Needs and wants of children living in Child Headed Households

Master thesis

Master Social Policy and Social Interventions
Master thesis
Student: Simone Wassink (3413551)
Supervisor University Utrecht: Prof. dr. Trudie Knijn
Research done by: Ndlovu Care Group, South Africa
Supervisor Ndlovu Care Group: Mariette Slabbert
18 July 2012

Universiteit Utrecht

NDLOVU CARE GROUP

Contents

Acknowledgements **7**

Introduction **9**

Child Headed Households 9
Child Headed Households in South Africa 10
Child headed household as a social problem 11
Child Headed Households in the township Elandsdoorn 12
Research purpose 13

Theoretical framework **14**

Needs of Child Headed Households 14
Theory of Maslow 14
Objective and subjective needs 17
Head of household 19
Measurement theories 19
Research question 20

Methods **22**

Operationalization 22
Participants 24
Data collection 26
Analysis 28
Scientific relevance 30
Social relevance 30
ASW-justification 30

Results **32**

Sub-questions 33
Demographic characteristics *33*
Head of the household *35*
Research question 37

Physiological.....*38*
Safety.....*40*
Social.....*41*
Esteem.....*44*
Self-actualization.....*45*
Overarching research question.....46

Conclusions.....49
Demographic characteristics.....49
Head of the household.....49
Child Headed Households and the theory of Maslow.....50
Reflection.....51
Recommendations.....53
Ndlovu Care Group.....*53*
Future research.....*53*

References.....55

Appendices.....57
Appendix 1: Topic list interviews Child Headed Households.....57
Appendix 2: Topic list interviews social workers and supervisor.....61
Appendix 3: Topic list staff Ndlovu Care Group.....63
Appendix 4: Demographic characteristics Child Headed Households.....65
Appendix 5: Need to belong scale.....66
Appendix 6: Self-esteem scale Rosenberg.....67

Acknowledgements

This is the research “Needs and wants of children living in Child Headed Households”. The topic of Child Headed Households was a topic which got my interest immediately, and after doing research in the townships for four months, my interest for this topic has only increased. As a student of the master Social Policy and Social intervention at the University of Utrecht I have had a lot of pleasure in conducting this research in South Africa. Doing this research was a challenging and educative process in many ways.

Apart from the efforts of myself, the success of any project depends largely on the encouragement and guidelines of many others. I take this opportunity to express my gratitude to the people who have been instrumental in the completion of this project. First of all I would like to gratefully acknowledge the enthusiastic supervision of Trudie Knijn during this work. Her feedback and guidance has always been very helpful. I would like to thank Hugo Tempelman and Mariette Slabbert and all the other staff of Ndlovu Care Group. The time in Groblersdal has been inspiring and interesting and I learned a lot from my time at Ndlovu Care Group. I would like to thank Angela. We shared a lot of memorable moments, especially in Elandsdoorn during the interviews. Our academic competences were complementary and I learned from those of Angela.

Then I would like to thank those people who have always been on the background but have been a huge support for me. First and foremost I would like to thank my beloved Thijs. He always encouraged and inspired me in the long hours of telephone conversations. I would like to thank him for his trust, support and unconditional love. I would also like to thank my family and friends. They are always there for me and they are always supporting me. They are my tower of strength.

I would also like to thank the life skills facilitators who acted as translators in the interviews, but also as guides in Elandsdoorn. Last, but not least, I would like to thank all the respondents, as without their participation this research project would not have succeeded. They were always very open in sharing their feelings and stories. Their stories were not only of great value to this research, but also touched me on a personal level.

Simone Wassink
18 July 2012

Introduction

This research focuses on the needs of Child Headed Households in the area Elandsdoorn in South Africa. This research design first gives an overview of the difficulties around the concept of Child Headed Households. Then it will introduce the situation of Child Headed Households in South Africa in general, and in the township of Elandsdoorn in particular. It will outline why Child Headed Households should be defined as a social problem. Then the research purpose, including the aim of the research will be discussed. This will be followed by the theoretical framework with subsequently, the methods of the research, the results and finally the conclusions will be reported including the conclusion of the results, a reflection of the research and recommendations.

Child Headed Households

In the literature a lot of research has been done on Child Headed Households (CHHs). Although this seems like a clear concept, it is not. There are two main problems; firstly, there are different terms referring to the same phenomenon; secondly, there are different definitions of the terms.

Terms that are used are for example Child Headed Households; Youth Headed Households; Child Only Households; Adolescent Headed Households; and Sibling Headed Households. These all refer to a household where there is no parental caretaker. Then there are also different definitions of the different terms. Meintjes, Hall, Marera, & Boulle (2010) describe a 'child' as a person below the age of 18. In South Africa someone belong to the 'youth' when that person is aged between 14 and 35 years (Government of the Republic of South-Africa, 1997). But these definitions are not always followed. Many researchers describe their own specific definition of Child Headed Households, often without age criteria. For example the following definition ("Helping AIDS orphans in CHHs in Uganda", 2005, p. 2):

> "Given the above, we define a "Child-Headed Household" (CHH) as a household where the children are double orphans (i.e. both parents have died) and is headed by a child that is recognized as being:
> • Independent
> • Responsible for providing leadership and making major decisions in the running of the household;
> • Responsible, along with other children, for feeding and maintaining the household;

• Caring for younger siblings and adopting de facto adult / parent roles".

The word 'children' is not further defined in this definition, and the reference is to double orphans. Depending on the definition of CHHs it is, in a household headed by an child, not necessarily the case that the parents died. It is often the case that one of the parents is still alive, or even both of the parents but that they have abandoned their children. Another phenomenon concerning CHHs is that the double orphaned children live with (one of) their grandparents, but that the grandparent(s) are too old or too weak to take care of the children, in that case there is still no caretaker available for the children. The children are actually taking care for the grandparent(s).

Child Headed Households in South Africa

Due to HIV/AIDS, armed conflicts and natural disasters there are many orphans in Sub-Saharan Africa (Philips, 2011). Loss of parents also means loss of parental care. But loss of parental care can also mean the parent is still alive and a member of the household, but not able to take care of the children due to illness for example. The United Nations define children without parental care as "all children not in the overnight care of at least one of their parents, for whatever reason and under whatever circumstances" (United Nations (UN), 2010, p. 6). These children have to rely on forms of so-called 'alternative care', such as kinship care, foster care, residential care and supervised independent living arrangements for children (UN, 2010). Alternative care is not only provided by adults (mostly family members), but also by children. These children are mostly the oldest children in a household that suffered the loss of parents. The households continue to exist with (most of the time) the oldest child or children taking over the responsibilities of the parent. This form of living is known as a CHH (Philips, 2011). Due to gender-based discrimination, girl children are most likely to take care of a terminally ill parent or family member and of the household (Ministry of Social Development, 2010). Although the number of these households is rather small (0,67% of children in South Africa lived in this situation in 2006, around 122.000 children), children in these households are extremely vulnerable (Meintjes, et al., 2010). Risks they face are a lack of protection, physical care and psychological distress and poverty. Additional risks concern participation in society like the impossibility to go to school because of care responsibilities for younger siblings and lack of financial resources, stigma and isolation (Ministry of Social Development, 2010).

Because the children living in a CHH are extremely vulnerable, they have special needs. The needs of these children are very complex and diverse. Of importance are that their rights

and dignity are compromised. The older children in CHH are often fulfilling the parenting roles and tasks e.g. household chores, helping siblings with homework, providing emotional support, taking care of ill parents, securing safety for their siblings etc.

Child headed household as a social problem

The impact of adults suffering from HIV/Aids on children is multifaceted and affects all aspects of a child's life. Traditional safety nets such as the extended family and community support mechanisms are under increasing stress due to the impact of HIV/Aids and poverty. Children's roles are changing in response to these circumstances. Children have to take on care giving roles, often at an early age, not just for younger siblings but also for terminally ill parents (Germann, 2005). The death of a parent impacts negatively on the protection, quality of care, psycho-social well-being and access to basic services for any affected child. These CHHs are extremely vulnerable to all types of abuse. They are at risk of contracting HIV and Aids as a result of sexual exploitation (Ministry of Social Development, 2010). Because they are very poor and have to take care of their siblings, older children are often not able to get a good education. If children are not supported, these experiences may have long-term negative consequences on their development. This in turn could affect the stability of societies in countries with high HIV/Aids prevalence rates (Germann, 2005).

In recent years, the problem of children without parental care got more international attention, for example by the UN guidelines for alternative care of children (UN, 2010). As described by Philips (2011) the international attention to this problem also caused an increase in national policies regarding these children, and CHHs in particular. In South Africa national statutory guidelines regarding care for CHHs are stated by the Ministry of Social Development in the *National guidelines for statutory services to child-headed households* (Ministry of Social Development, 2010). These are guidelines for social workers on how to treat children in a CHH. The ministry sees the solution for care for CHHs in collaboration between different national departments and the local offices of the Department of Social Development and NGO's. The Local Office of the Department of Social Development should play an important role in the coordination of programs and the alignment with other programs creating structures for children (Ministry of Social Development, 2010). In this document local NGO's are asked to facilitate early identification of CHHs and to mobilize resources to support CHHs and to do this primarily by supporting family and communities to provide alternative care (Ministry of Social Development, 2010). Problematic for the development of programs and policies is that the knowledge of the circumstances and number of children living in CHHs differs by region. It will

often be the case that these methods and instruments are not yet validated for the specific target population when they are developed in another country or in another socio-cultural setting. In some areas a complete picture exists of the number of Child Headed Households (CHHs) and policy has been developed. In other (especially rural) areas not much research is done yet on the needs of CHHs and little systematic programs are developed.

There are assumptions that the needs of children in CHHs should be different from those of other people, but this is not specified and not thoroughly investigated. Research is done on the needs of children in poverty (Prince & Howard, 2002) and on needs of, and care for orphans (Loening-Voysey & Wilson, 2001; Dunn, 2005). So research is done on needs of children in vulnerable positions, and some research is done on needs of CHHs (Germann, 2005). In order to create useful interventions this research will determine the needs of the CHHs, only then can the intervention respond to these needs. That is why it is necessary to do research on the actual needs of these children and not to merely assume their needs. Worldwide over the last twenty-five years there has been a growing recognition of the importance of listening to children's views and wishes. This is because there have been changes in the attitudes towards children. There is increasing acknowledgement that children are experts on their own lives and adults (and researchers) should take what children say seriously (Germann, 2005).

Child Headed Households in the township Elandsdoorn

This research will focus on an area where no previous research on CHHs has been done yet. The research will be undertaken in the working area of the Ndlovu Care Group (NCG). This South African NGO is a community development group that has been operating in rural areas in South Africa, among which the township Elandsdoorn, Limpopo Province (www.ndlovucaregroup.co.za). In this township, Ndlovu Care Group has already reported more than 40 CHHs to the local Department of Social Services. Once the CHHs are reported, social workers of this department assist these households with their needs. This reporting to the Department of Social Services occurs on an individual basis every time a new CHH arises because of parental death or illness, or is detected later on. However no overview exists of the exact number of CHHs in the township Elandsdoorn, neither is an overview available of the exact needs and wants of these households. This lack of information makes it difficult for the Ndlovu Care Group to offer social programs which guarantee sustainable help to these households or to provide the Department of Social Services with the necessary information to offer programs or financial resources. Ndlovu Care Group attaches great value to the views and opinions of the people in the field and in the community to design interventions. So the needs of

the CHHs should be investigated before an appropriate intervention can be made. The Ndlovu Care Group works with the Asset-Based Community Development (ABCD) model of community development. This is described as the "process and method aimed at enhancing the capacity of communities to respond to their own needs, through community mobilization, strength-based approaches and empowerment" (Tempelman, Slabbert, Gosling, & Vermeer, 2010, p168). An overview of the needs of the CHHs in the community could contribute to a sustainable program to assist CHHs.

Research purpose

As stated above the problem of children without parental guidance and protection poses a serious social problem. The NGO Ndlovu Care Group wants to design some programs for these CHHs but in order to ensure that these programs are related to the current practice, research has to be done on CHHs in this area.

In this research the wants and needs of children living in CHHs in the township Elandsdoorn will be explored in a very broad sense. There will be a focus on the perceived needs of children. These will be compared with available resources in the community. The purpose of this research is to give an overview of these needs and resources in order to see to what extent there is a mismatch between the available resources and the unfulfilled needs and wants of the CHHs. The results of this study can be a guideline for the development of social programs for CHHs.

Theoretical framework

In this paragraph the theoretical framework will be discussed. First the specific needs of CHHs will be discussed shortly. This will be followed by an explanation of the theory used in this research: the theory of the needs hierarchy pyramid of Maslow. After this a discussion of objective and subjective needs will be given. This will be followed by a short theoretical framework of why someone becomes the head of the household. Then the measurement theories will be explained and finally the research question will be outlined.

Needs of Child Headed Households

Policy documents assume that children in CHHs have special needs and wants and are extremely vulnerable to abuse; exploitation; child trafficking; and commercial sex work due to the fact that they do not have an adult to ensure their protection and safety (Ministry of Social Development, 2010). These assumptions are based on the fact that HIV/Aids is one of the main contributing factors to the existence of CHHs. Due to the illness and/or death of the caregiver, he or she is not able to contribute economically to the household, nor to provide emotional security, psychological stability and care for the children (Ministry of Social Development, 2010).

Theory of Maslow

For studying the needs of CHHs, a useful theoretical basis is Maslow's hierarchy of needs. The theory of Maslow is a commonly used and widely accepted theory for investigating the needs of human beings. Maslow (1970) stated that individuals have needs (basic to their existence) and that these needs are prioritized in a certain hierarchy. That means that first the primary needs have to be satisfied before an individual can start to work on the needs higher up in the hierarchy (Walsh, 2011). The needs defined by Maslow are from the lowest level of needs (the most basic needs) to the highest level; these include physiological needs, safety needs, social needs, esteem needs, and self-actualization (see Fig. 1). The most basic need group, physiological needs, relates to the body's need for food, water, oxygen, optimal temperature, and sleep, in order to maintain physiological homoeostasis and survival. A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else (Maslow, 1970). The second need group, safety needs, is the need for physical

safety, including the needs for security, protection, stability, and freedom from fear or constant anxiety (Harper, Harper, & Stills, 2003). Everybody will work on feeling physically safe in their own environment. If one has their physiological needs met but feels unsafe in their environment, the person's behaviour will be focused on achieving physical safety. The need for safety is seen as an active and dominant mobilizer of the organism's resources only in emergencies, e.g., war disease, natural catastrophes, neurosis (Maslow, 1970). Social needs, the next level, is described by Maslow as the need to belong to and feel loved by a group; such as one's family, religious group, work group, professional group, social club or fraternity, or even one's youth gang. Relationships such as friendships, romantic attachments, and families help fulfil this need for belongingness and acceptance, just as involvement in social, community or religious groups. For children this layer is very important because children who receive sensitive and reliable responses from their parents or caregivers during the early years of their life are able to develop successful, secure relationships (Prince & Howard, 2002). The next hierarchical level, esteem, has to do with self-esteem for one's accomplishments or achievements and deserved esteem from others, based on one's accomplishments, status, or appearance. All people in our society (with a few pathological exceptions) have a need for a stable, firmly based, (usually) high evaluation of themselves, for self-respect, self-esteem, and for esteem of others (Maslow, 1970). The highest Maslowian need is self-actualization, which is the need to develop one's common potential and unique talent at the highest possible level of growth and achievement (Harper, et al., 2003). This tendency might be phrased as the desire to become more and more what one is, to become everything that one is capable of becoming (Maslow, 1970). "The full use and exploitation of talents, capacities and potentialities, etc." (Maslow, 1970, p. 150). Actualization is the final aspect of Maslow's hierarchy, but he did not mean it to be an ending point. Actualization is an individual's awareness of his or her full potential, and is an ongoing process that involves many growth decisions that entail risk and courage. Actualization entails applying being values, such as truth, beauty, justice, simplicity, orders and purposefulness, to everyday life. Maslow describes actualization needs the hardest to satisfy, but the most important to work towards. This is because when figuring out who you are as an individual, you are locating your place in society, as well (Maslow, 1970). As regard to hierarchy of needs, Maslow (1968, 1970) explains that the most important needs of the person occupy the conscious efforts and striving towards satisfaction, while the less important needs are minimized, suppressed, or denied. Therefore, when one need is satisfied, the next need in hierarchy emerges to dominate the drive or conscious motivational efforts of the person (Harper, et al., 2003).

Figure 1: Maslow's pyramid of hierarchy of needs

Maslow (1970) posits that all human beings, regardless of culture, have the same five basic needs that can be hierarchically arranged, but they may differ individually and culturally in their ability to fulfil their needs. Harper and Stone (1999, 2003) suggest that the ease versus difficulty of a human being to fulfil basic needs is often influenced by that person's ethnic, social-class, economic, political, or religious status within a given culture, as well as the environmental resources or opportunities that are available for the need-fulfilment of people of a given culture or country. Within the framework of Maslow's basic needs, crisis events and environmental conditions may present challenges to the fulfilment of the needs of children (Harper, et al., 2003).

Ndlovu Care Group uses the theory of Maslow for the development of their programs. For example the Rural Advancement Program (RAP). This is a program consisting of community health and community care programs that identifies, supports, and attempts to excel individuals in rural populations. For this program Ndlovu Care Group has been using the hierarchy of the needs of Maslow to identify the human needs. Ndlovu Care Group wants to make programs for the fulfilment of all the needs of the pyramid of Maslow. The programs can be assigned to the layers of the pyramid of Maslow (Tempelman, et al., 2010). Using the theory of Maslow in this research fits well with the ideology of Ndlovu Care Group.

Children in CHHs are continually at risk of being unable to fulfil their basic human needs, as described by Maslow, (Harper, et al., 2003) adequately. Regarding CHHs, it seems likely that problems might exist in the fulfilling of needs in each 'layer' of Maslow's hierarchy;

especially physiological needs and needs regarding safety are already mentioned in the existing data (www.ndlovucaregroup.co.za). The needs mentioned by Maslow might be a useful starting point for an exploration of the needs of children in CHHs.

Objective and subjective needs

Maslow assumes coherence between objective and subjective needs. In the objective approach, the focus is on measuring 'hard' facts, such as income in dollars or living accommodation in square meters (Veenhoven, 2002). The subjective approach in contrast considers 'soft' matters such as satisfaction with income and perceived adequacy of dwelling (Veenhoven, 2002). Maslow's theory is difficult to evaluate objectively; many of the phenomena that Maslow describes are subjective and difficult to quantify. In his theory there is a difference between the lower layers and the higher layers. The lower layers, including physiological needs and safety needs are the universal basic needs. The higher layers, including social needs, esteem and self-actualization, are the context or person-specific wants. Everybody haves these needs but they are formed by individual preferences rather than bodily requirements, which are determined by personality, social position, and culture (Camfield & Guillen-Royo, 2010). So the lower two layers could be defined as needs, as goods or services that are required to live. The higher three layers could be defined as wants. Wants are goods or services that are not necessary but that are desired. The needs and wants can be subjectively experienced though, this are the perceived needs and wants of people. For example, somebody with only a few clothes can have the need to have more clothes to have, in his opinion, enough clothes. Somebody without clothes will have the need for only a few clothes to have, in his opinion, enough clothes. Clothes are an example of the physiological needs described by Maslow but this does not mean that clothes are always a need. For example, clothes can be a need, but designer clothes a want. For this research the subjective needs and wants of CHHs are more interesting, because this research is not focused on the absolute needs of CHHs, but more on the experienced needs and wants of CHHs. This way Ndlovu Care Group can have a overview of their needs and wants and based on this overview they can develop programs for the CHHs. That's why this research will focus on the perceived needs of the CHHs. For example: two children who will receive the same amount of food every day, may experience this differently. The one could say that he has got enough food everyday and the other might say that he do not have enough food every day. Why the answers differ, does not matter in this research, because this research focus on the perceived needs of members of CHHs. This research is a first and exploratory research with the focus on *what* the needs and wants of CHHs are and not *why* these are their needs and wants. What their needs are

is the basis from which Ndlovu Care Group can start to make programs for the CHHs. Maslow postulates all kinds of human needs. This research focused on all the need layers described by Maslow. Both the objective and the subjective layers, respectively the lower two and the higher three layers, can be perceived needs and wants, as shown in the example above. Because this research will be the basis for Ndlovu Care Group to develop programs for the CHHs, the most useful approach is to investigate the perceived needs and wants of the CHHs of all the five layers of the pyramid of Maslow.

Veenhoven (2002) gives reasons why to use subjective indicators in social policy research. With these subjective we do not mean the three highest layers of the pyramid of Maslow. With this subjective indicators is meant the more general assumed division between objective and subjective. As stated above this research focused on the perceived needs and wants of CHHs. For the perceived needs and wants it is more useful to use subjective indicators. Veenhoven (2002) describes that "social policy is never limited to merely material matters; it is also aimed at matters of mentality. These substantially subjective goals require subjective indicators. Progress in material goals can not always be measured objectively. Subjective measurement is often better. (…) Using subjective satisfaction better indicates comprehensive quality" (Veenhoven, 2002, p.33). Veenhoven (2002) describes a distinction between substance matter and assessment. He describes objective and subjective substance and objective and subjective assessment as shown in table 1.

Substance	**Assessment**	
	Objective	*Subjective*
Objective		
Subjective		

Table 1. Configurations of objective subjective differences (Veenhoven, 2002, p. 36)

He describes the table as follows: "The two top quadrants concern extrinsic substance matters, such as physical condition, mental aptitudes and social position. The quadrant top left denotes the combination of objective substance and objective measurement. An example is the actual 'wealth' of a person when measured by her bank account. The top right quadrant also concerns

objective substance, but now measured by self-estimate. An example is measuring wealth by perceived wealth. The two bottom quadrants concern subjective matters, such as identity, happiness and trust. The bottom left quadrant combines subjective substance with objective measurement. An example is measuring happiness by suicide. The bottom left quadrant measures subjective substance using subjective appraisal, for instance, measuring happiness by self-report" (Veenhoven, 2002, p. 35-36). He also describes that subjective indicators are indispensable in social policy, both for selecting policy goals and for assessing policy success. For selecting the policy goals, researchers must find out what people want and what they need. Much of this information requires subjective indicators to be obtained.

Head of household

As said before, when loss of parental care occurs in a household, a child will become the head of the household and will take over parenting roles and tasks e.g. household chores, helping siblings with homework, providing emotional support, taking care of ill parents and providing spiritual guidance to family, siblings etc. (Philips, 2011). In the literature two reasons are given why a child will become the head of the household. The first reason is that often older children in child-headed households are found to be fulfilling parenting roles and tasks (Ministry of Social Development, 2010). The second reason is that due to gender-based discrimination, girl children are most likely to take care of the household (Ministry of Social Development, 2010). Gender analysis is of particular interest because literature suggests an increasing proportion of female headed households in developing countries (Kossoudji & Mueller, 1983). Another study by Bongaarts (2001) from his analysis of Demographic and Health Survey (DHS) also indicated that the proportion of female headed households was substantial (Bongaarts, 2001). In the literature maintains that in most cases these households have limited access to resources, are disadvantaged and tend to be poor (World Bank, 1991).

Measurement theories

This research investigated all the needs-layers of Maslow in CHHs. The national guidelines for statutory services to child-headed households (Ministry of Social Development, 2010) also uses the theory of Maslow and for the physiological needs they distinguish the topics food, water, shelter, sanitation, clothing, primary health care and income. This research used these topics for investigating the lowest layer of the pyramid. The following topics are used for defining the need of safety; security; stability; dependency; protection against abuse, neglect and

exploitation; freedom from fear, anxiety and chaos (Elton, 1996) (Loening-Voysey and Wilson, 2001). The three highest layers of Maslow are the most difficult ones to do research on. The third layer of social needs is described by Dunn (2005) as identity through birth, education and schooling and cultural identity. The need for belonging was assessed using the Need to Belong Scale developed by Schreindorfer and Leary and modified by Leary, Kelly, Cottrell, & Schreindorfer (2005, as cited by Mellor, Stokes, Firth, Hayashi & Cummins, 2008). "The modified version consists of 10 items that assess the degree to which respondents desire to be accepted by other people, seek opportunities to belong to social groups, and react negatively when they were shunned, rejected, or ostracised" (Mellor, et al., 2008, p. 3). This scale is used in the interviews for the data collection of this research (see appendix 5). The layer of esteem is difficult to investigate. Campbell, Eisner, and Riggs (2010) describe that "the best known procedure for measuring self-esteem has been a 10 question survey introduced by Rosenberg in 1965" (p.1). A questionnaire like Rosenberg's (see appendix 6) measures only global self-esteem; it can not account for variation in self-esteem across domains of living (Harter, 1999). But for the purpose of this research that is actually a good thing because this research do not wants to go into depth in the different need layers, but wants to create a overview of the most prominent needs in the different needs-layers of the pyramid of Maslow. Besides that, with an investigating of all the five of the needs-layers in only five months, it is practically impossible to use the whole Rosenberg scale. This research used some relevant elements of the Rosenberg scale instead. In order to investigate the highest layer of the pyramid of Maslow, the self-actualization, this research used elements of the Brief Index of Self-Actualization. This 40-item index was developed from Sumerlin's 65-item Personal Attitude Survey (Sumerlin & Bundrick, 1996). Sumerlin and Bundrick (1996) describes that there is "surprisingly no measure of self-actualization theory developed exclusively from Maslow's composite writings to measure self-actualization as he conceptualized it" (p.1). In their paper they present such a measure. This research used relevant elements of that measure. Selecting the relevant elements was done by deciding which elements were applicable to the environment and the situation of the CHHs as described in the literature and observed by ourselves.

In order to investigate for what reasons a particular child become the head of the household, this research focussed on two factors: gender and age. According to some literature gender is a decisive factor because of the gender-based discrimination it is more likely that a girl becomes the head of the household. The factor age is important because according to other literature age is a decisive factor because the oldest member of a household will become the head of a household.

In order to get some background information of the CHHs and to see the bigger picture

of the situation of the CHHs, this study also looked at the demographic characteristics of CHHs. This study focused on the names; gender; date of birth; education; number of brothers; number of sisters; father; mother; grandparents; living area; and school.

Research question

This master thesis will focus on the needs and wants of children in Child Headed Households, and is complementary to the master thesis of Angela van Dril. She is conducting her master thesis research on the resources of children in Child Headed Households. With the two theses together, the overarching question of our theses will be answered:

"What resources are available for children living in Child Headed Households in Elandsdoorn and to which extent do these resources fit their needs and wants?"

The research question for this individual research is the following:

What are the physiological, safety, social esteem and self-actualization needs and wants of children in Child Headed Households in Elandsdoorn?

In order to answer this question, the two sub-questions will be answered:

- *What are the demographic characteristics of the Child Headed Households in Elandsdoorn?*
- *For what reasons did a particular child become the head of the household?*

Methods

In this paragraph the methods of this research will be discussed. First the operationalization of some topics will be discussed. Subsequently the sampling of the participants will be explained followed by the methods of data collection. After this, the data analysing will be explained. This will be followed by the scientific and social relevance of this research and finally the ASW-justification will be explained. For practical reasons for both the participants as for ourselves, Angela van Dril and I did the recruitment and the data collection together.

Operationalization

The term 'household' in Child Headed Household is defined differently and used inconsistently. For instance, a household is defined as "a group of persons (or one person) who makes common provision for food, shelter and other essentials for living" (Bongaarts, 2001, p. 263). The October Household Survey and Population Census in South Africa, define a household as consisting of a person or group of people who live together for at least four nights a week, who eat together and who share resources (Statistics South Africa, 1999). This last definition of the October Household Survey and Populaion Census in South Africa is the definition used in this research to identify a household.

Our population consists of the CHHs in the area Elandsdoorn. As stated above, the term Child Headed Household is used in this research, because it is the most common used term for the phenomenon investigated. In this research the following definition of a CHH is used;

A CHH is a household where:

- there is no caretaker (older than 25 years old) living permanently in that household
- the oldest member is up to and including 25 years old
- if someone older than 25 years old is living permanently in that household, this is a person who is dependent on the care of the children instead of the other way around

This definition is used because this research is focusing on households were there are no parents or caretakers living permanently. Sometimes there are members of the household older than 25 years old, but this might be the parent who is not able to take care of the children due to illness

for example. Or it might be a (very) old grandmother or grandfather. In this case the person is dependent on the care of the children instead of the other way around. This makes it even harder for the children to run a household. The state of South Africa is not only using the term CHH but also the term 'Youth Headed Household'. In their criteria this means that the oldest member of such a household is maximum 24 years old (South African Department of Social Development, 2009). In the first instance, we were using a age limit of 24 years as well, but it was very hard to find households fitting the criteria. There were some families who did fit all the criteria, but the oldest was 25 years old. That is why we decided to raise the age limit from 24 to 25 years old. A reason for this was that those families, where the oldest is 25 years old, have been CHHs for a long time already. So when they became a CHH, they were still under 24 years of age. Another reason is that only one of the members of such households is 25 years old, the rest of the family is younger.

This research uses the theory of Maslow to investigate the needs and wants of CHHs in Elandsoorn. For the lowest level of the physiological needs, this research distinguishes the topics food, shelter, sanitation, clothing, primary health care and income. These factors are described as physiological needs in the literature and are applicable and important to the CHHs. The following topics are used for defining the need of safety: security; stability; dependency; protection against abuse, neglect and exploitation; freedom from fear, anxiety and chaos (Elton, 1996) (Loening-Voysey and Wilson, 2001). These factors are described in the literature and applicable and important for the CHHs. The literature and observations in the township by ourselves have been used in order to define, for both the physiological and the safety needs, which factors are important and applicable to the CHHs. For the third layer, social needs, elements are used of the Need to Belong Scale, developed by Schreindorfer and Leary and modified by Leary, Kelly, Cottrell, & Schreindorfer (2005, as cited by Mellor, Stokes, Firth, Hayashi & Cummins, 2008). The Need to Belong Scale includes ten items rated on a 5-points scale (1 = strongly disagree, 5 = strongly agree). For each of the statements on the scale, the respondent has to indicate the degree to which he/she agrees or disagrees. Items expressing a low need to belong were reverse scored so that higher scores reflected a greater need to belong. This Need to Belong Scale is used in this research because it is a succinctly way to get a idea of the need for belongingness for an individual in general. This scale stays on the surface with regard to the need to belong, which is perfect for this research taken into account that this research will give a broad overview of all the needs of the needs hierarchy of Maslow. That is also the reason why this research only uses some elements of the Need to Belong Scale. The elements are chosen on importance and applicability for the CHHs based on the literature and

our observations in the township. For the layer of esteem, elements of the Rosenberg scale are used. The Rosenberg Self-Esteem Scale is perhaps the most widely used esteem measure in social science research. The scale is a ten item Likert scale with items answered on a four point scale (1 = strongly agree, 4 = strongly disagree). The scale ranges from 0-30, with 30 indicating the highest score possible. This research only used the important and applicable elements of the scale for CHHs based on the literature and our observations. In order to investigate the highest layer, self-actualization, this research used elements of the Brief Index of Self-Actualization. This 40-item Brief Index of Self-Actualization was developed from Sumerlin's 65-item Personal Attitude Survey (Sumerlin & Bundrick, 1996). The new instrument was developed wholly from Maslow's composite writings to measure his self-actualization model. This index is a measure of the self-actualization theory developed "exclusively from Maslow's composite writings to measure self-actualization as he conceptualized it" (Sumerlin & Bundrick, 1996, p.1). This research only selected relevant items from the scale because otherwise it would be far to much to investigate in only little time. Selecting the relevant elements was done by deciding which elements were applicable to the environment and the situation of the CHHs as described in the literature and observed by ourselves.

For the recruitment of the participants, the life skills facilitators of Ndlovu Care Group helped a lot. The life skills facilitators are six individuals from the community (so they know the community very well) who are working for Ndlovu Care Group to increase the awareness of HIV/Aids and its risks amongst children in the community.

Participants

In order to recruit a sample of CHHs for this research, we tried different pathways. Initially we planned to visit schools and to ask the principals of the school to ask the orphans to come after school to one of the Ndlovu Nutrition Units (NNUs) for a meeting with us, with yhe life skills facilitators of Ndlovu Care Group as translators. We went to four schools in the area of Elandsdoorn and we arranged some meetings with the orphans from those schools at the NNUs. After the second meeting with the orphans we found out that there has been a misunderstanding and that also single orphans showed up. We had to send them away and we stayed with the double orphans, but we found out that most of them were living with their grandparent(s). Per meeting about 20 to 30 children showed up, but after two meetings we only found three CHHs. This method of finding CHHs took a lot of effort and time (both for us as well as for the children) with very little result. So we decided to stop this method and we found out at the same

time about a list which has been made a community worker of Ndlovu Care Group, especially for vulnerable children. This was a two year old list with no addresses or GPS locations of the households. In order to find them anyway, we arranged a meeting with the community worker and all the life skills facilitators. First we divided the households into areas and then we allocated that specific area to one, two or three specific life skills facilitators. Because of the fact that the list was a list of all kind of vulnerable children and not specific CHHs, we explained our criteria for a CHHs to the life skills facilitators. We also gave them a scheme in which each group of life skills facilitators had their own specific dates to make appointments to prevent double appointments. With all this information and the scheme, the life skills facilitators visited all the households on the list and when they fit the criteria they immediately planned an appointment in the scheme. We gave them a week to visit all the households. After this week, we arranged a meeting with the life skills facilitators. They had made a lot of appointments. From this point we could go and interview them, together with the life skills facilitators as translators and to find the households. So the life skills facilitators were really important for the recruitment of the CHHs.

Another method we used in order to find CHHs is via the Home Based Care (HBC) organizations in the community. These organizations offer support to vulnerable children in the community. For example, they provide some meals during the day. HBC organizations are really involved in the community and are aware of what is going on in the community. People can report vulnerable children to them, and they will in turn report them to the Department of Social Development. We went to one of the HBC organization and asked them if they knew about CHHs. They had four CHHs they were aware of. Together with the head of the HBC organization we went to visit those four households and we made appointments with them.

Another method we used to find CHHs is the “snow-ball method”. One of the households we interviewed knew about another household in the neighbourhood who was also a CHH. Directly after the interview with the first CHH we visited that household as well and interviewed them immediately. Because the life skills facilitators were really involved in our research topic, they sometimes put forward some CHHs they knew themselves or via via.

In total we found sixteen CHHs which fit the criteria of our research. The sum of all the members of all the households together is 75 individuals. Of these 75 individuals we interviewed 52 members. The members which we did not interview were either too young or, in the case of the deaf and blind granny, too old.

Because social workers of the Department of Social Development are the ones that are supposed to support the CHHs we have compared their perspectives on the needs of the CHHs. We

interviewed them in order to be able to compare their opinion on the needs of CHHs with the perceived needs of the children themselves. We also interviewed a supervisor of the social workers. In order to get in contact with the Department of Social Development we tried to get an appointment with the head of the Department of Social Development. This seemed to be impossible. We decided to just go there ourselves and to ask for the head of Department of Social Development. We arrived at the department and within five minutes we were talking to the Head of Social Development. She helped us a lot and within another five minutes she arranged an appointment with three social workers and one supervisors.

As we are doing this research for Ndlovu Care Group we should also know their perspective on the needs and wants of CHHs to compare this perspective with the perspective of the CHHs themselves and the perspective of the Department of Social Development. We have interviewed the chief executive officer (CEO) of Ndlovu Care Group, and the chief operating officer (COO) of Ndlovu Care Group.

Data collection

The data collection is divided into four phases:

Phase 1: *pilot study; open interviews with children living in Child Headed Households*

Based on literature study we compiled a topic list with possible needs and related resources requirements of CHHs. We used this topic list for open interviews with a pilot group of three CHHs (n=11). Purpose of this phase is to clarify what needs and resources are most crucial to the various children in a CHH.

Phase 2: *semi-structured interviews with Child Headed Households*

In this phase we interviewed CHHs based on the qualitative analysis of the open interviews in phase one. We made a standardized interview with a topic list (see appendix 1) that allows for open answers about the needs of children living in CHHs (n= 52).

Phase 3: *semi-structured interviews with social workers and supervisors of social workers*

After analysis of the pilot study with CHHs and after finishing phase two we used the revised topic list to have open interviews with social workers and one of their supervisor (see appendix 2) Purpose of this phase is to get an umbrella view of what needs are important to CHHs in Elandsdoorn according to Department of Social Development.

Phase 4: *semi-structured interviews with management Ndlovu*

In this last phase we interviewed some of the management of Ndlovu Care Group. We used a topic list made of all the information collected in phase one, two and three (see appendix 3). The purpose of this phase is to investigate the perspective of the needs of CHHs by the management

of Ndlovu.

In phase one, we had a very general topic list based on the literature concerning possible needs and resources of CHHs. The topics of the needs are in line with the pyramid of Maslow (1970). So this will be: physiological needs, safety needs, social needs, esteem and self-actualization. In this phase three CHHs were interviewed. Doing the pilot study was useful as we found out that the sequence of our questions needed improvement as well as some topics. So we revised the topic list for phase two.

In phase two, we interviewed the Child Headed Households using a semi-structured interview based on the qualitative analysis of the pilot study. In total we interviewed seventeen CHHs, but one did not fit the criteria. So in the end we had sixteen useful interviews with CHHs and a total of 52 respondents. The interviews were held in the houses of the households. Because of this we were able to observe the living conditions and the environment of the CHHs ourselves. The interviews were held with all the members of the household together. This is a mix between a focus group and individual interviews. The reason for this is the language barrier and to make all the members of the CHH feel at ease (especially smaller children). Sometimes they were a little bit afraid of us or hesitant to talk about their experiences. The older children could make them feel at ease and helped to explain some questions to the younger children. The questions were asked individually but in the presence of all the members of the household. It was useful to do it this way because it made participants feel more confident and with that more open to us. In this phase we started every interview with some questions on the demographic characteristics of the CHHs (see appendix 4). In this section we asked names, ages, gender, whether they were going to school and what kind of school, whether their parents were still alive and when they died (if they died), whether their grandparents were still alive, in which area they lived and we noted their GPS location. In order to retrieve their GPS location we used our navigation system, a TomTom. The names, living areas and the GPS locations were besides for the data collection of this research also obtained for the use of Ndlovu Care Group so they can find them again when they want to include them in a program or support them etc. For the demographic characteristics we used a questionnaire compiled in English. This questionnaire was filled in by the life skills facilitators because they had to translate the questions. Another reason why we did not let the members of a CHH fill in the demographic characteristics questionnaire by themselves is because we were not sure if everybody could write. We later on filled out the demographic information in an Excel sheet.

The questions to obtain information about the needs and wants of CHHs were divided into five parts equivalent tot the five layers of the pyramid of Maslow. The first part consist of

questions about the physiological needs. For this need we used the topics food, water, shelter, sanitation, clothing, primary health care and income. We asked whether they had enough, food, water, clothes, and income and why (not). We also asked whether the shelter, sanitation and primary health care were good enough and why (not). For the safety needs we asked whether they felt safe in their houses and community and why (not). We also asked which things helped them to feel safe and if they missed anything in that. Then we asked if any kind of danger ever happened to them. We asked this to see if there is a relationship between the fear they have and the dangers which has occurred. For the social needs we used certain items of the need to belong scale. The topics used were friends, community, acceptance by other people, and we added the topic school and social clubs, based on the observations and the pilot study. For the fourth layer of esteem we asked what was going well in their households and why. We also used the Rosenberg scale and used the topics pride, satisfaction and whether or not they felt useful and why. We also asked what they wanted to achieve for next week and next year. For the layer of self-actualization we used relevant topics of the Brief Index of Self-Actualization. These topics were about their future perspective, if they had dreams and what kind of dreams, if they have talents and what kind of talents. And if they thought they had talents if they had the opportunities to develop those talents. For the investigation of this layer we asked the questions: "When you wish upon a star, what would you wish for?". This way we tried to find out their wants. To obtain the required information in order to answer the sub-question "For what reasons did a particular child become the head of the household?", we used the information of the depth questions of the other topics and from the demographic characteristics. We asked who the head of the household was and what his/her tasks were and why he/she became the head of the household and not somebody else.

In order to thank the CHHs for interviewing we bought them a bag of food (including: maize meal, carrots, onions, rice, cabbage, thee, sugar, salt, some candy and chicken) and a soccer-ball after the interview. In order to thank the life skills facilitators with all their help recruiting the CHHs and for all the translation, we took them out for dinner. They also got paid per day by Ndlovu Care Group.

In phase three, we interviewed social workers and one of their supervisors from the Department of Social Development using a semi-structured interview based on the topics we used for the CHHs themselves, because we want to investigate the same topics, but from a different perspective. For the three social workers we used a small focus group of just the three social workers and us, so without translators. We used a focus group because the social workers would talk more openly and discussions could occur. Some topics in the interview covered the tasks the social workers have and how this is related to their actual daily work. We thought the

social workers would be more honest about these topics in a group setting with colleagues. For the supervisor we used a semi-structured interview without translators. Both the social workers and the supervisor were interviewed at the Department of Social Development itself. For the interviews with the CHHs, in both phases one and phase two, and for the interviews with the staff of the Department of Social Development we obtained "informed consent". In this informed consent is written that we will use all the data anonymously, that the participants can withdraw from participation in the interview without consequences, at any stage. The participants had to sign this informed consent and all of the participants did so.

In phase four, we used semi-structured interviews including some of the same topics as in phase two and three because we wanted to have their perspective but on the same topics. We added also some topics about Ndlovu Care Group as an organization and about the past and the future.

Analysis

All the interviews were recorded with two voice recorders. We used two voice recorders for several reasons. One reason was the security. If something happened with one of them, we still had the other, for example dead batteries. Another reason is that because sometimes the families were large and we were with the two of us and one or two life skills facilitators as translators, there were a lot of people to record. It was useful to have two points to record to have a better sound quality of what people were saying. After doing the interview they have been written out in text. After this the texts were coded in the way Boeije (2005) describes. First the texts are open coded followed by axial coding and after that selective coding. The open coding of the collected data is a process of conceptualizing and categorizing the data by reading the texts carefully and split them up in fragments. Boeije (2005) describes a inductive way of coding. This means that the researcher has to interpret the data totally blanc. In this research, though, a theoretical frame work has developed and that theoretical frame work has been the basis of the questions of the interview. Because of this a few concepts has already been distinguished, a deductive way of working. In this research this were the concepts: physiological needs, safety needs, social needs, esteem needs, and self-actualization. Fragments were placed into these five codes with their own sub-code. Aspects that has not been mentioned in the literature received a new code.

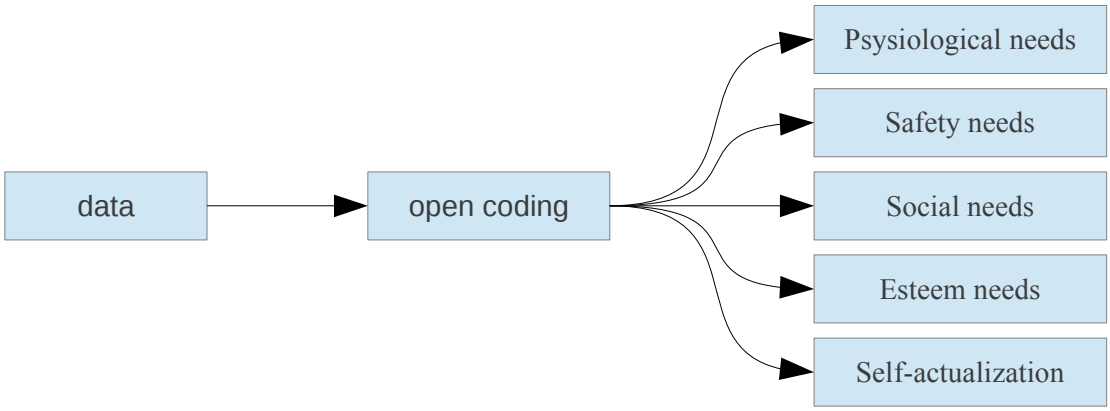

Figure 2: Open coding

In the axial coding phase a reduction of the codes has been made. Synonyms of different codes are reduced to one code. In this phase also a hierarchy is made of the important and less important codes and some codes are even deleted. In this phase the codes are revised with in mind the research and the research questions. In this research this has let to the code tree as shown in table 2.

The last phase of coding is the selective coding. In this phase the codes are integrated and connections between the codes are made. This phase is a more interpretative phase and is a preparation to the writing phase. In this research the relationships between the different needs and the different actors and their different perspectives are contemplated.

All the three phases of coding were done with the help of the qualitative analysis program MAXQDA. The texts are imported into this program and the codes and sub codes are made in this program. After all the phases of coding, the data was analysed, also with the help of MAXQDA. For the demographic characteristics we used an Excel sheet from which we analysed our data.

Psychological
Caretaking
Sanitation
Health care
Income
Clothes
Food
Water
Safety
Housing conditions
Safety
Abuse
Safety environment
Social
Belongingness
School
ID
Missing parents
Feeling different
Social clubs
Community
Esteem
Self-esteem
Proud
Satisfied
Last time very happy
Last time very sad
Self-actualization
Future perspective
Playing
Wants
Head of the household
Tasks
Age
Gender

Table 2: Code tree

Scientific relevance

This research is an addition to the review of the theory of Maslow. In this research the theory of the need pyramid of Maslow is applied to CHHs so this research tests whether or not the theory of the need pyramid of Maslow also holds true for this specific group of CHHs. This research is also of additional value of the research done on CHHs. With this research there is more insight in the needs and wants of the CHHs.

Social relevance

There is no scientifically based reason why this research is done in Elandsdoorn and not in any other rural South African area, but as we are doing this research for Ndlovu Care Group and they are concerned with the development of Elandsdoorn, it makes sense that this research is done in this specific area. Ndlovu Care Group wants the work they are doing and the programs they are developing to be scientifically based. In most of the research done on CHHs, the needs and wants of these households are taken for granted. This is a real shortcoming in previous research. This research is of big importance for the development of policies and programs by Ndlovu Care Group on CHHs in Elandsdoorn. In order to make good policies and programs it is useful to know the needs and wants, the differences in needs and wants between the head of the CHHs and the rest of the CHHs and the influence of stigma on these needs.

ASW-justification

The principles of Interdisciplinary Social Sciences (ASW) are interdisciplinary and problem oriented approach. Interdisciplinarity is an important and a complex issue. It is important as modern society increasingly demands application-oriented knowledge, and the usability of scientific knowledge generally requires the combination and integration of knowledge form various scientific disciplines. Interdisciplinary creates its own theoretical, conceptual and methodological identity. Consequently, the results of an interdisciplinary study of a certain problem are more coherent, and integrated (Van den Besselaar & Heimeriks, 2001). Interdisciplinary is aimed too high for our research, because this presupposes a theory in which various disciplines together are associated at the conceptual level. In multidisciplinary research, the subject under study is approached from different angles, using different disciplinary perspectives. However, neither the theoretical perspectives nor the findings of the various disciplines are integrated in the end (Van de Besselaar & Heimeriks, 2001). This research is multidisciplinary because insights from different disciplines will be combined in order to answer

the research questions. This research uses insights from the disciplines: pedagogy; psychology; sociology; and cultural anthropology. This research is using insights from pedagogy to look at the development of the CHHs but relates this also to the psychology of the members of a CHH. For example the psychological well-being. Of course is the township in which the CHHs are living a different environment as for example a big city. To have a better idea of the society of the CHHs this research is using insight from sociology. Because South Africa is different than other (African) countries this research is also using insights from cultural anthropology. The articles used for this research are all from this different disciplines.

The other principle of Interdisciplinary Social Sciences is the problem oriented approach. This principle is strongly present in this research because it will focus on the needs of CHHs in order to make appropriate policy in Elandsdoorn by Ndlovu Care Group. The policy to be made must enable CHHs to improve their circumstances.

Picture 1. Shopping for the CHHs

Results

In this results section the two sub-questions will be discussed and answered. The two sub-questions consist of the following:

- *What are the demographic characteristics of the Child Headed Households in Elandsdoorn?*
- *For what reasons did a particular child become the head of the household?*

Answering these sub-questions leads to the answering of the research question of this research:

What are the physiological, safety, social, esteem and self-actualization needs and wants of children in Child Headed Households in Elandsdoorn?

After answering this question the overarching research question will be answered. This master thesis is complementary to the master thesis of Angela van Dril. She is conducting her master thesis research on the resources of children in Child Headed Households. Her research question is:

What resources are available for supporting children living in Child Headed Households in Elandsdoorn and what are barriers for access and eligibility to these resources?

With the two theses together, the overarching research question of our theses will be answered:

"What resources are available for children living in Child Headed Households in Elandsdoorn and to which extent do these resources fit their needs and wants?"

Sub-questions

Demographic characteristics

In this section an answer will be given to the sub-question:

What are the demographic characteristics of the Child Headed Households in Elandsdoorn?

In order to investigate this sub-question, every interview with a CHH started with some demographic characteristics. This part consisted of names, ages, gender, whether they were going to school and what kind of school, whether that person is the head of the household, whether their parents were still alive and when they died (if they died), whether their grandparents were still alive, in which area they lived and we noted their GPS location (see appendix 4). This information was filled out in an Excel sheet. Some interesting facts were found by analysing this Excel sheet.

Household composition

A first result from the demographic characteristics is that the household composition of CHHs is very complex. Members of CHHs, especially the female members, often have children of their own. The father of those children is almost always absent. In more than half of the CHHs (9 out of 16) that were interviewed, there were children younger than five years old. These households also do not only consist of siblings and their children. Often there are also cousins living in those families whose parent is not staying there. Those cousins are the children of the siblings of, most of the time, the head of the household. The parents are often working in the big city, Johannesburg or Pretoria, and leave their children with their siblings who have to take care of them. Sometimes they still visit them every now and then, sometimes they do not. Maybe because of this, the households are quite large. The average number of members in the CHHs that were interviewed is 4,7 members. The average age of the household members was 14,1 years old (*sd*= 7,06).

In the recruitment process for CHHs, a lot of households were found who actually fit most of the criteria, but there was a grandmother living with them. In some cases the grandmother was too weak to take care for the children and instead, the children were taking care for her. These households were included in the research. The CHHs do often still have contact with their grandmother, but they won't even mention their grandfather. In the interview was asked whether their grandparents were still alive and most of the time they just mentioned their grandmother and the grandfather had to be specifically asked for, even if he was still alive.

CHHs are created due to the death of the parents by HIV/AIDS (Philips, 2011). Loss of parents also means loss of parental care. But loss of parental care can also mean the parent is still alive and a member of the household, but is not able to take care of the children due to illness for example. Different reasons has been found why the CHHs we studied have lost parental care: the father and/or the mother sometimes died, sometimes the parents where living in another city, sometimes the parents abandoned their children and sometimes the parents just disappeared. Of course a combination of these factors is possible, for example a father and/or mother could have abandoned their children and living in another city. When the father and/or mother were living in another city they still knew where they were living and sometimes they would still have contact. Sometimes the father and/or mother deliberately abandoned the children for whatever reason. Then the children were aware of the fact that they were abandoned. But very often the father and/or mother just disappeared. The children do not know them, and they do not have a reason why. They simply disappeared. The abandonment and disappearance factor is very often the case with the fathers. Of only seven of the sixteen CHHs interviewed, both their parents died. Some of the CHHs where only the mother died (4 out of 16), and even less where only the father died (2 out of 16). So in total there are five CHHs in our research which still have a mother. Four of them are working as a farm worker and only one of them abandoned their children. There are seven CHHs in our research which still have a father. The reason why the father is not taking care of them is abandonment and disappearance. The difference in loss of parental care does not make a difference in the experiences of the CHHs of living on their own. Except from when the mother of a CHHs is a farm-mother.

There are four CHHs that were interviewed of which the mother was a farm worker. In these situations the mother is still a member of the household. She does seasonal farm work and because of this she is absent from the household most of the time. In the households with a farm worker mother that were interviewed for this research, the mother lived permanently at the farm, but she would visit her children once in one or two months. The children do not have a caretaker living in their houses permanently, but they do have a mother who visits them once a month and in some cases once in two months. Although they live most of the time alone, they still have the feeling that the mother 'is around', and in times of emergencies they can ask their mother advice. This makes a difference in their perception of living alone.

	Number of CHHs
Both parents alive	3
Mother dead, father alive	4
Father dead, mother alive	2
Both parents dead	7
Total	16

Table 3. Status of CHH's biological parents

School

Of the 52 respondents of this research only three of them never went to school. The rest of the respondents attended school. Most of them were still attending school at the time of research. In this research 49 of the 52 respondents attended school.

Head of the household

This section will give an answer to the sub-question:

For what reasons did a particular child become the head of the household?

In the interviews with the CHHs, questions were asked specifically about this topic.

The answers to the question "what makes somebody the head of the household?" were all about what kind of tasks this person assumes. Most of the time the respondents described the tasks of the head of the household, as the tasks the parent(s) had when he/she was still alive. More specifically they described those tasks as cooking, cleaning and fetching water.

The answers to the questions "who is the head of the household" and for what reason, can be divided into two categories. If the oldest one is the head of the household, the reason for that is because they have the opinion that the other members of the household are still too young for those tasks. For instance the respondents believe that the younger siblings can not cook. The opinion that the oldest member of the household should be the head of the household is expressed very clear in the following fragment:

> *R: Our oldest sister is the one who has to take care of us and it sometimes stresses and confuses her if she comes home and find out there is no food. Now she is the one who has*

to make a plan so the younger sisters can eat. First the mother took care of us and now she is the one who has to take care of us because she is the oldest.
I: And when you mother was still alive did she also do the household?
R: Yes, and after that I did it as my sisters were still too young.

If they are running the household together and are together the head of the household, the reason for this is because they want to help each other, as clearly expressed in the following fragment:

I: And who is the head of the household?
R: The three of us. We are just helping each other. We don't want it to be someone else's daily job. So then we are just helping each other. The others don't help because they are still too young.

The division of the CHHs into those two categories as described above depends on two factors of the household composition:

1) When the oldest in a household is by far the oldest, everybody just assume that because he/she is the oldest, he/she is best capable of running a household. When the ages of the members of a CHH are close to each other, they often help each other in the household and they run the household together. This way they are all responsible for each other and for the household itself, whereas in the first category the oldest member of the household is kept responsible for the other members of the household as well as for the household.
2) Another factor is the ages of the members of CHHs in general. There are CHHs where all the members are just bit older and CHHs where all the members are just a bit younger. One could say that there are "older CHHs" and "younger CHHs". In the older CHHs it is often the oldest member of the CHHs who takes care of the rest of the household by him or herself. In the younger CHHs the members of the household are often running the household together and would say that they are together the head of the household. This could be explained by the fact that the oldest member of the older CHHs is better able to run a household because he/she is a bit older in herself. The members of the younger CHHs are less capable of running a household because they are younger in general, so they are running it together. This way they can help each other and is the responsibility divided. The very small children and the babies are excluded of course. There has been specifically asked about the ability of the members of the CHHs to run a household. A result found from the data is that the younger CHHs would say they were not really able

to run their household and that the older CHHs would say they were able to run their household.

A good example is a household that was interviewed consisting of 5 members. The second fragment above is of this family. The family obviously belongs into the younger CHHs, because the oldest one is only 17. The oldest three were running the household together; those ages were close to each other. The youngest two were a lot younger so they were not participating in running the household. The oldest three were taking care of the younger two and of each other. They shared the responsibility and the 'head of the household tasks' among the three of them.

Notable is that gender does not play a role in the reason why a particular child becomes the head of the household. The only reason given why a particular child became the head of the household is age. It is always the oldest member of the household who became the head of the household, no matter whether it is a boy or a girl. Some answers of the tasks division in the household where actually gender-related as is evident in the following fragment:

I: And what do you do when you come back from school?
R: Me and my sister come back and clean the house and cook, and our brother, he fetches water from the water tank.
I: And why are you two cooking and why not your brother?
R: We believe that is because we are ladies. We believe that the ladies should cook and the man should just fetch water.

Sometimes this gender-related household tasks division was mentioned in the interview, but not that often. This has got nothing to do with whether or not a particular child became the head of the household.

Research question

In this section the research question will be answered:
What are the physiological, safety, social, esteem and self-actualization needs and wants of children in Child Headed Households in Elandsdoorn?
The theory of Maslow will be used for this question, comprising the following needs: physiological, safety, social, esteem, and self-actualization. All these layers will be discussed one by one starting with lowest layer in the pyramid of Maslow; the physiological needs.

Physiological

None of the CHHs that were interviewed had a shower. Instead of a shower they were washing themselves in buckets. Half of the CHHs which that were interviewed did not even have a toilet. Half of the CHHs who did have a toilet said there toilet was not good enough and unsafe. So only ¼ of all the CHHs that were interviewed had a toilet which is in a good condition. When CHHs do not possess a toilet they are forced to go to the toilet of their neighbours or even go into the bushes.

Another physiological need is the need for water and food. Although none of the respondents that were interviewed appeared underfed, 14 out of 16 of the households experienced a need for food. They explained they do not have enough food for everyone every day. What is missing is breakfast most of the times. It is often the case that the leftover dinner from the previous evening is also the breakfast of the next morning. But most of the time there is no left over because there is not enough food in the first place, so as a result, there is no breakfast. Hence, the children are going to school without breakfast. The lunch, which is provided at school, is their first meal of that day. The food they have is not very varied. Most of the food consists of maize meal. The CHHs have to fetch their water from a borehole constructed by Ndlovu Care Group. Of course it is a good thing that they have access to water, but sometimes they have to walk very far to fetch water. Some of them have to walk about 25 minutes, one way. However, most of the households, that were interviewed, lived close to a borehole.

Clothes are also a physiological need. Every single household that was interviewed experienced a shortage of clothes. They especially miss the warm clothes for the winter. The winters can be very cold in Elandsdoorn. At night it can be freezing. They also experience a lack of school uniforms. Most of the school going respondents that were interviewed did have a school uniform but some of them said that the school uniforms are worn-out totally. The need for school uniforms is not as big as the need for normal clothes because it is easier for them to get a school uniform. Both Ndlovu Care Group as Department of Social Development provide school uniforms to vulnerable children.

Another topic which belongs to the physiological needs is income. Of all the households that were interviewed there was only one member of one household who had a job. The money he earned with that, however, was only for himself and not for the household. Of course there are also the farm mothers who are working. They use the money for the household. Then there were also some members of some households who had some piece jobs, such as bricklaying,

doing hair and helping people in the neighbourhood with chores. Those people are in the absolute the minority. There are also some members who said that they have tried to find a job but that it is really hard to find a job, especially with the composition of the household and the lack of education.

I: Does one of you have a job?
R: No.
I: And why is that?
R: Now it is difficult to find a job or something. Now I can maybe work temporary at the farms and that makes that I can not stay with my younger sisters. That is the reason why I want to go to school and find a suitable job so I could pay for my younger sisters. Now it is not possible to find a good job and that is why I went back to school.

Another important reason why members of CHHs can not get a job is because they often do not have an ID document, which is necessary in order to get a job. Almost all of the CHHs that were interviewed (13 out of 16) received different kinds of grants, such as child support grant and foster care grant, as the main income and most of the time as the only income. Two of the three CHHs are in principle eligible for receiving grant, but they did not have an ID document or birth certificate, so they can not access any kind of grant, because to apply for any kind of grant one will need an ID document or birth certificate. A lot of the CHHs are supported with food and/or money monthly by a family member not living in the household. This can be an uncle, aunt, sister, brother, etc.

Primary health care is another topic of the physiological needs. Because of the fact that there is no caretaker available in the CHHs they rely on each other when someone falls ill. The governmental clinic is for free, so they can go there if that is necessary, but these clinics are not very good. If someone is critically sick they rather go to a doctor, but this is not for free and most of them do not have money to pay for the doctor. It is hard for CHHs when there is no caretaker living permanently with them, especially when some one is ill as illustrated in the following fragment:

I: And can you give an example when you miss a caretaker?
R: Maybe when a child is sick in the house, that's when we need some one.
I: And what kind of support do you need then, if somebody is sick?
R: Either the caretaker stays at home to look after the child, or takes the sick child with

him/her.

When a member of a CHH is ill, then they often need the help of somebody else, for example to take them to the hospital. This could be a neighbour or a family member living in the neighbourhood.

Shelter also belongs to the physiological needs. All of the CHHs that were interviewed were living in a house. This could be a one-room house, a shack, or a multiple-roomed house. Only one CHH in our research was living in a shack. The others had a house either provided by the government or inherited from parents or family.

The Department of Social Development is focused the most on these physiological needs. Food, school uniforms, income and shelter are from their perspective the most urgent needs of CHHs, just like the CHHs themselves. These are the needs which they can provide. They distribute food parcels and school uniforms and people can apply for different grants and for a house. None of the CHHs interviewed in this research received any kind of this support from the Department of Social Development. Ndlovu Care Group shares the perspective that these physiological needs are the most important and urgent needs. In special programs for orphans and vulnerable children, they provided them with food, clothes, school uniforms and houses. Some of the CHHs interviewed in this research said to do receive this kind of support from Ndlovu Care Group. When they did receive this kind of support from Ndlovu Care Group they experienced that as pleasant and helpful.

Safety

As described above everybody has a shelter to live in. The conditions of these shelters are the topic of the second layer of the theory of Maslow; the safety needs. Almost all of the CHHs did not think of their house as a good house in general. Some deficiencies mentioned are; roof leaking, doors broken, windows broken, locks broken, holes in the house, cracks in the house, a bad fence, etc. The most obviou deficiency is that the house is too small. Some of the CHHs that were interviewed live in a one-room house (3 out of 16), and as mentioned before, the CHHs consist of a lot of members. In one of the one-room houses there were eight people living, for example.

Another important topic for the safety needs is the safety of the environment. Half of the CHHs in this research feels safe at home, also during the night-time. The other half of the households experienced the environment as dangerous, because there are thieves around, rape occurs and there are dangerous snakes in the neighbourhood which can kill people.

The Department of Social Development observes very often, that when children are living alone, without a caretaker, that this is a huge lack for their safety. They also recognize the dangers of burglary and rape.

Ndlovu Care Group recognizes the lack of safety of the houses of the CHHs, and the bad conditions of the CHHs. They also recognize the dangers of burglary and rape, which is related to the poor housing conditions, for example the broken locks, broken doors, broken windows and it not having from a proper fence. Ndlovu Care Group also thinks that because of the living conditions of the CHHs they are more likely to end up in the juvenile prostitution and in the juvenile delinquency.

Social

As mentioned before most of the respondents we have interviewed were attending school, or went to school in the past. From our data it appears that school is very important to the CHHs. At the schools, all children are in a register with the status of their parents, whether they are still alive or not. So the schools knows which children are (double) orphans. For the children who were interviewed this does not make any difference at school, except from a few exceptions. Some of the respondents did experience a difference if the school knew that they are (double) orphans. They experienced for example some extra support and help from the school. Most of the respondents though did not feel treated differently by the teachers or by other students. They also do not get extra attention or extra help with anything from school. They feel treated like any other student at school. Apart from an exception this makes them all feel good and accepted at school, and most of the children do have friends at school. This is important because school is a major part of the daytime activities of the children.

The social needs of the CHHs interviewed is mostly emotionally. They miss their parents in giving advice to them in difficult situations, for example when somebody of the family is ill, and having a sympathetic ear. They miss the love and affection from an adult caretaker. The family of the CHHs is very important to them, especially for the social needs. The (extended) family really helps the CHHs a lot. This could be uncles, aunties, sisters, brothers, etc. They help them with the household, with money, with food and with emotional support. They feel affection from their family. Although they experience help and affection from their (extended) family, they also explained that they miss their parents. They miss their parents in different ways; practically and emotionally. They miss their parents practically for the purposes of running the household, providing food and money, providing school uniforms etc. as can be seen in the following fragment:

I: And can you describe the biggest difference from when you were living with your parents and now you are only living with your siblings?
R: When our parents were still here we had usually something to eat every day, and then we would go to school with pocket money and sometimes we came back from school our mother was cooking and she also helped us with the clothes in terms of washing them, and now that's no more, so that is difficult.

As stated above do they miss their parents emotionally for the purposes of love and affection and for the purpose of guidance. The issue of guidance is explained clearly in the following fragment:

I: And can you describe the biggest difference from when you were living with your parents and now you are only living with your siblings?
R: The difference is that when we lived with our parents we had guidance. Sometimes it is hard if we have a problem and we don't now were to tell. But if the parent was there you were going to see them and they would guide you. It was very difficult to live without the parent.

The issue of missing the parents emotionally is expressed very nice in the following two fragments. The first fragment is of a CHH with a farm working mother:

I: And when the mother is here, once in a moth, what the biggest difference from when she is not here for that one time in a month?
R: When our mother is in the house there is joy, it is good in the house and we feel warm.

I: In what way do you miss your mother?
R: Our mother loved us, and when we think of her we always have to cry, because she gave us love and care.

Although the CHHs miss love, care and affection from their parents, they do experience love, care and affection from their siblings and other members of the CHH.

Another important issue in the context of social needs is the neighbourhood of the CHHs. Almost all the CHHs that were interviewed had a good relationship with the neighbours and they felt part of the community (14 out of 16). If the CHHs experienced some support from

the neighbours, this had not much to do with the relationship of the CHHs with the community. The support described by the CHHs is most of the time very superficial and consist of giving some food or old clothes to the CHHs. The CHHs are aware of the gossiping in the neighbourhood but they do not think that is because they are a CHH, but because gossiping is everywhere. Not all of the CHHs experienced support from the neighbourhood.

Social clubs, friends and church is another issue concerning the social needs of CHHs. Some of the members of the CHHs interviewed do go to social clubs and some do not go to social clubs. The most frequently mentioned social clubs were soccer and netball. An reason why members of CHHs are not going to a social club is because they do not have time to go to a social club, although they would love to go. This is illustrated by the following fragment:

> *I do not go to play netball because when I am at the net-ballfields and stuff there is no one there to cook for my younger sisters. But I do like netball and my youngest sister always goes to play netball.*

All of the members of the CHHs who are going to a social club are saying to experience mental support from this social club, as illustrated by the following fragment:

> *I: Do you experience any kind of support from this organization?*
> *R: Yes, mentally I do, because if we are around playing with other kids we get to forget the problems at home and we feel free. Then there is nothing to worry about.*

All of the members of the CHHs who go to social clubs also mentioned the friends they have at that social club. If they have some friends, these friends were really important to them for the need to belong and the need for acceptance. If they did not want to have friends it is because they did not like the gossiping and they said they did not need friends.

Another social issue is the church. Only two of the households we have interviewed did not go to church. All of the other CHHs in this research went to church and the importance of the church to them varied in degree. For some the church was a huge mental support, but for others it does not mean so much.

The Department of Social Development argues that the biggest need of CHHs concerning the social needs is the need for a care-taking adult, somebody who will listen to them. When these children are still small and do not have a care-taking adult, the social workers have to place them in a place of safety, for example a children's home. This happened to none of the members of the CHHs which were interviewed for this research. After that they will look out

for some one who is willing to take these children, to become foster parents. They prefer to find a relative who is willing to take care of these children because they have a better bond. When they can not find a relative who is willing to take care of these children, than they will look for somebody else to take care of them, for example a neighbour. The bad thing about this is that it is often the case that these people do not really care about the children, but that they will only become a foster parent to receive the grants the children are receiving. This has not been found in the data collection of the CHHs. According to the Department of Social Development, the need for somebody who is *willing* to take care of them is an urgent need for the CHHs. The CHHs do describe that they miss love and affection and an adult caretaker but they do not describe the issue that somebody is taking care of them just for the money. They also argue that CHHs are more isolated than other households and that the community does not care for a CHH at all. The CHHs themselves do not confirm this statement. The CHHs interviewed do not feel isolated and some of them do experience support and care from the community. In the best case they report the CHH, but that is about it. Ndlovu Care Group says that the biggest social needs of the CHHs are "an adult to talk to" and "family structure". They think CHHs need more structure as there is not much structure in their lives at the moment. In their opinion the community around these CHHs does not really care about those children so the social needs must be family related.

Esteem

The esteem needs are more difficult to investigate. Some results, however, did show up. As mentioned before are almost all of the children are going to school. They all experienced school as very important and they all have confidence in themselves that they will succeed at school and they will make it to the next grade every year and in the end will pass their matriculation. Matriculation, usually shortened to 'matric', is a term commonly used to refer to the final year of high school and the qualification received on graduating from high school, although strictly speaking it refers to the minimum university entrance requirements. They feel that they are a person of worth, at least on an equal plane with others. They do not feel different than others and most of the time they would say they are proud of their lives. Most of the children who were interviewed would report that they have some kind of talent. This could be; playing netball, bricklaying, drawing, studying, soccer, welding, singing, etc. Although they recognize that they have these talents, they are not sure whether and/or how they can develop these talents.

The Department of Social Development is actually focused at the three lowest layers of the theory of Maslow. But for children who are reported to the Department of Social

Development they have a program to train orphans and vulnerable children to become an auxiliary social worker, this is like a social worker assistant. For this job one must have finished his matriculation and do the program for auxiliary social worker for one year and one will get a certificate. There is no age limit and most of the time they pick orphans. They have used this program for a few children already but not for any respondent of this research. Ndlovu Care Group thinks that the need of esteem for the CHHs is the courage to go to school. They recognize the need of the CHHs to develop their talents and they have programs for that, for example the Ndlovu Care Group choir.

Self-actualization

A result which is remarkable concerning the self-actualization is that, despite the living conditions of the CHHs which were interviewed, they all had a future perspective. They did have dreams for the future about what they wanted to be when they grow up, and what their lives would look like in about ten years. Questions contain the short term future and the long term future of the CHHs. It is remarkable that for the shrt term future almost everybody is focused on school, to pass the matriculation. For the long term future nobody is very clear. Sometimes they said things like "have a better life" without specification what that meant for them. Some would say a better life means not having to struggle to get enough food everyday and enough clothes. The most basic, physiological needs. School is the most important growing process for almost all the participants interviewed. The next fragment is a typical answer to the question to the question what they wish for the future:

> *I: And if you could wish for anything for the future, what would you wish?*
> *R: We all have the same wish; that is to complete our studies and get work somewhere so we can live a better life. My brother also wishes to buy a car one day and a house to live in.*

Maslow described self-actualization as "the full use and exploitation of talents, capacities and potentialities, etc." (Maslow, 1970, p. 150). This is the idea of Maslow that what a man can be, he must be. In this perspective the CHHs have a great need for self-actualization. They do have potentials, but the way to becoming what they *can* be is very long and hard for them. This layer also includes the wants of the children. Answers to the question what they really wanted, consisted in almost all cases of topics of the first two layers of the theory of Maslow, physiological and safety needs. They wanted to have enough food, enough clothes, a house big

enough for all the members of the CHH, a safe house without defects, and a job.

The Department of Social Development thinks the members of a CHH can not accomplish their full potential because they are stuck in their basic needs. Especially dropping out of school is a big obstacle for members of the CHHs to accomplish their full potential, according to the Department of Social Development. Only one of the respondents interviewed in this research dropped out of school and she already started with adult education. So according to the data of this research, members of CHHs do not drop out of school a lot. Ndlovu Care Group care group argues that the biggest self-actualization need for the members of CHHs is to finish their secondary school, and the biggest wish is to get bursaries for further studies.

Overarching research question

In this chapter the overall research question of the thesis of Simone Wassink and Angela van Dril will be answered. This question is:

"What resources are available for children living in Child Headed Households in Elandsdoorn and to which extent do these resources fit their needs and wants?"

This question will be answered by considering to what extent the needs of each layer of the Maslow hierarchy are met, and what resources are available or lacking to meet these needs.

The physiological needs of children living in CHHs are partly met. Needs like food, basic shelter clothes and care are in most cases available, but only to a very minimal degree and they are of minimal quality. This has to do with the fact that children living in CHHs do not have access to a resource that can provide them with enough income to cover all those needs. The Department of Social Development should provide those needs if necessary, but none of the CHHs interviewed in this research did receive support, in order to fulfil those physiological needs, from the Department of Social Development. The way CHHs derive their income can be characterized as 'packaging'. Packaging is combining of resources from all kinds of welfare and income suppliers to make ends meet (Knijn, 2004, p.21). They combine for example social grants with salaries in order to provide enough income to meet their basic needs. Often even this combination of income is not sufficient to meet the physiological needs of the CHHs.

The safety needs of children living in CHHs concern the need for physical safety, including the needs for security, protection, stability, and freedom from fear or constant anxiety

(Harper, Harper, & Stills, 2003). The extent to which safety needs are met is firstly determined by the physical environment the children live in. Often the houses are not well maintained, meaning that it is easy to break into the house. As stated above the households often do not have the material resources to maintain their houses. Besides that they have no access to people who can actually maintain the house for them. Secondly the need of feeling safe is often not met because the most important resource to meet this need is an adult who can protect the children against harm. The Department of Social Development agrees that when children are living alone, so without a caretaker, that this is a huge lack for their safety. They recognize the dangers burglary and rape. Neighbours are often mentioned as the persons the children will go to in case of emergency; however this means neighbours are only a resource in those cases where an unsafe situation already occurred and that neighbours are no resource to prevent unsafe situations on a permanent basis. The fact that CHHs often have no resources that can prevent them from unsafe situations means they may live with a continuous feeling of fear. Therefore their safety needs are not met.

Concerning the resources that are necessary to meet the social needs of the children the same problem of a lack of an adult caretaker occurs. The fact that no adult caretaker is permanently available in the households, makes that the social needs of children living in CHH are only partly met. Children miss the love and affection they can only retrieve from an adult caretaker. The Department of Social Development agrees upon this need. According to them the biggest need of CHHs, concerning the social needs, is the need for a care-taking adult, somebody who will listen to them, at all times. The social needs concerning contact with peers and siblings are met by CHHs. Often children in CHHs retrieve a lot of social support from belonging to peer-groups, social clubs, school and church. They value these contacts because they are treated there just like other children. The fact that they do not have an exceptional position makes that especially their needs concerning sense of belongingness are met.

One important aspect of esteem is confidence. A resource for confidence is the fact that CHHs manage to run their own household. When asked what they are proud of they often mentioned the fact that they were able to manage the household all by themselves. Another aspect of esteem is self-worth. School is a resource for this aspect. Successful mastery of school work will foster the children's sense of self-worth. Equal chances to have good school results, which in turn can help to meet their needs of esteem, are on one hand facilitated by the fact that (basic) education is free and therefore accessible to CHHs. On the other hand, CHHs have different living circumstances to other children (such as more care responsibilities) that makes it more difficult for them to succeed at school. The Department of Social Development describes a program within the Department of Social Development to train orphans to become an auxiliary

social worker. According to them this can fulfil the need of esteem for members of CHHs. None of the members of CHHs interviewed in this research has followed this program. The social clubs, church and friends are an important resource for the feeling of acceptance by others, which is an important aspect of esteem as well. About half of the participants in this research mentioned this.

Self-actualization is a process to become actualized in what he is potentially. This is an ongoing process to be fulfilled during someone's entire life. An important resource to meet self-actualization is time to develop talents. As described above, and in accordance with the theory of Maslow, children in CHHs are often too busy with the fulfilment of their basic needs (consisting of the first three layers of the theory of Maslow) meaning they are not focused on their talents and how they can develop these talents. This is also the case for the layer of esteem. Ndlovu Care Group can be a resource in this process of self-actualization by identifying talents of vulnerable children and giving them the opportunity to develop those talents, for example in the Ndlovu Care Group Choir and the sports programs. The Department of Social Development thinks the members of a CHH can not accomplish their full potential because they are stuck in their basic needs. Especially dropping out of school is a big obstacle for members of the CHHs to accomplish their full potential, according to the Department of Social Development. In this research dropping out of school was not an issue for the CHHs because only one of the respondents dropped out of school.

Conclusions

In this paragraph the results will be fed back to the literature and discussed. After this a reflection of the research will be given including the limitations and strengths of this research. Finally some recommendations will be given. In the first place for Ndlovu Care Group, and in the second place for future research concerning the topic of CHHs.

Demographic characteristics

In the literature, CHHs are households where the parents died or are too ill to take care of them (Philips, 2011). As found in this research the parents are not always dead or very ill. A lot of fathers for example were alive but just "disappeared" out of the children's life. Only some of the CHHs we have interviewed were double orphans, so children of whom both the father and the mother died.

In the literature, CHHs are very vulnerable and this might result in the lack of going to school (Philips, 2011). This is something remarkable that was not found in this research. Almost all of the children in this research were going to school.

Head of the household

In the literature there are two main reasons why a child becomes the head of a CHH. The first one is that it is mostly the oldest children in a household that suffered loss of parents that assume the care-taking role. The households continue to exist with (most of the time) the oldest child or children taking over the responsibilities of the parent (Philips, 2011). The second one is that due to gender-based discrimination, girl children are most likely to take care of a terminally ill parent or family member as well as of the household (Ministry of Social Development, 2010). In the data of this research we found confirmation of the first theory; it was only a matter of age that made someone the head of the household. There were some gender based differences in the household tasks though, but this has got nothing to do with who becomes the head of the household.

Child Headed Households and the theory of Maslow

Maslow (1970) stated that individuals have needs (basic to their existence) and that these needs

are prioritized in a certain hierarchy. The needs defined by Maslow are from the lowest level of needs (the most basic needs) to the highest level, these include physiological needs, safety needs, social needs, esteem needs, and self-actualization. A key aspect of the theory is the hierarchical nature of the needs. The lower the needs in the hierarchy, the more fundamental they are and the more a person will tend to abandon the higher needs in order to pay attention to sufficiently meeting the lower needs. That means that first the primary needs have to be satisfied before an individual can start to work on the needs higher up in the hierarchy (Walsh, 2011). This aspect is also reflected in the data. For the CHHs it is clear that they do not meet all their first level, physiological, needs. They experience a lack of food and clothes and income. The needs of the second layer, safety, are met even more poorly than the needs of the first layer. Because they are focused on those basic things they do not focus on needs higher up the hierarchy of the pyramid of Maslow. This can also be seen in the answers given to the question "what would you wish for if you could wish for anything in the world?". The answers to this question always consisted of needs and wants at the lower two levels. The most frequent given answers were food, clothes and a better house. They were still focused on the lower layers of the pyramid because those layers are not met yet. The results of this research fit the theory of Maslow perfectly concerning this aspect.

The results of the second layer, safety are remarkable. They do have a shelter, but the conditions of these shelters are bad and with that the safety of the CHHs in their own house. Still half of the CHHs interviewed feels save in their environment. If they do not feel safe in the environment, the main reason for this is thieves. The issue of sexual abuse has only been mentioned twice in our research.

The results of the third layer, social needs, are striking with the theory of Maslow. Prince and Howard (2002) describe that the most important persons for fulfilment of the social needs for children are their parents. For the CHHs these parents are not there any more, for whatever reason, for the fulfilment of the social needs of the members of the CHHs. Because of this it is a logical consequence that they do not meet their social needs. However, it is not the case that they do not meet any social needs. They still have their siblings and other members of the CHHs and as stated before, school is very important to them including the friends they have at school. The social clubs are to some of them important as well, also because of the friends they have at the social clubs.

The fourth and fifth layers of the pyramid of Maslow, esteem and self-actualization, are very difficult to investigate in itself. As mentioned above the theory of Maslow fits this research very well. Meaning that the CHHs are stuck in the first two layers of the pyramid of Maslow because they do not meet those first needs. That is why they are not focused on other needs.

That is also reflected in the data. The participants are simply not focused on these higher needs. Especially the fifth layer is a process which continues over a person's lifespan. The participants were still quite young for this process.

Reflection

Although this research has been done with the best intentions, there are some limitations to this research. In the first place the sample of the CHHs interviewed for this research is created by a list made by an employee of Ndlovu Care Group. This means that the families on this list were already known by Ndlovu Care Group, which in turn means that they already received some kind of support from Ndlovu Care Group. The substantial support of Ndlovu Care Group will have influence on the needs of the CHHs. There have also been some CHHs which were not found on the list, but via different pathways. These CHHs did not received support from Ndlovu Care Group. This is a bad thing for the internal validity. The internal validity in qualitative research refers to the conduct of the study such that inferences from the data are accurate. That is, the study is conducted in such a way that extraneous factors on events are ruled out in the interpretation of the data. But the influence of the support from Ndlovu Care Group on the needs of the CHHs is not ruled out in this research. A positive effect on the internal validity is the fact that the interviews were standardized as much as possible as well as the procedures. Included are; we asked the questions of all participants in the same way; we put the interviewees at ease by asking a general, easy-to-answer question first; we conducted all interviews in their homes where the individuals felt comfortable; and we ensured the interviewees that their particular answers could not be identified with them. Another issue is the external validity. This research was conducted in the area Elandsdoorn. Ndlovu Care Group has been operating in this township for twenty years already. These twenty years of support have changed the township in total. It may well be so that the basic development of the township Elandsdoorn is higher than the basic development of other rural townships. This makes it hard to generalize the findings of this research to other rural townships. This means that the external validity is not very good either.

Another limitation of this research is the data collection method, for several reasons. In the first place the way of interviewing. As said before, for this research a mix between a focus group and individual interviews was used. The reason for this is the language barrier and to make all the members of the CHH feel at ease (especially smaller children). The older children could make them feel at ease and help to explain some questions to the younger children. The questions were asked individually but in the presence of all the members of the household. It was useful to do it this way because it made participants feel more confident and with that more

open to us. On the other hand this way of interviewing has some limitations. Because they were all sitting together there is a chance that they would give socially desirable answers to some questions. For example the answers to the question whether they felt safe. When all your brothers and sister, for example, would say they feel safe, there is a social peer pressure to give the same answer.

A good thing of the data collection is that we interviewed the CHHs in their own houses. This way we could also observe the living conditions and this way the participants felt more at ease than at another location, for example a Ndlovu Nutrition Unit (NNU). Another asset of doing the interviews at the CHHs own place is that there was a smaller chance that the interview would not proceed. When the participants had to come to, for example, a NNU then less people would show up, or the wrong people would show up. By visiting them we were more in control.

The other limitation of the data collection method is the translation of the interviews. As said before, the life skills facilitators of Ndlovu Care Group acted as translators. They are not professional translators. Some of the information might be lost in translation. Sometimes a participant would give an answer consisting of 'yes' or 'no' and would give the reason why he said 'yes' or 'no'. The life skills facilitators often abbreviate this to a simple 'yes' or 'no' without the explanation. Another limitation of having the life skills facilitator as translators is that they interpret the answers from their own reference framework. For example: a topic of the research is about the sanitation. One question was whether or not the toilet was good enough for the participants. When we asked this question, the life skills facilitator stood up and checked out the toilet himself, came back and said: "Yes, the toilet is good enough". For this interview six life skills facilitators were used with all of them their own references framework. This is not good for the validity because this way we do not investigate the opinion of the toilet of the members of the CHHs, but of the translators. A good thing about having the life skills facilitators as translators is that, although they were no professional translators, they were very well aware of the intentions of this research so they would probably not have left out information that is absolutely important for us. Furthermore they would give us some background information of the CHHs (because they usually had visited the family in advance for making a appointment) and about cultural habits. For example, they taught us that it is more polite to sit down immediately after entering a house than to keep standing.

Another limitation of the data collection is the fact that we had to introduce ourselves as staff of Ndlovu Care Group. Ndlovu Care Group is a phenomenon in Elandsdoorn associated with getting support in any way whatsoever. By interviewing them in the name Ndlovu Care Group, they might have exaggerated their poverty a little bit. This is bad for the validity of this research. On the other hand, we did observe their situation as well. This way we were able to see

their living conditions and we were able to estimate their degree of exaggeration.

In order to secure the reliability of this research as much as possible, all the interviews are recorded with two voice recorders, saved on the computer and typed out. The interviews are also standardized which is good for the reliability. The fact that the whole data collection is done by two individuals is conducive for the reliability. All the interviews were conducted by the two of us and during the data collection we have had constant dialogue about the interpretation of the interviews. This is good for both the reliability and the validity of the research.

Recommendations

Ndlovu Care Group

The biggest recommendation to Ndlovu Care Group is to develop a program for children in order to meet their needs. As said before it is impossible to say whether the results of this research are related to only children of CHHs in Elandsdoorn or to all children in Elandsdoorn, or to a specific group of vulnerable children in Elandsdoorn. On the basis of this study there could be extra attention to the special needs of the members of CHHs. For example the social needs will be different for them because these social needs consist usually of the contact with the parents and for the members of CHHs this contact is absent.

Another recommendation for Ndlovu Care Group is to cooperate with the Department of Social Development and the Home Based Care organizations. Both the Department of Social Development and the Home Based Care organizations can, in principle, fulfil some needs of members of CHHs. If those three organizations can cooperate this will be the best for the child, in the end.

Future research

This research did not have a control-group. A recommendation for future research would be to investigate the needs of children orphans and vulnerable children (OVC) in Elandsdoorn in order to compare the findings of this results with another category. This way an investigation is possible whether or not the results in this research are specific for CHHs. Another interesting control-group to compare with would be 'normal' children. So no vulnerable children and/or orphans and/or CHHs. This way the differences can be made clear between different categories of children and their needs.

This research is still a very broad and exploratory study. In this research all the members of the households were grouped together. For future research, a distinction can be made between

the needs of the head of the household and other members of the household, for example. To find out, whether or not, these different members of the household have different needs. This way one should interview all members of the household individually to obtain some new insights into the needs of all the members of the household individually, which can be compared to each other. This way there might also be a possibility to investigate the taboo issues, because those taboo issues might influence the needs of the children.

Another specification of this research could be on the theory of Maslow. This research focused on all the five layers of the pyramid of Maslow. The fourth and the fifth layer are the least useful to investigate because the needs of the first three layers are not even met. Future research could focus more in depth on these first three layers in order to obtain more in depth information of the needs of these layers.

Picture 2. Doing an interview with a CHH living in a one-room house

References

Besselaar, P. van den, & Heimeriks, G. (2001). Disciplinary, multidisciplinary, interdisciplinary: Concepts and indicators. *Social Science Informatics Program,* The Netherlands: University of Amsterdam.

Boeije, H. (2005). *Analyseren in kwalitatief onderzoek: Denken en doen.* Amsterdam: Boomonderwijs.

Bongaarts, J. (2001). Household size and composition in the developing world in the 1990s. *Population Studies*. 55: 263-279.

Camfield, L., & Guillen-Royo, M. (2010). Wants, needs and satisfaction: A comparative study in Thailand and Bangladesh. *Social Indicators Research,* 96: 183-203

Campbell, R.L., Eisner, S., & Riggs, N. (2010). Sources of self-esteem: From theory to measurement and back again. *Department of Psychology,* 28: 338-349

Dunn, A. (2005). *HIV/AIDS: What about very young children?* Working Paper 35. Bernard van Leer Foundation, The Hague, The Netherlands.

Elton, L. (1996). Strategies to enhance student motivation: A conceptual analysis. *Studies in Higher Education,* 21: 57-67.

Germann, S.E. (2005). *An Exploratory Study Of Quality Of Life And Coping Strategies Of Orphans Living In Child-Headed Households In An Urban High HIV-Prevalent Community In Zimbabwe, Southern Africa.* (Unpublished doctoral dissertation) South Africa: University of South Africa.

Government of the Republic of South-Africa. (1997). National Youth Policy.

Harper, F.D., Harper, J.A., & Stills, A.B. (2003). Counseling children in crisis based on Maslow's hierarchy of basic needs. *International Journal for the Advancement of Counseling,* 25: 11-25

Harper, F.D., & Stone, W.O. (1999). Transcendent counseling (TC): A theoretical approach for the year 2000 and beyond. In J. McFadden (Ed.), *Transcultural Counseling: Bridging Cultures* (83-108), (2nd ed.). Alexandria, VA: American Counseling Association Press.

Harper, F.D., & Stone, W.O. (2003). Transcendent counseling: An existential, cognitive-behavioral theory. In F. D. Harper & J. McFadden, J. (Eds.), *Culture and counseling: New approaches* (233-251). Boston, MA: Allyn and Bacon.

Harter, S. (1999). *The Construction Of The Self: A Developmental Perspective.* New York: Guilford Press.

Helping AIDS orphans in child-headed households in Uganda (2005).

Knijn, T. (2004). Family Solidarity and Social Solidarity: Substitutes or Complements? In Knijn, T.&Komter, A. (Eds) *Solidarity between the sexes and the generations: transformations in Europe.* (18-31). Northampton: Edward Elgar Publishing.

Kossoudji, S., & Mueller, E. (1983). The economic and demographic stams of female-headed households in rural Botswana. *Economic Development and Cultural Change*, 31: 831 -859.

Loening-Voysey, H., & Wilson, T. (2001). Approaches to caring for children orphaned by aids and other vulnerable children: Essential elements for a quality service. Republic of South Africa.

Maslow, A.H. (1970). *Motivation and personality* (2nd ed.). New York: Harper and Row.

Meintjes, H., Hall, K., Marera, D., & Boulle, A. (2010). Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa, *AIDS Care*, 22: 40-49.

Mellor, D., Stokes, M., Firth, L., Hayashi, Y., & Cummins, R. (2008). Need for belonging, relationship satisfaction, loneliness, and life satisfaction. *Personality And Individual Differences,* 45: 213-218

Ministry of Social Development (2010). National guidelines for statutory services to child-headed households. Republic of South Africa.

Philips, C. (2011). *Child-headed households: a feasible way forward, or an infringement of children's right to alternative care?* (Unpublished doctoral dissertation) The Netherlands: Leiden University.

Prince, D.L., & Howard, E.M. (2002). Children and their basic needs. *Early Childhood Education Journal,* 30: 27-31

South African Department of Social Development. (2009). *National Action Plan for Orphans and other children made vulnerable by HIV and AIDS in South Africa 2009-2012*. Retrieved from http://www.cindi.org.za/files/nap_2009-2012_v8_final.pdf

Statistics South Africa (1999). *October Household Survey.* Pretoria: Statistics South Africa.

Sumerlin, J.R., & Bundrick, C.M. (1996). Brief index of self-actualization: A measure of Maslow's model. *Journal of Sociat Behavior and Personality,* 11: 253-271.

Tempelman, H., Slabbert, M., Gosling, A., & Vermeer, A. (2010) *A Model For Integrated Health, Child And Community Care In Rural South Africa.* Amsterdam: VU University Press.

United Nations (2010). *Guidelines for the alternative care of children.*.

Veenhoven, R. (2002). Why social policy needs subjective indicators, *Social Indicators Research,* 58: 33-45.

Walsh, P. (2011). Creating a ''values'' chain for sustainable development in developing nations: where Maslow meets Porter. *Environment, Development and Sustainability*, 13: 789–805.

World Bank (1991). *Gender and Poverty in India.* The World Bank, Washington, DC.

http://www.ndlovucaregroup.co.za.

Appendices

Appendix 1: Topic list interviews Child Headed Households

Simone Wassink & Angela van Dril

- **Introduction**

- Aim of the interview
- Informed consent form
- Demographic characteristics

- **Physiological needs**

- Can you tell us what your day was like today?
- Do you have breakfast/lunch and dinner every day?
  If not > is this sufficient, what would you like
- Who makes sure there is food and how do you do this?
- Do you have enough clothes for everybody (for every season)?
  If not > What do you need, what would you like
- Who provides the clothes for you and how often do you get new clothes?
- Do you have a good shelter to live in? How many beds do you have?
  If not > What do you need, what would like?
- Do you have a toilet/bath?
  If not > What do you need, what would like?
- Who takes care of you when you are sick?
- If you are sick, can you afford to go to a doctor or to the clinic?

- **Material resources**

- Can you tell something about where you get money from to pay for clothes, food and other things you need?
- Who of you does have a job?
  If not>
- Would you like to have a job?
- Have you ever been looking for a job? Why did you not find a job?
  If yes>
- How did you get this job?
- what kind of job do you have?
- Is your job sufficient to earn money to take care of the family?
- Do you do any other activity for yourself (like selling fruit or piece jobs) to earn money?)
- Are there any other sources you get money from (grants, family, community, church)?

- **Grants**

- Do you know what a child support Grant is?
- Who of you receive a child support Grant?
- Who organized that you receive this Grant? (Ndlovu, social work, Home Based Care)

- Was is easy to get this grant?
  If not:
- Did you choose not to apply (and why?)
- If you did apply: what made you did not receive the grant?
- What could help you to apply for a grant?

- **Safety needs**
- Do you feel safe in this house, do you feel safe to go to sleep?
- Do you feel safe in your community, do you feel safe to go on the street?
- Who is taking care of your safety?
- To whom do you go to if you do not feel safe?
- What are the things that make you feel unsafe?
- Which things help you to feel safe, do you miss something in that?
- Which dangers are you scared off?
- Are you scared people will try to hurt you?
- Did that happen before? And in what way?
- Who do you go to for help in these cases?

- **Social needs + social resources**
- Who is the most important person in your life? Why?
- What other people do you know who are important for you?
- (neighbor, family, friends, teacher, social worker, boyfriend/girlfriend)
- Are any of these people supporting you?
- What does this support involve? (material, emotional, giving advice)
- Do you ever go to one of those people if you need help, advice of something else? (why/why not?)
- Do they come to you on their own initiative to ask if you need anything or to see if you're OK?

- Are there any family members supporting you?
- Do you ask your family for help rather than other people?

- Do you feel dependent of other persons? In what way?
- Do you mind to ask for help?
- Do you mind if other people know you need help or have problems?
- *If yes>*
- What are you afraid of if people know you have problems?
- What kind of help from other people would you like in your life?
- Do you feel different then other children as you are living in a CHH?
- Do you feel you are treated different then other children (for example by teacher, classmates, community, neighbors).
- What changed most in your life since your parents died?

- **Community resources**
- Who of you go to school?
  If not:
- What is the reason you do not go to school?

- Would you like to go to school?

- How often do you go to school?
- Did you report at school you live without parents? (Why/ Why not?)
- Do you get any extra support of your teacher? (extra attention, assigning to social workt etc.)

- Do you have friends at school?
- Do you see them after school (playing)?
- Are friends important for you? (Why/why not?)

- Do you do any activities outside school or work?
- Are you member of any organization? (Church, Ndlovu, School) and is this important for you?
- Do you receive any support from these organizations (and what?)

- Do you feel like being part of the community? In what way? Is that important to you?
- Do you receive any support from the community? (what kind of support?)

- **Social work and Home Based Care**

- Do you have an official adult supervisor or guardian? (who for example organizes grants, money for food etc.)
- Do you have any contact with the social workers or Home Based Care?
  If yes >
- Can you describe what they do for you to support you? (+how often?)
- Is the social worker/ home based care helpful for you? Can she organize things you can not organize yourself?
  If not>
- Did you try to get any contact with them? (why/why not?)
- Do you think contact with a social worker would have added value for you?
- What would you hope a social worker could do for you?

- **Esteem + resilience**

- What do you think goes very well in your household? (Enough food, good clothes, going to school, having fun, being independent, live together)
- Do you feel useless at times?
- When was the last time you were very happy? And why?
- When was the last time you were very sad? And why?

- What makes that you can manage to run this household?
- What are you proud of in your household?
- Why do you think this goes so well?
- How did you achieve this?

- What would you like to go better in your household?
- When would you be satisfied with the way you run the household?
- What do you think you need to achieve this?

- What would you like to achieve in the next week? (What has to happen to say you had a good week?)
- What would you like to achieve in the next year? (What has to happen to say you had a good year?)

- **Self actualization**

- What are your dreams for the future?
- What do you think your future will look like?
- What do you think your talents are?
- Do you have opportunities to develop talent your talent?
- Do you think you developed some talents already?
- When you wish upon a star, what would you wish for?

- **Nldovu**

- As we told we do this research for Ndlovu. What would be your advice to them how they could help CHH best?

Appendix 2: Topic list interviews social workers and supervisor

Simone Wassink & Angela van Dril

- **Introduction**
- Aim of the interview
- Informed consent form
- Can you describe what SD does to support CHHs?
- Can you describe what your task is regarding CHHs?
- How are CHHs reported to you? (outreaching?)
- Can you give some specific examples of support you give to children living in CHHs?

- **Perception of needs of CHH**
- How do you assess the needs of CHHs?
- What do you think are the needs of CHHs?
  - food
  - water
  - clothes
  - income
  - shelter
  - safety (house, community)
  - connection with community / family (stigmatized?)
  - do you think they are aware of their own good qualities?
  - do you think they are satisfied with their lives?
  - do you think they have the opportunity to develop talent?
  - future perspectives
  - getting the best out of life
- What needs are most urgent in your opinion?
- Can you describe what are specific needs of CHHs compared to other vulnerable children?
- Do you think CHHs in Dennilton have special needs compared to CHH in other areas?

- **Perception of resources of CHHs**
- What are the most important resources to fulfill the needs of CHHs in your opinion before you come in?
- What resources of help do you find in the community/family for CHHs?
- Do you think CHHs receive support from school, church, social clubs etc.?
- What do you think are barriers in the community/family to help CHHs? (stigmatization, abandoning)
- What important sources of help do children receive from the state?
- What do you think are barriers to get access to these resources? (lack of knowledge, no ID's)
- What material resources do you think they have? (piece jobs, jobs)
- What do you think are strengths of CHHs themselves, what is going well in these households?
- Do you think CHHs in Dennilton have special resources compared to CHHs in other areas?

- **Resources provided by Social Work**

- Do you assign the children to an official adult supervisor or guardian?
- Can you organize things for CHHs they can not organize themselves?
- What do you consider as the most ideal way to support CHHs and why?

- **Nldovu**

- How do you see the role of Ndlovu in supporting CHHs?
- Do you see any kind of cooperation between Ndlovu (and you) desirable? (and in what way)

Appendix 3: Topic list staff Ndlovu Care Group

Simone Wassink & Angela van Dril

- **Introduction**
- Aim of the interview
- Informed consent form
- Why does Ndlovu consider CHHs as a relevant topic?
- Do you think CHH in Denillton have special characteristics compared to CHHs in other areas?

- **Perception of needs of CHH**
- What do you think are the needs of CHHs on:
  - food / clothes and shelter
  - safety
  - love/belongingness
  - self-esteem
  - self-actualization

- What do you think are the most urgent needs of CHHs?
- To what amount do you think these needs are already fulfilled?
- Do you think CHH in Dennilton have special needs compared to CHHs in other areas?

- **Perception of resources of CHHs**
- What are in your opinion the most important resources for supporting CHHs at this moment?
- What do you consider as the most important resources for CHHs to fulfill their needs? (state, market, family, community). For sustainable help.
- What do you think are barriers for access to these resources at the moment?
- How do you think these resources can be activated?
- What kind of resources would you like the CHHs to receive from Ndlovu?
- Do you think CHHs in Dennilton have special resources compared to CHHs in other areas?
- What do you think are strengths of CHHs?
- Do you see options to use the strengths (resiliency) of the CHHs themselves?
- What do you think CHHs themselves consider as the best way to support them?

- **Perception of support to be provided by Ndlovu.**
- What do you consider as Ndlovu's task concerning CHHs?
- Why do you consider support to CHHs as a task for Ndlovu?
- What do you see as Ndlovu's responsibility for CHHs and what as the responsibility of social work?
- How do you see the collaboration with social work?
- How does support on CHHs fit in the vision of Ndlovu?
- What kind of program would you consider as most helpful for CHHs and why?
- What kind of programs did Ndlvou have for OVC in the past? And where were they based on? And why did these stopped?

- Did you think these programs were helpful for the Orphans and Vulnerable Children (OVC), and CHHs in special?
- Do you think CHHs need(ed) specific programs and why?

- **Future perspective of Ndlovu**
- Can you describe what you think Ndlovu should do to support CHHs in the future?
- Are you actively looking out for CHHs?
- Are you planning to make new policies on CHHs in the future (and what kind)?
- In what way do you think our research can be useful for Ndlovu?
- How do you see the role of other actors (Social Development, Home Based Care) in the future?
- Do you see any kind of cooperation between them (and you) desirable?

Appendix 4: Demographic characteristics Child Headed Households

Date of interview	
Respondent Number	
Name	
Gender	O Male O Female
Date of Birth	
Higest education	O None O Primary O Secondary O Vocational
Number of Brothers	
Number of Sisters	
Father	O Disappeared O Living in other city O Died ……. (year) O Abandoned children O Other reason ……
Mother	O Disappeared O Living in other city O Died ……. (year) O Abandoned children O Other reason ……
Grandparents alive?	O Grandmother O Grandfather O Both alive O Both died
Living area	
Name school	

Appendix 5: Need to belong scale

Need to Belong Scale

(Leary, Kelly, Cottrell, & Schreindorfer, 2005)

Instructions: For each of the statements below, indicate the degree to which you agree or disagree with the statement by writing a number in the space beside the question using the scale below:

1 = Strongly disagree
2 = Moderately disagree
3 = Neither agree nor disagree
4 = Moderately agree
5 = Strongly agree

_____ 1. If other people don't seem to accept me, I don't let it bother me.

_____ 2. I try hard not to do things that will make other people avoid or reject me.

_____ 3. I seldom worry about whether other people care about me.

_____ 4. I need to feel that there are people I can turn to in times of need.

_____ 5. I want other people to accept me.

_____ 6. I do not like being alone.

_____ 7. Being apart from my friends for long periods of time does not bother me.

_____ 8. I have a strong need to belong.

_____ 9. It bothers me a great deal when I am not included in other people's plans.

____ 10. My feelings are easily hurt when I feel that others do not accept me.

Appendix 6: Self-esteem scale Rosenberg

Rosenberg Self-Esteem Scale
The scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State. Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.*	At times, I think I am no good at all.	SA	A	D	SD
3.	I feel that I have a number of good qualities.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.*	I feel I do not have much to be proud of.	SA	A	D	SD
6.*	I certainly feel useless at times.	SA	A	D	SD
7.	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.*	I wish I could have more respect for myself.	SA	A	D	SD
9.*	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self esteem.