every child in South Africa has the right to basic nutrition, shelter, basic health-care services and social services. These rights are free of internal limitations in terms of progressive realisation. Socio-economic rights applicable to everyone have internal limitations because the Constitution requires that the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of these rights. No such limitation applies, to the socio-economic rights of children. In addition, the constitution makes provision for children to be protected from abuse, neglect and degradation. The constitution also ensures that no child should work when under age, or do work that would interfere with his or her education or development. Children should be jailed only as last resort and should be protected during all times of conflict. The sub-section, a very important clause, says that a child’s interests are the most important consideration in any matter concerning the child.

As prescribed in international law, the State has a duty to respect, protect, promote and fulfil all the rights in the Bill of Rights. The constitution adds the duty to promote these rights, which is absent from international law.

Section 28 of the South African constitution provides for what could be termed “Children’s Human Rights,” aimed to provide special protection for children in recognition of their vulnerability. While the provisions in section 28 assure one of the commitment of South Africa to provide the best for children, realising children’s rights does not end there and requires intentional, professional steps to make these rights a reality. The application of international law as an imperative tool within the South Africa legal system is provided for in section 39 (1) (b) of the South African Constitution, which provides that courts must consider international law when interpreting the Bill of Rights. Section 233 of the Constitution further provides that, in interpretation of the legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with the international law over any alternative that is inconsistent with International law (Lerato, 2010: 175).

3.5.2 CHILDREN’S ACT 2005

“We must give meaning to the rights of children enshrined in our constitution and create a society that is fair and just. We invite all sectors of society to work together to implement proposals in the National Plan of Action for Children in South Africa 2012-1017” (Hall et al., 2012b: 10).

The Children’s Act came into full effect on the 1st April 2010 (Jameson et al., 2012: 14). It provides for a comprehensive range of social services for children and their families and introduces a new developmental approach to South Africa’s child care and protection system; “however, some of the challenges have arisen because the policy choice made in the law are not reasonably conceptualised to deliver the service to the target group, or the policy choice was not clearly made by the legislature , which has left the law open to multiple interpratations”. (Jameson et al., 2012: 14). The preamble of the Childrens Act No. 38 of 2005 reads: “To give effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children;” to define parental responsibilities and rights; to make further provision regarding children’s courts; to provide for the issuing of contribution orders; to make new provision for the adoption of children; to provide for inter-country adoption; to give effect to the Hague Convention on Inter-country Adoption; to prohibit child abduction and to give effect to the Hague Convention on International Child Abduction; to provide for surrogate motherhood; to define and make illegal certain new offences relating to children; and to provide for matters connected therewith.

Whereas the Constitution “seeks to establishes a society based on democratic values, social justice and fundamental human rights and seeks to improve the quality of life of all citizens and to free the potential of each person; and whereas every child has the rights set out in section 28 of the Constitution;" and "whereas the State must respect, protect, promote and fulfil those rights; and whereas protection of children's rights leads to a corresponding improvement in the lives of other sections of the community because it is neither desirable nor possible to protect children's rights in isolation from their families and communities; and whereas the United Nations has in the Universal Declaration of Human Rights proclaimed that children are entitled to special care and assistance; and whereas the need to extend particular care to the child has been stated in the Geneva Declaration on the Rights of the Child, in the United Nations Declaration on the Rights of the Child, in the Convention on the Rights of the Child and in the African Charter on the Rights and Welfare of the Child and recognised in the Universal Declaration of Human Rights and in the statutes and relevant instruments of specialised agencies and international organisations concerned with the welfare of children; and whereas it is necessary to effect changes to existing laws relating to children in order to afford them the necessary protection and assistance so that they can fully assume their responsibilities within the community as well as that the child, for the full and harmonious development of his or her personality, should grow up in a family environment and in an atmosphere of happiness, love and understanding" (Hall, 2012: 12). What is apparent is that the constitution of South Africa holds in its core the intention of the South Africa Government recarding the health and welfare of its nations children.

The objectives of the Children's Act are to:

(a) promote the preservation and strengthening of families
(b) give effect to the constitutional rights of children, namely,
  - Family care or parental care or appropriate alternative care when removed from the family environment,
  - Social Services,
  - Keeping the best interests of the child paramount in every matter concerning the child;

(c) give effect to the South African Republic's obligations concerning the well- being of children in terms of international instruments binding on the Republic;
(d) give effect to the Republics obligations concerning the well- being of children in terms of international instruments binding on the Republic of South Africa;
(e) make provisions for structures, services and means for promoting and monitoring the sound physical, psychological, intellectual, emotional and social development of children;

(f) strengthen and develop community structures which can assist in providing care and protection for children;
(g) protect children from discrimination, exploitation and any other physical emotional or moral harm or hazards;
(h) provide care and protection to children who are in need of care and protection; and
(i) recognise the special needs that children with disabilities have and generally to promote the protection, development and wellbeing of children.

The Implementation of the Act implies:

(1) That it should be implemented by organs of state in the national, provincial and where applicable, the local spheres of government subject to any specific section of this Act and regulations allocating roles and responsibilities, in an integrated, coordinated and uniform manner and that,
(2) recognising that competing social and economic needs exist, organs of state in the national, provincial and where applicable, local spheres of government must, in the implementation of this Act, take reasonable measures to the maximum extent of their available resources to achieve the realisation of the objectives of this Act.

3.5.3 Social Assistance Amendment Act, No 5 of 2010

The constitution of South Africa, section 27 (1) (c) says that everyone has the right to have access to social security , including, that if they are unable to support themselves and their dependents, appropriate social assistance must be provided".

The UN Convention on the rights of the Child (article 27) states that every child has the right "to a standard of living adequate for his or her development" and obliges the state "in the case of need" to "provide material assistance". Article 26 guarantees "every child the right to benefit from social security".

Section 26 of the Constitution of South Africa provided that "everyone has the right to have access to adequate housing". And section 28 (1) (c) gives children the right to shelter" (Hall, 2012: 101). "Every child has the right to a standard of living adequate to for his/her development" and obliges the state "in case of need" to "provide material assistance and support programmes, particular with regard to housing" (Hall, 2012: 98).

Section 27 (1) (b) of the constitution of South Africa provides that everyone has the right to have access to sufficient water" and section 24(a) states that " everyone has the right to an environment that is not harmful to their health or wellbeing" (Hall, 2012: 101). Article 14 (2) (c) of the African Charter on the Rights and Welfare of the Child obliges the state to ensure the provision of safe drinking water" (Hall, 2012:101).

Article 24(1) (c) of the UN Convention on the Rights of the Child says that state parties should " recognise the right of the child to the enjoyment of the highest attainable standard of health..." and to this end should take appropriate measures to combat disease and malnutrition including the provision of clean drinking water" (Hall, 2012: 101).

The state parties are obligated by law to provide for the rendering of social assistance to persons; to provide for the Mechanism forth in rendering of such assistance; to provide for the establishment of an inspectorate for social assistance; and to provide for matters connected.

The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), provides that everyone has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance; and obliges the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and since the effective provision of social assistance requires uniform norms and standards, standardised delivery mechanisms and a national policy for the efficient, economic and effective use of the limited resources available for social assistance and for the promotion of equal access to government services; are essential. Therefore, in order to prevent the proliferation of laws, policies and approaches to the execution thereof from materially prejudicing the beneficiaries or recipients of social assistance as well as the economic interests of provinces or the Republic as a whole or from impeding the implementation of a national social assistance economic policy; and in order to assist in securing the well-being of the people of the Republic and to provide effective, transparent, accountable and coherent government in respect of social assistance for the Republic as a whole. In this manner a basic standard of living would be provided for all persons living in republic of South Africa.

Objectives of Social Assistance Act

- Provide for the administration of social assistance and payment of social support grants
- Make provision for social assistance and to determine the qualification for social support grants

- Ensure that minimum norms and standards are prescribed for the delivery of social assistance
- Provide for the establishment of an inspectorate for social assistance.

Provision of social grants

The Minister must, with the concurrence of the Minister of Finance, out of moneys appropriated by Parliament for that purpose, make available:

- Child support grant
- Dependency grant
- Foster child grant
- Disability grant
- An older person’s grant
- A war veteran’s grant and
- A grant-in-aid.

Child support grant

A person is eligible for a child support grant if he or she is the primary caregiver of that child.

Care dependency grant.

- A person is eligible for a care dependency grant if he or she is a parent, primary care giver or foster parent of a child who requires and receives permanent care or support services due to his or her physical or mental disability.
- A person contemplated in paragraph *(a)* is not eligible for such a grant if the child
- is cared for on a 24-hour basis for a period exceeding six months in an institution that is
- Funded by the State.

Foster child grant

A foster parent is eligible for a foster child grant for a child for as long as that child needs such care if

- the foster child is in need of care; and
- he or she satisfies the requirements of the Child Care Act, 1983 (Act No. 74 of 1983).

Disability grant

A person is, subject to section 5, eligible for a disability grant, if he or she

- has attained the prescribed age; and
- is; owing to a physical or mental disability, unfit to obtain by virtue of any
- service, employment or profession the means needed to enable him or her to
- provide for his or her maintenance.

Older persons grant

A person is, subject to section 5, eligible for an older person's grant if

- in the case of a woman, she has attained the age of 60 years; and
- in the case of a man, he has attained the age of 65 years.

War veteran grant

A person is, subject to section 5, eligible for a war veteran grant if he or she

- has attained the age of 60 years; or
- owing to a physical or mental disability, is unable to provide for his or her maintenance, and- has performed any naval, military or air force service during the Great War of 1914-1918 as a member of any Union or British Force, or was a member of the protesting burgher forces during the period September1914 to February 1915; performed any naval, military or air force service during the war which commenced on 6 September 1939 as a member of the Union Defence Forces or, in the case of a Union national, as a member of any British or Dominion Force or any force of a government which was allied to the Government of the Union during that war; while he or she was not a Union national, performed any naval, military or *air* force service during the war referred to in sub -paragraphs (i), (ii) or (iv) as a member of any British or Dominion Force and who is a South African citizen on the date on which he or she applies for a war veteran's pension; or while he or she was a member of the Union Defence Force signed an undertaking to serve in connection with the hostilities in Korea and who during such hostilities performed any naval, military or air force service on or after the date on which he or she had been detailed for duty in connection therewith.

Grant in aid

A person is, subject to section 5, eligible for a grant-in-aid if, that person is in such a physical or mental condition that he or she requires regular attendance by another Person.

Social relief of distress

The Minister may provide social relief of distress to a person who qualifies for such relief as may be prescribed.

South Africa has very high rates of child poverty. In 2010, 60% of children lived below the poverty line of R575 per month. The following represents numerically the numbers of children in the Eastern Cape receiving CDG, FCG and CSG:

- In **2005 1,078,442** children in the Eastern Cape were in receipt of a CSG. **In 2012** that number had **risen to 1, 860,405.**
- In **2005 53, 383** children in the Eastern Cape were in receipt of a FCG. In **2012** that number had **risen to 124, 291.**
- In **2005 19,925** children in the Eastern Cape were in receipt of a CDG. In **2012** that number **fell to 18,267** (Hall et al., 2012a: 91).

3.5.4 Child Justice Act (NO 75 OF 2008)

The purpose of this act is to establish a criminal justice system for children who are in conflict with the law and accused of committing offences, in accordance with the values underpinned in the constitution and the international obligations of the republic to provide for the minimum age of the criminal capacity outside of the criminal justice system; to make special provision for securing attendance in court and the release or detention and placement of children; to provide for the holding of a preliminary inquiry and to incorporate, as a central feature, the possibility of diverting matters away from the formal criminal justice system in appropriate circumstances; to make provision for child justice courts to hear all of the trials of children whose matters are not diverted; to extend the sentencing options available in respect of children who have been convicted; to entrench the notion of restorative justice in the criminal justice system in respect of children who are in conflict with the law.

The constitution of the Republic of South Africa ,1996, as the supreme law of the republic, was adopted to establish a society based upon democratic values, social and economic justice, equality and fundamental human rights and to improve the quality of life of all of its people and to free the potential of every person by all means possible. The constitution whilst envisioning the limitation of fundamental rights in certain circumstances, emphasises the best interests of children and singles them out for special protection, affording children in conflict with the law special safeguards, among others the right :

- not to be detained, except as a measure of last resort, and if detained, only for the shortest possible appropriate time;
- to be treated in a manner and kept in conditions that take account of the child’s age;

- To be kept separately from adults, and to separate boys from girls while in detention
- to family parental and appropriate care;
- to be protected from maltreatment, neglect, abuse or degradation and not to be subjected to practices that could endanger the child's wellbeing, education, physical or mental health or spiritual , moral or social development.

The current statutory law does not effectively approach the plight of children in conflict with the law in a comprehensive and integrated manner that takes into account their vulnerability and special needs and should acknowledge that there are capacity, resource and other constraints on the state which may require a pragmatic and incremental strategy to implement the new criminal justice system for children.

The objectives of the act are therefore as follows, to:

- promote the rights of children as provided for in the constitution;
- promote the spirit of Ubuntu in the child justice system through
  a) fostering children's sense of dignity and worth;
  b) reinforcing children's respect for human rights and the fundamental freedoms of others by holding children accountable for their actions and safe-guarding the interests of victims and the community; and
  c) supporting reconciliation by means of a restorative justice response: and involving parents, families, victims and where appropriate other members of the community affected by the crime in procedures in terms of the Act in order to encourage the reintegration of children.
  d) Provide for the special treatment of children in a child justice system designed to break the cycle of crime, which will contribute to safer communities and encourage these children to be law-abiding and productive adults,
  e) Prevent children from being exposed to the adverse effects of the formal criminal justice system by using where appropriate, processes and procedures and mechanisms and services or options more suitable to the needs of children in accordance with the constitution, including the use of diversion and
  f) Promote cooperation between government departments and the nongovernmental sector and civil society, to ensure an integrated and holistic approach to the implementation of this act.

3.5.2 CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT NO 32 OF 2007)

No judicial officer sitting in South Africa today is unaware of the extent of sexual violence in the country and the way in which it deprives so many women and children of their right to dignity and bodily integrity and, in the case of children, the right to be children; to grow up in innocence and, as they grow older, to awaken to the maturity and joy of full humanity. “The rights to dignity and bodily integrity are fundamental to our humanity and should be respected for that reason alone” (Jameson et al., 2012 :17).

Whereas the Bill of Rights in the Constitution of the Republic of South Africa,1996, enshrines the rights of all people in the Republic of South Africa, including the right to equality, the right to privacy, the right to dignity, the right to freedom and security of the person, which incorporates the right to be free from all forms of violence from either public or private sources, and the rights of children and other vulnerable persons to have their best interests considered to be of paramount importance.

There are, several international legal instruments, including the United Nations Convention on the Elimination of all Forms of Discrimination Against Women, 1979, and the United Nations Convention on the Rights of the Child, 1989, which place obligations on the Republic towards the combating and, ultimately, eradicating of abuse and violence against women and children. The South African government further, recognises these international instruments within its domestic legislation.

The pre amble of the Sexual offences and related matters amendment act reads as follows: “Whereas the commission of sexual offences in the Republic is of grave concern, as it has a particularly disadvantageous impact on vulnerable persons, the society as a whole and the economy; Whereas women and children, being particularly vulnerable, are more likely to become victims of sexual offences, including participating in adult prostitution and sexual exploitation of children; Whereas the prevalence of the commission of sexual offences in our society is primarily a social phenomenon, which is reflective of deep-seated, systemic dysfunctionality in our society, and that legal mechanisms to address this social phenomenon are limited and are reactive in nature, but nonetheless necessary; Whereas the South African common law and statutory law do not deal adequately, effectively and in a non-discriminatory manner with many aspects relating to or associated with the commission of sexual offences, and a uniform and co-ordinated approach to the implementation of and service delivery in terms of the laws relating to sexual offences is not consistently evident in Government; and thereby which, in too many instances, fails to provide adequate and effective protection to the victims of sexual offences thereby exacerbating their plight through secondary victimisation and traumatisation” (RSA, No 32 of 2007 2).

Objects of the Criminal Law (Sexual Offences and Related matters) Amendment Act.

The objects of this Act are to afford complainants of sexual offences the maximum and least traumatising protection that the law can provide, to introduce measures which seek to enable the relevant organs of state to give full effect to the provisions of this Act and to combat and, ultimately, eradicate the relatively high incidence of sexual offences committed in the Republic by:

- enacting all matters relating to sexual offences in a single statute;
- criminalising all forms of sexual abuse or exploitation;
- repealing certain common law sexual offences and replacing them with new
- and, in some instances, expanded or extended statutory sexual offences, irrespective of gender;
- protecting complainants of sexual offences and their families from secondary victimisation and trauma by establishing a co-operative response between all government departments involved in implementing an effective, responsive and sensitive criminal justice system relating to sexual offences; and
- promoting the spirit of *Batho Pele (“the people first”)* in respect of service delivery in the criminal justice system dealing with sexual offences by—
    - (i) ensuring more effective and efficient investigation and prosecution of perpetrators of sexual offences by clearly defining existing offences, and creating new offences;
    - (ii) giving proper recognition to the needs of victims of sexual offences through timorous, effective and non-discriminatory investigation and prosecution
    - (iii) facilitating a uniform and co-ordinated approach by relevant government departments in dealing with sexual offences;
    - (iv) entrenching accountability of government officials; and
    - (v) minimising disparities in the provision of services to victims of sexual offences;

- providing certain services to victims of sexual offences, including affording
- victims of sexual offences the right to receive Post Exposure Prophylaxis in certain circumstances; and

- establishing a National Register for Sex Offenders in order to establish arecord of persons who are or have been convicted of, sexual offences against children and persons who are mentally disabled so as to prohibit such persons from being employed in a manner that places them in a position to work with or have access to, or authority or supervision over, or care, of children or persons who are mentally disabled.

The Criminal Law (Sexual Offences and Related matters) Amendment Act defines and categorises sexual offences and details prosecution procedures. The Act recognises that children and adolescents are vulnerable to the psychological influence of adults. The Act tries to protect them from the abuse and exploitation by creating ages of consent to sexual activity. It is unlawful to perform a sexual; act on a child younger than 16 years. The Act is commonly known as the Sexual Offences Act (Jameson et al., 2012: 16).

Criminalising teenage sex potentially violates a number of children's rights enshrined in the Constitution and international law, namely, the best interests principle, which is the right to bodily and psychological integrity and the right to privacy.

3.5.5 South African Schools Act 1996 (ACT NO.84 OF 1996)

Section 29(1) (a) of the South African Constitution states that everyone has the right to a basic education; and section 29(1) (b) says that "everyone has the right to further education", and that the state must make such education progressively available and accessible".

Article 11(3) (a) of the African Charter on the Rights and Welfare of Children says state parties to the present Charter shall take all appropriate measures with the view to achieving the full realisation of this right and shall in particular... provide free and compulsory basic education".

Article 28 of the UN Convention on the rights of the child recognises "the right of the child to education" and also obligates the state to "make primary education compulsory and available and free to all".

Whereas as a result of the painful legacy of apartheid South Africa has suffered an uneven development and the disparities continue to be reflected in the provisioning of infrastructure for schools; and whereas the state continues to provide infrastructure, water, sanitation and electricity to the major schools that were previously disadvantaged and all schools built after the dawn of democracy have exceeded the minimum norms and standards; and whereas there are strides that have been made in creating conditions conducive to learning and teaching, and it is important to continue to progressively and within available resources, realise a safe and caring environment for learners; and whereas the state developed and continues to develop and continues to implement plans to eradicate unsafe and unsuitable school infrastructure; and whereas it should be appreciated that within the context of the needs, the Department of Basic Education and the Provincial Education Departments must develop plans for the long-term and the short-term to progressively implement these regulations and within available resources; (RSA, 1996 No 84: 1).

Objectives of Act:

- The objectives of the Act are to provide for:
  a) the determination of national education policy by the Minister in accordance with certain principles;
  b) the consultations to be undertaken prior to the determination of policy,
  c) and the establishment of certain bodies for the purpose of consultation;
  d) the publication and implementation of national education policy; and
  e) the monitoring and evaluation of education.

Laws are not static; they are living documents that evolve after Parliament passes them. The natural cycle of law ensures that ambiguities in laws are clarified and that laws continue to be relevant and practical to implement. When law is not clear it becomes open to multiple interpretations as has happened with the Children’s Act. Sometimes the original law contains errors or omissions that need to be corrected, as was the case with the Sexual Offences Act. Changes to the laws by interpretation or amendment should help improve services for children (Hall et al., 2012b: 19). Many of the key 2011/2012 legislative developments affecting children came about as a result of civil society calling on the courts to interpret various laws. The above-mentioned legislation has direct relevance to children living as orphans in South Africa and amongst all the domestic legislation within South Africa is the key legislation regarding the actualisation of children’s rights in South Africa.

3.6 LEGISLATIVE CHANGES IN 2011/2012 RELATING TO THE ACTUALISATION OF CHILDREN’S RIGHTS IN SOUTH AFRICA

3.6.1 Children’s Act

Equality is both a founding value of the South African Constitution and a fundamental right. As a founding value, along with human dignity and freedom, equality must underpin how courts, tribunals or forums interpret the Bill of Rights. As a fundamental right, equality requires that everyone is equal before the law and has the right to equal protection and benefit of the law and that no-one is unfairly discriminated against on the grounds of race, gender, age or disability. Despite the centrality of equality in the constitution, inequality persists. Children in particular experience multiple overlapping layers of inequality and they are dependent upon adult care and supervision for their safety and wellbeing (Jameson et al., 2012: 14).

Some challenges have arisen because the policy choice made in the law is not reasonably conceptualised to deliver the service to the target group, or the policy choice was not clearly made by the legislature, which has left the law open to multiple interpretations. This is the case with the mechanisms designed to provide social services and grants to orphaned children living with family members. In one place the Act says that they cannot be placed in foster care and in another it says that they can. Being placed in foster care determines whether or not a caregiver can apply for the foster care grant (FCG). The ambivalence of the Act has led different government departments and magistrates to interpret and apply the Act differently, resulting in unequal treatment of children and unconstitutional delays in access to both grants and services. One way of ensuring clarity is to approach the high court to interpret the Act.

In *Centre for Child Law v Minister of Social Development* and others the Centre for Child Law (CCL) and the government worked together on a court-ordered statement. This resulted in the reinstatement of a large number of foster care grants that had lapsed due to court orders not being extended in time. The Children's Act requires most foster care orders to be renewed and extended by the courts every two years whilst the Social Assistance Act requires the South African Social Security Agency (SASSA) to stop a grant payment if the extended court order is not submitted to SASSA in time. Social workers and magistrates courts are not able to extend children's foster care orders timeously because of the large number of children in the foster care system. As a result over 113000 lost their FCGs between 1 April 2009 and 31 March 2011. This constitutes a serious violation of these children's constitutional rights to social assistance, nutrition, social services, healthcare services and education (Jameson et al., 2012: 14).

The settlement order between the CCL and the government allowed SASSA to reinstate the lapsed grants despite the expired court orders. As a result approximately 80,000 lapsed grants were reinstated between 1 Jan and 30 Nov 2011. The settlement order also extended to the expired court orders to May 2013, however, the settlement applies only to foster care orders granted between 1 April 2009 and 1 April 2010. Orders granted after this date, the majority of which expire in 2012, all have to go back to the court to be extended. Taking into account the temporary nature of the settlement and its application only to some foster care orders, the parties agreed in the settlement that the minister of Social Development must design and implement a comprehensive solution to address the foster care crisis by Dec 2014 (Jameson et al., 2012: 14).

Whilst approximately 80,000 lapsed grants were reinstated between Jan and Nov 2011, only 20,000 new FCG applications were added to the system over the same period. The settlement applies only to foster care orders granted between the 1st April 2009 and 1st April 2010. Orders granted after this date, the majority of which expire in 2012, all have to go back to court to be extended. This shows that, while the settlement addressed the problems of lapsed FCG's the backlog in new FCG applications was added to the same system over the same period. This shows that, while the settlement addressed the problems of lapsed FCG's, the backlog in new FCG applications for the estimated 1.1 million orphans in need of social assistance is getting worse (Jameson et al., 2012: 15).

A second court case on foster care, SS vs The Presiding Officer of the Children's Court, District Krugersdorp and others, was heard in the South Gauteng High Court in April 2012 and involved an appeal against a Children's Court ruling that a 10-year old orphaned child (identified only as SS) could not be placed in foster care with his great aunt and uncle. As a result they could not be foster parents and therefore could not get the FCG for the child. The family were receiving the lower valued Child Support Grant (R280 per child per month in April 2012); but wanted to apply for their higher FCG (R770 per month per child in April 2012), due to the poverty faced by the family.

To access the FCG they had to approach the Children's Court to have child SS declared a child "in need of care and protection in section 150 (1) (a) of the Children's Act requires a child to be orphaned "without visible means of support". before the court can find the child to "be in need of care and protection". The court found child SS was already in the care of his extended family and had been for the past 8 years. He thus had "visible means of support" and did not qualify as a child "in need of care and protection". The Children's Court therefore ruled that he could not be placed in foster care, meaning the family could not apply for the FCG.

Currently there are approximately 1.1 million orphaned children living with extended family in situations of poverty. Some children's courts are interpreting section 150(1)(a) in a way that allows orphaned children living in extended families to be placed in foster care, while others are interpreting it in the opposite way, or in variations between the two extremes. This results in unequal treatment, with approximately 600,000 of these children getting the Child Support Grant (CSG), others getting the FCG (approximately 400,000) and a similar number receiving neither grant. "The large numbers of families applying for the foster care to access the higher grant amount is also putting strain on social workers and also on courts. This has unfortunately resulted in lengthy delays for children receiving their grants as well as delays and inadequate services for abused and neglected children who require support and intervention from the same social workers and courts (Jameson et al., 2012: 15).

In the judgement in the case involving child SS, the high court distinguished between orphaned children who had an enforceable claim for support against relatives bearing a common law duty of support and those who did not have a common law of duty. Child SS was living with his great aunt and uncle who did not have a common law duty to support him; therefore the court upheld the appeal and ruled that SS could be placed in foster care with them. If they had been an adult sibling or grandparent the final result could have been that they did have a common law duty to support; however, it is important to highlight the following: that when making decisions on Foster Care children’s Courts should be guided by the spirit and the purpose of the Children’s Act particularly the “best interests” of the child principle.

A comprehensive solution to the foster care crisis for the many orphans living in extended family requires the government to choose the most effective rights-based mechanism to provide an appropriate and adequate social grant, as well as a mechanism to link these families to prevention, early intervention and protection services where needed. The Department of Social Development has finalised and commissioned a study, with a costing on this social assistance question and is in the process of reviewing the Children’s Act towards amendments; however, this reform needs to be fast-tracked if the department is to make the deadline for a comprehensive solution to be placed by December 2014. The judgement in the case of child SS also heightens the urgency for an alternative solution as it potentially creates an inequitable situation because orphans living with aunts and uncles qualify for a FCG while those living with grandparents and adult siblings will generally have to rely on the lower CSG.

In December 2012, the Department of Social Development announced an intention to create a kinship grant that family members caring for orphans would be able to access directly from SASSA as a top-up to the CSG. This will ensure that orphans living with extended family can access an adequate grant timeously and it will improve the services for abused children because it will reduce the load on social workers and the courts. “At the time of this publication the department has not as yet announced the time frames for the reform” (Jamieson et al, 2012: 16).

3.6.2 Criminal Law (Sexual Offences and Related Matters) Amendment Act

“Criminalising teenage sex potentially violates a number of children’s rights enshrined in the Constitution and international law, namely, the best interests principle, the right to bodily and psychological integrity and the right to privacy.”

The Criminal Law (Sexual Offences and Related Matters) Amendment Act defines and categorises sexual offences, and details prosecution procedures. The Act recognises that children and adolescents are vulnerable to the psychological influence of adults. It tries to protect them from abuse and exploitation by creating ages of consent to sexual activity, it is unlawful to perform a sexual act on a child younger than 16 years. The Act is commonly known as the Sexual Offences Act. There are key aspects of this act which have direct bearing upon children’s rights in South Africa.The Act makes consensual sexual penetration between children aged between 12 to 16 years a crime. Other consensual acts like kissing and caressing are also offences. This means that children between the ages of 12 to 16 years who engage in sexual activities with other children can be charged, arrested and prosecuted and sentenced. This is also ethically problematic for professionals providing support for these children, as the Act obliges anyone with knowledge of a sexual offence to report it to the police and failure to report constitutes a crime. Nurses working with young people find this requirement extremely challenging as reporting is in conflict with their obligation to respect the confidentiality of their patients and to realise children’s rights to health. In 2008, 38% of learners reported having sex. The Sexual Offences Act lists 29 sexual offences that have no specific penalty. In May 2012 the Western Cape High Court ruled (in an appeal from the magistrate’s court) that, in the absence of specific penalties, these offences do not constitute crimes and cannot be prosecuted. Thus the courts could not send someone to prison when he/she committed any of these serious crimes. Parliament however responded quickly by passing an Amendment Bill on the 7th June. The Amendment Act gives courts the power to use their discretion to apply a sentence where no penalty is specified in the Sexual Offences Act. This means sexual offenders can be convicted and sentenced in future.

On the 15th June the Supreme Court of Appeal ruled that the penalty provisions in section 276(1) of the Criminal Procedure Act empower courts to impose sentences upon people convicted of offences under the Sexual Offences Act, and the fact that the Act does not contain penalty provisions does not nullify charges laid or convictions secured under the Act. (Jameson et al., 2012: 17).

3.6.3 National Health Act

“ Children who have lost parents to AIDS are an extremely vulnerable group that need psycho-social support and health services; yet the provisions under the National Health Act will make it almost impossible to conduct research with orphans to determine their needs” (Jameson et al., 2012: 17).

Section 71 of the National Health Act came into force in April 2012. This Section specifies the requirements for therapeutic and non-therapeutic research on children. Therapeutic research aims to cure the disease or to ease the pain within the child. Such research or experimentation must be in the best interests of the child and with the expectation that the therapy will do more good than harm. The parent or guardian of the child must also give consent which is problematic for the approximate 5.5 million children who live with caregiver, i.e. grannies, aunts, uncles or an adult sibling who is not their parent or legal guardian. Non-therapeutic research or experimentation requires the consent of the Minister of Health in addition to the parent or child. Even when they cannot legally consent, children should be given information about any research or experimentation and the opportunity to express their views. The Department of Health guidelines recommended that a child’s refusal to participate in research must be respected; i.e. such refusal settles the matter (Jameson et al., 2012: 18).

3.6.4 Social Assistance Act

There are three social grants for children; the Child Support Grant (CSG), the Foster Care Grant (FCG) and the Care Dependency Grant (CDG). Originally these grants were only available to caregivers who were South African citizens or permanent residents, however, the Refugees Act states that a refugee enjoys full legal protection including the rights set out in chapter two of the South African Constitution. Following litigation the Minister of Social Development amended regulations to the Social Assistance Act in 2008 to grant refugees access to certain social grants including the FCG but not the CSG or the CDG. Civil society however continued to advocate for the full realisation of the right to social security for the children of refugees. Following a High Court application by lawyers for Human Rights, the Minister of Social Development issued a new amendment to the Social Assistance Act Regulations, in August 2011 and in March 2012 respectively, to allow refugees to claim CDG and CSG.

3.6.5 Traditional Courts Bill

“The Bill of Rights entrenches the principle that ‘a child’s best interests’ are of paramount importance in every matter concerning the child”. The Traditional Courts Bill states that the Bill of Rights must be observed and respected during the trial and in judgement and penalties. However, without an explicit reference to the ‘best interests’ principle there is danger that the presiding officers will not apply it” (Jameson et al., 2012: 19).

“The Traditional Courts Bill aims to align the traditional justice system with the constitution; but women’s and children’s advocacy groups have criticised it for opening up opportunities for the violation of woman’s and children’s rights. These include children’s rights to have their best interests considered of paramount importance in matters that affect the right to participate in matters that affect them; to legal representation; to be protected from child labour; and the right of child offenders to be treated in a manner consistent with the child’s sense of dignity and worth” (Jameson et al., 2012: 18).

Traditional courts have jurisdiction over a range of issues affecting children. They can, hear civil disputes but not cases involving the care and guardianship of children or the interpretation of wills; they can also hear a limited number of criminal matters in which children are victims or offenders (where grievous bodily harm has not been inflicted) and hear cases of theft, malicious damage to property and the act of unlawfully, intentionally and seriously impairing the dignity of another.

The bill also suggests that no-one, including children, can have legal representation during the traditional court proceedings. The traditional courts bill does also not set standards to ensure the protection of children during the court processes, especially when it comes to publicity, the protection of child witnesses and psycho-social support or counselling services for children who are witnesses, offenders and victims. The Child Justice Act makes provisions for children to be diverted from the criminal justice system towards restorative justice programmes. The traditional courts bill, however, provides for none of these safeguards for children accused of crimes, thereby creating a lower standard for children under the jurisdiction of these courts than for those tried under civil law.

The constitution makes it clear that, whilst everyone has the right to enjoy his or her culture, this right may not be exercised in a manner inconsistent with any provision of the Bill of Rights. This particular Bill therefore has to perform a delicate balancing act by providing forums for people to exercise their rights to practise and live within the preferred cultural norms but at the same time ensuring it does not violate children's rights to equity, dignity, justice, protection and participation.

3.7 NATIONAL PLAN OF ACTION FOR CHILDREN (NPAC 2012-2017)

The National plan of Action for Children (NPAC) is a comprehensive overarching plan that brings together the Government's obligations in the realisation of the rights of children in the Republic of South Africa. The Department of Women, Children and People with Disabilities mandate is to ensure the promotion, protection and fulfilment of the rights of children and has coordinated the development of this NPAC. The success of the NPAC is embedded in the commitment of all government departments at national, provincial and local levels to ensure that they meet their obligations and work together in its implementation. All departments, provinces and municipalities have a role to play in the realisation of children's rights, whether through their legislative frameworks, policies strategies or programmes.

The NPAC is seen by the Government of South Africa as an opportunity to enhance the status of children and to improve the quality of their lives.

Government departments have an obligation to deliver services to children in order to promote, protect and fulfil their rights. The advent of laws intended to promote and protect the rights of children require that policy-makers, service planners, administrators and all individuals involved in service delivery to children have a full understanding of the context of children's rights as well as the State's constitutional and international; obligations (DWCPD, 2012-2017 :92).

Local municipalities are the primary location where children find themselves and together with the provincial and national government, organisations in civil society and the community, create an environment that either directly or indirectly impacts on children. Local authorities have a key role to play to ensure that children's rights as embodied in the United Nations Convention on the Rights of the Child, the African Union Charter on the Rights and Welfare of the African Child and the principles of the South African Constitution are made a reality for children (DWCPD, 2012-2017: 91).

Local Municipalities make important decisions that impact on the lives of the people that live within the municipality boundaries and their planning and decision-making is critical to the welfare of children. Municipalities can inter alia, ensure that:

- children's rights are considered in all decisions that are taken;
- all relevant bylaws are reviewed against child rights principles,

- “the best interests of the child” is the central principle in all decisions and actions of the municipality;
- children and their families are consulted in a meaningful manner on all matters that affect them; and
- all local developments are assessed in terms of the impact that it will have on children (DWCPD, 2012-2017: 92).

The following table presents the lead government departments and the roles and responsibilities of these government departments to enable the actualisation of children’s rights to orphans and vulnerable children.

Table 3.1: Roles and Responsibilities of the lead government departments

Department	Roles and Responsibilities
Department of Social Development	• Facilitate the co-ordination of service delivery for fulfilment of the rights of orphans and other children made vulnerable by HIV and AIDS • Provide psychosocial support and material assistance to vulnerable children andtheir families • Mobilise communities to protect, care for and support children • Mobilise and distribute resources • Establish child-care forums at community level • Provide alternative care options • Establish and support poverty alleviation programmes • Registration of Non-profit Organisations (NPOs) • Establish and maintain partnership with key stakeholders • Establish and strengthen home community-based care and support programmes • Building capacity for families, caregivers, community members, volunteers and other service providers • Develop legislation, policies and programmes for the protection of orphans and vulnerable children (HIV) • Establish and strengthen early childhood development programmes that cater for the needs of orphans and other children made vulnerable by HIV and AIDS

	• Provide Social Assistance to vulnerable groups • Implement policy framework for the prevention and management of child abuse, neglect and exploitation
Departments	**Roles and responsibilities**
Department of Women, Children and People with Disabilities	• Facilitate the development of a national framework for the advancement and coordination of children’s rights delivery.(provincial and local frameworks as well) • Mainstream a child-centred approach to policy, planning, programming, strengthen communication and funding process in government • Facilitate mainstreaming capacity building for children’s rights focal points in government • Advocate for children’s rights delivery in government • Monitor and evaluate children’s rights delivery in Government. • Co-ordinate an integrated children’s rights policy implementation in government
Department of Health	• Identify the various roles of the supporting departments • Provide a comprehensive treatment, care and support programme for the management of HIV and AIDS • Provide a comprehensive Primary HealthCare Service Package • Implement Integrated Management of Childhood Illnesses (IMCI)protocol • Implement the Protein Energy Malnutrition Programme (PEM), which provides food supplement to children who are malnourished • Implement the Expanded Programme for Immunisation, which provides routine administration of vaccines against measles, TB, diphtheria, and influenza • Implement the Prevention of Mother-to-Child Transmission Programmes aimed at administration of anti-retroviral therapy

	to HIV infected mothers before, during and after labour and to the new-born baby • Monitor and evaluate health programmes to support children • Co-ordinate and facilitate access of all communities to all health services
Department of Basic Education	• Educate learners about HIV and AIDS to reduce stigma and discrimination • Develop mechanisms for school-based support systems • Provide academic support for orphans and other children made vulnerable by HIV and AIDS • Develop capacity-building programmes for educators to enable them to respond holistically to the needs of orphans and other children made vulnerable by HIV and AIDS • Provide education for all as a priority and key coordinating mechanisms for protecting orphans and other children made vulnerable by HIV and AIDS while promoting opportunities for these children • Develop and ensure that referral system to other relevant service-providers e.g. social workers, nurses are in place • Develop and implement appropriate life skills programmes for orphans and other-children made vulnerable by HIV and AIDS • Provide Primary School Nutrition Programme and Food fortification • Develop and implement early childhood development programmes
Department of Home Affairs	• Promote, facilitate and provide birth, death, marriage and identity documents • Provide mobile units in communities for registration purposes to ensure that services are more accessible to the community members

Department of Justice and Constitutional Development	• Ensure that the rights of orphans and other children made vulnerable by HIV and AIDS are protected through the judiciary system • Ensure that uniform interpretation and implementation of the Children's Act 38 of 2005 is based on the child's rights approach and the best interests of the child • Train commissioners on the integrated approach to effectively address the plight of orphans and other children made vulnerable by HIV and AIDS • Provide legal representation • Enforce parental responsibility through Maintenance Laws. • Protect the inheritance rights of orphans and other children made vulnerable by HIV and AIDS
Department of Agriculture	• Promote and facilitate food security amongst households for OVC • Provide grants for farming to the poor communities • Provide training to child-headed households and community members on food production. • Ensure sustainability through strengthening community co-operatives
Department of Human Settlements and Rural Development	• Ensure that the housing needs of households affected by HIV and AIDS are addressed through low-cost housing schemes • Support initiatives of other government departments
Department of Co-operative Governance and Traditional Affairs	• Provide infrastructure e.g. early childhood development centres, the provision of land, sport and recreation facilities etc • Support the initiatives of NGOs, CBOs, FBOs, civil society and traditional leaders • Provide free basic services to the poorest households (means tested)

Department of Public Works	- Provide and maintain infrastructure
Department of Correctional Services	- Protect the rights of orphans and other children made vulnerable by HIV and AIDS who are awaiting trial for crimes committed - Build the capacity of personnel regarding HIV and AIDS
Department of Trade and Industry	- Develop entrepreneurship skills of child headed households
Department of Labour	- Protect the rights of orphans and other children made vulnerable by HIV and AIDS through the enforcement of legislation related to children e.g. child labour - Develop skills of youth
Department of Justice and Constitutional Development	- Investigate crimes against children; - Improve prevention and awareness services relating to crimes against children - Refer children "in need of care" to the Department of Social Development to places of safety or, where possible, refer children "in conflict with the law" to secure care facilitie; - Ensure that children are detained as a measure of last resort and in conditions that are consistent with human dignity (adequate accommodation, nutrition, reading material and exercise- in accordance with section 35(2) of the Constitution of the Republic of South Africa, 1996(Act No. 108 of 1996) - Ensure that injured or sick children in the custody of the South African Police Service receive medical treatment, including hospitalization, where necessary
Department of Sports and Recreation	- Provide safe child-friendly recreational facilities within communities including disability-friendly facilities

Department of Transport	• Provide safe, affordable and adequate transport
Department of Water Affairs	• Provide safe water to households
Department of International Relations and cooperation	• Ensure good relations with other countries regarding issues of children and HIV and AIDS cooperation

3.8 CHAPTER SUMMARY

Fusing global children's rights imperatives, with appropriate local arrangements and understandings serves to imbue the whole of the children's rights framework with familiarity, relevance and legitimacy literally brings children's rights home (Kaime, 2009: 185). Human rights in general and children's rights in particular are gaining ground within African constitutions and legislation, with the introduction of children's rights into domestic legal systems (Kaime, 2009: 187).

The South African Constitution is hailed as one of the best in the world; but, this cannot be celebrated in isolation. Children's rights, as contained in the Constitution, were largely influenced by the provisions of the CRC. The ACRWC has also become an important instrument from which provisions with regard to specific issues relating to children in Africa can be drawn. Families, governments, NGO's, intergovernmental institutions and academics that are involved in work relating to the rights and welfare of children are all united in the achievement of one aim, that is, the protection of the dignity of each individual child. The efforts of these various partners are different due to the nature of their mandates and competencies. Similarly academics often find it more convenient to write about the rights of children; but there has to be actual engagement with the reality of children, particularly orphans and vulnerable children. In this manner there is a process of research in which deconstructing and reconstructing of concepts relating to children's rights must be undertaken. Proper assessment of the needs of children relating to children's rights can be secured if theoretical and desk research is complemented by the contributions from others such as professionals working with children or the children themselves to appraise the situation “on the ground” (Kaime, 2009: 180).

The purpose of the many rules regarding specific aspects of the child survival and development is not to ensure the presence of child-friendly laws on statute books or to enable delegations to present the state of their child law before important committees. Rather it is to ensure that the pre-conditions for children to achieve their dignity and realise their full potential are satisfied and they can continue to be met as they grow up as children. For children’s rights to be realised in practice there is a need to pull together the strengths of many constituencies starting with the children themselves, families, NGO’s, local authorities, national governments as well as intergovernmental agencies. In line with the Lomwe adage that “it takes a whole village to raise a child,” it requires the contribution of many stake holders to contribute to the actualisation of children’s rights (Kaime, 2009: 180).

The involvement of the various disciplines regarding the implementation of children’s rights ought not to be restricted to academia; but must be pursued at all levels of children’s rights work and by all manner of children’s rights workers, both within the spheres of international law, national law, multidisciplinary approaches and the children themselves. There is a need to engage with local knowledge, local agents and local organisations working with children. Unless children’s rights are brought into the homes of African children, they will remain paper rights with no significant contribution towards securing the dignity of African children (Kaime, 2009: 189).

CHAPTER FOUR

DISCUSSION OF RESULTS AND LITERATURE CONTROL

"Safety and security don't just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear. AIDS is a war against humanity. We have an obligation to provide proper care and support for these children. “Nelson Mandela, former President of South Africa;” reprinting by permission of the (Nelson Mandela Foundation in: The aWAKE Project, Uniting against the African AIDS Crisis, (Mandela, 2002: 78).

4.1 INTRODUCTION

The research design and method were described in detail in chapter two. Chapter four will present the analysis of the data collected by means of in-depth interviews. The results of reflective and field notes made by the researcher soon after completion of the interviews were added to the data. The results will be discussed in conjunction with the literature control which allows for the verification of the findings.

4.2 OPERATIONALISING FIELDWORK

Prior to data collection, the researcher obtained formal written permission to conduct this research study from the Faculty of Research, Technology and Innovation Committee at the Nelson Mandela Metropolitan University. Written permission was also obtained from the Department of Health, Epidemiological, Research and Surveillance Management Department which enabled the researcher to conduct the research in primary healthcare clinics which are managed by the Municipality in Nelson Mandela Bay. Permission was also obtained from the District Manager in the Province of the Eastern Cape Department of Health and from the Senior Manager in the Eastern Cape Department of Social Development. The managers of each selected clinic acted as “gatekeepers” for the primary healthcare practitioners in each PHC clinic; and the managers of the satellite offices where social workers and psychologists were based acted as the “gatekeepers” for the social workers and psychologists.

The researcher conducted two pilot, in-depth interviews, the first with a Primary healthcare practitioner in the PHC clinic’s and the second with a social worker based in a satellite office. Once the right of entry to the research sites was obtained from the afore-mentioned administrators. The researcher encountered no problems with the pilot study interviews which are therefore included in the data analysis.

Data collection is described by Creswell, (2007: 118) as a series of interrelated activities aimed at getting good information to answer emerging research questions. Data collection for this study was conducted from May to July 2012 and consisted of the steps suggested by Creswell (2007: 118) which are included in the figure 4.1:

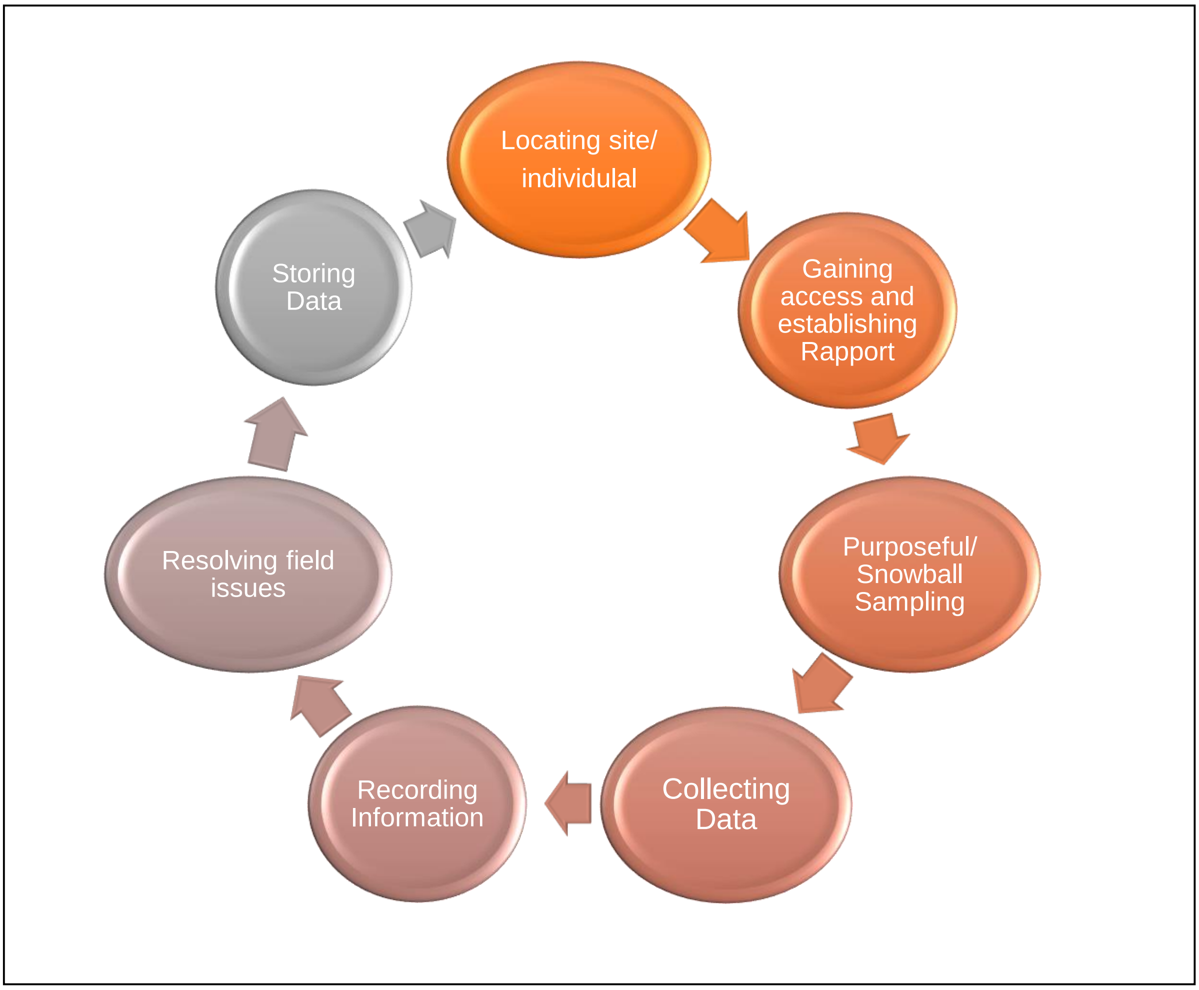


Figure 4.1: Data -collection activities (Creswell, 2007: 118).

Group One participants consisted of ten primary healthcare practitioners working in PHC clinics who care for and support children who are AIDS orphans living in the townships. The data collection process comprised in-depth interviews with each of the primary healthcare practitioners. The researcher depended on the "gatekeepers" at each clinic to arrange interviews with each primary healthcare practitioner, this caused least disruption to their daily work schedule as the managers organised the time of the interview convenient for the participant. The “gate keepers” in this instance were the managers who had responsibility for the primary healthcare practitioners working in the PHC clinics.

The inclusion criteria for the participants were:

- primary healthcare practitioners in primary healthcare clinics in Nelson Mandela Bay, who provide care and support to children orphaned by AIDS living in townships; had
- formal registration with SANC as a professional nurse, and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

The following main questions were used by the researcher for the in-depth interviews with the primary healthcare practitioners working in PHC clinics in the townships.

How do you experience providing care and support to children who are AIDS orphans living in the townships communities?

What recommendations would you like to make to improve the quality of care and support provided to children who are AIDS living in the townships?

The researcher was keen to hear their stories regarding how they coped with caring for and supporting such vulnerable and distressed children. The researcher had to adapt, using various interviewing techniques in this instance, such as establishing rapport and trust by demonstrating an interest in all that the participants were saying, encouraging responses without leading and suggesting answers and being as relaxed as possible (King and Horrocks, 2011: 48-55).

Group Two participants consisted of eight social workers and six psychologists based in satellite offices in the townships providing care and support to children who are AIDS orphans living in the townships communities. The manager of the social workers arranged interviews with the social workers for the researcher while, the researcher organised interviews with the psychologists by making appointments that would suit their schedules, using the phone or via e mail, with the knowledge of the satellite office manager. This sometimes meant meeting participants during their lunch breaks or towards the end of their working day.

The data-collection process for Group Two comprised in-depth interviews. The inclusion criteria for this group included: The researcher interviewed eight social workers and six psychologists for this research study. All social workers and psychologists were interviewed by the researcher in their satellite offices in the township communities in Nelson Mandela Bay;

where they are based to provide care and support to children who are AIDS orphans living in the township communities.

- Social workers and psychologists working in satellite offices in the Nelson Mandela Bay providing care and support to children living as AIDS orphans in townships.
- And be registered with their associated professional body, and
- had experience of providing care and support for a minimum of six months to children living as AIDS orphans in the townships

The following main questions were used for the in-depth interviews with social workers and psychologists.

How do you experience providing care and support to children who are AIDS orphans living in the townships communities?

What recommendations would you like to make to improve the quality of care and support provided to children who are AIDS orphans living in the townships?

From the main questions the interviewer was able to probe further as the interview progressed, in order to enable the participants to elaborate on their initial answers which has been previously described above. The researcher established that all of the participants in this research study were willing to be interviewed by her. The researcher was pleasantly surprised by the willingness of the participants to share their experiences openly and the openness of the participants enabled the researcher to collect data which was “rich, thick and full” (King and Horrocks, 2011: 55).

4.3 DATA ANALYSIS

Data analysis was conducted simultaneously with data collection. The voluminous amount of data was reduced to themes and sub–themes by implementing the Data Analysis Spiral (in Creswell (2007: 150-155). This process of data analysis is described in detail in Chapter Two. An independent coder assisted in the identification of themes occurring in the data obtained from the interviews, field notes and the reflective notes of the researcher. These themes were in direct alignment with the themes identified by the researcher which were then verified and agreed upon and consensus reached with the promoters.

The researcher carried out a content analysis of the data, or an analysis of the themes and patterns that had emerged from the narrative content (Polit and Beck, 2012: 505). Descriptive Qualitative studies are said to present in-depth summaries of a phenomenon and are considered to be a form of constructive paradigm, found in the post-modern movement and assumed relativist ontology (Denzin and Lincoln, 2003 35). In other words constructivism is a perspective that views knowledge as constructed by human beings and their respective environments and is considered subjective, always developing, changing and dependent on circumstances (Holloway, 2008a: 48).

Post-modern thinking emphasises the value of deconstruction, which denotes taking apart old ideas; and reconstruction which means putting together ideas and designs in new ways (Polit and Beck, 2012: 127). The post-modern movement was defined in part by a concern for literary and rhetorical tropes and the narrative turn, a concern for storytelling in new ways (Denzin and Lincoln, 2003 2). Adding to this Polit and Beck (2010: 12) write in a similar vein revealing the notion that "the voices and interpretations of study participants are crucial to understanding the phenomenon of interest, and subjective interactions are the primary way to access them". Therefore the findings from constructivist inquiry then are essentially considered to be the results of the communication between the researcher and the participants.

In this section of the study the researcher will present every theme and sub-theme, which will be substantiated by appropriate quotations from the raw data and compared and contrasted with the relevant literature and research. This is done to determine current knowledge regarding the experiences of children who are AIDS orphans living in the townships. According to Creswell (2007: 1102), the literature review assists the researcher to determine the source of the research problem and enables the research study to be positioned within the literature regarding the topic. The literature review in qualitative research should be used in a manner consistent with the methodological assumptions. Accordingly it was used inductively so that it did not direct questions asked by the researcher (Creswell, 2007: 102-103). One of the reasons for conducting a qualitative study was the desire to establish a new way of thinking regarding the care and support of children who are AIDS orphans living in the townships. The researcher also discovered that not much had been written on this topic regarding the care and support of children living as orphans in the township communities. The researcher therefore considered qualitative research to be crucial in order to enable her to build a picture based upon the participants' experiences regarding the care and support of children living as AIDS orphans in the townships, by health and social care practitioners in this instance, primary healthcare practitioners in PHC clinics, social workers and psychologists based in satellite offices responsible for providing care and support to these vulnerable children. The use of literature was used in moderation by the researcher in the beginning of this research study in order to present an inductive design.

4.4 DISCUSSION OF RESULTS

The discussion of the results will be presented in four sections coordinating with the four themes emerging from the data-analysis process. Health and social care practitioners' means: professional nurses working in primary healthcare clinics and social workers and psychologists based in satellite offices in the township communities. This discussion will be presented in the following four themes and related sub–themes, with the direct quotes from the participants' being written in blue.

Table 4.1: Themes and Sub-themes of the experiences of Health and Social Care Practitioners relating to the provision of care and support to children who are AIDS orphans living in the township communities.

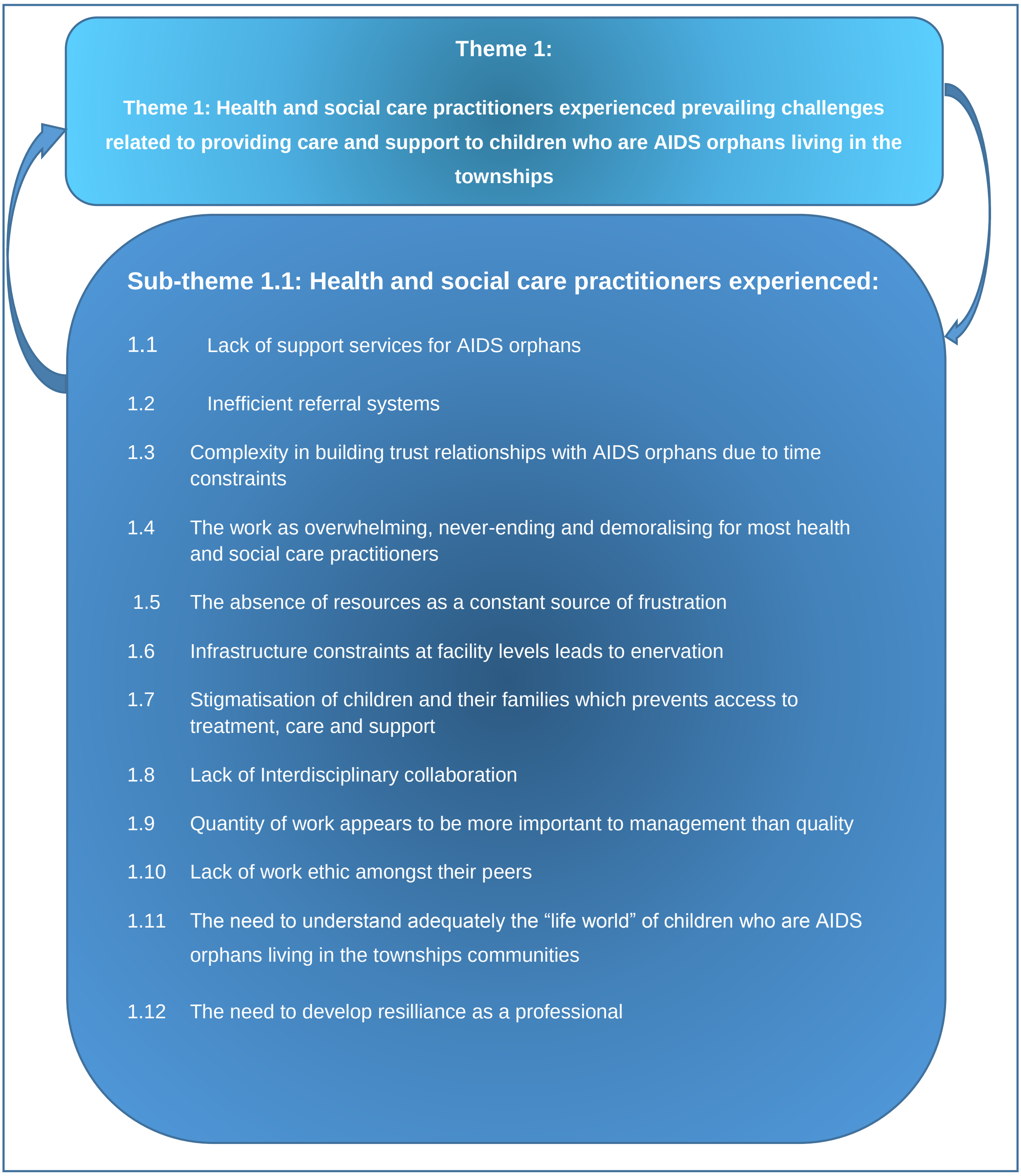
MAIN THEMES	SUB-THEMES AND CATEGORIES
Theme 1: Health and social care practitioners experienced prevailing challenges related to providing care and support to children who are AIDS orphans living in the townships	**Sub-theme 1: Health and social care practitioners experienced:** 1.1 Lack of support services for AIDS orphans 1.2 Inefficient referral systems 1.3 Complexity in building trust relationships with AIDS orphans due to time constraints 1.4 The work as overwhelming, never-ending and demoralising for most health and social care practitioners 1.5 The absence of resources as a constant source of frustration 1.6 Infrastructure constraints at facility levels leading to enervation 1.7 Stigmatisation of children and their families which prevents access to treatment, care and support 1.8 Lack of interdisciplinary collaboration 1.9 Quantity of work appears to be more important to management than quality 1.10 Lack of work ethic amongst their peers

	1.11 The need to understand adequately the “life world” of children who are AIDS orphans living in the township communities 1.12 The need to develop resilience as a professional
Theme 2: Health and social care practitioners had unique experiences related to providing care and support to children who are AIDS orphans living in township communities	**Sub-theme 2.1**: **Psychologists experienced:** 2.1.1 Children who are AIDS orphans as having complicated emotional needs 2.1.2 Developing trust in a therapeutic relationship as challenging 2.1.3 The extent of the suffering of the children as unbearable 2.1. 4 Lack of resources as hampering their ability to intervene effectively to provide care and support **Sub-theme 2.2: Primary health care practitioners experienced:** 2.2.1 Critical lack of associated health and social care practitioners, as obstructive to the provision of care and support to children who are AIDS orphans 2.2.2 Sadness at their inability to care optimally for vulnerable children 2.2.3 The emotional demands of working with AIDS orphans as distressing 2.2.4 Anger at the devastation that HIV/AIDS is wreaking on communities 2.2.5 Rage at the lack of intervention by healthcare systems to assist AIDS orphans 2.2.6 Inadequate management at local and provincial level **Sub-theme 2.3: Social Workers experienced:** 2.3.1 The barriers to accessing grant money for needy families as frustrating 2.3.2 Misuse of grant spending causing a lack of care and support to AIDS orphans

	2.3.3 Lack of resources as wearisome 2.3.4 Case loads as excessive allowing quantity but not quality of work 2.3.5 Challenges concerning the implementation of the Childrens Act 2.3.6 Discouragement at the lack of immediate care available for children in need 2.3.7 Sorrow at the enormity of suffering that they witness on a daily basis
Theme 3. Health and social care practitioners experienced certain short-falls related to "best practice" in the health and social care systems in which they worked	The health and social care practitioners experienced: 3.1 A lack of adequate education for the children and their caregivers regarding the antiretroviral medication 3.2 A lack of assistance by some health and social care practitioners related to helping AIDS orphans in their grief 3.3 The need for improved management concerning the provision of care and support to children who are AIDS orphans living in the townships
THEME 4: Health and social care practitioners experienced the need to improve the care and support for children who are AIDS orphans living in the township communities	Health and social care practitioners experienced the need: Sub-theme 4.1: For holistic strategies to provide care and support for children who are AIDS orphans living in the township communities Sub-theme 4.2: For support groups for children who are AIDS orphans living in the township communities Sub-theme 4.3: For improved interdisciplinary team collaboration Sub-Theme 4.4: Debriefing for all health and social care practitioners

4.4.1 Discussion of Theme 1 and related sub-themes to: Health and Social Care Practitioners Experienced Significant challenges related to providing care and support to children who are AIDS orphans living in the townships.

A diagrammatical representation of Theme 1 with related sub-themes presented in Figure 4.2 as follows:



Theme 1:

Theme 1: Health and social care practitioners experienced prevailing challenges related to providing care and support to children who are AIDS orphans living in the townships

Sub-theme 1.1: Health and social care practitioners experienced:

1.1 Lack of support services for AIDS orphans

1.2 Inefficient referral systems

1.3 Complexity in building trust relationships with AIDS orphans due to time constraints

1.4 The work as overwhelming, never-ending and demoralising for most health and social care practitioners

1.5 The absence of resources as a constant source of frustration

1.6 Infrastructure constraints at facility levels leads to enervation

1.7 Stigmatisation of children and their families which prevents access to treatment, care and support

1.8 Lack of Interdisciplinary collaboration

1.9 Quantity of work appears to be more important to management than quality

1.10 Lack of work ethic amongst their peers

1.11 The need to understand adequately the “life world” of children who are AIDS orphans living in the townships communities

1.12 The need to develop resilliance as a professional

Figure 4. 2: Health and Social Care Practitioners experienced prevailing challenges related to providing care and support to children who are AIDS orphans living in the townships.

THEME 1: HEALTH AND SOCIAL CARE PRACTITIONERS EXPERIENCED PREVAILING CHALLENGES RELATED TO PROVIDING CARE AND SUPPORT TO CHILDREN WHO ARE AIDS ORPHANS LIVING IN THE TOWNSHIPS.

“The fight against HIV/AIDS requires leadership from all parts of government-and it needs to go right to the top. AIDS is far more than a health crisis. It is a threat to development itself ” Kofi Annan (UNICEF, 2003: 1).

All the participants in this research study expressed the importance of their undertaking as health and social care practitioners in the provision of care and support to children who are AIDS orphans living in the townships communities; yet they were at times overwhelmed by the challenges. Some even referred to their profession as a “calling”. Many professionals regarded the health and social systems within which they worked as not conducive to the provision of holistic care and support to children who are AIDS orphans living in the township communities and this at times caused them to feel overwhelmed, burdened, stressed, angry, depressed and fatigued. Significance relates to something being important worthy of attention: a challenge pertains to a calling for the full use of one’s resources or abilities in a difficult but stimulating endeavour (Oxford English Dictionary, 2009: 998).

“I don’t consider what I do just as a job. It’s a calling. When I was six years old, I knew I wanted to be a social worker” [Interview 16, p.g1].

“Being a nurse is not a profession for me alone. It’s also a calling. I am a nurse because I felt “called” to be one” [Interview 11, pg. 2].

When children become AIDS orphans and are living in the township communities, every paradigm of their life alters. Health and social care practitioners explained to the researcher that they experienced staff shortages causing increased workloads, lack of resources, inefficient referral systems and were relentlessly presented with the overwhelming needs of the children who were AIDS orphans to whom they provided care and support. They found the needs of the AIDS orphans overwhelming as they listened and were unable to respond to their needs. Their conviction as professionals was to provide care and support and so alleviate suffering of AIDS orphans but they were unable to do so because of the significant challenges they faced.

There has been significant progress made in South Africa regarding the care and support of vulnerable children. The Combined Second, Third and Fourth Periodic State Party Report to the Committee on the Rights of the Child, (reporting Period 1998-June 2012) from the Government in South Africa recognised "that whilst significant progress has been made since 1998, to bring South Africa's legislative framework in line with international obligations, it also recognises areas requiring further attention, particularly in the area of policy implementation"(DWCPD and UNCRC, 2012a: 12) . The legislative framework is in place, the policies are in place; yet when children become AIDS orphans they become impoverished sick and largely uncared for and unsupported. Many health and social care practitioners used the word "destitute, discarded, abandoned, the bottom of the pile" when they described the children they met who were AIDS orphans living in the township communities. It's this "lived experience" of children living as AIDS orphans whom the health and social care practitioners interviewed in this research study experienced daily in their professional lives as they listened to and sought to provide care and support to children who are AIDS orphans living in the townships.

"I see children in this clinic every day who are destitute. They are hungry cold and not going to school. It's overwhelming to see these children every day because their lives are full of challenges. They tell me what's happening in their lives and all I hear is that no one cares for and supports them and they are poor" [Interview 8, pg. 5].

Most countries experiencing high HIV prevalence have weak and poorly resourced health systems, particularly in sub- Saharan Africa. When the USA President's Emergency Programme for AIDS relief (PEPFAR) was initiated in 2003, it was recognised that the physical and human infrastructures that were essential to achieving the HIV/AIDS programme's large-scale goals were deficient and that interventions were urgently required. The essence of these interventions can be summarised as training health and social care practitioners, providing incentives to encourage workers to stay, capacitating healthcare delivery systems and improving infrastructure and institutional capacity (Moore and Morrison, 2007: 1-2).

The DWCPD has initiated a process of drafting a revised National Plan of Action for Children (NPAC) (DWCPD, 2012-2017), which establishes a "mechanism that enhances coordination, collaboration and mainstreaming of children's rights by providing a holistic framework for the integrated programming, organisation and implementation of inter-sectoral programmes for the betterment of children in South Africa (DWCPD, 2012: 15). However, the implementation of these policies lies largely within the fabric of the Department of Health and the Department of Social Development. The intentions of these government departments has in essence two "world views" within which the provision of care and support is provided. The Department of

Health in the provision of primary care finds its roots in the Alma Ata conference of 30 years ago. The Declaration of the Alma Ata launched primary healthcare as the route to “health for all” (WHO, 2008a: xii). In South Africa the mode of “health for all has been incorporated into health policy in theory, in practice it has failed to address the HIV/AIDS pandemic” (WHO, 2008b: xii)

The World Health Report 2008 (WHO, 2008a: xii) affirmed that the health systems were not performing as well as they could. Adaptation and change within the health systems in order to reach the vision of “health for all” needs to occur to meet the ever changing health and social needs of populations, particularly in the presences of the HIV/AIDS pandemic. Service delivery reforms are necessary to ensure that primary health systems are socially relevant. Health and social policy needs to be formulated within the ever changing needs of the population to whom it is rendering health and social care and support. Within the department of Social Development there has been a move away from a welfare approach to a developmental approach, which is seen to encourage self-reliance and promote participation in decision-making at individual, family and community level (van Dyk, 2008: 13). The social workers who participated in this research study told the researcher that the welfare system was not relevant to the needs of children who were AIDS orphans living in townships and they found the system slow, cumbersome, difficult to access and there were not resources to meet the needs of AIDS orphans.

Most international organisations (such as UNICEF) argue that the care for orphans and vulnerable children should come from the family and community who are the first line of response to the epidemic according to the widely endorsed framework for the protection, care and support of AIDS orphans and vulnerable children living in a world of HIV and AIDS (van Dyk, 2008: 12). However, the safety net of the extended family has been severely eroded through poverty caused essentially through unemployment.

The researcher found, however, in the presence of the overwhelming needs presented to the health and social care practitioners by the children who were AIDS orphans living in the township communities and the constraints and ineffectiveness of the systems within which health and social care practitioners worked, that there was resilience and ingenuity as the health and social care practitioners embraced the challenge to provide care and support to children who were AIDS orphans living in the townships communities.

SUB-THEME 1.1: Health and social care practitioners experienced a lack of support services for AIDS orphans

The premature death of parents due to HIV/AIDS impacts on children left as orphans in a variety of ways. It certainly leads to significant changes in the household structure. The needs of children who become AIDS orphans in the township communities are many. The health and social care practitioners described to the researcher that these needs were essentially physical, emotional, psychological and financial. Health and social care practitioners conveyed to the researcher that, when children became AIDS orphans and were living in the township communities they experienced physical hardship due to poor nutrition leading to sickness, or sickness because the AIDS orphans were themselves HIV-positive. Children who become AIDS orphans further experience emotional and psychological trauma due to the loss of their parents, home, financial security, friends, health and the ensuing grief process as a result of these multiple losses and also financial hardship due to living with the extended family or the hardship of living in a child-headed-household without any means of “visible support” to provide for their most basic needs such as food, clothing and education. The health and social care practitioners told the researcher that there was a total lack of support services for children who were AIDS orphans living in the townships and that their physical, emotional, psychological and financial needs remained largely unmet because of a total lack of support services to provide care and support to these vulnerable children.

“The only thing I can do for these children when they come to the clinic is to give to them ART. This is not enough, they have many social, financial and psychological needs. Many of them can’t take their ART because they are hungry: when they say there is no food at home there is no food at home. They need to have a psychologist and a social worker to help them also. There are very few NGO’s who we can refer them to; we are very lacking in support services for orphans and vulnerable children; that is why our crime is so high in South Africa “[Interview 10, pg. 2]

“You know, when we are trained in South Africa to give holistic care: physical, emotional, spiritual, psychological and social support. But in the clinics we don’t have the resources to implement care and support in all of these aspects. These children are the bottom of the ladder, there is a total lack of support services for orphans and vulnerable children. They are hungry, malnourished, and sick and grief-stricken. We see this every day” [Interview 10, pg. 4].

For many children, the loss of parents is associated with destitution, reduced access to schooling and stigmatisation by family and members of the community. For instance, children who have lost their parents to HIV/ AIDS may be at greater risk of malnutrition, illness and early school termination (Skinner et al., 2013: 105). The discrimination often associated with HIV/AIDS may further deprive children who are orphans of basic social, health and education services, (Skinner et al., 2013: 109). There is evidence that children who are orphans may lose many basic material resources that the caregiver usually provides (Cluver and Gardner, 2007: 7). They may further experience deepening debt and loss of their few assets because of the loss of their breadwinner (Foster et al., 2005: 39). This situation can strain the traditional extended family and overwhelm already stretched health, social and education systems (Cluver and Gardner, 2007: 318). “Orphan status in children increases the risk of negative outcomes” (Skinner, et al. 2013: 112).

“Some of the children I see in the clinic for their ART, they don’t want it……. All they want is food to eat, they are tired of feeling weak and hungry “[Interview 10 p.g.3].

“The worst cases I see are grandmothers who are looking after their grandchildren who are orphans and who are not old enough for a pension. The only money is then a Child Support Grant (CSG). This is too desperate. I once saw a three-year-old child have a seizure because she hadn’t eaten for three days. All I could do was refer to a social worker and the NGO next door and give some porridge which is actually meant for our TB patients for her granny to take home to feed her grandchild” [Interview 5, pg. 3].

Kanana Township is part of the city council of Klerksdorp, a major gold mining are of the North West Province. In this township the following was discovered: Access to food in Kanana, was very limited 41% of all children received 1-2 meals per day and 51% of children were reported to go without food for one day a week. Investigations of the standardised residuals revealed that both paternal orphans and double orphans were significantly more likely to have limited access to food, with double orphans being most vulnerable with regard to meals per day and going without food for one day per week” (Skinner et al., 2013: 117).

The psychologists interviewed in this research study explained to the researcher that most of the children they saw who were AIDS orphans were grief-stricken and traumatised because of the loss of their parents to AIDS and the ensuing hardship of their everyday lives, living as AIDS orphans in the township communities. It’s as if their lives entered a cycle of loss and destitution they were unable to stop. Psychologists told the researcher that the hardship of the children’s lives was overwhelming as they sought just to stay alive. They told the researcher that children who were AIDS orphans living in the township faced extreme trauma and that the support services were simply not there to provide care and support to prevent this trauma and to enable them to begin to process the grief of losing their parents.

“As a psychologist based in the townships I see many children who are orphans. They are very vulnerable. I can listen to their grief of losing their parents but I can’t put windows in their homes, or give them seeds for a food garden or buy them school shoes or make sure that they have food on the table every day. There is a total lack of support services for children who become orphans living in the townships. We expect them to take their ART without food, we expect children who are AIDS orphans to overcome grief; yet they are constantly hungry, and increasingly vulnerable if they are not able to remain in school. I refer them to NGO’s in the township who can help them if they have resources to do so” [Interview 24, pg. 4].

“I see children who are grief-stricken and traumatised. They are grief-stricken because of losing their parents and traumatised because of the hardships they face living as AIDS orphan in the township communities. Quite simply their lives are full of suffering. They are bewildered because of the lack of care and support they receive when they become orphans and have to stand up in very cruel and harsh realities that actually kill a child’s soul. I can listen but it’s not enough. These children need food, clothing, physical safety and care. We don’t have the support services in place to provide what they need so they suffer. It’s a harsh reality living as an AIDS orphan in the township. Many times they tell me “No one cares about us”. Most of the children I see as a psychologist have post-traumatic symptoms of distress [Interview 13, pg. 6].

Cluver and Gardner (2007: 14) found that children who had become AIDS orphans were significantly more likely compared to other orphans to be depressed, have social problems and demonstrate post-traumatic stress symptoms. There are few support structures available in the township communities to help meet the needs of children who become orphans living in these communities. The vulnerability of children increases in all aspects of their lives when they become orphans living in the township communities.

The social workers who contributed to this research study were largely overwhelmed because of the challenges of accessing welfare support in the form of grants for children living as AIDS orphans. They were aware that some of the children’s needs could be alleviated through the provision of financial support yet accessing the financial support through the grant system in South Africa was slow, cumbersome and largely inefficient. Social workers articulated that the current grant system and resources available in the grant system for children living as AIDS orphans were both insufficient and ineffective.

“You know most of the children I see who are orphans are living with their grandmothers. They are dependent on the grandmother’s pension from the government. The money is too little. Yet it is the only means of financial support. So we have to consider this when we run support groups for these children. I can’t tell the children all about healthy nutrition to stay healthy when there is no money for food at home. This is the context in which we live. We can’t even provide food for them in the support groups unless we buy it out of our own pockets” [Interview 16 pg. 2]

Children living in the township communities are increasingly vulnerable because of poverty. Any child who is orphaned living in these communities is compromised due to the difficult circumstances imposed through poverty, lack of attention, lack of access to services for healthy education social and psychological support (Skinner et al., 2013: 120).

SUB-THEME 1.2 Health and social care practitioners experienced inefficient referral systems

Referral is the process of noticing a concern regarding a child, deciding on the action that needs to be taken and reporting that concern to someone with the relevant responsibility. This might be a direct referral or giving information to the child or guardian of the child about where they can go for future assistance (Roelen et al., 2012: 2).

The debate on referral mechanisms and case management for vulnerable children and how they can ensure positive outcomes, is extremely pertinent and timely. Momentum is growing around the need for responses to vulnerable children to take a systems approach rather than relying on a fragmented service delivery. As pointed out in UNICEF (Abrahams and Matthews, 2011: 14), a functioning social welfare system –typically inclusive of social protection and child protection services – is a vital safety net for children and families made vulnerable by HIV and AIDS as well as other risks. An understanding of childhood and orphan vulnerability is imperative when considering how referral mechanisms and case management are to facilitate an appropriate response.

There is a general recognition that the multiple and complex needs of vulnerable children and families in Eastern and Southern Africa are not sufficiently being responded to, leaving many children in very vulnerable if not destitute situations (Roelen et al., 2012: 1).

The health and social care practitioners used words like despondent, frustrated, angry, depressed, fearful, hopeless, inefficient, ineffective, inadequate and overwhelmed when describing the referral systems in place in South Africa, through which to access care and support for children who are AIDS orphans living in the townships communities. The health and social care practitioners told the researcher that children who were AIDS orphans living in the township communities were often left destitute when they were vulnerable and in need, because of the failure of these referral systems.

“You won’t believe it. I called the hospital yesterday to re schedule an appointment for one of our orphan children to go to the ENT consultant. That was his secretary calling back. I can only get another appointment in 3 months’ time” [Interview 4, pg. 4].

“As a nurse I can’t just say to the child, ‘Take your treatment and go home’ when I can see they are distressed. These children need a psychologist. If I refer them to a psychologist it takes months for them to be seen. Many of them don’t go because they have no bus fare to attend these appointments which are usually far from their homes” [Interview 11, pg. 2].

“Most of the children I see in this clinic are orphans who are HIV-positive. I am supposed to refer them to the Psychological Centre at the Missionvale Campus. However I found out recently there are only educational psychology internship students there. These children I see need psychological support because they are distressed and overwhelmed because of the grief of losing their parents. It’s so important for HIV-positive children to have psychological support otherwise their ART compliance is very poor because they just want to die” [Interview 12, pg. 1].

“Children who come to this clinic for their ART, TB or any other medication for illnesses need more support than we can give where they are orphans. They need psycho-social support. We can’t cure their hunger nor can we help them with their grant applications. Yet they need this too. They need social workers to visit them at their homes. When I refer these children it takes months for them to see a social worker because the social workers have such huge case loads. When the children are traumatised through grief. They need to see a psychologist. Yet it also take months from when I refer these children to a psychologist for them to see one We have totally inefficient referral systems in South Africa. [Interview 24, pg. 4].

A minimum package of essential social protection should cover essential healthcare and benefits for children, informal workers, the unemployed, older persons and persons with disabilities (AU, 2008: 1). A complex and interlinked set of factors, relating to intra-household dynamics, livelihoods and resilience and issues of cultural, social or economic exclusion makes it hard for those children to benefit from increased coverage of basic services (UNICEF, 2010: 7). Despite the recognition that vulnerability is multifaceted, policies still tend to take the short cut by focusing on narrowly defined groups or by applying rigid socio-economic data e.g. double orphan, granny-headed household or assuming that providing services will automatically lead to access for all (UNICEF, 2010: 7).

“This child came to me one day. They are orphans in a family and there is no money at home to buy food. I filled out a form referring this family to receive a food parcel. Six months and still nothing Six months!!! I must help these children. If I don’t who will?” [Interview 18, pg. 5].

“The most disheartening thing for me as a nurse in this clinic is referring orphans to social workers, psychologists, dieticians and SASSA. (South Africa Social Security Agency).I refer these children and their grandmothers. It takes a long time for referral appointments to come through. When they do the people don’t go because they are far away and there is no money for food let alone bus fare.”[Interview 18, pg. 6].

“When I refer families to court to apply for a foster care grant it takes a long time. On average it takes 18 months through our court system in Port Elizabeth. I tell clients however it is likely to take 3 years. I have one client and it has actually taken 6 years” [Interview 19, pg. 1].

“Many times when I refer to social workers they would say, I am sorry I can’t help you. Many times I refer to psychologists or psychiatrists and they say ‘I am sorry I can’t help you’ [Interview 22, pg. 5].

No system means no case management. A referral mechanism requires that children or families can be introduced into the “system” at the right time and consequently be referred to the right services. Case management requires that needs are assessed overtime. Protocols that spell out roles and responsibilities for making such referral mechanisms and case management systems work, but these systems were found to be missing in South Africa (Roelen et al., 2012: 1). The growing interest in social protection interventions across South Africa provides interesting opportunities for accessing new resources. Without a clear sense of the cost and benefits (the “added value”) of an effective referral and case management system that can demonstrate positive outcomes for national development indicators, it makes it hard to develop a business case for investing in such a system that links different sectors, including child protection and social protection South Africa has undertaken a process of budget analysis to see where child protection resources come from. A strong referral and case management system leads to more promising practice which can only strengthen the lives of orphans and vulnerable children (Roelen et al., 2012: 1).

The health and social care practitioners told the researcher that if the referral systems were quick and easy to access for children who are AIDS orphans living in the townships communities, then a lot of unnecessary suffering caused through time delay in accessing care and support through these inefficient referral systems would be alleviated.

SUB-THEME 1.3 Complexity in building trust relationships due to time constraints

Trust is a key ingredient in exchange relationships (Gulati, 1995: 85). Many definitions of trust have been provided over the years due to the complexity of this concept which spans several areas such as nursing, psychology, sociology, economics and law. The definition of trust is not unique, however, trust can be defined as the “firm belief and reliability or truth or strength of an entity” (Moyano et al., 2013: 1). It can also be described as a firm belief in the reliability, truth, ability, or strength of someone or something or as a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behaviour of another. Moyano et al, (2013: 3), further say that trust is a generalised willingness to accept vulnerability with respect to a trustee and is also a component of a therapeutic relationship. In the instance of this research study the orphans accept vulnerability, in establishing assistance through developing a therapeutic relationship with the health and social care practitioners.

The therapeutic relationship is central to all health and social care practitioners and is based upon trust and establishing communication which promotes understanding, help and mutual respect. For example, in mental health and community nursing, the therapeutic relationship may be the primary intervention to promote awareness and growth and/or to work through difficulties. In other areas of nursing practice, for example ICU, the therapeutic relationship may be more in the background, serving as the intervention through which comfort, support, and provision of care are facilitated. Regardless of setting and clinical situation, the therapeutic relationship always needs to be established” (Grispun, 2002: 5).

The health and social care practitioners participating in this study all spoke about the difficulty in establishing trust or therapeutic relationships with children who were AIDS orphans. They acknowledged that time was one of the key components of establishing a good therapeutic relationship through which AIDS orphans could receive care and support. Yet because of the numbers of children accessing the health and social care practitioners for care and support they were unable to develop the relationships of trust through which orphans were to access vital help and support. A therapeutic relationship is defined as a relationship that maximizes the possibility of healing of body, mind, and spirit. In the process of creating such a relationship some sense of personal closeness or bonding between clinician and patient is inevitable, even with the professional in the relationship (Hallenbeck, 2012: 21).

“When I first met a child who was an orphan …… I realised it takes time to establish what’s going on in their homes and also in their hearts. It takes time to understand their life world. I need to create space for children to say what’s going on, on the inside so they can feel understood and develop their own coping mechanisms. It is difficult to create long term therapeutic relationships because I move clinics and they move homes. There is a huge pressure in my first meeting with an orphan to establish a trusting relationship. The reality is we have few resources. You can see my office is a cupboard, the phone is always ringing and we are constantly interrupted. How can a child open up to me in this environment? They can’t

…… I don't have the time or resources to build a therapeutic relationship with the children I see I am very sad about this. Some of the children I have seen for a long time come to see me on their way home from school. They say things like 'I want to tell you how good I did in my maths', then I know they will be ok as they have learnt to trust and be open again [Interview 12 pg. 3].

When children become AIDS orphans they experience much emotional, and psychological stress due to loss and adverse change in life circumstances. So they rely upon primary healthcare practitioners in primary healthcare clinics, social workers and psychologists to provide the necessary care and support to enable them to overcome their loss, cope with the enormity of change and rediscover hope to continue living.

The primary heathcare practitioners have explained that there is much trauma in the lives of children when they become AIDS orphans because they experience such hardship and loss. Sometimes in the extended family homes children are exploited because they are a burden to the extended family or bullied by other children in the home because they are not wanted. Health and social care practitioners explained to the researcher that AIDS orphans found it difficult to explain to health and social care practitioners their problems and therefore arising care and support needs, because the children found it difficult to talk and be open. Health and social care practitioners told the researcher that AIDS orphans found it difficult to trust adults because they felt either abandoned or exploited by adults and were largely withdrawn, stressed and in emotional and sometimes physical pain as a result of extreme emotional trauma, loss and physical hardship.

"Sometimes I see children who say they are sick but I examine them and I can't find anything wrong. But I know that something is wrong. I know it is stress causing these symptoms because they are orphans and live in a house where they must do everything. They are exploited and neglected. So I know I must not fail this child because they already have a solution and the solution is suicide. So when they speak you must listen very carefully, but then I am under pressure because there is a queue of other people outside my door waiting to see me. Mostly these children want to go and live with their grandmother, aunt or school teacher. It is so difficult for me to access a social worker to help children in this situation, so I speak to them kindly and I make sure that they have been heard. I don't have the time to listen to all the children who came to see me" [Interview 6, pg. 6].

"I see a lot of anger in children who are orphans. They kick out and are rebellious; they don't go to school and they withdraw from relationships and they don't do their school work. It takes time for me to build relationship with these children. They must learn to trust me, I feel pressure because of that as there are so many of them to see" [Interview 7p.g1].

“When children come to me as a social worker I must help them if they are to trust me. It’s difficult for them to trust me when I tell them the grant application process is going to take so long, or that I can’t help them with immediate assistance for school shoes or food. I have so many children to see my time is so little. How will they trust me if I don’t have time for them?” [Interview 14 pg. 3].

“Children who are orphans have lost an ability to trust adults. They have to regain that ability to trust and it happened through me and other professionals building relationship with them that are honest, caring and supportive [Interview 14 pg. 10].

“I’ve had to wait for him to speak and it’s taken him a year. He wanted to be in control of what he told me concerning the loss of his mother. I asked him about the loss of his mother, I needed to be very conscious of his pain as this was a very confusing place for him. The privilege of helping him in this was to just be present with him in the moment as he explained what it meant for him to lose his mother. It took a year to develop a therapeutic relationship with him at that level” [Interview 17p.g5].

When there is inability to form a therapeutic relationship based upon trust with a healthcare professional; it has been noted that there is a decreased patient and nurse satisfaction, emotional burnout, increased length of stay in hospitals or decreased quality of care as seen in outcomes such as functional independence, pain, social functioning and patient satisfaction (Aiken, et al., 2001:189.

“Because of a lack of time I am not able to build relationships with these orphans in a way where they can trust me. I am sad about this because I know if I had more time to build relationship with them I could give them more care and support than I currently am able to [Interview 21: pg. 4].

In a report on establishing best practice in 2006 recommendation 8 reads as follows:

“Agencies will ensure that nurses’ work- load is maintained at levels conducive to developing therapeutic relationships”(Grispun, 2002: 5).

The health and social care practitioners all spoke of the dissatisfaction they felt because of the time constraints they experienced in building therapeutic relationships with AIDS orphans due to work-load demands. Primary healthcare practitioners, social workers and psychologists all acknowledged the need to build relationships of trust with AIDS orphans and that establishing trust was crucial to enable AIDS orphans process the loss of their parent and access support and care through the primary healthcare and welfare structures. Health and social care practitioners were largely committed to providing good care and support to AIDS orphans but felt limited in this because of the sheer numbers of children seeking care and support through them and the time constraints imposed upon them because of this workplace reality.

SUB-THEME 1.4. The work as overwhelming, neverending and demoralising for most health and social care practitioners

To be overwhelmed is to be rendered powerless especially by an excessive amount or profusion of something; "a desk flooded with applications"; "felt inundated with work"; "too much overcome to notice"; "a man engulfed by fear"; "swamped by work" (Oxford English Dictionary, 2009: 749).

The health and social care practitioners in this study relayed their experiences to the researcher regarding their work-load as causing them anguish, despair, anger, frustration depression, fear and also at times the necessity to disengage from the people whom they provided with care and support. They sometimes experienced themselves withdrawing emotionally, in order to protect their own physical, emotional and psychological well-being. They were in many instances overwhelmed by the numbers of children to see and the enormity of the suffering they were listening to and seeing every day in their professional lives.

"Every day I come here to this clinic. You can see outside my office the queue of people, it's never-ending. The people queue outside the clinic from 5:30 in the morning. Yesterday I saw 55 clients, it's so overwhelming to see all these people in need every day. It's endless and demotivating. I had burn out once before and I was actually in hospital. I feel hopeless and demoralised because of all the heart ache I listen to every day. Sometimes I feel like the clients are my enemy. I just can't give any more, you know I see people every day who think HIV/AIDS is normal. I want to scream at them that it is not normal" [Interview 22, pg. 5].

"I came into this profession to help people in need who were suffering. I wanted to make a difference. I wanted to help children who are suffering in our communities because they are orphans. But all my compassion is gone because I am overwhelmed every day. Many of my colleagues and I have time off because of stress, otherwise we would have burn-out" [Interview 15, pg. 3].

"When I come to the clinic I must see everyone. I can't just see 20 clients. I must see all 50. How can I then spend 2 hours helping someone? Then I will only see 20 clients and send the other 30 home. There are too many clients to see and I am only one person" [Interview 6, pg. 5].

The health and social care practitioners expressed their concern that constantly listening to the distress of AIDS orphans and seeing every day how they were suffering because of hunger, sickness, distress and trauma caused the health and social care practitioners to experience trauma themselves. Many of them reported not being able to switch off and not actually being able to face another day in the clinic or in the satellite office because of the relentless nature of their challenging work and the overwhelming needs of the AIDS orphans. Some health and social care practitioners felt they simply just couldn't care anymore and felt that the system within which they worked caused them to be so overwhelmed that whether they cared and invested in the lives of the AIDS orphans, or not their efforts were futile because of the over whelming needs of the AIDS orphans. They felt opening up to care and being moved by compassion was simply too costly for them as they experienced such extreme pain and relentless sorrow.

Constant exposure to people who are traumatised or suffering leads to compassion fatigue, a term initially coined by Fridgely (2002: 22). It describes secondary trauma stress incurred by helping professionals working with survivors of natural disasters and terrorism. Fidgley (2002: 23) included Health and social care practitioners in this definition, since these providers often deal with unrelenting suffering. Compassion fatigue is often interchanged with the term burnout. (Streit, 2013: 1) differentiates compassion fatigue and burnout by yielding that compassion fatigue arises when one is unable to "rescue or save an individual from harm," which leads to remorse and sadness. In comparison, burnout is thought to arise from failure to meet personal goals, which results in frustration (Streit, 2013: 1). According to Landro (2012) cited in (Streit, 2013: 1), compassion fatigue leads to decreased job satisfaction, decreased job productivity, higher job-turnover rates and cynicism in the health and social care practitioner arena. All these factors can affect patient satisfaction and patient care outcomes.

While daily interventions are offered to provide support to orphans and their families, the effect of compassion fatigue upon health and social care practitioners can pose a threat to positive patient outcomes.

"As a psychologist I hear the same story over and over again: stories of suffering and pain; pain of loss, pain of poverty. Somehow it seems to make a difference in the lives of children to just acknowledge they are hungry. I can't take their hunger away but somehow by acknowledging the children's suffering it seems to help, but I feel overwhelmed by this, I can't feed all the hungry people I see!!!!!!" [Interview 12, pg. 3].

Compassion stress can be defined as natural behaviours and emotions that arise out of listening to, and knowing about, traumatising events experienced by others (Fidgely, 2002:2).

"I have so many clients to see. The other day I spent the whole day filling in Foster Care placement forms with a family. It's so demoralising because I know it will take so long for the grant to come through. I hear the same story of suffering of children who are orphans every day…. It's so hard to listen to their pain I go home exhausted because how can I not care? I felt overwhelmed by the number of children whom I see who are orphans and who I must place in foster care , it is never ending , and every day there are referrals of new cases it overwhelming" [Interview 22, pg. 3].

There is a cost to caring professionals who listen and try and assist children and people in need who have or are suffering difficult and traumatic experiences. The professional work of people who are trained to provide care and support and to alleviate suffering involves absorbing information about the lives of children and people who are suffering. Many health and social care practitioners who engage with people who are suffering every day often experience sadness, depression, fatigue, loss of sleep, loss of appetite and anxiety (Fidgely, 2002: 5). This was certainly true of the participants in this research study. The health and social care practitioners experienced compassion fatigue because of the suffering they were experiencing and listening to every day; and they experienced huge amounts of frustration and anger because of the relentless work-load full of hopeless ness and challenge. Most of the health and social care practitioners experienced depression, loss of sleep and spoke to the researcher concerning the anxiety they felt as a result of the relentless workload.

SUB-THEME 1.5. The absence of resources as a constant source of frustration

The frustration process seems to have aspects of emotion, tension, conflict, inhibition, aggression and withdrawal, which have been examined in terms of the studies of frustration. The frustration process is delineated as consisting of a frustrating situation, a pattern of effects involving the frustrated organism, and a reactional system. The frustrating situation is analysed in terms of barrier or obstruction and of interference with goal-attainment and of reward-expectation. The factors of failure, change in tension, cognitive effects and frustration-tolerance are attributed to the frustrated organism. The cultural implications of frustration are also considered in this connection. Reactions to frustration may be aggression, withdrawal, regression, resistance, anger, guilt remorse, shame and embarrassment (PsycINFO Database Record (c) 2012, APA: 2).

Obviously, not all frustration is translated into aggression for if the frustration is over someone or some entity that is perceived to be standing in the way of one's success, a person will experience frustration (Miller, 1941: 339). In the instance of this research study, health and social care practitioners experienced frustration as they could not provide the care and support in the manner they wanted to children who were AIDS orphans living in the townships, because of a lack of resources both people resources and material ones. This caused health and social care practitioners to experience aspects of the above-mentioned frustration cycle. Some experienced feelings of anger while others withdrew, which at times caused them to experience shame. After all, they had come into their chosen profession to care for and support vulnerable children and they felt shame as they were unable to do this in a manner which was up to their expected standards and or indeed alleviate the suffering of children who are AIDS orphans, living in the township communities.

"I get very frustrated working in this clinic. I see children who are orphans all day every day. I want to run a support group for them and give refreshments, but I can barely see all of the children that I need to throughout the course of the day and there are no refreshments for the children, unless I use my own money or I take porridge which is meant for the TB patients" [Interview 11, pg. 3].

Every individual aspires to be able "to be" and "to do." Whatever the specifics are, there is a requisite "functioning" level for the individual to achieve these aspirations. In exploring the possibility of an early warning system for the incidence of conflict, we need to identify obstacles or factors that inhibit the full realization of these "functionings" such that these factors are perceived to result from government action or inaction with respect to a certain group of individuals (Miller, 1941: 340).

Health and social care practitioners admitted to a profound sense of frustration they felt because the interventions they made as health and social care practitioners to care for and support AIDS orphans didn't help the AIDS orphans. In trying to provide care and support to children who are AIDS orphans, health and social care practitioners were constantly hindered because of a lack of consistent people and material resources. Health and social care practitioners would see the AIDS orphans in their clinic or satellite office cold, tired, hungry and overburdened; and even after interaction with the children they would watch AIDS orphans leave their clinic or satellite office in the same manner: cold, hungry and overburdened. This caused frustration and anger in the lives of the health and social care practitioners, since they rarely felt that their interventions had met the need of the AIDS orphans and they all felt the care and support they gave in their respective professions simply wasn't enough to meet the needs of these vulnerable children. Health and social care practitioners expressed their intention to help but were hindered from doing so because of the constant lack of people and material resources.

“I see children who are orphans. It’s difficult for me to help younger children as I have no resources to facilitate play. If I had some toys and some refreshments to give these younger children I am sure I would be able to help them more. Younger children talk through play, it’s the language they heal with. Also, I think how uncomfortable it is for people to talk when they are cold and hungry. I have no heater in my room nor any food to give them. I don’t even have tissues to use if people cry, only the ones I bring in my handbag. It’s very frustrating to work in such an environment” [Interview 12, pg. 6].

South Africa's transition to democracy in 1994 was accompanied by the development of progressive policies in all sectors to address the past structural inequities inherent in the apartheid system and entrench the far-reaching rights in the Constitution (i.e. ‘the progressive realisation of the right to healthcare, housing and education’). Since 1994, South Africa has made considerable investment in primary healthcare through increased infrastructure, rapid expansion of TB, HIV, and maternal health-related programmatic intervention (Nxumalo et al., 2013: 1). However, these efforts and investments have not resulted in the expected improvements in the MDG’s and other health outcomes due to the complex and growing burden of disease and the failure to develop and implement an efficient district health system (DHS), responsive to local needs (Nxumalo et al., 2013: 1).

The increasing numbers of service delivery protests by local communities around the country, after 18 years of democracy, demonstrate the frustration of many who have yet to benefit from the provision of basic services. Both the district and sub-district health structures in South Africa struggle to provide adequate facility-based care. “As DENOSA, we have reached a point where we are not able to forgive this long chain of unnecessary blunders, when linens at the Nelson Mandela Academic Hospital are getting contaminated because there is not sufficient equipment to wash and dry them” (DENOSA, 2013: 1). The provincial government of the Eastern Cape failed to spend R1.47 billion on its budget allocation for its budget ending in March 2013, with just over R1 billion of this meant for salaries. Furthermore the Department of Health among others, has not spent funds at the time when the province is short of more than 9000 nurses (DENOSA, 2013: 1).

South Africa spent an estimated 8.8% of GDP on healthcare in 2009. Total expenditure on healthcare is higher than in most other upper to middle income countries and similar to that of some high income countries. This is more than China, which spent 7.4% of GDP on healthcare but far less than America which spends 16.2% on GDP. Despite substantial expenditure on healthcare, South Africa's health status indicators are much worse than those of many countries with a similar level of economic development. South Africa's healthcare system consists of a large under-resourced and overused public sector and a much smaller well-funded private sector. The public health sector provides healthcare for 85% of the population whilst the remainder is covered by the private sector through insurance schemes. The Government proposes to create a National Health Insurance (NHI) system, but this will be introduced gradually, over a five-year period because of the cost and logistical implication (DOH, 2010b: 2).

"This clinic I am working in is meant to accommodate 500 clients per month. Its far more than that now. Currently we are 30 nurses seeing 11000-13000 clients per month. It's very frustrating because we don't have the time or the space to give the services that the community needs like privacy and support groups. You can see we lack space. We have containers in the yard we have converted into rooms for some of our ART patients. An NGO gave us those and converted them and put shading up so people don't have to sit in the sun" [Interview 10, pg.4].

What is apparent is that despite government intention and increased spending the resources required by the health and social care practitioners to enable them to meet the care and support needs of children living as AIDS orphans, the resources are simply not available to do so. The lack of resources causes the health and social care practitioners to experience at times desperate levels of frustration.

Primary healthcare practitioners, social workers and psychologist also told the researcher that there was a lack of human resources to meet the demands of all of the children and families coming to them for care and support, which made them feel completely overburdened.

South Africa currently requires approximately 35,000 extra nurses to fill in the public health sector gaps, although only approximately 3, 000 nurses are produced annually (Kornik et al., 2011: 13). In South Africa nurse density was 4.08% per 1000 population. Whilst South Africa had higher nurse density then India, Thailand and Kenya, South Africa still suffered from the misdistribution of nurses, shortages in undeserved rural areas and still had insufficient nurses to meet public health needs (Mayosi et al., 2012: 12). According to Cameron et al. (2012: 98), there were 388 nurses per 100,000 population in SA in 2012. What is apparent is that whilst South Africa is training nurses to degree standard there are insufficient nurses in South Africa to meet the public health need (Ataguba and McIntyre, 2012: 2). The same is true of both psychologists and social workers.

The total number of psychologists in South Africa was approximately 5000 in 2008, relative to the country's population of 51.8 million according to the 2011 South African census (StatsSA, 2011: 3); thus leaving a dismal psychologist-to-client ratio and an even more problematic situation with regard to the availability of black psychologists (Gylseth, 2008: 2). The total population of social workers registered with the South African Council for Social Services Professions (SACSSP) as at March 2012 was 16, 740. Of these social workers only 6655 (40%) were employed by the government. In the Eastern Cape the ration of Social workers to population was to 1: 4,903; according to the department of Social Development (DSD), the current international norm for population-to-social-worker ratio is to 1:5,000. In its integrated service delivery model developed in 2005 , the desirable caseload per social worker is 60 cases, but the Minister of Social Development, Bathabile Dlamini, concedes that owing to high levels of poverty, deprivation and a high incidence of HIV/AIDS, the actual case load per social worker is much higher (Moloi, 2012: 1).

> "One of the reasons for our frustration is that there are not enough people to do the work. That is why when we refer to others it takes time and why the systems are so slow. As a social worker I must oversee 100 cases. How can I possibly do that and do it well? When the needs are overwhelming of the people I am helping, we need more time to address the multiple needs the children have"[Interview 18, pg. 1].

Health and social care practitioners interviewed in this research study all articulated to the researcher that their high caseloads reflected insufficient numbers of professionals within their respective healthcare professions to enable the provision of care and support to children who were AIDS orphans living in the township communities.

SUB-THEME 1.6 Infrastructure constraints at faculty levels leads to enervation

Enervation is the lack of vitality and "an enervation" of mind is greater than fatigue. To be enervated is to be left feeling extreme weakness, lacking in physical and mental strength, liability to failure under pressure or stress or strain; a serious weakening and loss of energy; debilitated, enfeebled, weakened and depressed (Oxford English Dictionary, 2009: 339).

The health and social care practitioners interviewed as part of this research study experienced enervation. They had given as much as they could in the rendering of care and support to AIDS orphans living in the townships and were battling with fatigue and the desire to give up. They had become depleted, physically, emotionally and psychologically and were resigned on many levels to working in a very difficult working environment with limited resources trying to provide care and support to children who are AIDS orphans living in the townships with overwhelming needs. They were experiencing enervation because of the challenges of rendering care and support to children who were AIDS orphans in a restrictive environment with very limited resources. They experienced high levels of stress which had affected them physically, emotionally, psychologically and spiritually.

“Sometimes I feel so heavy in my body like I have been in a fight. All I have done is come to work. It’s like living in a cycle of hopelessness. I want to help the orphans I see but I am unable to. We have no space and no resources so I just listen to the same thing over and over and am not in a position to do anything about it. I feel so tired by this. Last year I took 3 months’ leave because I couldn’t face it anymore. It’s so frustrating and demotivating not to be able to help children who are suffering. It’s very difficult to just flick a switch at five o’clock and say ‘I am going home now’…… ” [Interview 14, pg. 7].

Physiological stress represents a wide range of physical responses that occur as a direct effect of a stressor causing an upset in the homeostasis of the body. Upon immediate disruption of either psychological or physical equilibrium the body responds by stimulating the nervous, endocrine and immune systems. The reaction of these systems causes a number of physical changes that have both short-and-long term effects on the body. There is a link between high levels of cortisol and depression. It has been found that people with with major depression exhibit decreased brain serotonin (5-hydroxytryptamine, 5-HT) function and elevated cortisol secretion has reached the status of truism. More recent formulations have suggested that elevated cortisol levels, probably caused by stressful events or long exposure to challenging circumstances, may themselves lower brain 5-HT function and this in turn leads to the manifestation of an enervated or depressive state (Dinan, 1994: 367).

The long-term, constant cortisol exposure associated with chronic stress produces further symptoms, including impaired cognition, decreased thyroid function, and accumulation of abdominal fat, which itself has implications for cardiovascular health. The bottom line is that both episodes of acute stress and more prolonged stressful circumstances precipitate lower levels of general health, and exposure to such stress should be minimized (Dinan, 1994: 369).

The health and social care practitioners interviewed in this study expressed their concern to the researcher that they at times felt depleted, experienced back pain, loss of motivation and some had suffered severe physical symptoms, namely, episodes of breathlessness, panic attacks, high blood pressure, sleeplessness, depression and hospitalization due to cardiac arrest. They reported to the researcher that they felt as if they had hit a brick wall and were physically and emotionally unable to face the challenges of their working environment and the challenges of caring and supporting AIDS orphans.

“I would like to run a support group for orphans, but you know I don’t even have chairs for the children who could attend to sit on. You can see my office is like a cupboard. The fridge over there is the one the nurses use for their vaccines. They are in and out all of the time. There is no privacy at all. I am tired of fighting to do the best for children in this environment. It’s so tiring. Sometimes I leave work and I am so tired I don’t even know how I drive home” [Interview 12 pg. 5].

“You can see how small my office is. I see all of the clients in here every day. I am in this room. The window is so small. You can see my files stacked on the fridge. I got TB two years ago I know it was from a patient here at the clinic because the ventilation in my office is so little. I don’t even have a window that I can open. If I just had more space it would help. It’s very frustrating working in such a small space [Interview 15, pg. 3]

“At my desk, I can’t even say it’s my office because we are four that share an office, I can hear everything my colleagues say to their clients. If I want to talk privately to a client I must stand with them in the corridor outside my office….. I feel very demotivated by this. It’s frustrating that I am unable to do the best for my clients because of the poor environment in which I work, and I feel very demotivated by this. It’s very demotivated” [Interview 18 pg. 8].

“It’s very difficult to come to work every day and know you can’t do your best because of a poor working environment and a lack of resources. The people we serve are very poor and vulnerable particularly the children. We don’t even have a nice office in which to see those. Most of our clinic rooms are like cupboards. I had a panic attack last year at work. I couldn’t take it anymore. I was anxious all of the time. I went to my GP and he signed me off for three months.MY blood pressure was so high. I saw a child that day who was 15 years old. She was an AIDS orphan and taking care of her three siblings in a CHH. I felt so helpless. We have no resources to help children like her. She is trusting me to help her and I can’t because we have no resources. I don’t even have a quiet room to sit her in to talk to her. I couldn’t do it anymore. Our systems are breaking and that day I broke too” [Interview 15 pg. 3].

“Sometimes I just don’t want to come to work and do this job any more. My office is small, I can overhear my colleagues all of the time. There is no space …. I run a support group in a cupboard and listen to orphans and buy refreshments for them out of my own pocket. I am demotivated by this. My job takes all of the life out of me. I am a young person but I feel old [Interview 1, pg. 3].

“I was driving home on the freeway from the clinic and I had terrible chest pain. I pulled over in my car. I had a heart attack. I was in hospital for 6 weeks. My husband told me I can’t go back to work in that clinic. It's just too much. The people are too many; the clinic is too small; we have few resources and not enough nurses" [Interview 21, pg.3].

When people can do what they are supposed to do without restriction or hindrance they feel such energy and joy... but when they can't and their plans are dormant...the levels of frustration can cause stress leading to enervation and depression (Dinan, 1994: 372). The health and social care practitioners told the researcher that they constantly felt tired because of the challenges they faced and the restrictions they felt caused by infrastructure constraints which added to the sense of depletion they felt as health and social care practitioners caring for and supporting AIDS orphans living in the townships.

SUB- THEME 1.7 Stigmatisation of children and their families which prevents access to treatment, care and support

The health and social care practitioners were frustrated at times by the delay in their attempts to help children and their extended families to care for and support AIDS orphans who were coming to them for care and support. Yet at the same time they recognised that it was stigmatisation of the families and children by the community members in the communities in which they lived which, caused these children and their families to feel this shame. The health and social care practitioners attested to this shame associated with HIV/AIDS preventing children and their families from accessing the health and social care practitioners for care and support. The health and social care practitioners told the researcher that the children found it difficult and were unable to say that their parent/ parents died of AIDS.

"The children I see who are AIDS orphans in this clinic, some are on ART but they will not tell their friends at school why their parents died or that they are on ART. They will say their parents died of TB. They tell me other children who are known at school to be AIDS orphans are bullied" [Interview 6, pg.3].

The problem of the AIDS orphans or pre- orphans should be seen against the background of stigmatisation of people suffering from HIV/AIDS (Chakalane-Mpeli and Rocks, 2007: 2). HIV/AIDS and the stigmatisation thereof affects children long before their parents die. "Pre orphan" is a term used to describe a child who has not yet lost a parent to HIV/AIDS, but is nonetheless, caring for his/her terminally ill patient (World et al., 2002: 6).

HIV/AIDS stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is characterised by rejection, denial, discrediting, disregarding, underrating and social distancing. It frequently leads to discrimination and violation of human rights. If stigma is to be addressed then it has to be understood. We should focus our attention on understanding what causes us as a society to react in this way to people living with HIV/AIDS, people who are suffering enough, either physically or mentally to be challenged yet again by the judgement of others. The Hon.F.T Sumaye, Prime Minister of Tanzania" UNAIDS: Intercountry Team for East and Southern Africa, Health and Development Networks (NDN), Swedish International Development Agency (SIDA) UNAIDS, 2001).

The health and social care practitioners told the researcher that despite huge publicity regarding HIV/AIDS in the communities, people who died of AIDS, their families and the children they left behind suffered from discrimination because of the stigma still associated with HIV/AIDS.

" I see children who are thin and bullied every day because they are AIDS orphans. You can't hide AIDS in our communities especially when you are an orphan. Because you become so poor so quickly. Its very difficult because these children are stigmatised every day. They are stigmatised before they are orphans because they are caring for their parents who are dying of AIDS" [Interview 6, pg. 2].

Peter Aggleton, who wrote in UNAIDS describes stigma as an ancient idea that has historical association for many illnesses, for example, leprosy, cancer, tuberculosis, mental illness, many STD's and now HIV/AIDS: (Intercountry Team for East and Southern Africa, Health& Development Networks (HDN), Swedish International Development Agency (SIDA), (2001:16) Stigma causes individuals to be discredited or devalued based on the identification by society of certain attributes which these individuals possess and occurs as a result of ignorance combined with past fears and prejudices. In the case of HIV, positive status is considered undesirable, therefore those living with HIV/AIDS are set apart, principally due to the severity and terminal nature of the disease (Dlamini et al., 2007: 390). However one views stigma, it is clear that it reinforces existing social equalities and perpetuates relations of power and control (UNAIDS: Intercountry Team of East and Southern Africa, Health & Development Networks (HDN), Swedish International Development Agency (SIDA) 2001:16).

"Yesterday I saw a grandmother. She came to the clinic to get her ART. She contracted it through caring for her daughter who had AIDS and who has now passed away. I watch her face as she comes to the clinic. She is shocked, but she takes her treatment as she has to care for her grandchild who is now an AIDS orphan. When she comes to the clinic she doesn't want other clients to know….. because they are stigmatised. Everyone knows they are HIV-positive because of their folders. So I put all the grannies' who are HIV positive notes in, a brown envelope so that no one knows they are on ART" [Interview 13, pg. 6].

Discrimination was described in UNAIDS : Intercountry team for East and Southern Africa, Health7 Development Networks(HDN), Swedish International Development Agency (SIDA), (2001:16) as an aspect of stigma such as exclusion, restriction of expression, marginalisation or even prevention from access to services. Discrimination can be conveyed by force; “from avoidance to life threats, lynching and death.” Equally disturbing are the incidents in which women are beaten or murdered for being brave and responsible enough to disclose their status (Orford, 2006: NP).

In South Africa Gugu Dlamini who was 36 years of age and working to persuade South Africans not to discriminate against HIV-infected people, was beaten to death by her neighbours, who accused her of bringing shame to their community by revealing that she was HIV positive (McNeil, 1998: NP).

Despite global efforts to reduce and eliminate AIDS-related stigma and discrimination (UNAIDS, 2002a), stigma continues to be extremely common around the world with an increasing number of countries reporting discrimination against people living with AIDS (Barrero, 2006: 1219).

“It’s very difficult for people to disclose their HIV status still because of being stigmatised. Even in this clinic one of our colleagues last year she did disclose died of AIDS. She didn’t disclose to any of us but we knew…. She was ashamed that is why she could tell us and she suffered because of this” [Interview 22, pg. 14].

The health and social care practitioners told the researcher there was still much stigmatisation in the clinic regarding HIV/AIDS and that there was a lot of shame regarding HIV/AIDS which made it difficult for people to disclose their HIV status and a lot of shame in children regarding the term ‘AIDS orphans’. They told the researcher that AIDS still has the stigma because of its association with “low morals”. This in turn causes shame in children whose parents die of AIDS.

“I saw a teenager who was an AIDS orphan. He remembers coming to the clinic with his mother for her ART. He used to feel so humiliated because his mother had AIDS. He felt a deep sense of shame because his mother died of AIDS. He spoke how it was for them in the community. His mother was considered a “bad woman” because of HIV/AIDS. But he loved and cared for his mother” [Interview 8, pg. 5].

The health and social care practitioners also conveyed to the researcher that children who were AIDS orphans felt ashamed because of poverty. Children felt it was obvious that they were AIDS orphans because they were poor and everyone in the community could see that they had no parent providing for them. Heathcare professionals felt that children who were AIDS orphans often "acted up" because of this.

"Many children say they hate being AIDS orphans because of the shame of their parents dying of AIDS and because they are now poor with no one to take care of them. As I see children in my role as a psychologist, I see a lot of anger in children who are AIDS orphans, mainly because of the stigma of HIV/AIDS and also the poverty children face on becoming AIDS orphans" [Interview 13, pg. 3].

Food insecurity, stigma and bullying all independently increase the likelihood of clinical-range psychological disorder in children who are AIDS orphans (Orkin and Cluvera, 2009: 1). AIDS-related stigma, bullying and poverty are all linked together to intensify the vulnerability of AIDS orphans and AIDS-affected children. The combined interactive effect of two environmental factors-food insecurity and stigma-increased proportions of children with internalising disorders from 19% to 83% (Orkin and Cluvera, 2009: 8).

Regarding the factor of AIDS-related stigma specifically, one finds that there is no known study evaluating the effects of stigma-reduction strategies on AIDS orphans in particular. However, reviews of strategies aiming to reduce stigma towards HIV-infected people suggest positive results of legal protection and provision of ART in reducing public fears of HIV (Orkin and Cluvera, 2009: 8).

"Some children who are living in Aunty-Headed Household (AHH) tell me they are treated differently from the rest of the family. They are a burden because of AIDS and stigmatised because the other children in the home think they are HIV-positive when they are not" [Interview 14, pg. 4].

What became apparent to the researcher was that even with vast amounts of education regarding HIV/AIDS nationally and the known vulnerability of children and their extended families due to the loss of family members to HIV/AIDS, the stigma and resulting shame of HIV/AIDS still prevent children who were AIDS orphans and their extended family accessing care and support they so surely needed from health and social care practitioners.

SUB-THEME 1.8 Lack of interdisciplinary collaboration

Interdisciplinary collaboration occurs when "a group of people with complementary skills who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable, to take action to change things for the better" (HSDC, 2012: 5; Jefferies, 2004).

The terms ‘multidisciplinary’ and ‘interdisciplinary’ are often used interchangeably. Leathard (1994) identifies the various prefixes (‘multi’ and ‘inter’) and adjectives (‘disciplinary’ and ‘professional’) which researchers and practitioners use. Multidisciplinary team (MDT) working is described by Jefferies and Chan (2004: 1) as being “the main mechanism to ensure truly holistic care for patients and a seamless service for patients throughout their disease trajectory and across the boundaries of primary, secondary and tertiary care”.

There are different types of MDT the purposes of which may vary to some extent; but all involve representatives of multiple disciplines working together to improve the response of care and support to vulnerable persons. Thus these teams are able to bring various “puzzle pieces” together to form care and support to clients seeking assistance from health and social care practitioners (HSDC, 2012: 8).

“ You know the multidisciplinary team is a wonderful gift and if it is used appropriately all aspects of care and support for orphans and vulnerable children could improve and we wouldn’t be facing a generation of broken hearted delinquent children who can’t function” [Interview 12 pg. 5].

The health and social care practitioners in this study were disillusioned because of the dysfunction of the multidisciplinary team. They felt referral systems were inadequate to enable the multidisciplinary team to function in a collaborative manner and that because of this the provision of care and support to children who were AIDS orphans living in the townships was very severely lacking. They articulated keenly that it was the breakdown of the functioning of this multidisciplinary team which caused children who were AIDS orphans to suffer, as they waited to receive adequate care and support through this multidisciplinary team which was supposed to provide them with care and support.

“Right now we don't know where to send these children to … we need social worker services, psychologist to help us but we as nurses don’t even know how to find these members of our multi-disciplinary team. It’s like they are just not there [Interview 10, pg. 6].

While the primary purpose of the multi MDT is to help team members resolve difficult cases, MDTs may fulfil a variety of additional functions namely to, promote coordination, communication and increase relationships between service agencies:

- provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed;
- provide a “heads-up” to member agencies about clients that may potentially utilize services from them in the future;

- identify service gaps and breakdowns in coordination or communication between agencies or individuals;
- provide support and validation for team members;
- allow team members to "network" among professional groups;
- raise awareness of trending issues in the elder and dependent adult populations; and
- enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches (MHC, 2008: 13).

"Sometimes it is not the medication that makes a child well, it's when they have help from social workers and psychologists too. How do we find these professionals in the township communities to really help these children? I try to make referrals but I simply can't find these people who are part of the multi-disciplinary team" [Interview 7, pg. 3].

The researcher also found it challenging to locate social workers and psychologists working in satellite offices located within the township communities.

The health and social care practitioners acknowledged that it was difficult for children who were AIDS orphans to negotiate complex service networks in order to receive the care and support they required. Health and social care practitioners recognised that children who are AIDS orphans were left even more vulnerable in this instance as they could not access efficiently the care and support from the health and social care practitioners which they required with the result that AIDS orphans and vulnerable children were subsequently left uncared for, unsupported, feeling frustrated, vulnerable and often traumatised as they sought to access care and support through a multi-disciplinary team which is already overstretched by the sheer numbers of children trying to access care and support through it; and the poor referral systems which caused constant delay in enabling the necessary care and support to be delivered to them. Children who are AIDS orphans living in the townships often "fall through the cracks" and become destitute at a time in their lives when they require immediate access to care and support.

"I often see grandmothers who come to me to try and get help for their grandchildren who are AIDS orphans. They tell me they go here and there and no-one will help them. They are told to go somewhere else. Simply they give up because of the distances to travel and the money this costs them. Our multidisciplinary team is unable to give holistic care and support because we are too few and the needs of the AIDS orphans are many. Children who are orphans suffer because of this" [Interview 15, p.g4].

According to Junior, Hole and Gillis (1994: 2), a coordinated multidisciplinary team is known to “maximise clinical effectiveness”. Multidisciplinary teams convey many benefits to children who are AIDS orphans when they function as they should, such as continuity of care. The ability to take a comprehensive, holistic view of the AIDS orphans needs the availability of a range of skills within the MDT and mutual support and education; however, when the team isn’t collaborative in its approach the outcome is often a lack of service delivery to the end recipient. In these instances the researcher found this to be true for children who were AIDS orphans living in the townships communities. The fragmentation and resultant lack of coordination within and between government departments at all levels was a common and significant constraint to improving access of care and support to children who were AIDS orphans living in the township communities (Nxumalo et al., 2013: 4).

Health and social care practitioners recognised and admitted to the researcher the stress and suffering AIDS orphans were experiencing because of the ineffectiveness of the multi-disciplinary team in the holistic provision of care and support. Health and social care practitioners recognised that the malfunctioning of multi-disciplinary teams in South Africa was causing more harm to already vulnerable children.

“I think the social workers should be the key workers for children who are AIDS orphans, because they have a pivotal role in ensuring that all the correct grants are applied for, for the child who has become an AIDS orphan. They are the key persons in the multidisciplinary team as children who are AIDS orphans have many social needs” [Interview 2, pg. 5].

“Sometimes it is not the medication that makes a child well, it’s when they have help from social workers and psychologists too, but we are too few in South Africa to have a good multidisciplinary team to help these vulnerable children” [Interview 7, pg. 3].

“You know ,yesterday I was very distressed. I saw a grandmother coming to this clinic. She has simply gone mad. Her mind can’t cope. We have failed that grandmother. She is taking care of a child in her family who is an AIDS orphan and all that family do is wait… I think it’s the waiting for help has made her to be mad. Our multi-disciplinary team just doesn’t work like it should because systems are slow and we have many children to see [Interview 11, pg.3].

“You know, I sit here. I fill in referral form for a psychologist, social worker or dietician. In a few months these forms come back to me. Meanwhile the child has not been seen” [Interview 22, pg. 4].

“Our social workers in South Africa need to visit in the homes of the children who are orphans. That is what will make the biggest difference because I often see children in the clinic, they have a foster care grant yet I see they are so thin and their shoes have holes in them. They tell me ‘my grandmother she is drinking beer because of too much stress so there is no money for food’. If the social workers could visit the child in their homes I think this world stop” [Interview 11, pg. 4]

“It is very difficult to refer a child to see a psychologist in the township communities. Even when the referral is successful the sessions are sporadic. A child who is an AIDS orphan can’t just see a psychologist now and again. These children are very vulnerable and need regular support “[Interview 15, pg. 1].

Coordination of the multidisciplinary team can only be achieved if the higher levels of management are coordinated. If those people that design the key performance targets for the specific departments spoke to one another, it would be so much easier to coordinate at the bottom. Children who were AIDS orphans living in the townships often gave up going to the various members of the multidisciplinary team for care and support as they found it difficult to navigate this fragmentation of the referral systems and were constantly discouraged because of the nominal support provided through them (Nxumalo et al., 2013: 4).

SUB-THEME 1.9 Quantity of work appears to be more important to management than quality

“Quality of care operates largely as a rhetorical device that attaches legitimacy and justification to service and policy initiatives by verbal association” (Goldenberg, 2012: 243). Quality has also been defined regarding health and social care as “the degree to which health and social care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Bostridge, 2008: 1).

“We are not providing a quality service. We are always looking at quantities and not quality. We do as much as we can. You know I did a report once. It was a very complicated case, but I was trying to do the best for my client. There were many lawyers involved in this case. I cared about the detail of that case. The children’s court said ‘No, you can’t print this report anymore it’s too detailed’. They only care about quantity of cases they see not the quality of the outcome for the child” [Interview 18, pg. 7].

Health and social care practitioners explained that there was a tension between themselves as practitioners and management. Whilst health and social care practitioners were interested in and motivated towards, giving quality of care and support to children who were AIDS orphans, management were represented to the researcher as being more interested in the number of children seen by the health and social care practitioners. Conversely health and social care practitioners attested success to being able to give the care and support which met the care and support needs of the AIDS orphans living in the townships. Health and social care practitioners would rather have seen fewer children and been able to care for and support them appropriately and felt discouraged by seeing many children and not being able to give care and support appropriate for the needs children were representing to the health and social care practitioners.

"I feel when managers just come to my office all they want is statistics. They want to know how many children I have placed into foster care. I want to say to the. Do you know how many people come into my office every day! How many people I listen to, give money to for bus fare? Do you know how many forms I fill in and how many home visits I do? But they don't want to know about this. They want to know numbers, numbers, numbers. I don't care about numbers; I care about the quality of assistance I give to people and that doesn't count in their eyes. I don't like quantities, I don't like quantities I really don't like them. We care just about quantity and not quality. I sit with my families and I make sure I am doing the right thing for them, the most suitable thing for them. If I am looking to provide quantity then I won't provide the service to my clients because I only concerned about numbers" [Interview 18, pg. 10].

The institute of medicine defines healthcare quality as the extent to which health and social services provided to individuals and patient populations improve desired health outcomes and that the provision of care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision-making. Total quality is best defined as an attitude, an orientation that permeates an entire organization and the way in which that organization performs its internal and external business. People who work in organizations dedicated to the concept of total quality constantly strive for excellence and continuous quality improvement in all that they do (Bostridge, 2008: 3).

The components of quality according to Bostridge are:

- **Safe –** avoiding injuries to patients from the care that is supposed to help them.
- **Effective –** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- **Patient-centred –** providing care that is respectful of and responsive to individual patient preferences, need and values and ensuring that patient values guide all clinical decisions.

- **Timely –** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient –** avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- **Equitable-** providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic status (Bostridge, 2008: 3).

"Our numbers are important to the managers, We see between 11,000 to 13,000 clients per calendar month. Yet we would be happier if we could provide more comprehensive care and support to children who are AIDS orphans who attend out clinic. Yet we have to see such a huge number of clients every day and we cannot give the quality of care and support they need and deserve" [Interview 10, pg. 4].

Quality can also be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Perrin, 2012: 152). Quantity on the other hand is defined by amount, weight and number; anything that can weighed, measured or counted; a large or a considerable amount. In Maths it is an entity having a magnitude that may be denoted by a numerical expression (Oxford English Dictionary, 2009: 271).

"You can see outside the number of children waiting for me to see. If I saw 20 clients per day and cared only about quality then I would see only 20 clients a day. There are so many people to see I need to see at least 50 a day. The managers see this as success. I don't because it takes a lot of time to provide the care and support to children who are AIDS orphans who attend this clinic" [Interview 6 pg. 4].

What is obvious from the health and social care practitioners is that it takes time to care for and support children who are AIDS orphans living in the township, yet there is pressure from management to "get the numbers up". Seeing the numbers of people that management requires is not conducive to providing good quality care and support. There is some measure of overall quality being improved if more people are seen; but there are two principle components to be considered if the services in place to assist children who are AIDS orphans living in the townships are to provide quality care and support. The two principle dimensions of quality care are access and effectiveness (Perrin, 2012: 151). What became apparent to the researcher when speaking to heath and social care practitioners was that just "getting the numbers up" was not effective in providing quality care and support to AIDS orphans living in the township communities because seeing quantities of clients was not effective in meeting the needs of AIDS orphans for care and support.

SUB- THEME 1.10 Lack of work ethic amongst their peers

“Always you have been told that work is a curse and labour a misfortune; but when you work you keep peace with the earth and the soul of the earth. If you cannot work with love but only with distance, it is better that you should leave your work and sit at the gate of the temple and take alms for those who work with joy “ (Bode, 1997: 115).

Work is a rational human activity through employment of corporal or spiritual powers for the maintenance and unfolding of a person’s life, of society and of the world at large (Peschke, 2004: 667). Ethics are a set of moral principles or values that govern a person’s behaviour or the conducting of an activity (Oxford English Dictionary, 2009: 129).

Ethics or values can be regarded as “ preferred” end states of existence and preferred ways of “attending those states “and they are a functioning of the cultural , institutional and personal forces that act upon " a person in their lifetime (Kretzschmar, 2012: 56). They can thus be viewed as “preferential standards”, that are used in the selection of objects and actions., ways of resolving conflict and may involve social sanctions and coping with needs of claims of socio-psychological defences. The value holder determines the importance of his well-being in the selection of concepts that reflect aspects of his environment, be that objects, persons, ideas or events (Bode, 1997: 12). Values are conceptions of the desirable that translate into components of human behaviour that are embedded in normative dimensions of conduct. Conceptions of the desirable will simultaneously occur in the groups and social systems that carry that culture as well as the personalities of the members of that group. In culture values take on the form of criteria for the selection of orientations possible in situations (Bode, 1997:12). For example if a person values materialism then his or her work ethic would be different from that of a person who holds Christian or Patronage values. Patronage or Clientism (Kretzschmar, 2012: 57) can be defined as an extreme promotion of one’s family, ethnic group or political supporters at the expense of other members of the population. Hence patronage leads to the abuse of power and the looting of public resources (Kretzschmar, 2012: 4).

Values determine attitudes; so values will determine attitudes toward work. An attitude can be described as a relatively stable, learnt disposition to react to objects; people and situations (Hattingh et al., 2006: 21).

The following excerpts from the research interviews attest to the differing work ethics experienced by differing health and social care practitioners interviewed by the researcher.

"I have to say that the social workers don't work like they should do. I make referrals and it's so slow. They should be doing home visits but the reality is they don't want to. They are demotivated" [Interview 12, pg. 3].

"I see in this clinic that when nurses start they are so busy and full of enthusiasm. In the first six months this changes. They become slow disengaged and they appear as though they don't want to work anymore. They become slow" [Interview 13, pg. 3].

In essence work values encompass the small qualities and characteristics as values discussed earlier; but they have their application in the work domain. Nathan (1992: 22) says that values in relation to work represent the degree to which a person regards his work as "worthwhile" (Nathan, 1992: 22). Wollack in de Jong (1985: 1) commented on the Protestant Work Ethic. His work comprised of six values which contribute to the ethic of work: status, competition, and pride in work, activities, earnings and participation. In South Africa a list of work values based upon intuitive selection were compiled by Linhard in Bode (1997: 31). These are: security, money, status, independence, social values, intellectual values and satisfaction derived from work itself. Some authors have classified these values into intrinsic and extrinsic work values. Intrinsic values are inherent to the work activity and satisfaction is derived from achievement, independence and self-actualisation. Extrinsic values are associated with rewards the work can offer the worker such as money, security or status (Bode, 1997: 34). The development of strong work values and highly productive work behaviour depends heavily upon the development of self-discipline, self-control and personal initiative.

Health and social care practitioners told the researcher that over time their enthusiasm for their job had waned. They derived little job satisfaction because they saw little difference in the lives of AIDS orphans in the interventions they made and this affected their motivation within the workplace.

"When I make referrals I find other professionals reluctant to get involved because it takes time and commitment to help children who are AIDS orphans" [Interview 22p.g 9].

"My colleague is a manager at Bhisho. She also doing the job of her manager because she is slow at her work and the work doesn't get done!" [Interview 22, pg. 16].

According to Cherrington (1980: 3), outstanding workers have a strong work orientation which is generally acquired during early childhood and adolescence. He further goes on to say that the most influential techniques in the development of the work ethic are induction and modelling i.e. teaching by precept and example.

"When different cultures work together they view their work differently" [Interview 22, pg. 16].

Stones and Philbrick (1992:42) conducted a study of the work ethics of black South African students with regard to the Protestant Ethic Scale (PES). Results showed that the means PES score obtained by university men was not only higher than that obtained by their female contemporaries but was also higher than any means PES score outside Africa.

If every professional did their job properly we could go far as a nation" [Interview 22, pg. 16].

What became apparent to the researcher was that the understanding of the development of a work ethic in people is complex and unique to each individual and that the reasons for this are complex to understand. The development of a work ethic is based upon the complex value systems which as humans we develop from childhood (Stones, 1992:13). The intrinsic and extrinsic components of its development are unique to each person. Work values if cultivated in an environment which facilitates "good work" can lead to much satisfaction of the worker. Cherrington (1980) developed a continuum of importance to conceptualise work values. Which ranges from a low end (g), where work is undesirable and has no meaning or importance to a high end (a), where the importance of work is exaggerated to the extent that it impairs a person's physical and emotional health. The traditional work ethic is defined by points B and C along the continuum. At these points work is highly regarded at either terminal (where work itself is valued as a desirable activity) or an instrument value (where work is valued because it produces desirable consequences). Movement along the continuum is characterised primarily by two factors: the rewards of work and a time perspective. The rewards or outcome of work can be positive, such as self-esteem, promotion, service to the community and accomplishment of goal. The outcomes may also be negative, such as boredom, fatigue and loss of personal freedom.

The researcher can attest to the complexity of understanding how people's differing work ethic is seen by colleagues. Is there a differing work ethic because of a differing world view regarding work or because of a relentlessly challenging work, environment or the challenging factors of health and social care practitioners' working lives? but what is apparent is that there was diversity in the expression of the seen ethic of work; but, the understanding of this is complex due to both intrinsic and extrinsic factors.

SUB-Theme 1.11 By the need to understand adequately the "life world" of children who are AIDS orphans living in the township communities.

HIV/AIDS has taken its relentless toll on children and the situation of orphan hood is fuelled by poverty, prejudice and ignorance. Accordingly the ability and /or desire of the affected families and communities to support these children is vastly reduced or non – existent. The traditional African surrogate parenting has become dysfunctional because of a lack of understanding born out of stigma, discrimination and fear regarding the nature of HIV/AIDS; and has denied too many children surrogate parenting by the extended family. The families and communities that are expected to respond to the plight of AIDS orphans are also faced with social and economic problems themselves since poverty affects their commitment to care for and support children living in their communities who are AIDS orphans. Grandparents are usually poor and old and have to struggle to raise orphaned grandchildren on meagre government grants (Chakalane-Mpeli and Rocks, 2007: 84).

The AIDS epidemic has the following consequences for children: they may become orphaned or abandoned as a result of HIV/AIDS; they may be members of a HIV positive family and be at risk of becoming infected themselves or they may be living in an affected family but be members of a community which has suffered socio-economic devastations brought on by HIV/AIDS and the legacy of apartheid (Chakalane-Mpeli and Rocks, 2007: 82). As parents become ill or die children are left at a crossroads, where their lives have the possibility of following one of several courses. They can be taken in and cared for by the extended family such as aunt and uncles (AHH), they may be cared for by grandparents (GHH), or they may care for themselves with the eldest child becoming the head of the households caring for siblings in a child -headed household (CHH). In most cases families or communities who could have taken the responsibility and made a difference in providing care and support to children who are AIDS orphans turn away from these vulnerable children.

The needs of orphans living in the township essentially fall into four categories.

- Physical Needs (food, clothes, shelter)
- Economic Needs (financial capital, physical capital)
- Psychological Needs (relationships, love, belonging, self-esteem, information and counselling)
- Control Needs (independence, family unit)

(Chakalane-Mpeli and Rocks, 2007: 85).

The health and social care practitioners found it difficult to adapt their care and support interventions to the ever emerging and changing “life world” of children who are AIDS orphans living in the township communities. This was further complicated by the fact that health and social care practitioners in South Africa were living and understanding their own history and culture often different from the “life world” and the challenging and shocking reality of children who are AIDS orphans living in the townships communities. Health and social care practitioners had to learn and adapt to the changing care and support needs of AIDS orphans, who are victims of the AIDS pandemic in South Africa. This was a challenge to them and presented the reality of a “life world” they had not experienced and a reality which was beyond their own “lived experience,” both professionally and personally.

“I am a psychologist I am white I live in the suburbs; yet I work in the township communities. Understanding the plight of children living as AIDS orphans is a challenge as it’s a foreign reality to me. I don’t know poverty, yet I see children living in poverty every day. How can I help these children if I don’t understand their life world” [Interview 12 pg. 4].

“You see, our township communities are poor, very poor especially in the informal settlements. Look out of my window; you see poverty, you see shacks, no running water, people sitting, and people sick and waiting to die. That is what our communities face. That is what children face living in the townships: unemployment, rape, alcoholism, HIV/AIDS” [Interview 11, .g: 2].

South Africa is deemed to be a middle-income country, yet it has one of the greatest levels of income inequality in the world. “While the wealthiest 10% of the population account for 51% of the country’s income, the poorest 10% have only 0.2% (Majumdar and Mazaleni, 2010: 1). Health and social care practitioners admitted to the researcher that on the first occasion they met children who were AIDS orphans they had been shocked at the extent of the need and suffering of these children. They attested to having little frame of reference as to the extent of AIDS orphans experiences, challenges and suffering. They had to embark on the challenge of understanding the “ life world “ of AIDS orphans; which was daunting for them on every level,so that they could render appropriate care and support.

The health and social care practitioners spoke about the complexities of understanding the needs of AIDS orphans in the light of the poverty that was evident in the communities in which these children lived. Many of the AIDS orphans’ needs were understood by the health and social care practitioners as being social because of the ensuing cycle of poverty children faced on becoming AIDS orphans living in the township communities. Health and social care practitioners found it challenging at every level to give the necessary care and support to meet AIDS orphans physical, emotional, psychological and social needs in the ensuing cycle of poverty which created a challenge for them at every level in the interventions required to meet the care and support needs of children who are AIDS orphans living in the townships communities.

“Poverty includes deprivation, constrained choices and unfulfilled capability;” all of which impact on well-being and accordingly the standard of living, which equates with quality of life. It’s a never-ending cycle of a lack of money, an associated lack of assets and skills with which to alleviate financial pressure; so the cycle continues (Mbirimtengerenji, 2007: 605). Added to HIV/AIDS a vicious cycle results because the impact of HIV/AIDS increases poverty and social deprivation, whilst poverty and social deprivation escalate susceptibility to HIV-infection. There is no doubt that there is a strong association between poverty and ill health, which is evidenced by life expectancy indicators in developed versus developing countries.

"I see children come to me for care and support. They sit where you are sitting. They are hungry. In winter they are cold, they have holes in their shoes and their clothes are too small. They tell me they don't want to take their ART anymore. They want to die and go and be with their mother" [Interview 11, pg., 3].

Health and social care practitioners all acknowledged they were overwhelmed by the suffering of AIDS orphans and felt ill-equipped as professionals to assist in the provision of care and support to them. They all expressed the shock and bewilderment they felt as professionals when AIDS orphans spoke about the suffering of their lives and present them with their overwhelming needs.

Children who are AIDS orphans often experience depression, abandonment and social isolation once the diagnosis of HIV/AIDS has been made and is known amongst members of the community to which the child belongs. The fear, stigmatisation and ostracism of people with HIV and AIDS is reflected on the children when they too are discriminated against or when they isolate themselves from their peers due to the shame they feel for a parent who has suffered or who is suffering from HIV/AIDS (Chakalane-Mpeli and Rocks, 2007: 83) .The health and social care practitioners spoke about the time it took to understand the everyday lives of AIDS orphans living in the townships. They had to learn a new "life world," one full of grief, sorrow, loss, vulnerability, sickness and need on every level. Many health and social care practitioners spoke about being ignorant of the plight of AIDS orphans until they began to interact with them in their professional lives and to understand the challenges of delivering care and support to them within their various professional roles.

"It's so difficult to see children suffering: I use the word suffering because they do suffer. When they say they have nothing, they have nothing. Many give up on life and don't bother going to school because they are bullied for being AIDS orphans and they feel less than other children" [Interview 21, pg. 13].

"The most heart-rendering thing I ever heard was when a brother and sister came to see me. They were staying in a CHH. They were so thin I got porridge from the clinic to give them. The brother said there are times when we sleep without food and my sister cries. But I am always comforting her saying 'God is watching over us'. I remember those children. They are doing better now. I tell them that because you are alive, God still has a plan for your life; otherwise you would not be here" [Interview 20, pg. 23].

“It was a big shock the first time I saw an orphan. To try and understand their life is very difficult. Their life is just very hard. They struggle at home; they struggle in school. We collect clothes from our colleagues, friends and churches to give these children because they get cold in winter really cold. The students also bring us their clothes from the local university [Interview 5, pg. 3].

Many health and social care practitioners said they found it hard to listen to and to acknowledge the suffering of,AIDS orphans and they found it difficult to give medication to children and send them home into homes where there was no food. Health and social care practitioners experienced personal and professional tension in accepting the suffering of children who were AIDS orphans living in their own communities since access to food for HIV/AIDS pre-orphans and orphans is very limited (Bejane et al., 2013: 76).

“When I see children who find it hard to take their ART, it is always because they don’t have food at home. Many of them have just one meal a day. The fortunate ones have two. I am always giving advice about how they are to take their medication without food. I wish I could do something about this. Sometimes I give money from my own purse for them to buy mealie-meal. To be sick, hungry and an orphan in the township is a very hard life” [Interview 7, pg. 3].

“What I see is that when children become orphans, they tell me all the money dies too. They come to me to help them process the grief of losing their parents. I buy juice and biscuits for them from my purse. They come to me from school. Many of them have only had breakfast so I buy juice and biscuits for them because they don’t even know if there will be food for them when they return home from seeing me. Most of the children I see have only a CSG or are living off their grandparent’s pension. All the houses I visit where there are AIDS orphans are poor. The worst are the AHH if no-one in the family is working and CHH “[Interview 24, pg. 2].

The health and social care practitioners spoke about how difficult and heart rending it is to see children who are poor suffering and deprived every day. Health and social care practitioners (Bejane et al., 2013: 77) were often frustrated because the needs the children presented with could not be met by the health and social care practitioners because of a profound lack of resources. Children who are AIDS orphans living in the township communities are poor and always victims of the breadwinner being lost from the family home, either through death, unemployment or disability (Bejane et al., 2013: 79).

“I often see children who are orphans who are bullied at school or in their community. They talk about this to me. They are bullied because of their poor-fitting old school uniform. I see them when they come to me. They look poor and they feel poor. They are desperate to be normal but they don't fit in at school because of how they look and feel inside" [Interview 14, pg. 3].

Many health and social care practitioners told the researcher that they found it difficult when they went home at the end of the day to switch off, disengage from what they had seen and experienced during their working day and guilty that they went home to homes full of comfort, warmth, food, clothing and the privileges of wealth, when they left behind in the township communities children who were suffering because of so much lack. This caused anxiety in the lives of health and social care practitioners as they sought to embrace their own reality of living in South Africa with the "life world "reality of AIDS orphans living in the townships. It was as if the plight of AIDS orphans in a sense eroded their world full of comfort and caused them to embrace a battle of conscience at the deepest level, professionally and also within their own humanity. It was as if the foundation of the world in which they lived was shaken as they saw the reality of suffering children. They entered a cycle of soul-searching to answer difficult questions, concerning suffering children and poverty, whilst experiencing a life of privilege, comfort and to a greater extent well-being.

Clothes do not only fulfil the need for comfort, warmth and protection but also fulfil the psycho-social need for conformity to the group, recognition by others and the building of self-esteem (Bejane et al., 2013: 19). Often children who are orphans do not attend school not only because they feel unsafe and vulnerable but also because they don't have the necessary clothing and shoes to fit in like the rest of the children.

"Children who are orphans often tell me that can't learn because they are too sad. They tell me 'my life died when my mother dies'. They lose their home, their parents, their financial support, their education and their friends. They also lose their place in community because of shame, poverty and HIV/AIDS. They deal with multiple losses and they are grief-stricken because of this. They tell me it helps them to talk but they need more support" [Interview14, pg. 4].

"AIDS orphans are children who are neglected. They are sick because of poverty, psychologically disturbed because of trauma and vulnerable because of living in poor social conditions; All I do is give them tablets, a bit of money for food and sent them home where they sleep without food, cold and sometimes in darkness. I ask myself, what kind of life is that? At the end of the day I fill in the register to say how many clients I have seen. It just isn't enough. We don't do enough for these children" [Interview 21 pg. 5].

"Many times in the day I see children sat in front of me with holes in their clothes and shoes. I hear their plea that life simply isn't fair. They are poor and they feel poor. They feel worthless because they don’t even have decent clothes to wear. I ask how I would feel if I were made to wear old clothes with holes in” [Interview 21, pg. 6].

Children’s rights cannot be made meaningful without full acknowledgement of their very violation, especially economically and socially. Children who are AIDS orphans are deprived daily of food security, healthcare, housing and education (Mahon, 2010: 172).

Many health and social care practitioners interviewed for this research study were frustrated because of a lack ability to provide holistic care and support for the children who were AIDS orphans living in the townships. They recognised the need for a holistic approach in caring for these vulnerable children and that the care and support needs of children living as orphans was complex and multifaceted. It is recognised by PEPFAR that a holistic and sustainable approach based upon research-endorsed social policy would enhance the well- being of children who AIDS orphans living in the township communities (Beverly et al., 2012: 127): yet high targets provide the motivation needed only for the most affordable and flexible services rather than the services which are most needed. This sometimes led to hasty role out of commodity based responses (Beverly et al., 2012: 127), but this is not the best way to deliver quality services to meet the needs pertaining to children’s well-being. There are six fundamental domains of child well-being: health, education, shelter, care, food and nutrition, psychological support and protection from abuse and neglect. An additional area of economic strengthening has also been recognised as a means of improving a family’s ability to provide for a child’s needs (Beverly et al., 2012: 128).

Health and social care practitioners felt there needed to be changes to the resource base and health systems in South Africa regarding the provision of this holistic care for children who are AIDS orphans living as AIDS orphans living in the township communities. They told the researcher that although the “life world” of children who are AIDS orphans living in the townships was more apparent and well documented there needed to be drastic improvement in the provision of care and support to these children from the way their ‘life world’ was being recounted and presented to health and social care practitioners. Health and social care practitioners told the researcher that the ‘health and social systems’ care and support responses were not in place to adapt and respond to the “lived experience” of children who are AIDS orphans living in the townships communities. Many felt management to be out of touch with the plight of AIDS orphans even though health and social care practitioners had made the needs of these AIDS orphans known through the systems in place. They felt deeply challenged as they gained ever-increasing knowledge of the “lived experience” of children living as AIDS orphans; yet implementing care and support to address the needs of the“lived experience” of AIDS orphans was overwhelming, frustrating and full of challenge.

The response to vulnerable children requires accountability and responsibility. Child vulnerability and its links into the different sectors and services needs to be understood comprehensively and thus seen as a national development priority to create the required level of accountability and sense of shared responsibility across all many stakeholders have a largely reactive, as opposed to proactive, approach to the response to vulnerable children. There must be a clearly agreed upon national definition of what referral mechanisms and case management systems for vulnerable children seek to achieve and a common understanding of how they will function. The strength of a case management system is its collaborative nature which oversees the process of assessment, planning, facilitation, coordination and advocacy for services to meet the individual care, protection and justice needs of all children who are vulnerable to violence, abuse, exploitation and neglect (UNICEF and Malawi, 2012: 4).

SUB- THEME 1.12 The need to develop resilience as a health and social care practitioner

Resilience is a dynamic capability which can allow people to thrive on challenges, given appropriate social and personal contexts. The dimensions of resilience (which include self-efficacy, self-control, ability to engage support and help, learning from difficulties, and persistence despite blocks to progress) are all recognised as qualities that are important in health and social care practitioners. Developing professionalism is a core expectation of modern health professional education but also the concept of resilience, which appears to relate to the long-term ability of individuals to survive in and thrive on adversity (Howe et al., 2012: 349).

Health and social care practitioners told the researcher that they felt challenged to develop resilience to enable them to cope with the overwhelming challenges of providing care and support to children who were AIDS orphans living in the townships communities. Health and social care practitioners encountered suffering which challenged their beliefs to the core, concerning their respective professions and the world as they knew and appreciated it. Many professionals told the researcher they didn’t realise that children who were AIDS orphans experienced such suffering, although they had previously acknowledged that they were aware of the plight of AIDS orphans in South Africa and had been severly shocked when they met face-to-face children who were AIDS orphans and heard and saw first-hand the hardship of their lives and the extent of their suffering.

“I remember the first time I met an AIDS orphan. She was 12 years old. I remember thinking ‘it’s not right for a child to be so sad at 12 years of age’. I was shocked when she told me her story, I didn’t think children lived like this in our city” [Interview 9, pg. 3].

“I feel like I don’t understand the world I live in anymore, when I see how children suffer as AIDS orphans. It’s wrong how these children suffer it’s just wrong, “[Interview 1, pg. 5].

“I once went to a child-headed household. Children were sleeping on a bed without a mattress, and I ask myself. What kind of world do we live in, if children have to sleep on a wire frame of a bed like that? I also learnt these children beg for food from the neighbours. When I placed these children who were AIDS orphans in a place of safety they slept under the bed on the floor. I ask myself, ‘What happened to people in our county? Why do children have to live like this? You know they didn’t even chew their food, they just swallowed. The staff in that place of safety had to teach them to chew. The boy was already 10 years old” [Interview 20, p.g7].

The assumptive world is the set of values and beliefs a person has about how the world works. This assumptive world is so fundamental that people hardly question it; however, when this assumptive world is challenged, it can cause trauma and people either experience post-traumatic stress disorder or they experience post-traumatic growth, otherwise termed ‘adversarial growth’. This is different from resilience, since resilience is learning the ability to be minimally affected by trauma whilst post traumatic growth is the struggle to overcome major trauma Tedeschi, in (Moore and Barnett, 2013: 329) . There are according to Tedeschi five areas of post-traumatic growth: appreciation of life, personal strength, relationships with others, new possibilities and spiritual change. Tedeschi further says that, when a person can reconstruct an effective core belief system or an assumptive world through a process of reflection, he/ she is able to construct a revised life narrative and have a positive outcome Tedeschi in, (Moore and Barnett, 2013: 322).

The health and social care practitioners acknowledged that the world as they had appreciated it had changed and that their values and priorities and the things they valued had also altered. Many professionals told the researcher they were shocked by the extent of the suffering of AIDS orphans but whilst initially shocked or traumatised by what they heard and saw, they predominantly developed resilience and were able to adapt to the challenge of their professional roles to care for and support children who were AIDS orphans living in the townships. They also told the researcher that they had also changed as people although they had experienced some post-traumatic growth as they revaluated their own lives and their professional roles. They appreciated the life they had more readily; appreciated their families and friends more and were also more aware of God and their need of Him, to strengthe, guide and help them to give comfort and hope to children who were AIDS orphans. They also evaluated positively and appreciated differently “the difference” they could make in the lives of children who are AIDS orphans living in the townships in their respective roles as health and social care practitioners.

“I realise that when he walks out of my office he walks into God’s care. So I help him to stay in God’s care by praying for him. He was God’s before he came into my office and he is God’s when he leaves. My job is to be kind, to listen to him and to show consideration for all he talks about, when he comes to see me” [Interview 8, pg. 5].

“It was hard for me when I first started to work in this clinic, I didn’t really know what children who were AIDS orphans in the township faced. Now I do know. It’s a huge adjustment to understand their lives. Many times I have asked myself,’What good I can do?’ To help these children, I live in a different world to them. But then I think If don’t help them, how can I expect others to? I realise that how I am with them helps them; so I am gentle and kind and I listen and tell them their lives are important and that the future can be better” [Interview 4, pg. 2].

“I am a psychologist and I am working mostly with children in CHH who are AIDS orphans. It’s too terrible what they face every day. I go home and I don’t want to eat, once I was shouting at my own child saying, ‘Eat your supper!’ There are children I see who don’t eat. My child said to me, ‘Why do you shout at me?’ I realised these AIDS orphans were affecting me. But I know I must eat and take care of myself as these children need me to help them. I realise I was wrong to speak to my son like this; but I want him to appreciate what we have. We are so fortunate as a family. I don’t complain like I used to and I worry less. In my family we have more than enough. These children have taught me to be more grateful” [Interview 14. pg. 6].

Health and social care practitioners who were constantly exposed to the suffering of AIDS orphans did, however, experience symptoms of post-traumatic stress disorder, mainly loss of appetite, sleepless nights, anxiety and panic attacks, not being able to get these children out of their minds and fatigue, because of all they were experiencing concerning the lives of AIDS orphans every day in their respective professional roles. It was as if professionals had to embrace a process of adaptation, as their assumptive world altered and they had to be able to evaluate positively. They were able to develop resilience and appraise that they were able to make a difference in the lives of AIDS orphans. Some health and social care practitioners in this process of adaptation and new appraisal of the fact that they were having to affect positively the lives of children as AIDS orphans, were signed off from work by their GP. One psychologist was away from work for six month with stress.

The American Psychiatric Association describes post-traumatic stress disorder as the exposure to an event in which the person experiences or witnesses actual or threatened death or serious injury to which the person’s response involves intense fear, helplessness, or horror. The symptoms of Post-Traumatic Stress Disorder include re-experiencing the event (nightmares, flashbacks, distress, and physiological changes when recalling that event); avoidance of the trauma thoughts (loss of interest, detachment, emotional numbing, and psychogenic amnesia), and hyper-arousal symptoms (insomnia, irritability, hyper-vigilance, sleeplessness, loss of appetite and memory problems), (Khokhar, 2013: 45).The following exerpts from the interviews with participants demonstrate this.

“I found it difficult to sleep in the night when it’s raining. I worried about how the children in the township are. I know they are probably hungry and cold, I don’t feel good about this. I appreciate more what I have in my home. I don’t take things for granted like I used to. I find myself less critical and many times I say to myself: ‘I have nothing to worry about’ ” [Interview 20, pg. 8].

“I often phone children in the evening just to make sure they are safe in their homes and to let them know someone cares. I sleep better if I phone them otherwise I just lay in my bed awake. I am thankful I have food to eat, a bed and a loving family. Truly I must say I am wealthy” [Interview 14, pg. 5].

“When I come to this clinic I must leave my feelings at the door. If I feel too much I can’t help these children; so it’s best that I don’t feel. During the day when I see AIDS orphans I tell myself they belong to God and I do my best and I pray for them and for His angels to watch over them” [Interview 5, pg. 2].

“Sometimes my husband tells me I am distracted at home. I find it hard not to think about these children. My children have so much. These children have so little, I worry about them especially at night. I lose my appetite if I am stressed. When I first started working with ADS orphans I was so stressed I just didn’t want to eat and I felt guilty all of the time. Its better now but it was like that” [Interview 1, pg. 3].

Health and social care practitioners have to sustain long periods of hard work, manage high levels of demands and responsibility, ever-changing circumstances (in terms of patients, staff and organisational requirements) and increasing public expectations for support and care, while living up to the standards required of all health and social care practitioners and their regulatory bodies. Primary healthcare practitioners are always at risk of periods during which workload, adverse events, emotional demands and the lack of supportive relationships an other factors may act as stressors that can undermine professional practice. Coping with these demands requires stamina, good health, appropriate knowledge and skills and the ability to respond positively to challenging experiences (Howe et al., 2012: 350); but health and social care practitioners also need to be able to care for themselves in order to offer the best care to their patients. ‘Resilience’ has been referenced as flexible adaptability in the face of challenge, which can be recognised in both individuals and social groups. One study has defined resilience as a set of attributes demonstrated by an individual over a period of time as: ‘the ability to succeed, to live and to develop in a positive way ... despite the stress or adversity that would normally involve the real possibility of a negative outcome”. Martin and Marsh have usefully summarised the dimensions of individual resilience as ‘confidence (self-efficacy), coordination (planning), control, composure (low anxiety) and commitment (persistence), (Howe et al., 2012: 353).

The health and social care practitioners revealed to the researcher the need to take care of themselves in order to help AIDS orphans, explaining to her, that they had to cope and stay strong as these AIDS orphans needed to hear the words of hope, comfort and encouragement that they spoke to them every time they saw the AIDS orphan. Most of the professionals prayed for the AIDS orphans, which helped themselves to cope on their way home by praying and appreciating they were just one person and could only do so much. Health and social care practitioners also recognised the need to be really determined and positive in order to help these very vulnerable children.

“It was hard for me when I first started to work in this clinic. I didn’t really know what children who were AIDS orphans in the township faced. Now I do know. It’s a huge adjustment to understand their lives. Many times I have asked myself ‘What good I can do to help these children? I live in a different world to them’. But then I think If don’t help them how can I expect others to? I realise that how I am with them helps them; so I am gentle and kind and I listen and tell them their lives are important and that the future can be better” [Interview 4, pg. 2].

“I realised early on these children need me to be strong. I must be positive and stay well otherwise how they will trust adults if I also let them down? So I pray. That’s what I do. I pray. God keeps me strong to do this work as a social worker for these children” [Interview 19, pg. 4].

According to the work of Antonovsky, a medical sociologist, resilient individuals are recognised as those who ‘manage stress stay well’ who learn from, and find meaning in, what might otherwise be significant or overwhelming psychological threats. In practice this means that resilient professionals believe that what they do can have a positive impact on a situation that some components of the ‘system’ can be controlled or influenced by one’s own actions; that persistent effort is worthwhile; and that setbacks or potentially threatening events are inevitable and surmountable; but do not need to cause excessive anxiety or withdrawal. Tedeschi in, (Moore and Barnett, 2013: 325).

Health and social care practitioners told the researcher they could “make a difference” in the lives of children who were AIDS orphans living in the townships if they were realistic about what their interventions could yield in the lives ofthese children. Many were positive in their assessment of the differences they could make in the lives of children who were AIDS orphans, speaking about adding value by their attitude of kindness openness comfort and encouragement. Outside the work place many through their caring and supportive attitudes raised awareness concerning the plight of AIDS orphans and organised churches and local businesses to become involved in collecting school uniforms, school shoes and school bags to give to AIDS orphans.

"I realised the best way I can help children who are AIDS orphans is to speak positively to them and speak words of comfort and hope. I have told them many times, if God did not have a purpose for your life you would not be alive. Because you are alive there is a purpose for you. I think this gives them strength to continue" [Interview 19, pg. 1].

"I always tell the AIDS orphans 'I see you don't have to stay poor.If you can get an education you can get a good job. I tell them how poor I was growing up and now I live in a home which cost over R300, 000. I tell them to focus. That's what I had to do. If I feel sorry for them. I can't help them so I speak strength and hope to them and tell them God cares about them" [Interview 10, pg. 4].

"I always make a point of telling the children that I see in my office something lovely about them. One girl she like to show me her school work, I always praise her. She always says 'Thank you, sister' when I do" [Interview 10, pg.2].

"We have an orphans' day every year where we celebrate our orphaned children. We give them everything they need for school and try as best we can to make them feel special. We work with local churches, schools and NGO's to make this happen for the children" [Interview 5, pg. 4].

Health and social care practitioners went through a process of adapting to the responsibility of caring and supporting children who were AIDS orphans living in the townships despite experiencing stress and trauma which challenged the assumptions they had concerning the world they lived in and which caused them stress and tension as they went through a process of adaptation and re-evaluation to appraise life differently and make the best contribution they could as health and social care practitioners in caring and supporting children who were AIDS orphans living in the townships. They embraced the challenge of developing resilience to enable them to "manage stress" in their respective professions and still appraised themselves as "making a difference" in the lives of AIDS orphans that came to them.

In summarising theme one, the researcher would like to highlight the following aspects: Health and social care practitioners who experienced prevailing challenges related to providing care and support to children who are AIDS orphans living in the townships told the researcher that there was a lack of support services for AIDS orphans living in the township communities which caused the health and social care practitioners to feel overwhelmed at times, as well as experiencing severe stress, anger, depression and fatigue because of the lack of these support services.They felt that the lack of health and social support services was not at all conducive to the provision of holistic care and support to children who were AIDS orphans living in the townships communities.

The health and social care practitioners further conveyed to the researcher that when children became AIDS orphans they experienced physical, psychological social and financial distress, which was exacerbated by the inefficient referral systems. Primary healthcare practitioners in primary healthcare clinics, social workers and psychologists, further complained that the overwhelming numbers of children accessing them for care and support made it impossible for them as professionals to have the time required to build a trusting therapeutic relationship with the children who had become AIDS orphans. They further found this even more distressing. Most felt overwhelmed and frustrated that they were unable to have a meaningful therapeutic relationship with children due to time constraints, through which the necessary care and support for these AIDS orphans could be facilitated.

The health and social care practitioners experienced the absence of people and material resources in the work place as a constant source of frustration and that infrastructure constraints at faculty level led to their experiencing enervation. This at times undermined the reasons that had caused them to pursue their respective health and social care professions yet another cause of their distress and, at times, depression.

Primary healthcare practitioners in primary healthcare clinics, social workers and psychologists all repeated that children who were AIDS orphans living in the townships and their extended families delayed accessing care and support from health and social care practitioners; because the children experienced shame, from being stigmatised by community members due to being AIDS orphans and that childen were reluctant to admit they were AIDS orphans as, they felt ashamed their parents had died of AIDS.

The health and social care practitioners further felt that the lack of interdisciplinary collaboration hindered the provision of holistic care and support to children who were AIDS orphans and this further caused the health and social care practitioners to experience frustration and at times extreme anger and a feeling of being devalued and misunderstood as they felt the quantity of work was more important to management than quality. They felt the care and support they gave to AIDS orphans which they presumed added value took time and was a quality intervention which was not represented in the statistical data appraised by management personel. Health and social care practitioners also experienced a differing work ethic amongst colleagues, which at times caused frustration and tension in the respective places of work. The researcher ascertained that this was complex to understand as there were both intrinsic and extrinsic factors which cause this differing work ethic.

The health and social care practitioners were challenged to understand and facilitate the provision of care and support to AIDS orphans as the “life world”, of children who were AIDS orphans was beyond the health and social care practitioners own experience and lived reality. The “life world” of children who are AIDS orphans was experienced as being overwhelming challenging and deeply sorrowful. They were challenged in their respective health and social professions to render effective care and support to children who were suffering and living in very difficult circumstances as AIDS orphans in the township communities. Finally in completing this summary the researcher would like to comment on the considerable challenge health and social care practitioners experienced in the need to develop resilience, a process of deep reflection and re-evaluation for they had to re-evaluate the context of their “assumptive world” and embark on a process of personal and professional adaptation to enable them to develop resilience as health and social care practitioners, making valuable and necessary contributions in the provision of care and support to very vulnerable children, who were AIDS orphans living in the township communities.

4.4.2 Discussion of Theme 2 and related sub-themes: Health and Social Care Practitioners had unique experiences related to providing care and support to children who are AIDS orphans living in the townships communities.

A diagrammatical presentation of Theme 2 with related sub-themes is presented in Figure 4.3 as follows:

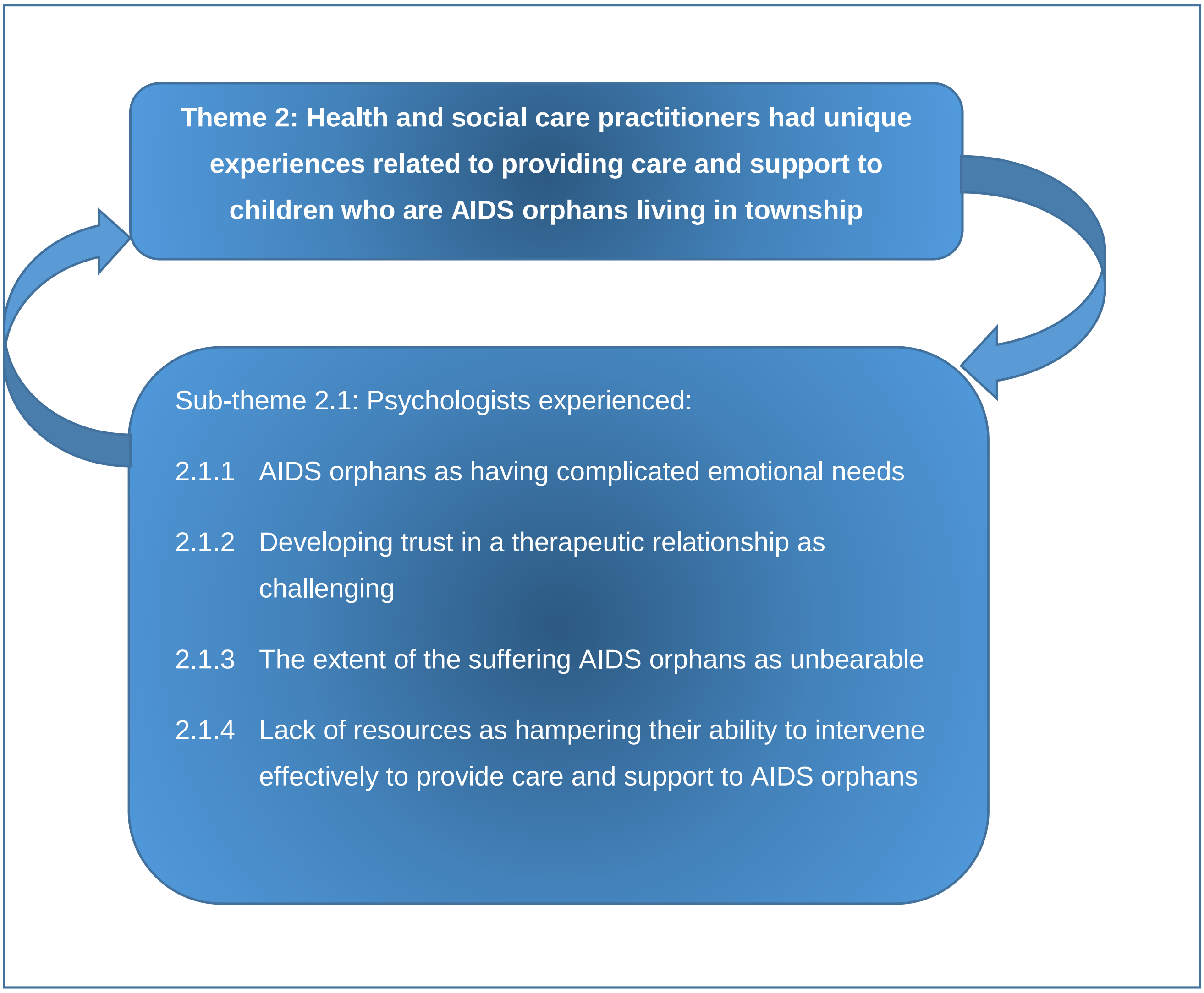


Figure 4.3: Health and Social Care Practitioners had unique experiences related to providing care and support to children who are AIDS orphans living in the townships communities.

THEME 2 Health and Social Care Practitioners had unique experiences related to providing care and support to children who are AIDS orphans living in the townships communities.

Psychologists, primary healthcare practitioners and social workers all had different experiences in providing care and support to children who are AIDS orphans living in the townships communities. Experience refers to practical contact with an observation of facts or events; to do with the acquisition of knowledge or a skill acquired by a period of practical experience, especially referring to something that is gained in a particular profession. In this instance, professionals learnt skills relating to rendering care and support to children who are AIDS orphans living in the township communities. Experience can also pertain to an occurrence which leaves an impression on someone (Oxford English Dictionary, 2009: 213).

"The first time I met a child who was an AIDS orphan living in the township, I was deeply moved by their plight. It was a new experience to meet a child who was an AIDS orphan" [Interview 12, p.g:5]

"Each of us is a unique strand in the intricate web of life and are here to make a contribution." (Chopra, 2013: 1). Uniqueness refers to 'being one of a kind, unlike anything else', which is the situation health and social care practitioners are in, regarding the provision of care and support to children who are AIDS orphans living in the townships communities. Uniqueness is connected to a particular situation, a particular group of people or an experience. To be unique is to be remarkable to be special, to be one of a kind.

"The children I see who are AIDS orphans living in the township communities are unique, they are resilient and have suffered so much. They are learning to cope with adversity and to go forward in life. We celebrate them every year at our orphans' day, but we should be celebrating them every day" [Interview 14, pg. 5].

The health and social care practitioners interviewed for this research study all had unique experiences concerning providing care and support to children nwho are AIDS orphans living in the township communities. This will be represented in the following sub-themes.

SUB- THEME. 2.1. Psychologists experienced AIDS orphans as having complicated emotional needs

According to Wood, Chase and Aggleton (2006: 3), the way in which children respond to parental loss is in a complicated way and depends upon factors such as their developmental age, survival drives, sensitive caring and the amount of comfort and encouragement they receive from their social environment. For children the grieving process normally includes a series of experiences starting with parental sickness until the time of the parents death as well as the consequences they face due to their status as orphans.

The psychologists experienced children who are AIDS orphans living in the townships communities as having complicated emotional needs which were distressing at times for the psychologists to listen to. Psychologists told the researcher that when children became AIDS orphans they experience multiple losses. It’s the experiencing of these “multiple losses” and the “emotional trauma” of adapting to the hardship of living as an AIDS orphans in the township community that causes children’s emotional needs to become complicated. Processing the grief of losing their parents becomes complicated because of these factors and the associated suffering and shame which is related to their parent’s death due to AIDS.

“It’s so difficult to listen to the heart rendering stories of these AIDS Orphans. It’s difficult for them to talk, but when they do it’s like a waterfall. Children who are AIDS orphans experience multiple losses: they lose their parents, their standing in the community, their education, their friends and their dignity because of poverty. They are angry, very, very, angry. I listen to a lot of anger expressed by children who are AIDS orphans living in the townships. Because of this anger they have difficult behaviour and often leave school to consume alcohol and drugs because the emotional pain is too hard for them” [Interview 8, pg. 3].

When children lose their parents to HIV/AIDS their lives are adversely affected, they become become seriously affected psychologically, socially and economically. These children are already overwhelmed by the loss of their parents but they often also face further psychological problems that may interfere with the grieving process, (Li et al., 2008: 157). A study by Cluver and Gardner (2007: 3) found that children who are HIV/AIDS generally showed a higher degree of psychological problems than non-orphaned children. In addition, the study found that children orphaned by HIV/AIDS were more likely than other children to internalise symptoms of depression and stress-related disorders.

The psychologists told the researcher that most of the children they saw who were AIDS orphans, were experiencing emotional trauma which caused the children to experience many emotions such as sadness, depression and also anger. Children struggled to accept that their parents had died of AIDS and all of the challenges they now faced as AIDS orphans living in the township communities.

“There are many practical difficulties children living in the township face. I see these children live with a deep sense of sadness. If the children are also HIV-positive they also face a lot of fear because of the vulnerabilities of their own health” [Interview 8, pg. 1].

"It is healing for children if they can vocalise their sense of loss. They change in their behaviour when they are able to speak about the loss that they experienced. Many children I see who are AIDS orphans live with repressed grief; they face so many losses when they lose their parents. Children with repressed grief find it difficult to concentrate in school. They may not even be able to function in the school environment because the school environment reminds them when they did have parents and what their life was like then. They can become difficult acting out, being aggressive and disengaging in relationships that used to be important to them" [Interview 8, pg.2].

Children who become AIDS orphans are even found to have suicidal thoughts and also exhibit higher levels of delinquent behaviour and other behavioural problems than non-orphaned children. In addition , UNAIDS, UNICEF and USAID (2002: 4), reported that many children orphaned by HIV/AIDS suffered severe mental and physical pain as a result of trying to assist their sick, parents back to health and being forced to watch them as they died, often one after the other. Issues relating to children's loss of parents due to HIV/AIDS are very serious and difficult because children are frequently faced with the difficulties of having to witness the process of dying as well as their parents growing inability to carry out their duties as parents. This has severe consequences for the child as he or she has to take over the role of a parent while at the same time witnessing the parents' pain and suffering (Loening-Voysey, 2002: 4).

Psychologists told the researcher that many children they saw in their professional role, suffered with suicidal thoughts because children are unable to embrace the multiple losses, ensuing hardship and emotional pain of watching their parents die of AIDS and all of the resulting challenges in their own lives. Some have experienced such emotional pain because of the loss of their parents and ensuing hardship that they see suicide as a release from a life that in the depth of their own sadness and loss they don't regard as worth living anymore. This is what the psychologists recounted to the researcher.

"My own granddaughter is an AIDS orphan. I lost my daughter to HIV/AIDS. My granddaughter is 15 years of age. She finds it difficult to express her feelings. We have to teach her to cope. I say to my granddaughter 'Spiritually your mother is watching over you'. This comforts her a lot. I see children who are orphans lose all sense of security in life. Your parent is like an anchor in your life and when you lose a parent you lose your anchor. Sometimes my granddaughter says, 'I just want to die so I can be with my mother' " [Interview 9, pg.3].

"A teenage boy came to see me last week. He said 'I don't want to live anymore'. He wanted to go to be with his mother. He told me 'When you are an orphan no one loves you, no-one will ever love you like a mother. I just want to die. It was heart rendering to hear him speak this to me" [Interview 12, pg. 2].

According to Schonteich (2002: 2), children who witness the process of their parents dying as a result of HIV/AIDS are more severely affected psychologically than children who lose their parents through other means (UNAIDS et al., 2002: 4). HIV/AIDS poses a unique challenge in terms of parental loss as there is a high likelihood that if one parent of the child is HIV-positive then the other is also. As a result, children are faced with the possibility of losing their parents with in a short space of time. The situation is further worsened when the person caring for the children also dies of AIDS, thereby causing the children to suffer multiple losses. The children also suffer losses as they are separated from one another. UNAIDS 2004 reported that of the many traumas experienced by children orphaned by HIV/AIDS, being separated from their siblings was one of the major traumas.

As a result of these traumatic events children experience deep sadness, develop angry feelings towards others, blame themselves and worry about the future as they face life on their own. All of these negative experiences can cause children to develop serious negative emotional problems that can lead them to engage in inappropriate behaviour such as excessive use of addictive substances, aggressive tendencies and potential suicide (UNAIDS, 2004: 4). Donahue in Foster et al, (2005: 2) found that for many orphaned children, parental illness provokes angry feelings and feelings of sadness coupled with feelings of fear associated with loss. Owing to these confusing emotions many of the children in Donahue's study were depressed and lacked ambition for the future.

The psychologists explained to the researcher that they heard a lot of anger when they counselled children who were AIDS orphans. Children are angry that they are abandoned by their parents and angry their parents died of AIDS. They feel shame regarding this, which causes them to be very angry at times.

"Most of the children I see in the clinic don't cope at school. There is a lot that makes them not to cope at school. They are repeatedly doing the same classes year after year. They can't concentrate. I also find that these children are aggressive to their grandmother or even aggressive to their teachers at school. They are not having good behaviour. They are not progressing at school because they have a big pain inside of them because of losing their parents. They can't see the future. They don't want to take their ART because they want to die" [Interview 11 pg. 2].

"Many children I see are angry. They feel a huge sense of injustice that their parents died of AIDS" [Interview 17, pg., 6]

Children who experience the loss of their parents experience feelings of loss and grief as a result of losing someone of value. The five stages of loss or bereavement are: shock, denial, anger, bargaining, depression and acceptance (van Dyk, 2008: 301).

The psychologists recounted to the researcher that it was difficult to assist children in the processing of the grief of losing their parents because of all the other traumas children faced on becoming an AIDS orphans. Psychologists explained to the researcher that many children who became AIDS orphans lost their homes and faced much financial insecurity because of the death of their parent or parents; and that children appeared to lock away the grief of losing their parents as they battled to survive the challenges in the township of being financially poor because of becoming an AIDS orphan.

"He is a young African man. He grew up feeling alienated, isolated and with a low self-esteem. He grew up not knowing who he was and without sibling support, and without a deep sense of belonging. He felt treated with indifference in the extended family because he didn't have a deep sense of belonging. He wasn't able to be secure in the family as this lack of deep sense of belonging undermined every aspect of his life. I and my colleagues assist him financially. On one level you are just dealing with Maslow's hierarchy of needs: food shelter, clothing and education. Just getting the bare basics together, so that he can achieve educationally because as he begins to achieve educationally he will begin to be able to take care of himself" [Interview 17 pg.1].

"It is very difficult for children to process their grief when their physical needs remain unmet. It goes back to Maslow's hierarchy of needs. If I am hungry my need is for food, just food nothing else" [Interview 11, pg.2].

In 1954 Abraham Maslow attempted to synthesize a large body of research related to human motivation. He created a visualization of his hypothesis in the shape of a pyramid which is divided into five levels. At the bottom of the pyramid is the physiological level which includes food, water and shelter, the most basic needs for human survival. The premise is that unless an individual's basic needs have been met, higher levels in the pyramid are of no relevance, as survival is the most basic human component.

Maslow posited a hierarchy of human needs based on two groupings: deficiency needs and growth needs. Within the deficiency needs, each lower need must be met before the person can move to the next higher level. Once each of these needs has been satisfied, if at some future time a deficiency is detected, the individual will act to remove the deficiency. The first four levels are:

1) Physiological: hunger, thirst, bodily comforts, etc;

2) Safety/security: being out of danger;

3) Belongingness and Love: being affiliated with others, and accepted; and

4) Esteem: achievement, competence, gaining approval and recognition.

According to Maslow, an individual is ready to act upon the growth needs if and only if the deficiency needs are met. Maslow's initial conceptualization included only one growth need--self-actualization. Self-actualized people are characterized by: 1) being problem-focused; 2) incorporating an ongoing freshness of appreciation of life; 3) a concern about personal growth; and 4) the ability to have peak experiences. Maslow later differentiated the growth need of self-actualization, specifically identifying two of the first growth needs as part of the more general level of self-actualization (Huitt, 2007: 1) and one beyond the general level that focused on growth beyond that oriented towards self, Maslow, 1971 in (Huitt, 2007: 3). They are:

5) Cognitive: to know, to understand, and explore;

6) Aesthetic: symmetry, order, and beauty;

7) Self-actualizating: to finding self-fulfilment and realizing one's potential; and

8) Self-transcendencing: connecting to something beyond the ego or to help others find self-fulfilment and realize their potential.

The psychologists attested to this, explaining that the children who became AIDS orphans could only process the grief of losing their parents when their basic needs for food and shelter had been met. Some psychologists expressed concern to the researcher that the nature of the violence seen in South Africa was because of the anger associated with the repression of grief.

“I see so much repressed anger in children who are AIDS orphans because they have suffered. I am sure this is why we see such violence in our townships because of all the suffering people endure and they can’t express their anger in a healthy way so they repress it. Then we have riots and people don’t know why they are rioting but they are just angry, angry at life, angry at those who have and angry at God” [Interview 7, pg.6].

“He kept his pain locked away for 11 years, following the death of his mother. He wasn’t safe enough to open it up. It took a year of counselling for him to open up and talk about the grief of losing his mother, partly because it took time to establish trust and also because he was dealing with other hurt surrounding this loss, to do with a low self-esteem because of the effects of bullying because he was poor and hungry as a young boy" [Interview 17, pg. 2].

"He said to me he often feels like he is falling. In order to survive he creates an almost dream world for himself. Some of these young people I see who are orphans are almost schizoid "[Interview 17 pg. 2].

The term "schizoid" was coined in 1908 by Eugen Bleuler to designate a human tendency to direct attention toward one's inner life and away from the external world, a concept akin to introversion in that it was not viewed in terms of psychopathology (Ball, 2010: 12-18).

One psychologist took time to explain to the researcher that as a team of psychologists they are able to discuss clients at team meetings. Psychologists felt this tendency of schizoid behaviour in young people was an adaptive behaviour and that the root of this behaviour in these young people who had become AIDS orphans and were compelled by the need to be in control; failing was not an option for them. Independence is their breakthrough in life; so these young people repress an ability to be vulnerable. When children become AIDS orphans it is as if they collapse emotionally and have to be rebuilt. This rebuilding happens through the processing of grief. The challenge for these children who become AIDS orphans is the layers of challenge they face making it difficult for them actually to process grief in a way which brings healing.

"This young man stands out in my mind because he survives. He is resilient and eloquent and expresses himself well. He is not a drop out. Some young people they do however drop out mainly due to substance abuse. Resilience is the key for these orphans. If their parents have modelled resilience to them, they do well. If not then they tend to drop out" [Interview 17, pg. 3-5].

The term 'resilience' is used to refer to the finding that some individuals have relatively good psychological outcomes despite suffering risk experiences that would be expected to bring about serious consequences. In other words, it implies relative resistance to environmental risk experiences, or the overcoming of stress or adversity. Essentially, resilience is an interactive concept that is concerned with the combination of serious risk experiences and a relatively positive psychological outcome despite those experiences (Rutter, 2006: 2).

"A young man came into my office. He grew up an AIDS orphan. He had matured in years but on the inside was a six-year-old boy who was crying because his Mum died of AIDS. As he spoke he was able to re-contextualise this grief and re-join the dots of his story. He moved from a place of grief and despair to a place of wholeness and hope. He even began to speak about what he gained in life lessons from his mother's life and death. He began to speak more about the future than the past. He was strengthened as he told his story, making sense of it in a different way. It was a humbling experience for me as a psychologist as I was present in the moment with him as he opened up and shared his loss with me" [Interview 7, pg. 7-8].

Psychologists explained to the researcher that when children were able to process the grief of losing their parents they experienced children and young people "re-joining the dots of their life story". In this manner psychologists were able to assist AIDS orphans to process their complicated, and at times overwhelming, emotions concerning the death of their parents and the challenges of living as AIDS orphans in the township communities. In this manner children were able to begin to articulate the voice of hope and resilience rather than despair and suicide.

What became apparent to the researcher was that children who became AIDS orphans, faced many emotional challenges because of the loss of their parent or parents to HIV/AIDS, and the ensuing hardship of becoming an AIDS orphans living in the township community. It became clear to the researcher from what the psychologists said, that children who became AIDS orphans found it difficult to process the grief of losing their parents, due to, so many other challenges they had to face. Children living in the township communities as AIDS orphans faced complex emotional needs because of these factors apart from the grief of losing their parents to AIDS.

SUB-THEME 2.1.2 Developing trust in a therapeutic relationship as challenging

Children who undergo unpleasant experiences may later develop feelings of mistrust and doubt towards others in their environment (Newman and Newman, 2006: 3). In this instance it takes time to develop a relationship of trust in which children can open up and talk about events which have profoundly affected their lives. Trust has been identified as a critical component of an effective therapeutic relationship. As a consequence, the building of a therapeutic relationship must include time and consistency which assist in establishing and fostering trust between councillor and counselee (Orser and Beck, 2013: 410).

The psychologists spoke to the researcher regarding the stress they experienced in developing trust in their therapeutic relationship with AIDS orphans. Trust is the key component in the therapeutic relationship between the psychologist and AIDS orphans. Developing trust is pivotal, as it provides the basis for which psychologists provide care and support to assist in the alleviation of emotional and psychological distress through a counselling relationship with AIDS orphans.

“Mostly children don’t talk, it takes time for them to open up and to share their sense of loss. I think they have lost all sense of being able to trust , particularly to trust adults because they feel let down abandoned and uncared for by them” [Interview 9, pg.3].

“It takes time to develop a relationship which can be trusted. It’s important for these children who have been orphans to learn to trust again. It only when children trust that they will be open and begin to share their life stories” [Interview 17, pg. 2].

“One girl I counselled who was an orphan just wanted the time to say to someone how she was really feeling and what was really happening in her life. I watched her eyes and she seemed lighter just because somebody was listening to her. Her heart was able to engage again because she had the time to develop relationship and be heard and understood” [Interview 12, pg. 3].

“When children begin to talk, they give something away of themselves. If I can trust you enough to tell you this, can I trust you to tell you about how I felt as an 8 year old boy when my mother died” [Interview 17 pg.].

Mikuliner in (Newman and Newman, 2006: 19) reported that adults considered a trusting relationship to be a relationship in which people felt appreciated and believed that they could rely on those they loved and trusted to remain sensitive to their feelings. According to Newman and Newman (2006: 16), when people are in a relationship with each other they discover certain qualities about the another person and in this way they start developing feelings of trust and start revealing things about themselves that they would not normally share with anyone. Confiding sensitive aspects about their lives with others allows the strength of trust developed earlier in the relationship to be tested.

The psychologists all emphasised to the researcher that the trust component was vital in their therapeutic relationship with AIDS orphans and that each interaction they had with AIDS orphans either developed or eroded that trust. Psychologists experienced the pressure of this, understanding that to gain and build trust with already distressed children took time and that in the dynamic of the relentless workload, they too at times experienced anxiety. Psychologists were keenly aware of the need to manage this anxiety, as they were working towards establishing trust in every interaction with children who were AIDS orphans.

“When a child loses their parent at a young age, they become insecure and very vulnerable. They are motivated out of a sense of fear and not out of a deep sense of belonging. At first sight they go around the mountain over and over again and they are afraid to allow their expectations to change. It’s a lifestyle to become alone, ‘because I am afraid of rejection’. It takes time to help these young people to gain insight to know that they are feeding this by cognitive reasoning and emotional responses. It takes time to help these young people to break out of these patterns of isolation and withdrawal. They only break free when they begin to trust and it takes time for these children to trust" [Interview 17, pg. 3].

"You can see people waiting outside my door. Yet I am to help children who are AIDS orphans process their grief as well as emotional and psychological pain. I need to take care to listen to each child. I must be present in the moment with them and not distracted. I feel the pressure of this because I know there are always other people waiting to see me. Children will not trust me if they think I am pre occupied with anything other than what they are saying to me. It takes time to counsel children because of all they are processing as AIDS orphans and trust is initially fragile and must be built upon with every interaction I have with them. These children have been hurt, abandoned and let down. They won't trust me if I am distracted because of being pre-occupied by my work-load" [interview 14, pg. 7].

"The young man I saw this morning is now 22 years of age. He kept inside all of the grief he experienced as an eight-year-old boy. It took a year to build a trusting relationship with him to enable him to let the grief of this little boy inside out. He trusted that I would understand the depth of all he had walked and felt safe enough to trust me as a psychologist with the deepest pain he had suffered, when he lost his Mum to HIV/AIDS" [Interview 17, p.g.8].

Events turn the cognitive gears of trust (Liu and McKnight, 2013: 122); events change trust over time, based upon three cognitive mechanisms or gears: attention, attribution and judgement. The model regarding the development of trust proceeds through all three gears. At gear one level the event passes through the perception and memory module, which provides a basis for noticing or ignoring the event. Gear two refers to whether the trustee notices the event. If the event is noticed then the subsequent gears are engaged but if no subsequent gears are engaged then trust stays the same and the gears await the subsequent event. Gear three involves the attribution to see if the event contradicts the current levels of trust. After attribution, the trustee or assesses whether the attributed contradiction is serious enough to exceed the threshold of updating the trust level to gear 4. If not, the trust level is not up-dated and processing awaits the next event. If so, the updated gear is initiated which increases/ decreases the trust level.

- Gear 1 : Event
- Gear 2: Attention to the event
- Gear 3: Sense-making about the event which contradicts current trust base
- Gear 4 Impact threshold 'fully me': are children who are AIDS orphans met at their level of need? If so they will proceed to the next gear:

- Gear 5 Updated level of trust to where the trustee can have a healthy regard for the event which occurred and proceed in life to “Whole” (Liu and McKnight, 2013: 123) .

Psychologists were keenly aware of the need to build trust in their therapeutic relationship with AIDS orphans. They recognised the difficulty children experienced in beginning to trust because of the emotional and psychological distress, thechildren had experienced on becoming AIDS orphans. Psychologists sought to build trust in every interaction they had with children who were AIDS orphans and recognised the need to protect that trust. This at times caused psychologists to also experience considerable stress, because of the workload they had to manage and the challenge of building trusting relationship with vulnerable children who were experiencing emotional and psychological distress on becoming AIDS orphans living in the townships. Psychologists were challenged that every interaction they had with children who were AIDS orphans either grew or eroded the trust relationship they were building with these vulnerable children.

SUB-THEME 2.1.3 The extent of the suffering of AIDS orphans as unbearable

“But it is an illusion to suppose or to postulate that there could be a relationship with God in which there was only praise and never lamentation” Westermann, 1974 in (Bartlett, 2002: 27). Praise, which results from hope, can retain its authenticity and naturalness only in polarity with lamentation.

Children who are AIDS orphans living in the townships lament and the psychologists who assist them along with primary healthcare practitioners and social workers hear this lament. To lament is to let out a cry of sorrow and grief. "Their pitiful laments could be heard throughout the land” (Soanes and Stevenson, 2008: 127). When psychologists heard the AIDS orphans lament over their pain of loss and their subsequent plight they did at times find it unbearable.

“It’s unbearable at times to listen and to see the psychological distress children experience when they become AIDS Orphans” [Interview 12, pg. 1].

“I saw a 12-year-old girl who is an AIDS orphan last week. She eats just one meal a day. She is hungry. Listening to the distress she experiences on being hungry; caused her to have hope; I found it unbearable to hear the anguish she experienced” [Interview 12, p.g3].

Children orphaned by HIV/AIDS show higher degrees of depression, anxiety and post-traumatic stress disorder (PTSD) (Cluver et al., 2011: 363). Cluver et al,further say that the negative mental health outcomes amongst children orphaned by HIV/AIDS are maintained or worsened over a 4-year-period. The outcome of Cluver’s longitudinal study concerning the psychological effects suggests that negative psychological impacts of parental bereavement caused by HIV/AIDS may be more enduring and more severe than the impacts of other bereavements (Cluver et al., 2011: 368).

"She just kept saying to me there is no warmth at home. By listening to her and enabling her to feel like she was human again helped her "[Interview 12, pg. 2].

To describe something as unbearable is to say that it is painful or intollerable and you feel unable to cope with it accept it or deal with it (Oxford English Dictionary, 2009: 379). For the most part children who are AIDS orphans living in the townships find life unbearable because of the grief they experience in watching their parent's die of AIDS and the ensuing grief they feel in suffering the loss of their parent or parents followd by the cycle of poverty, rejection, neglect, isolation, bullying and loss of education associated with living as an AIDS orphan in the township communities.

Abebe in (Newman and Newman, 2006: 20) revealed that there was a strong correlation between endemic poverty, child destitution and orphanhood. Most of the hurdles faced by orphans are poverty-related and leave children who are AIDS orphans very vulnerable. All situations relating to poverty impact heavily on the children leaving more harm on the parentless child.

The psychologists who had listened to children who were AIDS orphans explained to the researcher that they experienced the suffering of AIDS orphans as unbearable at times. They explained that children who became AIDS orphans entered a life often void of care and love and full of challenge, suffering and loss.

"The issues that the orphans have to deal with are very big. The children understand they have been referred to me to talk; it is however difficult for these children to speak because they have been so hurt. It's too overwhelming for them. The pain of their lives is unbearable. I struggle to listen to them when they do talk because it's so unbearable" [Interview 12, pg. 5].

"The children are in pain and psychological torment. They lose their parents, their home, their education, their hope and their future Its unbearable. " [Interview 17 pg. 8].

"Some of the children say that they try to talk about their dead parents at home. Nobody in the family wants to talk to them about the loss they feel; this doesn't help them. It's like they have to put a lid on their grief. But they struggle with this; I find it unbearable that they have to bottle up the grief they feel" [Interview 12, pg. 5].

"Without psychological support children who are AIDS orphans are not able to move forward in life; yet listening to their grief and all they have endured in the poverty and loss that surrounds their lives is at times unbearable; yet it is necessary to listen and help children understand the process of their soul in the grief of losing their parents so that they can move forward and go on living” [Interview 24 pg. 3].

All people who suffer cry out. It’s an instinctive reaction. The fact that the cry can be formalised into language does not stifle its intensity; but rather underlines the quality of this human language of suffering (Cluver and Gardner, 2007: 8). When we utter the language of suffering the questions ‘Why’? and ‘How long?’ are from a place of pain anguish and despair. It is this language and the suffering behind the language that psychologists at times find unbearable in listening to children who are AIDS orphans. The first step towards overcoming suffering is in finding a language that leads one out of the prison of suffering. Yet when the language is spoken it can be unbearable to those that listen. In this instance the psychologists found the lament of children living as AIDS orphans unbearable.

SUB-THEME 2.1.4 Lack of resources as hampering their ability to intervene effectively to provide care and support to AIDS orphans

Psychologists relayed to the researcher that lack of resources in the workplace hampered their ability to provide care and support to children who were AIDS orphans and this caused them to experience stress because of frustration. The resources psychologists had were so few that they even needed to bring their own tissues to the work-place. Psychologists also provided refreshments in the form of cool-drink and biscuits to children who were AIDS orphans and resources for support groups. They also brought their own pens and pencils to their place of work. Psychologists also told the researcher of the stress they experiences due to a restrictive work space for instance having to run support groups in very small places where those at times attending the support groups had to sit on tables as there were not enough chairs.

Situational constraints, which are factors that are absent from an employee’s immediate work environment impair as a result his/her ability to accomplish successfully critical job tasks (Oliver, 2012: 6). Employees in work settings which are high in situational constraints are expected to experience stress and frustration due to their inability to achieve important goals (Phillips and Freedman, 1984: 331). Such frustration is expected to be demotivating and thus impairs performance and negatively impacts work outcomes and effective work states; and also impact negatively traits that would normally assist in coping with stressful situations (Oliver, 2012: 8).

“My office is so small and if I am to run a support group I have to buy refreshments out of my own money. I even have to buy my own tissues and paper and pens for children to draw with. I find the lack of resources very stressful” [Interview 24, pg. 4].

“There are so many people needing help. Our referral systems simply just aren’t enough to cope with the numbers of people. This is very stressful as it means we are unable to give the care and support these vulnerable children need” [Interview 12, pg. 3].

“You can see my room is so small. I have no resources apart from a telephone. Young children who are AIDS orphans don’t have the language to express themselves. They need toys and resources to draw with; but we have nothing, only that which we provide for ourselves. You can see I don’t even have a window in this room. It is like a cupboard. I don’t even have pictures on my wall. I find the lack of resources very stressful. I can’t care for and support children who are AIDS orphans in the manner I know I can because of a lack of resources. We have to provide everything ourselves even tissues and refreshments for people. Its very stressful [Interview 12, pg. 3].

“Last week I ran a support group for AIDS orphans on behavioural management related to anger. Three young people had to sit on my desk as there were not enough chairs to sit on. I find the lack or resources we have to work with very stressful” [Interview 24, pg.4].

Research has shown that increased dissatisfaction, stress and other negative affective responses to work are likely due to job-related factors such as decreased autonomy, less involvement in decision-making processes at work, as well as role ambiguity and a lack of resources (Karasek and Theorell 1990: 27).

Stress has been of great importance both in physics as well as in behavioural sciences. Hans Selye, the pioneering endocrinologist, termed “stress” and defined it as the non-specific response of the body to any demand placed upon it and further as; “any external event or internal drive which threatens to upset the organism’s equilibrium” (Selye, 1976: 718). Fred Luthans (2002: 2) defined stress as an adaptive response to an external situation that results in physical, psychological, and or behavioural deviations for organisational participants. Terborg (1977: 1) has stated that how we define stress determines not only how we research it but also how we explain our results and those results are converted into organisational and public policy. The European Commission (2002:3) defined stress as “a pattern of emotional, cognitive, behavioural and psychological reactions to adverse and noxious aspects of work environment. It is a state characterized by high levels of arousal and distress and later by feelings of not being able to cope” (Schell et al., 2012: 2).

What became apparent to the researcher was that psychologists experienced considerable stress due to the constraints of their place of work and lack of resources and this as they weren’t able to give the care and support to AIDS orphans they wanted to. They were stressed by the overall lack of resources in the health and social care systems to provide care and support to children who were AIDS orphans and were keenly affected by the lack of physical resources in their own working environment.

“What is stressful is seeing children who are orphans living in shacks in child-headed households and not having the resources to help them. When I leave them after I have visited them in their homes, the doors remain broken, their shoes remain with holes in them, and there is still no food in the home and no clothes for school. I want to be able to do the best I can for these children but I can’t because our resources are so few [Interview 12:7].

“I get fed up of writing referrals to social workers. I write them to help children who are orphans that I see, to assist them with grant applications. The grants are often the only financial resource these children have. Yet even our referral systems are so slow. I get very frustrated by this, because even writing referrals doesn’t help these vulnerable children. I get so demotivated by our lack of resources. It’s as if whatever I do actually doesn’t help. I find this very stressful” [Interview 12, pg. 7].

According to Vallerard (1997: 275), situational factors can be facilitators or inhibitors of performance. When employees are in situations in which they have limited resources, they are expected to become frustrated, and their performance is likely to be negatively impacted. It is also expected that situations that provide more resources than necessary should have the opposite effect on employees (Bakker et al., 2005). Situational constraints are theorised to affect performance directly to the extent that situational constraints impair the actual ability to perform tasks (Peters and O’Connor, 1980: 79).

When people feel they are unable to accomplish a task they are more likely to feel decreased feelings of engagement, commitment and satisfaction with the task that they are performing (Oliver, 2012: 29). Sometimes referred to as “resource inadequacy” within the literature, situational variables have been proposed as feasible contributors to work stress and thus seen as directly influencing relevant outcomes (Kahn et al., 1964: 2) . Employees in work settings with high situational constraints are expected to experience frustration due to their inability to achieve important goals (Phillips and Freedman, 1984: 4). Several studies have demonstrated that job resources are negatively related to exhaustion (Bakker and Demerouti, 2007: 4) and positively related to work engagement. The following excerpt from one of the research interviews demonstrates this.

“When I occasionally work in the private sector we have everything we need. The children I see here who are AIDS orphans can’t spend R500 to see a psychologist privately. I literally sit here in a cupboard and counsel AIDS orphans. I find it so stressful and demotivating. If the children cry and I don’t bring tissues these children don’t even have tissues to wipe their tears with. How is that giving care and support to vulnerable children? It isn’t. I get so frustrated by our lack of physical resources to help these very vulnerable children. Sometimes I feel so demotivated. Our referral systems are inadequate, our people resources are few and our physical environment is so small. Sometimes I just want to give up" [Interview 14, pg. 5].

What became apparent to the researcher was that the lack of resources in the health and social care systems, the physical lack of resources for psychologists in the work-place and the physical restrictions of the psychologists' physical working environment caused psychologists to feel hampered in providing care and support to children who were AIDS orphans living in the township communities. These factors caused psychologists to experience extreme stress and frustration which at times led them to become demotivated in their professional role as psychologists.

In summarising theme 2.1 the researcher would like to present the following comments. Psychologists who were interviewed as part of this study, told the researchers that children who became AIDS orphans experienced complicated emotional needs as a result of the multiple losses they experience on becoming AIDS orphans and the psychological distress they also experienced in watching and caring for their parents as they died of HIV/AIDS. It was reiterated by the psychologists and represented in literature that children who become AIDS orphans experienced anger, depression, sadness and suicidal thoughts. Psychologists, whilst recognising the complicated emotional needs of children who became AIDS orphans, experienced challenges and stress in establishing a trusting therapeutic relationship with them due to intrinsic and extrinsic factors. They found situational constraints and the complex emotional needs of AIDS orphans as hinderences to establishing a threrapeutic trusting relationship. Psychologists experienced listening to the "lament" of children living as AIDS orphans as unbearable which caused them as healthcare practitioners to experience stress and anxiety and which was further increased as they felt hampered in assisting children who had become AIDS orphans in processing their grief and developing resiliance because of the the lack of resources they had.

SUB-THEME 2.2: PRIMARY HEALTHCARE PRACTITIONERS EXPERIENCES: Figure 4.4 presents Primary healthcare practitioners experiences in the related sub- themes;

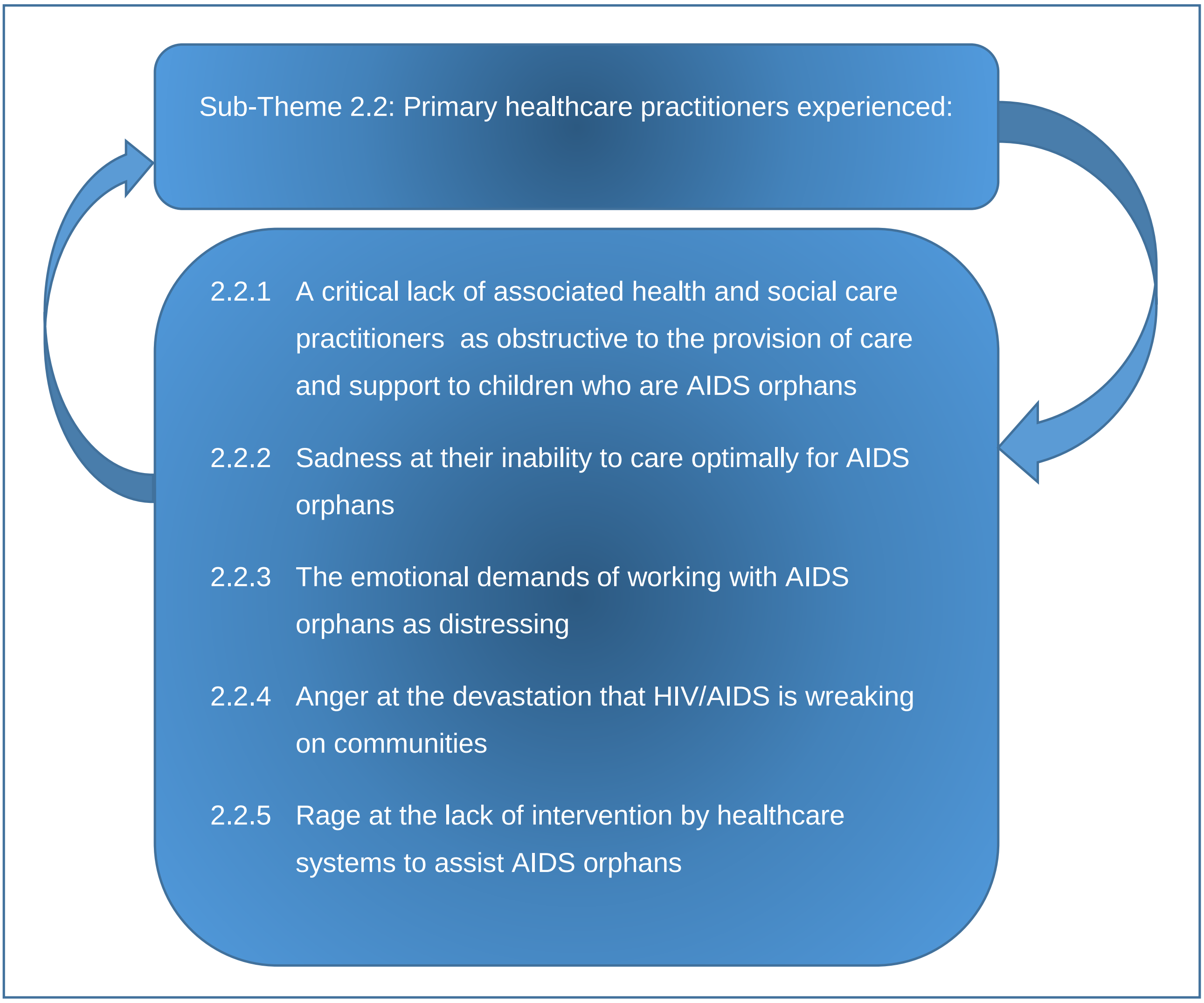


Figure 4.4: Diagramatic representation of sub-theme 2.2 Primary Healthcare Practitioners Experiences.

Sub- theme 2.2.1 Primary healthcare practitioners experience a critical lack of primary healthcare practitioners and associated practitioners, as obstructive to the provision of care and support to children who are AIDS orphans living in the townships communities

“There is a severe lack of nurses in South Africa leaving those in the system overworked and exhausted” (Child, 2013: 5).

The World Health Report 2008 (WHO, 2008b) relies on the joint learning initiative (JLI) global assessment of shortfall, which states that countries with fewer than 2.5 healthcare practitioners (counting only doctors, nurses and midwives) per 1000 population will fail to reach their minimum desired levels of 80 percent services-cover rate. It bases this measure on an estimation of the availability of health workers required to achieve a package of essential health interventions and the Millennium Development Goals (Mgqolozana and Wildschut, 2009: 135). Nonetheless one needs to remember that the norm is a very low minimum and the countries that fall below it are among the poorest in the world. One also needs to remember the very specific needs in South Africa relating to demographics of disease within the country and also consideration of the type of nurse needed. Also an important consideration is in the number of inactive nurses included within the nurse-to-population ratio (Mgqolozana and Wildschut, 2009: 136).

The South African Nursing Council (2007) provided the following breakdown of its total (191, 269) number of nurses on the register for 2005: 52% Primary healthcare practitioners (PN's), 19% Enrolled Nurses (EN's) and 29% Enrolled Nurse Assistants (ENA's). There are 57 countries that fall below this threshold and that are defined as having a critical shortage. Shockingly thirty-six of them are in sub- Saharan Africa (WHO, 2006: 12). In 2005 South Africa had a ratio of 343:100,000 based upon Department of Labour (DoL) data and population figures. Therefore rated against the norm, there seem to be enough nurses for the population (Mgqolozana and Wildschut, 2009: 136). The SANC calculates nurse-to-population ratio based upon its own list of RNs and EN's, however includes nurses who are not active. In 2006 the nurse to population ratio was 1:241 nationally; but there were disparities within this ratio. For example the nurse-to-population ratio was 1:177 in Gauteng and 1:349 in Mpumalanga.

The primary healthcare practitioners told the researcher that the constant lack of primary health care practitioners, enrolled nurses, social workers and psychologists, caused AIDS orphans and their families long waiting times in the clinics and was obstructive to the provision of holistic care and support to these vulnerable children. Primary healthcare practitioners told the researcher there were too few of them to provide adequately the care and support required of them due to being overworked. They felt constantly under pressure and tired because of the sheer number of children and their families seeking care and support from them. Primary healthcare practitioners also felt children were at risk in the clinic of contracting TB and that the clinic environment was unpleasant for children, who had to sit so long, waiting with very sick people to see primary healthcare practitioners, social workers, doctors or psychologists in the clinic.

“We are always waiting in South Africa because we have few staff to do the work. If I refer to the doctor, children must wait, the children must wait to see me and they must wait for referrals to see social workers. Because we do not have enough people in the multidisciplinary team, we cannot give the care and support children who are AIDS orphans need “[Interview 6, pg. 6].

“Sometimes the children who come to see me they just need time to talk and be understood. They don’t just want tablets; they want time and relationship. We are so few nurses, I can’t give them the time they need. I often feel guilty about this “[Interview 7, pg. 3].

“Children sit in the clinic all day. This is not good for them. Most of the AIDS orphans are malnourished and they sit with TB patients who are coughing or next to people with AIDS. Sometimes they say to me, this lady outside, she reminds me of my mother. This is not good for them to see so much sickness when they have already seen their parents die of AIDS” [Interview 10, pg. 10].

“The children I see who are AIDS orphans, they need spiritual support, emotional support, financial support and physical support. How can we give them that when we are so few nurses, doctors and social workers?” [Interview 7, pg. 3].

The proportion of registered nurses working for public health institutions to all registered nurses in SANCA, remained about 42% to 45% between 2000 and 2010. It slightly increased to 47% in 2011. The average proportion of enrolled nurses working in the public health sector declined to 47% in 2011. Another statistic to take cognisance of is the statistic regarding the vacancy rate of the number of posts for nurses in the public sector which was 46.3% in 2010. In the Eastern Cape it was 59% (George et al., 2010: 2). This means that close to half of all of the registered nurses’ posts are vacant in the public health sector. Moreover the shortage of nurses in South Africa is expected to continue at the same time as the demand for nurses in South Africa is expected to increase continuously (Sato, 2012: 1).

- The population of South Africa is 51.8 million according to the 2011 South African census (StatsSA, 2011: 3).
- The HIV-infection rate in the nation remains high and nurses are required to provide treatment, care and support to huge numbers of HIV positive people and AIDS orphans
- The country’s primary healthcare policy advances as more and more clinics and hospitals are expected to be built in the rural areas; thus the overall demand for nurses will increase (Sato, 2012: 1).

Day and Gray (2008: 92) pointed out that the ratios of professional and staff nurses to people in the public health sector had worsened over time. The ratio with regard to primary healthcare practitioners was 251:100,000 in 1994 but 116.6: 100, 000 in 2008. With regard to staff nurses, the ratio was 59.7: 100, 000 in 2001 but 55.4:100,000 in 2008 (George et al., 2012: 2). When the WHO 2008 report mentioned its intention to revitalise the principles and practice of primary healthcare (WHO, 2008b), one facet of this agenda was to ensure an adequate number of appropriately skilled health personnel to deliver services (George et al., 2012: 1). In South Africa according to Cameron, et al, there are 69 doctors and 388 nurses per 100 000 population (Cameron et al., 2012: 2). What is apparent is that South Africa has a serious shortage of healthcare personnel which affects the provision of care and support to AIDS orphans. With the declining numbers of primary healthcare practitioners and the growing demands of the population in the wake of the HIV/AIDS pandemic, pressure is experienced by the primary healthcare practitioners and other affiliated professionals who render care and support to children who are AIDS orphans.

The HRH for the Health Sector Strategy: 2012 and 2013-2016 and 2017 of the national Department of Health (DoH), duly acknowledges the concern regarding the diminishing number of primary healthcare practitioners and has duly acknowledged the need to employ broadly more healthcare staff (DoH, 2011:4).

The primary healthcare practitioners attested to the shortage of numbers affecting service delivery to AIDS orphans. They told the researcher that there were too few health and social care professionals in every professional discipline who needed to be accessed in the provision of care and support to children who were AIDS orphans. The effect of this was that children who were AIDS orphans did not receive the care and support they required at a basic level, never mind a holistic level. This was stressful for primary healthcare practitioners who faced every day being overworked in their professional role.

“Many of the AIDS orphans who come to this clinic are living in child-headed-households. They have huge needs that are beyond the scope of this clinic because we are too few staff and we have too few resources” [Interview 10, pg. 2].

“Children who come to this clinic, they wait. You can see I have a queue of 30 children still waiting to see me outside. I have already seen 25 this morning. AIDS orphans wait to see me, they wait to see the social workers, they wait to see a psychologist; they wait for their ART. Children who are AIDS orphans receive poor care and support because there are too few professionals to assist them in the way they need. I feel very sad about this “[Interview 6, pig 5].

“When I see children who are AIDS orphans I am always writing referrals. I write referrals for social workers, doctors and psychologists. These AIDS orphans need so much help from other professionals but we are too few. I was told there were psychologists at Mission vale. I had a six-year-old child who was raped brought to me. I took the child myself to Mission vale but there were no psychologists there” I lost hope this day it’s a losing battle here is South Africa. We are too few nurses for the people” [Interview 11, pg. 3].

The Department of Social Development issues the numbers of social workers per 100, 000 population: 20 per 100,000 in urban areas, 22 per 100,000 in peri-urban areas and 33 per 100,000 in rural areas (Earle-Mallison, 2009: 57). The Department of Social Development has suggested that the current pool of 11,000 social workers in South Africa is insufficient and the number of 16, 000 represents the number required by the Department of Social Development (Earle-Mallison, 2009: 57). There was according to the DSD in 2005 a vacancy rate of 51% in South Africa. If the current trends in the social work profession in South Africa continue there will be a shortage of 17, 149 social workers in South Africa by 2012 (Earle-Mallison, 2009: 63).

Primary healthcare practitioners told the researcher that when children became AIDS orphans they required intervention from social workers because all of them living in the townships present with social issues due to poverty. They told the researcher that children’s health needs could not be seen in isolation and children who are AIDS orphans are very vulnerable and need assistance from many professionals in the multi-disciplinary team. Primary healthcare practitioners acknowledged that this care and support was lacking because of the lack of associated professionals, namely, social workers, and psychologists.

“Children who are AIDS orphans have many social needs, in fact their main problems are psycho-social. Yet our social workers are so few. I refer these children to social workers but take ages for them to be seen. How can they feel cared for and supported when we don’t have the skilled people available to assist them” [Interview 10, pg. 7].

The primary healthcare practitioners also told the researcher that there were too few doctors in the clinics which also affected the provision of care and support to children who are AIDS orphan’s living in the township communities.

In 2006 a total of 33,220 medical practitioners were registered with the Health Professions Council of South Africa (HPCSA), which represented a 14% increase since 1999. In the Eastern Cape in 2004 there were 2.7 medical practitioners per 100,000 population; but in 2007 this had fallen to 1.7 per 100,000 uninsured population (Erasmus and Brier, 2010: 114). StatsSA (2011), report that 85% of the population of South Africa do not have a medical aid and are reliant upon the public sector; however, only 41% of medical doctors are working in this sector. Conversely 15 per cent of the population do have a medical aid and utilise the private sector, where approximately 59% of the medical doctors are working (Brier et al., 2009: 115). It is also worth considering the following, namely, that the operational plan for comprehensive HIV/AIDS care, Management and Treatment (DoH, 2004: 112) noted that the role out for ART would require a substantial increase in human resources. It estimated that a total of 21, 824 new staff would be recruited between March 2004 and March 2008 of 975 would be doctors and 6, 822 nurses. What happened was that these targets were not met.

The DoH has subsequently produced a National Human Resource for Health Planning Framework (hereafter called the NHR Plan) that makes no reference to the human resources required to deal with the HIV/AIDS pandemic (DoH, 2006b). There can be little doubt in view of this that there is an acute shortage of medical doctors in South Africa, mainly in the public and rural areas. Nowhere in the country of South Africa do the numbers of doctors compare with doctors per population of middle-income countries (Brier et al., 2009: 127).

“Our doctor is here in the clinic two days a week. We have all the ART roll-out to do and we are here to help and support AIDS orphans. We are two nurses on the paediatric side, we do immunisations primary health; everything. We can’t care for and support AIDS orphans as they need to be. We are too few nurses and doctors and social workers to do this” [Interview 4, pg. 10].

“Some of the children we see here in the clinic need to see a doctor or a social worker or a psychologist. Our doctor is here two days a week, our social worker one day a week and our psychologist one afternoon a week. How can we support these children who are orphans with so few professional people? How can we? We let these children down all of the time and we shouldn’t because they are vulnerable” [Interview 14, pg. 7].

‘Skills shortages’ is the idea that the demand for certain skills exceeds supply. In the discourse of labour economics, labour supply refers to the individuals who participate in the labour market with given endowments of human capital, whereas labour demand refers to the private and public entities that employ individuals. Mediating between these is the set of institutional arrangements that help form and shape the nexus between labour demand and supply, including educational institutions in civil society and training providers in the private and the public sectors (Daniels, 2007: 2).

The South African Nursing Council (SANC) identifies a shortage of nurses in South Africa; but simultaneously presents a positive picture by noting past gains (Mgqolozana and Wildschut, 2009: 132). Thus it asserts that “although there may still be a shortage of qualified nurses in the Republic of South Africa, the positive side to the overall picture is that growth in the nursing figures has exceeded that of the population of South Africa by quite a margin" (SANC 2008:2). The Democratic Nursing Organisation of South Africa (DENOSA) however asserts that there is a shortage of nurses, stating that South Africa is not producing / training sufficient nurses to deal with its health needs' (DENOSA, 2013: 2), and recognises that this directly impacts upon the health sector to deliver an efficient service and is hindering South Africa from meeting the health targets set out in the MDG's.

The national `Scarce Skill List 2006 of the Department of Labour (Erasmus and Brier, 2010: 49) specifies primary healthcare practitioners (PN's), social workers, doctors and primary healthcare nurses as having the scares skills, quantifying the need in these occupations. The Master List of Scarce and Critical Skills identifies a shortage of 14, 370 nurses (10 250 PN's and 4120 primary healthcare nurses) A primary healthcare practitioner is a registered nurse who has been comprehensively trained or has a post basic qualification in community health (Erasmus and Brier, 2010: 132).

What became apparent to the researcher was that the primary healthcare practitioners were all overworked, exhausted and facing a demanding relentless work-load as there were many AIDS orphans accessing them for care and support. Primary healthcare practitioners experienced overwhelming stress because there were too few of them to care adequately and support the number of AIDS orphans requiring their professional skills. They were further stretched because of the lack of associated professionals whose expertise was also required in the provision of care and to support to children who were AIDS orphans.

"It's very demoralising when I come to this clinic to work. I can say that. We are too few nurses to care for and support these AIDS orphans. There are also too few social workers, psychologists and doctors also. I can say that these AIDS orphan suffer because of this. I must use the word suffer, because they suffer as they have so many needs and we are too few to help them when they are so vulnerable and seeking help. If we were more we could do more …it is just like that" [Interview 13, pg. 6].

A research study undertaken in South Africa in 2012 demonstrated that thinking about the shortage of healthcare personnel merely in terms of insufficient numbers prevented sound strategic interventions from being intriduced to solve the country's human resources for health (HRH) problem. The review demonstrated that the numbers shortage was a facet of a broader problem which included the mal- distribution of HRH; production of the wrong nursing skills in nursing care; the attrition of staff from the public health services; and contextually the ever changing demands on the health services. The challenge in South Africa was furthermore to train and retrain healthcare personnel with skills and expertise that were commensurate with the changing demands on the public health services (George et al., 2012: 2).

SUB-THEME. 2.2.2: Primary healthcare practitioners experience sadness at their inability to care optimally for AIDS orphans.

"Tears are words that need to be written" (Izard, 1992: 559).

Emotions have been touted in the scientific literature as important response tendencies encompassing multiple elements and connecting aspects of our biological, cognitive and motivational systems. Theorists have long suggested that emotions exert functional capabilities in that they enable adaptive responses to environmental occurrences (Izard, 1992: 561).

Sadness pertains to the state of emotion of being gloomy or sorrowful and makes one grave, serious and dejected. It halts progress and forces one to see the negative side of things rather than the brighter side. So, kill sadness or if possible, stay away from it. In the words of Percy Bysshe Shelle, "Change is certain. Peace is followed by disturbances; departure of evil men by their return. Such recurrences should not constitute occasions for sadness but realities for awareness, so that one may be happy in the interim" (Hoppmann and Blanchard-Fields, 2011: 1).

Sadness is an emotion one of the most central and pervasive aspects of human experience. Since cognition can influence and be influenced by our emotions, the study of human emotion constitutes one of the essential components of our probe into human cognition. The most readily available access we have to emotions is through language and linguistic analysis. Cognitive semantics believe that the conversationalised language used to talk about the emotions can be an important tool in discovering structure and content regarding the concepts of emotion (Ding, 2012: 124). Human emotions which are abstract in nature, are to a larger extent conceptualised and expressed as a metaphor grounded in bodily experience (Ding, 2012: 138). Sadness shares a myriad of synonymies like melancholy, gloom, grief, lament, sorrow, dejection. Depression, dismay, disconsolation and pensiveness. According to Webster's third international dictionary sadness is: an emotional attitude characterised by an unpleasant feeling or tone and expresses itself in sighing, weeping as well as in passive and diminished tones of the voluntary muscles. It is an emotion characterised by the feeling of being disadvantaged, lost and helplessness. A philosopher called Baruch Spinoza, defined sadness as the "transfer of a person from a large perfection to a smaller one" Sadness can be viewed as a temporary lowering of mood, whereas depression is defined as a persistent low mood (Ding, 2012: 184).

Primary healthcare practitioners told the researcher the profound sense of sadness they experienced in not being able to care optimally for children who were AIDS orphans living in the townships but also explained how they experienced compassion towards children and could visibly see their distress and hear the pain of these children; yet were unable to help in a manner they wanted to, mainly because of their huge work-load, constraints in infrastructure and lack of resources available to assist in meeting the care and support needs of children who were AIDS orphans. They were disappointed and disillusioned because they had been trained to provide holistic care and support; yet were prevented from being able to do this because of the constraints within the health and social systems in which they worked.

"Yesterday I went to the home of four children who are AIDS orphans living in a child-headed household. They were grief stricken, sad and hungry. I can offer them advice and write referrals but this is not enough. I was so sad that I could not help and support them as they needed" [Interview 12, pg. 7].

"I sit in this office listening to children who are AIDS orphans every day. They are angry and sad. They need so much support and care which they don't get. Our referral systems are so slow and our resources are few. I am unable to support and care for them as they need I feel sad about this (Looks out of the window)" [Interview 9, p.g3].

" Children who are AIDS orphans have come to see me and tell me they have no money for food and clothes and that they have doors and windows missing in their homes. They are fearful about this and become stressed. I can't help them with all of this and I feel sad about that. They leave my office hungry. If I could so something to really help them I would feel better about my work. But our time is limited and our resources are few" [Interview, 14 pg. 6].

"I am sad about how children in South Africa are treated when they become AIDS orphans. They are just neglected. That is all I can say. The support structure they need to help them they need it to be cared for they need help and support" [Interview 20, pg. 3].

The attaining of goals whether they be personal or work related leads to the experiencing of positive emotion. Goals act as a developmental compass and can contribute to a sense of meaning, direction and well-being (Baltes et al., 1999: 471); are also intrinsically tied to emotional experiences, and previous research demonstrates that goal progress is associated with a variety of positive outcomes, including increased well-being and positive affect (Hoppmann and Blanchard-Fields, 2011: 3). True, attaining one's goals has been found to be related to positive emotions and persistence toward reaching one's goals has also been linked with self-reported enhanced abilities to deal with experiences of stress (Carver and Scheier, 1998: 37). Primary healthcare practitioners told the researcher how it felt when they could assist children who were AIDS orphans. They recounted the following to the researcher:

"It's wonderful when we have our orphans' day at this clinic. We celebrate the children and we are able to give them resources for school. We have a big party for them and give them presents. They love this day, we also love this day because we can do something positive for them which is very good for them and also good for us" [Interview 9, pg. 2].

"Last week I had a visit from a young boy. His mother died of AIDS. He was staying with his aunt a few years ago. It was difficult for him to stay with her because of the cousins. I referred him to the social worker and he is with his grandmother now. He came to tell me the FCG came through; he came to thank me. He is a happy boy now. I helped him. I wish it could always be like this" [Interview 11, pg. 5].

Similarly, modifying one's goals may be difficult in that it requires the acknowledgement of holding potentially unachievable goals (König et al., 2010: 52), perhaps making persistence a favourable choice. At the same time, difficulties with making progress on goals can lead to stress and negative emotion (Hoppmann and Klumb, 2006: 889) and may therefore be undesirable under certain circumstances. Importantly, negative emotions may not only be an outcome of problems or difficulty with goal progress; but they may also help flag which goals need to be adjusted, ultimately guiding goal-regulation (Ilies et al., 2010: 121). In a study conducted by Slade in 2012, the results confirmed that daily sadness was positively associated with goal disengagement (Slade, 2012: 33). Emotional states such as sadness have developed to assist with less than desirable circumstances but sadness can be adaptive, because what sadness does is promote thinking through things (Slade, 2012: 34). This can be seen as positive as it leads to a process of goal adaptation.

Primary healthcare practitioners spoke to the researcher concerning the deep sadness they experienced in not achieving their professional goal of optimally caring for and supporting children who are AIDS orphans living in the townships but they also re-evaluated the difference they made at times concerning how their kind words and caring attitudes brought comfort and support to AIDS orphans and that they were glad about this.

"I came into the nursing profession to care for people. I saw it as a calling, not a profession. I realise I can only do so much as our system of referral is slow and our resources are so few. I had to accept my own limitations because I got so sad and depressed I ended up in hospital. I actually had a heart attack because of all the sadness, depression and stress I experienced in seeing so many AIDS orphans. Now I have learnt to do the best in the system. I can only do what I can do to care for and support children who are AIDS orphans living in the townships. I still feel sad about this but at least I can cope now" [Interview 22, pg. 8].

Primary healthcare practitioners saw sad children telling their sad stories concerning their lives as AIDS orphans in the townships but were unable to alleviate the suffering of these children holistically so the researcher would like to record how deeply concerned and sad the primary healthcare practitioners felt concerning about this.

SUB-THEME 2.2.3: Primary healthcare practitioners experienced the emotional demands of working with AIDS orphans as distressing.

"If nurses are able to deliver care of a quality that matches their personal aspirations and that is seen as in the best interests of the patient, the nurse then experiences feelings of gratification, personal enrichment and privilege; however if nurses are unable to meet their aspirations they experience guilt, regret, frustration and distress" (Bridges et al., 2013: 760).

What became apparent to the researcher early on in this research study was that primary healthcare practitioners experienced distress in trying to provide care and support to children who were AIDS orphans living in townships. Primary healthcare practitioners confided to the researcher that they experienced severe distress, when presented daily with the overwhelming needs of very vulnerable children who were suffering as AIDS orphans living in the townships; and being unable to meet the care and support needs of AIDS orphans because of factors beyond their control.

"Last week I saw a child who was two years of age who was raped. She was already HIV-positive. I was distressed because at 2 years of age she was able to give details to the police. It was horrifying and distressing, and she knew what had happened to her" [Interview 6, pg. 1].

Patients who are dying or who have overwhelming needs prompt emotional distress in nurses as the nurses bear witness to the suffering of patients and their families (Mackintosh, 2007: 982). Moral distress can be triggered when nurses perceive that they contribute to unnecessary additional suffering through a treatment plan they do not agree with or because they are unable to relieve the suffering of the patients because of factors outside their control (Bridges et al., 2013: 768). Nurses were also noted to experience distress when organisational conditions in their working environment prevented them from building a therapeutic relationship with patients in which the patients' 'best interests' were considered and their care and support needs met (Bridges et al., 2013: 760).

“When a parent dies all of the money dies in the family. I see poor and vulnerable children every day who are AIDS orphans .This is very distressing as their needs are overwhelming. I see children with overwhelming needs every day of my working life” [Interview 9, pg. 4].

“Our nurses are distressed because they are emotionally affected when they see children who are AIDS orphans in the clinics and they give them ART medication and then send them home into homes where they know there is no food. They are distressed because of the poverty of the children they see” [Interview 10, pg. 2].

“Most of the children we see in this clinic aren’t eating a balanced diet because of poverty in their homes. It’s so distressing to see hungry children. We can’t do anything about this because we haven’t enough resources” [Interview 5, pg. 3].

Hamaidah (2013: 167) conducted a research study to examine the intensity level of moral distress and found nurses identified a range of situations that were morally distressing, including witnessing unnecessary suffering, being forced to provide care that compromised values, negative judgments about patients, inability to act due to institutional constraints or a failure to pursue a right course of action. They linked these situations to contextual constraints such as workload and described the responses, including feeling incompetent and distancing themselves from patients (Hamaidah, 2013: 167).

Primary healthcare practitioners spoke to the researcher concerning the distress they experienced because they felt helpless to assist in caring for and supporting AIDS orphans in the situation of their working environment which was full of restrictions due to lack of resources.

“It’s very distressing to see children who are AIDS orphans suffering every day; knowing you can’t alleviate their suffering because we haven’t the means to. I find it distressing to see children suffering and I am unable to help them. Our systems in South Africa are poor; this is why” [Interview 5, pg. 2].

Hamaidah showed that the intensity level of moral distress was found to be moderately high, especially in an ‘unethical conduct by caregivers’ subscale. Age, income level, nurses' years of experience, and caseloads correlated significantly and negatively with moral distress, while educational level and intention to leave the current job correlated significantly and positively with moral distress. Interestingly, job satisfaction did not significantly correlate with moral distress. Income level, caseloads, burnout level, attending workshops in mental health and educational level were the best predictors of moral distress. According to the primary healthcare practitioners more studies on moral distress and continuing educational interventional programs aimed at minimizing the levels of moral distress and burnout at institutional and individual level are required urgently (Hamaidah, 2013: 174).

Primary healthcare practitioners spoke about their concern regarding burning out. They were aware of the possibility of burn out because of their relentless workload and through being distressed by the overwhelming needs of the AIDS orphans they saw and the lack of assistance they could provide due to system and resource constraints.

“I actually ended up in hospital with burn-out. I couldn’t cope anymore with the constant feeling of failing these children every day. When I see children who are AIDS orphans in the clinic, I see this child is my child. It’s so distressing to see and hear the suffering of these AIDS orphans. We work in an environment where there is no support for us as nurses it makes our work very very difficult and at times distressing. We have few resources to help AIDS orphans, I feel we fail them every day and I find this distressing” [Interview 22, pg. 5].

The findings of Bridges et al in 2013 were that when nurses aspirations of providing care and support in the best interests of the patient were not achieved, they began to experience distress and a desire to withdraw from caring for a particular patient or from caring work altogether. Other empirical work has confirmed that there is often a difference between what nurses think they ought to be doing and what actually happens in practice; and have linked this theory/practice gap with morale, job satisfaction and retention difficulties within the nursing profession (Bridges et al., 2013: 772).

“In this clinic we see children who are malnourished. We sometime have porridge in the clinic but we haven’t had any since December last year. It’s so distressing to see these children suffer because they are hungry. When you are an AIDS orphan you suffer in the township communities it is just like that. It’s actually pathetic what we do to help these children. A person feels worthless when they are hungry; it’s distressing very, very distressing to work with these AIDS orphans in the clinics” [Interview 15, pg. 2].

“We try to solve the problems of the AIDS orphans the best we can; but it is not enough. Most of the nurses in this clinic feel distressed because of the workload and the sheer number of children we have to see every day. We have them coming through our clinic doors the whole day” [Interview 5, pg. 3].

“Many children who are AIDS orphans’ that I see are very withdrawn. They sit in front of me and they don’t speak. I remember the first child I saw who was an AIDS orphan. I am thinking all of the time, if this is my child how would I want this child to be cared for? I was very distressed by this. I did my best but it wasn’t enough” [Interview 15, pg. 4].

Distress inherent in nursing work can cause nurses to develop defensive strategies against the anxiety raised by the painful feelings invoked by nursing work: “nurses are no longer present in the therapeutic relationship” (Menzies, 1960: 46). The findings of Bridges et al, also illustrated that the disengagement behaviours of nurses resulted from the moral distress they experienced arising from the inability to give adequate care and support to their patients. Lack of time and a poor working environment all restricted the nurse’s capacity to provide care. Nurses who experienced this distress were found to withdraw emotionally from the nurse-patient relationship as they did not receive the support they needed in the form of correct organisational conditions of work (Bridges et al., 2013: 770).

“I got to a point where I couldn’t feel anymore. I couldn’t face seeing any more distress that I couldn’t alleviate through my professional expertise. I was sad all the time and lost my ability to care. It became too costly. I realised that day I was burnt out because of all of the distress I experienced. I was off work for three months because of this. I still ache now but in a different way. I was scared because of how distressed I felt” [Interview 15, pg. 5].

Primary healthcare practitioners experienced at times the need to emotionally withdraw because of the pain, anguish and distress of providing care and support to children who were AIDS orphans. It was as if their souls had become saturated with sorrow due to distress and they needed to withdraw in order to recover so they could reengage again at a different level and in a different way. What was apparent was that primary healthcare practitioners experienced distress due to the emotional demands of providing care and support to children who were AIDS orphans living in the township communities and because of factors outside of their control which restricted them in their capacity as health and social care practitioners in the provision of the necessary care and support.

SUB-THEME 2.2.4: Primary healthcare practitioners experienced anger at the devastation HIV/AIDS is wreaking on communities

“I have been working in this clinic for twenty-five years. All I can say is HIV/AIDS is killing our communities and robbing us of our children and grandchildren. I hate the effects of AIDS it is like It’s eating our people. I am very angry about this as it causes too much suffering” [Interview 4. pg. 2].

On World AIDS day, 1st Dec 2011, the President of the Republic of South Africa, President Jacob Zuma officially launched the New National Strategic Plan (NSP) on HIV, STI’s and TB, 2012-2016. Concering the the framework of the NSP, the South African Government has adopted the UNAIDS vision of zero new HIV/AIDS infections, zero discrimination and zero

AIDS-related deaths. South Africa has adopted a fourth zero in the plan: “zero new infections due to mother-to-child- transmission” (UNAIDS, 2011: 1).

“I am responsible. We are responsible, South Africa is taking responsibility” has been successful; reaffirming the fact that we are indeed united in our efforts to reduce new infections and to create an environment that is conducive to the health and wefare of all, (DoH, 2012: 8). This was the Moto behind the National Strategic Plan 2012-2016.

The primary healthcare practitioners described to the researcher the changes they had seen in the communities and the effect HIV/AIDS was having upon families within the communities. Primary healthcare practitioners were also not left untouched by the HIV/AIDS pandemic in their own families. HIV/ AIDS was affecting some professionals in their personal lives as well as in their professional lives which caused some to become incensed by the injustice of all of this suffering they experienced due to AIDS.

“It’s very difficult to see children suffering because of HIV/AIDS. I feel very angry about what AIDS is doing in our communities” [Interview 5, pg. 2].

“Poverty and AIDS are destroying our communities. I am normally a soft person; but I do get angry because of all the suffering I see because of AIDS. I once saw a young girl of four years of age. She was raped by her uncle; he was HIV positive. She couldn’t even walk properly; I felt so angry about this so angry: poverty and AIDS, that’s what we see in this clinic” [Interview 5 pg.3].

“My own granddaughter is an AIDS orphan. She stays with me I take care of her. The pain is very big for her and for me. All I can say is HIV/AIDS is killing our people and I feel very angry about the suffering AIDS is causing” [Interview 9, pg. 6].

Anger is an emotional state that may range from minor irritation to intense rage. The physical effects of anger include increased heart rate raised blood pressure and levels of adrenaline and noradrenaline. Anger causes a behavioural pattern designed to warn aggressors to stop their threatening behaviour; or when a person experiences pain or loss. The following words can be used to describe anger: anger is heat (Lakoff, 1987: 380); anger is the heat of a fluid in a container; so if the body is considered a container for emotions, anger is the heat in the container (Ding, 2012: 231).

Primary healthcare practitioners explained to the researcher that HIV/AIDS had changed the township communities telling her that their weekends are full of funeral processions because of AIDS. Primary healthcare practitioners experience a lot of suffering because of AIDS; they are always hearing the sounds of grief in their workplace, communities and families because of AIDS and felt very angry about this at times.

“Someone is always suffering because someone they love die of AIDS. It’s like this in our communities now. It was never like this AIDS is killing our children. I get so angry because of this. It’s not right that children die before their parents but it’s like this now” [Interview 15, p.g 3].

“Most of the children I see in this clinic are HIV-positive and their parents have died of AIDS. Some I see have diarrhoea and some have psychosomatic illness. They pretend to be sick because they want help, usually because they are living in an abusive home where they are neglected; and it is the only way they can see a professional who will help them. I am angry about all the suffering I see in children because of HIV/AIDS” [Interview 6, pg. 5].

“You know in this clinic each weekend we attend many funerals because of AIDS. I get angry about this. It’s as if AIDS eats my life too because of all these funerals. It’s terrible” [Interview 11, pg. 4].

“AIDS is all around us. Even our colleagues have it. Last year one of the sisters in this clinic died of AIDS. She left an eight-year-old daughter. She didn’t even tell us. I was angry about this because we could have helped her and her daughter. I feel angry that she suffered” [Interview, 22 pg. 9].

South Africa has a generalised HIV epidemic driven largely by sexual transmission. Using the Spectrum model, the 2009 HIV prevalence in the adult population (aged 15–49) was estimated to be 17. 8%. In 2009 an estimated 5.63 million adults and children aged 15 years and older were living with HIV; of these, 3.3 million were females and 334, 000 were children (DoH, 2012: 12).

Primary healthcare practitioners expressed how angry they felt, in the light of the AIDS pandemic as they experienced the HIV/AIDS pandemic getting worse, not better.

“The problem of AIDS is not going away. I get angry about this because we see children who suffer every day in this clinic because they are AIDS orphans. It is wrong that a parent dies before a child, just wrong and AIDS is causing this in our communities” [Interview 7, pg. 1].

“Some children tell me that they don’t have grants because their parents didn’t even get a birth certificate for them. They tell me they get ridiculed at school because they are poor. They have holes in their shoes and nothing to eat because they are poor. They say ‘AIDS did this to me because it took my mother and made me to be poor'. I get angry that I see this every day when I care for and support children who are AIDS orphans" [Interview 15, pg. 3].

Negative emotions may be an important signal that flags situations that require alterations in current events or activities and calls for adjustments, in our goals (Caver and Scheier, 1998: 37) as such negative emotions may play a key role in goal regulation and adjustment. In the instance of HIV/AIDS in South Africa anger and rage regarding the effects of HIV/AIDS in the communities has caused treatment and prevention of HIV/AIDS and care of OVC's to be increased as the Government sets goals regarding zero HIV-infection rate in accordance with UNAIDS (DoH, 2012: 37). On considering the anger within the communities one needs to consider that in 1990 there were less than 2% antenatal seroprevalence rates; but in 2010 the prevalence rate in antenatal HIV had risen to 30 % (DoH, 2012: 14).

The primary healthcare practitioners spoke about the poverty AIDS had brought to the communities and how children who became AIDS orphans suffered because of this poverty.

"In our communities what we see is poverty causing AIDS and AIDS causing poverty. Our communities were never like this; but now they are dying. We have funerals all weekend, every weekend, even on Fridays and in the week. I am very angry about what AIDS has done to our communities. AIDS even stole my daughter from me. Now I see suffering as a nurse every day and I see suffering in my granddaughter; all because of this AIDS" [Interview 15, pg. 3].

There is a significant variation in HIV prevalence per province, with the Eastern Cape (EC) reportedly having an average prevalence rate of 28%. Hence South Africa is likely to be the country with the highest percentage of children orphaned by AIDS within its population. Orphanhood is a major consequence of the AIDS pandemic and in South Africa, with an estimated 2.2 million AIDS-orphaned children, if current trends continue this is set to increase to 11.188 per 100,000 by 2015 Hayman and Kidman in Reynolds (2013: 34). What is obvious is that the HIV/AIDS pandemic is causing extreme, untold and severe suffering. Primary healthcare practitioners witness this suffering every day in their workplace as they seek to provide care and support to AIDS orphans. Being exposed to this suffering of vulnerable children caused primary healthcare practitioners to feel angry as they experienced first-hand how much severe suffering AIDS was causing in the lives of children, living in already vulnerable communities.

SUB-THEME 2.2.5: Primary healthcare practitioners experienced rage at the lack of intervention by healthcare systems to assist AIDS orphans

Primary healthcare practitioners complained to the researcher that the provision of care and support to AIDS orphans living in the township communities was slow because of the inadequacy of the health and social systems in South Africa through which care and support to children living as AIDS orphans was supposed to be provided. This caused the primary healthcare practitioners at times to feel incensed.

Health systems are a means, developed by societies, to help achieve ends such as the MDG's. Health systems can be a vehicle for accelerating progress on health-related goals; but they can also be a source of constraints, impeding progress. Health system performance can be thought of as the results produced by health systems—the ends societies seek to achieve. The challenge faced by policymakers and the analysts who support them is, therefore, to figure out how to improve health system performance to achieve better results (Briton and Berman, 2011: 2). The participants made the following commnets to the researcher:

"We live in a very complex society in South Africa where our health systems are slow, there is a lot of anger in our communities because of poor service delivery. As a primary healthcare practitioner I get angry that our referral systems are so slow very angry as it adds to a sense of injustice children who are already AIDS orphans feel. Our health systems in South Africa stop us from caring for children who are AIDS Orphans living in the township communities in a way which would help them and alleviate their suffering" [Interview 8, pg. 4].

"We must not fail the children who are AIDS orphans, because they are vulnerable but we do because of our poor systems. I get angry about this, really angry. AIDS orphans always have to wait, they wait; for a social worker; they wait for their grant; they wait to see a doctor and psychologist; they are always waiting, I get angry about this because they suffer whilst they wait" [Interview 6, pg. 6].

"It's very stressful seeing children left alone because their parents have died of HIV/AIDS. Grandmothers and aunts are desperate for the support grants; yet they have to go to SASSA to get them. In South Africa everything takes times. I get angry about this; but everything is so slow. Our health and social systems fail our people all of the time. I feel angry about this as I can only do my best which isn't enough" [Interview 13, pg. 3].

Health-related goals are prominent globally, nationally, and locally. As one example, four of the eight Millennium Development Goals (MDGs) include outcomes specifically related to health. MDG's 4, 5, and 6 are being monitored with specific indicators related to health status for children, women and communicable diseases. MDG 1, which focuses on poverty, is also closely related to health. Child under-nutrition is one key indicator for MDG 1, which is itself influenced by health financing. For example, there is widespread evidence that the lack of financial risk protection for health-related household expenditures is an important cause of impoverishment in developing countries (Xu et al., 2007: 977).

"At its core a health system is a means to an end – a system which exists and evolves to serve societal needs- with components that can be utilised as policy instruments to alter health outcomes" (Autim, 2012: 4). Health systems are open systems with interlinked components that interact in the context within which the health system is situated, thereby forming a whole with properties beyond the component parts. Interacting elements influence one an other with positive (amplifying) or negative (balancing) feed- back, collectively determining the systems' behaviour (Senge, 1990: 22).

"You know, I referred a young girl who is an AIDS orphan to a social worker. She was placed in a place of safety and was sent home for a holiday to her family in East London. She was raped by her uncle there many times and became HIV-positive. In the place of safety they did nothing. The social workers did nothing. Our systems in South Africa are failing our children, I am angry about this, very angry. I shouted at this social worker" [Interview 22, pg. 10].

Healthcare systems play a critical role in improving health; but only functioning health systems make possible the achievement of good health with efficient use of available resources. Effective health systems also enable responsiveness to legitimate expectations of citizens and fairness of financing. By helping produce good health effectively health systems also contribute to economic growth (Autim, 2012: 4). Well-functioning health systems are critical in mounting effective responses to emerging public health emergencies and addressing the burden of disease, ill health and poverty due to communicable and non-communicable diseases and cancers (Farmer et al., 2010: 1187). The primary healthcare practitioners articulated to the researcher some of their experiences when the health and social systems in South Africa failed to meet the needs of AIDS orphans.

"Some children I see in this clinic are so withdrawn because they watched their parents die of AIDS. They are so traumatised. As a result they take drugs or drink alcohol. I make referrals for these children to a unit in St George's hospital. It takes so long for them to be seen, they can die in the time it takes. I get very angry about this" [Interview 19, pg. 7].

“ As health and social care practitioners we must work together to provide care and support to children who are AIDS orphans; yet this is difficult as I refer children to social workers, psychologists, dieticians and doctors; yet everything takes so long as our health systems are so slow. Even if I do refer children to other professionals I often have to give them money to attend these appointments because they won’t even attend the appointments because they have no money to get there. I get angry that our systems in South Africa are as they are. They don’t help us care for our people;they hinder us” [Interview 5, pg. 1].

In the instance of HIV financing and highly cost effective innovative preventative medication is available during pregnancy to prevent mother-to-child transmission (PMTCT); yet in 2010 globally only 48% of HIV-positive pregnant women received treatment to prevent transmission to their child (25% in Central and Western Africa and 42% in Southern Africa) with the unacceptable consequence that in 2010 almost 400,000 children were born with HIV- all readily preventable (Briton and Berman, 2011: 11). The reasons for poor uptake of PMTCT, a highly cost-effective innovation, ranged from weak health systems to poor attention by Health and social care practitioners to the problem and to low political commitment (Tudor et al., 2012: 9). In this research study the researcher found that the healthcare systems within the Eastern Cape were failing to assist in the provision of care and support to children who were AIDS orphans living in the township communities which left primary healthcare practitioners incensed.

To be incensed is to be extremely angered at something unjust or wrong : "an indignant denial"; "incensed at the judges' unfairness"; "a look of outraged disbelief"; "umbrageous at the loss of their territory" (Oxford English Dictionary, 2009: 1194). Primary healthcare practitioners were incensed by the frustration of trying to work in poorly-functioning health and social systems when they were doing their utmost as professionals to render care and support to vulnerable children who were AIDS orphans.

“The problems children who are AIDS orphans living in the townships face are huge; yet these problems cannot be put in a box. That is why they are difficult to solve because they are difficult to understand. I get so angry at times because our healthcare systems are so poor. It’s our systems that fail in South Africa and people have lost trust in the systems as they expect them to fail” [Interview 2, pg.3].

“I ask all of my patients who are HIV positive: ‘Do you regularly come to the clinic for ART? Mostly they say ‘No’ because they feel so sick they can’t walk to the clinic for their medication because they are too poor. I am telling you our health systems are failing our people. I get angry about this because these AIDS orphans are already suffering. Then they suffer more because of poverty and poor systems which are supposed to help them" [Interview 21, pg. 3].

"Children who are AIDS orphans often don't go to the clinics for help because the clinics are very far. They don't have the money to travel there. Our systems in South Africa are not meeting the needs of children who are AIDS orphans living in the township communities. I am angry about this because we are supposed to care for and support these children and we don't. Mostly they are left destitute and very vulnerable in out poverty-stricken violent communities" [Interview 21, pg. 3].

"Targets are wonderful,….. but why are we not making it? We can in principle stop everybody who is suffering from HIV/AIDS from dying, because we have anti-retroviral treatment. Where is it? …. It cannot get there because the whole logistical procurement system, etc. is not there to guarantee that it is getting where it should do" Several studies , including one from the WHO (Briton and Berman, 2011: 4) attribute slow progress to poorly functioning health systems (Hafner and Shiffman, 2013: 46) . Recently organisations involved in global health have paid increasing attention to health system-strengthening which, has been primarily driven over global concerns regarding the slow progress on the health MDG's and the impact of global health initiatives on health systems. Health system -strengthening is seen as predominantly a national issue; but the commitment of global actors is worth monitoring since they influence financing, national priority and policy approaches (Hafner and Shiffman, 2013: 41).

SUB-THEM 4.2.2.6: Primary healthcare practitioners experienced inadequate management at local and provincial level.

Reports that doctors have not been paid in the Eastern Cape recently is supported by the fact that a nurse who was appointed from the Western Cape to a hospital in the Eastern Cape was never paid. In desperation she returned to the Western Cape where fortunately the Department was able to re-employ her. A situation such as this cannot promote quality healthcare and is to an extent the cause for the continued rise in patient numbers in the Western Cape over the last several years, Minister Theuns Botha, (WCG, 2012: 7)

The Eastern Cape Health Department lost R800 million to corruption between January 2009 and June 2010. One of the manifestations of the breakdown in health services in the Eastern Cape is the failure to pay suppliers and in recent times even pay staff. Thirty doctors from just one region in Eastern Cape had not been paid in April and two people had worked for three months without pay. It seems some of the problems were caused by clerical errors, others by the Health Department hiring staff without the authorisation of the provincial treasury (WCG, 2012: 6). The Eastern Cape Government released the following intention regarding the provision of healthcare in the Eastern Cape:

- “To provide and ensure comprehensive integrated services in the Eastern Cape emphasising the primary healthcare approach, utilising and developing all resources to enable its present and future generations to enjoy health and quality of life (WHO, 2008b).

In South Africa provincial health departments provide and manage comprehensive healthcare services, via a district-based, public healthcare model. Local hospital management has delegated authority over operational issues such as budget, and human resources to facilitate responses to local needs. “South Africa is besieged with a quadruple burden of diseases. The burden becomes overwhelming if one has to look at it holistically and taking inefficiencies and challenging factors that are worsening the situation like the unavailability of proper healthcare systems or at least dysfunctional plethora of health systems in the country because of a lack of leadership management and stewardship” (Doherty and Gilson, 2011: 3). If management was a licenced profession on a par with law or medicine, there might be fewer opportunities for inefficiencies and corruption (Mbabane, 2009: 34).

Primary healthcare practitioners were discouraged and frustrated by inadequate management at both local and provincial level and felt strongly that failure of these management systems directly affected their ability to provide care and support to children who were AIDS orphans living in the townships. They told the researcher that material and people resources which were to be organised and provided through these management structures simply were not available.

“We are putting in orders for milk in this clinic every month but we never receive any. We haven’t had any milk powder in this clinic for nine months. This is supposed to be for malnourished children who are poor. I met a grandmother who was giving her baby granddaughter water in a bottle with sugar and egg white. Our people are desperate” [Interview 11, pg. 3].

“The worst for me as a sister in this clinic is the mis -management at Bhisho. When a member of staff leaves it take so long to replace them and this put pressure on all the other nurses. There is a lot of corruption in our government. I know nurses and doctors in this municipality that were not paid for three months last year. It’s disgraceful” [Interview 21, pg. 4].

"I have to say that there is incompetence in our management structures. Sometimes our managers they fill in forms, to acquire resources for the clinics from Bhisho and the manager isn't even in their office for weeks to receive the form. A colleague of mine she went to Bhisho to work. She told me it's appalling. The people there don't know what they are doing. She got burnt out in six months because she was doing the work of three people. She said our health system is falling apart because of poor management which is corrupt. Did you see the article in the Herald newspaper about the fraudulent grant applications? It's just awful and the people are suffering because of it" [Interview 22, pg. 16].

"At this point in time it is common knowledge that the health system in the Eastern Cape is falling apart. A special Investigation-unit probe into the Eastern Cape Health Department revealed corruption involving R200 million and thousands of officials. The investigation, launched in December, found that 15, 900 department officials were illegally receiving child support grants totalling R58 million per year. The leaked report also revealed that almost 4 000 officials were illegally receiving housing subsidies from the human settlements department amounting to R86 million. Assets valued around R19 million, which were transferred to district offices, apparently went missing (WCG, 2012: 5).

Primary healthcare practitioners interviewed by the researcher used words such as 'incompetent, ineffective, dishonest, non–functioning and failing' when describing the local and provincial management structures in the Eastern Cape.

"The management at Bhisho are interested only in themselves, not in the people they are supposed to be helping. I have to say they are incompetent and dishonest and we suffer in the clinics because of this. Sometimes professional people are not paid, and we fill in so many forms for resources which simply never arrive in this clinic" [Interview 22, pg. 9].

"We fill in forms we apply for milk powder; we fill in forms for food parcels but still nothing comes The government is doing nothing for these AIDS Orphans nothing . And what is worse there are many of them" [Interview 11, pg. 4].

"Our management isn't very good in the Eastern Cape. In our office I have the use of a car for one day a month. How can I possibly do a good job when I can only visit the most vulnerable families one day a week? If our management system was more efficient we could do more" [Interview 22, pg. 8].

Khurana et al. (2005: 211) define managers principally as salaried employees of an organisation who performs tasks involving the coordination of labour of others in positions requiring a minimum of a four-year college degree and with general knowledge of one or more business functions. According to Mintzberg (1971: 196), managers fulfil 10 different highly interrelated roles which could be divided into three sets of roles, namely, interpersonal, informational and decisional. In turn managers require three sets of skills to perform these roles: technical skills, human skills and conceptual skills (Elmati, 2004: 449) . Primary healthcare practitioners attributed the lack of resources in the clinics to inefficient management.

"The big problem for me is the lack of efficient management. People are put in jobs because of their colour and not because they can do the job. That have no management skill yet they are put in management positions. In this clinic I burnt out because I had to help and orientate a manager who didn't know what she was doing. I still do a lot of her work for her. Our service delivery suffers because of this poor management" [Interview 22, pg. 17].

The Ministry of Health's role in providing overall guidance on activities that contribute to improving levels of health in South Africa has generally been characterised by good policies, but without equivalent emphasis on the implementation, monitoring and assessment of policies through the system. The scarcity of human resources in rural areas and at low levels of the health system management has presented one constraint to policy implementation, but another key constraint has been inadequate stewardship, leadership and management (Coovadia et al., 2009: 817).

The rapid transition from the failed stewardship of ex- President, Thabo, Mbeki, and the disastrous policies of his Health Minister Mantombazana Tshabalala-Msimang, to the leadership shown by the present Health Minister, Arion Motsoaledi, and his team could not have been more striking. Barbara Hogan took the first steps, initiating several projects to deal with the disarray in the Department of Health in the short term as Minister of Health. These changes were followed by decisive actions, indicating that the government was leading future plans and programmes, spending on antiretroviral drugs were being accelerated and a new national strategic plan for HIV, sexually-transmitted infections and tuberculosis for 2012-2016, was being intentional (Mayosi et al., 2012: 11).

"I once had a meeting with a manager from Bhisho. I wanted to start an initiative to help AIDS orphans in our communities. They told me that they weren't interested in helping as they were only in that position to further their own political career. That was the day I lost all hope regarding our management system in Bhisho" [Interview 13, pg. 4].

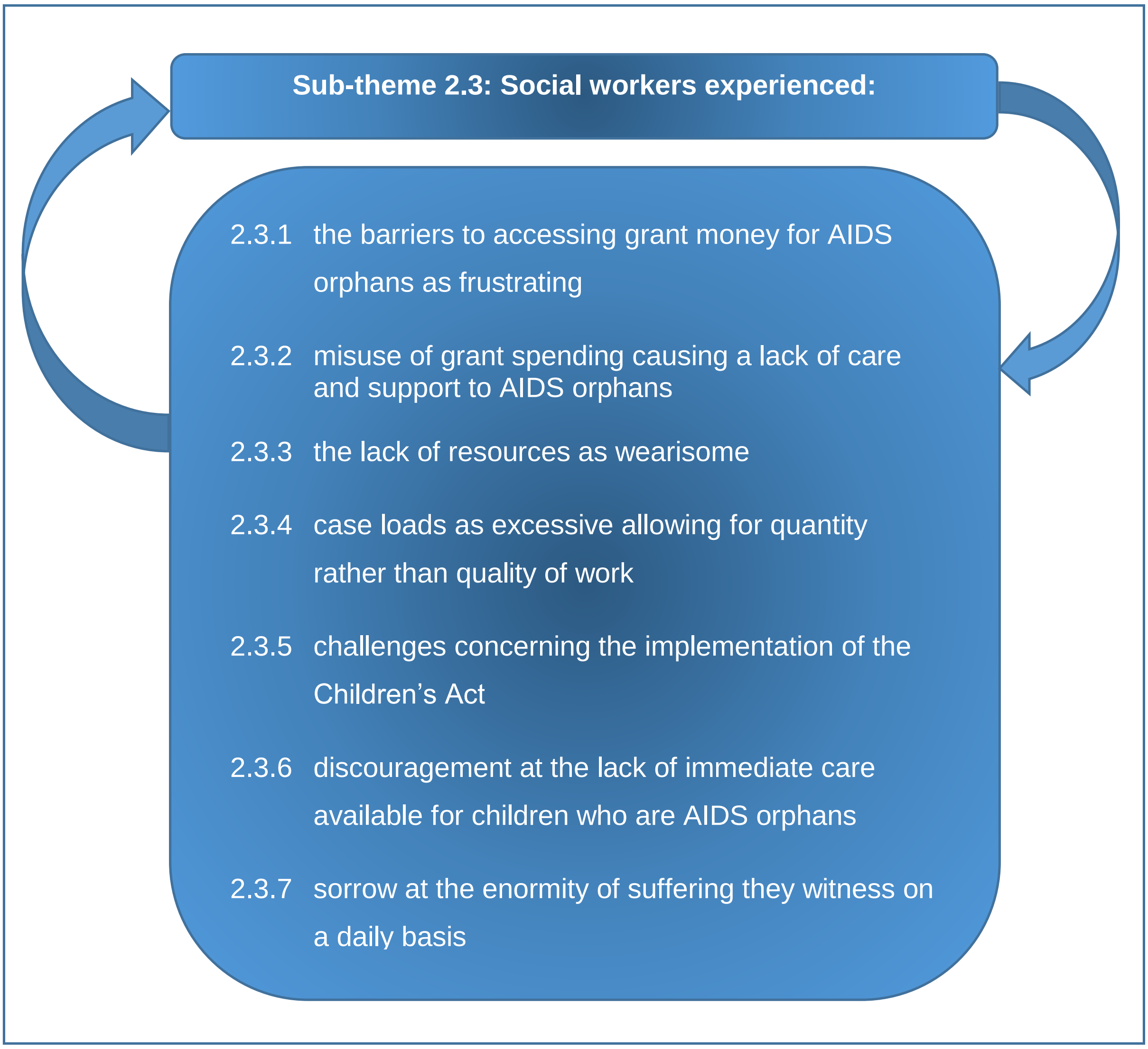
Leadership, however, extends beyond its most prominent individuals and includes managers and others in positions of responsibility to effect change through their own initiatives. Although at the highest levels the Minister of Health and his senior staff have made radical policy changes and have had proactive involvement with society, the stasis of the last ten years in the health management bureaucracy has been slow to change. Management are particularly important for service delivery. They should go beyond routine implementation of rules and instructions from their superiors and instead use local information to guide and lead their areas of responsibility. Gilson and Daire (1998: 2) emphasised that recommendations made in 1998 about delegation of responsibility at faculty level and development of managerial training and support had still not been implemented in 2011 except for the strengthening of management by assessment of performance with a common competency framework.

"The people last week were burning tyres in Walmer Township so the clients came here for their treatment. It's terrible that people suffer because of poor and inefficient management. People are fed up with corruption. They need services not managers stealing money" [Interview 13, pg. 4].

The development of management capabilities should be located in a framework that explicitly understands and effects institutional change and addresses the needs of managers (Mayosi et al., 2012: 5). Development and leadership training should be matched with a systematic plan to transform the dysfunctional civil service into a responsive, caring, stable and effective service which would necessitate reorientation of organisation rules and protocols of the present health system (Mayosi et al., 2012: 6). What is apparent is that the transformation of political commitment into well-planned and effectively implemented evidence-based programmes and services will only occur through effective management which is essential in achieving the lofty plans of the Government and in the achievement of the MDG's (Mayosi et al., 2012: 9).

In summary of theme 2.2 the researcher would like to highlight the following; primary healthcare practitioners used such words as disgraceful when recounting to the researcher how children who were AIDS orphans living in the townships experienced care and support. Primary healthcare practitioners told the researcher that a critical lack of primary healthcare practitioners and associated health and social care practitioners was obstructive in the provision of care and support to children who were AIDS orphans living in the townships communities. Primary healthcare practitioners also experienced being overwhelmed because of the lack of resources they had available to assist desperate families caring for AIDS orphans and expressed the distress they experienced in providing care and support to children who were suffering as AIDS orphans living in the township communities.They described feeling angry because of what they saw HIV/AIDS causing in the lives of people living in the township communities. They also spoke about how they felt incensed and enraged by the lack of intervention of the health and social care systems in place to provide care and support to children who are AIDS orphans, and the inadequacy of management at both a local and provincial level. Primary healthcare practitioners expressed to the researcher their distress at how children who were AIDS orphans living in the township communities experience extreme suffering such as neglect.

SUB-THEME 2.3: SOCIAL WORKERS EXPERIENCE: Figure 4.5 represents social workers experiences in the related sub- themes



Sub-theme 2.3: Social workers experienced:

2.3.1 the barriers to accessing grant money for AIDS orphans as frustrating

2.3.2 misuse of grant spending causing a lack of care and support to AIDS orphans

2.3.3 the lack of resources as wearisome

2.3.4 case loads as excessive allowing for quantity rather than quality of work

2.3.5 challenges concerning the implementation of the Children's Act

2.3.6 discouragement at the lack of immediate care available for children who are AIDS orphans

2.3.7 sorrow at the enormity of suffering they witness on a daily basis

Figure 4.5: Diagrammatic representation theme 2.3; and related sub-themes.

SUB-THEME 2.3.1 Social workers experienced barriers to accessing grant money for AIDS orphans as frustrating

There is increasing recognition globally that there is value in cash transfers as they assist governments with tackling poverty and reducing vulnerability in children, whilst promoting broader developmental impacts (DSD et al., 2012a: 3). Cash transfers reduce poverty in very vulnerable households; are relatively easy to administer; reduce inequality, provide more consumption decisions in households; and enable children to gain an education improve in health and attain better nutrition. Cash transfers thereby improve standards of living of very vulnerable children and also provide a safety net by enabling families to cope with risk by providing a minimum income level (DSD et al., 2012b: 5). The two grants or cash transfers about which social workers spoke to the researcher with regard to care and support of children who are AIDS orphan's living in the township communities, were the Child Support Grant a (CSG) and the Foster Care Grant (FCG). Social workers told the researcher that the application process for the CSG was relatively straight-forward for families if they had the correct documentation, but that the monetary value of this grant was too small to alleviate the distress AIDS orphans experienced due to lack of financial provision. A FCG had an increased monetary value but also it had a much more complex application process, which delayed the provision of financial support to very vulnerable AIDS orphans.

"The main thing that children who are orphans need is money into the home to buy food and clothes and to enable them to go to school. They need social workers to help them apply for grants. But our processes are complicated to apply for grants and the social workers are few. This is very frustrating" [Interview 23, pg. 3].

"We struggle to help these children who are orphans because in many cases they don't even have a birth certificate. Some children don't even have a clinic card; and without a clinic card and knowing their place of birth it is impossible for us to get their birth certificate. It's just impossible and very frustrating"[Interview 1, pg. 1].

"Mostly the grandmothers they don't apply for the FCG or CSG because they don't know they can; and the application process is too difficult for them" [Interview 9, pg. 5].

"It's so frustrating chasing documents, I went to one home to collect the birth certificates' of two children who were orphans, and the aunt tells me the father has the birth certificates, then the father says 'No' the pastor does. So in the end I went to SASSA. I found the boy was registered but his sister was not. Then it's a nightmare because some of these children have no clinic cards and don't know their date of birth. So I can do nothing in this instance" [Interview 21, pg. 12].

The Child Support Grant (CSG) of R100 per month was introduced in 1998 for children aged 0-6 years whose caregivers qualified in terms of an income-based test. The main goal of the CSG is to ensure that primary care givers of children living in poverty are able to meet the basic needs of the child. Since then policy reforms have progressively expanded the age of eligibility (all children born after 1993 are now eligible), raised the income level to reach all poor children effectively (currently set at 10 times the value of the grant), and adjusted benefit levels for inflation (As of August 2011 the grant value was R270 per child per month). The CSG has become the largest programme for alleviating poverty in South Africa, and the number of beneficiaries increased significantly from 70,000 children in 1998 to 10.5 million by April 2011 (DWCPD and UNCRC, 2012a: 63).

“The Child Support Grant (CSG) is an important instrument of social protection in South Africa, reaching over 10 million South African Children every month, (DSD et al., 2010: 2). The results of this study by UNICEF, DSD and SASSA were supposed to lead to:

- promoting nutritional, educational and health outcomes
- preventing the multiple dimension indicators of poverty
- promoting better gender outcomes and reduces inequality
- adolescents receiving the CSG being more likely to have some positive educational outcomes and being less likely to experience child labour: and less likely to engage in behaviours that put their health and well-being at risk

The South African Child Support Grant Impact Assessment was a study commissioned and funded by The Department of Social Development (DSD), the South African Social Security Agency (SASSA) and the United Nations Children Fund (UNICEF).

The results of this research study, which was to assess the impact of the CSG, conveys several key messages: (DSD et al., 2010: 6).

1. The CSG generates positive developmental impact that multiplies its benefit in terms of directly reducing poverty and vulnerability.
2. Early enrolment in the CSG programme substantially strengthens impacts. Promoting continuous access to the CSG for eligible children through adolescence would help to maximise the potential benefits of the grant.
3. Receipt of the grant by adolescents generates a range of positive impacts, not least of which is the reduction of risky behaviours, which in the context of high HIV-prevalence rates as particularly protective impact (DSD et al., 2012a: 107).

The main reasons regarding the barriers to accessing the CSG are: according to (DSD et al., 2010: 24) were, misunderstanding regarding eligibility criteria of CSG application, accessibility to documentation required by the applicant and extension regarding the age threshold of the CSG eligibility.

Eligibility for the CSG is determined by three factors: income, age and nationality. There seems to be confusion when the means test assesses the income of the CSG applicant (the childs biological parent or primary caregiver, the income of the spouse or partner and the income of the beneficiary (who is dependent child);the sum of the three incomes must fall below a threshold that is adjusted every year in order for the child to qualify as eligible. In 2010/2011 the means test of the CSG was set at R2500 per month for a single caregiver and R 5000 per month for a married caregiver plus spouse, plus dependent children.

With regard to the grant application process of the CSG, the social workers attested to the following as reasons for the barriers in the application process of the CSG which they found frustrating: chasing documents, caregivers not knowing they were eligible to apply for a CSG and confusion regarding the age threshold for the CSG.

“Most of the orphans I see are cared for by their grandmothers. Grannies are overwhelmed in the grant application process, they are overwhelmed mainly because of the documentation required that quite simply their grandchildren don’t have. We have to equip these grannies to tell them what to do and where to go. But they are old and tired and they have a lot of cares because their children have died of AIDS” [Interview 9, pg. 1].

“A lot of the grandmothers I help to apply for the CSG and FCG for their grandchildren are illiterate. The government must understand that the current system doesn’t help the people who need it the most. This is very, very frustrating” [Interview 9, pg. 5].

“So many grandmothers I see don’t know they are eligible to apply for the CSG. I spend a lot of time with grandmothers and explain how to apply for a CSG. If they have the documentation it’s easy for them. They don’t need a social worker they can just go to SASSA, get a receipt and wait. Many of the grandmothers are anxious and overwhelmed about applying. This is a problem we as social workers have to overcome. It’s frustrating always explaining the same thing” [Interview 19, pg. 6].

Accessibility to documentation required for CSG application is the biggest barrier and frustration regarding the grant application process (DSD et al., 2012a: 26). According to the Eastern Cape Government website 2013 the following documentation is required by the applicant in order for the CSG to be applied for: the 13 digit –bar -coded South African Identity document and the child’s birth certificate; proof of any maintenance the applicant receives for the child; proof of earnings of the applicant and or marriage certificate of the applicant. If the applicant is divorced then a court order is required saying the applicant has custody of the child. If one of the parents are dead or missing, the death certificate of the deceased or proof that the parent is missing is required e.g. a missing person's report from the police.

If the applicant doesn't have a 13-digit-bar-coded South African identity document, the applicant will need the following documentation: a completed affidavit on standard SASSA format in the presence of a Commissioner of Oaths who is not a SASSA official, a sworn statement by a reputable person (e.g. a counsellor, traditional leader, social worker or minister of religion) who knows the applicant and child, proof that the applicant has applied for a birth certificate at the Department of Home Affairs, a temporary ID issued by the department of Home Affairs, a baptismal certificate if available, road-to-health clinic card if available and a school report if available. The process is then simple: the person needs to complete the application for the CSG in front of, or with, a SASSA official and to keep the receipt. One of the social workers told the researcher just how frustrating it was to assemble the necessary documentation in order to be able to access the CSG grant-application process.

"I can tell you I spent three days in Home Affairs to make an application for a birth certificate. The family were destitute. The child who was an AIDS orphan was staying with the grandmother, but the grandmother is too young for an old-age pension. So we ran around for documents to just make an application for a CSG. This aunt had no money even for bus fare to go to the home affairs. This a big problem chasing documents. Its takes a lot of time and costs a lot of money in bus fare. I got really frustrated. Even as a Social Worker I had to wait in home affairs. I was so frustrated about this" [Interview 19, pg. 9].

"I have many grandmothers who say 'I didn't know I can apply for this CSG'. I find many times when I explain that they don't need a social worker for this but just to go to SASSA. They wish they had known sooner so they can apply for this CSG" [Interview 1, p.g4].

The social workers in this research study clearly explained to the researcher that the reasons grandmothers and other caregivers gave, for not applying for the CSG, were not having the correct documentation or having insuffient money for busffare to go to the various government departments which were geographically far from the township communities, finding it difficult to access a social worker and being overwhelmed by the grant application procedure. Social workers found this frustrating.

The use of the foster care system and grants for children orphaned by AIDS has been encouraged by certain government ministers, including the former Minister of Social Development. Zola Skweyiya in Meintjies et al. (2003: 1), Ministe Skweyiya is quoted as saying in 2002 that "the Department of Social Development is encouraging relatives to take care of orphaned children under the foster care package". Similarly in November 2007, in the second debate on the Children's Amendment Bill in the National Assembly, the Minister emphasised the "importance of family preservation" and highlighted a "provision for the placement of children with a family member" (McEwen and Woolard, 2013: 144).

Foster care grants are available to foster parents who have a child placed in their care by an order of court. The grant is significantly greater than the CSG, at R800 per month per child in 2013. Like the CSG, the number of FCG recipients had increased particularly over the last six years, from just over 27000 in 2005 to 5222,000 as of April 2011 (DWCPD and UNCRC, 2012a: 26). In order to qualify for a foster care grant the child must be placed by a court in the care of the foster parents. The placement process is time – consuming and complex process. The social workers told the researcher how lengthy this application process was regarding a FCG, as it was dependant on the report and assessment of a social worker who presents a child to the court along with all supporting documentation regarding the placement of the child in question with a member of the extended family.

In this instance social workers told the researcher that the AIDS orphans were normally placed in the care of the grandmother or aunty. Social workers found the process of FCG-application cumbersome and frustrating. Complaining it was a lengthy process for FCG to be awarded which they find they found both frustrating and demotivating. They also spoke to the researcher regarding the backlog of their cases and the need to make applications for the FCG, FCG reviews and also new cases which needed to be reviewed. Social workers were also frustrated by the volume of their caseload saying this further frustrated their ability to maintain a perspective in the grant application process, as they never felt they had completed their work.

"Most of the orphans I see are cared for by their grandmothers. Grannies are overwhelmed in the grant application process; they are overwhelmed mainly because of the documentation required that quite simply their grandchildren don't have. We have to equip these grannies to tell them what to do and where to go. But they are old and tired and they have a lot of cares because their children have died of AIDS" [Interview 9, pg. 1].

"The government now says that we have to find the fathers of the children before placing them in foster care. If you want to do a foster care application you must bring the father. Even if he is alive but not working you must bring him, to do a fresh children's court enquiry. The foster care assessment must be very thorough. Most of the families don't want us to find the fathers because the fathers are not working. So they want us to make a FCG application. What takes the time is that the FCG application process must be so thorough. This is very frustrating as I feel like I am always chasing paper" [Interview 21, pg. 3].

"My work as a social worker is never done. There are always case reviews, always new cases and always foster care placement to organise. I feel like all I do sometimes is fill in forms. I fill in all the forms for a Foster Care Placement and then I know the family must still wait. It's frustrating to fill in all this paper and then the grant being awarded still takes so much time" [Interview 20,pg.4].

"Grannies are eligible for FCG's but most of them are unaware of this. Yet I get frustrated. We give them hope of financial provision for their grandchildren and then tell them they must wait for at least 18 months" [Interview 9, pg. 1].

"When it comes to the case of social development, the cases that are not placed with a social worker remain unsolved. The cases that are not emergency cases get put on our case load. There is a backlog. I have cases in my case load where the application was made when the child is 14 years old and we are still waiting to go to court. This is very, very, very frustrating. Children suffer because of our slow processes [Interview 22, pg. 4].

Almost three quarters of Foster Care Grant beneficiaries are AIDS orphans (McEwen and Woolard, 2013: 152) : however despite the high probability of a Foster Care Grant beneficiary being an orphan, the take-up of the Foster Care Grant by the caregivers of orphans is very low. In fact, orphans are more likely to receive a Child Support Grant than a Foster Care Grant. Maternal orphans appear significantly less likely to receive any form of grant than paternal or dual orphans or non-orphans. The reason for this seems difficult to identify. About 12% of the care givers of maternal orphans under 15 cite a lack of documents as the reason that they have not applied for the grant.

The Foster Care Grant has increasingly become a de facto orphan grant, albeit one that is hard to access; yet, while the most recipients of this grant are orphans, most orphans are not receiving the Foster Care Grant. One of the barriers regarding the FCG application is to ascertain proof regarding the father of the child. The burden of proof is high regarding the father of orphans since it is difficult to establish whether or not the child's father is deceased if his whereabouts are unknown or if he himself is unknown. Research is contentious in the issue of the FCG being the right policy prescription for orphans (McEwen and Woolard, 2013: 154).

Over half a million caregivers (20% of those eligible and not receiving a grant) cited a lack of the correct documents as the reason for not applying. As Leatt et al. (2005: 16) point out , it is generally the poorest people who do not have a birth certificate and are unable to travel to

Home Affairs for identity documents, police stations for affidavits and the DSD for the grant-application processes.

A decision to place a child in foster care is made by a children's court which is satisfied on the basis of a social worker's report that the child is in need of care and protection, that the prospective foster parent is fit and proper and that the placement is in the child's best interests. Once a child is placed in foster care, there must be ongoing social work supervision of the placement and subsequent reports to court, usually every two years, to recommend whether the foster care placement should be extended. What is apparent is that there is too much pressure on the foster care system. The cumbersome application process means that social workers are devoting time to chasing the system for grants, while children who are being abused or neglected, orphaned or abandoned, are not receiving prompt services. This is a huge barrier which causes untold frustration among the social workers and the families seeking to care for and support AIDS orphans. The foster care system began to lurch in 2010 and by January 2011, 123 236 Foster Care Grants had already lapsed. Alarmed, civil society organisations approached the Centre for Child Law, a law clinic based at the University of Pretoria, which undertakes litigation on children's rights.

The Centre brought an urgent application to the High Court in an attempt to resolve the crisis and prevent any further children from being dropped from the foster child grant system. It was evident, the court papers averred, and that the lapsing of such large numbers of Foster Care orders was due to systemic failure. The Department of Social Development did not oppose the application; and a draft order was presented to the North Gauteng High Court by agreement between the parties. The court order provided that until such time as the foster care backlog could be resolved, but not later than the end of 2014, an administrative process similar to the one previously applicable under the Child Care Act must be utilized in respect of children whose foster care orders (originally granted prior to 10 April 2010) were due to lapse. The court order also provided that all orders that had already lapsed would be deemed not to have lapsed. The court order provided a temporary solution, but it is clear that further action is required to properly resolve the crisis (Skelton, 2012: 3). One of the social workers explained this to the researcher.

"I have placed many children in foster care with their extended families who are with grandmothers or aunts. The families are approved and apply for FCG. Every two years I have to do a review of each foster care placement and re-submit papers to the court. I get mad about this because in most cases children who are fostered don't receive the money of the FCG. So I must do the review and tell the court this. I really don't know why this delay is like this, but it is. If the foster care review lapses then I must start over. This is a ridiculously frustrating system. It doesn't work at all" [Interview 20, pg. 9].

The social workers explained to the researcher that the FCG was a good amount of money to assist grandmothers and aunts in caring for and supporting AIDS orphans in their own families; but they regarded the process of placing the child in foster care, the children's court appearance and the subsequent waiting for the administration of the FCG as very frustrating, demotivating and causing more suffering to already very vulnerable children.

"The Foster Care Grant is enough money to live on to provide basic provision if it is spent properly. You know it differs from place to place how quickly the FCG is awarded. It should take between 3 to 6 months but it usually takes between 1 to 3 years. It should take a maximum of 3 months. I go to the family do my report. I can do this in a week if the family has all of the documentation. From there it should go to court, as soon as the case goes to court and the placement is approved it should take no longer than 3 weeks to process the FCG. I have a case on my books it's taken 6 years and we still don't have it. We have a terrible backlog of cases in the Nelson Mandela Bay" [Interview 19, pg. 5].

"When it comes to the case of social development, the cases that are not placed with a social worker remain unsolved. The cases that are not emergency cases get put on our case load. There is a backlog. I have cases in my case load where the application was made when the child is 14 years old and we are still waiting to go to court. This is very, very, very frustrating. Children suffer because of our slow processes" [Interview 22, pg. 4].

"Sometimes you find 14-year-olds even when they are becoming 17 years they still haven't received their FCG. I currently have a case where the child will be 20 years old the day after going to court. Our backlog in the Easter Cape is very, very, very bad" [Interview 22, pg. 4].

The cumbersome application process concerning FCG application was highlighted by child SS a 10-year old orphan who waited for more than five years for a South African Government grant. The way the state will support children in need has to change. A press release by the South African Government in November 2012 reads as follows "In the light of these circumstances, the department resolved to introduce the new kinship benefit to children, so that even if orphaned children are living with members of their extended family they can receive support. The exact amount of the new grant must still be determined. Indications are it will be less than the Foster Care Grant, but more than the Child Support Grant.

Social workers told the researcher that the persons who would be receiving the FCG or the CSG were also fed up with chasing paper and the time delay in grants actually being awarded.

“So many clients tell me: ‘I went to the referral but nothing changed for me’. We need good support and referral structures but we simply don’t have them. It takes about 3 years on average to get a FCG for a family. It’s just a never-ending cycle of collecting paper, filling in forms and waiting. It’s a cycle of hopelessness which causes frustration and suffering” [Interview 22, pg. 14].

Of the estimated 1.2 million orphaned and vulnerable children in South Africa (due mostly to the impact of HIV and AIDS), NGO and government welfare services together are currently only able to reach and deal with around 200 000 - leaving 1 million to fend for themselves. The backlog of processing foster care grants, which can take up to 2 years, is blamed largely on the fact that there are insufficient numbers of social workers and magistrates to deal with applications, with the consequence that the thousands of poor families who are forced to take in these children are increasingly unable to carry the cost burden of the extra mouth to feed over such an extended period of time (Pretoria News, 2006: 4).

South Africa currently has one of the largest and most ambiguous social assistance programmes in the developing world. Government spending on cash transfers has increased markedly since the end of Apartheid, reaching just over R80 billion, or 3.3% of the GDP in 2009/2010 financial year (McEwen and Woolard, 2013: 141); yet the grant application processes remain slow, causing social workers endless frustration and stress as they seek to care for and support children who are AIDS orphans living in the township communities. Social workers experience the processes of acquiring grants for beneficiaries as too time-consuming, costly; the process for application is too complicated, high transport costs to get to the SASSA offices is also a well-documented barrier in the CSG and FSG application process as are long assessment processes and court processes to see the awarding of FCG to very vulnerable children (DSD et al., 2012b: 29).

SUB-THEME 2.3.2 Social workers experienced misuse of grant spending as causing a lack of care and support to AIDS orphans

In South Africa the two main support grants affecting the provision of financial care and support to AIDS orphans are the CSG and the FCG. There has been a change in thinking regarding the administration of these grants.

The programme theory of change underpinning the Child Support Grant (CSG) and the Foster Care Grant (FCG) would suggest that caregivers are the recipients of the grant and are likely to use this money for the benefit of those in their care, in this case children. This coupled with information campaigns stressing that the grant is child-specific and intended for educational support should lead to a range of child- specific uses of the grant (DSD, SASSA & UNICEF, and 2010:40). In a research study by DSD, SASSA and UNICEF in 2010 the following were recorded by the researcher as uses of the CSG by the beneficiaries.as a result of the fifty two interviews conducted in this above mentioned study, the following were mentioned by the participants: school related expenses 95 times, food 90 times, clothing 36 times, transport 8 times, health 5 times, beauty 5 times, investment, twice and job search once (DSD et al., 2010: 27).

Social workers spoke to the researcher about the intense frustration they felt regarding the misuse of the spending of grant money by families to whom grants had been awarded. They found it intolerable that when either CSG or FCG were awarded to the families to assist in the provision of care and support to AIDS orphans, the grants were misspent by the families and that the provision of CSG and FCG to families did not alleviate the suffering AIDS orphans experienced due to a lack of financial support. Social workers found it intolerable to listen to children report that grant money was being spent on alcohol or on the purchase of goods not in the interests of the well-being of the child; the grant was intended.

“I see children who come to me and they are on ART. They tell me that there is no money at home yet they know they have a FCG. They tell me family members are drinking the money. We need social workers to visit children at home to monitor how the grant is being spent” [Interview 2, pg. 3].

“Children tell me that their families don’t want them. They just want the grant money. They tell me that when the grant money comes through the aunt will spend the money in a wrong way, in buying clothes or having a haircut for themselves. The children are angry about this” [Interview 16, pg. 3].

“I find as a social worker the best foster parents are grandparents. When the grandmother receives the grant she will spend it on caring for the grandchild she will not misuse it. The children who report to me misspending of the grant money are those staying in AHH” [Interview 16, pg. 4].

According to primary care givers, school-related expenses include items such as crèche fees, pre-school fees, Grade R fees, pens, bags, calculators, transport, soccer trips and clothing. Food-related expenses covered general groceries such as eggs, biscuits, mealie-meal, polony, yoghurt as well as child-specific food such as formula milk, baby food, Lactogen, yoghurt for kids, food for lunch boxes and school lunches. Soap and nappies were also highlighted by some respondents. Other reported uses of the CSG by carers were: to take children to the clinic for their immunisations, help visit family members when they were in hospital and for payments to burial societies. Adolescents who received grant money reportedly spent it on school books, school uniform, socks, calculators, shoes, sweets, toiletries, underpants, body spray, chips, pies, lunch and airtime (DSD et al., 2010: 41). Although the value of the grant is small it nonetheless makes a difference (DSD et al., 2010: 42).

Except that in the presence of grinding poverty in many communities “who the grant is for” the money seems to be lost as the household needs are huge; therefore in many instances the grant is used for the general household budget top-up and not for child specific needs (DSD et al., 2010: 43). According to the experiences of the social workers recorded by the researcher during the undertaking of this research study (misuse of the grant seems to occur in the following instances):

- Teenage mothers do not use the grant wisely and rely on grandparents and others for child care while misspending the money on themselves.
- When mothers ask relatives to care for their child/ children or even “abandon” the care of their children with relatives they do not relinquish the control of the grant to new carers.

The reported perceptions regarding the misuse of the spending of the grant were mainly in the purchase of alcohol by the carer; visits to the hairdresser by the caregiver; spending on boyfriends; spending on luxury foods (such as KFC) and gambling, cell phones and clothes for the caregivers (DSD et al., 2010: 43). It is also important to consider that a driving hypothesis behind the provision of CSG to poor households is that extra resources will enable the household to consume or purchase items that otherwise they would have been unable to buy; but in the context of poverty in the township communities, the dominant theme emerging from the above mentioned research study is that low levels of income and high basic needs provision means that the grant is necessarily diluted across the family in the name of basic needs provision (DSD et al., 2010: 46).

Whatever the intended or perceived use of the CSG or FCG is, it is primarily used as a basic household income top-up such as to buy food and consumption needs for the household. The social workers told the researcher that the reasons they found for most of the grant spending misuse was: widespread poverty, unemployment, ignorance, absence of education and limited income at home.

“Grant spending within families is a contentious issue. It’s hard to supervise grant spending. However I do write budget plans with grandmothers who are receiving a FCG to assist them in the planning of spending of the grant. This helps the grandmothers” [Interview 21, pg. 3].

“I get angry when families receive FCG and misuse them. I see poverty every day but even in poverty people have choices to make. I work so hard to apply for FCG. I get angry and demoralised when they are appropriated and then misspent” [Interview 20, pg. 3].

“You know I see in poor families that it takes a lot of integrity to spend money in the right way. There is a lot of temptation in families where there is poverty to spend money on the children’s needs and not on the needs of the caregiver. That is why it’s better for grandmothers to care for their grandchildren, because they genuinely do care for the well-being of their grandchildren” [Interview 16, pg. 4].

Whilst it is evident from both literature and the conversations the researcher had with social workers regarding the misuse of grants, there does need to be an acknowledgement that whilst there is misuse in spending of some of the grants awarded to care givers, in most instances the provision of grants to the homes of children who are AIDS orphans does improve their well-being through the provision of finances to address the provision for some household needs.

SUB-THEME 2.3.3 Social workers experienced the lack of resources as wearisome

Ashley Theron, the first ever black, male national executive director of Child Welfare South Africa, states that there is no point to being able to identify vulnerable children if there aren’t the social workers and financial resources to assist them (Earle, 2008: 3). The social workers told the researcher that they experienced weariness because of the constant lack of resources which hindered their ability to render care and support to children who were AIDS orphans living in the townships communities.

“My biggest frustration as a social worker is working with a total lack of resources. I get so tired of coming to work and being told, ‘We don’t have resources for this, we don’t have resources for that’, and I get fed up of that” [Interview 1, pg. 7].

“We don’t even have petty cash available to give people money for bus fare or bread if we can see they are hungry. This must come out of our own pocket. How can I make a grandmother walk for two hours away from my office with a baby on her back? It’s these things the government must know about” [Interview 2, pg. 7].

“In our office we are four social workers sharing a phone a printer and I can book the department car for one day a month. Yet my caseload is 12 cases. How can I look after my families where there are no resources? I have my own purse and I collect clothes from neighbours and friends” [Interview 4, pg. 4].

“I don’t even have space for my clients to sit; they must stand in my office. If we need to have a private talk or I need to counsel them I must stand in the corridor. I get tired of the working conditions social workers in South Africa face” [Interview 11, pg.5].

“We don’t even have paper in my office. What kind of an office works and doesn’t even have paper?” [Interview 11, p.g4].

“We are told to run support groups; but there are no resources. Sometimes I have to wait for paper even in my office to do the statutory reports like foster care placements. It’s too terrible sometimes to work with the few resources we have sometimes. I get very, very tired of this. Tired of the suffering of people and this system of no resources, just tired” [Interview 18, pg.9].

To be wearisome is to experience "the deadening effect of some routine tasks or the ongoing drone of difficult circumstances" (Dictionary, 2013: 975). When something is wearisome it is, trying, wearing, boring, exhausting, dull, annoying, fatiguing, troublesome, oppressive, exasperating, tiresome, monotonous, prosaic, humdrum, burdensome, uninteresting, numbing, irksome, bothersome, vexatious a long and wearisome task or unending challenge.

The working conditions for most social workers in the welfare sector in South Africa – regardless of whether they are based within the public or the private arenas – are generally very poor. The following inter-related issues emerge from the work of authors such as , Brown and Neku (2005: 1) and Earle (2007), as well as from the media:

Social workers are frustrated with the overwhelming needs of the community in relation to their own relatively low numbers and their limited (or lack of) access to resources such as adequate supervision, stationery (pens, pencils, rubbers, rulers and paper), office space and furniture, information technology, administrative and language support, vehicles and supporting professionals and institutions such as places of safety. Furthermore, with statutory work by law taking precedence over the group work and community work that attracts funding, the latter is generally crowded out and social workers find themselves continually torn between the two. Statutory work is the work related to fulfilling government legislation, for example, the work related to the Child Care Act includes the removal of children, children’s court appearances, case reports, placement of children in homes, foster-care or after-care, etc.

“What I can say to you is this: we are too few social workers to help meet all of the needs of the people and we don’t have enough resources to help the people we do see. This is very frustrating for me, as I see suffering people and children every day suffering. I get tired of this, tired of all the paperwork and not being to help children by running support groups. I never have enough time to properly counsel children. Yet I know if I can then this helps them [Interview 18, pg. 4].

There is also a lack of understanding among the general public as well as other professionals and those involved in community development, as to what social workers know and are able to do and what limited resources they have to work with in reality. Owing to the small numbers of social workers in certain government offices and NGO agencies, the opportunity for specialisation (which is said to increase productivity and reduce work- related stress) is very limited, with social workers forced to do all forms of social work, which are also sometimes considered to cause conflict. The combination of these factors results in extremely high caseloads, inefficiency, workplace stress and anxiety, empathy exhaustion, emotional burnout and even incidents of malpractice as social work is reduced to crisis management. Related to this, the staff turnover of social workers, particularly in NGOs, is high, with this exacerbating the conditions for those left behind as workloads increase proportionally and time is lost in retraining new junior staff.

Social workers spoke to the researcher about having to build up their own resources because they were only able to access a few resources through the Department of Social Development. They essentially did this through liaising with NGO's working in the township communities, local businesses, churches and schools.

"I have over the last four years written my own resources book concerning NGO's in the Nelson Mandela Bay so that I know where the NGO's are and the support they can specifically give to children who are AIDS orphans"[Interview 16,5].

"last year we worked through a local church I belong to able to raise enough money to purchase school uniforms for twenty children who are AIDS orphans on my caseload" [Interview 20, pg.8].

"We have a support group I run in Missionvale. A local businessman provides all of the resources we need for that support group. That helps the children who are AIDS orphans in this group so much" [Interview 19, pg.7].

"I can say all the resources we have for AIDS orphans have been donated to us through local churches and schools. A local school gave us 60 school bags to give to children who are AIDS orphans. We have many AIDS orphans on our case loads and this helped us a lot. I can say all of the resources we give to children who are AIDS orphans are donated to us, through social workers networking outside of their workplace. We can't even get food parcels from the Department even when we fill in forms" [Interview 21, pg.7].

The quotation given which is taken from the interview with two social workers working for the Limpopo government and based at sub-district level, and serves to highlight the problems: 'This one computer, we share between all six people … And if you want to make a copy, sometimes there are no pages, and the photocopy machine is not working. I don't even get a pen – I have to buy my own. No, stationary is a problem! …even the furniture, a table to write on … my colleague across the way waited …almost two years for a table and a chair! … [Yet] despite the problems, this office is not bad. In the Guiyani sub-district office, they do not even have a telephone – they have to walk or drive 2km to even make a call' (Earle, 2007a: 55).

Sub Theme 2.3.4 Social workers experienced case loads as excessive allowing for quantity rather than quality of work

In a study by Lombard (2008: 125) social workers reported that caseloads of social workers in South Africa are generally in excess of 120 cases (compared with a maximum of about 12 in the UK), leading to high levels of stress and frustration among professionals. Lombard (2008: 129) argues that the vast majority of these extremely high caseloads consist of statutory work, for which there is an ever-increasing demand. This is due to the HIV/AIDS epidemic and the fact that social work in South Africa is the primary social service profession intervening on a statutory level (Kasiram, 2009: 646). Social workers told the researcher that junior social workers, that is social workers who had been qualified for fewer than six months, even had a case load of between 55 and 65 cases. The social workers told the researcher that they mostly had case loads of 85 to 130 cases. They reported this case load to the researcher as excessive and one of the main reasons for the discontentment they experienced regarding their dissatisfaction in providing quality care and support to children who were AIDS orphans living in the townships.

"Last year one of my colleagues she went to England. We are still in contact via E mail. She tells me in London she is having just 22 cases!!! I currently have 105. Now I know why I feel like I do as a social worker in South Africa. If I just had 22 cases, I could do so much more to help people and not just chase paper for court cases and fill in forms" [Interview 18, pg. 5].

"When I started as a social worker here in Ibhayi 18 months ago I had 55 cases, now I have 120. How can I give what people need when they are so many and I am just one person?" [Interview 19, pg.9].

According to these authors, social workers within the NGO sector additionally have to face even higher caseloads than those within the government welfare sector. This arises out of a complex interplay of factors. NGOs have limited ability to refuse government referrals for fear of losing their funding subsidies. At the same time these institutions suffer from high turnover of staff as social workers seek to move – either into the government sector where workloads are not only slightly lighter but where salary packages are also considerably better, or to careers in another country or outside the social welfare sector (Waters, 2012: 1). One of the social workers the researcher interviewed worked in a clinic in the township; but was employed by an NGO. She told the researcher:

"I can say that working for an NGO is better because we have more resources. But I can say the number of people we see are the same. I still have to process the same paper work to help people with their grant applications and childrens court appearances. But it is better to have more resources particularly for children who are AIDS orphans." [Interview 16, pg. 2].

These issues are directly linked to insufficient numbers of social workers available for and/or willing to fill posts, with Lombard (2008: 127) asserting that the 'devastating impact has reached crisis proportions for social services in South Africa'. They additionally argue that if the current high caseloads are to become the norm, social workers should not formally be charged with unprofessional conduct or negligence arising out of their inability to manage these inhuman workloads.

At the more specific level, a study by Brown and Neku (2005: 309) reports that social workers in rural areas describe their work as 'overwhelming' and 'frustrating' because 'the needs of the community are many; but the numbers of professionals available to assist families in rural areas are few'. Government social workers in East London echo these sentiments. One of the key elements impacting negatively on their job satisfaction is that they are expected to do too much within the limitations of the lack of resources. As such they feel that the more social workers need to be employed (Budlender et al., 2011: 2).

Only Scherick (2004a: 22) explicitly refers to 'shortages' among social workers by making reference to the first announcement of social work as a 'scarce skill' by the Minister of Social Development, Zola Skweyiya, in a Mail & Guardian article on 22 August 2003. She argues that in the light of the HIV/AIDS pandemic and extensive poverty in South Africa, statutory work is the work related to fulfilling government legislation. For example, the work related to the Child Care Act includes the removal of children, children's court appearances, case reports, placement of children in homes, foster-care or after-care.

Social workers told the researcher that they attributed their high case load to simply not having enough social workers in their respective places of work to carry out the work necessary to provide care and support to AIDS orphan and their families which they refered to as value and quality and not just quantity. The social workers told the researcher:

"There are not enough of us to do the work. Simply it is like that, which is why we have very high caseloads to manage. It's not possible to care for and support 120 cases, I am just one person" [Interview 19, pg. 12].

“I can say I am stressed by my high case load. I have over 120 cases on my books” [Interview 21, pg. 4].

“I have a colleague in another office. She has 140 cases as of the last of last week. How is that possible?” [Interview 21, pg. 9].

What is apparent is that the caseloads of the social workers are very high as there are not enough social workers in the posts to carry out the work necessary for their statutory work and to expand services to enable implementation of the Children’s Act.

Sub Theme 2.3.5 Social workers experienced challenges concerning the implementation of the Children’s Act

> “There is a severe shortage of social workers in South Africa which has serious implications for the effective implementation of the Children’s Act. Provincial budget allocations for children’s social services in 2009/10 have increased; yet they are not sufficient to meet the lowest level of implementation of the Children’s Act” (Save the Children Fund, 2010: 6).

Social Development Minister, Zola Skweyiya explained last week that the bulk of the Children’s Act dealt with matters that needed to be implemented on a practical level, which meant regulations were required before it could be fully implemented. "The Act, however, also deals with principles that are fundamental to the manner in which children are treated and protected," he said. “To ensure the application of these important principles to all matters affecting children, the legislation containing the principles should be put into operation as soon as possible" (Skweyiya, 2013: 3).

The researcher has already in previous sub-themes presented some aspects regarding the challenges social workers experience in rendering care and support to children who are AIDS orphans living in the township communities. The researcher would like to present in this sub-theme what the social workers said in direct relation to the Children’s Act. The social workers identified four key areas concerning the challenge of implementation of the Children’s Act in South Africa:

- Lack of social workers to implement the Children’s Act
- Lack of resources to develop services to implement the Children’s Act
- Failing grant system to administer the grants applied for
- Lack of education amongst social health professionals concerning the content of the Children’s Act and the implementation thereof

The law in South Africa concerning children's rights has altered significantly in the last two decades and since 2010 with the Children's Act becoming law, the need for the further actualisation of children's rights in South Africa is paramount for the progression of democratic values of the new South Africa be realised.

Social work, as a core human service discipline, is often left to pick up the consequences of macro-socio-political and economic policies as they impact directly on people's lives at the micro-level; The Children's Act which came into full operation in April 2010 mirrors a new approach to children's rights in South African law, which if applied with the 'best interests' of children as a guiding factor, holds the great potential of transforming the application and interpretation of the law for children and alleviating some of the challenges faced by African children (Songca, 2011: 359).

The Act and its Regulations fall under the remit of the Department of Social Development. It is of note that provincial MEC's for Social Development are required by law to make budgetary provision for all sections of the Act that are their responsibility; but the actual amounts are determined by the provincial treasury. Bids for funding under the Children's Act have to compete with the demands of other government sectors for programme support; so funding cannot necessarily be expected to follow need (Dawes and Ward, 2008: 77).

The challenge facing South Africa now is to see that the Children's Act is fully implemented and to ensure that all children – particularly the poorest and most vulnerable – receive the services that they need. Alongside other necessary enabling factors, this requires money to pay for the services (Budlender et al., 2011: 3).

The Children's Act places the primary responsibility on government to ensure that the services are delivered and the Department of Social Development has the greatest share. Provincial departments of Social Development are responsible for more than 80 percent of the cost of implementing the act, with the National Department of Social Development responsible for less than one percent (Budlender et al., 2011: 3). The Children's Act's provisioning clauses for prevention and early intervention services, protection services, and child and youth care centres say that the Member of the Executive Council (the provincial "minister") "must, from money appropriated by the relevant provincial legislature, provide and fund" these services These include the following clauses: 105,146 and 193:

105: Child protection services: Reporting of abuse, removal of children at risk of harm and placement in alternative care (foster care, adoption and child and youth care centres) and mentorship for child- headed households.

Clause, 146: Prevention and early intervention programmes: Parenting skills programmes, counselling for children who have suffered trauma, programmes providing information on how to access grants and services.

Clause, 193: Child and youth care centres: Places of safety, centres for street children, children's homes, secure care centres, schools of industry and reform schools.

In 2011 research was carried out by the Children's Institute at the University of Cape Town. The research which was titled, "the funding of services required by the Children's Act". The research ascertained the following:

- Implementation Plan low: defined as good practice standards and norm for the priority services; lower norms and standards for other services. Cost R7.5 Billion
- Implementation Plan High: defined as good practice standards and norms for all services. Cost 10.8 Billion
- Full Cost, Low Implementation: defined as good practice standards and norms for priority services, lower norms and standards for other services. Cost R30.0 Billion
- Full Cost High Implementation: defined as good practices and norms for all services. Cost R59.2 Billion (Budlender et al., 2011: 3).

The 3.4 billion allocated by the Provincial Department of Social development 2010/2011 is equivalent to about 45% of the IP low estimate and 5% of the Full Cost High Implementation plan. The Eastern Cape was the worst performer with only 25% of Implementation Plan low and 3% of Full Cost implementation cost funded by the Department of Social Development (Budlender et al., 2011: 3). With regard to limited resources in relation to implementation of the Children's Act, social workers complained that there just weren't the resources available to implement the Children's Act.

"We don't have food parcels or even paper sometimes. How can I do everything in the new Children's Act? I have a backlog of cases just in foster care reviews" [Interview 20, pg. 3].

"I am supposed to do support groups and home visits much more than I do because of this new Children's Act. How do I do that when I can't even see the people in all of the cases I have?" [Interview 21, pg. 4].

"I know if they want to implement this Children's Act it will take many more resources and lots more money. If we didn't have the NGO's in Nelson Mandela Bay, then our AIDS orphans will really be in trouble" [Interview 20, pg. 9]

“I can say that the Children’s Act is a dream for South Africa. We need many more resources to make it happen” [Interview 3, pg. 7].

The gap between policy and service delivery is significant. A major challenge in providing the legislated services is the sheer scale of family vulnerability. Long-term poverty in the majority of households, high levels of domestic and community violence, substance abuse and the failures of care associated with AIDS provide a toxic cocktail of risk to child and family well-being. The need to support vulnerable families is significant, but the human resources available to assist are simply not sufficient. For example, and based on costing of the Children’s Act (Jameson et al., 2012: 12). If all the social workers employed in the Western Cape in 2005 were deployed to provide statutory services to children alone, the ratio would be one social worker to 2, 200 children, leaving almost no social workers to deliver preventive and other services to children and adults (Jameson et al., 2012: 12).

All of the social workers interviewed told the researcher about their huge caseloads due to there being insufficient numbers of social workers already employed to care for and support the numbers of children being accessed by them for care and support. This was comprehensively presented in previous sub-themes and will only be mentioned in this instance. What is apparent though is that there are simply not enough social workers in post in South Africa to carry the workload of implementing the Children’s Act.

“We are too few social workers to do the work we already have to do” [Interview 19, pg. 6].

As of October 2012, the South African Council for Social Service Professions reported that there are 17, 583 registered social workers and 3, 533 registered social auxiliary workers. This represents a 60% shortage of social workers in terms of the requirements of the Children's Act alone – and they are likely to be much more dramatic shortages if the full set of needs for social workers are taken into account (Waters, 2012: 2).

The experience of social workers regarding the CSG and FCG system in South Africa has also been previously discussed. With regard to the care of AIDS orphans as mentioned in the Children’s Act, the researcher would like to highlight the fact that: ambiguity around the application of the Child Support Grant and the Foster Care Grant for orphans was a second major factor frustrating effective implementation of the Children’s Act. “Owing to the increase in orphans combined with the shortage of social workers – relying on a social worker and court-based system - to process poverty alleviation grants to relatives caring for orphaned children was not sustainable” (Jameson et al., 2012: 1). One of the social workers told the researcher:

Managers want us to tell them about the foster care placements only because this shows them we are doing the new things in the Children's Act. But our foster care system is too slow to care for all of the children who are AIDS orphans" [Interview 16, pg. 9].

According to the Children's Institute at the University of Cape Town, there are four major problem areas preventing effective implementation of the Children's Act namely human resources, the crisis in the foster care system, the budget required to implement the Act and the training of social workers comprehensively regarding the implementation of the Children's Act. Discussion regarding these aspects of the Implementation of the Children's Act occurred in a meeting on the 13th June 2011: The documents handed out at the meeting were:

- Children's Act Guide for Child & Youth Care Workers
- Children's Institute South African Child Gauge 2007/2008
- Child-headed households in South Africa: A statistical brief
- Government and Donor Funding Available for Implementing the Children's Act: 2010/11 – 2012/13
- Children's Amendment Act, 2007, No. 41 of 2007
- Implementation of the Children's Act 38 of 2005:
- Implementing the Children's Act: Analysis of human resource capacity & constraints
- Government and Donor Funding Available for Implementing the Children's Act: 2010/11 – 2012/13
- Summary of court case on NPO funding: Nawongo v MEC for Free State (June 2011)
- Research on government and donor funding for the Children's Act

The Chairperson welcomed everyone and especially Ms D Ramodibe (ANC), the Chairperson of the Portfolio Committee on Women and Children and People with Disabilities, and some of its members. The following comment which was documented in the minutes of this meeting reads: "It would not be possible to train members on the whole Act as it was very extensive." (Abrahams and Matthews, 2011: 5)

The social workers spoke to the researcher regarding the lack of education they had received concerning the Children's Act: They told the researcher that they had to find out from colleagues concerning the Children's Act or social workers contacted the magistrate of the children's court to help them understand the implementation of certain aspects of the Children's Act. In some instances this was unsuccessful as social workers interpreted the act as they understood it and did not receive the desired outcome as the magistrates were still unfamiliar with aspects of the implementation of the Children's Act.

"One of the biggest problems for us is the new Children's Act. I think this is why the managers are so obsessed with numbers. This is how they show that the Children's Act is being implemented but it's not working as we are too few social workers to do all the statutory things, never mind all the new things too. I am confused about this Children's Act. It's a big document to understand. So what we don't know is, we call the magistrate at the children's court, they help us there" [Interview 1, pg. 2].

"This Children's Act is just lots of words. There is no money for the things they write. I can say the government doesn't know really whas going on. AIDS orphans suffer because we are too few social workers, too few resources and our system is too slow in processing grants" [Interview 3, pg. 5].

"I didn't know what the Children's Act is till I read it online. It's not possible for us as social workers to do all of those things in it because we aren't enough and our resources are too few" [Interview, 1 pg.4].

"We are the ones supposed to be implementing this Children's Act. We don't even know about it" [Interview 19, pg. 9].

"I learn about this Children's Act from my colleagues or the magistrate if the forms change and I don't know what to do. We never had any formal training about it that. I do know that" [Interview 2, pg. 3].

"You know I realise about this Children's Act sometimes even the magistrate don't know. I went through the whole procedures of helping a CHH apply for a FCG. I did it like the Act said. Yet I am told in the court that we can't do this……. by the magistrate. So we couldn't place these children in the care of their older sibling but the Act say that we can. It's just paper it doesn't work. I knew something the magistrate didn't… " [Interview 21, pg. 13].

According to the department, the main objectives of the Act are to:

- make provision for structures, services and means for promoting and monitoring the sound physical, psychological, intellectual, emotional and social development of children;

- strengthen and develop community structures which can assist in providing care and protection for children; protect children from discrimination, exploitation and any other physical, emotional or moral harm or hazards;
- provide care and protection for children who are in need of care and protection;
- recognise the special needs that children with disabilities may have;
- promote the protection, development and well-being of children;
- promote the preservation and strengthening of families;
- give effect to certain constitutional rights of children; and
- give effect to the Republic's obligations concerning the well-being of children in terms of international standards, treaties provisions and requirements.

> The Children’s Act (as amended) is a fine piece of law that has the potential to bring about services that would enhance both the development and protection of children; but, like so much of our law and policy, it is way ahead of the capacity to deliver services at ground level. It should be recognised however that this law is aspirational (as indeed our Constitution was). It enables us to hold government to account; it provides for much-needed services; specifies responsibilities; and points us toward a situation in which the rights and well-being of vulnerable children in particular can be realised (Songca, 2011: 5)

To realise its promise of improved preventive and rehabilitative services, there is no doubt that a significant scaling-up of finance and staffing will be required. For those in the field of child and adolescent mental health, both researchers and practitioners, the Act presents the challenge of developing an evidence base for cost-effective interventions to improve prevention and support for vulnerable families. It also presents training institutions with the opportunity to establish courses that equip practitioners for new roles (Dawes and Ward, 2008: 81).

Sub Theme 2.3.6 Social workers experienced being discouraged by the lack of immediate care available for children who are AIDS orphans

To be discouraged is to be deprived of hope to have hope take away from and to cause one to feel discouraged, to have lost enthusiasm for and to become disheartened, while to discourage is to hamper by discouraging; to deter from, to try to prevent by expressing disapproval or raising objections less hopeful or enthusiastic. Researchers who were discouraged by the problem's magnitude became apathetic, disheartened and discouraged. When people become discouraged by failure they can become dispirited (Oxford English Dictionary, 2009: 46). Social workers told the researcher that they were discouraged by the lack of immediate care available for children who had become AIDS orphans and their extended families. They were concerned because of the overwhelming needs children as AIDS orphans had and the lack of capacity within the social system to enable social workers to meet these care and support needs.

"I have no resources to provide immediate relief to children who are AIDS orphans. Except for that which is in my purse, I find this discouraging that children who are AIDS orphans suffer like this" [Interview 16, pg.6].

"I see grandmothers with their grandchildren in my office who are hungry. So I take from my own purse and give them bread. One grandmother I know is looking after eight AIDS orphans in her family. She is on a pension and has some CSG's. It's too little money for them to live on. The children are sick and hungry. If that grandmother dies I fear for this children, I really do" [Interview 1, pg. 6].

"As a social worker I like to sort things out and I like to be able to sort things for children especially these AIDS orphans. For example, I send people to the Department of Housing. How can children live in a shack without resources or nothing to sleep on. But then the children must wait. There is nothing I can do immediately to help AIDS orphans except to make referrals and to give what's in my own purse. I find this a hard reality on my job and very discouraging" [Interview 16, pg. 7].

Well-functioning National Child Protection Systems can provide well-coordinated, equal, comprehensive, reliable and sustainable responses to children's protection needs. Essential components of such a system include: child-protection laws and policies; meaningful coordination across government departments and between sectors at different levels; knowledge and data on child-protection issues and good practices; regulations, minimum standards and oversight; preventive and responsive services; a skilled child protection workforce; adequate funding; children's voices and participation; and an aware and supportive public. When these components are present, they work together to address the multiple protection problems that children experience and strengthen the protective environment around each child (Save the Children Fund, 2010: 1).

In South Africa most government departments have approved the relevant international and regional human rights instruments pertaining to children, including the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. There is also an increasing movement to harmonise national laws and policies in line with these instruments. Yet, despite this encouraging progress, international commitments to protect children from violence are often not translated into action at national and local levels. Instead, child protection remains fragmented, uncoordinated and tends to focus on issue-based programming. It has also been found that efforts to address violence against children are frequently reactive and focus on symptoms and consequences and not causes, with insufficient resources being allocated. Government departments in the region are all publicly committed to children's involvement in all aspects of the National Child Protection Systems; however, the mechanisms to ensure that this occurs regularly and in a meaningful way have not been formalize (Save the Children Fund, 2010: 6).

Social workers spoke to the researcher about the appalling conditions they found children in and the frustration and discouragement they experienced in not being able to offer immediate assistance to these children or indeed in desperate situations which required immediate intervention. Social workers also spoke about the fragmentation of the system in which they worked which delayed much necessary immediate assistance to very vulnerable families and particularly to children who had become AIDS orphans.

"Some children are just left in the clinics or hospitals by their families, usually because the families have no means to support these children. They are usually sick, malnourished and weak" [Interview 16, pg. 5].

"For immediate help I can refer these children to Home Community-based-Care (HCBC). I write an urgent referral and request immediate assistance, while I wait for a children's court investigation. I can do this and refer to an NGO that I may know or help out of my own pocket. That is all I can do to immediately hep AIDS orphans. It is discouraging" [Interview 20, pg.4].

"For me as a social worker in this clinic I can say I am blessed because of the centre next door. If we are not next to this centre then I can say I cannot help children immediately when they are AIDS orphans except for what is in my purse" [Interview 1, pg.4].

"I went to do a home visit once. The children were sleeping on the frame of a bed in their school clothes. They were freezing. I took the children straight to the place of safety. If there is no space in the place of safety then I must find a neighbour or relative to take the child in the middle of the night. Once I put children to bed in a police station cell because they had nowhere else to sleep that night. We have so little resources to help in these children" [Interview 21, p.g.12].

"I once did a home visit to a CHH. There were 4 children in that home which was a shack. There were no window in the bedroom. So we got cardboard to fill in those windows. We have no resources to fix things like that. These children in these families are very vulnerable. I get scared for these children" [Interview 16, pg. 5].

“The reality is this, we expect poor people to take care of more poor people with no extra resources. This is not working which is why we have CHH and street children” [Interview 18, pg. 4].

“I was asked to go to a tavern once in Kwadwesi, to collect a four year old boy who was an AIDS orphan from under a table. His grandmother got drunk and left him there. She couldn’t cope with taking care of him anymore. I found the aunt of this boy and he stayed with her. In the aunt’s family I found no one is working, but there is some grant money for food. This boy stayed with them. I am still the social worker for this family. It took three years for the FCG to come to this family” [Interview 20, pg. 8].

“Our system in South Africa is very fragmented. You must go here for this and here for that and even when you have everything you need for applying for a grant or a better house, you must still wait. All I can do mostly is refer these children to HCBC, start a children’s court enquiry, refer to NGO’s and help out of my own purse. Our system in South Africa is like that for AIDS orphans” [Interview 21, pg. 5].

In the majority of cases, extended family take on primary responsibility for care of AIDS-orphaned children. These families confront a number of challenges including migration, financial stresses such as decreased employment and work-care conflicts, food and poor physical and mental health outcomes. Caregivers of AIDS-orphaned children have lower levels of perceived social support compared to caregivers of other-orphaned children and caregivers of non-orphaned children. Social isolation may be related to AIDS as the cause of parental death, rather the experience of caring for an orphaned child (Kuo et al., 2012: 638).

Studies have shown that AIDS-affected households face a multitude of challenges and may be negatively affected by the HIV/AIDS pandemic. HIV /AIDS can exacerbate food security and poor health among caregivers of AIDS-orphaned children. Lower social support may add a further dimension to the vulnerability of these households, with less coping resources available to respond to challenges, as well as higher health risks Fewer social support resources may also have negative implications for the well-being of children cared for by their extended family. The social vulnerability reported by caregivers of AIDS-orphaned children has important implications for policies and programmes seeking to support this population. For example, we need to understand how family deaths contribute to loss of social support for caregivers, including how relationships to the deceased and presence and length of the deceased individual’s illness contribute to caregivers need for social support (Kuo et al., 2012: 635).

What is apparent is the mechanisms to ensure that child protection occurs in South Africa regularly and in a meaningful way, have not been formalised. And that this has a direct impact upon the welfare of children who become AIDS orphan and their extended families. Although a strong suite of child protection laws has recently been passed, including the Children's Act, these have not yet translated into comprehensive, integrated services at a local level. A critical shortage of social workers, underfunding and poor coordination across government and between sectors, including with community-based organizations, are some of the factors which plague the system on all levels (Save the Children Fund, 2010: 6).

Sub- theme 2.3.7 Social workers experienced being sorrowful at the enormity of suffering that they witnessed daily

Social workers are constantly confronted with loss experiences and the impact of these losses on the social functioning of people who need their services daily

(Drenth et al., 2013: 4).

To be sorrowful is to experience being sad, mournful, unhappy, depressed, distressed, grieved, tearful, heartbroken or heavy-hearted (Oxford English Dictionary, 2009: 745; Bartlett, 2002). In the words of Abraham Lincoln in his letter to Fanny McCullough he writes "In this sad world of ours', sorrows come to us all, and to the young it comes with bittered agony because it takes them unawares. The older have learnt to accept it". The social workers spoke to the researcher concerning the overwhelming needs they were being presented with daily as social care professionals. Social workers listened to and saw heart break every day in the lives of children who were AIDS orphans living in the townships and this at times caused social workers to experience deep sorrow. The social workers told the researcher:

"We all carry heavy emotional burden because of what we see and hear every day. We are never de briefed so we internalise our feelings and become sad. I see grief every day it's normal for me to see people suffering. Sometimes I feel sad. I have seen many of my colleague's burn our because of this grief and stress sometimes I get scared it will happen to me" [Interview 1, pg.7].

"I see and hear suffering every day in my work as a social worker. I end up feeling the peoples' pain especially the children who are AIDS orphans. I get distressed by this. It's as if their pain becomes my pain" [Interview 3, 2].

“The needs of children who are AIDS orphans is overwhelming. The worst is going to the homes and doing the home visits. It’s shocking how some of these orphans live. I get very distressed and sad about this” [Interview 16, pg. 6].

“The worst cases are the ones where AIDS orphans are raped. I get very distressed by this. These children suffer enough being orphans then they have to deal with being raped. This makes my heart sore” [Interview 20, pg.5].

“It’s so sad to me when children have to go to a place of safety because there is no one to take care of them. I get distressed about this. You know children are raped in these places. But what can I do?” [Interview 19, pg.9].

“It’s very sad to work with AIDS orphan especially if they are HIV positive. I find this very, very sad and distressing. It’s so sad to see children suffering so badly” [Interview 21, pg.2].

In sorrow and in suffering are hidden the springs of a peace and a power that can be affected by no outward storms. It is a great thing, when one has grown strong through that trial which melts away the dross and proves the true gold; when, being driven to the handling of many expedients, he has been trained to detect all counterfeit comforts, and to discriminate between unsubstantial good and that which abides every test; when he has learned to dispense with all outward props, can let riches, honours, health drop away from him, and yet feel that all this does not touch his real life; while above these coils of uncertainty and mutation he lifts his aked personality erect in its own spiritual resources. Surely, prosperity has never generated such depths of power, such intrinsic and full consolation Chaplin in (Bartlett, 2002: 72)

In summarising theme 2.3, the researcher would like to present the following comments; Social workers told the researcher of the appalling and desperate conditions in which they found children who were AIDS orphans, explaining to the researcher about the barriers they experienced in helping families accesss financial support for AIDS orphans they were caring for through the grant system in South Africa. Social workers spoke about a fragmented and cumbersome social care system which was inadequate to meet the care and support needs of children who are AIDS orphans living in the townships communities. Social workers were weary because of the lack of resources they had to work with and the difficult working conditions. They attributed their high case loads to there simply not being enough social workers in the posts and their high case-loads as obstructing there efforts to provide much needed care and support to distressed children who were AIDS orphans. They spoke about the challenges of implementing the Children’s Act due to there not being enough qualified people and material resources and because of the amount of statutory work which they had to accomplish in their workload. Social workers expressed the distress and discouragement they experienced every day because of the lack of immediate care and support available for children who were AIDS orphans and not being able to intervene in desperate situations to give care and support to these AIDS orphans who were suffering acutely.

THEME 3: HEALTH AND SOCIAL CARE PRACTITIONERS EXPERIENCED CERTAIN SHORT-FALLS RELATED TO "BEST PRACTICE" IN THE HEALTHCARE AND SOCIAL CARE SYSTEM IN WHICH THEY ARE WORKING

A "Best Practice" is commonly defined as "a technique or methodology that, through experience and research, has proved reliably to lead to a desired result. The term is used frequently in areas such as health, government administration, the education system, project management and others. In the context of health programmes and services, a practical definition of a "Best Practice" is "knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts" (WHO, 2008a: 3). The use of the word "best" should not be considered in the superlative sense. In other words, the term "Best Practice" is not about "perfection", the "gold standard" or only elements that have been shown to contribute towards making interventions work or be successful. Results can be partial and may be related to only one or more components of the practice being considered. Indeed, documenting and applying lessons learnt on what does not work and why it does not work is an integral part of "Best Practice" so that the same types of mistakes can be avoided by other programmes and projects. "Best Practice must involve meeting some of the following criteria:

- Effectiveness: This is a fundamental criterion implicit in the definition. The practice must work and achieve results that are measurable.
- Efficiency: The proposed practice must produce results with a reasonable level of resources and time.
- Relevance: The proposed practice must address the priority health problems in the WHO African Region.
- Ethical soundness: The practice must respect the current rules of ethics for dealing with human populations.
- Sustainability: The proposed practice must be implementable over a long period of time without any massive injection of additional resources.
- Possibility of duplication: The proposed practice, as carried out, must be replicable duplication: elsewhere in the Region.

- Involvement of partnerships: The proposed practice must involve satisfactory collaboration partnerships: between several stakeholders.
- Community involvement: The proposed practice must involve participation of the affected communities involved.
- Political commitment: The proposed practice must have support from the relevant commitment national or local authorities (WHO, 2008a: 5).

By definition, “Best Practices” should meet at least the “effectiveness”, “efficiency” and “relevance” criteria in addition to one or more of the other criteria. A “Best Practice” needs not meet all the above criteria. This is because a “Best Practice” can be anything that works to produce results without using inordinate resources, in full or in part and that can be useful in providing lessons learned (WHO, 2008a: 7).

“I came into this profession because I wanted to help children. I want to do my best, but I can’t because of my work-load, If we could do our best for these AIDS orphans every day they would be helped ………..; but we can’t because of the system we work in” [Interview 2, pg.5].

“We know what we want to do and should do; but we can’t because of the systems in which we work. AIDS orphans and their families suffer because of this” [Interview 12, pg.7].

A shortfall is a failure to attain a specific amount or level; the amount by which supply falls short of an expected need or demand. A short-fall can be defined using such words as a shortage, a deficiency, a loss, a default or arrears (Oxford English Dictionary, 2009: 895). For example, South Africa did not meet the ambitious targets of 50% reduction in HIV incidence and 80% ART coverage of the National HIV/AIDS and STI Strategic Plan for 2007–11. Under the previous plan, HIV frequency in pregnant women rose slightly from 29·1% in 2006, to 30·2% 2010; and it increased in the general population from 10·2% in 2006 to 10·6% in 2011. Through a detailed consultative and inclusive process, a new plan has been developed for 2012–16 (Mayosi et al., 2012: 2). The new plan sets the same ambitious HIV incidence and treatment targets as the previous plan and establishes several other targets, such as a 50% reduction in new tuberculosis cases and deaths, 30 million people tested for HIV by 2016, and a further reduction in mother-to-child transmission to less than 2% at 6 weeks after birth.

Transformation of political commitment into well-planned and effectively implemented evidence-based programmes and services will be essential to achieve the lofty goals of the new plan. What is apparent is that the implementation of these plans is dependent upon the health and social systems in place in South Africa through which these plans will be implemented (Mayosi et al., 2012: 2).

“A lot of children I see at this clinic are HIV-positive. They don’t even know they are HIV-positive because they have had it since birth. They stop taking this medication because they don’t know why they are taking it. No one explained it to them then the grandparents they come to me for advice. These children stop taking this medication because no one explained it to them why they are even taking ART. It’s as simple as that” [Interview 12, pg.1].

“We see so many children with HIV taking ART. I can’t spent the time they need with them to answer all of their questions as I have too many others to see. Also what’s the point? These families have no money for basics so why must I spend my time telling them about eating a balance diet? I know they will only have mealie meal when they go home” [Interview 2, pg.3].

“I see children on ART every day who are AIDS orphans. I can tell them to take their medication but they have no food at home. They are sick because they are malnourished and have HIV. ART will not help their sickness because of poverty” [Interview 8, pg. 6].

“It’s a shock for me when children say ‘I am taking medication for a fever on my chest?’ Meanwhile they are taking ART for HIV” [Interview 16, pg.1].

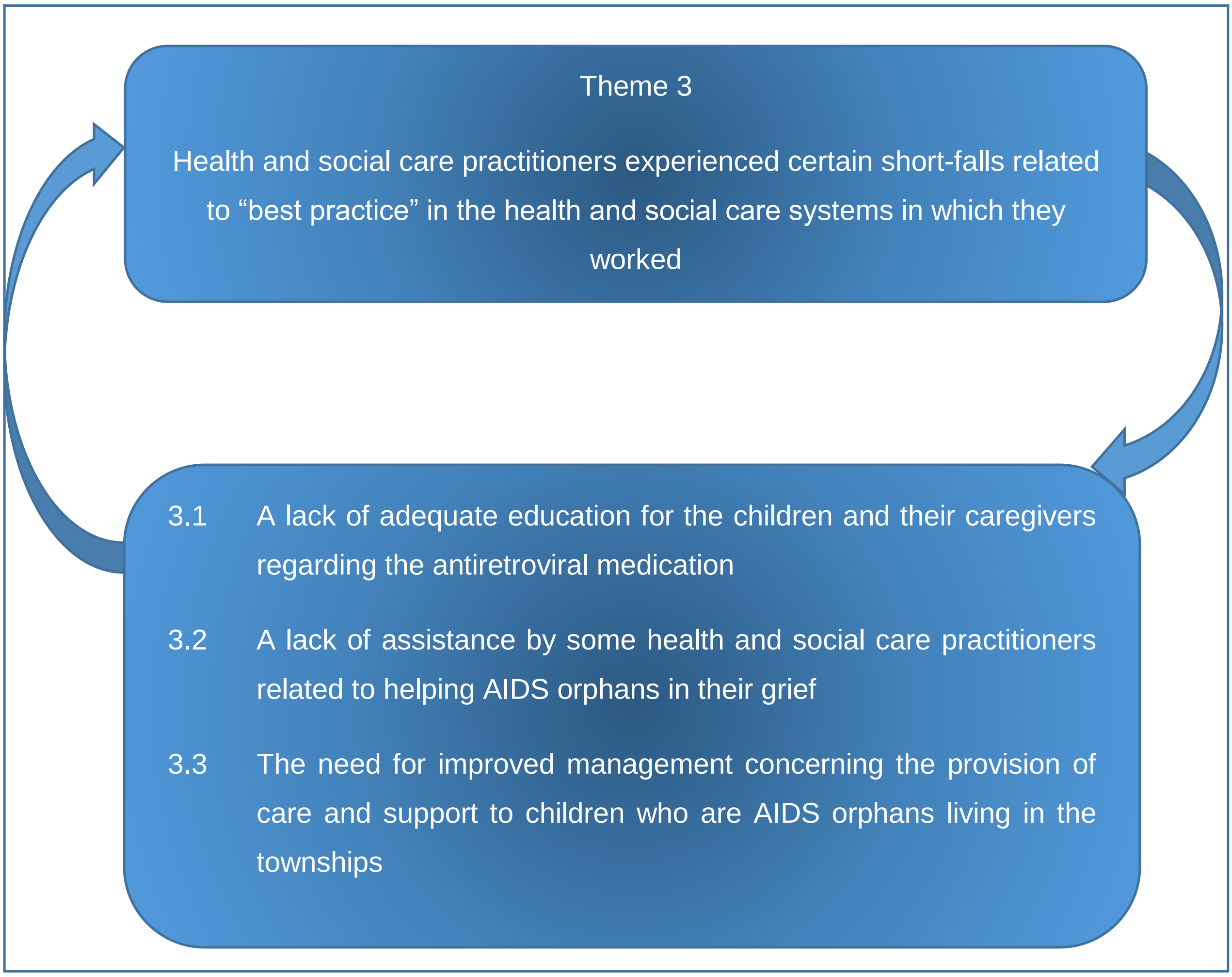
What became apparent to the researcher was that health and social care practitioners related many incidences of children who were AIDS orphans and HIV-positive taking medication for HIV infection but didn’t know they were taking it. Some health and social care professionals articulated the difficulty of applying the“best practice” principle regarding ART administration because of poverty, children already taking ART and not knowing they were indeed HIV-positive and also short-falls in the health and social care systems in which they were working.

A proportion of the population in South Africa is entirely dependent on the publicly funded system for healthcare and social welfare and that the health and social care systems are overburdened by the volume of persons accessing these systems for care and support (Ataguba and McIntyre, 2012: 6). Because of the HIV epidemic and under performance of the health system, South Africa was one of only a dozen countries worldwide with increased mortality since 1990 for MDG’s 4 (child survival) and 5 (maternal health) in 200 (Mayosi et al., 2012: 8).

The experiences of health and social care practitioners with regard to certain short-falls related to “best practice” in the health and social care system in which they work, will be presented in the following related sub-themes:

4.4.3 Discussion of Theme 3 and related sub-themes, related to health and social care practitioners experiences

A diagrammatic representation of theme 3 and related sub-themes is presented in figure 4.6:



Theme 3

Health and social care practitioners experienced certain short-falls related to “best practice” in the health and social care systems in which they worked

3.1 A lack of adequate education for the children and their caregivers regarding the antiretroviral medication

3.2 A lack of assistance by some health and social care practitioners related to helping AIDS orphans in their grief

3.3 The need for improved management concerning the provision of care and support to children who are AIDS orphans living in the townships

Figure 4. 6: Health and Social Care Practitioners experienced shortfalls related to "Best Practice" in the Health and Social System in which they worked.

Sub- theme 3.1 Health and social care professionals experienced a lack of adequate education for children and their caregivers regarding the antiretroviral (ART) medication

“Health is all about people. Beyond the glittering surface of modern technology, the core of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them (Frenk et al., 2010: 1925).

Health and social care practitioners are expected to communicate with educate and treat their patients in healthcare, in primary healthcare clinics with their knowledge, technical competence, service orientation, social accountability and ethical commitment, in order to make an essential contribution to the well-being of individual’s families and communities. Comprehensive care of those living with HIV is essential and consists not only of the supply of antiretroviral medication but also other needs related to its provision, not the least of which is the need for health education to convey relevant information to enable the person receiving to cope and to remain in good health (Ayers et al., 2006: 1005).

HIV/AIDS prevalence is highest amongst economically productive adults of child bearing age, hence the impact upon families and communities. ART is being made more affordable through primary healthcare centres as part of a package of treatment care and support for those who require ART. The package includes co- trimoxazole prophylaxis, counselling, management of opportunistic infection, comorbidities and nutritional and emotional support (Campbell et al., 2011: 175). Inclusion of all aspects of this package would indicate “best practice” in the care and support of AIDS orphans who are HIV-positive. Yet the experience of health and social care practitioners was contrary to this. Health and social care practitioners spoke to the researcher concerning instances where children were taking ART; but didn’t know why they were taking it. They spoke about the anxiety grandmothers and caregivers of HIV-positive children experienced regarding the need to tell children they were HIV positive, they spoke about how illiteracy and poverty affeced the health of children who were AIDS orphan who were also HIV-positive and the difficulty of encouraging compliance in childrenwho were HIV-positive on ART and never been told why they were taking ART. These factors are contrary to “ best practice” concerning the provision of ART to HIV-positive children.

“In some instances, children who live with their grandparents are disadvantaged. How can ART medication be given correctly if grandparents are unable to read?” It’s not that these grandparents don’t care; it’s that they have not got or been given the necessary skills to do so correctly” [Interview 2, pg.2].

"One of the biggest problems we have regarding compliance of ART is that children don't have enough food in their homes and constantly take their ART medication on an empty stomach" [Interview 11, pg. 7].

"I find that children on ART become sexually active. I look up about this. I feel that someone must do some research about this, I found out a 13-year-old girl is sleeping with an 11-year-old boy. She is HIV-positive he is HIV negative. How is this thing?" [Interview 11, pg.7].

"I see many young people who are on ART and they don't even know they are HIV positive" [Interview 12, pg.7]

"I see many children who are on ART for HIV. They don't know why they are taking this medication…… but they are angry that their parents died of HIV/AIDS and don't know they are HIV-positive" [Interview 14, pg.4].

"I find children who find hope again will begin also to take their ART again. But look at our clinic. How do you find hope here, you can't" [Interview 16, pg.7].

"I have many questions from grandmothers saying how I tell my grandchild they are HIV-positive, meanwhile the grandchild is taking ART! Many times I hear this story" [Interview 18, pg.2].

"I try to give advice to grandparents to help the health of their HIV-positive grandchildren. It's hopeless, they don't even have money for food, never mind anything else" [Interview 22, pg.16].

"I see so much worry in grandmothers when their grandchildren are asking about their ART medication. Many children take ART and don't even know they are HIV-positive. How can we run support groups regarding ART compliance when children don't even know they are HIV positive?" [Interview 24, pg.4].

Effective learning and health education require that clients can access accurate and meaningful information. This would make an essential contribution to the well being of children and their caregivers who visit the primary healthcare clinics (Frenk et al., 2010: 1296). Health and social care practitioners are a vital link between patients and the healthcare systems, especially for women seeking information and counselling to care for and support them. Education remains imperative for those with HIV and those caring for children with HIV. Treatment education would particularly enable those taking ART or giving ART to children to understand the benefits and importance of adherence. Part of this education should be aimed at mitigating the impact of HIV on affected communities by communicating the knowledge that those with HIV are no different from the majority (Aggleton et al., 2011: 496-497).

Literature supposes that with sufficient health and social care, health outcomes would improve in most communities. Health and social care practitioners are the service providers who link those in need with information and knowledge so that health can be improved. As communicators and educators, health and social care practitioners are the human faces of the health system (Frenk et al., 2010: 1926). It seems that limited education is being given to those attending the clinic for ART despite the obvious need.

"One young boy told me: 'I am fed up of taking these pills on an empty stomach. We have no food at home, no one works, I am dying of HIV, there is no future no hope. So I stopped taking my medication because I don't want to be poor anymore I want to die' " [Interview 14, pg.7].

"I saw a young boy. He says he has asthma because he has a bad chest and has to take medication. He is taking ART; but he thinks it's asthma. His grandmother knows he is HIV-positive: he knows his mother dies of AIDS but he thinks his chest is sick because of asthma not because of HIV" [Interview 16, pg.1].

A lot of children I see at this clinic are HIV-positive. They don't even know they are HIV-positive because they have had it since birth. They stopped taking this medication because they didn't know why they is taking it. Then the grandparents they come to me for advice, these children stop taking this medication because no one explained it to them. One girl thought she is taking ART for her chest. She thought she had asthma. So when her chest is better she stops taking ART. Now we have to tell her the real reason for taking ART" [Interview 12, pg.1].

"So many take their ART without food. It's shocking to me the conditions these children live in in the townships, shocking. You only see it by doing home visits. We can't educate these people when we don't know how they live. So we tell these children take your ART with water" [Interview 22, pg. 15].

What became apparent to the researcher was that, regardless of the reasons, children receiving ART and the caregivers seemed to be ill-informed regarding the comprehensive care and support required for children who were AIDS orphans and who were receiving ART for HIV infection. In this instance the administration of ART to HIV-positive AIDS orphans suffered because "best practice" could not be implemented due to short-falls within the health and social care systems in which they worked.

Sub- theme 3.2 Health and social care practitioners experienced a lack of assistance by some health and social care practitioners related to helping AIDS orphans in their grief

"Sometimes there are fewer problems because [we're]... getting down to the big core problems with the patient ... [We're] dealing with that and getting right down to the nitty gritty. Then all of a sudden all of the other problems disappear and ...they're just happier, they're happier with the staff and they're happier with their care just because someone spoke to them that day about what was important to them" (Grispun, 2002: 7).

Children are understandably one of the most vulnerable groups during the illness and after the loss of a parent or both parents. Drenth et al, (2013: 7) highlight the cumulative losses suffered by children orphaned by AIDS: 'poverty, poor nutrition and increased work-load beginning with the onset of a parental illness. They experience the loss of love, guidance, socialisation, and skills transfer by their parents, who often die in quick succession'.

Children who are forced through the death of both parents to become the sole provider for younger siblings are common in South Africa. Living alone without adult supervision, high poverty levels and hunger points to the fact that grief may be seen as a luxury in the face of survival. This in turn may lead to the development of complicated grief when emotional, social and psychological aspects of grief are not adequately addressed (Drenth et al., 2013: 8). The health and social care practitioners told the researcher that they were unable to help children who were AIDS orphans in their grief. They understood that the grief of AIDS orphans was complex but owing to the health and social care system short-falls, they were unable to give the assistance required to help AIDS orphans in their grief.

"What happens is that children go to the clinic for their ART. They get their medication, reprimanded if they don't or haven't take it and get sent home. We as social workers help them apply for grants and they never process their grief because no-one has time to help them" [Interview 2, pg.5].

"We tend to neglect the feeling and emotions of AIDS orphans as it time-consuming to help these children; we need to correct this" [Interview 16, pg.1].

"Children who are AIDS orphans are very anxious, because they have many unanswered questions. It's emotionally frustrating for them that their parents died" [Interview, 16 pg.1].

"Children who are AIDS orphans withdraw socially because they feel grief. It's our responsibility as professionals to help them talk but we don't have time. They need to talk to develop coping strategies but no-one has time to listen because there are too many of them" [Interview 16, pg.3].

"If we could have support groups for AIDS orphan's it would help a lot. They like to talk these children but we don't have time to listen. Only when there is a crisis. We need volunteers to run these groups or people outside as we are not enough to do this as well as our other work" [Interview 18, pg.8].

"We expect the grandmothers to help the children grieve, but they are also sad because they have watched their own child die of AIDS" [Interview 23, pg.4].

What needs to be acknowledged by health and social care practitioners is that grandparents caring for these children also experience intense emotions such as grief, guilt or anger towards their sons and daughters who are not parenting their own children. AIDS as a cause of death poses numerous challenges in terms of bereavement and an increased risk for complicated grief (Drenth et al., 2013: 12).

In South Africa one would suppose that a high proportion of bereaved persons fall into complicated grief. The suffering and misfortune of children who experience complicated grief are basic components of care and support which must be acknowledged and responded to by health and social care practitioners in their respective roles. South African health and social care practitioners have an important role to play in at least the following areas considering complicated grief: social justice and human rights, advocacy for the bereaved, development of bereavement programmes and services to include accessibility of service, and ethical and legal issues relating to complicated grief (Drenth et al., 2013: 16).

When one is considering the role of health and social care practitioners to enhance the "well-being" of patients, who are accessing them for care and support, it is apparent that the "best practice" in giving counsel to alleviate suffering caused by grief, is not evident; as whilst health and social care practitioners recognised that AIDS orphans experienced grief they were unable to help children in their grief due to a short-fall in both the health and social systems in which they worked.

Sub- theme 3.3 Health and social care practitioners experienced the need for improved management concerning the provision of care and support to children who are AIDS orphans living in the townships

Warren Bennis: “Management or leadership is the capacity to translate vision into reality.”

The Department of Health is taking decisive action to strengthen the South African health system to address the multiple health challenges facing the South African population. Re-engineering of primary healthcare and other efforts to strengthen the public health system are critical in themselves, as well as providing the foundation for the development of national health insurance (NHI). The development of a comprehensive human resource policy is vital to all other efforts. These new policy directions provide the guiding frameworks for all who work within the public health system and outline the vision and goals that should drive our actions. They are supported passionately by the Minister of Health. However, bringing the vision alive will require leaders and managers who have the drive, commitment and entrepreneurial spirit to translate it into real changes on the ground (Ms MP Matsoso; Director General National Department of Health) (Doherty and Gilson, 2011: 3). “Whatever we do must be nationally enabling and locally empowering’’ (Doherty and Gilson, 2011: 7).

Best practice guidelines in management should be used where possible to support decision-making, to support the development of policies, procedures, protocols and programmes and to be used as a resource tool. The challenge in South Africa is to translate policy into practice. “The greatest single challenge facing our globalised world is to combat and eradicate its disparities” Nelson Mandela in (Doherty and Gilson, 2011: 8); however within the health and social systems in South Africa there are disparities between the intention of government and implementation of the intention. These disparities have even been referred to as “gaps” by Dr Aaron Motsoaledi. These “gaps” or “short-falls” in the “best practice” of managers have been articulated by the health and social care practitioners. In one instance a social worker told the researcher that it was as if management were not even there and she relied on her colleagues and God for support. Since the root causes of these problems are varied and complex, the system set in place to deal with them must be suitably comprehensive. The participants told the researcher that the “gaps” concerning management support were apparent and affected their ability as health and social care practitioners to implement “ best practice” concerning caring for children who were AIDS orphans living in the townships, because of a short-fall in the management systems in their respective professions.

“We need more social workers and more nurses but our managers don’t do anything about this. They never support us. So we put up with very difficult working days, to help children who need us to help them” [Interview 20, pg.7].

“We can’t rely on management that isn’t there. Sometimes we must just do the best we can and use our colleagues and our own personal experience to help these AIDS orphans” [Interview 19, pg.3].

“I find my strength in my colleagues and God, not management. They are supposed to help us but they don’t. We are not enough to do the work. They could support us through debriefing but they don’t; so we talk to our colleagues because we understand each other. It’s hard to care for and support AIDS orphan with very few resources” [Interview 19, pg.8].

“We have a good supervisor, he is helping us but he also feels pressure because our difficult cases go to him. He says to me he needs to be debriefed ….. So we might get it too” [Interview 20, pg.7].

“Management try to tell us what we must do but they don’t see the pressure we are under. If they supported us more by giving us resources and employing more people it would help us a lot I can say that” [Interview 5, pg.6].

Leadership is critical and the Department of Health intends to provide it throughout the process of the core value management process (Dr Aaron Motsoaledi MP) (DOH, 2010b: 3). Developed with extensive input from many different partners, these “best practice” standards speak to everyone. Most importantly they address staff caring for patients and the managers of clinics and hospitals, whether public or private. The National Core Standards reflect a vision for South Africa’s health services, rather than introducing a list of new requirements. They focus on what needs to be done to meet that vision. Continuous assessment to ensure compliance with these standards will go a long way towards providing basic quality care. It will also mean that when an external audit team comes to measure compliance, all services should be good enough to meet quality standards. Dr Aaron Motsoaledi in Doherty and Gilson (Doherty and Gilson, 2011: 4).

Quality is the level of attainment of health systems’ intrinsic goals for health improvement and responsiveness to legitimate expectations of the population (WHO, 2008a: 5). The importance of providing quality health services is non-negotiable. Better quality of care is fundamental in improving South Africa’s current poor health outcomes and in restoring patient and staff confidence in the public and private healthcare system. If quality is defined as “getting the best possible results within available resources”, then these National Core Standards set out how best to achieve this. All managers at all levels are expected to ensure that these standards are met (Doherty and Gilson, 2011: 5).

Simply reminding healthcare staff of their basic duty is not enough to achieve widespread and sustainable improvement in South Africa's quality of care. The factors that contributed to the current situation must also be taken into account: poor management, a lack of accountability, a culture of mediocrity rather than excellence, demotivated staff and even an erosion of professional ethics, are all to blame (Doherty and Gilson, 2011: 5). The participants related to the researcher the following concerning the short-fall they experienced concerning management.

"Our management doesn't help us. It's like they don't exist. We order drugs they don't arrive. Some of our Drs are not paid for months and we are never helped to do our job well. We must get our own support to survive" [Interview 23, pg.5].

"We are professionals and we need support from management. We need management to help us help the children and adults we see; but they don't, they just collect figures, sometimes we don't even have supplies because of the poor management systems we have. We wait weeks at times to even get through to a person at Bhisho we need speak to apply for food parcels " [Interview 18, pg.7].

"Our supervisor is supposed to help us; but she already has too many social workers to oversee. I can say is that our system of management needs to be improved so that we can feel supported" Interview, 18, pg.8].

This gap is being addressed through a tool for managers, which makes clear what is expected of them both in terms of the systems that need to be in place and the outputs that should be delivered. It is hoped that this will achieve more than just better guidance – the tool is also provided so that managers can assess themselves and close the gaps they find. It is believed that managers will be given further incentives by the knowledge that at some stage they will be assessed and held accountable by an external body. All of this is relevant not just for frontline managers in the establishments, but also for those who supervise and support them and whose job it is to enable them to deliver quality care. Many of the health and social care practitioners told the researcher they were unable to implement "best practice" because of lack of support and resources through their respective management structures.

"To me it's like our managers are invisible, we try to find them to help us with more resources mores support for us but they are not there. Sometimes I event think they do not exist" [Interview 22, pg.14].

Implementing these National Core Standards throughout every healthcare establishment in South Africa will take time and effort. To focus managers' and supervisors' efforts, six quality priorities have been identified for the first phase of implementation. These priorities reflect patients' most pressing concerns regarding services, especially in the public sector (WHO, 2008a: 2).

Of these six priorities, improving the cleanliness of facilities is the most obvious and urgent. The others (reducing queues and waiting times, improving patient safety, preventing health facility acquired infections and ensuring availability of medicines through improved procurement and supply management) require process-based improvement strategies and a certain degree of process change over time. However, the last priority is a process of cultural change: achieving more positive values and attitudes among staff and managers is part of a bigger shift – towards a future where a caring and positive attitude to patients and their families, as well as one another, is the norm (Doherty and Gilson, 2011: 3).

"We had riots here last week in the location because of poor service delivery. But we are here every day working to help children who are AIDS orphans it's not enough. I can say we are too few professionals and we have too few resources. The people are angry" [Interview 13, pg.5].

Although at the highest levels the Minister of Health and his senior staff have made radical policy changes and have had proactive involvement with society, the stasis of more than 10 years in the health management bureaucracy has been slow to change. Managers are particularly important for transformation and service delivery. They should go beyond routine implementation of rules and instructions from their superiors and instead use local information to guide and lead change in their areas of responsibility. The recommendations made in 1998 about delegation of responsibility to facility level and development of managerial training and support, had still not been implemented in 2011, except for the strengthening of management by assessment of performance with a common competency framework. The development of managerial capacities should be located in a framework that explicitly understands and enables institutional change and addresses the needs of managers (Mayosi et al., 2012: 9).

Development and leadership training should be matched with a systemic plan to transform the dysfunctional civil service into a responsive, caring, and enabling service, which would necessitate restructuring and reorienting of the organisation, rules and protocols of the present health system. A central element of leadership is the strength of engagement between the state and its agencies and the population of South Africa. The bond between the key political parties and the people they serve has frayed after many service-delivery protests and huge disappointments with overall government performance. A robust long- term strategy of programmes to renew trust through community involvement and effective governance could reduce alienation of the people (Mayosi et al., 2012: 1).

In summarising theme three the researcher would like to refer to the following: Health and social care practitioners experienced certain short-falls relating to “best practice” within the health and social systems in which they worked. These short-falls caused children who were AIDS orphans and on ART for HIV infection and their caregivers, to receive inadequate education regarding their ART treatment for HIV infection. Health and social care practitioners also experienced a lack of assistance from some of their respective professionals concerning helping children who were AIDS orphans in their grief, emphasising how necessary it was to assist AIDS orphans in the processing of their grief and that this was indeed “best practice” concerning the “best interests” of children, who had become AIDS orphans. Yet health and social care practitioners were unable to do so because of the short-falls within the health and social systems in which they were working. If “best practice” intention regarding management of the health and social care systems is as follows (as already referred to previously): “ Whatever we do must be nationally enabling and locally empowering” (Doherty and Gilson, 2011: 7), therefore what the participants told the researcher needs to be highlighted in this summary. Health and social care practitioners told the researcher that they experienced the need for improved management of the health and social care systems in which they worked in order for children who had become AIDS orphans to receive the care and support they so desperately required.

THEME 4: HEALTH AND SOCIAL CARE PRACTITIONERS EXPERIENCED THE NEED TO IMPROVE CARE AND SUPPORT OF CHILDREN WHO ARE AIDS ORPHANS LIVING IN THE TOWNSHIPS COMMUNITIES.

“The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular it requires solidarity. We have 30 million orphans already. How many more do we have to get, to wake up?"

Kofi Annan (Abrahams and Matthews, 2011: 3)

To ‘need’ is to require something because it is essential or very important rather than being just desirable circumstances in which something is necessary or that require some course of action (Oxford English Dictionary, 2009: 375). To ‘improve’ is to raise to a more desirable or more excellent quality or condition, to make better, to increase the value or productivity of, to put to better use or to make beneficial changes to. To ‘ameliorate’ is to improve circumstances that demand change (Oxford English Dictionary, 2009: 176). In this instance health and social care practitioners experienced the need to see improvement in the way children living in the township communities were cared for and supported expressing due concern to the researcher regarding how poorly children who were AIDS orphans living in the townships were being cared for and supported.

“I see a huge need for us to care for and support children who are AIDS orphans living in the township communities. They are very vulnerable” [Interview 8, pg.6].

“I can say when children become AIDS orphans living in the townships they become very poor. There are few people and resources to help them and their families and this needs to be improve very quickly” [Interview 12, pg.6].

“I can say children who are AIDS orphans receive the worst care and support of anyone we see in this clinic. They are left to fend for themselves and live very poor lives full of suffering and pain. We need to do more for them ,It’s not right that we see them and send them away to homes with nothing in” [Interview 15, pg.3].

According to Barnes (2012: 1) care is an never-ending and contested issue in health and social policy and empirical research and policy analysis have addressed many issues concerning the political economy of care, shifting assumption about where the responsibilities of care actually lie. The issues are about who cares and what the personal and interpersonal social impacts are of giving and receiving care. Beyond the discipline of health and social policy care has been the subject of sociological, psychosocial and physiological debates well as critiques and challengers who have given and received professional care. Care is fundamental to the human condition and necessary for both the survival and flourishing of individuals (Barnes, 2012: 2).

“On the most general level we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue and repair our world so that we can live as well as possible. That world includes our bodies, ourselves and our environment, all of which we seek to interweave in a complex life-sustaining web” (Taylor in Barnes, 2012: 4).

One of the characteristics of care is that it is purposive. It is a normative concept and one that is an essential part of social policy as that of social justice (Taylor in Barnes, 2012: 5). However one also needs to think about care as a practice. What is involved “to care?” We need to care about in order to care for. Care involves taking the concerns for others as the basis for our action. It’s the principle of caring for one anothers well-being in a spirit of mutual support. Each individual’s humanity is ideally expressed in his/ her relationship with others and this in turn through a recognition of the individual's humanity. 'Ubuntu' literally means that I am a person through you. It also acknowledges both the rights and the responsibilities of every citizen as promoting societal well-being (Barnes, 2012: 7). Health and social care practitioners emphasised to the researcher the need for AIDS orphans to be properly cared for because of their overwhelming needs and vulnerability as children: yet explained to the researcher how they experienced children as AIDS orphans not being cared for. This has been presented in previous themes in detail but will be highlighted in:

"Children who are AIDS orphan are discarded, I can say it is like that. They are hungry, left fighting for their education, hungry, sick, unwanted and grief-stricken. They are like forgotten children. I see many who come to me in this clinic. The have holes in their uniform and school shoes and are hungry. I can say they are mainly uncared for" [Interview, 6 pg.6].

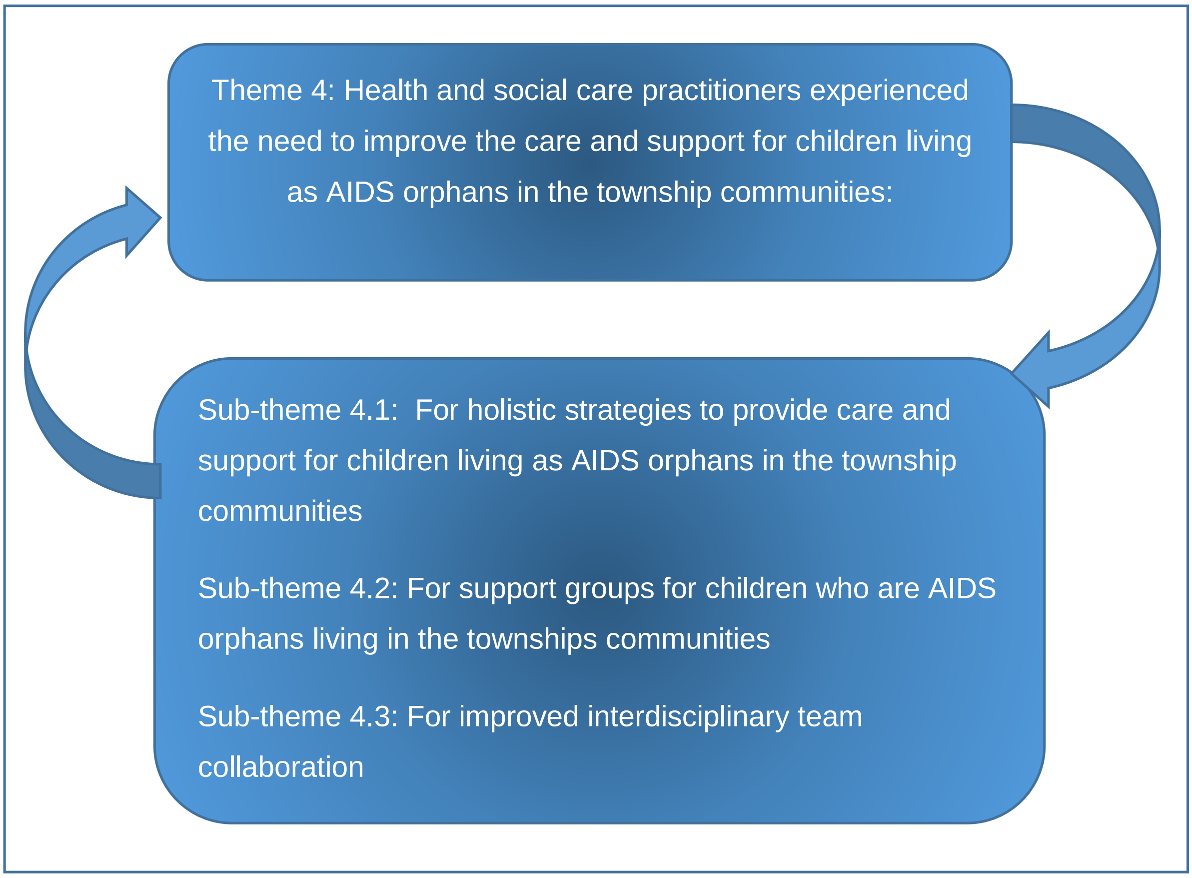
"We are supposed to support vulnerable children. How we can do this? We don't have porridge or support groups ….. We have some medicine. That is what we have so that is what we give. That is not support…. They are AIDS orphan, yes …; but they are children. They need care and support" [Interview, 8, pg.3].

According to Soanes and Stevenson (2008: 1449), 'support' means to give assistance, encouragement or approval, to be actively interested in someone or something. In order to give assistance health and social care practitioners should need to embrace the role of support wholly, to give strength to.

The health and social care practitioners expressed to the researcher that children who were AIDS orphans living in the township communities are largely left uncared for and unsupported and that there was an urgent need to improve the way in which children who were AIDS orphans living in the townships were cared for and supported. This will be expressed in the following sub- themes:

4.4.4 Discussion of Theme 4 and related sub-themes, related to health and social care practitioners experiences

A diagrammatic representation of theme 4 and related sub-themes is presented in figure 4.7:



Theme 4: Health and social care practitioners experienced the need to improve the care and support for children living as AIDS orphans in the township communities:

Sub-theme 4.1: For holistic strategies to provide care and support for children living as AIDS orphans in the township communities

Sub-theme 4.2: For support groups for children who are AIDS orphans living in the townships communities

Sub-theme 4.3: For improved interdisciplinary team collaboration

Figure 4. 7: Health and Social Care Practitioners experienced the need to improve the care and support for children who were aids orphans living in the townhip communities.

Sub-theme 4.1: Health and social care practitioners experienced the need for holistic strategies to provide care and support for children who are AIDS orphans living in the townships communities

“The whole is more than the sum of its parts” Aristotle in Bartlett (2002: 46) “If the whole be greater than the part, a whole man must be greater than the part of him which is studied in a book”

(Bartlett, 2002: 47)

'Holistic' refers to being characterised by a comprehension of the parts of something as intimately interconnected and explicable only by reference to the whole. With regard to health and social care, it is characterised by the treatment of the whole person, taking into account the psychological, social, spiritual and physical factors (Oxford English Dictionary, 2009: 245). The health and social care practitioners spoke to the researcher about the need for AIDS orphans to be cared for and supported holistically. They spoke about the paradox of learning about the need to care and support people holistically: when children become AIDS orphans living in the townships these vulnerable children suffer from severe neglect and are not cared for or supported in a holistic manner; but they needed to be, in order to prevent them suffering from neglect due to a lack of the provision of holistic care and support.

"I can say that when I see children who are AIDS orphans they are mostly neglected. They have many needs and we do not care for them holistically. They need that because they are children; but we don't do that….. We should though". [Interview 12, pg.6].

"I see children who are AIDS orphans every day traumatised by loss. I can give them ART but I can't help them grieve. They suffer because we don't help them like we should" [Interview 18, pg.1].

"We are taught at university to help people holistically; but in practice we don't do this and children who are AIDS orphans suffer because of this" [Interview 15, pg.6].

"I can say that the structures of supporting children who are AIDS orphans in South Africa have fallen apart. These children are vulnerable and neglected because they need holistic care and support and they never receive that, but I can say is we must try and help them the best that we can" [Interview 19, pg.1].

What is apparent is that the HIV/AIDS pandemic has affected the daily context in which millions of children in South Africa now live and that children who become AIDS orphans present with holistic needs which need to be met if children who become AIDS orphans are to grow up cared for, supported and not neglected.

"Strategy" is about shaping the future and is the human attempt to get to a desirable end with available means; a plan of action designed to achieve a long-term or overall aim; It is a high-level plan to achieve one or more goals under conditions of uncertainty; or a plan of action or policy designed to achieve a major overall goal, or a plan to address a problem :a pattern in a stream of decisions. Strategy is important because the resources available to achieve these goals are usually limited (Oxford English Dictionary, 2009: 958).

Health and social care practitioners told the researcher that there needed to be a strategy in place specifically to provide care and support to children who were AIDS orphans living in the township communities. They told the researcher that they felt care and support to children who are AIDS orphans living in the township community was fragmented and ad hoc and emphasisied that a strategy based upon the care and support needs of children who were AIDS orphans living in the township would stop children who were already vulnerable from becoming deprived of this much-needed care and support.

“We don’t have a plan for these children who are AIDS orphans. How we help them most is by writing referrals and by giving from our own pockets. If we have a well-resourced plan I can say these children who are AIDS orphan will be helped” [Interview 19, pg.8].

“It’s like we don’t plan in Africa. We just pick up the pieces when life happens. If we had a plan to help children who are AIDS orphans, it would stop them from living poor and neglected lives in the township communities. It’s better that we plan, but we seem not to do it but we need to” [Interview 23, pg.3].

“Seems we always live in crisis in South Africa. AIDS orphans need to be cared for and supported. We must plan for them; they are children, we are adults. We must plan to help AIDS orphans; but we don’t… it’s all ad hoc, so we open our own purses to help them, because they need food to live ” [Interview 19, pg.4].

You’ve got to think about big things while you’re doing small things, so that all the small things go in the right direction.”
Alvin Toffler in Bartlett (2002: 69)

Sub- theme 4.2: Health and social care practitioners experienced the need for support groups for children who are AIDS orphans living in the townships communities

“Out of suffering have emerged the strongest souls; the most massive characters are seared with scars.” (Kahlil Gibran)

Worldwide 20 million children are orphaned by AIDS. Large-scale studies demonstrating the negative psychological impacts of the HIV/ AIDS pandemic have emerged recently.

Accumulating evidence suggests that AIDS orphanhood status is accompanied by increased levels of psychological distress such as anxiety, depression, intense guilt, shame, and anger (Kumakech et al., 2009: 1039).

HIV/AIDS undermines, then destroys, the fundamental human attachments essential to normal family life and child development. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. These problems are often compounded by cultural taboos surrounding discussion of AIDS and death. It cannot be assumed that children and their caregivers are always able to cope without support. Children who are AIDS orphans need plenty of opportunity to express their feelings without fear of stigma, discrimination and exclusion. Health and social care practitioners spoke to the researcher concerning the need for support groups for children who are AIDS orphans living in the townships communities and the benefits AIDS orphans received in going to support groups and being strengthened through peer support and understanding.

“One of the most important initiatives a social worker can do is to start support groups for children who are AIDS orphans in the township communities. If we had the resources to start these groups I can say they would help children who are AIDS orphanss a lot” [Interview, 1, pg.6].

“If I had the resources the first thing I would do is to start a support group. This is a good way for AIDS orphan to be understood and help each other,. My friend is working in Pretoria. She tells me that when her organisation runs support group for AIDS orphan it does help the children a lot” [Interview 7, pg.3].

“We have to recognise that the focus on children’s outer behaviour and scholastic problems is because of the root of loss and not being able to cope with overwhelming pain of losing their parents. It is good for children to speak about their pain. They must do this in a safe environment. The safest is a support group for AIDS orphan as they are strengthened through understanding and mutual support from their peers” [Interview 8, pg. 2].

“I can say our orphans need practical help, emotional help, physical help, social help and psychological help. One of the best ways we can help these children is to get them together in support groups to talk. They like to talk to other AIDS orphans as then they don’t feel alone in their pain. They can help each other” [Interview 9, pg.2].

Peer support has been evidenced through support groups for AIDS orphans to reduce their anxiety-anger and depression (Kumakech et al., 2009: 1039). A cluster randomized control trial of a school-based peer-group support intervention with 326 AIDS orphans (aged 10-15) in Mbarara District, Uganda found that peer-group interventions when led by teachers and complemented by healthcare check-ups significantly decreased anxiety, depression and anger among the intervention group. Of the children, 42.6% were double orphans. The intervention provided twice-weekly peer-group support meetings conducted by a trained teacher over the course of ten weeks and supplemented these sessions with monthly healthcare examinations and treatment. The support meetings presented topics of concern to orphans through plays, poems, stories and games, asked the orphans to identify the problems embedded in the activities, inquired whether they had experienced similar issues, explored the causes of the problems and their effects on families, and brainstormed solutions. Although the children in the intervention group had started out having lower self-concept scores and higher indications of depression than the control group, the intervention group had lower scores of anxiety, depression, and anger (Kumakech et al., 2009: 1039).

This study demonstrated that peer-group support intervention decreased psychological distress, particularly symptoms of depression, anxiety and anger; thus, the use of peer-group support interventions should be incorporated into existing school health programmes (Kumakech et al., 2009: 1039).

“When you've suffered a great deal in life, each additional pain is both unbearable and trifling.”

Yann Martel, Life of Pi (Bartlett, 2002: 28)

“One of the best things I can do to help AIDS orphans in this clinic is to run support groups. These AIDS orphans change in the support groups as they feel understood by their peers. This is very important for them. We need more resources for more groups because these groups really help these children who are suffering. They have to share their suffering with people they trust, otherwise they will die in their hearts” [Interview 14, pg.2].

“Support groups help children walk through the tunnel of being orphans into the future. They cannot do it alone, they are children. They receive a lot of strength through support groups and this helps them a lot” [Interview 16, pg. 3].

“We need to develop the self-esteem of children who are AIDS orphans. A good place for this is support groups. Children who are AIDS orphans need on-going professional support, we can help many of them through support groups because these children understand each other. They all have the same shared experience” [Interview 16, pg.3].

All of the health and social care practitioners interviewed as part of this research study explained to the researcher of the benefits of providing peer support groups to children who were AIDS orphans as they found intervention in the lives of children who were AIDS orphans in the form of peer support groups decreased psychological distress, particularly symptoms of depression, anxiety and anger, thus the use of peer-group support interventions should be incorporated into existing school, health and social programmes programs (Kumakech et al., 2009: 1039).

Sub-theme 4.3: Health and social care practitioners experienced the need for improved interdisciplinary team collaboration

A multidisciplinary care team can be defined as a partnership among health and social care practitioners of different disciplines inside and outside the health sector and the community with the goal of providing continuous, comprehensive and efficient quality services (IAPAC, 2011: 2).

Collaboration is the ability to work with one another to do a task, a recursive process during which two or more people or organisations work together to realize shared goals. This is more than the intersection of common goals seen in co-operative ventures, but rather a deep, collective, determination to reach an identical objective for example, an endeavour that is creative in nature by sharing knowledge, learning and building consensus. Most collaboration requires leadership, although the form of leadership can be social within a decentralized and egalitarian group. In particular, teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources (Gardner, 2005: 3).

Structured methods of collaboration encourage introspection of behaviour and communication. These methods specifically aim to increase the success of teams as they engage in collaborative problem-solving. Forms, rubrics, charts and graphs are useful in these situations to document objectively personal traits with the goal of improving performance in current and future projects (Gardner, 2005: 4).

“Without proper psycho social support, children who are AIDS orphans will not be able to go forward in life. The need the full support of a coordinated approach of the multidisciplinary team” [Interview 24, pg.3].

“What we need is the multidisciplinary team to work together to find a better, more together way of caring for and supporting children who are AIDS orphans, because we all have a contribution to make and we must make it” [Interview 21, pg.7].

The health and social care practitioners spoke to the researcher regarding the need for multidisciplinary team collaboration, acknowledging the care and support needs of children who are AIDS orphans living in the townships communities as being holistic that, in order for the care and support needs of the AIDS orphans to be met, the response from the multidisciplinary team needed to be collaborative. They used word like togetherness and contribution.They told the researcher:

"Just like it is difficult to integrate theory and practice, it is difficult to get the multidisciplinary team to work together. What would help our AIDS orphans the most is an integrated approach from all departments and all professionals" [Interview 1, pg.8].

"You know if we could refer to other professionals and these referrals worked then children who are AIDS orphans would get the help they needed through the multi-disciplinary team working together" [Interview 22, pg.]

"What would be really good is if we had the multidisciplinary team under one roof, I mean the social worker, psychologist and us the primary healthcare practitioners. This would help our clients a lot. They would only have to walk down the corridor and not travel across town" [Interview 22, pg. 7].

What was apparent to the researcher was the acknowledgement from the health and social care practitioners that one of the ways in which care and support to children who are AIDS orphans living in the townships could be enhanced was through multidisciplinary team collaboration. If each member of the multidisciplinary team was able to give of their expertise to children who are AIDS orphans living in the townships, then the provision of care and support to children who were AIDS orphan's living in the township communities, would be more comprehensive.

"…change should be evolutionary rather than revolutionary."

Dr. Jehu Iputo, Walter Sisulu University (IAPAC, 2011: 7)

Sub-Theme 4.4: The need for debriefing for all health and social care practitioners

Debriefing is often perceived by those being debriefed, as a caring response to trauma. It is seen as assistance to help those who have been exposed to something which has caused stress or pain. Debriefing suggests a taking away of something; in the instance of health and social care practitioners debriefing is seen as taking away something of the bad experience which has caused stress or pain. Overwhelming debriefing seems to mean the possibility of help to health and social care practitioners who are stressed, traumatised or in emotional pain or anguish. Debriefing recognises the hurt or trauma and the presence of complicated and difficult work-related circumstances. It also is seen as bringing the reality of hope to health and social care practitioners by communicating “You are cared for, we have concern for your well-being” (Raphael and Wilson, 2000: 42).“No act of kindness is too small. The gift of kindness may start as a small ripple that over time can turn into a tidal wave affecting the lives of many.” Kevin Health in Bartllett’s (2002: 44).

Stress related to a critical incident can adversely affect individuals and their capacity to respond adaptively at work or at home. Unexpected events or critical incidents have an emotional impact that overwhelms a person’s usual coping skills and causes significant distress in otherwise healthy people. Often, health and social care practitioners have only relatively informal resources for coping with the extremes of sadness and grief they might experience after traumatic events. Thus, stress management programmes can provide myriad benefits to both staff and employers. Debriefing can be considered as part of stress reduction and alleviate distress in healthcare professionals facing stressful situations in their place of work (Cant and Cooper, 2011: 34).

The ‘debrief’ is a common form of retrospective analysis of critical incidents in primary healthcare practitioners and related professions(Raphael and Wilson, 2000: 39). Debriefing has been described as a critical-incident stress-reduction technique that includes structured stages of group discussion (Mitchell, 2003: 59). The health and social care professionals spoke to the researcher about the desperation they felt regarding their need for debriefing.

“We don’t have debriefing but we need it. Sometimes we debrief each other in the corridors before meetings. Last week I spent 3 hours with an AIDS orphan girl. I can’t get her out of my mind. How am I supposed to cope with all the suffering I heard from her” [Interview, 1, pg.7].

“ I reach breaking point at times, because off all the suffering I see every day, I just take a day off . It helps; I think debriefing would help also” [Interview, 22 pg.10].

“We need debriefing because we are listening to traumatic stories every day” [Interview, 24, pg.5].

“This is what I have been through… and sharing it with someone. That’s what debriefing is. I just need someone to know what I have been through. Then you don’t have to absorb as much” [Interview 17, pg.10].

Formal debriefing is debriefing facilitated by two (sometimes three) practitioners who are trained in debriefing in healthcare settings. The most common model for debriefing is Critical Incident Stress Debriefing or Critical-Incident Stress Management that was developed by Jeff Mitchell PhD – Founder of the International Critical-Incident Stress Foundation. Formal debriefing usually lasts about an hour and is followed by suggestions on how to manage the potential residual signs or symptoms, which may be present for professionals after the stressful or traumatic event has taken place. Informal debriefing occurs when teams take a few minutes to process a difficult case as well as the effect that it had on them both professionally and personally.

Healthcare professionals spoke to the researcher about their need for professional debriefing, as they felt overwhelmed and stressed in their professional roles in the provision of care and support to children who were AIDS orphans living in the township communities. Health and social care practitioners considered their work as relentless and characterised by tragic stories of children's experiences of suffering. Quite simply health and social care practitioners found the extent of the suffering they saw and listen to daily as traumatic and they felt they needed professional help in coping with the stress of dealing with all of this suffering they witnessed and heard. This is what they told the researcher with regard to their need for professional debriefing:

"I can say I am overwhelmed by the suffering I see in my job. If I could ask for anything it would be to be debriefed. I get too much stress working with these AIDS orphans. I would like help with this stress. Sometimes I don't know what to do about what I do see. I get stressed about this…." [Interview 1, pg.9].

"I think if we were debriefed it would help to manage the stress of our jobs. Its very challenging and stressful working with AIDS orphans"[Interview 16, pg.5].

"I think a lot about how caring and supporting AIDS orphans affects us. I think debriefing would help us a lot … to manage stress and to not worry about all we see and hear every day" [Interview, 18 pg.7].

"In our work place there is no debriefing …. We are told about it in the university but we don't get it I can say that. Only by talking to our colleagues and that's if they do have time for us" [Interview, 19 pg.4].

“We need debriefing as our work is very, very stressful. We are always having colleagues off work because of stress and sometimes it is for weeks at a time that we don’t see them” [Interview 20, pg. 5].

“I used to work in an NGO before working for the department. We got debriefing in that NGO, I can say that did help a lot” [Interview, 22, pg.6].

According to Leys, (2013: 2) there are three benefits to debriefing:

Case Review: allows your team to process systemically their feelings, responses and interactions with patients, families and colleagues in a manner which helps explore opportunities for enhanced care, team cohesiveness and collaboration across levels of care and support.

Stress Reduction: having the opportunity to meet (even if only for a short time) and debrief after an event has taken place allows teams the opportunity to communicate their feelings and actions related to what happened. These interactions help reduce the physical and emotional stress that health and social care practitioners may have when working in relentless stressful situations

Retention: debriefing after difficult cases or high-volume periods helps teams become more cohesive and collaborative. It also helps teams’ transition between cases more expeditiously. Debriefings also provide a critical opportunity for health and social care practitioners to observe the supportive interactions provided by all team members,and also helps to build trust and support.

Debriefing is widely perceived as being helpful in the processing of traumatic instances in the work place which cause stress or trauma to health and social care practitioners. Working with children who are AIDS orphans living in the townships is challenging and stressful. Health and social care practitioners did attest to the benefits as mentioned in literature concerning the benefits of being professionally debriefed and it was something they would like to have provided for them, as they seek to provide care and support to vulnerable, needy and suffering children who are AIDS orphans living in the township communities.

The researcher would like to highlight the following in the summary of theme four: The health and social care practitioners related to the researcher that children who became AIDS orphans and who are living in the township communities were largely left uncared for and unsupported. Health and social care practitioners spoke to the researcher about the need they experienced to improve the care and support for these children. Participants also spoke to the researcher concerning their experience for the need to develop holistic strategies to provide improved care and support to children who are AIDS orphans living in the townships. There was the need for debriefing of health and social care practitioners, because of the suffering they saw and heard every day when providing care and support to children who were “suffering” as AIDS orphans living in the townships. The need for peer support groups for children who were AIDS orphans and the need for inter- disciplinary collaboration amongst health and social care practitioners was also highlighted by the health and social care practitioners.

4.5 CHAPTER SUMMARY

Chapter Four focussed upon the discussion of the results which emerged from the data collection step and the process of data analysis of this study. The results of this discussion were divided into four themes which comprised health and social care practitioners’ experiences in providing care and support to children who are AIDS orphans living in the townships communities.

This chapter has accordingly presented an analysis and discussion of these research findings through the identified themes and related sub-themes, appropriate verbatim quotes, and comparisons with relevant literature.

The central concept of this study has been identified by the researcher as *holistic care and support,* to optimise care and support to children who are AIDS orphans living in the township communities.

This concept will be defined and analysed in Chapter Five, and will serve as the foundation for the development of holistic strategies for the provision of care and support of children who are AIDS orphans living in the township communities.

CHAPTER FIVE

A DESCRIPTION OF A CONCEPTUAL FRAMEWORK TO DEVELOP STRATEGIES TO PROVIDE HOLISTIC CARE AND SUPPORT FOR CHILDREN WHO ARE AIDS ORPHANS LIVING IN TOWNSHIP COMMUNITIES

> "The growing population of children orphaned by HIV/AIDS is a concern, because had it not been for HIV/AIDS, the global percentage of orphans would be declining instead of increasing" (DWCPD and UNCRC, 2012b: 1).

5.1 INTRODUCTION

> "New attitudes are not promulgated by law, but spread from one person to another" Zeldin in Chesterman (1997: 2).

In Chapter Three the researcher presented an overview of international law concerning the rights of children internationally and the integration of these international laws ratified by the South African Government, into the constitution and domestic policy of South Africa. The principles of justice regarding how children in South Africa are defined and presented in the legal and domestic policy is both comprehensive and overarching; yet finds little realisation or expression in implementation through the health and social systems within South Africa. Herein lies the dichotomy of justice as presented in the law and domestic policy of South Africa and the injustice as expressed by the health and social care practitioners who have the responsibility in their professional practice of rendering care and support to children who are AIDS orphans living in township communities. The experiences of these health and social care practitioners were presented in Chapter Four of this research study. The results were presented from the in-depth research interviews, analysis and discussion of these results. The objective of this research study were:

- to explore current international, national and regional legislative and policy frameworks in South Africa and write an analysis of current legislation concerning the rights of children living in South Africa
- to explore and describe the experiences of primary health care practitioners in primary healthcare clinics who provide care and support to children who are AIDS orphans living in township communities;

- to explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the township communities;
- to create a conceptual framework in order to develop strategies to provide holistic care and support to children who are AIDS orphans living in township communities; and
- develop strategies that could be embraced by the Department of health and Social Development to enable primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists to facilitate care and support to children who are AIDS orphans living in the townships

In this chapter the researcher will present a conceptual framework using the research results in Chapters Three and Four in order to develop strategies to provide holistic care and support to children who are AIDS orphans living in township communities. In order to develop a conceptual framework for the development of the strategies, the survey list of Dickoff, James and Wiedenbach (1968: 435) will be used by the researcher.

5.2 CONCEPTS AND CONCEPT ANALYSIS

Concepts are basically vehicles of thought that involve images and are important for organising our thought life allowing us to have summarised representation of our world (Maraschal et al., 2010: 27) Concepts are also words that describe objects, properties or events and are basic components of theory (Fawcett and Gigliotti, 2013: 2). Concepts provide a concise summary of thoughts, related to a phenomenon therefore without concise labelling through concepts, we would have to go into great detail to describe the phenomenon. Labeling a concept may make it more feasible to continue to analyse and develop it. Concepts are the basic unit in the language of theoretical thinking and are words that represent reality and enhance our ability to communicate (Maraschal et al., 2010: 29).

According to Hardy, 1974 in Walker and Avant (2011: 26), concepts are the basic building blocks of theory building (knowledge creation) and the mental images of phenomena, ideas, or constructs in the mind regarding things and actions. Concepts allow a person to classify experiences in an expressive way and a significant way so that others can find them equally meaningful. A concept may be empirical when observed or experienced through senses, and abstract when not observable, such as hope and infinity. Concept analysis is an important linguistic enterprise which determines the defining attributes of the concepts identified in a research study. The analysis itself has to be rigorous and accurate so that the concept being analysed can be differentiated from similar and dissimilar concepts (Walker and Avant, 2011:

63). Concurrent with concept analysis is the fluidity of the concepts; noting that the meanings of concepts can alter over time. Thus the researcher will be capturing the critical elements from the concept analysis at the current moment in order to encourage communication. The researcher is aware that the precision in defining the attributes of the concept is to be used in the development of strategies to provide holistic care and support to children who are AIDS orphans living in township communities in order to promote understanding with regard to the phenomenon being discussed (Walker and Avant, 2011: 64). Attempts to analyse concepts that are of significance to nursing practice should facilitate greater conceptual clarity among nurses and nurse researchers (Polit and Beck, 2010: 131).

5.2.1 IDENTIFYING, CLASSIFYING AND DEFINING THE MAIN CONCEPTS FOR THE DEVELOPMENT OF STRATEGIES

Identifying, classifying and defining the main concepts for the development of the strategies will facilitate the creation of conceptual meaning by expanding the possible application and meaning of words. The approach of Walker and Avants (2005: 163-164) to definition and classification of concepts involves a detailed review of both dictionary and subject literature's definitions of main concepts. The dictionary definitions listed and described the attributes of each concept and therefore provided their diverse uses. Subject literature provided theoretical definitions and gave the researcher a way of expressing the richness of the concept within the development of strategies, thus offering wider sources of meanings of the concepts within the relevant field of study (Walker & Avant, 2005:164). Creating conceptual meaning provides an intellectual definition of the concept, which enables the researcher to convey and express as accurately as possible application and meaning of words; and then also expands awareness of the scope of the possible application and meaning of words regarding what is required, so that the members of the respective discipline can follow the reasoning and logic on which a theory is based (Chinn and Kramer, 2008: 190-192).

5.2.1.1 Identifying the concept

The main concepts for the development of the strategies were identified from the results of the analysis of the main themes described in chapters three and four, which emerged from the in-depth interviews which the researcher conducted with the research participants and the overview of current legislative and policy frameworks concerning the rights of children living in South Africa. The analysis aspect of this research process was complex due to the amount of data yielded through the data-collection component of this research study. This was in part due to the amount of information available regarding AIDS orphans living in townships in South

Africa and also the extent to which the participants shared the weight and depth of their professional experience with regard to rendering care and support to children who are AIDS orphans living in township communities. During this process the researcher also relied upon her reflective field notes in order to give greater meaning and insight to the thematic discussions regarding the research findings. Copies of table 4.1 were distributed to and discussed with the research promoters and the independent coder, all of whom were experienced in the field of qualitative research and the development of strategies. The aim of this process was to verify the researcher’s objectivity, to provide credibility for the study and to identify the main concepts of the study.

According to de Haan, (2005: 4) a comprehensive approach to attaining and maintaining optimal health for people requires that the factors affecting health are identified, which includes both positive and negative factors. Accordingly the demonstration of holistic care and support to children who are AIDS orphans living in township communities, requires an improvement in all aspects pertaining to health and welfare.

The themes describing the experiences of the health and social care practitioners highlighted the need for improved capacitation of the health and social care systems in general. The health and social care practitioners were of the opinion that much needed to be improved in the primary healthcare and satellite offices in which health and social care practitioners worked in order for them to provide holistic care and support to children who are AIDS orphans living in township communities.

Health and social care practitioners detailed their experiences to the researcher, expressing their discontent, frustration anger and despair over the circumstances in which they were expected to work effectively trying to provide care and support to children who were AIDS orphans. In some instances the health and social care practitioners expressed to the researcher their scathing opinions regarding the ineptitude of management with particular regard to the operation of both the health and social systems. Many strong emotions were expressed to the researcher concerning this, indicating that the situation in many primary healthcare clinics and satellite offices might be hopelessly underestimated regarding service delivery.

Health and social care practitioners have a desperate need to be empowered and capacitated in order for them to care for holistically and support children who are AIDS orphans living in township communities. Primary healthcare and social care practitioners felt particularly stretched as they sought to coordinate the care and support of AIDS orphans through their professional roles within the multidisciplinary team. All health and social care practitioners seek to provide care and support to children who are AIDS orphans living in township communities and require structured de briefing to assist them in coping with the challenges of providing care and support to these children, whilst working in their professional roles. With the numbers of AIDS orphans accessing the health and social care practitioners for care and support; primary healthcare practitioners, social workers and psychologists are overwhelmed and lacking the time in their daily schedule of work to process the enormity of the sorrow and suffering they are exposed to daily. The depth of the emotion the health and social care practitioners experienced was expressed in the words they used in the in-depth interviews and was demonstrated through the intensity of facial expression, silences and tears during some of the interviews conducted in this research study.

On a positive note, the resilience and professionalism of the health and social care practitioners was apparent to the researcher who felt humbled listening to their experiences of providing care and support to children who were AIDS orphans living in township communities. The health and social care practitioners were motivated by a deep-seated conviction and desire to alleviate through care and support the intense suffering of children who are AIDS orphans living in township communities.

In reflecting on this research study, what is apparent to the researcher is that there is insufficient care and support provided to children who are AIDS orphans living in township communities.

HIV/AIDS is a complex disease which has altered the demographics in communities through death and suffering. Children who are AIDS orphans living in township communities are vulnerable and largely left uncared for and unsupported as the safety net in place to care and support them is stretched and not suitable to provide for, and meet the care and support needs which children living in the township communities require on becoming AIDS orphans.

Following discussion with the promoters and peers and researching data related to this field of study, the researcher was left with, one main concept, namely to demonstrate the provision of holistic care and support to children who are AIDS orphans living in township communities. Health and social care practitioners were contending for this provision within their practitioner roles; but were having to do so in a poorly-resourced, poorly-managed system and overwhelmed by the numbers of AIDS orphans accessing them for care and support. Following discussion and literature searches the researcher identified the concept of “holistic care and support”. The effects of poorly-coordinated care and support are evident for persons living with, or affected by, a chronic condition and for people who try to navigate complex health and social care systems to receive the care and support that they require (NQF, 2010: 2).

5.2.1.2 Classifying the concepts

Figure 5.1 illustrates the researcher’s thinking map regarding the identification and categorisation of the major concepts and associated concepts, which will be presented further in this chapter.

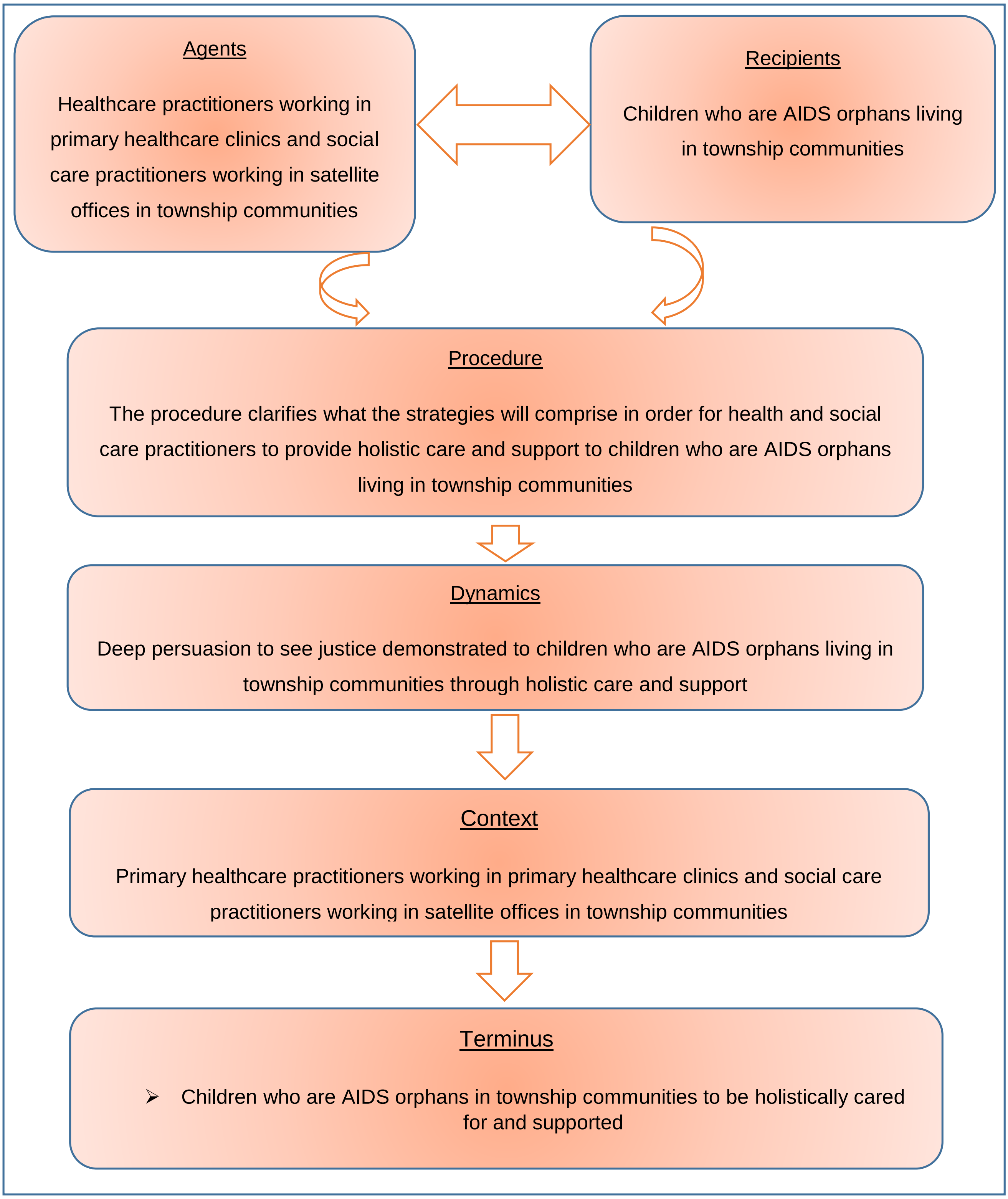


Figure 5.1: Thinking map for the clarification of concepts

Dickoff et al,(1968: 423) developed a survey list with which to classify the concept that form part of a conceptual framework which is required for the generation of theory. The survey list is an inventory of factors which are affecting movement towards a goal or purpose (Chinn and Kramer, 2008: 53). A purpose or goal is required in order for the path to achieving the goal can be developed. In this instance the goal is to develop strategies to provide holistic care and support for children who are AIDS orphans living in township communities. For this reason the survey list described by Dickoff et al. (1968: 423) was used to classify the concepts which were then utilised in the development of strategies by providing " six perspectives of the same thing" in the expectation of revealing different features as the perspectives move. The survey list includes:

- **Agency** (Who or what performs the activity?)
- **Patiency or recipiency** (Who or what is the recipient of the activity?)
- **Procedure** (What is the guiding procedure, technique or protocol of the activity?)
- **Dynamics** (What is the energy source for the activity, whether, chemical, physical, biological, mechanical or psychological?)
- **Context** (In what context is the activity performed?)
- **Terminus** (What is the endpoint of the activity?)

(See figure 5.1 for concept clarification)

The **agent** of the strategies as described by Dickoff et al (1968: 422) is the person who performs or facilitates the activity which is designed to attain the desired goal. The agents described in this conceptual framework are primary healthcare practitioners working in primary healthcare clinics and social workers and psychologists based in satellite offices in the township communities. The primary healthcare practitioners, social workers and psychologists all have professional roles in providing holistic care and support to children who are AIDS orphans living in township communities. The agent as described by Dickoff et al. (1968: 422), is the person who performs or facilitates the activity which is designed to attain the desired terminus. The agent, described in this conceptual framework is the primary healthcare practitioner working in the primary healthcare clinics and social workers and psychologists working in satellite offices in the township communities.

The health and social care professionals are expected to be able to provide comprehensive care and support in their professional roles whilst playing a variety of roles. Both health and social care practitioners are expected to fulfil these professional roles within the limits of policies implemented by the Government and regulation of their professional associated bodies. Health and social care practitioners, include healthcare practitioners with direct involvement in ‘hands-on ‘patient care; health educator, health promoter, welfare provider, patient advocate, researcher and provider of care and support. In the context of this study, considering the facilitation of holistic care and support the researcher would like to focus on the following fundamental aspects of the of the responsibilities of the health and social care professionals (Hess et al., 2012: 10):

- Promotion of health and welfare
- Facilitation of healing
- Alleviation of suffering

- **Promotion** in a general sense is to further the growth or progress of anything, contributing towards growth and demonstration of progression, attempting to popularise; advocating furthering encouragement; assistance in flourishing, spurring on backing up, advancing, plugging, boosting, enabling the achievement of, encouraging the cause of something to become visible or demonstrated (Urding and Swallow, 1991: 789).

  Antonyms for promotion: Concealment, delay, hiding, hindrance, withholding, obstruction.
- **Health** is defined as “the state of being free from illness and injury; a person’s mental and physical condition. The origin of this word is whole (Soanes and Stevenson, 2008: 658) and is delineated as ‘condition of fitness, wellness, of sound constitution; sturdiness, thriving, salubriousness’ (Urding and Swallow, 1991: 549). The origin of health, which is whole is described as entirety, completeness, fullness, unbrokenness, in one piece, unharmed, undamaged, unimpaired, well, healthy, strong, (Urding and Swallow, 1991: 549).
- **Welfare** to give something which causes or promotes well-being, a state of contention for wellbeing, wellness or goodness. Giving by the government of financial aid to vulnerable persons in need. Consideration of wellbeing of others. In middle English the word ‘well faren’ ‘to farenn’ was to fare well, to get along. To be involved in giving assistance. To be committed to providing benefit to, ease of and goodness of (Soanes and Stevenson, 2008: 962).

  Antonyms of welfare are: disadvantage, misery, sadness, sorrow, and woe
  (Urding and Swallow, 1991: 375).

- **Facilitation** is the process of betterment for provision of; concern with the tasks of enabling the production, coordination, demonstration or provision of; the act of assistance or making easier; the process of improving something; the furtherance of an effort or purpose of; giving of aid to.

Synonyms for the word facilitation include the following: service, collaboration, assistance relief of; backing up; boasting, benefiting and contributing to the process of betterment.

Antonyms for the word facilitation are: delay, damage, to block, stop, thwart, harm impeded loss and discourage.

- **Healing** the process of becoming whole and healthy again; restore action of health, wholeness, repair; returning to a place of well-being; the active process of restoring health; tending towards care, support, strengthening and harmonising, giving of assistance, the process of supporting, restoring and rebuilding.

  Antonyms of healing are: damage, harm, hurt, ignoring, neglect, ruin, weakening and aggravation

- **Alleviate,** comes from the Latin word to "allevire" or the old English word "alleviat" which means to lighten; to reduce severity of, deficiency or challenges; reduce pain, diminish, dull, lessen, soften, relieve discomfort.

  Synonyms for the word 'alleviate' are: soothe, assist, improve, ease, allay, subdue; make improvement by bearing the pain, suffering, disease or torment of others; to "take the bite out of; "to pour oil onto, to mollify or to assuage (Soanes and Stevenson, 2008: 22).

  Antonyms for the word 'alleviate' are: to increase, worsen, aggravate, irritate, incite, or heighten (Urding and Swallow, 1991: 24).

- **Suffering** means pain, distress, misery, wretchedness, trouble, sorrow and hardship causing anguish torment and pain; undergoing and enduring of adversity, sorrow and pain. The state of being stricken by disadvantage and lamination. The experience of enduring a profound hurt. Enduring extreme hardship, sorrow, pain and loss. Enduring through a senses of throbbing (Soanes and Stevenson, 2008: 748)

  Antonyms of the word suffering are: Calmness, soothing, strength and assuaging (Urding and Swallow, 1991: 890).

The **recipient** of these strategies are children who are AIDS orphans living in township communities; (see Chapter One regarding concept clarification of AIDS orphan and township community).

The **context** of the strategies is the primary healthcare clinics and satellite offices in the township communities, in which the interviews were conducted. And which are widely dispersed in the township communities in Nelson Mandela Bay, South Africa (see Chapter Two regarding contextual description).

The **dynamics** of the strategies is justice. Health and social care practitioners were motivated by a deep conviction to provide that which was deemed good, right and fair regarding the provision of care and support to children who are AIDS orphans living in township communities. The concept of 'motivated by justice' will be presented in the following section of this chapter.

The **procedure** clarifies what the strategies will consist of in order to provide holistic care and support to children who are AIDS orphans living in township communities. This will be presented in an integrated manner, as the procedure emerged during this phase of the research study. The procedure culminated in the "steps of progression" and they are presented in figure 5.3 of this chapter.

The **terminus** is the development of strategies to provide holistic care and support to children who are AIDS orphans living in township communities.

5.3 DEFINING THE MAIN CONCEPTS

A conceptual framework is used to promote a schematic representation of the relationship between concepts. Dickoff et al (1968: 421) state that a situation-producing theory has three essential ingredients as follows:

1. Goal- content specified as aim for activity
2. Prescriptions for activity to realize the goal content
3. A survey list to serve as a supplement to present prescription and as a preparation for future prescription for activity towards the goal content

The aim of this study is not to produce a nursing theory but to develop strategies to assist the DoH and DSD as well as primary healthcare and social care practitioner in providing holistic care and support to children who are AIDS orphans living in the township communities; but in order to do so the essential ingredients of the situation-producing theory, namely the terminus and the prescriptions of the survey list, are required. The goal of this research study is to develop strategies for the DoH and DSD as well as health and social care practitioners to enable the provision of holistic care and support to children who are AIDS orphans living in township communities. The prescriptions for activity to realise the terminus content of this research study are the strategies which may be used by the DoH and DSD aswell as primary healthcare and social care practitioners. A survey list will be used for the development of the conceptual framework.

The conceptual or theoretical framework of the research study is built up from a structure of concepts which are the images or representative figures that assist in the explanation of an abstract idea. Concepts therefore are the main elements that make up the theory and are then used to explain the abstract ideas, within the theory (Lobindo-Wood and Haber, 2010: 58). Concepts are said to be primitive, concrete or abstract depending upon their ability to be observed in the real or physical world. Primitive concepts are those that share in common meaning such as the colour ‘pink’, which is ‘pink’ or not ‘pink’ when defining a colour. Concrete concepts are those which can be defined by primitive concepts; are limited by time and space; and can be observed in the real world. For instance, although the word ‘temperature’ is abstract, if the temperature for today in Port Elizabeth is given, this is concrete because the concept is dependent on a specific time and place. Abstract concepts are not observable and are independent of time and space; but they can be defined by primitive or concrete concepts (Walker and Avant, 2005: 26).

Creating conceptual meaning is a theory- building approach that carefully examines opinions and understandings which are generated in connection with word symbols. Although considered a logical starting point for the creation of theory, it does not necessarily have to be undertaken first. Conceptual meaning is not discovered but created, or intentionally formed from experience so that it brings a dimension of meaning to a conscious, communicable awareness. Therefore conceptual meaning conveys thoughts, feelings, and ideas which reflect the human experience of the concept. Conceptual meaning is developed by considering all three sources of experiences related to the concept; the word, the object, and the associated feelings. The same word can be used to represent more than one phenomenon or a single phenomenon can be represented by numerous words. Each word conveys a slightly different meaning since the evolution of words and their multiple meanings are complex (Chinn and Kramer, 2008: 186).

Definitions describe the quality of meaning which provide information about conceptual meaning, in that they can bring clarity to the abstraction that the theorist is constructing. In other words, they help to illustrate and highlight common uses and ideas associated with the concept. Existing definitions can help to identify core elements about objects, perceptions or feelings which can be represented by the word and suggest how word representations of an idea are expressed in experience (Chinn and Kramer, 2008: 226). Concepts may be defined in or by word definitions that are accessed via dictionaries, which provide synonyms and antonyms and convey commonly accepted ways in which the word is used and not explained. In other words, descriptive definitions do not supply or explain the full range of perceptions associated with the word, especially when the word has a unique use within a discipline or represents a relatively abstract concept (Walker and Avant, 2005: 164).

As concepts of the theory are identified and conceptualised, theoretical definitions develop, which then form the basis for and signify empiric indicators and operational definitions for concepts which are needed in research. In this manner meanings are conveyed that pertain to the domain of the discipline from which the theory comes (Chinn and Kramer, 2008: 210).

In view of the above discussion, both dictionary and subject definitions will be used to give conceptual meaning to the main concept identified in this study. Various dictionary, subject text books, internet sites academic journals and peer review journals were explored and extensive reading undertaken to describe and give understanding to the main concept identified.

The main concept 'Holistic care and support' is now defined. Each concept will be described individually. Various literature resources as indicated previously will be used. The results of concept analysis, if done precisely, in that the attributes of concepts used in theory development are carefully defined, make it easier for others to gain greater insight and understanding of the phenomenon being discussed (Walker and Avant, 2005: 64).

- **Defining the concept 'Holistic'**

The word holism comes from the Greek word 'holos'. The Oxford dictionary defines it as 'the theory that certain wholes are to be regarded as greater than the sum of their parts". It also adds that it is 'the treating of the whole person, including mental and social factors rather than just the physical symptoms of disease". The South African philosopher and politician, Jan Christian Smuts who coined the term 'holism', introduced it in his book "Holism and Evolution". Smuts saw that matter and life consisted of atoms, cells and units which produced natural wholes that we call bodies and organisms. He observed that the feature of 'wholeness was characteristic of the universe'. Two particular atoms illustrate the idea of holism nicely: a water molecule is much more than the sum of all of its parts namely two hydrogen atoms and one oxygen atom. The oxygen and hydrogen atoms are the components of invisible gasses. Oxygen and hydrogen are colourless, tasteless bland and odourless; but we cannot live without them. Hydrogen is also imperceptible. Together the two gases combine to form water: a vital, visible liquid, something more, much more than the individual constituents. "Water quenches thirst, is a gardener’s dream when its advent is timely and brings joy and laughter in the swimming pool” (Aghadiuno, 2012: 12).

Holism, is defined in Soanes and Stevenson (2008: 680) as the treating of the whole person, rather than just the symptoms of the disease. In Urding and Swallow (1991: 515) holism or wholism is defined as a ‘philosophical concept in which an entity is seen as more than the sum of all of its parts’. Holistic is defined as ‘of, or pertaining to, the whole; considering all factors, as in holistic medicine’. Most importantly, holistic healthcare is defined as a system of comprehensive or total patient care that considers the physical, emotional, socio-economic and spiritual needs of the person, the response to an illness and the impact of an illness on the person’s ability to meet self-care needs, including all aspects with regard to **well-being**:

‘Holistic’ refers to the composites of the paradigm in that holistic solutions speak of validation and value of multifaceted care and support and having a symbiotic relationship between the whole and the parts of the whole. It’s to do with all of the interlocking aspects and consideration of the care, support and assistance being given/ offered to the wholeness of the interlocking components. Holistic speaks also of competence, fulfilment, and consideration of all aspects related to the whole.

Other words related to holism are: intentionally mindful of the aspects of alleviation of suffering when pertaining to an individual and structured relationship-centred interactions related to the wellbeing of a whole person. The concept of holism emerges from a deep understanding of the awareness of the parts. Being an integrative response to the well-being of individuals, it relates to the uniqueness of each individual and its organisational development related to collaboration with others to fullfil the roles regarding, promotion of health, healing and the alleviation of suffering (Hess et al., 2012: 1-4)

Reduction is often viewed as the opposite of **holism.** Reductionism in science says that a complex system can be explained by a reduction to its fundamental parts.

- **Definitions of the concept ‘care’:**

The concept of **care** is defined as the provision of all that is necessary for the health, welfare, maintenance and protection of someone or something. Serious attention or consideration applied to a comprehensive plan of action; to having, doing or giving something; looking after or providing for the needs of (Soanes and Stevenson, 2008: 213). Pearsall (1998: 275) adds that care means serious attention or consideration applied to doing something or avoiding damage or risk. In the Chambers Dictionary (Kirkpatrick, 1983: 228) care translates to relief of affliction, anxiety, (residential or non-residential), medical or social welfare services, to being concerned, providing for, looking after, to watching out for, to watching over, caring or maintaining caregiver or carer. In industry the derivation of ‘maintain’ or ‘maintenance’ refers to ‘keeping in found condition’ e.g. the hospital building is maintained.

In Varley (1992: 124) **care** is defined as ‘in a serious attention or thought condition’; avoidance of damage or loss; to provision protection of and supervision for someone. Care is an action to be seen or a thing to be done for and a willingness to do or to provide for that which causes concern. Fox, Moon and Stock (1987: 206) define the concept of care as: importance given to interest in, concern about, choosing to do something for, the act of consistently providing what a person or a thing needs to keep them in good condition or to maintain their well-being or to keep them well; and making sure that they do not come to harm. To do something with care is to do it slowly with great attention, properly, not make mistakes or damage anything; making sure there is no harm done, van der Wal (2011: 22) lists words associated with **care** and **caring** as commitment, competence, compassion, communication, empathy, empowerment, holism, justice, knowledge, listening, self-actualisation, self-care, self-development therapy.

The concept **concern** means, relating to, being connected, involved with, solicitude, consideration, regard, care, interest in, of importance to, attentiveness (Urding and Swallow, 1991: 226).

The concept **interested** means, attentive, concerned, giving, intent, engaged, engrossed, captivated, fascinated, curious, and involved (Urding and Swallow, 1991: 227).

In social work, **care** refers to ‘protective custody or guardianship provided by local; authorities for children whose parents have died’ (Pearsall, 1998: 275). Waite (2008: 116) adds the following to the definition of **care** that is woven into the context of this research study namely ‘safe- keeping, supervision, management, guidance, superintendence, responsibility, trust’. Other words that further explain the concept of care are also important aspects of this research study. These include; ‘handling with care, work with observance towards giving attention to and with caution being concerned. Corresponding meanings include ‘choose words with care, show discretion towards and use judiciousness, circumspection or accuracy. Words showing the opposite meaning are ‘worry, trouble, tribulation, affliction, woes, suffering, pain pressure, (Waite, 2008: 116).

Words also used to further define the concept care are level of active concern towards, a lack of negligence, towards, avoidance of harm, risk or possible dangers: move away from mistakes, pitfalls and risks and to have a duty or legal obligation towards

(Businessdictionary.com). Awareness of, heed, prudence towards, tend, watch, guard, be willing to do for the maintenance and well-being of; to keep safe, to provide for; to keep guidance and management of.

In Dorland (2007: 300) **care** is defined as a ‘service rendered by health professionals for the benefit of the patient, also called treatment,’ which is quite a ‘sterile’ interpretation of what should be a core component in healthcare provision. Conversely Kyle and Carman (2013: 12), in discussion about nursing care and children, believe that the overall goal for children is to promote and assist the child to maintain optimal levels of health whilst recognising the influence of the family regarding the child’s well-being. These authors submit that parents/caregivers play a critical role in the health and well-being of children in their care, especially since children require care which is continuous comprehensive, holistic, family-centred and compassionate, which focuses upon their rapidly-changing physical, developmental, emotional and well-being needs. It is proposed that this is best achieved within the family focus of care, so that atraumatic therapeutic care is ensured. These submissions are particularly relevant to this study which is based upon developing strategies to provide holistic care and support to children who are AIDS orphans living in township communities.

Caring is an essential quality regarding the provision of health and social care. Caring is also regarded as doing what is right by and for others, and is accordingly a central ethic in nursing (van der Wal, 2011: 17). Caring is based upon an attitude of nurturing, to act by affection and regard and includes growth and optimisation of potential. It excludes all forms of neglect and oppression and focuses upon protecting, enhancing and preserving humanity by helping the patient and his or her loved ones to find meaning in illness suffering, and pain. By caring for patients and their families, a sense of inner harmony can be re–established regardless of the difficulties experienced within pain and suffering (van der Wal, 2011: 23).

Caring is multifaceted. According to van der Wal (2011: 24-25) a whole range of moral and religious concepts and principles are involved in caring. Caring is based upon knowledge, skills, experiences and values; is culturally situated and regarded as being about doing what is right for the patient in one’s care. All primary healthcare and social care practitioners should integrate principles of caring such as a compassionate attitude and appropriate emotions, together with scientific knowledge and technical skill embedded in ethical codes of care. With regard to nursing literature and the literature concerning moral philosophy. The semantics of the terms ‘care’ and ‘caring’ are used synonymously: for care can at times imply procedure and scientific orientation which is lacking in compassion or empathy. Therefore meaning occurs, namely, emotion and doing/action (van der Wal, 2011: 23). Caring includes activities such as active listening, comforting, getting to know the patient as a person, respect, therapeutic touch, providing the patient with information which is empowering and conducive to health and well-being. Caring includes being the patient's advocate, enabling the patient and his/her family to make informed decisions and promoting autonomy (Rankin et al., 2005: 4). Caring embraces helping the patient to feel safe, comforted and valued, which will be enhanced by the accuracy and commitment of the clinical and caring knowledge of the health and social care practitioners. Accordingly the health and social care practitioners' caring practices are intertwined with their clinical and professional knowledge which should result in good quality care (Rankin et al., 2005: 4). **Caring** is said to be a delicate balance of comfort and challenge and a creative ability to maximise resources for the patient's benefit (Rankin et al., 2005: 4). What is apparent is that the nurse, patient and the patient's relationship with social care practitioners, is essential for the patient to experience the benefits of care; thus caring is firmly linked to the nurse-patient relationship (Mckinnon, 2011: 64-65).

The health and social care practitioners form an essential component of caring, without which the patient is reduced to a set of problems, complaints and insulated organic disease states, or suffering which need to be addressed. According to the afore-mentioned author, the greater the investment in the expert personal delivery of care through high levels of qualified practitioners, the more positive the outcomes are for patients. Therefore the relationship between patients and the social care practitioner is vital if patients are to experience their needs of care being met.

- **Defining the concept of support**

Support is an important but complex concept of caring and has been described as an interactive process which affects all the health and welfare of an individual. Support is linked to the attachment process and attachment roles. Attachment will affect both the individual's ability to interact with other people and also the individual ability to trust other people. Both the ability to provide (provider) and the ability to receive (recipient) support are affected by the person's age, experience and social environment. The support offered can be either emotional, appraisal, informative or practical (Cassidy and Shaver, 1999: 21).

Emotional support promotes a sense of safety and belonging while appraisal support promotes a sense of ability and competence; informative support is provided through giving information regarding helping to solve a particular issue or problem and practical support is practical help in solving the actual problem. Support which is perceived as positive by the recipient is more likely to have a positive impact and the emotional part of support is described as the most important part for support to be experienced as positive. The environment where support is offered will affect the quality and perception of support (Thorstensson and Ekstrom, 2012: 1).

Non-judgemental attitudes are described as important aspects of support. In order to offer adequate support it is not only necessary to consider what support is required but also when this support is needed.

Support has been one of the most rigorous and researched concepts associated with the notion that people feel the need to be associated with others who provide love warmth and a sense of belonging and help. Support mediates assistance, enabling individuals to cope better with stressful events thereby reducing some of the effects of stress. Support has been identified as a useful coping mechanism when dealing with stressors and the provision of support has been attributed to preventing burn-out caused through stress. To support is to give strength, to bear the weight of, to give assistance to, to endure with, to hold up, in corroboration with and to give approval and encouragement to.

Care interventions with professional support should aim to strengthen social support. Social support being offered within the social network, requires reciprocity and relationships whilst professional support does not require reciprocity in the same manner and should be directly available from professionals in the society (Thorstensson and Ekstrom, 2012: 2). Professional support is also limited by the professional domain, professional knowledge and professional resources available but it can and should be empowering (Page and Czuba, 1999: 1).

Empowerment can be considered both a process and an outcome and a process which strengthens individuals and is an important aspect of caring. The empowerment process can be described as a partnership in which professionals have power within an individual's life to enable the provision of intervention of services to bring about problem-solving interventions. Defining empowerment is to say that it's a multi-dimensional social process which enables people to gain control over their own lives and a dynamic process which fosters power in people to use in their own lives addressing issues which are priorities (Page and Czuba, 1999: 1). It is multidimensional in that it occurs within the dynamic of the multidisciplinary team; it is a social process, since it occurs in relationship with others; it is also a process in that it is similar to a path or journey, one that develops as we work through the process of it. What is recognised is that individual change is a pre-requisite for community social change or empowerment (Speer and Hughey, 1995: 730).

According to Kriesberg, power is having the capacity to implement (Kriesberg, 1992: 4). It is this definition of power as a process which occurs in relationships which gives us the possibility of empowerment. Words that can be used within the definition of empowerment are power, helping, achieving and succeeding.

Health and social care practitioners need to consider the possible distinction between ‘to care for ’and to ‘give support to’. Etymologically, this is understood as the provider having ‘trust’ in the capacity of the recipient expecting that the recipient will ‘take charge’. Suggesting that the provider mainly provides means that the recipient will be enabled or strengthen to cope with within his/her given situation, therefore empowering the recipient. While to ‘care for’ could etymologically be understood as the provider expecting to ‘be responsible for’ and the recipient ‘to be taken care of’ (Thorstensson and Ekstrom, 2012: 1). Health and social care practitioners’ support should aim to be empowering, facilitating and have a positive development for the individual’s ability to cope with challenging and stressful situations in life such as becoming AIDS orphans. In order to empower individuals it is essential that professionals support is sensitive to an individual’s unique needs in a given and specific situation (Langford et al., 1997: 95). In the context of this research study, health and social care practitioners through demonstrating holistic care and support, can empower children who are AIDS orphans living in township communities.

- **The concept of motivated by Justice**

Motivation is defined as the process which initiates, guides and maintains goal-orientated behaviour. It is what causes a person to act according to rightness, strong conviction or persuasion. Motivation is seen in actions. Synonyms for the word motivate include: encouragement, impetus, inclination towards, action, provocation, stimulus, instigation, fire, action, movement and **demonstration**. Antonyms for the word motivation are: discouragement, hindrance, indifference, prevention.

To **demonstrate** is to express through actions, explain, display or show the existence of the truth of something, to prove or evident, to reveal, to manifest deliberately or to prove as being real.

The root of the Latin meaning is to “see completely”. To ‘demonstrate’ is to establish openly, to show, to make noticeable, to authenticate through establishment, to indicate through appearance and to make noticeable to authenticate through establishment to indicate through appearance and to make evident. Antonyms of the word demonstrate are to conceal, hide and disprove.

Justice is a legal, ethical and ontological word. It is a common and a living concept (Dukor, 1997: 497). Aristotle an ancient Greek philosopher, saw the ambiguity and the cluster of varying notions of it and said “Now it appears that the words ‘justice’ and ‘injustice’ are ambiguous; but as the different senses covered by the same name are very close to each other, the equivocation passes unnoticed and is not comparatively obvious as to where they are far apart (Dukor, 1997: 497). What is apparent is that fairness with regard to the rights of human beings is the core aspect of the concept of justice, and goodness is an aspect of this concept.

The Greek word for ‘justice’ means “observance of custom or of duty”, righteousness, fairness, honesty, legally and morally right, right action, what is due to or from a person. The concept of justice refers to fairness in relation to human beings’, rights and liabilities. Some major formulations concerning justice are based upon equality (Dukor, 1997: 497).

Cephalus a Greek philosopher, defined ‘justice as honesty in need and honesty in deed’. He also went onto define justice as “helping one’s friends and harming one’s enemies”. According to Leo Strauss, “Justice thus understood would seem to be unqualified good for the giver and for those receivers who are good to the giver” (Dukor, 1997: 500). If justice consists in giving to others what belongs to them then a just man must know only what belongs to those with whom he has any dealings. A just man, according to Socrates the Greek philosopher, will help a just man rather than his friends and will harm no-one. Justice must be an art comparable to medicine, the art which knows and produces what is good for human bodies (Dukor, 1997: 500). Thrasymarchus was another person in the Greek Republic who had discussion with Socrates on the question of justice, defined justice as an interest of the stronger (Plato, 1941: 1).

The three virtues in the individual psyche are wisdom, courage and moderation, whilst those of the political state are the money makers, the warriors and the rulers. Justice achieves harmony and maintains equilibrium on both sets of virtues (Strauss, 1981: 9).

Aristotle regarded justice as a particular virtue and the most necessary to a state of welfare. According to him ‘just’ means lawful and fair and ‘unjust’ means ‘unlawful and unfair’ (Aristotle, 1948: 172). According to Aristotle, there are two kinds of justice, one natural and one legal. The natural justice is ‘that which has the same validity everywhere and does not depend upon acceptance’. The contribution Aristotle made to the meaning of justice, an act can be legal but unjust: ‘there is an oligarchic view that there is stratification in society which invariably justifies slavery. Slavery, however, is an unjust act and slaves are unjustly treated (Aristotle, 1948: 9). In the context of this research study, what children who are AIDS orphans living in township communities are entitled to through health and social policy may be legal but can still be unjust; for they need far more than what is perceived to be legally enough and what is demonstrated to them through provision fails to meet their most basic care and support needs.

According to the conventionalist, they believe justice is rooted in emotion and may vary from one person to another and from one context to another. According to Alf-Ross 'to use the word just or general order, rather than of a particular decision in accordance with rule, is merely to express emotion, like for instance banging on a table'.

According to David Hume we should 'set up to end contention and discord rather than questions of fitness and suitability'. According to John Rawles that view of a just order is that body of principles that anyone might recognise. According to him the duty of justice or fair dealing would emerge from the reciprocal recognition by a community of rational egotists that they had a similar and competing interest and that no-one could count on getting his way against all of the rest. Conventionalists approach the concept of justice as a sociological concept.

The golden rule concerning justice is an ethical injunction which has been exposed by religious and ethical books. Simply put, 'one should do to others as one would have them do to us'. This Golden rule is a precept of justice, though it might not cover all we can construe justice to be.

The doctrine of utilitarianism is a creed which holds that actions are right in proportion as they tend to promote happiness and wrong or as they tend to produce the reverse of happiness. It holds that good is pleasure and happiness. John Stuart Mill, stated the 'Act Utilitarian' that we should always perform that action which will have the best overall result and if there is an optimistic act, perform one of the set which will have an equally desirable result (Emmons, 1967: 145). The philosophers always ask the question 'what will happen if I do X, Y, Z? All of these presented views on the rightness and wrongness of an action, border on what justice is or isn't. Philosophers say that the principles of justice derive their moral force from the fact that there are general interests.

For the intuitionists the concept of justice is the view that 'terms of 'good' and' ought' do not stand alone. They imply that the goodness of an activity like artistic creation or rightness of principle such as that of justice and liberty, is a matter of seeing or grasping quality. At a foundational level they would say, 'We simply recognise the rightness of actions having empirical properties and then generalise the results of these isolated moral intentions. Others infer the truth as being the injunction of the form that 'actions of type X are prima-facie right (or wrong). (Stanley, 1967: 343).

The concept of formal justice is related in two distinct ways to the moral, social and legal rules, of the community. In one sense 'the existing rules in the community maybe said to determine at least which actions are just' (Stanley, 1967: 343). In this sense 'justice' is used to cover the whole field of principles and procedures that are to be followed with regard to this aspect that a demand for justice is often a demand that rules themselves must meet with certain standards of justice.

Whilst other philosophers see this as a natural principle of justice, others see it as a principle of fairness. The principle of fairness is often therefore substantial in a way that formal justice quite simply isn't. The reason it is wrong to break rules is that it is simply unfair to do so. Raphael maintained that the idea of justice, both in legal and moral thought, was plainly concerned with the ordering of society (Raphael, 1970: 166). Raphael implies that justice involves rules which, if breached, would constitute an injustice. According to him, justice protects the established order of society which then establishes distribution, rights and, in the event of breaches, requires restitution to the status quo, According to DC Emmons's conception of justice 'an action (or class of actions or institutions) is just if (and only if) it results in an equal distribution of good and evils in proportion to ones' merits: each one receives a share but since all cannot have a share, some are neglected; but those who are deprived are chosen by lot (Dukor, 1997: 508)

Some synonyms for the word justice are equity, rightness, fairness, impartiality, Antonyms for justice are; corruption, dishonesty, falsehood, unfairness and inequality.

What is apparent is defining and understanding the concept of justice is difficult and complex. Chaim, Perelman, adumbrated the following with regard to the concept of justice:

- To each the same thing
- To each according to his merits
- To each according to his works
- To each according to his needs
- To each according to his ranks
- To each according to his legal entitlement

Given all of the differing aspects of justice as presented above, according to Chaim Perelman, 'the concept of justice is the principle of action in accordance with which beings of one and the same category must be treated in a fair manner, according to equality, merit, work and needs' (Dukor, 1997: 509).

5.4 DIAGRAMATIC REPRESENTATION OF THE CONCEPTUAL FRAMEWORK

The following two figures 5.3 and 5.3, below diagrammatically describe the conceptual framework.

In figure 5.2 the diagram represents an overall perspective as told in the previous chapters of this research study. The first puzzle in the figure indicates that when children living in the township communities become AIDS orphans their lives fragment into pieces as they experience sorrow, neglect and suffering. The health and social care practitioners conveyed this to the researcher and the results of this were presented in chapter four of this study. The lives of the children who have become AIDS orphans fall into the hands of their extended family and health and social care practitioners, who try with the professionalism, skills, resources and capacity to care for and support children who are AIDS orphans living in township communities.

The second puzzle in the figure demonstrates the fragmentation of the lives of children who have become AIDS orphans the blue figures represent the health and social care practitioners who provide a care and support response to these vulnerable children. The blue figures are bent over to represent the experiences of health and social care practitioners in providing care and support to these children as they felt, overburdened and overwhelmed with the weight of providing care and support to the increasing number of children who are AIDS orphans living in township communities with insufficient resources to enable them to meet AIDS orphans care and support needs. The cracked white circle on which the blue figures are standing, is to demonstrate the creaking, broken and inadequate health and social system within which these practitioners have to work when trying to provide care and support to children who are AIDS orphans living in township communities.

The third puzzle in the figure demonstrates what could happen to the health and social systems and the health and social care practitioners working in these systems, if they are strengthened and supported through strategies with the purpose of providing holistic care and support to children who are AIDS orphans living in township communities.

The orange triangle demonstrates the strategies developed in this research study to facilitate holistic care and support to children who are AIDS orphans living in township communities. The strategies aim to strengthen the existing health and social systems and enable capacitation and resourcing of the health and social care practitioners working in these systems. The blue men are now bigger, stronger and enabled to stand in a stronger system which is represented by a solid circle in which the blue figures are standing. The health and social care practitioners are now bigger, standing tall and strong; no longer overwhelmed and overburdened; in a strengthened system and able much more adequately than before to care for and support children who are AIDS orphans living in township communities through the provision of holistic care and support.

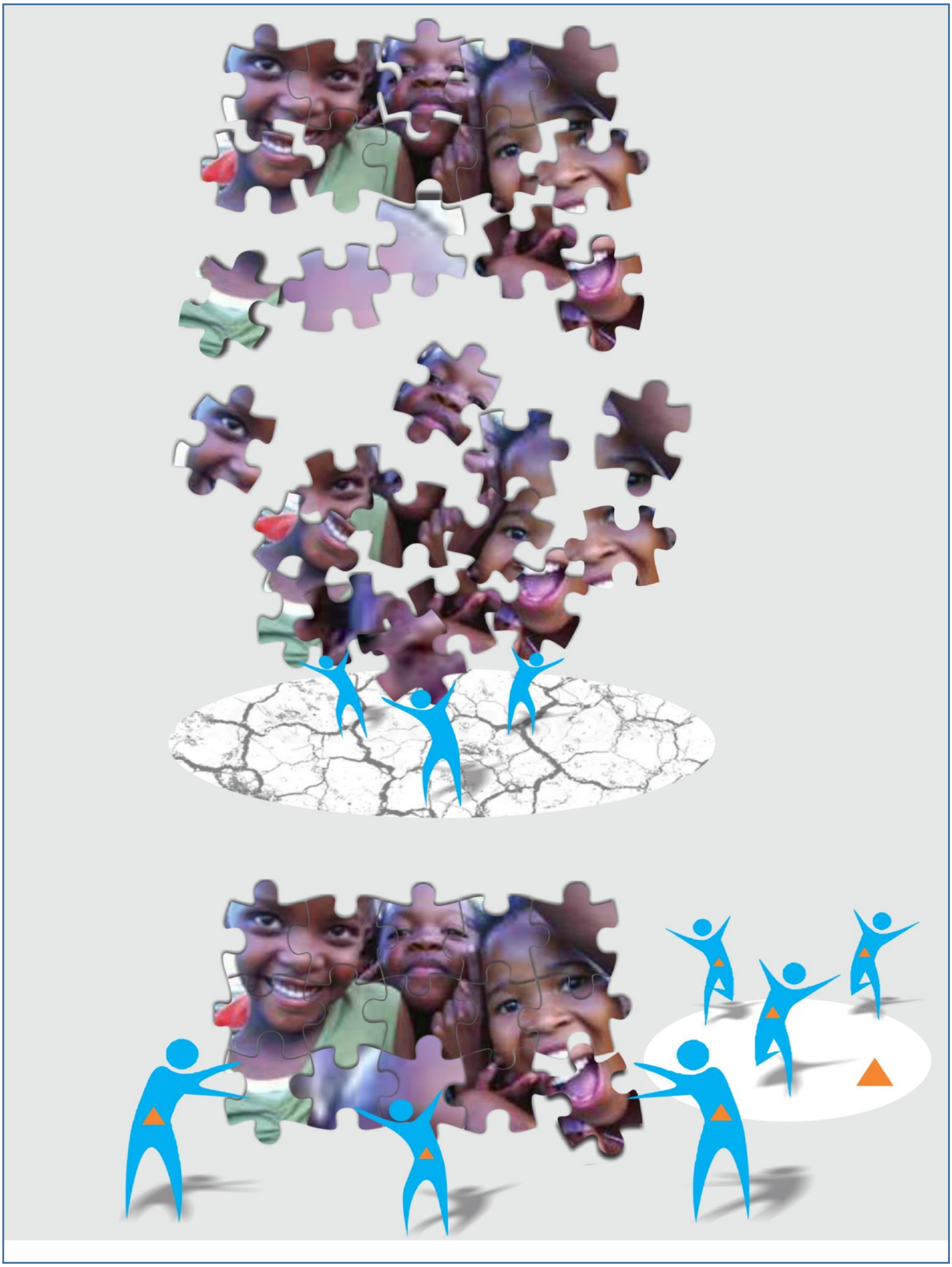
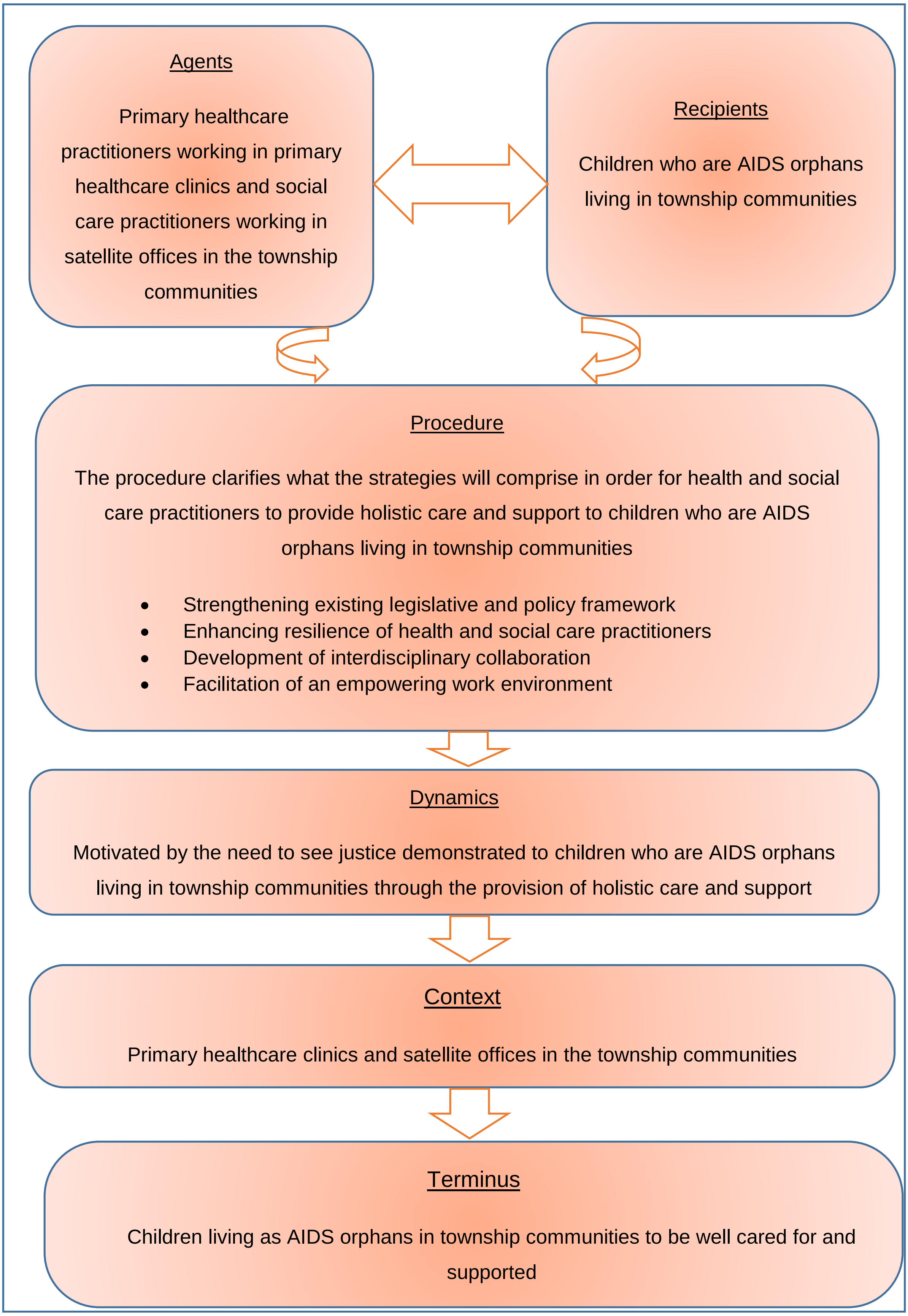


Figure 5.2: Diagrammatic representation of the conceptual framework

The following figure demonstrates the “steps of progression” in the provision of holistic care and support to children who are AIDS orphans living in township communities. In Chapter Six of this research study the researcher will present strategies concerning the following: Strengthening of existing legislative and policy frameworks in which health and social care practitioners work; enhancing resilliance of the health and social care practitioners, development of interdisciplinary collaboration and facilitation of an enabling work environnment; which will lead to the provision of holistic care and support to children who are AIDS orphans living in township communities. The concept of health and social care practitioners being motivated by justice: as previously explained in this chapter is the dynamic of this procedure, and enables the “steps of progression” to occur therfore facilitating the provision of holistic care and support to children who are AIDS orphans living in township communties.

Figure 5.3: Diagrammatic representation of the procedure and dynamics of the conceptual framework



Agents

Primary healthcare practitioners working in primary healthcare clinics and social care practitioners working in satellite offices in the township communities

Recipients

Children who are AIDS orphans living in township communities

Procedure

The procedure clarifies what the strategies will comprise in order for health and social care practitioners to provide holistic care and support to children who are AIDS orphans living in township communities

- Strengthening existing legislative and policy framework
- Enhancing resilience of health and social care practitioners
- Development of interdisciplinary collaboration
- Facilitation of an empowering work environment

Dynamics

Motivated by the need to see justice demonstrated to children who are AIDS orphans living in township communities through the provision of holistic care and support

Context

Primary healthcare clinics and satellite offices in the township communities

Terminus

Children living as AIDS orphans in township communities to be well cared for and supported

Figure 5.4: Detail of concepts related to the provision of holistic care and support to children who are AIDS orphans living in the township communities

5.5 CHAPTER SUMMARY

In Chapter Five, a conceptual framework to be used in the development of strategies to assist primary healthcare and social care practitioners in the provision of holistic care and support to children who AIDS orphans living in township communities was discussed. The importance of the concept as the dynamics of the motivation response of both health and social care practitioners was presented. The conceptual framework was based upon the work of Dickoff et al. (1968:427), who proposed a survey list to provide a guide for the construction of strategies. The steps of progression towards the demonstration through provision of holistic care and support to children who are AIDS orphans was presented as the procedure of the survey list. These aspects of the components of justice providing the motivation for the demonstration of holistic care and support were presented according to various schools of philosophical thought concerning the concept of justice.

In Chapter Six the researcher will discuss strategies which will be developed with the guidance of the conceptual framework. The aim of this study is to develop strategies to provide holistic care and support to children who are AIDS orphans living in township communities.

CHAPTER SIX

STRATEGIES FOR THE PROVISION OF HOLISTIC CARE AND SUPPORT TO CHILDREN WHO ARE AIDS ORPHANS LIVING IN TOWNSHIP COMMUNITIES

“What one generation tolerates the next will embrace “John Wesley (Wesley, 1991: 4)

6.1 INTRODUCTION

Chapter Five described the development of a conceptual framework forming the basis of the development of strategies which DoH, DSD, primary healthcare practitioners in primary healthcare clinics and social care practitioners in satellite offices could use to provide holistic care and support to children who are AIDS orphans living in township communities. The primary healthcare and social care practitioners play a variety of roles in everyday practice in providing care and support to AIDS orphans, creating an opportunity through the provision of holistic care and support to influence positively children who are AIDS orphans living in township communities.

Chapter Six describes the strategies and implementation activities which may be used by the DoH, DSD, primary healthcare and social care practitioners within the multidisciplinary team to facilitate the provision of holistic care and support to children who are AIDS orphans living in township communities. The survey list proposed by Dickoff et al (1968: 421) and described in Chapter Five, guided the development of the strategies. Dickoff et al (1968: 421) describe the survey list as a “supplement to present prescription and as preparation for future prescription for activity towards the goal content”. The development of the strategies includes identification of the agent and recipient, the desired goal or terminus as well as the means the procedure and dynamics, to be used by the agent in order to achieve the goal. The strategies which will be driven by the primary healthcare practitioners, include social care practitioners as members of the multidisciplinary team. The reader is reminded that the strategies have not yet been implemented and refined but have been evaluated by a panel of experts. Implementation of the strategies does not form part of this study. The panel of experts will consist of experienced primary healthcare practitioners, researchers familiar with the research subject, experienced social workers and psychologists.

6.2 BACKGROUND TO PROPOSED STRATEGIES

Responding to children affected by HIV/AIDS remains complex in sub-Saharan Africa as it involves multi-sectorial collaboration and coordination and the development of various systems to identify and support the well-being of vulnerable children. South Africa identified its National Action Committee for children affected by HIV/AIDS (NACCA) as the permanent coordination body to address the need to strengthen intra- and inter-department coordination at all levels and ensure that municipalities play a leading role at a district and local level to deliver effective and coordinated services to orphans and others made vulnerable by HIV/AIDS. The NACCA was considered the relevant response to address the challenge of "functional integration (which is seriously undermined by government's structure of department mandates, separate budgets and programmes which do not necessarily complement one another). "Coordination at service-provider level requires considerable and ongoing investment at all management levels and policies for integrated planning need to be addressed at every service of delivery" (UNICEF, 2012: 2).

However, since South Africa's complex administrative structure and linkages between provincial and district level services are weak, it is extremely difficult for the NACCA as the central coordinating body to have any significant impact on improving children's lives. Furthermore since the department of Cooperative Governance and Traditional Affairs is mandated to coordinate the local municipalities, not all departments, such as the Department of Health and Social Development are represented at this level.

Accordingly the National Action Plan for Orphans and other children made vulnerable by HIV/AIDS has identified the following six strategies (Save the Children Fund, 2010: 14):

Strategy 1: Strengthen and Support the capacity of families to protect and care for OVC's

Strategy 2: Mobilise and strengthen community-based responses for care, support and protection of OVC's

Strategy 3: Ensure that legislation, policy strategies and programmes are in place to protect the most vulnerable children.

Strategy 4: Ensure access of OVC's to essential services

Strategy 5: Raise awareness and advocate for the creation of a supportive environment for OVC'S

Strategy 6: Strengthen mechanisms to drive and support the implementation of the National Action Plan for OVC's

Unfortunately the implementation activities of these strategies are not stated; therefore their implementation remains weak. These strategies are statements of intent rather than mobilised policy rooted in well-resourced and coordinated action. The following table from the National Plan of Action for Children (NPAC 2012-2017) demonstrates this. It is an excerpt from NPAC the aspect of the NPAC directly related to Orphans and Vulnerable children.

Table 6. 1: Responsibilities of the Department of Health and the Department of Social Development have in South Africa according to the NPAC 2012-2017 (DWCPD, 2012-2017: 66):

Department of Social Development	• Facilitate the co-ordination of service delivery for fulfilment of the rights of orphans and other children made vulnerable by HIV and AIDS • Provide psychosocial support and material assistance to vulnerable children and their families • Mobilise communities to protect, care and support children • Mobilise and distribute resources • Establish of child-care forums at community level • Provide alternative care options • Establish and support poverty alleviation programmes • Registration of Non-Profit Organisation (NPOs) • Establish and maintain partnership with key stakeholders • Establish and strengthen home community-based care and support programmes • Capacity building for families, caregivers, community members, volunteers and other service providers • Develop legislation, policies and programmes for the protection of orphans and vulnerable children (HIV). • Establish and strengthen early childhood development programmes that cater for the needs of orphans and other children made vulnerable by HIV and AIDS • Provide Social Assistance to vulnerable groups • Implement policy framework for the prevention and management of child abuse, neglect and exploitation

Department of Health	• Identify the various roles of the supporting departments. • Provide a comprehensive treatment, care and support programme for the management of HIV and AIDS • Provide a comprehensive Primary Healthcare Service Package • Implementation of the Integrated Management of Childhood Illnesses (IMCI)protocol • Implementation of the Protein Energy Malnutrition Programme (PEM), which provides food supplement to children who are malnourished. • Implementation of the Expanded Programme for Immunisation, which provides routine administration of vaccines against measles, TB, diphtheria, and influenza. • Implementation of the Prevention of Mother to Child Transmission Programmes aimed at administration of anti-retroviral therapy to HIV infected mothers before, during and after labour and to the new-born baby • Monitoring and evaluation of health programmes to support children • Co-ordinate and facilitate access of all communities to all health services

The National Plan of Action for Children 2012-2017 aims to bring together existing international and national priorities in one coherent framework for the survival, protection and development of children in South Africa. It provides, within the broader context of the South African Human Rights Framework, a children's rights impetus to national planning, implementation, monitoring and evaluation of national policies. The overall vision of the NPAC is to "put children first" (DWCPD, 2012-2017: 12) and its mission is "to promote the realisation of children's rights to survival, development, protection, participation and to mobilise resources on all levels" (DWCPD, 2012-2017: 12).

The general principle of the "best interests of the child" is a central and all-embracing principle stipulating that "in all actions concerning children, the best interests of the child shall be the primary consideration" (DWCPD, 2012-2017: 13). South Africa's ratification of international treaties since 1995 relating to children's rights obligates the country to ensure that its domestic legislation is in harmony with international laws and commitments. Although the National Plan of Action for children is developed within the context of these treaties, it is firmly rooted in the provisions of the South African constitution as well as in domestic legislation and policies (DWCPD, 2012-2017: 13).

South Africa has made significant progress concerning the progression and fulfilling of the rights of children. The country has one of the most progressive constitutions in the world, including a system of laws and programmes to ensure the realisation of children's rights through the delivery of services to children but, despite the gains made in expanding services, inequalities still persist and affect negatively the health and welfare of children who are unable to access the opportunities that the country has ratified for the fulfilment and realisation of children's rights. Fulfilling the children's rights through comprehensive service delivery to meet their needs and reduce vulnerabilities is a moral imperative and necessary for the total development of South Africa (DWCPD, 2012-2017: 97).

What is apparent is that the situation of children who are AIDS orphans living in township communities' causes' extreme vulnerability. This situation requires from policymakers in South Africa a child-centred approach when planning and developing government programmes, budgets and monitoring systems. There is still a need for policymakers to redress the inequalities of the past as well as tackling the substantial barriers that children still face today in accessing care and support to meet their needs as they live in the vulnerable circumstance of being AIDS orphans in township communities (DWCPD, 2012-2017: 96).

While strategies may be used to provide a perspective on a particular situation, they may also be used to influence changes in perspective (Mintzberg et al., 2005: 27). The strategies presented in this chapter are aimed at the provision of holistic care and support to children who are AIDS orphans living in township communities. This may be done through influencing the existing health and social care systems and the health and social care practitioners working within these systems. Through capacitation, coordination and adequate resourcing, health and social care practitioners can begin to provide the necessary holistic care and support to children who are AIDS orphans by the removal of barriers, as presented in Chapter Four of this research study.

The goal or terminus of the strategies is for children who are AIDS orphans living in township communities to receive holistic care and support. In order for this to occur there needs to be capacitation at each of the "steps of progression" to move towards the provision of holistic care and support. The focus of strategies will be to optimise, capacitate, coordinate and resource health and social care practitioners in order to bring about the provision of holistic care and support to children who are AIDS orphans living in township communities.

Strategies should be developed through a process aimed at the achievement of a specific outcome or goal (Minnaar, 2010: 64). The reason or rationale for the creation of a specific strategy must be identified and shall guide the development process. Methods used for implementation of the strategy should be indicated. As the implementation and evaluation of these strategies are not part of this research study, other components and completion guidelines for the implementation process and methods of evaluation and measurement are not included. When government departments are developing strategies, value for money has to be constantly borne in mind so that they are effective, efficient and economical as possible (Minnaar, 2010: 86).

The South African legislative policy framework concerning the care and support of children who are AIDS orphans living in township communities, had the guiding principle of the "best interests" of the child, as its measurement of legislation and policies concerning the care and support of all children in South Africa, including children orphaned by HIV/AIDS. Provision of holistic care and support to children who are AIDS orphans is in the "best interests" of the child; and is also in line with the core values of the national plan of action for children 2012-2017 "to promote the realisation of children's rights to survival, development, protection, participation and to mobilise resources on all levels" (DWCPD, 2012-2017: 12). The development of these strategies is to assist in the fulfilment of this goal.

Primary healthcare practitioners do not work in a vacuum; their attempts to fulfil their function are often influenced by factors such as government policies and the lack of coordination of healthcare services. Each of the following strategies has components. Some of the strategies are on the level of grand strategies to be implemented on a macro or meso level, whilst the functional strategies may be implemented on a micro level by the primary healthcare practitioners and social care practitioners acting as agents.

6.3 STRATEGIES TO BE USED FOR THE PROVISION OF HOLISTIC CARE AND SUPPORT TO CHILDREN WHO ARE AIDS ORPHANS LIVING IN TOWNSHIP COMMUNITIES

Thompson and Strickland cited in Tembani (2009: 184), state that strategy development "is the process that seeks to challenge assumptions and beliefs about paradigm shifts and creates visions for the future". Creating relevant strategies is a means to achieve the previously mentioned criteria, particularly with regard to creating a vision for the future for the provision of holistic care and support for children who are AIDS orphans living in township communities.

When government departments are creating strategies to modify health, the World Health Organization suggests that negative behaviours should be addressed by three types of interventions, namely, universal, selective and targeted interventions (Browning and Thomas, 2005: 45). Universal interventions are directed at the population at large and include legislative action such as making sure children are registered at birth. Selective interventions are aimed at people who are non-symptomatic, and are designed for the prevention of a disease or a condition such as HIV/AIDS. These include public awareness campaigns and screening projects. Targeted interventions are specifically aimed at people diagnosed with the condition and are intended to prevent or delay further symptoms and complications. The strategies that follow address the varied levels of intervention.

The four strategies which were identified during the data analysis and comprehensive literature search, address needs and gaps identified by both groups of participants and are closely related and interconnected. Together they are aimed at the overall health and welfare of AIDS orphans living in township communities which is concurrent with the health and social development policies favouring the welfare and healthcare delivery to children, as promoted in South Africa since the development of National Health Plan in 1994 and the NPAC in 2010. The titles of these four strategies which follow describe the “steps of progression” to provide holistic care and support to children who are AIDS orphans living in township communities.

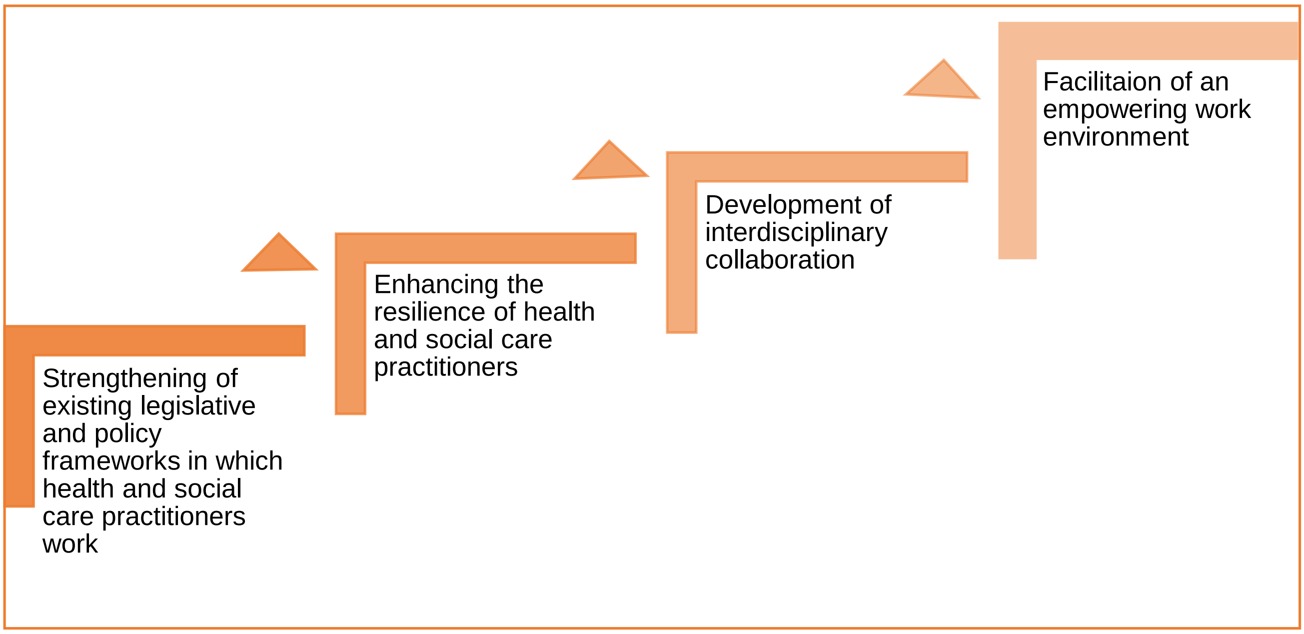


Figure 6.1: “Steps of Progression” to facilitate the provision of holistic care and support

Each of the above-mentioned strategies incorporates both grand and functional sub-strategies (Ehlers and Lazenby, 2010: 200). Grand strategies are those which require implementation on a macro (National) or Meso (Provincial or district) level for effective functioning at grassroots or micro level. Functional strategies are those on a micro level which the primary healthcare and social care practitioners are able to implement in every-day clinical practice, and will be discussed in greater detail than grand strategies.

6.4 DESCRIPTION OF STRATEGIES TO FACILITATE THE PROVISION OF HOLISTIC CARE AND SUPPORT TO CHILDREN WHO ARE AIDS ORPHANS LIVING IN TOWNSHIP COMMUNITIES

The following table summarises the strategies which comprise the “steps of progression” approach to the provision of holistic care and support to children who are AIDS orphans living in township communities. The title of each strategy forms an umbrella term which may be described as either grand or functional strategies.

Each grand and functional strategy will be described as follows:

- Background information
- Rationale
- Proposed outcome
- Implementation activities

Persons responsible for the implementation of the strategies will be indicated in the discussion. As previously stated, the primary healthcare practitioner will not be able to implement some of the strategies personally, but the grand strategies should be in place to enable the primary healthcare practitioners and social care practitioners to fulfil the functional strategies and facilitate the provision of holistic care and support to children who are AIDS orphans living in township communities

Table 6.2: Strategy overview for the provision of holistic care and support to children who are AIDS orphans living in township communities

“STEPS OF PROGRESSION” STRATEGIES	Sub -strategies	Proposed outcome
1. Strengthening of the existing legislative and policy frameworks in which health and	1.1 Grand strategy:	
	1.1 (a) Develop a National Strategy for the provision of care and support to children who are AIDS	Development of a National Strategy for the holistic care and support of children who are AIDS orphans living in township

social care practitioners work	orphans living in township communities	communities. Policies and legislation which have previously been developed must be constantly reviewed and adapted on a micro and meso level by policymakers in government to ensure that implementation on a micro level can occur
	1.2. Functional strategies	
	1.2 (a) The primary healthcare and social care practitioners will assist in the implementation of policies and legislation concerning the provision of holistic care and support to children who are AIDS orphans living in township communities 1.2 (b) The primary healthcare and social care practitioners should facilitate the care and support response to children orphaned by HIV/AIDS 1.2 (c) The primary healthcare and social care	Primary healthcare practitioners and social care practitioners will implement policies and legislation aimed at improving care and support for AIDS orphans. A feedback system incorporated in the implementation process will encourage further development of policies and legislation related to the care and support of children who are AIDS orphans living in township communities Children who are AIDS orphans will receive the care and support that they need Children who are AIDS orphans can receive holistic care and

	practitioners should promote through advocacy the plight of AIDS orphans to increase the levels of care and support to children who are AIDS orphans living in township communities	support, through an increased support network of comprehensive care and support provision
	1.2 (d) Development of guidelines to assist AIDS orphans and their families to navigate the current health and social systems in order to gain access to care and support through personal responsibility	AIDS orphans and their families will be informed by health and social care practitioners regarding how to access care and support available to them through the existing systems and organisations.
2. Enhancing the resilience of health and social care practitioners	Grand strategy	
	2.1 (a) Provision of people and material resources to enable holistic care and support to be given to children who are AIDS orphans living in township communities	The outcome of this strategy will be the provision of holistic care and support to children who are AIDS orphans living in township communities
	Functional strategy	
	2.2 (a) develop and support the capacity of the	The support and capacity of the health and social care professionals will be improved to enable them to be effective in the

	health and social care practitioners	provision of holistic care and support to children who are AIDS orphans living in township communities
3. Development of Interdisciplinary collaboration	Grand strategy	
	3.1 (a) Develop interdisciplinary collaboration through coordination and cooperation	An efficient and coordinated interdisciplinary approach adopted to provide holistic care and support to children who are AIDS orphans living in township communities
	Functional strategy	
	3.2 (b) Primary health care and social care practitioners to facilitate the implementation of functional aspects related to coordinating the care and support response of the interdisciplinary team	Interdisciplinary collaboration will assist in the provision of holistic care and support to children who are AIDS orphans living in township communities
4. Facilitation of an empowering work environment for health and social care practitioners	Grand strategy	
	4.1 (a) Development of orphan care centres, “Ithemba Elitsha” (In Xhosa “New Hope”), within the existing health and social care structures	An interdisciplinary, collaborative and integrated approach will be adopted for the provision of holistic care and support to children who are AIDS orphans living in township communities

	Functional strategy	
	4.2 (a) Education, care, support and resourcing of health and social care practitioners, concerning the provision of care and support to children who are AIDS orphans living in township communities	Health and social care practitioners to be cared for, supported and resources in a working environment which enables the provision of holistic care and support to children who are AIDS orphans living in township communities

6.4.1 Strategy One: Strengthening of the existing legislative and policy frameworks in which health and social care practitioners' work.

In order for children who are living as AIDS orphans in township communities to be holistically cared for and supported, a variety of actions on a number of levels is required. On a grand strategy level action by policymakers is required to develop appropriate and implementable policies and legislation on a macro level (national /supporting policies and frameworks) and meso level (community, health and social care, for example, provincial, health and social development departments) in order to facilitate the provision of necessary care and support to AIDS orphans. Functional strategies include the implementation of those policies at a grassroots or micro level. The primary healthcare and social care practitioners act as advocates of the AIDS orphans to coordinate, facilitate and provide holistic care and support to children who are AIDS orphans living in township communities.

6.4.1.1 Grand Strategy

Policies and legislation which are implementable are required to provide holistic care and support to children who are AIDS orphans living in township communities.

6.4.1.1 (a) Develop a National Strategy for the provision of holistic care and support to children who are AIDS orphans living in township communities

One of the ultimate aims of government is to promote the general health and welfare in the population governed (Minnaar, 2010: 16). Health and welfare initiatives in the community may also be directed by official policies and legislative frameworks, giving value to health and welfare services. In order for health and welfare policies to be successful, it is necessary to “look for a greater pace of change in the political legal, commercial, educational, and administrative systems upon which successful health and welfare policies rely” (Potter and Harries, 2006: 841). Co-operation is necessary between a variety of role players responsible for the development of health and welfare, regarding the provision of holistic care and support to children who are AIDS orphans living in township communities; as envisioned by a National Strategy for this purpose, in order for efficient health and welfare services to reach vulnerable children who are AIDS orphans living in township communities.

- **Background information**

On the 27th May 2013 the “South African National Conference on Orphans, Vulnerable Children and Youth (OVCY)” in Durban was a partnership between the Department of Social Development in South Africa and PEPFAR (Presidents Emergency Plan for AIDS Relief). This national conference focused on changing the lives of orphans, vulnerable children and youth.

The opening remarks of the conference by charge d’ affaires, Virginia Palmer, were: “Together we must ensure that no child has to grow up with HIV and that children and youth and their families are not made vulnerable by this disease”. In the conference proceedings Virginia Palmer said “No generation is spared the catastrophic consequences of the AIDS pandemic from new-born babies of HIV-positive mothers to elderly caregivers; the disease does not discriminate. One of the most tragic consequences is the toll on our children”. The commitment of PEPFAR through a new initiative called “PFIP” (which is the Partnership, Framework, and Implementation Plan) is seen as a roadmap for the transition of the PEPFAR programme from an emergency initiative to a sustainable programme led by the South African Government.

The following aspects emerged from the conference:

- An opportunity to document activities that have been successful and are designed to promote an exchange of ideas and information, leverage of technical and financial resources, and encouragement of partnerships, collaboration and coordination among programmes supporting Orphans, Vulnerable Children and Youth (OVCY).
- Support for the objectives of the Department of Social Development by working together to improve the quality of OVC services by strengthening systems and the oversight framework for coordination, planning, implementation, monitoring and evaluation of children’s services.
- Evaluation of the programmes’ support through USAID and other government agencies and essential services for children affected by HIV and AIDS, including

psycho-social support, educational support, HIV-prevention activities, income-generation activities and clinical care. This multi-sector approach must also include support for the elderly persons who shoulder the burden of raising their grandchildren and great-grandchildren.

- The recognition that HIV/AIDS is more than a health crisis. All sectors of society – education, agriculture, business, and others are dramatically affected by the pandemic. No single intervention can adequately address the dynamic and destructive forces unleashed on a household affected by HIV and AIDS. The problems of children and families are complex and interlinked. All too often an ill caregiver receives home-based care while opportunities to provide prevention messages and psychosocial and economic support to other household members are missed.
- The recognition of the need to work with families to help them become more economically stable so they can access essential services and better provide for their children.
- Improving the lives of children living in South Africa by thinking in the long-term and investing in efforts to strengthen systems of care and support, including social services.

The declaration regarding the conference was a commitment to continue to support the objectives of the Department of Social Development by working together to improve the quality of OVC services by strengthening systems and the oversight framework for coordination, planning, implementation, monitoring and evaluation of children’s services.

Development of a national strategy concerning the provision of holistic care and support of AIDS orphans would consolidate health and welfare service delivery to ensure optimal use of personnel and financial resources for the provision of holistic care and support to children who are AIDS orphans living in township communities.

In order to promote and protect the rights of the child at all levels, state parties need to develop a national strategy for children based upon the Convention on the Rights of the Child. The strategy must set realistic and achievable targets and must include adequate allocation of human , financial and organisational targets (Save the Children Fund, 2010: 8).

The lack of a policy framework within which to understand the whole subject of children and HIV/AIDS in South Africa was identified as a barrier to effective coordinated action. The National Strategic Framework should be finalised as a matter of urgency, disseminated and then actively promoted as the framework within which all sectors of society should develop their priorities (Save the Children Fund, 2010: 10).

South Africa is one of the first African countries to demonstrate the existence of a National Plan of Action for Orphans and Vulnerable Children, however in the light of South Africa's complex administrative structures, weak linkage exists between provincial and district level services and there is a lack of representation by the DOH and the DSD, which are not always represented at a local municipal level. "Coordination at service-provider level requires ongoing investment and coordination at all management levels; and policies for integrated planning need to be addressed at every level of service delivery" (Save the Children Fund, 2010: 20). A national strategic plan regarding the holistic care and support of children who are AIDS orphans living in township communities would assist in the prioritised and coordinated efforts to address the care and support needs of AIDS orphans. Together with related policies and legislation, care, support and implementable initiatives, health and social care practitioners could improve the holistic care and support response to children who are AIDS orphans living in township communities.

- **Proposed outcome**

A National Strategy aimed at implementable policies for the provision of holistic care and support to children who are AIDS orphans living in township communities must be developed. Policies and legislative frameworks which have previously been developed must be consistently reviewed and adapted on a macro, meso and micro level by government policymakers to ensure the visibility of government legislation and policy on a micro level.

- **Rationale**

The South African Government has the overall responsibility to ensure that all the citizens in South Africa receive health and social care appropriate to their needs. The legislation created by the government also influences and controls to some extent care and support response to AIDS orphans through the Non-Governmental (NGO) structures within South Africa. Participants in this research study explained to the researcher that there was a gap between legislative frameworks, policies and the implementation of these respectively. This leads to unmet care and support needs of children who are AIDS orphans living in township communities.

Taking action to improve healthcare services is not limited to the government, and NGO's other sectors can make a considerable contribution to have a significant effect on the care and support being given to children who are AIDS orphans. In this manner private sector companies may, as part of their social responsibility programmes, invest time and money in improving the care and support response to children who are AIDS orphans living in township communities. Social enrichment in this manner may provide funding for some of the following strategies (Hellriegel et al., 2010: 121).

A concerted effort to address the care and support response to AIDS orphans requires a national strategy to strengthen the existing legislative and policy framework and to provide a coordinated approach to reduce the suffering of children who are AIDS orphans living in township communities'. A National Care and Support Strategy for AIDS orphans may be influential in enabling a realisation of children's rights though implementable policy.

- **Implementation Activities**

The implementation activities presented here are broad and require resources not accessible to the professional health and social care practitioners; but, these implementation activities influence in the meantime the ability of health and social care practitioners to fulfil their professional roles regarding the provision of care and support to AIDS orphans. The following activities should be implemented on a macro level:

- Develop a South African 'Children's Charter' specifically regarding the realisation of children rights of children who are AIDS orphans living in township communities.
- Develop a National Care and Support Strategy for AIDS orphans. This should be complied and implemented as a matter of urgency. In order to compile such a strategy the following groups should be informed with regard to:

    - National Action Group for the provision of care and support to AIDS orphans should include:
        - ✓ Health and social care practitioners providing care and support to AIDS orphans,
        - ✓ Management from the Department of Health and the Department of Social Development,
        - ✓ Policymakers from the Department of Women and Children and People with Disability (DWCPD),
        - ✓ Children's Institute University of Cape Town, Centre of Child Law Pretoria University,
        - ✓ UNICEF partners working in South Africa providing care and support to AIDS orphans,
        - ✓ Save the Children partners in South Africa providing care and support to AIDS orphans; and

    - ✓ South African NGO’s providing care and support to AIDS orphans living in township communities.
- National Action Group should meet every six months in order to monitor effectively and evaluate the impact of implementing policy changes or new legislated initiatives.
- A parliamentary action group should promote implementable policies complete with action plans, time plans and feedback of implementation activities to the parliamentary action group.
- The parliamentary action group to develop and promote policies which:
    - ✓ Ensure primary healthcare service delivery to AIDS orphans; including comprehensive ART to AIDS orphans who are HIV positive
    - ✓ Ensure AIDS orphans have access to social workers and psychologists
    - ✓ Ensure the administration of a “kinship grant” as per recommendation from the institute of child law and the acknowledgement of the DSD of the failing foster-care system in South Africa

EXPLANATION OF KINSHIP GRANT

Ann Skelton of the Centre for Child Law said that ‘the issue of a special ‘kinship grant’ which avoids taking all cases through the foster-care system has been on the table for some time, and the Minister can avert any possible crisis through creating such a grant.’ Paula Proudlock of the Children’s Institute, University of Cape Town said that ‘if a new ‘kinship grant’ could be accessed by relatives directly from the SA Social Security Agency (SASSA), instead of via social workers and the magistrate’s courts, it will be in the best interests of all children affected by the crisis in the foster-care system. It could mean that orphans will get their grants faster and more efficiently, and abused and neglected children will get better quality protection services from social workers and courts. This will not cost any extra budget - it will just mean shifting these cases from the foster-care system into the normal grant application system.’

Lucy Jamieson also of the Children’s Institute, University of Cape Town said that ‘social workers and courts are currently swamped by foster-care applications. The complex foster-care system was designed for 50 000 children but at the end of April 2012 there were 544 000 children getting the foster child grant and hundreds of thousands in various stages of application. The majority of orphans, like the 12 year old boy in the recent High Court case, wait up to four years before they get their grants.

Resources for the following activities should be provided on a national level.

- A social marketing programme for NGO’s should be developed to enable the business sector and NGO sector to collaborate with social responsibility criteria for the provision of care and support to children who are AIDS orphans living in township communities. The marketing programme should include:
    - Marketing campaigns to inform the public regarding the plight of AIDS orphans living in township communities and good stories from AIDS orphans living in these communities following a successful intervention and present to the wider community “what works” and “how much, what works costs, in terms of time and money”.
    - Compilation by the DoH and DSD of directories online via their websites and written directories for health and social care practitioners identifying NGO’s in their local communities who are providing care and support to AIDS orphans living in township communities. The directories should include the services these NGO’s provide and details concerning the selection criteria regarding the accessing of these services. For example is the service offered for all children who are orphaned by HIV/AIDS, or children orphaned by HIV/AIDS who are living in Child Headed Households (CHH).
    - The National Care and Support Strategy should include the care and support services available to AIDS orphans through health and social care practitioners working for the DoH and the DSD. Provision should be made for AIDS orphans to have access to:
    - A primary healthcare practitioner, who will provide care and support through the primary healthcare structures through treatment, care and support and by referral within the multidisciplinary team.
    - A social worker who will coordinate social care through welfare initiatives
    - A psychological care and support through referral to a psychologist by the primary healthcare practitioner.
    - NGO services who provide care and support to AIDS orphans
    - Immediate health and social care and support on becoming an AIDS orphan

- The national strategic plan needs to address capacity gaps in terms of people and material resources
- The national strategic plan needs to address the role of the municipalities in capacity building and its services regarding the provision of care and support to AIDS orphans. For example, health and social care practitioners fill in referral forms

for food parcels which the DoH and DSD make available and of which health and social care practitioners are aware only to find that they go through the referral process and no food parcel ever arrives.

- It is essential to address the provision of an immediate comprehensive care and support response to children who become AIDS orphans and who are living in the township communities (this will be presented fully in strategy four of this chapter).

The Strategy drivers are:

International organisations UNICEF, Save the Children, PEPFAR, UNAIDS

Policymakers in national government DoH and DSD

Management of DoH and DSD

Members of National Action Committee

Senior primary healthcare and social care practitioners working at grassroots level

- **Functional strategies**

Policies and legislation created on a macro or meso level must be implemented on a micro level.

6.4.1.2 (a) The primary healthcare and social care practitioners will assist in the implementation of policies and legislation concerning the provision of holistic care and support of children who are AIDS orphans living in township communities

- **Background**

The professionals implementing the policies concerning the provision of holistic care and support to AIDS orphans on a micro level are the primary healthcare and social care practitioners who are members of the multidisciplinary team and who are most likely to have conctact with children before and after they become AIDS orphans. Social marketing may not be familiar concept to the primary healthcare and social care practitioners, but it is being used more frequently and can be particularly useful in influencing change regarding the provison of holistic care and support to children who are AIDS orphans living in township communities.

Social marketing includes identifying the target population and conducting an analysis of their needs to ensure that the availability and use of resources are maximised. Implementing strategies to address those needs and continuous analysis of the efficency of the strategies will ensure that any initiatives undertaken remain authentic in addressing needs and remaining cost effective (Kotler et al., 2002: 41).

- **Proposed outcome**

Primary healthcare practitioners will implement policies aimed at providing holistic care and support to children who are AIDS orphans living in township communities. A feedback system incorporated in the implementation process enhances further development of policies and legislation related to the provision of holistic care and support to AIDS orphans.

- **Rationale**

Policies and legislation concerning the actualisation of children's rights in South Africa has been represented in government policy and legislation since the change of government in 1994. There is clear intention by the government of South Africa to actualise children's rights which is well documented in the National Plan of Action for Children in South Africa 2012-2017; however these legislative frameworks and policies are not always implemented at grassroots level, despite the South African government succeeding in making many inroads into realising the rights and protection of children, particularly through its legal and social services frameworks. Although progress has been made in many areas, challenges remain, the key among them being the policy challenge of reducing inequities and bottlenecks in delivery systems which impede the impact of the realisation of children's rights at grassroots level (UNICEF, 2012: 32).

- **Implementation activities**

Implementation activities for policies and legislation related to the provision of holistic care and support to AIDS orphans living in township communities should include the following:

- Development by primary heathcare and social care practitioners of a "care and support forum for AIDS orphans" in order to present to DoH and DSD initiatives to improve the grassroots care and support services to AIDS orphans.
- Implementation of social marketing methods to increase the knowledge and awareness regarding the "lived experience" of children who are AIDS orphans living in township communities, will hight light the need for policymakers in government to write implementable policy to address directly the care and support needs of children who are AIDS orphans living in the township communities.
- Facilitation of social marketing activities which may be used:

- ✓ Conducting a needs assessment to identify the needs of AIDS orphans living in the township communities
- ✓ Analysing these needs in terms of priorities
- ✓ Identifying services required to address these needs
- ✓ Implementing initiatives to provide the required services
- ✓ Conducting follow-up studies to monitor the efficacy of services implemented

The Strategy drivers are:

DoH and DSD

NGO's

Senior primary healthcare and social care practitioners

6.4.1.2 (b) The primary healthcare and social care practitioners should facilitate the care and support response to children orphaned by HIV/AIDS

- **Background**

Early identification of children who are vulnerable in households where their parents are HIV positive or have AIDS should be identified using a "planned care and response" approach before children become AIDS orphans. In this manner primary healthcare and social care practitioners can assist in the care and support of vulnerable children before they become AIDS orphans.

- **Rationale**

Opportunities to create and coordinate a "planned care and support response" to children vulnerable to becoming AIDS orphans, will enable care and support provision through services to be mobilised before children become AIDS orphans. In this manner some of the suffering these vulnerable children experinece because of neglect can be alleviated.

- **Proposed outcome**

To enable children who are AIDS orphans to receive the care and support that they need to maintain health and well-being.

Implementation activities:

- Initiate a “planned care response” programme for AIDS orphans living in township communities.
- Help clients attending the clinic for ARV’s to make a planned response regarding the care of their children who will become orphans on their death.
- Provide an opportunity for parents dying of AIDS to plan for the care of their child who will become an orphan:
- Discuss the following with the parent dying of AIDS:
    - ✓ Who has access to plans which are in place for their funeral; give advice or refer them to a professional so that adequate plans can be put in place. For example, the following checklist could be used:
    - ✓ Who will take care of the child after they die?
    - ✓ How the child will be provided for financially following their death?
    - ✓ What they have told their child about their death?
    - ✓ How have they prepared the child for their death?
    - ✓ What legal documents have been secured so that the parent’s house, if applicable, will be left to the child?
    - ✓ Does the child have all the documentation required such as a birth certificate or Road to Health Card and does the child know that the death certificate must be kept in a safe place?
    - ✓ Does the child know how to get a death certificate?
    - ✓ Is the child prepared for the procedure of the funeral and who will take responsibility for that?
    - ✓ Does the child know how and where to access help once the parent has died?
    - ✓ Does the child know who will take care of him/her immediately following the funeral?
    - ✓ Has he/she met that person?
    - ✓ Does he/she have a relationship with that person?
    - ✓ Does the child have a social worker to help him/her and foster- care parent apply for the correct grant?
    - ✓ Is the school aware of the home situation, so that concessions can be made re school fees and other issues related thereto
    - ✓ Are church and community leaders aware of the situation so that help can be given to the child?
    - ✓ Have the relevant NGO’s been contacted to provide help and support?

- ✓ Contact PHCN's to provide time for parents dying of AIDS to make plans for their children and to refer dying parents to appropriate services for help and support

(Frood et al., 2007: 125)

Strategy drivers are:
Primary healthcare and social care practitioners

6.4.1.2 (c) *The primary healthcare and social care practitioners should promote through advocacy the plight of AIDS orphans to increase the levels of care and support to children who are AIDS orphans living in township communities*

- **Background**

> " If I wake up one day and see myself in the president's chair I would make a day for orphans so that they can be recognised by government. I would have in my calendar that day to take care of suffering people. But I don't want to be president, I want to be a scientist"
>
> (Cluvier, 2013: 31)

Acting as a patient advocate is a basic role for the primary healthcare practitioner in the provision of holistic care and support to AIDS orphans. There are many interactions the primary healthcare practitioner has with children who are AIDS orphans living in township communities requiring the primary healthcare practitioner to advocate for the AIDS orphan, for example, in the addressing of problems caused by a lack of ability to access care and support services due to financial limitations. The primary healthcare practitioner should be aware of evidence-based practice which may be used to improve the provision of care and support to AIDS orphans. Advocacy should also be included in the National Care and Support Strategy for AIDS orphans, because through advocacy the real needs of AIDS orphans can be represented to polcymakers. Participants of this research study spoke about the overwhelming needs of AIDS orphans to reach the ears of the politicians. The primary healthcare practitioners will also need to advocate for AIDS orphans when liaising with other menbers of the multidisciplinary team concerning the provision of holistic care and support to AIDS orphans.

Patient advocacy has a wide range of meanings and interpretations, from a personal level to that of national and international AIDS-orphan advocacy groups. On a personal level, the primary healthcare practitioner can act as an advocate whilst assisting in the care and support of AIDS orphans in making use of other members of the multidisciplinary team who can also make a service contribution to the provision of holistic care and support to AIDS orphans. The action of each member of the multidisciplinary team can improve the holistic care and support response to AIDS orphans. Some participants in this study indicated the sustained need to advocate for AIDS orphans on many health, social care and support levels to ensure that children who are living as AIDS orphans in the townships were not neglected but holistically cared for and supported.

The rise in the numbers of AIDS orphans in South Africa has heightened the plight of AIDS orphans and also encouraged international bodies to work with the South African government to develop and implement policies to bring about a more holistic response to the care and support needs of AIDS orphans. The importance of this collaboration will be presented in strategy three of this chapter.

- **Proposed outcome**

Effective use of the multi-disciplinary team through advocacy leads to more efficient provision of holistic care and support for children who are AIDS orphans living in the townships.

- **Rationale**

As an advocate for AIDS orphans in his/her care the primary healthcare practitioner will ensure the provision of appropriate care and support at the time needed in order to maintain optimum health and welfare. This can be done through the liaison with other health and social care practitioners in the provision of holistic care and support to AIDS orphans. By strengthening the care and support response to AIDS orphans delays in the provision of care and support to AIDS orphans, which are detrimental to their health and well-being, can be avoided. The primary healthcare practitioner might require the skill of an advocate to assist in creating awareness of the effects of prolonged and unnecessary delays in providing care and support for AIDS orphans amongst management and administrative staff working within the DoH and DSD. Financial constraints within the DoH and DSD have been cited as the cause of inadequate care and support provision to AIDS orphans, a factor which leads to neglect, which could be avoided with adequate, structured service delivery. As part of the advocacy strategy the primary healthcare practitioner should act in cooperation with the multidisciplinary team, NGO’s and services offered by volunteer groups offering programmes to assist in the care and support of AIDS orphans.

- **Implementation activities**

The role of patient advocate can be implemented on a number of different levels:

The primary healthcare practitioner should:

- have professional training concerning the "lived experience" of AIDS orphans and also be trained in how to navigate the DoH and DSD systems in order to access care and support for AIDS orphans;
- make use of evidence based practice when motivating for appropriate care and support for AIDS orphans;
- implement care and a support approach to assist AIDS orphans in making informed choices regarding assessing services available through which care and support can be accessed;
- offer emotional, spiritual and psychological support to AIDS orphans as part of the therapeutic relationship; and
- take part in professional and NGO networks, conferences, advocacy groups and partnerships related to the provision of care and support to AIDS orphans.

Strategy drivers are:

Primary halth care and social care practitioners

NGO's

6.4.1.2 (d) Development of guidelines to assist AIDS orphans and their families to navigate the current health and social systems inorder to gain access to care and support through personal responsibility.

The child who has become an AIDS orphan and the primary healthcare and social care practitioners need to become aware of developing a sense of self-awareness to the new vulnerabilities related to orphan hood, and assist these children to accept the new stressors associated with becoming an AIDS orphan living in the township community. The primary healthcare and social care practitioners need to become a part of the therapeutic relationships which the child has to build in order to assist the child who has become an AIDS orphan to overcome the health and welfare challenges which he/she will have to deal with. Undoubtedly children who have become AIDS orphans have to be assisted to accept personal responsibility for their health and welfare needs and be taught how to make choices related to accessing the care and support necessary for maintaining optimal health.

- **Background Information**

The development of self-awareness and personal responsibility are skills which are essential for anyone dealing with a change in health or welfare status (Johns, 2000: 6). If a person is aware of his/her needs and the services available to help meet those needs, then provision to meet the needs can be made, through taking personal responsibility. Being aware of services available to meet needs can be a motivation to assist AIDS orphans to move towards health and social care practitioners and NGO's who do provide care and support for AIDS orphans. Motivation may be intrinsic or extrinsic. Extrinsic motivation relies upon pressure from an outside person and may lead to short-term success regarding health and welfare needs; but is less effective in the long term. Intrinsic motivation, on the other hand, is reliant upon guidance from an outside person but is equally reliant upon the motivation of the AIDS orphan in order to strengthen the internal locus of control.

People with a strong internal locus of control will be able to cope better with stressors and take responsibility, with guidance, towards making choices concerning the provision of care and support so that health and welfare needs are met. Those with a less strong locus of control will require more assistance in the form of guidance, which can be done through education relevant to their needs in order to assist in the development of motivation towards personal responsibility. It is essential for the primary healthcare practitioner to acknowledge and accept that AIDS orphans have choices and to teach them to deal with "choices, control and consequences" regarding decisions made, both positive and negative (Anderson and Funnell, 2005: 13).

Primary healthcare and social care practitioners have to accept responsibility for their own actions, both professional and also in their private lives with regard to dealing with the consequences of choices (Johns, 2000: 172). Through the development of guidelines for AIDS orphans compiled by primary healthcare practitioners, these children could move towards accessing available health and welfare provisions in order to take some responsibility for their own health, social care and support.

- **Proposed outcome**

AIDS orphans and their families will be informed regarding access to care and support available to them through the existing systems and organisations.

- **Rationale**

Taking personal responsibilility for one's own actions is essential; therefore through making use of motivatioal skills as part of the therapeutic relationship, it is possible for the primary healthcare practitioner to enable change to take place through giving guidance to empower AIDS orphans to make choices towards receiving the of care and support they need. It is important that primary healthcare and social care practitioners are aware of their own need for professional responsibility in their own practice regarding the provision of care and support to children who are AIDS orphans living in township communities.

- **Implementation activiities**

There are various implementation activities for this strategy:

Primary healthcare and social care practitioners should ensure that children who are AIDS orphans living in township communities should:

- Develop awareness regarding their specific vulnerabilities with regard to orphanhood through taking part in the therapeutic relationship.
- Evaluate environmental, physical, emotional, psycho-social aspects of their lives and assist in goal setting to overcome stressors, difficulties and barriers regarding provisions to meet their care and supprt needs.
- Make health and social care and support choices attached to well-being, hope and provision.
- Be guided throught the health and social care systems to receive the provision of holistic care and support.
- Follow the simple guidelines which should be very specific in outcome, for example; "If you go to this office on this day at this time you will see a social worker and he/she will be able to do this for you and it will take this amount of time. Please come back to me on this date and give me feedback with regard to this intervention or if you go to this person at this NGO he/she will be able to assist you with the following or if you see this psychologist she will be able to support you in the following manner and this will assist you in the following way".

Strategy Driver:
Primary healthcare and social care practitioners

6.4.2 Strategy Two: Enhancing the resilience of health and social care practitioners

As the enhancing of resilience requires human and material resources such as training and employing more primary healthcare and social care practitioners and the redistribution of large sums of money within the social care system, a grand strategy is required. The primary healthcare and social care practitioners has to be able to develop resilience in a working environment which enables the development of resilience; but this requires input on a macro, and meso level in order to obtain the necessary resources to facilitate the development of an environment which supports the development of resilience.

Primary healthcare and social care practitioners need to accept personal responsibility for their own health and well-being because working with children who are AIDS orphans is challenging. Reflective practice is a valuable tool in both personal and professional development (Johns, 2000: 8), therefore reflective practice should be encouraged amongst primary healthcare and social care practitioners. A mentoring process for all health and social care practitioners who are providing care and support to AIDS orphans would be invaluable in enabling these practitioners to learn from one another's experiences.

- **Background information**

Health and social care practitioners experience high levels of stress in their respective professional roles in providing care and support to AIDS orphans. These practitioners experience suffering every day as they interact in their professional roles with AIDS orphans. Resilience can be defined as the ability to manage stress and to stay well. Dimensions of resilience include: self-efficacy, self-control, the ability to engage help and support, learning from difficulties and being able to persist in the midst of challenges and stay well.

- **Proposed outcome**

The outcome of this strategy will improve the care, support and capacity of the health and social care practitioners and enable them to be effective in the provision of holistic care and support of children who are AIDS orphans living in township communities.

- **Rationale**

Burnout is a reality for health and social care professionals overwhelmed by the suffering of AIDS orphans and the challenges of providing care and support to them in the township communities. Through capacitation within the health and social care systems and also through the care and support of health and social care practitioners the development of resilience can help to maintain the health and well-being of health and social care practitioners.

- **Implementation activities**
    - Capacity-building regarding people and material resources should be provided
    - Care and support of health and social care practitioners should also be provided

Grand Strategy: The provision of people and material resources will enable holistic care and support to be given to children who are AIDS orphans living in township communities

6.4.2.1 (a) Provision of people and material resources to enable holistic care and support to be given to children who are AIDS orphans living in township communities

Capacity building is one of the key implementation strategies of the national strategy for the provision of holistic care and support to children who are AIDS orphans living in township communities. In order to build capacity in the health and social care systems, it is essential to evaluate present services and to identify ways in which different uses of human and material resources can improve the cost-effectiveness and efficacy of the services provided (Reid et al., 2006: 2). With the approaching implementation of the NHI, capacity building in health and social care services will assist in the provision of care and support to children who are AIDS orphans living in township communities. Capacity building can be defined as being about " making what you have work better" (Minnaar, 2010: 27).

- **Background information**

Improving the quantity and standard of human and material resources is one of the most important commodities in health and social care and an integral part of capacity building. This applies to all levels of staffing as each person has the potential to improve the level of care and support to AIDS orphans. Staff at state facilities might become frustrated due to running out of resources or being overburdened by the numbers of AIDS orphans and their families trying to access financial support as well as care and support through the DoH and DSD. The sheer numbers of children and families trying to access primary healthcare practitioners for care and support puts a strain on the resources within the systems and causes stress amongst the health and social care practitioners working within these systems. Part of the strain in the health and social systems occurs when under-qualified officials are responsible for large public health and social care budgets but due to inexperience are inept at delivering the required services. The provision of care and support for AIDS orphans is necessarily expensive for any government particularly improvements concerning care and support provision at a grassroots level. Capacitation measures required include increasing the number of primary healthcare and social care practitioners being trained to work for the DoH and DSD, in line with recommendations as per millennium development goals, and the suggestions regarding the provision of financial support (through a kinship grant as instead of through a foster- care grant). Less expensive options would be the provision of food parcels and the support and care of health and social care practitioners. Both groups of participants in this research study spoke about their frustration and stress regarding the lack of resources within the systems in which they work. Suggestions made will be presented in the implementation activities of this strategy.

- **Proposed outcome**

Through capacitation in both the DoH and DSD, and the ongoing care and support of health and social care practitioners, holistic care and support can be provided to children who are AIDS orphans living in township communities.

- **Rationale**

Both groups of participants agreed that an efficient and cost-effective health and social care system making full use of a well-resourced multidisciplinary team was required in order to facilitate the provision of holistic care and support to AIDS orphans. In order to bring about efficiency within the health and social care and support systems, all people within the system need to be cared for and supported and understand the role that they are to play. Analysis of any capacity shortcomings is imperative in both the DoH and DSD systems. Quality assurance and governance tools should be used to establish best practice and to evaluate the ongoing health and social care and support services. Regular performance appraisals of staff and auditing of services will provide an indication of any progress and to ascertain where any re – allocations are required. Training and support initiatives for health and social care practitioners will be addressed in the implementation activities of this strategy.

- **Implementation activities**
    - Creation of a National Strategy should address capacity building for the provision of care and support for AIDS orphans.
    - Ensuring partnerships between relevant parties involved in the provision of care and support of AIDS orphans should be fostered
    - Training must be introduced regarding financial management and organisational training for those in administrative capacity in DoH and DSD to ensure the provision of an efficient supply of material and human resources, that could facilitate the adequate provision of care and support to children who are AIDS orphans living in township communities.
    - The other categories of staff related to the DoH and DSD e.g., procurement, with regard to people and material resources should be addressed.

- Reliable, professional and efficient communication, supply and feedback channels should be established for the provision of care and support to health and social care practitioners caring for and supporting children who are AIDS orphans living in township communities.
- Provision of material resources to the health and social care practitioners so they can give immediate practical assistance to AIDS orphans in the form of a food parcel, which can be given monthly until financial support is procured for the care giver, for the financial support of AIDS orphans.
- Money in the foster-care system should be diverted to the resourcing of a “kinship” grant; to be awarded through SASSA and not through the court system.
- Pharmaceutical companies who secure tenders to supply ART and other drugs within the scope of practice of the primary healthcare clinics could provide training for primary healthcare practitioners regarding optimal use of their drug products and the care and support required for patients receiving these drug products.

Strategy drivers are:

Policymakers

DoH, DSD

Managers at provincial level for DoH and DSD

Senior primary healthcare and social care practitioners

6.4.2.2 (a) Functional strategy: develop and support the capacity of the health and social care practitioners

Functional strategies are necessary to facilitate the provision of sufficient resources to health and social care practitioners in order for them to receive the care and support they also require as professionals to continue the provision of care and support to children who are AIDS orphans living in township communities.

- **Background information**

All the participants in this research study spoke about feeling overwhelmed in the workplace because of the incessant demands of their work, the enormity of the suffering they experienced daily and the frustration and anger they experienced working in inefficient systems with insufficient people and material resources to meet the overwhelming needs of AIDS orphans. They spoke about the risk of burnout and about the provision of help they needed as professionals to remain healthy in the work place. Caring for the carers is an important aspect for management in both the DoH ad DSD to consider.

- **Proposed outcome**

Improving the support and capacity of the health and social care professionals will enable them to be effective in the provision of holistic care and support to children who are AIDS orphans living in township communities.

- **Rationale**

Developing and implementing services which make provision for some of the care and support needs of professionals will enhance the development of resilience in health and social care practitioners. This will enable them to remain strong in the midst of a challenging working environment and allow for more efficiency regarding the provision of care and support to children who are AIDS orphans living in township communities.

- **Implementation activities**

Management in both the DoH and DSD should care for and support health and social care professionals in the following manner:

- ✓ Wellness programmes provided for health and social care practitioners should include;
  - ➢ Facilitation of training regarding physical wellness in terms of diet , exercise and management of stress
  - ➢ Coordination of stress-relief programmes to assist health and social care practitioners to develop healthy coping skills to manage stress related to their work
  - ➢ Facilitation of debriefing sessions monthly for health and social care practitioners, complete with action plans and feedback
- ✓ Create a communication channel between health and social care practitioners, management and policymakers so experiences and recommendations from health and social care practitioners can be heard by management and policymakers regarding the provision of care and support to AIDS orphans.

- ✓ Address working conditions allowing for the safety of health and social care practitioners, creating a safe working environment, allowing for meal breaks and facilitating a supportive relationship with management.
- ✓ Create a buddy system amongst health and social care practitioners to enable work colleagues to problem solve together and support one another
- ✓ Empower manager to seek assistance from local church and business leaders to run support groups for health and social care practitioners.

Primary healthcare and social care practitioners should assist one another regarding the development coping strategies related to their own professional role by:

- ✓ introducing a mentorship programme to assist new staff in their professional roles;
- ✓ encouraging the use of reflective journals to assist in reflective practice concerning the care and support of AIDS orphans (Johns, 2000: 42):
- ✓ coordinating support groups for health and social care practitioners to provide emotional and psychological support of health and social care practitioners:
- ✓ providing debriefing, regarding the suffering health and social care practitioners are exposed to, in providing care and support to AIDS orphans;
- ✓ encouraging facilitated workshops for health and social care practitioners with regard to staff health and wellness; and
- ✓ encouraging the attendance of health and social care practitioners at training workshops and conferences, related to staff health and the provision of holistic care and support for children who are AIDS orphans living in township communities.

Strategy drivers are:

DoH and DSD managers

Senior health and social care practitioners

NGO's

Business community

6.4.3 Strategy Three: Development of interdisciplinary collaboration

Collaboration is closely linked with coordination , i.e., to "work jointly on an activity or project" (Soanes and Stevenson, 2008: 280). Collaboration is a dynamic interpersonal process in which two or more individuals make a reciprocal commitment to interact authentically and constructively to solve problems and learn from one another to accomplish identified goals, purposes or outcomes. Collaboration which involves joint decision-making (McGee, 2009: 47), is necessary within all aspects of the multidisciplinary team regarding the provision of holistic care and support to children who are AIDS orphans living in township communities.

6.4.3.1 Grand strategy

Collaboration within the multidisciplinary team which requires implementation on a macro, meso and micro level is a prerequisite for the provision of holistic care and support to children who are AIDS orphans living in townships. These following strategies will enable primary healthcare and social care practitioners to provide holistic care and support to children who are AIDS orphans living in township communities.

6.4.3.1 (a) Develop interdisciplinary collaboration through coordination and cooperation.

In South Africa co-ordination of health services should be a priority due to the impending implementation of the NHI, but when creating strategies requiring co-operation and networking between different departments or organisations for the common good, institutional designs based upon strategy should be used as it is important that “structure must follow strategy and not strategy structure” (Minnaar, 2010: 123). Collaboration between the DoH, DSD, policymakers, managers and health and social care practitioners is imperative for the provision of holistic care and support to children who are AIDS orphans living in township communities.

- **Background information**

Historically, health and social care services in South Africa have been fragmented due to the present governments policies (Muller, 2009: 110), but now, several tiers of government responsibility ranging from macro (National), meso (provincial) and micro (local) levels have been highlighted regarding service delivery related to health and social care and support. “There is renewed political and policy commitments toward quality primary health care delivery, re orientation of health care workers, integration of primary care activities into other community- based development, improved management skills and effective coordination at all levels of the health system. There should also be optimal capacity building and skills development in problem-solving, communication, networking and community participation” (Dookie and Singh, 2012: 2).

The shift in focus introduced by the ANC government in 1994 from a hospital-centred policy to primary health care has added to the challenges in the co-ordination of services having to be addressed undoubtedly all policies require effective implementation in order to fulfil their purpose, a factor requiring significant effort in South Africa.

Collaboration of services is recognised by the WHO as an important method regarding the improvement of health and related service provision to low-and-middle-income countries (WHO, 2008a: 2), however, the report states that “collaboration must be seen as beneficial to both parties” which in this instance may include international organisations such as UNICEF, government departments and NGO’s. It will also include practitioners from different disciplines, in this instance primary healthcare and social care practitioners.

Private companies and corporations, as part of their social responsibility programmes, can be encouraged to assist with funding for specific projects (Kotler et al., 2002: 352). Cause-related marketing is becoming increasingly popular as companies often gain a larger market share by taking part (Kotler et al., 2002: 354). Coordination of these initiatives, which would be an important part of a National Strategy regarding the care and support of children who are AIDS orphans living in township communities, is required to ensure that the funds are used for their intended purposes and the efforts on the part of providers and sponsors are not wasted.

- **Proposed outcome**

An efficient and coordinated interdisciplinary approach adopted to provide holistic care and support to children who are AIDS orphans living in township communities.

- **Rationale**

For efficient service delivery to take place, the available services require a collaborative response through coordination. Participants in both groups of this study felt that the health and social care and support services were insufficient and inefficient regarding the provision of care and support to AIDS orphans. Owing to the rising numbers of children who are AIDS orphans it is vital that collaborative partnership are formed and maintained so that holistic care and support can be provided to meet the care and support needs of vulnerable children who are living as AIDS orphans in the township communities.

- **Implementation activities**

Collaboration of health and social care and support services to meet the needs of AIDS orphans should occur through collaborative responses to enable holistic care and support to be provided to AIDS orphans. Some activities which would improve a collaborative response are:

- Creating a forum for collaboration between international organisations, DoH and DSD, NGO's, managers and health and social care practitioners to enable pull through of policy to implementation.
- Developing more cause related marketing initiatives so that more resources can be generated to assist in the provision of care and support to AIDS orphans.
- Developing a data base highlighting government and NGO services caring and supporting AIDS orphans, and networking with local business to identify gaps in the services these government and NGO's have which could be met through increased financial support or availability of people resources through the business sector
- Facilitating TV- Media campaign "be involved" to encourage churches, business, school, retired people to become involved in working with NGO's government clinics as volunteers to become involved in the care and support of AIDS orphans.
- Encouraging retired professionals to coordinate small projects regarding the awareness of care and support needs of AIDS orphans. For example, through book clubs groups, societies, local churches and Rotary clubs to run initiatives to generate funds for School uniforms or food parcels for health and social care practitioners to give to AIDS orphans.
- Encouraging local newspapers, radio programmes and social media to pin-point how the local community can become involved in the care and support of AIDS orphans, for example through a "food bank" initiative to assemble food parcels to be distributed to clinics where health and social care practitioners are providing care and support to AIDS orphans.
- Enabling functional integration of the services providing care and support to AIDS orphans through the DoH and DSD to take place
- Making it easier to access services by:
    - providing for example a mobile clinic service specifically for children who are AIDS orphans living in the township communities and having a primary healthcare practitioner, social worker and psychologist on the mobile clinic to give care and support to AIDS orphans;
    - Facilitating social care practitioners and NGO workers going into schools to advise children and young people regarding the services available for providing care and support to children who are AIDS orphans living in township communities.

- Establish protocols to clarify position and responsibilities regarding each member of the multidisciplinary team with regard to the provision of care and support to AIDS orphans.
- Establish protocols to ensure that appropriate use is made of members of the multidisciplinary team with regard to the provision of care and support to AIDS orphans.

Strategy drivers are:

DoH, DSD

Ngo's Managers' Local TV and Radio station hosts and presenters,

Managers of local newspapers

Volunteers

Business and church community leaders

Health and social care practitioners

6.4.3.2 Functional Strategy

Coordination strategies are required to provide the necessary human and material resources in the DoH and DSD structures in order to facilitate an efficient provision of care and support to children who are AIDS orphans living in township communities

6.4.3.2 (a) Primary healthcare practitioners to facilitate the implementation of functional aspects related to coordinating the care and support response of the interdisciplinary team

In order for a strategy to be successful it has to be effectively implemented in the manner intended, which requires making use of available resources and the formation and good function of collaborative partnerships.

- **Background information**

The various roles of the primary healthcare practitioners described in Chapter Five lend themselves to the implementation of the functional aspects related to coordinating the care and support response of the multidisciplinary team to providing holistic care and support to children who are AIDS orphans living in townships. The role of the researcher in particular is required for compiling databases of information and for feedback on services provided regarding the provision of care and support to AIDS orphans (Reid et al., 2006: 11). Quality assurances surveys such as audits and competencies should also be implemented by the primary healthcare practitioner. Freely accessible information resources are an essential adjunct to collaborative initiatives. Suggestions made by participants included the need for centralised information facilities which persons requiring care and support for AIDS orphans could make use of in order to gain access to services for the provision of care and support while such information facilities can be coordinated by a primary healthcare practitioner, an alternative form of information facility is also the use of smart phones to utilise the Mobile Health Information System, which was introduced in public sector hospitals in the Nelson Mandela Bay in 2010 (van Zyl, 2010: 1). The smart phone gives access to library information resources which include guidelines on services relating to the care and support of children who are AIDS orphans living in township communities.

- **Proposed outcome**

Interdisciplinary collaboration through coordination will assist in the provision of holistic care and support to children who are AIDS orphans, living in township communities.

- **Rationale**

Collaboration through coordination will improve efficiency in the existing systems and effect a more comprehensive mobilisation of the provision of care and support to children who are AIDS orphans living in township communities. In this manner the intention of government policy regarding the “realisation of children’s rights” can be seen through efficient implementation.

- **Implementation activities**

The primary healthcare practitioner could assist in coordinating the care and support response of the interdisciplinary team in the following manner:

- Creating a resources catalogue of Government and NGO services who provide care and support for children who are AIDS orphans living in township
- Networking with NGO’s and professionals providing care and support to children who are AIDS orphans living in township communities
- Making use of market research methods to ascertain services caring for children who are AIDS orphans living in township communities and how to access them
- Liaising with community leaders

- Facilitating of community groups to assist in the care and support of children who are AIDS orphans living in township communities
- Facilitating a forum to invite social workers, psychologists and community volunteers to develop “action plans” for the coordination of care and support to children who are AIDS orphans living in townships. These action plans should involve specific targets and times for feedback. The plans should involve assessment of a problem, planning and intervention and also implementation and evaluation of the implementation. In this manner the response of the multidisciplinary team remains flexible to meet the specific care and support needs AIDS orphans.
- Utilising existing church, NGO and community groups such as Ubuntu, GoGo Trust, and the Missionvale care centre, to assist in the provision of care and support to AIDS orphans.
- Facilitating communication amongst role-players in health and social care to widen the availability and level of care and support provided by:
    - ✓ holding regular meetings which involve role players who provide care and support to AIDS orphans;
    - ✓ circulating notices of meetings, agendas and minutes of all meetings being circulated to all parties involved in the care and support of AIDS orphans; and
    - ✓ making use of newsletters to facilitate communication regarding initiatives concerning the provision of care and support to AIDS orphans.

- Implementing quality assurance and governance tools in all aspects related to the provision of care and support to AIDS orphans. Some examples of quality assurance tools which could be used include:
    - ✓ Auditing staff to assess work methods and knowledge and identify needs for further training.
    - ✓ Creating competencies to assist in the provision of staff trained for provision of care and support to AIDS orphans. Audit resources to ensure that adequate services are available to provide care and support to AIDS orphans.
    - ✓ Auditing of standard procedures regarding the care and support of AIDS orphans to ensure that they comply with best practice.
    - ✓ Auditing of service provision: ART medication and support medication supplies, food parcel provision, support group services for AIDS orphans living in the township communities.

- ✓ Benchmarking items to be identified and accessed to chart the progress of the release of care and support services to AIDS orphans. The following questions could be asked: (MAD, 2013: 1).
  - ➢ What are you doing?
  - ➢ How are you doing it?
  - ➢ How are others doing it?
  - ➢ How well are you doing it with reference to measure?
  - ➢ What and how can you or others improve?

- Collecting data for benchmarking on a macro, meso and micro level.
- Collecting and comparing local data with national levels to ascertain the effectiveness of the provision of holistic care and support needed for them.
- Compiling a data base concerning details of AIDS orphans which can be used by further research into the care and support of children who are AIDS orphans living in township communities.
- Encouraging assistance with research projects to improve the quality of care and support provided to children who are AIDS orphans living in township communities.
- Assisting in the coordination of research projects in all aspects related to the provision of care and support to children who are AIDS orphans living in township communities.
- Keeping a comprehensive record of all aspects of care and support given to each child who is an AIDS orphan living in the township community with particular regard to referrals made within the multidisciplinary team. These records should be kept by health and social care practitioners.
- Assisting in community development projects to enhance the provision of care and support to AIDS orphans.
- Setting up and facilitating community information centres regarding the provision of care and support to children who are AIDS orphans living in the township communities.
- Utilising the World Orphans Day as an opportunity to provide of information to the general public regarding the plight, care and support provisions needed for children who are AIDS orphans living in township communities.

Strategy drivers are:

UNICEF, Save the Children, UNAIDS, PEPFAR

DoH, DSD

NGO's;Business, church community leaders;Senior health and social care practitioners

6.4.4 Four: Facilitation of an empowering work environment for health and social care practitioners

A strategy to enable the facilitation of an empowering work environment for health and social care practitioners is essential for the adequate provision of holistic care and support to children who are AIDS orphans living in township communities in. A grand strategy is required to enable input from all stakeholders from a macro, meso and micro level so that all aspects relating to the provision of care and support to AIDS orphans can be considered and realistic implementation activities can be presented.

6.4.4.1 Grand strategy

This strategy requires human and material resources such as purpose-built facilities or adaptation of existing facilities; and the provision of specific resources to meet the care and support needs of children who are AIDS orphans living in township communities. The primary healthcare and social care practitioners are vital in the care and support response to these AIDS orphans; therefore they must be positioned in an empowering work environment.

6.4.4.1 (a) Development of orphan care centres "Ithemba Elitsha" (in Xhosa meaning "New Hope") within the existing health and social care systems

- **Background information**

During the course of this research study, the participants spoke about fragmentation of health and social care and support and also about the frustration they experienced because of hindrances in their current working environment and how these affected the manner in which they were able to provide care and support to AIDS orphans. This was extensively presented in chapter four of this study. Participants also spoke about the need for a better resourced working environment, in terms of people and material resources to enable the care and support needs of AIDS orphans to be met. The researcher met with a lawyer in Port Elizabeth during this research study, who discussed with her the writing of the Children's Act in South Africa and about the collaborative partnership between the National Prosecution Authority and the Thuthuzela centres (In the Xhosa language comfort centres) for persons who are victims of rape in South Africa. The reason for mentioning Thuthuzela centres is that the provision of them in South Africa establishes a working environment which facilitates and doesn't hinder the provision of care and support to persons who are survivors of rape. The working environment of the Thuthuzela centres facilitates a " process which ensures that service providers are available to a rape survivor in one location, rather than the person being shuttled through the criminal justice system" (UNICEF, 2008: 2). In this manner the working environment of the Thuthuzela centres enable the care and support needs of rape survivors to be met.

Thuthuzela centres are in operation in public hospitals, are an integrated strategy for prevention of, reaction to, and support of rape victims through an integrated approach including the following: interdepartmental collaboration from the following departments; Justice, Health, Education, Treasury, Correctional Services, Safety and Security, Local Government, Home Affairs, Social Development and designated civil society organisations. (UNICEF, 2008: 4). According to Advocate Majokweni "At the heart of the success of the Thuthuzela approach is the professional interface and a high degree of contact between the rape victim and the service providers" (UNICEF, 2008: 7). In the same manner "Ithemba Elitsha" centres could provide a working environment for health and social care professionals which is specifically resourced in both a human and material manner, to enable the provision of holistic care and support to children who are AIDS orphans living in township communities.

- **Proposed outcome**

To enable an interdisciplinary collaborative, integrated approach, with specific people resources and services, to enable the provision of holistic care and support to children who are AIDS orphans living in township communities in the township communities.

- **Rationale**

The facilitation of an empowering work environment will enhance the provision of holistic care and support to AIDS orphans by reducing the stress and frustration in the health and social care practitioners and through providing specific resources to meet the complex care and support needs of children who are AIDS orphans living in township communities.

- **Implementation activities**
  - Developing an "Ithemba Elitsha" action group, inviting all stake holders to assist with the planning of provision of holistic care and support to AIDS orphans though these centres. The following stakeholders should be involved:
    - ✓ DoH
    - ✓ DSD
    - ✓ Treasury

    - ✓ Policymakers
    - ✓ Provincial managers
    - ✓ NGO's
    - ✓ Business leaders
    - ✓ Home affairs
    - ✓ Researchers
    - ✓ Architects and building planners
- Planning for renovating existing buildings belonging to DoH or DSD, or building new purpose designed "Ithemba Elitsha" centres.
- Involving DoH and DSD researchers in the planning of the human and material resources required to provide the care and support services to meet the needs of AIDS orphans.
- Ensuring that primary healthcare practitioners caring for AIDS orphans, social workers and psychologists to be located in one place, whether in a new centre or in a renovated one.
- Enabling each practitioner to have a designated room to work in with the resources to ensure the provision of their specific care and support response, related to their professional discipline.
- Enabling each centre to have rooms in which support groups could be organised for AIDS orphans, grandmothers caring for AIDS orphans in their own families, CHH siblings or AHH caring for AIDS orphans, complete with a kitchen area toilet and bathroom facilities, materials for conducting discussion groups and workshops related to developing resilience in AIDS orphans and the well-being of those caring for them.
- Ensuring that the centres are decorated in ways which convey the message of "hope" and "future" to be spoken through every aspect of the interior décor and resources.
- Facilitating the culture of hope among the persons working with AIDS orphans, the focus on what "can be done" and not "what can't be done" and on "what we have" and not "what we don't have", rather than despondency and hopelessness.
- Providing a designated area within the "Ithemba Elitsha" centre for the storage and provision of food parcels, the responsibility for and the coordination of which should that of NGO's
- Creating a designated room for a visiting person from the Department of Home Affairs (a day a week) to assist families who are caring for AIDS orphans

regarding the documentation required, and how to attain it, for the application of welfare grants for AIDS orphans.

- Facilitating through partnership with local businesses, the setting up of "after-school-centres" within the "Ithemba Elitsha" centres where children who are AIDS orphans can come to do their homework. This can be overseen by retired teachers and social workers. A computer room, kitchen and dining room could be added to these centres, so children could be served a hot, nutritious meal, and those that are HIV-positive or who have TB could be given their ART and anti-TB medications at this time.

6.4.4.2 Functional strategies

In order for children who are AIDS orphans living in township communities to be holistically cared for and supported, health and social care practitioners need to be educated, resourced, cared for and supported.

6.4.4.2 (a) Education, care, support and resourcing of health and social carepractitioners, concerning the provision of care and support to children who are AIDS orphans living in township communities.

- **Proposed outcome**

Health and social care practitioners will be educated regarding the "life world" of AIDS orphans; cared for, supported and resourced in a working environment which enables the provision of holistic care and support to AIDS orphans.

- **Rationale**

The national Departments of Health and Social Development have an overall responsibility to ensure that all citizens in South Africa receive health and social care appropriate for their needs. Through the education of health and social care practitioners regarding "the life world" of children who are AIDS orphans living in township communities and the care, support and resourcing of health and social care practitioners, the provision of holistic care and support to children who are AIDS orphans living in township communities can be made possible.

- **Implementation activities**

- Provide workshops for health and social care practitioners, regarding the “life world” of children who are AIDS orphans living in township communities.
- Provide workshops regarding ART therapy to HIV-positive AIDS orphans
- Provide workshops regarding the “grant support” available to AIDS orphans and their caregivers
- Enable children who are AIDS orphans to speak to health and social care practitioners about their life experiences and their care and support needs
- Provide stress-management workshops for health and social care practitioners
- Provide monthly support groups for health and social care practitioners
- Provide resources for health and social care practitioners to enable them to facilitate running support groups for children who are AIDS orphans
- Improve the provision of monthly food parcels by the DSD to children who are AIDS orphans and who are waiting for the release of grant money to their caregivers.

6.5 EVALUATION OF STRATEGIES

Evaluation of the proposed strategies forms a part of the research process in order to establish trustworthiness of the study as described in Chapter Two. An expert panel was approached to evaluate the draft strategies. The comments of the members of the panel were incorporated into the final version of the strategies.

Specific criteria used for the evaluation of a nursing model were adapted to evaluate the proposed strategies in this study. The literature regarding the evaluation of nursing models and theories proposed a number of criteria which deal with both the internal and external validity of the proposed theories or models. The criteria which were selected for evaluation were derived from those suggested by Fawcett and Gigliotti (2013: 47-52), McKenna (1997: 227-235) and Pearson, Vaughn and Fitzgerald (1997: 27). The following criteria were selected as those common to the-afore mentioned authors and evaluate both the internal and external validity of the strategies: comments from the expert panel are written in italic:

6.5.1 Clarity of the strategies

The independent coder, and the researcher as well as the previously mentioned expert panel and the two promoters of the research study, found:

“the proposed strategies are clearly articulated in a manner that would be comprehensible to the range of practitioners for whom the strategies are intended”.

The researcher therefore concluded that the strategies were clear and understandable. The concepts are used in a manner which is consistent with the ‘“steps of progression”’ as identified during the development of the conceptual framework in chapter five of this study.

6.5.2 Simplicity of the strategies

The number of strategies and subsequent grand and functional developed were kept to a minimum to ensure clarity through simplicity. The following feedback was provided after the strategies had been given to the panel of experts:

“The strategies are simple to understand”

“I find the strategies clearly written and simple and logical to understand”

6.5.3 Generality of the strategies

The development of strategies to demonstrate provision of holistic care and support to children who were AIDS orphans living in township communities, was designed as a comprehensive tool for health and social care practitioners, in order to expedite the provision of holistic care and support to these AIDS orphans. Accordingly the research was contextual and the focus of the research study was not the generalisability of the data; but, these strategies have the capacity for broader generalisation, for example, in other primary healthcare clinics and satellite offices within other township communities in South Africa where children who are AIDS orphans living in these communities require the provision of holistic care and support.

“The strategies can, in my view, be transferred to other similar contexts in South Africa. Such transfer would need to acknowledge that are always nuanced differences in different community contexts”.

“Yes the strategies can be transferred to other contexts in South Africa”

6.5.4 Accessibility of the strategies

The definitions provided for the concepts for the development of the strategies reflect their meaning and thus ensure accessibility of the strategies. The outcomes identified in the strategies project the strategies as attainable.

“The focus on the policy level and advocacy is an important contribution – this needs further attention in the training alluded to in ***6.4.1.2 (c)*** *as it is my experience that advocacy, policy*

analysis and policy development are not part of the generic skills sets of most professionals. I would also suggest that the functional strategies focus not only on policy implementation and advocacy but both sets of professionals need to be actively engaged in influencing legislation and policy – this completes the cycle so to speak.”

“They are to be comprehensive and implementable and I enjoyed reading them.”

6.5.5 Significance of the strategies

Strategies to demonstrate the provision of holistic care and support to children who are AIDS orphans living in township communities have been developed to assist in the process of making legislative and policy frameworks implementable. The strategies are not ambiguous and do present solution to the Strategy drivers in clear continuous steps using the “steps of progression”. The following comments were made by the expert panel.

“The growing incidence of OVCs necessitates action beyond legislation and policy to ensure that these children’s basic constitutional rights are met. Such needs are not the purview of a single government department or professional group and thus strategies for inter-departmental and inter-disciplinary collaboration are crucial.”

“These strategies are significant as they present implementable solutions to an area of great need in our country”

It is evident that the strategies comply with the criteria of Fawcett and Gigliotti (2013: 47-52); in that they are clear, simple, general, accessible and significant/important in confirming the purpose of this research namely, the development of strategies to provide holistic care and support to children who are AIDS orphans living in township communities.

6.6 CHAPTER SUMMARY

The focus of this chapter was on the development of strategies to provide holistic care and support to children who are AIDS orphans living in township communities. The development of the strategies and implementation activities presented for the ‘“steps of progression”’ strategies were explained. The conclusion, limitations and recommendations of this research study are presented in the next chapter.

CHAPTER SEVEN

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

“Organisation is what you do before you do something, so that when you do it, it’s not all mixed up.”

(Milne and Shepard, 2002: 329)

7.1 INTRODUCTION

“ Steps of Progression” strategies to assist primary health and social care practitioners to enable the provision of holistic care and support to children who are AIDS orphans living in township communities were presented in chapter six of this research study. Chapter seven will focus on conclusions, limitations and recommendations for nursing practice, education and further research.

7.2 CONCLUSIONS

In this study, the researcher’s objectives were to explore current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa; explore and describe the experiences of primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS orphans living in the township communities and to explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in township communities. The purpose of the study was to utilise the data collected to create a conceptual framework which would form the basis of strategies which could be used by the DoH and DSD and health and social care practitioners to assist in the provision of holistic care and support to children who are AIDS orphans living in township communities.

A qualitative, exploratory, descriptive contextual research design was used to create understanding of the experiences of health and social care practitioners who render care and support to children who are AIDS orphans living in township communities. The study was conducted in four phases: the first of which consisted of an overview of International and the South African government’s legislative policy frameworks concerning the rights of children living in South Africa. Phase two included the research population and sampling procedure, the data-collection process and data analysis. A comprehensive literature control formed part of phase two. Phase three consisted of the compilation of a conceptual framework which was done with reference to the survey list of aspects of activity identified by Dickoff et al. (1968: 422). This conceptual framework was used during the formation of the "Steps of Progression" strategies. Phase four consisted of the development of strategies using the steps of progression which were developed to assist in the provision of holistic care and support to children who are AIDS orphans living in township communities.

The following research objectives were identified for this research study, namely to:

- explore current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa
- explore and describe the experiences of primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS orphans living in the township communities,
- explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the township communities,
- create a conceptual framework for the care and support of children who are AIDS orphans living in township communities and
- develop strategies that could be embraced by the Departments of Health and Social Development to enable primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists to facilitate care and support to children who are AIDS orphans living in the township communities.

Each objective will be individually reviewed to assess whether it has been achieved during this research study.

- **To explore current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa**

Analysis of current literature concerning the rights of children living in South Africa is voluminous and complex. There are many international conventions, treaties and covenants signed, ratified and acceded to by the South African Government. The expression of these international laws is contained within the "Bill of Rights" pertaining to the rights of children living in South Africa found in the constitution of South Africa; further expression of the "Bill of Rights" is found in national, and provincial legislative and policy frameworks, which are comprehensive in their written intention yet find poor expression in implementation. A comprehensive literature review presented in chapter three of this research study presents the international, national and provincial legislative and policy frameworks concerning children's rights in South Africa. There exists in South Africa a dichotomy between the intention of justice expressed by the South African Government and the injustice of poor service delivery to the poor and inept management. The tension of this dichotomy held in this instance by health and social care practitioners and expressed and represented in chapter four of this study. Unless children's rights are brought into the homes of African children, they will remain paper rights with no significant contribution towards securing the dignity of African children (Kaime, 2009: 189).

The objective of exploring current international, national and provincial legislative and policy frameworks concerning the rights of children living in South Africa was achieved in Chapter three of this research study.

- **To explore and describe the experiences of primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS orphans living in township communities.**

Analysis of the data obtained in the in-depth interviews with primary healthcare practitioners yielded a lot of data. Participants acknowledged a vast array of negative but also some positive experiences regarding how they experienced providing care and support to children who were AIDS orphans living in township communities**.** The primary healthcare practitioners were pleased and willing to share their experiences with the researcher in a deep, respectful, open and meaningful manner. These practitioners were mostly overwhelmed by the suffering they experienced daily in their professional interaction with children who were AIDS orphans living in township communities. They were also frustrated and angered by the inefficiency of the health and social systems in which they worked; but in the midst of challenges these practitioners had developed professional resilience and had innovative suggestions regarding how to improve the provision of care and support to children who were AIDS orphans living in township communities.

The objective of exploring and describing the experiences of primary healthcare practitioners working in primary healthcare clinics providing care and support to children who are AIDS orphans living in township communities was achieved with a description of the themes presented in chapter four of this research study.

- **To explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the township communities**

Analysis of the data obtained from in-depth interviews with social workers and psychologists working in satellite offices in the township communities, providing care and support to children who are AIDS orphans living in these communities, identified a number of themes, many of which supported the data analysis of the Group One participants. Social workers and psychologists have different professional responsibilities which was reflected in the data gathered from in-depth interviews with these participants. Social workers revealed how they also felt overburdened by the suffering the witness in caring for and supporting children who were AIDS orphans and the frustration and anger they felt regarding the inefficient systems within the Social Development in which they worked. Psychologists explained the challenges of providing care and support to AIDS orphans who experienced profound psychological disturbance due to multiple losses, trauma and complicated grief. These professionals were also willing to share the depth of their experiences in a manner which gave a lot of insight to the researcher.

The objective of exploring and describing the experiences of social workers and psychologists who were providing care and support to children who were AIDS orphans living in township communities was achieved with the presentation of themes in chapter four of this research study.

- **To create a conceptual framework for the care and support of children who are AIDS orphans living in township communities**

A conceptual framework for the provision of holistic care and support to children who are AIDS orphans living in township communities was created, making use of a survey list as described by Dickoff, et al.(1968: 421). The aspects of the list which were used in the creation of the conceptual framework were context, agent, recipient, procedure, dynamics and terminus or goal. During development of the conceptual framework, the concept of the expert panel as a sub-agent was also included. A major concept which was identified during the data analysis and coding process was that of the provision of holistic care and support to children who are AIDS orphans living in township communities.

The objective of the process of development of a conceptual framework has been achieved through the description of the conceptual framework presented in chapter five of this study.

- **To develop strategies that could be embraced by the Departments of Health and Social Development to enable primary healthcare practitioners working in primary healthcare clinics, social workers and psychologists to facilitate care and support to children who are AIDS orphans living in township communities**

Strategies to provide holistic care and support to children who are AIDS orphans living in township communities were identified. The strategies were designed to assist the DOH, DSD, health and social care practitioners working in the township communities who provide holistic care and support to children who are AIDS orphans living in these communities. Each strategy was presented and described on both a grand (macro and meso) and functional (micro) levels. Four strategies were identified and named the "steps of progression" to facilitate the provision of holistic care and support to children who are AIDS orphans living in township communities.

The first "steps of progression" strategy devise was for the strengthening of existing legislative and policy frameworks in which health and social care practitioners' work. This included the development of health and social development policies and legislation concerning the provision of holistic care and support to AIDS orphans living in township communities. On a macro level a national holistic care and support strategy is required, possibly through a children's charter for the provision of care and support to AIDS orphans. A national strategy will also assist in the provision of resources for the implementation of functional strategies on a micro level.

Enhancing the resilience of health and social care practitioners addressed the need for care and support of health and social care practitioners working under difficult and frustrating circumstances and with inefficient systems. Grand strategies include the provision of people and material resources to effect the provision of care and support to children who are AIDS orphans living in township communities. A functional strategy was presented to develop and support the capacity of health and social care practitioners, an aspect of which was to provide debriefing and support groups for health and social care practitioners who provide care and support to children who are AIDS orphans living in township communities.

Development of interdisciplinary collaboration and collaboration of the multidisciplinary team through coordination is essential. Collaborative responses were seen to include forum discussions, networking, development of databases and the use of media to engage business, NGO and volunteer sectors. Interdisciplinary collaboration is seen as essential in order for the provision of holistic care and support to children who are AIDS orphans living in township communities to be effectively implemented.

Facilitation of an empowering work environment was presented by the creation of "Itemba Elitsha" centres which could be created through the adapting of buildings already owned by the DoH and DSD or with investment in the building of purpose-built centres. In this manner a working environment could be created to assist health and social care practitioners to meet the specific care and support needs of children who are AIDS orphans living in township communities.

A description of the "steps of progression" strategies to enable the provision of holistic care and support to children who are AIDS orphans living in township communities and the implementation activities related to these strategies was presented in chapter six of this research study. Chapter six also included an evaluation of the strategies by an expert panel.

The following five criteria suggested by Chinn and Kramer (2008: 205) were used for critically reflecting theory and to evaluate the strategies:

- Clarity
- Simplicity
- Generality
- Accessibility
- Importance and significance

In the light of the above discussion, it can be concluded that the objectives of this research study were met.

7.3 LIMITATIONS OF THIS STUDY

The following limitations were noted during the research process:

- The study was limited to health and social care practitioner working in the Nelson Mandela Bay Municapalities. There was no input from health and social care practitioners caring for and supporting children who are AIDS orphans living in township communities in outlying semi-rural areas or working in other township communities outside Nelson Mandela Bay Municipalities.
- There was found to be a paucity of accurate statistical data on a national and district level regarding the number of children who are AIDS orphans in general.

7.4 RECOMMENDATIONS

The following recommendations are made by the researcher with regard to strategies to be implemented on a macro or meso level.

7.4.1 Recommendations for strategies to be implemented on a Macro or Meso level

As explained in chapter six, the primary health and social care practitioners are unable to implement functional strategies if action is not initiated at a macro or meso level. It is recommended that the following grand strategies be implemented

- Develop a South African “Children’s Charter” specifically regarding the realisation of rights for children who are AIDS orphans living in township communities
- Develop a national care and support strategy for the provision of care and support to children who are AIDS orphans living in township communities.
- Provide resources for activities as discussed in *Strategy One of Chapter*
- Coordinate health and social care people and material resources in such a manner as to improve the efficiency in both systems (*see Strategy Three coordination).*

7.4.2 Recommendations for nursing practice

The following recommendations are made by the researcher concerning nursing practice:

- Greater priority should be given to the resourcing and coordination of health and social care systems in the Nelson Mandela Bay to provide a well-resourced and coordinated care and support response to children who are AIDS orphans living in township communities.
- Policymakers and senior management in the DoH and DSD should be made aware of the findings of this research study as it presents the views of Government-employed health and social care practitioners who provide care and support to children who are AIDS orphans living in township communities. Articles in relevant health and social care peer-review journals and presentations at a research conference attended by policy makers will also aid in the dissemination of these findings.
- Guideline documents regarding the care and support of AIDS orphans living in township communities should be made available to health and social care practitioners who render care and support to these vulnerable children.
- A standardised training programme based upon these strategies should be implemented to health and social care practitioners providing care and support to children who are AIDS orphans living in township communities
- These strategies should be used in any PHC clinic or satellite office in the township community where health and social care practitioners are rendering care and support to children who are AIDS orphans living in these communities

7.4.3 Recommendations for nursing research

The following recommendations are made by the researcher with regard to research:

- The research study could lead to further investigation within the quantative paradigm in order to confirm the results of this study quantitatively.

- Similar research studies could be conducted in other provinces in South Africa. Assessments could be made to agree on transferability as applied in a wider perspective
- The strategies could be applied to the nursing and social care policy-making and practice environment of the provision of holistic care and support to children who are AIDS orphans living in township communities.
- Further research could be focused on many of the aspects covered in the data - analysis chapters, such as the need for interdisciplinary collaboration and the need for an empowering work environment.
- Further research could also focus on the rural and semi/rural township communities

7.4.4 Recommendations for nursing education

The following recommendations are made by the researcher with regard to nursing education:

- The strategies should be included and used as a frame of reference in undergraduate as well as post-graduate nursing education programmes pertaining to the provision of care and support to children who are AIDS orphans living in township communities.
- The strategies have a practical application regarding the provision of care and support to children who are AIDS orphans living in township communities. It’s essential that such aspects are related through education to health and social care practitioners.
- Training courses for health and social care practitioners should include how to provide holistic care and support to children who are AIDS orphans living in township communities.

7.4.5 Unique contribution of research

- The “steps of progression” strategies approach to the provision of holistic care and support to children who are AIDS orphans living in township communities is unique in that the implementation activities of the strategies are comprehensive, affordable and implementable.
- Since a qualitative research approach was used results were obtained directly from health and social care practitioners rendering care and support to children who are AIDS orphans living in township communities. In other words, in-depth individual interviews were used so that all participants could describe and discuss their experiences in a meaningful, honest manner in a setting conducive to disclosure.

- Through this research study, it is considered that, policy makers, managers within the DSD and DoH, and health and social care practitioners could gain a wider understanding regarding what is required to bring about the provision of holistic care and support to children who are AIDS orphans living in township communities
- The "steps of progression" strategies could be used to assist DoH, DSD and the health and social care practitioners working within these systems to provide holistic care and support to AIDS orphans living in township communities.
- The "steps of progression" strategies could provide DoH and DSD with an informed perspective regarding the challenges currently experienced by health and social care practitioners who provide care and support to children who are AIDS orphans living in township communities.

7.4 CHAPTER SUMMARY

"Do all the good you can, in all the ways you can, with all that you have, for as long as you can" John Wesley's rule of life in (Bartlett, 2002: 106).

In this final chapter the researcher has provided an overview of the overall research process and an account of the purpose and achievement of the objectives of the research study. The limitations of the study were accentuated and recommendations were made for nursing practice, research and education.

The researcher believes that the "steps of progression" strategies could be implemented by policymakers, DSD, DoH and health and social care practitioners working in PHC clinics and satellite offices in township communities who provide care and support to children who are AIDS orphans living in these communities.

This would be a further step to ensure that children who are AIDS orphans living in townships are well cared for and supported as in alignment with the "Bill of Rights" enshrined in the constitution of the Republic of South Africa.

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Appendix A: Information letter for Participants

Faculty of Health sciences

Department of Nursing Science

NMMU

Tel: +27 (0)41 504-2962 Fax: +27 (0)41-504-2616

26th April 2012-03-26.

Ref H12-HEA-NUR-001

Contact person: Miss S. L. Frood

Dear Participant,

You are being asked to participate in a research study. I will provide you with the necessary information to assist you to understand the study and explain what would be expected of you (participant). These guidelines would include the risks, benefits, and your rights as a study subject. Please feel free to ask the researcher to clarify anything that is not clear to you.

To participate, it will be required of you to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions.

You have the right to query concerns regarding the study at any time. Immediately report any new problems during the study, to the researcher. Telephone numbers of the researcher are provided. Please feel free to call these numbers.

Furthermore, it is important that you are aware of the fact that the ethical integrity of the study has been approved by the Research Ethics Committee (Human) of the university. The REC-H consists of a group of independent experts that has the responsibility to ensure that the rights and welfare of participants in research are protected and that studies are conducted in an ethical manner. Studies cannot be conducted without REC-H's approval. Queries with regard to your rights as a research subject can be directed to the Research Ethics Committee (Human), Department of Research Capacity Development, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

If no one could assist you, you may write to: The Chairperson of the Research, Technology and Innovation Committee, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

Participation in research is completely voluntary. You are not obliged to take part in any research. If you choose not to participate in medically related research, your present and/or future medical care will not be affected in any way and you will incur no penalty and/or loss of benefits to which you may otherwise be entitled.

If you do partake, you have the right to withdraw at any given time, during the study without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination in order to terminate the research in an orderly manner.

If you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes that it is not in your best interest to continue in this study, or for administrative reasons, your participation maybe discontinued. The study may be erminated at any time by the researcher, the sponsor or the Research Ethics Committee (Human).

Although your identity will at all times remain confidential, the results of the research study may be presented at scientific conferences or in specialist publications.

This informed consent statement has been prepared in compliance with current statutory guidelines.

Yours Sincerely,

Miss S. L. Frood

Appendix B: Request for permission to conduct research District Health Manager

Nelson Mandela Metropolitan University
for tomorrow

• PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

26th April 2012 .

Department of Health

Nelson Mandela Bay Health District Office

Conyngham Road

Parsons Hill

Port Elizabeth.

For attention: The District Manager: Mr T Oliver

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT PRIMARY HEALTH CARE CLINICS IN THE TOWNSHIPS IN NELSON MANDELA BAY

Dear Mr Oliver,

My name is Sharron Frood I am from the UK and currently studying as a Doctoral student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Doctoral thesis involves developing strategies to provide care and support for children orphaned by AIDS living in township. This project will be conducted under the supervision of Prof R. M van Rooyen

(NMMU, South Africa) and Dr E. J Ricks (NMMU, South Africa).

The aims of this research study are as follows:

- To explore current international, national and provincial legislative policy frameworks, in South Africa and write an analysis of current legislative, policy frameworks, concerning the rights of children living in South Africa
- To explore and describe the experiences of professional nurses in primary health care clinics in providing care and support to children living as AIDS orphans in the townships.
- To explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships
- To create a conceptual framework for the care and support of children who are AIDS orphans living in townships
- To develop strategies that can be used for the provision of care and support to children orphaned by AIDS living in the townships.

I am hereby seeking your consent to approach the staff at various Primary Health Care Clinics to request permission to interview the healthcare personnel involved in caring and supporting children living as AIDS orphans in townships. The staff will be asked to participate and are not forced to do so, this will be voluntary on their part. Each staff member will have a 45 minute interview with me.

I have provided you with a copy of my proposal which includes copies of the consent to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health (Nelson Mandela Bay Health District office) with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 041 3683442 or sharron@gogotrust.com . Thank you for your time and consideration in this matter.

Yours sincerely,

Miss Sharron L Frood

Nelson Mandela Metropolitan University

Appendix C: Request for permission to conduct research Executive Manager HealthNelson Mandela Bay

Nelson Mandela Metropolitan University
for tomorrow

• PO Box 77000 • Nelson Mandela Metropolitan University
• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

26th April 2012.

Nelson Mandela Bay Municipality: Health Services

Executive Director Public Health

Port Elizabeth.

For attention: Dr E. Chabula-Nxiweni

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT PRIMARY HEALTH CARE CLINICS IN THE TOWNSHIPS IN NELSON MANDELA BAY

Dear Dr, Chabula-Nxiweni,

My name is Sharron Frood I am from the UK and currently studying as a Doctoral student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Doctoral thesis involves developing strategies to provide care and support for children orphaned by AIDS living in township. This project will be conducted under the supervision of Prof R. M van Rooyen (NMMU, South Africa) and Dr E. J Ricks (NMMU, South Africa).

The aims of this research study are as follows:

- To explore current international, national and provincial legislative policy frameworks, in South Africa and write an analysis of current legislative, policy frameworks, concerning the rights of children living in South Africa
- To explore and describe the experiences of professional nurses in primary health care clinics in providing care and support to children living as AIDS orphans in the townships.

- To explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships
- To create a conceptual framework for the care and support of children who are AIDS orphans living in townships
- To develop strategies that can be used for the provision of care and support to children orphaned by AIDS living in the townships.

I am hereby seeking your consent to approach the staff at various Primary Health Care Clinics to request permission to interview the professional nurses, social workers and psychologists involves in providing care and support to children living as AIDS orphans in townships. The staff will be asked to participate and are not forced to do so; this will be voluntary on their part. Each staff member will have a 45 minute interview with me.

I have provided you with a copy of my proposal which includes copies of the consent and s to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health (Nelson Mandela Bay Health District office) with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 076 566 1937 or sharron@gogotrust.com . Thank you for your time and consideration in this matter.

Yours sincerely,

Miss Sharron L Frood

Nelson Mandela Metropolitan University

Appendix D: Informed Consent Form

NELSON MANDELA METROPOLITAN UNIVERSITY

Information and informed consent form

Researchers Details

Title of the research study	Strategies to provide care and support to AIDS orphans in township communities
Reference number	
Principal investigator	Miss S.L. Frood
Address	53 Both Street Mount Pleasant Port Elizabeth
Postal code	6045
Contact number	076 577 1937

A. DECLARARTION BY THE PARTICIPANT **Initial** **Signature**

I THE PARTICIPANT

ID number

Address

I the participant confirm as follows: I was invited to participate in the above mentioned research project which is being undertaken my Miss S L Frood from the Nursing Science Department of the Nelson Mandela metropolitan University

No pressure was exerted upon be by the researcher to consent or to participate in this research study and I understand that I can withdraw at any time without penalisation

Participation in this study will result in no cost to me

A1 **I HEARBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVEN MENTIONED STUDY**

Signature / confirmed at on day 2013

Signature of witness

Full Name of Witness

B	**STATEMENT ON BEHALF OF INVESTOGATOR**	Initial of investigator
1	**Miss S L Frood: I declare that:** have explained the information in this document to : Name of the participant	
2	He/ She was encouraged and given time to ask me any questions	
3	The conversation was conducted in (Please circle) English Xhosa Afrikaans Other	
4	And no translator was used OR this conversation was translated into (language) By	
5	I have detached Section D and handed it to the participant	

B	**THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT**		Initial
2.1	**Aim:**	The investigator is studying the experiences of health and social care practitioners in caring for and supporting children who are AIDS orphans living in township communities; The information will be used to/for Developing strategies to provide care and support to children who are AIDS orphans living in township communities	
2.2	**Procedures:**	I understand that I will be interviewed and that the interview will be recorded with the use of a digital tape recorder	
2.3	**Risks:**	None	
2.4	**Possible benefits:**	As a result of my participation in this research study, the researcher will be informed regarding what my experiences are regarding providing care and support to children who are AIDS orphans living in township communities	

2.5 Confidentiality:	My identity will not be revealed in any discussion, description or scientific publications by the investigator
2.6 Access to findings:	Any new information or benefit that develops during the curse of the study will be shared as follows:
2.7 Voluntary participation/ refusal/ discontinuation:	My participation is voluntary YES NO My decision whether to participate will in no way affect my present or future care/ employment/ lifestyle **TRUE** **FALSE**

C. THE INFORMATION ABOVE WAS EXPLAINED TO ME/ THE PARTICIPANT BY:

Initial

Sharron Frood using the English language
I the participant am in command of this language
I was given opportunity to ask questions and all of these questions were answered satisfactorily

D. IMPORTANT MESSAGE TO PARTICIPANT/ PATIENT/ REPRESENTATIVE OF PARTICIPANT

Dear participant/ patient/ representative of participant,

Thank you for your participation in this research study. Should you at any time during the study:

- An emergency arise as a result of the research, or
- You require any further information with regard to the study, or
- The following occur:
  - Should you feel that you are unhappy, sad or unable to cope following the interview, or worried for any reason with regard to the research interview kindly contact Miss S.L.Frood on 076 566 1937

Appendix E: Letter of permission to Sisters in Charge of PHC Clinics

Nelson Mandela Metropolitan University
for tomorrow

• PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

26th April 2012.

For attention: Professional Nurse in Charge of Primary Health Care Clinic

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT PRIMARY HEALTH CARE CLINICS IN THE TOWNSHIPS IN NELSON MANDELA BAY

Dear Sister in Charge,

My name is Sharron Frood I am from the UK currently studying as a Doctoral student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Doctoral thesis involves developing strategies to provide care and support for children orphaned by AIDS living in townships. This project will be conducted under the supervision of Prof R. M van Rooyen (NMMU, South Africa) and Dr E. J Ricks (NMMU, South Africa).

The aims of this research study are as follows:

- To explore current international, national and provincial legislative policy frameworks, in South Africa and write an analysis of current legislative, policy frameworks, concerning the rights of children living in South Africa
- To explore and describe the experiences of professional nurses in primary health care clinics in providing care and support to children living as AIDS orphans in the townships.
- To explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in the townships
- To create a conceptual framework for the care and support of children who are AIDS orphans living in townships

- To develop strategies that can be used for the provision of care and support to children orphaned by AIDS living in the townships.

I am hereby seeking your consent to approach the staff at various Primary Health Care Clinics to request permission to interview the healthcare personnel involved in caring and supporting children living as AIDS orphans in townships. The staff will be asked to participate and are not forced to do so, this will be voluntary on their part. Each staff member will have a 45 minute interview with me.

I have provided you with a copy of my proposal which includes copies of the consent and s to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health (Nelson Mandela Bay Health District office) with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 041 3683442 or sharron@gogotrust.com . Thank you for your time and consideration in this matter.

Yours sincerely,

Miss Sharron L Frood

Nelson Mandela Metropolitan University

Appendix F: Request for Permission to conduct research Executive Manager Department of Social Development Eastern Cape

• PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

Nelson Mandela Metropolitan University

for tomorrow

26th April 2012

Nelson Mandela Bay Department of Social Development

For attention: Mrs T Tatchell

Beacon Hill Office Park

Department of Social Development

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT SATELITE OFFICES FOR SOCIAL WORKERS IN THE NELSON MANDELA BAY

Dear Mrs Tatchell,

My name is Sharron Frood I am from the UK currently studying as a Doctoral student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Doctoral thesis involves developing strategies to provide care and support for children orphaned by AIDS living in townships. This project will be conducted under the supervision of Prof R. M van Rooyen (NMMU, South Africa) and Dr E. J Ricks (NMMU, South Africa).

The aims of this research study are as follows:

- To explore current international, national and provincial legislative policy frameworks, in South Africa and write an analysis of current legislative, policy frameworks, concerning the rights of children living in South Africa
- To explore and describe the experiences of professional nurses in primary health care clinics in providing care and support to children living as AIDS orphans in the townships.
- **To explore and describe the experiences of social workers** and psychologists who provide care and support to children who are AIDS orphans living in townships
- To create a conceptual framework for the care and support of children who are AIDS orphans living in townships

- To develop strategies that can be used for the provision of care and support to children orphaned by AIDS living in the townships.

I am hereby seeking your consent to approach the staff at various satellite offices in the townships in the Nelson Mandela Bay to request permission to interview social workers involved in providing care and support to children who are AIDS orphans living in townships. The social workers will be requested to participate and not coerced in any way to do so; this will be voluntary on their part. Each social worker would be requested to have a 45 minute interview with me.

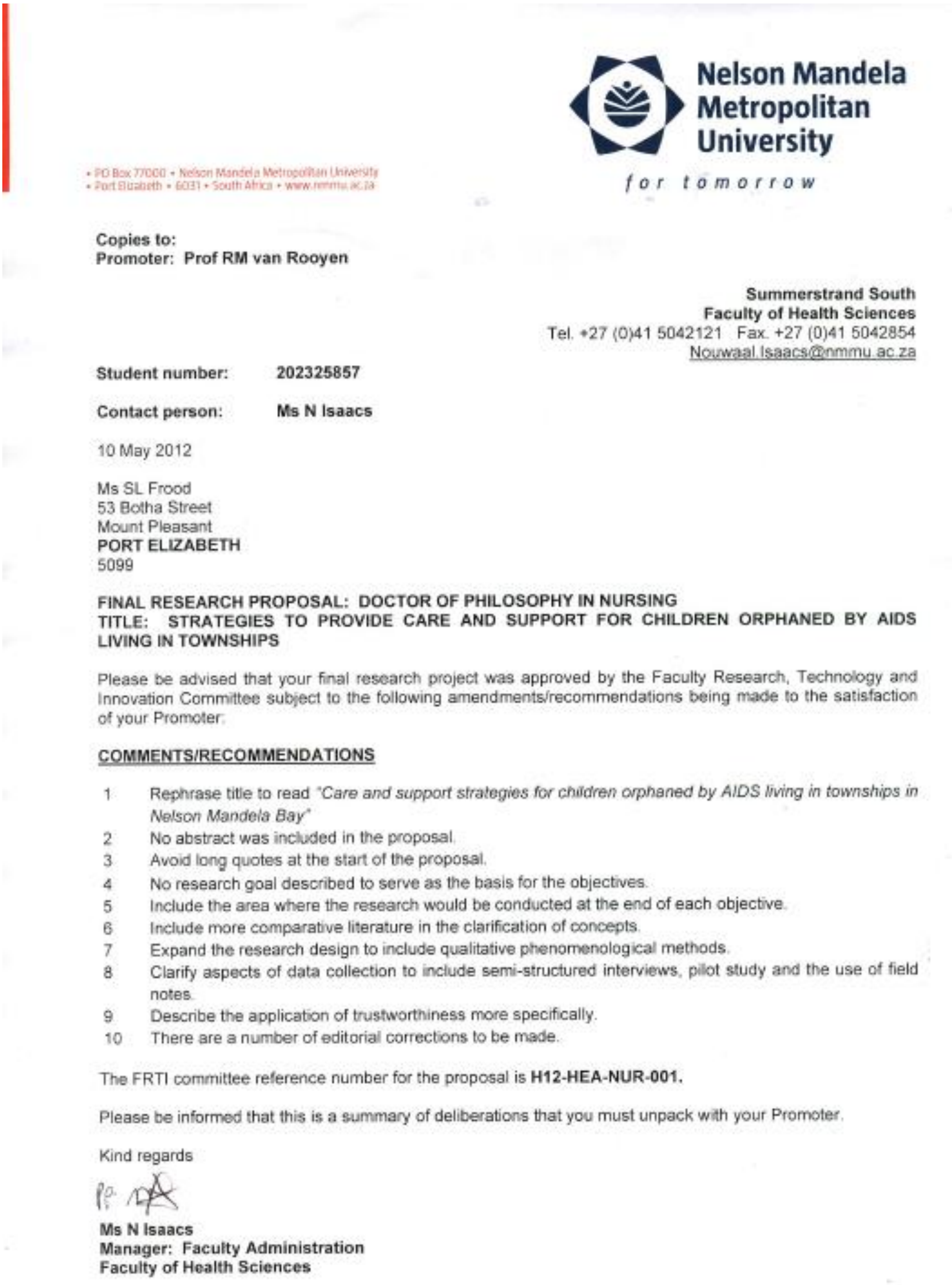
I have provided you with a copy of my proposal which includes copies of the consent form to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the NMMU library with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 076 566 1937 or sharron@gogotrust.com . Thank you for your time and consideration in this matter.

Yours sincerely,

Miss Sharron L Frood (Nelson Mandela Metropolitan University)

Appendix G: Faculty of Health Science Research Technology and Innovation Committee Permission to Conduct Research



Nelson Mandela Metropolitan University
for tomorrow

• PO Box 77000 • Nelson Mandela Metropolitan University
• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

Copies to:
Promoter: Prof RM van Rooyen

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042854
Nouwaal.Isaacs@nmmu.ac.za

Student number: **202325857**

Contact person: **Ms N Isaacs**

10 May 2012

Ms SL Frood
53 Botha Street
Mount Pleasant
PORT ELIZABETH
5099

FINAL RESEARCH PROPOSAL: DOCTOR OF PHILOSOPHY IN NURSING
TITLE: STRATEGIES TO PROVIDE CARE AND SUPPORT FOR CHILDREN ORPHANED BY AIDS LIVING IN TOWNSHIPS

Please be advised that your final research project was approved by the Faculty Research, Technology and Innovation Committee subject to the following amendments/recommendations being made to the satisfaction of your Promoter:

COMMENTS/RECOMMENDATIONS

1 Rephrase title to read *"Care and support strategies for children orphaned by AIDS living in townships in Nelson Mandela Bay"*
2 No abstract was included in the proposal.
3 Avoid long quotes at the start of the proposal.
4 No research goal described to serve as the basis for the objectives.
5 Include the area where the research would be conducted at the end of each objective.
6 Include more comparative literature in the clarification of concepts.
7 Expand the research design to include qualitative phenomenological methods.
8 Clarify aspects of data collection to include semi-structured interviews, pilot study and the use of field notes.
9 Describe the application of trustworthiness more specifically.
10 There are a number of editorial corrections to be made.

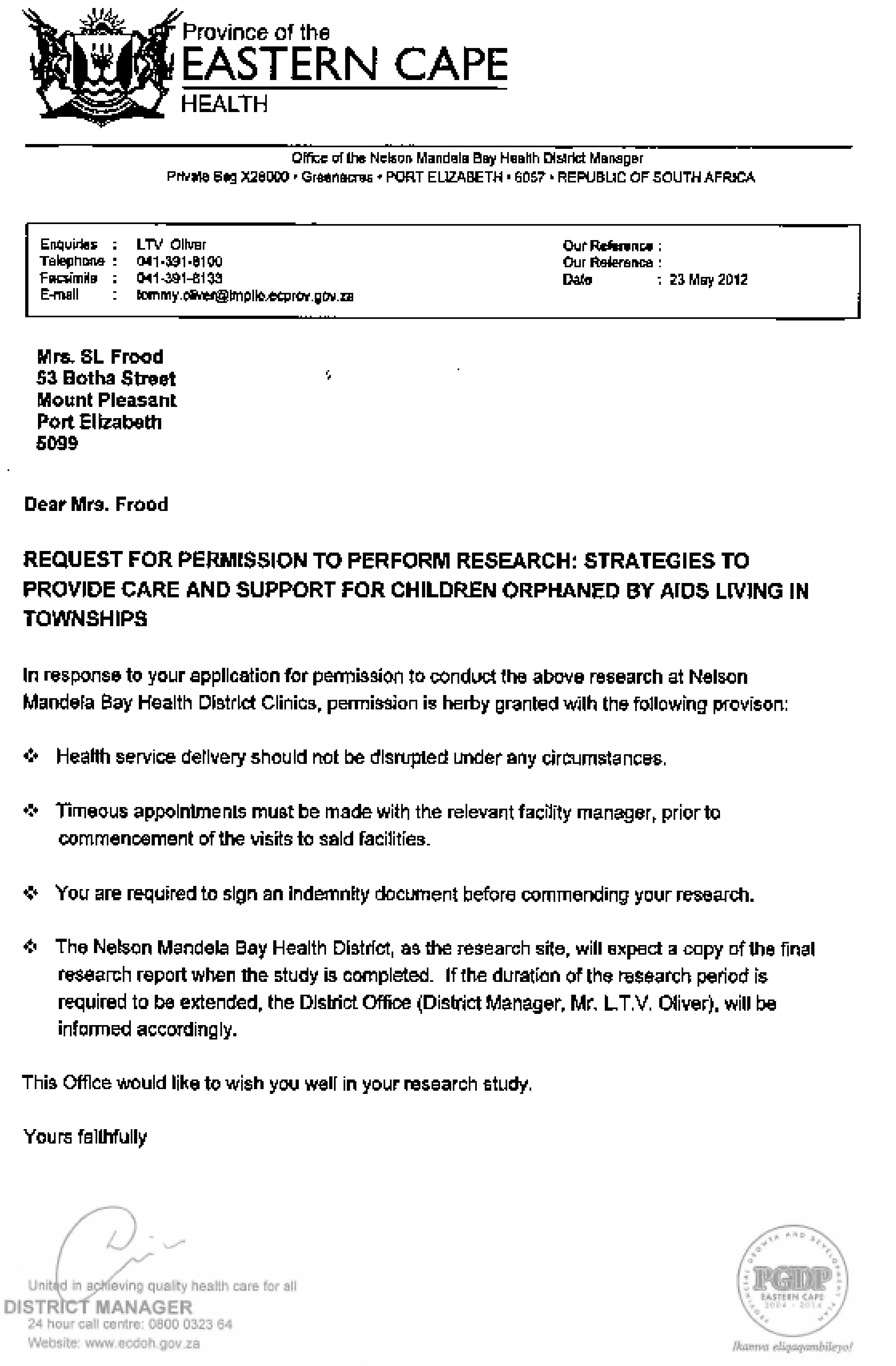
The FRTI committee reference number for the proposal is **H12-HEA-NUR-001.**

Please be informed that this is a summary of deliberations that you must unpack with your Promoter.

Kind regards

Ms N Isaacs
Manager: Faculty Administration
Faculty of Health Sciences

Appendix H: Letter of Permission from Eastern Cape Department of Health



Province of the
EASTERN CAPE
HEALTH

Office of the Nelson Mandela Bay Health District Manager
Private Bag X28000 • Greenacres • PORT ELIZABETH • 6057 • REPUBLIC OF SOUTH AFRICA

Enquiries : LTV Oliver
Telephone : 041-391-8100
Facsimile : 041-391-8133
E-mail : tommy.oliver@impilo.ecprov.gov.za

Our Reference :
Our Reference :
Date : 23 May 2012

Mrs. SL Frood
53 Botha Street
Mount Pleasant
Port Elizabeth
5099

Dear Mrs. Frood

REQUEST FOR PERMISSION TO PERFORM RESEARCH: STRATEGIES TO PROVIDE CARE AND SUPPORT FOR CHILDREN ORPHANED BY AIDS LIVING IN TOWNSHIPS

In response to your application for permission to conduct the above research at Nelson Mandela Bay Health District Clinics, permission is herby granted with the following provison:

- Health service delivery should not be disrupted under any circumstances.
- Timeous appointments must be made with the relevant facility manager, prior to commencement of the visits to said facilities.
- You are required to sign an indemnity document before commending your research.
- The Nelson Mandela Bay Health District, as the research site, will expect a copy of the final research report when the study is completed. If the duration of the research period is required to be extended, the District Office (District Manager, Mr. L.T.V. Oliver), will be informed accordingly.

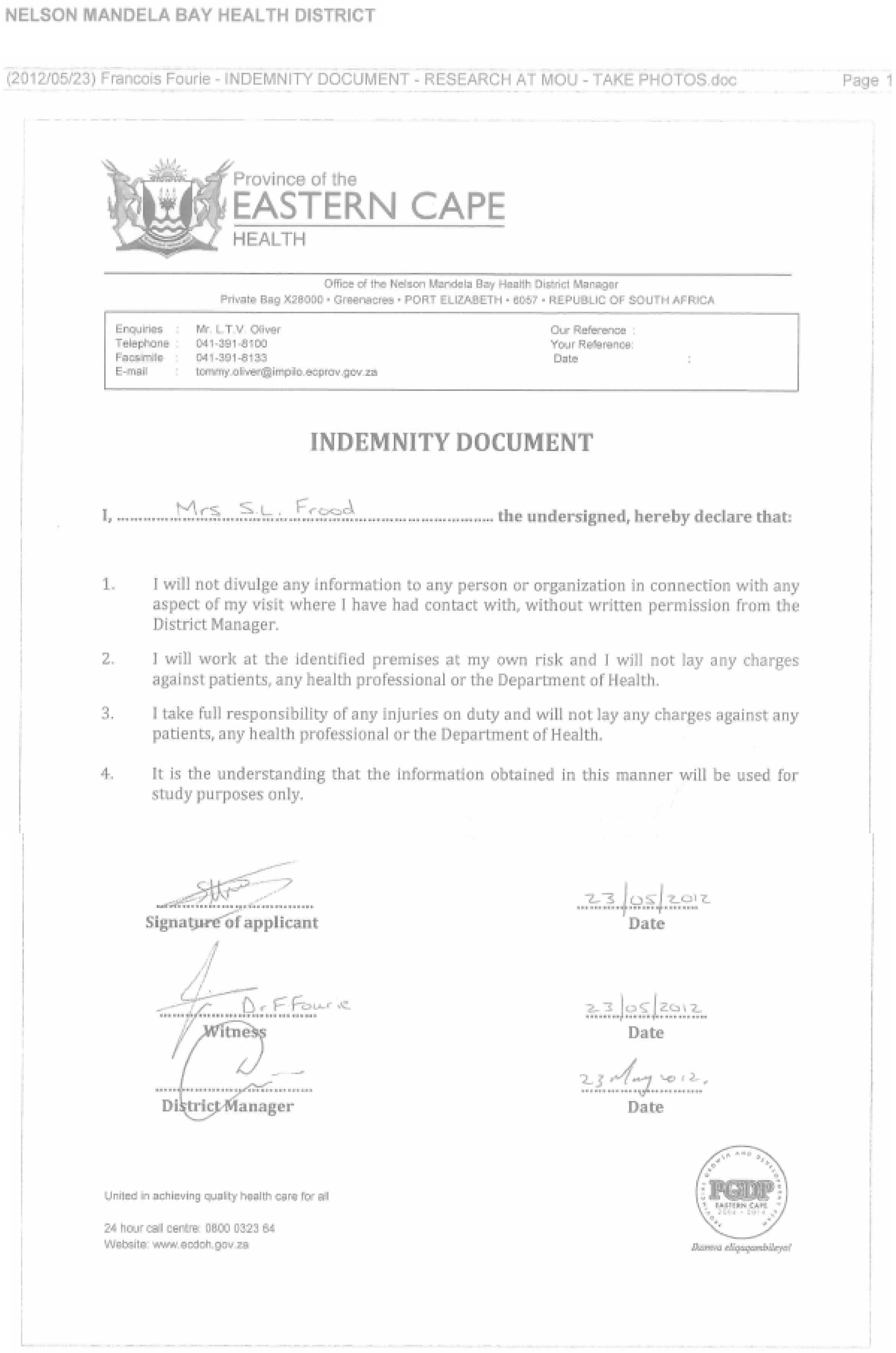
This Office would like to wish you well in your research study.

Yours faithfully

DISTRICT MANAGER

United in achieving quality health care for all
24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za

PGDP EASTERN CAPE 2004 - 2014
Ikamva eliqaqambileyo!



NELSON MANDELA BAY HEALTH DISTRICT

(2012/05/23) Francois Fourie - INDEMNITY DOCUMENT - RESEARCH AT MOU - TAKE PHOTOS.doc Page 1

Province of the
EASTERN CAPE
HEALTH

Office of the Nelson Mandela Bay Health District Manager
Private Bag X28000 • Greenacres • PORT ELIZABETH • 6057 • REPUBLIC OF SOUTH AFRICA

Enquiries : Mr. L.T.V. Oliver
Telephone : 041-391-8100
Facsimile : 041-391-8133
E-mail : tommy.oliver@impilo.ecprov.gov.za

Our Reference :
Your Reference:
Date :

INDEMNITY DOCUMENT

I, ...Mrs S.L. Frood...... the undersigned, hereby declare that:

1. I will not divulge any information to any person or organization in connection with any aspect of my visit where I have had contact with, without written permission from the District Manager.
2. I will work at the identified premises at my own risk and I will not lay any charges against patients, any health professional or the Department of Health.
3. I take full responsibility of any injuries on duty and will not lay any charges against any patients, any health professional or the Department of Health.
4. It is the understanding that the information obtained in this manner will be used for study purposes only.

.... 23/05/2012
Signature of applicant **Date**

.... Dr F Fourie 23/05/2012
Witness **Date**

.... 23 May 2012.
District Manager **Date**

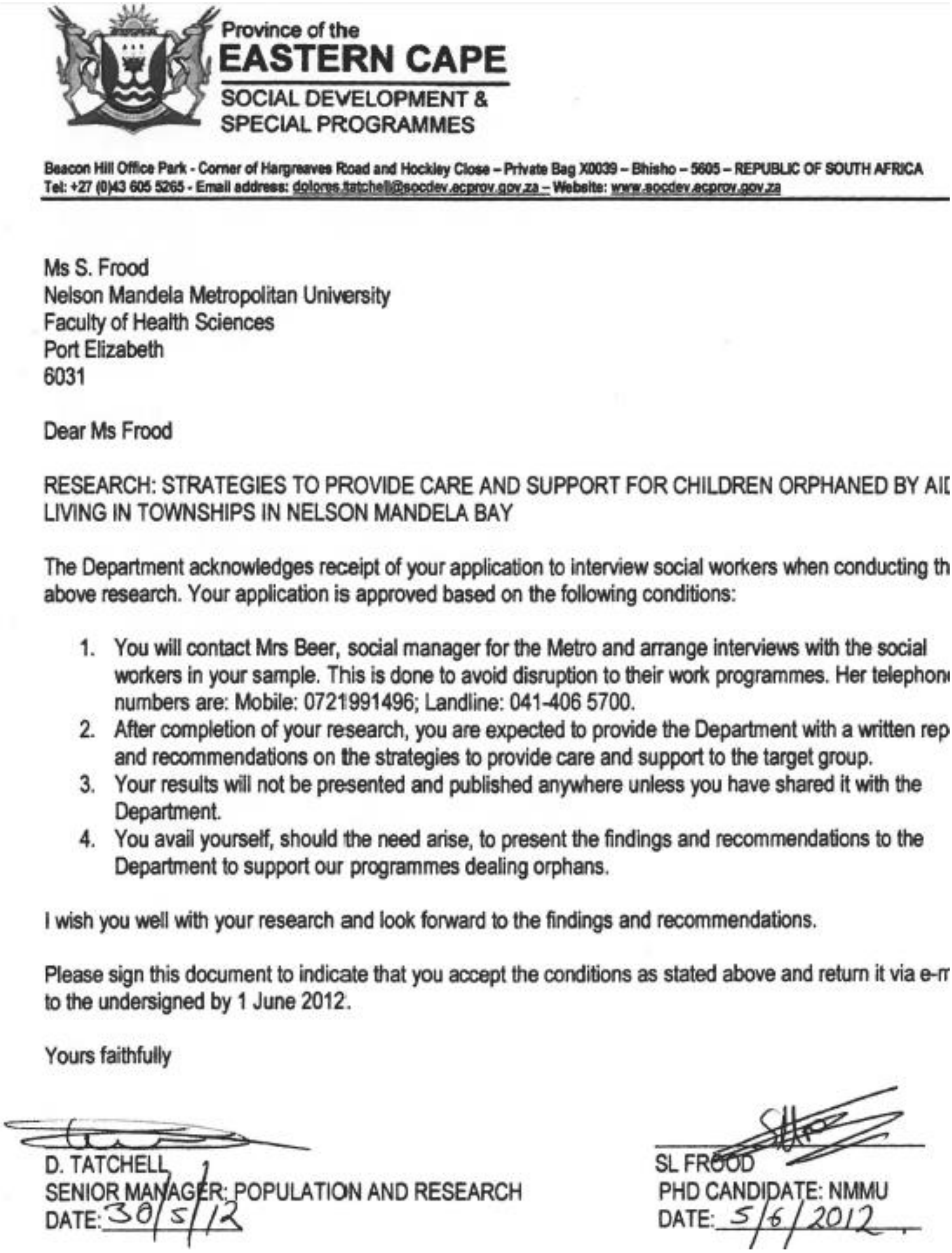
United in achieving quality health care for all

24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za

PGDP EASTERN CAPE 2004 - 2014

Ikamva eliqaqambileyo!

Appendix I: Letter of Permission from Eastern Cape Department of Social Development



Province of the
EASTERN CAPE
SOCIAL DEVELOPMENT &
SPECIAL PROGRAMMES

Beacon Hill Office Park - Corner of Hargreaves Road and Hockley Close – Private Bag X0039 – Bhisho – 5605 – REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)43 605 5265 - Email address: dolores.tatchell@socdev.ecprov.gov.za – Website: www.socdev.ecprov.gov.za

Ms S. Frood
Nelson Mandela Metropolitan University
Faculty of Health Sciences
Port Elizabeth
6031

Dear Ms Frood

RESEARCH: STRATEGIES TO PROVIDE CARE AND SUPPORT FOR CHILDREN ORPHANED BY AI
LIVING IN TOWNSHIPS IN NELSON MANDELA BAY

The Department acknowledges receipt of your application to interview social workers when conducting th above research. Your application is approved based on the following conditions:

1. You will contact Mrs Beer, social manager for the Metro and arrange interviews with the social workers in your sample. This is done to avoid disruption to their work programmes. Her telephon numbers are: Mobile: 0721991496; Landline: 041-406 5700.
2. After completion of your research, you are expected to provide the Department with a written rep and recommendations on the strategies to provide care and support to the target group.
3. Your results will not be presented and published anywhere unless you have shared it with the Department.
4. You avail yourself, should the need arise, to present the findings and recommendations to the Department to support our programmes dealing orphans.

I wish you well with your research and look forward to the findings and recommendations.

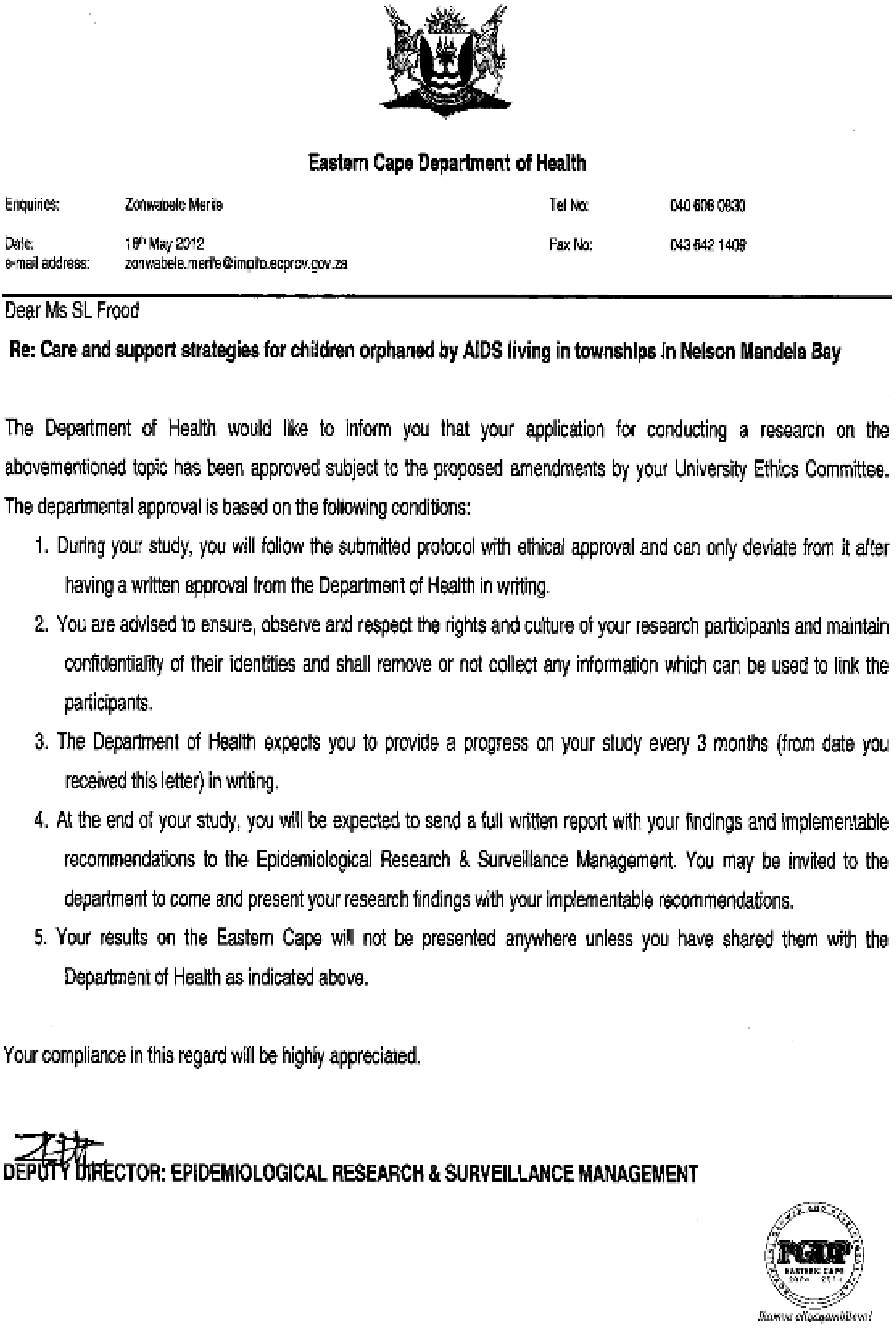
Please sign this document to indicate that you accept the conditions as stated above and return it via e-m to the undersigned by 1 June 2012.

Yours faithfully

D. TATCHELL
SENIOR MANAGER: POPULATION AND RESEARCH
DATE: 30/5/12

SL FROOD
PHD CANDIDATE: NMMU
DATE: 5/6/2012

Appendix J: Letter of Permission from Nelson Mandela Bay Municipality



Eastern Cape Department of Health

Enquiries: Zonwabele Merile Tel No: 040 606 0830

Date: 19th May 2012 Fax No: 043 642 1409
e-mail address: zonwabele.merile@impilo.ecprov.gov.za

Dear Ms SL Frood

Re: Care and support strategies for children orphaned by AIDS living in townships in Nelson Mandela Bay

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved subject to the proposed amendments by your University Ethics Committee. The departmental approval is based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

Appendix K: Copies of Interviews Conducted

Interview Six: Professional Nurse

Researcher:

Thank you for allowing me to interview you and for agreeing to participate in this research study I appreciate the time that you've made to enable me to conduct this interview. I would like to start by asking you the following question: How do you experience providing care and support to children living as AIDS orphans in the township communities?

Participant:

In this clinic my responsibility is seeing all the HIV positive children under the age of 12 years. I also see all of the children 0 to 12 years for their immunisations. What I experience is this, children attending the clinic as minors, according to the policy I'm unable to give them treatment without their legal guardians being present. Because I need to explain the administration of the medication that is prescribed; to an adult. Because the child might misunderstand the instructions and I'm giving. If I'm honest what I find is that most of the legal guardians who assumed responsibility for caring for orphans are not concerned about the well-being of the orphaned children but they're more concerned about the social grant and the money that is awarded to them, to provide care to these vulnerable children. When children attended the clinic without their legal guardian I send them home to fetch their legal guardian before I examine them or administer treatment to them. Most of the defaulters on immunisation programme are orphans. I find the minors who attend the clinic are often really afraid to be honest to speak to me in front of their legal guardians because they have to live with these people. They are afraid to tell you what is happening in the house while investigations are in progress. Last week I saw a child who was 2 years of age who was raped. I had to take the child to Dora Nginza hospital because the grandmother refused to go with us there. When we were in Dora Nginza hospital, the child was explaining everything in the rape crisis centre. The grandmother was not even with us so I had to go with the child to the police so that the police could have a statement from the child. The relatives get fed up because they get told to go this side go this side and in the end I don't want to go any more. So they become fed up, and they don't follow it up so we did this. We had to go far, to Algoa Park. This is very distressing no one follows it up and yet a child of 2-year-old has been raped.

When I started working here I have a prayer I saw people that were ignorant, not because they want to be because of a lack of education and they just don't know what to do they are hopeless when they see themselves in this situation they feel it's permanent they feel that they are doomed. The children and the young people don't take school seriously they take shortcuts. You can tell a 12-year-old child in other suburbs to go to school and they will go to school. They know that if they get a good education their life will improve. In these township communities it is just hopeless. Children and young people see hopelessness all around them, so telling a 12-year-old child to go to school makes no difference. All they see is unemployment, drunkenness, poverty, disease, death and rape. Yesterday I saw a 12-year-old boy who came to the clinic with his father, he's really unwell and I find out he's been mixing antiretroviral therapy, actually his mother's antiretroviral therapy with dagga. That child has to be referred now to SANCA. I told this child that I grow up very poor, that I grew up in a very poor community but I don't want to end up living like my parents did. I told him when I was in standard 8 I decided I could change something; if I studied hard at school. I want to change the situation the only way to change this situation for me was to go to school but if I don't go to school there is no hope. I told him this and I was explained to him that I started to excel in standard 8. I told myself I can live like this. My mother was working for an Indian lady earning 105 Rand per month. My father was sweeping the roads. I told him I don’t want to..... In fact I won’t end up like this. We were the poorest of the poorest and I told him don’t have to live like there’s a better way!! I told him I'm now living in a house worth 368,000 Rand in one of the suburbs in Port Elizabeth. I'm not going live like a pig. I decided then I wasn't going to grow up digging a hole for a toilet, I can have a flush toilet. Because they are orphans no one is telling them that life can get better. My mother was very much helping me and encouraging me. But they don't have this, no one is encouraging them if there is no food they go to bed hungry. At least with your mother at home you know you can eat even if it is bread you know you can eat. This child was listening to me yesterday because he saw that I had come from where he was. The other big problem is with the orphan girls. They are having older boyfriends and they sleep with them and they get something like a mobile phone, shoes or clothes or a little bit of money and they think this is improving their life but it isn't. It's peer pressure because my friend is wearing expensive jeans now I must wear expensive jeans and the only way I can get these expensive jeans is asleep with an older man.

I myself had abortion when I was 12 years of age. What happened to you also happened to me. People listen because I've been there I want to help them. I was pregnant by 12 years of age by an older man and the man was married and he was a married man. But my mother was always there to help me. This is not acceptable. These 12-year-old children these girls are getting pregnant and having STI’s because the parents are not there to stop them behaving like this, because they don't care. No one cares about what's in the best interest for these vulnerable children I'm telling you the communities don't care about these children. I'm telling them exactly as it is because I know exactly where they're coming from. Part of my role is to be a role model for these children and to give them hope. They do listen to me. I'm not reading from the book I'm telling them from a life experience. Sleeping with an older man didn't help me. Having an abortion didn't help me. I collapsed after my abortion I was bleeding in school I had to go to the hospital and nobody helped me. I had to have a blood transfusion because my blood level was very low. I was anaemic for a long time. This was my personal experience I know what it is like to be a child growing up in poverty in the township communities. When you’re a child and you are pregnant, you just want to get rid of this baby you don't think of anything else you just want to be rid of this baby.

I would have hope; I have hope now because I don't live in that any more. I tell them if they can survive this they can survive anything. I was raped when I was 8 years of age and I survived. I've never lost hope. Most of the orphans I see, who come here for care have lost hope. Life is not easy without parents. People say whatever they want to say about you no one is assuring you and so they lose hope. You are not nurtured as an orphan, you just have to survive. And children need to be nurtured. That is where they live and find hope. They feel overwhelmed that they will never make it in life. Because all around them is poverty. Based upon their circumstances they believe they will never make it. They need to hear the voice of hope, assurance, reassurance and future. During the family planning clinic that is when I helped them the most I can talk to them and they can talk to me. I have to gather information from them before I can give medication and then the girls will open up and talk to me.

We need support groups for these orphaned children at the clinics and we need social workers based in the clinics to help these families to apply for their support grants. During support groups, children will speak about their experiences and maybe they can find new hope and encouragement to go forward in life. Verbalising their problems is very important. Nothing is permanent I tell them nothing is permanent that they need to hear these things. I see over 50 clients a day which is too much. I can only listen to a few of these problems. I can't possibly listen to each one. I can't afford to have one hour with one client. Even if I book for a social worker they are not specifically trained to cope with orphans. I can't just send a child to a psychologist. I have to find out who is available, and when and where and I have to make sure that children have financial means to go to those appointments. The problem is sometimes boiling now but all I can do now but all I can do is refer. The referral system in Port Elizabeth is very, very slow. Orphans need to be able to attend youth programs, life skill programs, anger management programs. Young people need to hear stories of hope and hope from their own and within their own communities. The biggest problem is always waiting. Waiting for referrals, waiting for support grants. It's hopeless waiting when the needs are immediate. Sometimes when I was growing up I used to fall asleep without food. I'm not going to die poor. I start telling the young people that there are bursaries available for them so they can study. I had to discipline myself to study most of the time I was with my books and not out with my friends. And then I started making friends of my books. I made good choices and I want to teach young people to also make good choices. When I see these children when I look at them I see them educated, I see them with good jobs, I see them living in homes with their own families not living in poverty and I tell them this. I've got hope without hope the person is nothing? I think if we had food parcels to give to particularly female teenage orphans it would stop them from falling in love with older men and it would stop them getting STI's.

I saw a child the other day that was 3 years old... she collapsed in the clinic I was told by the grandmother as I took the blood sugar reading of this child that the child didn't eat for 2 days. I was able to give the grandmother two packets of porridge for this child. The child has been taking care of by the grandmother but the grandmother doesn't yet qualify for a pension because she is not old enough. This is a terrible situation and it's happening very often. How can a 2-year-old live with no food. This grandmother can't even apply for child support grant because the mother who was now deceased was married to a Nigerian man, who, we can’t find and there was never any birth certificate for this child. If there is no birth certificate then the grandmother can't apply for any grant. That's it; it's just like that you can’t get it. These children are very desperate. So what we do is we give porridge supposed to be for TB patients to this child. How can I not give this child food? This child doesn't fall under the criteria for our malnutrition programme..... But how can we not give this child food. Food parcels would help us a lot to give to families like this. Being a professional nurse caring and supporting children as orphans you have to be everything you have to be the, teacher, encourager, role model, psychologist, social worker and a professional nurse. You want to listen to these children; the time is against you because of the number of patients you must see in the day. You can see even now outside of my office there is a long queue of people waiting to be seen. I can’t turn patients away I can’t see just 20 patients a day who are sick and turn others away. I must see everybody that attends the clinic every day. I can’t spend 2 hours with a patient. I see at this clinic 50 patients every day. If we were two clinic sisters working, one in immunisation and the other working with sick children then we will be able to give more time to these vulnerable children. Most of the children I see at this clinic are orphans. Some of them are brought by a neighbour they are not even brought by their guardians. I see that these children are not taken care of properly because no one really owns them a child never is owned by anybody like is owned by its parent.

Most of the children I see in this clinic are HIV-positive and their parents have died of AIDS. Some have diarrhoea some of them have psychosomatic illness. They pretend to be sick because they want help, usually because they're in an abusive home, where they are neglected. And it's the only way they can see a professional, responsible adult. Sometimes orphaned children in the home are left to do everything, they cook and clean they go to school they do the gardening and they are exhausted and they come to the clinic with chest pain and it is because they don't rest. They are neglected and they're exploited. With these children I have to ask the adult to leave the room and then I speak to the child and the child tells me all of this. They have to go and collect water and they have to walk far. Then they must prepare meals. Then I must take care of my younger siblings. Then I must wash their clothes prepare them from school I must do my own schoolwork and then I'm tired. It is like this for them it is too much. But I see this very often. But I check everything, I check their peep, I do chest examination I do the temperature but I can’t find anything wrong but I know there is something. It is stress that is causing this. If you fail this child they will try suicide. I must make sure that I do not fail these children. I asked the child what you want to see happening. We mustn't fail these children as professionals we must help them. They have a solution within them and often that solution is suicide. So when they speak you have to listen very carefully, but often they have another solution they want to go and live with their grandmother or a teacher or they want to move it with an auntie. But it's difficult for us to access the social workers it is very, very, difficult we have to wait a long time. They are always busy and we must book but the problem is now but we must book. But we can wait. The least amount of time we wait is 2 weeks it's too long. Sometimes I've just take them to a psychologist without having a psychologist referral appointment. I just take them. I tell the psychologist I am coming and I am not making an appointment because it is so urgent. I just go because it's so urgent. They have many psychological problems these children. They will say things like if my mother was alive my life would be very different. If the child is staying with an aunt as an example and the aunt is paid. She will go out and she will buy everything for her own children but she will buy nothing for the orphaned child living in her home and these children feel less in their heart, they are sad. They feel they don't belong here. They need toys to play with and clothes they need to be able to speak and be understood and they need to be cared for. For us we have the Mission Vale centre next us if we didn't I don't know what would happen to some of our children. They do a very, very good work I cannot even think how we would exist as a clinic without that centre. It's very poor here very, very poor.

We need more staff and to alleviate some of the pressure of having to see, so many clients in the day. I even had to do postnatal examinations. I'm running about 5 programs and I'm one person. If we were just two sisters we would have more time to spend with each client. The referral system needs to be better. Social workers, psychologists and SANCA have all refused to take children that I wanted to refer to them because they already have too many clients on their own books. What do we do then? If I didn't believe in God and pray I wouldn't have hope and I couldn't do this job. I always pray God give me strength. I can do all things through Christ who gives me strength. I go to Christ in prayer and he helps me I believe and he helps me. I know he can take control of everything. He has died for me he's carried the cross he's done everything so I don't owe the devil anything I'm free. He paid the price for me by his blood. This is my hope this is my strength. I tell the children that come here I tell them who Jesus is that God is their father. I know that God loves me before I even know him. I can testify to them I've had an abortion I've been raped but I tell them I've forgiven and I have hope for the future I'm saved I'm living free. I tell them Christ is he is not a story; he has restored my life and he can restore your life too. I have the Prince of restoration governing my life. Leviticus chapter 19 verse 28 I tell all of the orphans that when we belong to Jesus our bodies are the temple of the holy spirit that I belong to God so that what I do my body must honour God. I tell them this because it's important that they know this. We must care for these children spiritually emotionally and physically. They need holistic care. I know who Christ is and I have hope. I don't think there's anything else that I can tell you think you are listening to what I have to say. I hope you research will be successful.

Researcher:

Thank you for being so open and for sharing your experiences with me I appreciate the input you have given thank you for your time.

Interview Twelve: Psychologist

Researcher:

Thank you so much for enabling me to make an appointment with you so that I can interview you as part of this research study.

Participant:

I hope the insights I have will be valuable to you. There's so much that needs to be done to improve the care and support we provide holistically to orphans living in the townships. .

Researcher:

I'd like to start by asking you the following question. How do you experience providing care and support to children living as AIDS orphans in the township communities?

Participant:

Most of the children that come to this clinic who are orphans I'm supposed to refer to the University Mission Vale campus. I refer children to the college campus at Mission Vale, but I see them here anyway just because that's what I do. Is difficult to turn children away, it's difficult to turn children away who are obviously in need of support because they're suffering from psychological distress.

A lot of the children I see are HIV-positive and they don't even know that they are HIV-positive because they've had it since birth. There was a little girl who really stood out for me. She didn't know she had HIV /AIDS. She was on medication since birth and she had stopped taking it and they don't know why. Then all the grandparents come and ask for advice, because, now the child is saying why I am taking this medication what's the matter with me because no one has explained it to the child.

Many of the children I see are living with their grandparents; they live better with their grandparents even if their parents are alive. In those households with grandparents there is a huge burden placed upon the grandparents to care for their grandchildren. It’s a financial burden, a physical burden and an emotional burden too. This particular little girl said she's tired of everyone moaning and shouting at her to take her medication. She just kept saying why bother there's no warmth at home why bother? By listening to her and enabling her to feel like she was human again helped. In the African culture children must do as they're told, they are not seen as human beings who have feelings and who need help. (Cellphone rings). Trying to help grandmothers cultivate warm, loving, relationship with their grandchildren is essential. Children have questions that need to be answered. It takes time to build trust with these children because they have been so hurt and disappointed in life. Sometimes children don't have the words to express the distress of what they feel and we have to give them the words to help them to communicate what's in their hearts.

For example in our African language there isn't a word for depression. So we have to understand the different language other than a person is depressed. Some children I've seen would complain about the circumstances of their lives and some children would just say I want my granny to listen to me!!! They would say things like my granny doesn't pack my lunch from, me my granny doesn't listen to me. And what the child is trying to say is; I want someone to listen to me and understand me. When I first met a child who was an orphan....... I realised it takes time to establish what's truly going on in their home and in their hearts; what's causing them to stop taking their antiretroviral medication? It takes time to understand their life world. It's so different to my reality. To be honest most of the children I see are suffering from depression because they are HIV-positive.

They wouldn't come into my office and say can you help me I'm depressed. We would have to help them to come to that conclusion themselves; for example they would say things like I am not coping at school and sleeping all of the time and feeling very flat; I feel hopeless. We are to help them to articulate in their own way what's going on inside of them. We give them tools to help them express their grief and anger at the depression the sense of loss that they feel.

They feel fearful of the future and fearful because of the trauma of what they see when they watch their parents die of AIDS. Some children just act out; they just want attention and to be understood. ummm others become withdrawn, others are blunted because of the trauma of what they've seen. It's as if they learn that nothing is ever gone a change; in a major switch off they disengage, they are withdrawn they've taught themselves not to feel. People need to be heard into a place of healing, they need to be listened to and understood so their hearts can heal, just like the body heals through medicine the soul heals through talking and being understood in being heard.

Counselling in the African culture is different than the white culture. This is a struggle for me. And to try and understand what people's real meanings are when they speak to me is very different it's a big learning curve for me. And to understand the context. I have to be careful not to project solutions from my worldview into their situation, so I try to create a space for children to verbalise what's going on, on the inside of them, so that they can feel understood and develop their own coping mechanisms to move forward in life. When people feel heard it causes them to have hope. It's difficult to create a long-term therapeutic relationship with these children because I move on and also they move households readily. You have to make it in, the first session I figured that that's the most important meeting I have with these children, it is that first meeting. There is a huge pressure on me in those first meetings to just get it right with these children so that they can be heard and understood. I need to know also who I refer them to. There are so many people needing help and the referral structures just simply aren't enough to cope with them. One young girl I saw just wanted the time to say to someone how she is really feeling what truly going on in her life. I watched her eyes and she seemed lighter just because somebody was listening to her. Is different for each of the children that I see. I have to be really really sensitive ummmmmmm to help draw these children out.

And the length of sessions I have is often not long enough... say 40 to 45 minutes. And I am dependent on other resources and I have, and you can see in this room I have no resources. But only a telephone. Children need support, real support, real reassurance real input from a social worker to establish a long relationship with them to help them understand the context of their lives. There are some things I can't do in a therapy room; they need to be done in the homes by social workers for example. Social workers need to be more visible in the lives of these children. Many social workers don’t visit orphans in their own homes. Children who are orphans need to be visited at home by their social; workers so that they can be closely monitored and helped within the challenges of their context. If I knew a child was in difficulty and I wasn't able to accommodate them I would follow up and make sure that they were okay but it’s not like that with our social workers. They need to have more contact time with the children to monitor what is happening in the homes particularly regarding neglect.

And we have an orphan support group here which is run by love life; an amazing organisation to help young people come to terms with their HIV /AIDS status. And the people who run love life are actually HIV positive themselves. .

I think if we had more support groups for orphaned children they would improve in all aspects of their development. These groups need to be facilitated by officials who can give hope to enable a new perspective to comfort children and young people. Many orphans and vulnerable children need to feel cared for in these groups; just with simple refreshments. Skills development groups would also be very helpful for children and young people within the context of these groups. These speak of future and hope which is good. It draws the young people forward in life. For example it can be good to run coping skills groups: communication groups, problem-solving, skills and anger management. Children need to learn to problem solve, young people need to know how the problem-solving enables them to make choices that are good and healthy. Orphans also need to be helped regarding aspects of developing a healthy self-esteem, things that will teach children to have a healthy self-esteem a good self-esteem. I think if there is an investment into the lives of young people through such groups they would automatically have hope for the future.

The office door opens.

Participant:

Where was I ummmmmm pause? You know in the African culture children who lose their parents are expected just to move on in life It is as if these children do not need to grieve and develop coping skills or an understanding of the process of the grief cycle so that they can hope and function in that. For some it is to acknowledge and hear that she has been through really difficult time. There's nothing worse than someone telling you to move on, when their heart is broken. When just saying God will take care of everything.

You know the multidisciplinary team is a wonderful gift and if it's used appropriately, all aspects of care and support for these vulnerable children could improve and we wouldn't be facing a generation of broken-hearted delinquent children who can’t function.

You know my working life here is a big challenge; I am just swamped by so much hopeless; one case after another and I feel like what I do is less than a drop in the ocean. It, insidious the need is just insidious. You know it's difficult for people to speak about their psychological well-being when their basic needs are not met; because how can people process grief when they are stressed about how they can put food on the table in the evening for their grandchildren or how can children begin to process grief when their fearful and anxious all the time because they don't know they can go to school, they don't know where they can eat and they don't even have a bed to sleep in. Sometimes I think or rather I hope it just helps that someone can acknowledge that it’s terrible for me and that helps me. I feel that is all that I do sometimes is to just acknowledge that it's difficult for people and I am so sorry it's like that for them. Sometimes it’s all I can do.

Researcher:

What recommendations would you like to make to improve the quality of care and support provided to children orphaned by AIDS living in the townships?

Participant:

You know we need equipment that is child friendly to give the children language to be able to express their grief and suffering and loss. But you can see in this room there's nothing I've got a table I don't even have a phone. I have to bringing crayons and paper and toys. And I have to teach grandmothers how to create space for their grandchildren for them to express anger in an appropriate way and to communicate in appropriate ways. I struggle with there not being enough privacy. Sharon you are the only person who's knocked on my door this morning the sisters just come in. There's no phones so what about the privacy of the person sitting with me when I now have to have a conversation a public place about intimate details of this person's life. Everyone knows who that person is because they've have seen them coming to see me as a psychologist. Basic things should be in place like tissues for example. Sometimes I am interrupted when somebody is (door opens without a knock the nurse comes into the room to get something from a cupboard). Speaking to me about what they feel about the HIV-positive. It's not conducive to people being able to open up and be vulnerable when I'm constantly interrupted. That's a problem for me. Lack of resources just look at the decor of this room its like sitting in a cupboard. Children need toys and drawing and all sorts of things to enable them to have language, teddy bears, crayons things to play with maybe a nice glass of juice and a biscuit to drink for example. You know I have to bring in my own resources that is the reality of it. The conditions are difficult. There are actually unbelievably difficult. You know never mind excelling with what you are supposed to be doing, just trying to do something basic for people is where my expectations are now. I constantly ask myself? Am I making any difference in the lives of these people or of these children? It's disheartening. I don’t receive any support in doing my job here. I have to rely on my colleagues and meet up and have coffee with them to stay sane and we use each other to do our debriefing sessions. My question is who would be able to help us. I know we are recommended to have supervision by the psychologist but we must pay for this ourselves. So we are advised to pay for psychological support essentially ourselves. So we are practising what we preach. They think the stress creeps up on you. It's like a psychic numbing, we are....... I am just bombarded by the overwhelming hardship in the lives of every person I see in my working day it is very difficult.

You know we often have young people come into my office who are hungry and just having someone that has heard them gives them the strength to go on for one more day. “Someone cares” that I have not eaten today, it is not solving the problem I wish there was more I could do. But this seems to give people strength to endure.

You know communicating across a culture is a challenge and yet I find it easier to ummmm struggle with the lack of resources and communication difficulties than to use an interpreter because if I use an interpreter it's another person in the room and another factor that prevents children from being open. You know we don't even have the basics Sharon I wish we had the basics but we don't. Because children don't have the words we have to have the resources to give them the words like toys like jigsaw puzzles like crayons. I supply my own resources like this I'm happy to do that. The conditions we work in are unbelievably difficult. You know burnout out! Kind of creeps up on you. It's difficult to stay motivated as a professional and I often feel hopeless because I feel swamped by the number of overwhelming needs in the lives of the people that I meet.

You know we know the symptoms of burnout as psychologists and we have to practice what we preach. You know I wish the social workers could do more.... I find the social workers that we refer to completely ineffective and I'm sure it's because they feel burned out.

You know some of the children I deal with...... a young boy lives with his bother ; he often don’t have food to eat he tells me... when I'm starving there's no future for me there's no money there is no education opportunities and so it is hopeless , everyone in my life is poor. I might as well give up now. You know I want these children to live;

we have to help them to find a reason to live. It's hard to see people living in hopelessness every day; it drains you of your strength physically, emotionally and spiritually. It's like helping orphaned children just takes the life out of you if you if you let it. Somehow we had to give these children meaning in their life to go on living; that there is a hope; there is a future that antiretroviral therapy works, that there are jobs for them ,that life can be better, this isn't how it has to be for the rest of their lives. But those around them in their communities live the reality of poverty and loss and AIDS. This negative reinforcement of death and poverty and unemployment and hopelessness doesn’t help. Where is the voice of hope? You know we have this tree of mental health and the trust and honesty component has to be there but it isn't there. People are not able to be honest because they don't trust. You know if I had a breakthrough with just one child I would feel like while there is hope there's a flicker of something, something worked.

You know sometimes I'm the last resort. You know we have to have a strong referral system it's important that we know that when we refer someone to a person that they can get the help that they deserve. We live in this system where there is a bureaucratic bounce. All of the inefficiency takes away the power and the credibility of the people that are doing something, who are working with integrity and diligence and professionalism.

It is hard to be faced with children who are orphans. They sit in front of me and they are hungry and on medication that makes them feel terrible and somehow we have to allow them the space to speak themselves into life and yet they are saying why bother why bother. It’s a harsh reality living in the townships, never mind if you are an orphan living in the townships and there's no money at home, and your grandmother is the only breadwinner on a pension what kind of support is that? What can a person really do with 1000 Rand? yet these grandmothers have to take care of their children and their grandchildren on just over a thousand Rand.

There's a lot of stigma attached to seeing a psychologist. I feel ineffective in working with African people because it's like they come to me and they want me to tell them what to do and I'm not going to actually do that. I think some people must come and see me for help and they wonder what this woman actually did to help me. I think there isn't acknowledgement in the communities of what psychology actually is and what the purpose of going to see a psychologist is. You can use all the resources you have but the reality is the children come into my office in poverty and they then leave still in poverty and their soul is traumatised permanently because of this....

I constantly feel the pressure of having to deliver how do I deliver? What do I deliver? And what is the purpose of me delivering? I constantly ask myself am I being effective. Its soul destroying when you feel consistently ineffective.

Researcher:

Thank you so much for everything that you have shared. Your experiences have given a lot of insight... Thank you

Interview Sixteen : Social Worker

Researcher:

Thank you so much for getting back to me and for being willing to be part of this research study. I would like to start by asking you the following question. How do you experience providing care and support to children living as AIDS orphans in the township communities?

Participant:

Starts with a big sigh.... I'm working in the Nelson Mandela Metro within the HIV and AIDS programme. Most of the orphans I see are living with their grandparents or members of the extended family. The biggest challenge for me with regard to HIV is that the focus tends to be on adults. With the mentality being that children know nothing. We tend to neglect the emotions and feelings of orphans. We need to correct this. Children do grieve just in a different way. When working with orphans and vulnerable children my question is; Are we really preparing them to deal with the death of their parents? It's emotionally frustrating for children to see that my parent is lying on a bed and is dying. They are many concerns; who can take care of me, who will pay my school fees and where am I going to live? These are big anxieties for children. In most children and orphans even when they’re not on antiretroviral therapy they don't know that they are HIV-positive. For example if a child is getting ill because they have asthma. And they go to the clinic to for asthma and end up having a HIV test in finding that they are HIV-positive and they didn’t even think about it. But they don’t even think they have HIV!!! This is a big shock too!!!!! They just think they have Asthma. But it is the HIV that is making their chest to be very sore!!!! The grandmothers who know that their grandchildren are also HIV-positive are also scared. They ask how? Can this happen to the children when they know their HIV-positive. The child knows they're taking treatment for asthma but they are also on antiretroviral therapy but they think they're taking antiretroviral therapy for asthma? HIV/AIDS still has so much stigma!!!! It’s a shock for me when the children say to me say I'm taking this treatment because I have a fever on my chest, meanwhile they are taking antiretroviral medication for HIV? This is not right yet I see this most of the time...... children who are on ART for

HIV are on medication and they think it is for something different...... . And when the fever is not going they have questions. Taking antiretroviral therapy is a lifetime commitment. If I'm coughing and my cough is better why am I still taking the treatment? I don't know why it's like that..... we must be honest with his children. When we interview the caregivers they will often say I don't think the child is ready to know that they are HIV positive. We have to be professional and deal with this at a child's level. For example we can tell them that there is a virus in the blood that is not going away and they must take this treatment for the rest of their lives..... We have to help them at the level at which they understand; for example because you have this virus in your blood you have to be careful of the following things. I run support groups for children who are orphans this is a big problem for them. They understand confidentiality; children know that what we discuss in the support groups is just for the support groups. It's right that they are able to speak about their HIV status. We must provide this space for them to be able to do this.

You know most of the children I see who are orphans are living with their grandmothers. And they are dependent on the grandmother's pension from the government. This is little money. Yet it is the only means of financial support which is coming into the family. So we have to consider this; when we run the support groups. I can't tell the children all about all of the of the healthy nutrition that they must have to stay healthy, if there's no money in the home, this is a very big tension for me as a professional but this is the context in which we work. Children who are AIDS orphans living in the township's are poor, because they are dependent on the grandmothers pension or on the child support grant. Both of which are very little and there are many people often in the homes that are dependents to this grant because the unemployment is so high in our communities.

For example maybe they just eat mealie pap for days on end. But this is their reality. You know children with AIDS or children are orphans at school are often withdrawn because they feel inferior to the other children.(The door opens we are briefly interrupted) we must help them with this we must help them to integrate, because they will find great support and healing through friendships with their peers. Most of the children I see are not eating healthily. They sometimes only have one meal a day.

We have to help them to regain their confidence and hope. We have to enable these children to speak about their feelings because when they are not able to express their feelings and emotions about being orphans they can’t concentrate at school and their behaviour becomes very bad. It affects their social interactions their self-esteem and ultimately their physical health. We know a lot of these children they are just withdrawn. They withdraw in the family they withdraw from their peers and they withdraw socially. They do play on the street with other children, but if only we can get them to go to school, we can help them to overcome and develop coping strategies; to deal with the loss of their parents. Children who are orphans need ongoing continued support; through professionals, through psychologists and through social workers. We need to develop their self-esteem and help them to understand grief. To teach them how to cope and how to embrace the future. These children also have dreams they want to look to the future and to live in it I think support groups are very good. We are all in the same boat we are all on one side and we have to go forward..... At the end of the tunnel we have hope we have a future. We must support these children to walk through this trial of becoming orphans. We don't dismiss their challenges and we help them develop coping skills to stay healthy the challenge is to make the right choices.... to develop and grow. We have to help them and support them to grow emotionally and psychologically through these challenges and not be broken. Social workers seem to be nurses, social workers and psychologists to these children which is challenging sometimes.

If you take a case of a child where both of the parents are deceased. Many times a neighbour would come to us and say there are children at home and they are alone. They live in a child headed household sometimes the eldest child is not even 18 years of age and mostly there is no income into that family at all. Then as a social worker I go to this family. I find out where are they staying... is it true? Who is staying in the home and where do they get any money for food. The relatives don't know where to start how to access the grant or how to care for these children legally. So I start by doing a home visit. Many times we are contacted through the social work department through concerned neighbours or extended family members. Sometimes we have referrals; directly from the nurses but I am the only social worker in the clinic one day a week. But it's helpful for me to be in the clinics because then the nurses can directly refer the children to me and I can start the process of organising a home visit and initial assessment straightaway. Sometimes the children are referred to us through NGOs. Sometimes children are brought to the clinic by neighbours and then the neighbours divulge to the nurses this is not my child but I'm staying near this child and you need to help them. The initial assessment is by nurses who find out who is this child staying with. Many times neighbours who bring their children to the clinics, will ask where do we get assistance with this children? They want to help but they don’t know how to. The birth certificate, clinic cards and death certificates of parents, and other documents we as social workers must have in order to start the process of foster care grant application. After the initial assessment I compile a report to the Commissioner of the children’s court. Then I get a date from the court and I take the family to the court with me. When a family is under oath was swear before the judge that they want to take care of this child that is presented before the court will start a Children’s court enquiry. With all of the documentation and the initial report then the children's Court will release date and on that date I present the child to the court. Then the court will release a court order and say this child is placed into your care legally and then you apply for a foster care grant.

With all of the investigations and the placing of children it should take about three months. It takes a long time sometimes getting date through from the Commissioner. Grandparents can apply for foster care grants for their grandchildren. We also referred grandparents and extended family to SASSA for the application of a child-support grant. We don't have anything to do with the application of these grants we just refer people to the SASSA office. I sometimes write a letter to SASSA just saying that I have done a home visit and I'm recommending this family to apply for a child-support grant.

You know children need social workers when they are orphans to help them. We provide a lot of social support and also the psychological support. You know the biggest challenge for us is when we have to place a child in a place of safety. This is our last resort always. We look to place the child within the extended family or with responsible community members within the immediate community. We do have children's homes as a backup plan. That's how I see it anyway. Not all families are willing to take in orphans within their own families because it is a financial burden. Sometimes even when we do place children within the extended family we have to remove them because of neglect sometimes. We see a lot of removal of children from homes into children's homes because of neglect. Often there are just not enough finances in the families to provide proper care and support for these children.

Researcher:

What recommendations would you like to make to improve the quality of care and support provided to children orphaned by AIDS living in the townships?

Participants:

You know as social workers we work with very difficult cases that are very emotionally challenging. We also have many issues in our own families because of the context of living in South Africa. We never get to debrief. I think if we were to be debriefed this would help us to manage the stress of our jobs better. You know when you visit these families and the children say so and so passed away it is not like I am unaffected by that. I am affected by that. I think if I had supervision by another social worker or psychologist it would help me better to cope with the stress of my job. But sometimes I do speak to colleagues but maybe it's just once a quarter. And really this is not really enough. But the reality is for debriefing I'm taken away from the working environment and there are already too many cases for us to review. I think practically there are many other things we can do to help children who are orphans in the townships. You know I would like to have more resources. Sometimes children are just dumped at the clinic. They are just left and now I have to place that child straightaway. In that instance sometimes just to have food parcels and clothing and some money for school fees or school uniform it would help a lot. It's difficult for families already in poverty to take orphans and vulnerable children into their homes. If there were immediate resources to give then it would be different. You know there are many queues at the clinics Sharron I am sure that you can see that! There are queues everywhere at SASSA, at the children's court and also in the clinics. You know, I would say the support grants are not enough but we need to help the communities to help themselves. Like food gardens, may be having some chickens, may be to sell some basic clothing items, to start sewing groups, beadwork groups, and maybe to see how to start a business. You know the main needs that children who are orphans have Sharron are psychosocial. Sometimes at the department of social development they have for example a back-to-school campaign. We must then identify a member of our case load who is an orphan or a vulnerable child. Then we give clothing to these children. You know for me always the challenge is to prioritise who is the most in need. You know the worst case scenario is a child headed household. For example the eldest child in the house maybe just only 16 years and is looking after four or three siblings. And they have no financial resources in these households at all. These children tell me this neighbour will give to me this.... this neighbour will give to me that! When the child is 18 years of age we can’t place them in the system because they are too old. It is also hard to not to break up these families. I can remove the small children but I can’t remove the 18-year-old.

You find that the older children drop out of school in these families and they will be involved in prostitution to provide food for their siblings. Many of them can’t find work because they haven’t completed even the minimum standard of education so they access money a quicker way!!! We have provision for child headed household in the new children's care act. If the head child is less than 18 years of age then I can remove all of those children put them in places of safety. But this is sad as they mostly want to be together and to remain in their own homes..... We should have better provision in SA to support these CHH so that resources can be given and siblings can be together even if they are younger than 18 years. These children are very resilient and they need to be able to stay together as a family even though they are vulnerable.

I feel very bad about this it is very, very, very, very stressful. These families need immediate relief it must be immediate. As a social worker when I leave their homes I have to just leave and of course I take it home with me. I have no resources to provide immediate relief except what is in my own purse. You ask yourself where can I start to get help for this family. Their needs are overwhelming. You think through how I strategize to help this family. So I make phone calls to try and make referral appointments and find out who can help me and who has had other cases like this and what they did and you feel the pressure of this all the time you just feel the pressure. If I don't do something for these children nobody's got the do anything for them and they would just be destitute. I need to be debriefed on this. It isn’t easy to set long-term goals but the immediate goals are very difficult to meet, they are the most frustrating to meet.

You know when you see a need you want to help. You must have a plan now in the short term as difficult to make their plan when you have no resources.

You know I only have a certain mandate as a social worker then I must link with other stakeholders. For example NGO's other department within the element. Takes time these referrals and liaison to take time. If it's about their certificates for example then I refer to home affairs. With NGOs I know some NGOs do give out food parcels so I can make a referral to those NGO's for specific children. You know if I could help people I would need to be debriefed but it's because I can't give help that I need to be debriefed because this is what causes me the stress. Sometimes I have to send people to the Department of Housing for example. I mean how children can live in a shack with no resources and with nothing to sleep on. You know as a social worker I like to sort out problems and I like to be able to sort out problems for these children. But it’s also hard to work within my own limitations and a lack of resources limits the amount of intervention I can make. I feel like the lives of these children are just stolen.

You know to change is a process all on its own. You know I look at children in the support groups and I see children that are withdrawn. Then over a period of time they begin to speak up and begin to speak out because they learning to trust. The group is a safe place because everybody has the same problems. It's a nice platform for them to speak. When children see other children speak they also want to speak. The support group also enables me to have insight into the lives of the children and then I can have a personal appointment with all of the children if that's what they require. You know sometimes children will be to see me for five times in the different sessions before they open up and share. You know these children that are orphans they lose confidence. As a social worker I have to help these children to gain confidence and to help develop their self esteem. It's important to help children find their voice again and for them to know that they are worth listening to. Sometimes we get feedback from the caregivers and they will say I've seen difference in the children. For example children will begin to take their antiretroviral therapy treatment again because they find hope again. They will begin to talk to their parents because they realise that they can. Continuity is very important in the lives of these children. Because they need to be able to regain trust.

Can I say anything?

Researcher: Yes you can say anything you want to?

I am not working for the Department of Health Sharron; I work for an NGO based in the clinic. It's an NGO who pays for me to work in the township clinics. It's good for social workers to be in the clinics. Because now I can specialise and I can focus to help orphans who are attending the clinics and people with AIDS. I think there are more resources because I'm working for an NGO. For example I can buy food parcels if I need to. You know but when I was working at the Department of Social Development you can do these things you just must network with the right people and build your own resource base. It's important to know your relevant stakeholders. As her social worker you have to take the initiative to develop your own networks. So I'm always looking at places to refer children who are orphans living in the townships.

With the Department of Health in the Eastern Cape they do have social workers at the hospitals. But you find at the clinics there are none. But in my experience of working in the clinics I find that there is a big need for us to be in these clinic facilities. In some of the clinics we find a dietician or a psychologist but it's better if we had everyone under one roof. For example here if there is a social problem and I am not here then they have to refer to the local hospital and then people have to have money to travel and they don't have money. It would be better if they just had to refer that all of the professionals were together. I can help many people every day in the clinic and I don't have to travel anywhere is much better. I can see many people and they never cancel their appointments.

You know many people don’t show for their referral appointments or to be followed up by specialist simply because people don't have bus fare. You know one of the good things about me being in the clinic is that sometimes people just want to find something out. I know the Department of Social Development and how it works. I can just make a phone call to find the answer to a person’s query and prevent them from having to travel there. This saves time and money. It's good to have an integrated approach in providing psychosocial support for children who are orphans living in the township. They need nurses, social workers, psychologists and they need to go to school. These are the fundamental services that they need.

You know so much is dependent Sharron on the individual social worker and the amount of initiative they create to generate their own resources. As a social worker you have to make yourself known in the NGO and stakeholder networks. I have to network a lot with social workers and other stakeholders. What I can’t provide I need to refer to social development to provide.

I think the government should put social workers in the clinics and not rely on NGOs to do that for them. There's no reason why social workers can be in all the clinics in the Metropolis and run support groups for orphans. The clients should be able to access social workers through their local clinics. You know many times the client doesn't need to go to the Department of Social Development they just need someone to make a phone call for them. It's far for them to travel Sharron to social workers. And in people finances there is already stress because there isn’t enough money even for food. I think this is the best recommendation I would like to make that they should have social worker services in the clinic facilities in the townships. This would make a big difference to people who are living in the township communities.

I have to go as I need to orientate a new volunteer to the clinic. It’s been lovely to talk to you.

Researcher:

Thank you so much for all of the insights that you have shared with me.

Appendix L: Letter to Independent Coder

• PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

26th April 2012

Letter to Independent Coder

Dear Mrs Williams,

My name is Sharron Frood I am from the UK currently studying as a Doctoral student at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Doctoral thesis involves developing strategies to provide care and support for children orphaned by AIDS living in townships. This project will be conducted under the supervision of Prof R. M van Rooyen (NMMU, South Africa) and Dr E. J Ricks (NMMU, South Africa).

The aims of this research study are as follows:

To explore current international, national and provincial legislative and policy frameworks, concerning the rights of children living in South Africa

To explore and describe the experiences of professional nurses in primary health care clinics in providing care and support to children living as AIDS orphans in the townships.

To explore and describe the experiences of social workers and psychologists who provide care and support to children who are AIDS orphans living in townships

To create a conceptual framework for the care and support of children who are AIDS orphans living in townships

To develop strategies that can be used for the provision of care and support to children orphaned by AIDS living in the townships.

I would be grateful if you could assist me as my independent coder? Re-code existing data if necessary. The coding process and data analysis were conducted according to the steps suggested in Creswell (2007:150), in which the analysis process is considered to conform to a general contour, which is best represented in a “spiral Image”, which he terms the “data analysis spiral”.

It comprises the following progressive phases of increasing complexity and meticulousness of analysis.

Data management is the first loop in this spiral and begins the process. This involves organising the data into files that can be retrieved when data analysis begins. The researcher may choose from various methods of data organisation

The next step in the process is **reading and memoing** in which the researcher gets a sense of the whole database by reading the transcripts in their entirety. Writing memos in the margins assists in this preliminary process. By reading and listening to the transcripts concurrently, with the field notes, the researcher is able to "hear" what the participants said. At this stage, initial categories could be formulated from the initial coding of data.

The researcher continues analysis by moving onto the next part of the spiral, which is termed **describing, classifying and interpreting**. In this stage codes and categories are developed that are described in detail so that the researcher provides an interpretation of the data. These categories of information are examined and sorted during the process of continually reviewing the database until the researcher can work towards limiting the categories to 25-30. This will assist in ultimately reducing the volume of data generated during the study to a workable five to six themes. **Classifying** is the stage of analysis during which the themes and sub themes are developed following further examination of the information available. **Interpretation** involves making sense of the data, whereby hunches, insights and intuition are utilised, plus a construct or an idea, or a combination of all of the above, which can lead to promoting and encouraging interpretation. During this part of the process the researcher steps back to allow a larger or deeper meaning to be formulated of the situation being researched.

In the final phase of the spiral, which is termed **visualising and representing,** the data are presented. This can be done in text, tabular or figure form, or a combination of these. During the phase an in-depth picture of the study is presented, which can in various forms, for example narration, a visual model or theory.

I appreciate your assistance with this aspect of my PhD.

Kind Regards

Sharron Frood

Appendix M: Letter and evaluation to panel of experts

Sharron Frood

sharron@gogotrust.com

10 Lloyd Road Walmer Port Elizabeth

076 566 1937

Dear Sir/ Madam,

Wishing you a Blessed and Happy New Year. Thank you for kindly agreeing to be part of an expert panel to review the PhD study with the title “Strategies to provide holistic care and support to AIDS orphans living in Township Communities”. This study was undertaken by the researcher in Nelson Mandela Bay; in the Eastern Cape of South Africa

Included you will find:

1. Chapter six which includes the developed strategies
2. An evaluation document stipulating the criteria which to evaluate the strategies with
3. Could you kindly state your initials ,surname and qualifications in **Section A**
4. Could you submit your evaluation electronically, on the attached evaluation form; under the relevant headings **Section B**
5. Due to time constraints could you kindly return this ASAP? I appreciate your valued contribution to this research study
6. Please do not hesitate to contact me. My number is 076 566 1937

Section A:

Initials: **Surname:**

Qualifications and expertise:

Section B:

1. Clarity of the strategies: Is the language of the strategies' clear and understandable?

Comments:

2. Simplicity of Strategies'

Are the strategies simple to understand and do they link theory and practice?

Comments:

3. Generality of Strategies'

The strategies were developed to assist in the improvement of the provision of holistic care and support to children who are AIDS orphans living in township communities; will it be possible to transfer the strategies to other township communities in other areas in South Africa?

Comments:

4. Usefulness of strategies'

Will the implementation of the strategies' enable improved provision of holistic care and support to children who are AIDS orphans living in township communities?

Comments:

5. Significance, importance of the strategies?

Comments:

Thank you for your time, your honest and expert opinion regarding the developed strategies:

Yours Sincerely

(Sharron Frood)

Appendix N: Letter of Confirmation from the Editor

22 Broadwood Manor
Keith Crescent
Broadwood
Port Elizabeth
6070
Eastern Cape

6th January 2014

To whom it may concern,

I have edited Miss Sharron Froods' doctoral thesis titles" strategies to provide care and support to AIDS orphans living in township communities". In doing so, I have checked grammar, semantics, punctuation and conventions of language, as well as technical aspects. The content is entirely Miss Froods' original writing.

Yours Sincerely

RABatchelor

Rose Batchelor

rose@batchelor.za.net
0835909222

Appendix O: Articles of the convention of the rights of the child (CRC)

Article 1 (Definition of the child): The Convention defines a 'child' as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger. The Committee on the Rights of the Child, the monitoring body for the Convention, has encouraged States to review the age of majority if it is set below 18 and to increase the level of protection for all children under 18.

Article 2 (Non-discrimination): The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn’t matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3 (Best interests of the child): The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers.

Article 4 (Protection of rights): Governments have a responsibility to take all available measures to make sure children’s rights are respected, protected and fulfilled. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families protect children’s rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones. Such legislative changes are not imposed, but come about through the same process by which any law is created or reformed within a country. Article 41 of the Convention points out the when a country already has higher legal standards than those seen in the Convention, the higher standards always prevail.

Article 5 (Parental guidance): Governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly. Helping children to understand their rights does not mean pushing them to make choices with consequences that they are too young to handle. Article 5 encourages parents to deal with rights issues "in a manner consistent with the evolving capacities of the child". The Convention does not take responsibility for children away from their parents and give more authority to governments. It does place on governments the responsibility to protect and assist families in fulfilling their essential role as nurturers of children.

Article 6 (Survival and development): Children have the right to live. Governments should ensure that children survive and develop healthily.

Article 7 (Registration, name, nationality, care): All children have the right to a legally registered name, officially recognised by the government. Children have the right to a nationality (to belong to a country). Children also have the right to know and, as far as possible, to be cared for by their parents.

Article 8 (Preservation of identity): Children have the right to an identity – an official record of who they are. Governments should respect children's right to a name, a nationality and family ties.

Article 9 (Separation from parents): Children have the right to live with their parent(s), unless it is bad for them. Children whose parents do not live together have the right to stay in contact with both parents, unless this might hurt the child.

Article 10 (Family reunification): Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family.

Article 11 (Kidnapping): Governments should take steps to stop children being taken out of their own country illegally. This article is particularly concerned with parental abductions. The Convention's Optional Protocol on the sale of children, child prostitution and child pornography has a provision that concerns abduction for financial gain.

Article 12 (Respect for the views of the child): When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. This does not mean that children can now tell their parents what to do. This Convention encourages adults to listen to the opinions of children and involve them in decision-making -- not give children authority over adults. Article 12 does not interfere with parents' right and responsibility to express their views on matters affecting their children. Moreover, the Convention recognizes that the level of a child's participation in decisions must be appropriate to the child's level of maturity. Children's ability to form and express their opinions develops with age and most adults will naturally give the views of teenagers greater weight than those of a preschooler, whether in family, legal or administrative decisions.

Article 12 (Respect for the views of the child): When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.

Article 13 (Freedom of expression): Children have the right to get and share information, as long as the information is not damaging to them or others. In exercising the right to freedom of expression, children have the responsibility to also respect the rights, freedoms and reputations of others. The freedom of expression includes the right to share information in any way they choose, including by talking, drawing or writing.

Article 14 (Freedom of thought, conscience and religion): Children have the right to think and believe what they want and to practise their religion, as long as they are not stopping other people from enjoying their rights. Parents should help guide their children in these matters. The Convention respects the rights and duties of parents in providing religious and moral guidance to their children. Religious groups around the world have expressed support for the Convention, which indicates that it in no way prevents parents from bringing their children up within a religious tradition. At the same time, the Convention recognizes that as children mature and are able to form their own views, some may question certain religious practices or cultural traditions. The Convention supports children's right to examine their beliefs, but it also states that their right to express their beliefs implies respect for the rights and freedoms of others.

Article 15 (Freedom of association): Children have the right to meet together and to join groups and organisations, as long as it does not stop other people from enjoying their rights. In exercising their rights, children have the responsibility to respect the rights, freedoms and reputations of others.

Article 16 (Right to privacy): Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.

Article 17 (Access to information; mass media): Children have the right to get information that is important to their health and well-being. Governments should encourage mass media – radio, television, newspapers and Internet content sources – to provide information that children can understand and to not promote materials that could harm children. Mass media should particularly be encouraged to supply information in languages that minority and indigenous children can understand. Children should also have access to children’s books.

Article 18 (Parental responsibilities; state assistance): Both parents share responsibility for bringing up their children, and should always consider what is best for each child.

Governments must respect the responsibility of parents for providing appropriate guidance to their children – the Convention does not take responsibility for children away from their parents and give more authority to governments. It places a responsibility on governments to provide support services to parents, especially if both parents work outside the home.

Article 19 (Protection from all forms of violence): Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after

them. In terms of discipline, the Convention does not specify what forms of punishment parents should use. However any form of discipline involving violence is unacceptable. There are ways to discipline children that are effective in helping children learn about family and social expectations for their behaviour – ones that are non-violent, are appropriate to the child's level of development and take the best interests of the child into consideration. In most countries, laws already define what sorts of punishments are considered excessive or abusive. It is up to each government to review these laws in light of the Convention.

Article 20 (Children deprived of family environment): Children who cannot be looked after by their own family have a right to special care and must be looked after properly, by people who respect their ethnic group, religion, culture and language.

Article 21 (Adoption): Children have the right to care and protection if they are adopted or in foster care. The first concern must be what is best for them. The same rules should apply whether they are adopted in the country where they were born, or if they are taken to live in another country.

Article 22 (Refugee children): Children have the right to special protection and help if they are refugees (if they have been forced to leave their home and live in another country), as well as all the rights in this Convention.

Article 23 (Children with disabilities): Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.

Article 24 (Health and health services): Children have the right to good quality health care – the best health care possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this.

Article 25 (Review of treatment in care): Children who are looked after by their local authorities, rather than their parents, have the right to have these living arrangements looked at regularly to see if they are the most appropriate. Their care and treatment should always be based on "the best interests of the child". (see Guiding Principles, Article 3)

Article 26 (Social security): Children – either through their guardians or directly – have the right to help from the government if they are poor or in need.

Article 27 (Adequate standard of living): Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who cannot afford to provide this, particularly with regard to food, clothing and housing.

Article 28: (Right to education): All children have the right to a primary education, which should be free. Wealthy countries should help poorer countries achieve this right. Discipline in schools should respect children's dignity. For children to benefit from education, schools must be run in an orderly way – without the use of violence. Any form of school discipline should take into account the child's human dignity. Therefore, governments must ensure that school administrators review their discipline policies and eliminate any discipline practices involving physical or mental violence, abuse or neglect. The Convention places a high value on education. Young people should be encouraged to reach the highest level of education of which they are capable.

Article 29 (Goals of education): Children's education should develop each child's personality, talents and abilities to the fullest. It should encourage children to respect others, human rights and their own and other cultures. It should also help them learn to live peacefully, protect the environment and respect other people. Children have a particular responsibility to respect the rights their parents, and education should aim to develop respect for the values and culture of their parents. The Convention does not address such issues as school uniforms, dress codes, the singing of the national anthem or prayer in schools. It is up to governments and school officials in each country to determine whether, in the context of their society and existing laws, such matters infringe upon other rights protected by the Convention.

Article 30 (Children of minorities/indigenous groups): Minority or indigenous children have the right to learn about and practice their own culture, language and religion. The right to practice one's own culture, language and religion applies to everyone; the Convention here highlights this right in instances where the practices are not shared by the majority of people in the country.

Article 31 (Leisure, play and culture): Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities.

Article 32 (Child labour): The government should protect children from work that is dangerous or might harm their health or their education. While the Convention protects children from harmful and exploitative work, there is nothing in it that prohibits parents from expecting their children to help out at home in ways that are safe and appropriate to their age. If children help out in a family farm or business, the tasks they do be safe and suited to their level of development and comply with national labour laws. Children's work should not jeopardize any of their other rights, including the right to education, or the right to relaxation and play.

Article 33 (Drug abuse): Governments should use all means possible to protect children from the use of harmful drugs and from being used in the drug trade.

Article 34 (Sexual exploitation): Governments should protect children from all forms of sexual exploitation and abuse. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 35 (Abduction, sale and trafficking): The government should take all measures possible to make sure that children are not abducted, sold or trafficked. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 36 (Other forms of exploitation): Children should be protected from any activity that takes advantage of them or could harm their welfare and development.

Article 37 (Detention and punishment): No one is allowed to punish children in a cruel or harmful way. Children who break the law should not be treated cruelly. They should not be put in prison with adults, should be able to keep in contact with their families, and should not be sentenced to death or life imprisonment without possibility of release.

Article 38 (War and armed conflicts): Governments must do everything they can to protect and care for children affected by war. Children under 15 should not be forced or recruited to take part in a war or join the armed forces. The Convention’s Optional Protocol on the involvement of children in armed conflict further develops this right, raising the age for direct participation in armed conflict to 18 and establishing a ban on compulsory recruitment for children under 18.

Article 39 (Rehabilitation of child victims): Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.

Article 40 (Juvenile justice): Children who are accused of breaking the law have the right to legal help and fair treatment in a justice system that respects their rights. Governments are required to set a minimum age below which children cannot be held criminally responsible and to provide minimum guarantees for the fairness and quick resolution of judicial or alternative proceedings.

Article 41 (Respect for superior national standards): If the laws of a country provide better protection of children's rights than the articles in this Convention, those laws should apply.

Article 42 (Knowledge of rights): Governments should make the Convention known to adults and children. Adults should help children learn about their rights, too. (See also article 4.)

Articles 43-54 (implementation measures): These articles discuss how governments and international organizations like UNICEF should work to ensure children are protected in their rights.

Chapter Two of the Constitution of South Africa

South Africa Bill of Rights

Chapter Two of the Constitution of South Africa contains the **Bill of Rights**, a human rights charter that protects the civil, political and socio-economic rights of all people in South Africa. The rights in the Bill apply to all law, including the common law, and bind all branches of the government, including the national executive, Parliament, the judiciary, provincial governments and municipal councils. Some provisions, such as those prohibiting unfair discrimination, also apply to the actions of private persons.

South Africa's first bill of rights was contained in Chapter 3 of the transitional Constitution of 1993, which was drawn up as part of the negotiations to end apartheid. This "interim Bill of Rights", which came into force on 27 April 1994 (the date of the first non-racial election), was largely limited to civil and political rights (negative rights).[1] The current Bill of Rights, which replaced it on 4 February 1997 (the commencement date of the final Constitution), retained all of these rights and added a number of new positive economic, social and cultural rights.

Application

The extent of the jurisdiction and application of the Bill of Rights is defined by sections seven and eight, entitled "Rights" and "Application" respectively. Section seven provides that the rights apply to "all people in our country" (although certain rights are limited to citizens) and requires the state (by which is meant government at all levels) to "respect, protect, promote and fulfil" the Bill of Rights. It also notes that the rights in the Bill are subject to the limitations provided for in section thirty-six and elsewhere in the Bill; see *Limitations* below.

Although section two already provides for the supremacy of the Constitution over all laws and government actions, section eight explicitly states that the Bill of Rights applies to all law and binds all branches and organs of government. It further states that the provisions of the Bill also bind private parties to the extent that they are applicable, given the nature of the rights in question, and requires the courts to develop the common law to this effect. Finally, section eight extends the benefits of the Bill of Rights to juristic persons, taking into account the nature of the rights and the juristic persons in question. Thus, for example, the right to human dignity and the right to health care clearly only apply to actual human beings, while the right to freedom of expression and the right to property apply also to corporations.

Main article: Section Nine of the Constitution of South Africa

Section 9 contains strong provisions on legal and social equality. Section 9 is in line with internationally recognised human rights law, but the provision is more detailed than for example in the Universal Declaration of Human Rights.

The Section starts with "Everyone is equal before the law and has the right to equal protection and benefit of the law. Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken."

The Section, like the Universal Declaration of Human Rights prohibits all discrimination "on one or more grounds, including...", but specifically lists the following grounds "race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth." This is list is more extensive than the equality provisions in most human rights instruments, noteworthy are the distinction between "gender" and "sex", the inclusion of "pregnancy", the distinction between "race" and "colour", the inclusion of "age" and "disability".

Section 8 again not only indicates negative responsibilities, in that the State is not allowed to discriminate, but also positive responsibilities in that it provides that "No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination." See negative and positive rights.

Section 8 includes the limitation "Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair." This limitation allows for the South African government to enact the Black Economic Empowerment program, which seeks to redress the inequalities of Apartheid by giving previously disadvantaged groups (black Africans, Coloureds and Indians who are SA citizens) preference treatment in employment, tenders, etc.

Human dignity

Section 10 states “Everyone has inherent dignity and the right to have their dignity respected and protected.”

Life

Main article: Section Eleven of the Constitution of South Africa

Section 11 states “Everyone has the right to life.” In *S v Makwanyane* this was judged to forbid the death penalty.

Freedom and security of the person

Section 12 protects "Freedom and Security of the Person". The Section sets out the rights contained under this provision, which include standard due process provisions, freedom from arbitrary arrest, freedom from torture, and freedom from cruel, inhuman or degrading punishment. The Section also stipulates the freedom from all forms of violence, regardless of whether a public or private source. This provision is unique amongst human rights instruments.

The Section starts with “Everyone has the right to freedom and security of the person, which includes the right not to be deprived of freedom arbitrarily or without just cause; not to be detained without trial; to be free from all forms of violence from either public or private sources; not to be tortured in any way; and not to be treated or punished in a cruel, inhuman or degrading way.”

The Section also covers reproductive rights, although not extensively defined. Adding to this the Section grants "security in and control over" the own body and to not be subjected to medical or scientific experiments without informed consent. These two provisions are unique amongst human rights instruments.

The Section reads “Everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction; to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent.

Slavery, servitude and forced labour

Section 13 states “No one may be subjected to slavery, servitude or forced labour.”

Privacy

Section 14 contains detailed provisions on the right to privacy. Defining the scope as follows “Everyone has the right to privacy, which includes the right not to have their person or home searched; their property searched; their possessions seized; or the privacy of their communications infringed.”

Freedom of religion, belief and opinion

Section 15 states “Everyone has the right to freedom of conscience, religion, thought, belief and opinion.”

The Section expands on the Right to freedom of religion by stating “ Religious observances may be conducted at state or state-aided institutions, provided that those observances follow rules made by the appropriate public authorities; they are conducted on an equitable basis; and attendance at them is free and voluntary.

The Section also seeks to define how the right to freedom of religion, belief and opinion is balanced against tradition and custom, by stating “This section does not prevent legislation recognising marriages concluded under any tradition, or a system of religious, personal or family law; or systems of personal and family law under any tradition, or adhered to by persons professing a particular religion. “ The Section also provides that “Recognition in terms of paragraph (a) must be consistent with this section and the other provisions of the Constitution.”

Freedom of expression

Section 16 contains detailed provisions with regard to freedom of expression, stating “Everyone has the right to freedom of expression, which includes freedom of the press and other media; freedom to receive or impart information or ideas; freedom of artistic creativity; and academic freedom and freedom of scientific research.”

Section 16 contains the following limitations to freedom of expression “The right in subsection (1) does not extend to propaganda for war; incitement of imminent violence; or advocacy of hatred that is based on race, ethnicity, gender or religion, and that constitutes incitement to cause harm.”

Assembly, demonstration, picket and petition

Section 17 states “Everyone has the right, peacefully and unarmed, to assemble, to demonstrate, to picket and to present petitions.”

Freedom of association

Section 18 states “Everyone has the right to freedom of association.”

Political rights

Section 19 sets out a detailed set of political rights, stating “Every citizen is free to make political choices, which includes the right to form a political party; to participate in the activities of, or recruit members for, a political party; and to campaign for a political party or cause.“

The Section also safeguards public participation by the means of election by stating “Every citizen has the right to free, fair and regular elections for any legislative body established in terms of the Constitution. Every adult citizen has the right to vote in elections for any legislative body established in terms of the Constitution, and to do so in secret; and to stand for public office and, if elected, to hold office.” These provisions contain the implied limitation that only citizens of South Africa have a right to vote, and that they must be "adults".

Citizenship

Section 20 states that “No citizen may be deprived of citizenship.”

Freedom of movement and residence

Section 21 provides that “Everyone has the right to freedom of movement. Everyone has the right to leave the Republic.” Hence these provisions are applicable to all humans, while the following are limited to South African citizens. “Every citizen has the right to enter, to remain in and to reside anywhere in, the Republic. Every citizen has the right to a passport.”

Freedom of trade, occupation and profession

Section 22 enshrines freedom of trade occupation and profession. This set of rights is unique among human rights instruments.

The Section states “Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law.”

Labour relations

Section 23 sets out a number of labour rights, including the right to collective bargaining, and to join a trade union. The Section also stipulates the rights of the employer, as well as the rights of a trade union or employers’ organisation, in great detail, which is unique amongst human rights instruments.

The Section states “Everyone has the right to fair labour practices. Every worker has the right to form and join a trade union; to participate in the activities and programmes of a trade union; and to strike.”

With regard to employers the Section states “Every employer has the right to form and join an employers' organisation; and to participate in the activities and programmes of an employers' organisation.”

The Section lists the following rights for trade unions and employer organisations “Every trade union and every employers' organisation has the right to determine its own administration, programmes and activities; to organise; and to form and join a federation. Every trade union, employers' organisation and employer has the right to engage in collective bargaining.”

The Section concludes with the following limitation “National legislation may be enacted to regulate collective bargaining. To the extent that the legislation may limit a right in this Chapter, the limitation must comply with section 36(1). National legislation may recognise union security arrangements contained in collective agreements. To the extent that the legislation may limit a right in this Chapter, the limitation must comply with section 36(1).”

Environment

Section 24 sets out a number of environmental rights, which is unique in terms of human rights instruments, although environmental rights are recognised in the African Charter on Human and Peoples' Rights, although not in detail, and the Stockholm Declaration.

Article 24 specifically puts environmental rights into the context of human health, stating “Everyone has the right to an environment that is not harmful to their health or well-being;” As well as recognising the rights of future generations in the context of sustainable development by stating “and to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that prevent pollution and ecological degradation; promote conservation; and secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.”

Property

Section 25 enshrines the right to property, which is a standard international human right. The Section is very detailed, making it unique among human rights instruments. The Section amongst others covers arbitrary deprivation of property and compensation in great detail, which is in the context of the South African post-apartheid era and the Black Economic Empowerment program.

The Section states “No one may be deprived of property except in terms of law of general application, and no law may permit arbitrary deprivation of property. Property may be expropriated only in terms of law of general application for a public purpose or in the public interest; and subject to compensation, the amount of which and the time and manner of payment of which have either been agreed to by those affected or decided or approved by a court.”

The Section makes detailed provisions on compensation by stating “The amount of the compensation and the time and manner of payment must be just and equitable, reflecting an equitable balance between the public interest and the interests of those affected, having regard to all relevant circumstances.”

The Section sets out the context in which these provisions may be of relevance, in stating “For the purposes of this section the public interest includes the nation's commitment to land reform, and to reforms to bring about equitable access to all South Africa's natural resources;

and property is not limited to land. The state must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis. A person or community whose tenure of land is legally insecure as a result of past racially discriminatory laws or practices is entitled, to the extent provided by an Act of Parliament, either to tenure which is legally secure or to comparable redress. A person or community dispossessed of property after 19 June 1913 as a result of past racially discriminatory laws or practices is entitled, to the extent provided by an Act of Parliament, either to restitution of that property or to equitable redress."

Housing

Section 26 grants the right to housing, which is recognised by the African Commission on Human and Peoples' Rights. In the case SERAC v Nigeria (2001), the Commission concluded that the African Charter on Human and Peoples' Rights should be understood to include a right to housing and a right to food. The Section states that "Everyone has the right to have access to adequate housing."

Section 26 places positive responsibilities upon the state in stating that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right." The primary responsibility for fulfilling this mandate lies with the Department of Human Settlements.

Section 26 also grants the right to due process with regard to housing, stating that "No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions."

Health care, food, water and social security

Section 27 sets out a number of rights with regard to health, including right to access to health care, including reproductive rights. Section 27 also enshrines the right to social security, the right to food, and the right to water. Section 27 also states that "No one may be refused emergency medical treatment."

Again, positive responsibilities are placed on the state, the Section stating that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights"

Children

Section 28 lists a number of rights held by children. These rights relate to domestic family life, child labour, education, imprisonment, and armed conflict. It is stated that “In this section "child" means a person under the age of 18 years.“ and “A child's best interests are of paramount importance in every matter concerning the child.“

The rights listed are as follows

- **”to a name and a nationality from birth;”**
- **”to family care or parental care, or to appropriate alternative care when removed from the family environment;”**
- **”to basic nutrition, shelter, basic health care services and social services;”**
- **”to be protected from maltreatment, neglect, abuse or degradation;”**
- **”to be protected from exploitative labour practices;”**
- **”not to be required or permitted to perform work or provide services that are inappropriate for a person of that child's age; or place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;”**
- **”not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be kept separately from detained persons over the age of 18 years; and treated in a manner, and kept in conditions, that take account of the child's age;”**
- **”to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result;”**
- **”not to be used directly in armed conflict, and to be protected in times of armed conflict.”**

Education

Section 29 enshrines the right to education, and defines the positive responsibilities of the state in this respect. The Section states “Everyone has the right to a basic education, including adult basic education; and to further education, which the state, through reasonable measures, must make progressively available and accessible.”

The right to education is amongst others recognised in the Universal Declaration of Human Rights, and Section 29 expands on this provision in detail with regard to language, and the right to establishment self-funded of private schools.

The detailed provisions with regard to language reflects the fact that South Africa is a culturally diverse nation and has 11 official languages. Chapter 1 (Founding Provisions), Section 6 (Languages) of the Constitution of South Africa is the basis for government language policy, and Section 29 (Chapter 2, Bill of Rights) places positive responsibilities upon the state in this regard. Section 29 states that "Everyone has the right to receive education in the official language or languages of their choice in public educational institutions where that education is reasonably practicable. In order to ensure the effective access to, and implementation of, this right, the state must consider all reasonable educational alternatives, including single medium institutions, taking into account equity; practicability; and the need to redress the results of past racially discriminatory laws and practices."

Language and culture

Section 30 also considers the issue of language in terms of cultural rights, although with limitation. Section 30 states that "Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights."

Cultural, religious and linguistic communities

Section 31 specifically considers cultural, religious and linguistic communities within South Africa. Section 31 does not grant these communities group rights, but reaffirms their individual rights to exercise a number of cultural rights.

Section 31 states that "Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community to enjoy their culture, practise their religion and use their language; and to form, join and maintain cultural, religious and linguistic associations and other organs of civil society."

Section 31 concludes with the following limitation "The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights."

Access to information

Section 32 provides for the right to access to information, also known as the right to know. This provision is unique among human rights instruments, but are comparable with freedom of information legislation in other countries. The right to know was enshrined in the South African Bill of Rights in reaction to the restrictive information policies by the Apartheid regime.

Section 32 states that “Everyone has the right of access to any information held by the state; and any information that is held by another person and that is required for the exercise or protection of any rights.”

Section 32 not only provides for access to information held by the state, but also from a third party if it is required to exercise or protect any right. This makes this provision unique, even among freedom of information legislation, which commonly only apply to public bodies. Section 32 applies to public bodies, as well as private bodies, including companies.[2]

Procedures for access to information under section 32, and the limitations on the release of information, are regulated by the Promotion of Access to Information Act, 2000.

Just administrative action

Section 33 states that “Everyone has the right to administrative action that is lawful, reasonable and procedurally fair.” This section is unique amongst human rights instruments in terms of its detail on administrative due process.

Access to courts

Section 34 effectively provides for the right to a fair trial. It states “Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.”

Arrested, detained and accused persons

Section 35 is a very detailed list of rights, or right to due process. The Section lists rights with regard to arrest, court appearance, detention and fair trial.

Limitations

Rights contained in the Bill of Rights are not absolute and may be limited by way of specific limitation clauses where individual rights are subject to limitations set out in the individual

Sections, e.g. Section 9 on equality. In addition, the Constitution provides a General Limitation Clause at Section 36, which provides for all rights in the Bill of Rights to be limited in terms of law of general application and that "limitations must be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom." Any limitation must therefore be reasonable and may only be made with good cause. Limits should also be less restrictive.

Organs of state, such as the judiciary, the legislature or the executive, may invariably limit rights in carrying out their functions. For example by limiting the freedom of a prisoner. Further, because of the horizontal application of the Bill of Rights, rights may be limited by the actions or decisions of other persons. The courts are empowered to test the validity of the limitation in terms of S36.

Section 36 provides certain factors that must be taken into account by the courts when determining if a limitation is reasonable and justifiable:

- The nature of the right.
- The importance of the limitation
- The nature and extent of the limitation
- The relation between the limitation and its purpose, and
- Less restrictive means to achieve the purpose.

These factors are not limited and other factors that the court may deem necessary may also be taken into account. When the nature of the right is considered, the courts will have to take into account the content of the right, the importance of the right and the interest which is protected. It is, for instance, very difficult to justifiably limit the right to life as the Constitutional Court held in *S v Makwanyane* where capital punishment was abolished. The promotion and protection of a permissible or lawful public interest will be important when considering the limitation and its purpose. Further, the Constitution requires a less restrictive means to be considered, rather than limiting the rights of an individual, in achieving that purpose.[3]

Comparison with other human rights instruments

The limitations clause under section 36 has been compared to similar clauses in the *European Convention on Human Rights*. Specifically, there are limits on privacy rights (Section 8(2)), "except such as is in accordance with the law and is necessary in a democratic society", limits on freedom of thought and religion (art. 9(2)), "subject only to such limitations as are prescribed by law and are necessary in a democratic society," etc. In Canada the *Canadian*

Charter of Rights and Freedoms was adopted in 1982. Section 1 of that *Charter*, like section 36 of the South African law, states that rights are "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[4]

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